

CareManagement

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As employers seek to mitigate the impact of the cost and duration of workers' compensation cases, companies are increasingly using integrated solutions to improve employee health and productivity. A key component is early intervention by a skilled clinical professional—a professional case manager. Case managers, particularly those who are board certified, have the requisite knowledge, skills, and expertise to act in a care coordination role to ensure access to the right care and treatment at the optimal time, in pursuit of desired outcomes, especially a successful return to work.

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Gary S. Wolfe

Meeting Patients' Mental Health Needs

Research shows that mental illness and substance use is common in the United States. Mental illness, which includes autism spectrum disorders, depression, anxiety, posttraumatic stress disorders, bipolar disorders, obsessive-compulsive disorders, schizophrenia, attention deficit disorders, eating disorders, and personality disorders, is one of the most important causes of suicide. The most common mental disorders are anxiety and depression. The burden of mental health in the United States is among the highest of all diseases, and mental disorders are among the most common causes of disability.

Mental illnesses are among the most common health conditions in the United States:

- More than 50% will be diagnosed with a mental illness or disorder in their lifetime.
- 1 in 5 will experience mental illness in a given year.
- 1 in 5 children, either currently or at some point in their life, have had a seriously debilitating mental illness.
- 1 in 25 American lives with a serious mental illness such as schizophrenia, bipolar disorder, or major depression.
- It is not uncommon for an individual to have more than one mental disorder.
- Many experiencing a mental health condition report an unmet need.

Mental health is essential to a person's well-being, healthy life, interpersonal relationships, and the ability to lead a full and productive life. Individuals, including children and adolescents,

with untreated mental health disorders are at high risk for unhealthy and unsafe behaviors, including alcohol and substance use, violent and self-destructive behavior, and suicide. Mental health problems can affect thinking, mood, behavior, and physical health. Many factors contribute to mental health problems:

- Biological factors such as genes or brain chemistry
- Life experiences such trauma or abuse
- Family history of mental health problems
- Having few friends
- Use of alcohol and/or recreational drugs
- Feeling of loneliness and isolation

Positive mental health allows a person to realize their full potential, to cope with the stresses of life, to be productive at work, and to make meaningful contributions to society.

Mental health disorders have a significant impact on physical health and are associated with the prevalence, progression, and outcome of some common chronic diseases such as diabetes, heart disease, and cancer. Mental health disorders can have harmful and long-lasting effects including psychological and economic—not only for people living with the disorder but for family, friends, the workplace, and communities.

There are many ways to maintain positive mental health: seek a professional when needed, connect with others, stay positive, be physically active, help others, get enough sleep, and

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Board Certification Leads to Salary Increases for Case Managers

Vivian Campagna, MSN, RN-BC, CCM

Across the care continuum, board-certified case managers are increasingly recognized for their contribution—including with higher compensation. A recent [survey](#) of Certified Case Managers® (CCMs) by the Commission for Case Manager Certification offers insights into who board-certified case managers are and how they are rewarded.

Some key findings from the survey include:

- Most (98%) CCMs have specialty experience in areas such as hospital case management, managed care, and care transitions.
- The median annual salary for board-certified case managers has increased since 2017, averaging between \$80,000 and \$85,000. This is well above the median pay for registered nurses and social workers, 2 of the most common professional backgrounds for board-certified case managers.

Vivian Campagna, MSN, RN-BC, CCM, is the chief industry relations officer for the Commission for Case Manager Certification, the first and largest nationally accredited organization that certifies more than 45,000 professional case managers and over 2,600 disability management specialists. Vivian has been involved in case management for more than 25 years, holding staff and administrative positions on both the independent and acute care side of the industry.

- Managers, executives, and staff have consistent salary increases. More than half of CCMs who hold executive positions earn more than \$100,000 annually.
- CCMs who are supervisors strongly recommend the credential (99% support), and 75% prefer or require certification when hiring.

The median annual salary for board-certified case managers has increased since 2017, averaging between \$80,000 and \$85,000. This is well above the median pay for registered nurses and social workers, 2 of the most common professional backgrounds for board-certified case managers.

Supporting the Case Management Practice

With an increasing demand for a well-trained workforce in health and human services, case managers are supporting lifelong learning as well as the pursuit of certification. Case managers need to be ready to address health care challenges across the community, not just in a hospital setting. As the largest and oldest nationally accredited organization that certifies case managers, the Commission is taking the lead in this area. In this regard, certification is crucial to consumer protection.

The Commission also seeks to improve and support quality and consistency in case management practice. It pursues these goals through the

combination of the CCM research-based examination, the requirement that all board-certified case managers adhere to the Code of Professional Conduct, and lifelong learning and professional development for recertification. By setting a high standard for achieving and maintaining certification, the Commission believes that

board-certified CCMs can showcase their expertise and adherence to the highest professional and ethical standards. In the same way, employers of case managers can be assured of the expertise and professional integrity of those who hold and maintain certification.

Case managers come from a variety of professional disciplines, including nursing, social work, rehabilitation, counseling, and mental health. To further professional diversity in the case management field, the Commission is working with other organizations to highlight how case management practice can enhance career development for health and human services professionals. For example, the Commission's collaboration with the [National Association of Social Workers](#) encourages more social workers to pursue board certification.

Board certification makes a difference in the case manager's career, as higher salaries for certification attests. But where value is really measured is in the difference case managers make in patient experience and the outcomes achieved. **CM**



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Disability Management and the Care Continuum

Stan Scioscia, M.Ed, CDMS

In the 3 years since the Certified Disability Management Specialist (CDMS) credential came under the umbrella of the Commission for Case Manager Certification (CCMC), we have amplified the role of disability management as part of the care continuum.

CDMS certificants demonstrate a level of competency across 4 identified practice areas. Together, these areas encompass both ill and/or injured employees who need accommodations and job modifications to return to work and employers who need to preserve human capital while mitigating the cost and impact of disability. The 4 areas are:

- **Accommodation and Disability Case Management.** This is a case management function, providing the services and interventions needed

Stan Scioscia, M.Ed, CDMS, has had a long career in disability and absence management, working for insurers. He is a Commissioner of the Commission for Case Manager Certification (CCMC), the first and largest nationally accredited organization that certifies more than 45,000 professional case managers and over 2,600 disability management specialists. The Commission is a nonprofit volunteer organization that oversees the process of case manager certification with its CCM® credential and the process of disability management specialist certification with its CDMS® credential.

to keep the employee at work or, if time away is needed, to assist the individual and his/her employer in a return-to-work/stay-at-work strategy.

- **Workplace Intervention for Disability Prevention.** The objective is to prevent the cycle of injury, illness, and related absence.

In this complex world of laws, regulations, and employer policies and programs, CDMSs are key players who have the expertise and knowledge to serve both employers and employees. As certified professionals, disability managers can navigate the complexity of legal compliance while reducing the cost and impact of disability on employers and also advocating for employees to facilitate their return to work.

- **Program Development, Management, and Evaluation.** Early intervention and stay-at-work and return-to-work programs minimize the impact of disability by enabling people to maintain or resume productivity as soon as medically feasible. Employees continue to heal and recuperate while on the job, often with modified or reduced duties. Metrics are used to evaluate programs effectiveness, such as tracking the frequency and duration of claims, which can be used to advance safety and wellness initiatives. Further, outcomes data are vital to determine adequate service levels, quality improvement, and workplace productivity.

- **Employment Leaves and Benefits Administration.** With the passage of the Family & Medical Leave Act of 1993, CDMSs are more engaged in managing leaves and assisting employers to be compliant. Other laws that apply include the Americans with Disabilities

Act (ADA), the ADA Amendments Act (ADAAA), and the Rehabilitation Act of 1973 (Rehab Act). State laws also apply, such as California's Fair Employment and Housing Act (FEHA), which is essentially a state version of the ADAAA to protect against discrimination and to preserve access to public and private sector jobs as well as housing and education.

Under current law, disability is broadly defined as a physical or mental impairment that substantially limits 1 or more major life activities; having a record of a substantially limiting impairment; or being regarded as having a disability. This broad definition is significant because it has changed the way employers must address disability. Limitations no longer need to be severe or significant to be considered "substantially limiting." Major life activities include bodily functions; furthermore, only 1 major life activity needs to be substantially limited to meet the

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Insights from Case Managers— Palliative Care

Jacquelyn M. Woodworth, MBA, RRT, CCM

Over the last decade, acute and long-term health care facilities have developed palliative care services. However, the concept of hospice care and palliative care remains under scrutiny in many settings and cultures. In the late 1950s, Dr. Cicely Saunders articulated her ideas about modern hospice care.¹ She observed dying patients and advocated for methods to relieve the dying person's pain in their home setting, which is currently the foundation of palliative care. In the 1960s, the release of the book *On Death and Dying* by the US psychiatrist Elisabeth Kübler-Ross provoked change. The book emphasized the importance of medical honesty with the patient to foster acceptance by all involved, addressing spiritual needs and providing comfort care for the dying patient. The concept was treated with opposition at the time because there were strong social and medical paradigms surrounding death. The book raised awareness about the natural process of decline, death, and the role of medical professionals in treating patients

Jacquelyn Woodworth MBA, RRT, CCMC, has expertise in complex ventilator care management, acute hospital care, and department management. She is currently working to improve care transitions in partnership with contracting insurance organizations and acute care hospitals.

who are dying. It revolutionized the standards at that time regarding death, dying, patient care, and family relationships.

Dr. Balfour Mount, a surgical oncologist in Montreal, Canada, is credited with popularizing the term “palliative care” in 1974. This term “palliative care” was used because the term “hos-

Case managers know that hospice care offers many benefits and resources for patients including wonderful care and pain management. Furthermore, hospice care is a legitimate professional specialty service generally covered by insurance as a valuable benefit. Among other services, hospice organizations often provide follow-up grief support.

pice” had a nonmedical meaning in the French-speaking world. Even today, patients and families don't want to hear the term “hospice.” Most people are still in the denial about impending death even when confronted with the reality that loved ones are no longer physically able to continue living. They often need time and education to understand that the body is wearing out from illness. People digest this tragic reality and understand it in different ways and on different time schedules.

There are now current improved care options for patients at the end of life. In 2004, Palliative Care Clinical Practice Guidelines were released by the National Institutes of Health that also included guidelines for other chronic or life-limiting illnesses.

Fellowship programs for palliative care were developed for physicians. The American Board of Medical Specialties offered certification in hospice and palliative care medicine for the first time in 2008. Palliative care physicians now work with interdisciplinary teams, provide hospital consultations, and have private practices. The culture is changing; patients want improved quality of life and pain management for life-limiting illnesses.

Case managers know that hospice care offers many benefits and resources for patients including wonderful care and pain management. Furthermore, hospice care is a legitimate pro-

fessional specialty service generally covered by insurance as a valuable benefit. Among other services, hospice organizations often provide follow-up grief support. Families often have difficulty understanding the benefits of palliative care during hospice for family members with a poor prognosis or chronic debilitating condition. An evaluation from the hospice liaison or palliative care medical provider helps patients understand their options and provides them with empowering information. Patients and family members should be encouraged to understand their options for hospice so that they can choose their preferred services and make educated decisions.

Palliative care services are also

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What Providers Should Do About Denials From Medicare Advantage Plans

By Elizabeth Hogue, Esq.

According to a Report from the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) entitled “Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials,” published on September 27, 2018, Medicare Advantage Plans cover more than 20 million beneficiaries in 2018. The large number of beneficiaries now covered by Medicare Advantage Plans and the capitated payment model used to pay Medicare Advantage Plans caused the OIG to be concerned about whether Medicare Advantage Plans were denying care inappropriately in order to make more money.

With regard to the capitated model of payment, a significant concern, according to the OIG, is the potential incentive the model creates for Plans to inappropriately deny access to services and payment in order to increase their profits. Plans that deny authorization of services for beneficiaries or payments to health care providers may contribute to physical or financial harm. Such denials also misuse monies that the Centers for Medicare & Medicaid Services (CMS) paid Plans for beneficiaries’ health

care. Even low rates of inappropriately denied services or payments can create significant problems for many Medicare beneficiaries and providers.

The OIG is preachin’ to the choir here! Many providers have experienced wholesale denials of payment in recent years. So, what should providers do?

As described in the report referenced above, the OIG found that when beneficiaries and providers

The Office of Inspector General found that when beneficiaries and providers appeal preauthorization and payment denials, Medicare Advantage Plans overturned 75% of their denials during the period 2014–2016. In fact, the Plans reversed approximately 216,000 denials in each of these years.

appeal preauthorization and payment denials, Medicare Advantage Plans overturned 75% of their denials during the period 2014-2016. In fact, the Plans reversed approximately 216,000 denials in each of these years. During the same period, independent reviewers at higher levels of the appeals process overturned additional denials in favor of beneficiaries and providers.

The OIG expressed concern about the high number of overturned denials in its Report. The OIG says that it raises concerns that beneficiaries and providers were initially denied services and payments that should have been rendered. The OIG was especially concerned because beneficiaries and providers rarely use the appeals process that is specifically designed to ensure access to care and payment. In

fact, during 2014-2016, beneficiaries and providers appealed only 1% of denials to the first level of appeal.

According to the OIG, audits by CMS also reveal widespread and persistent problems with Medicare Advantage Plans related to denials of care and payment. In 2015, for example, CMS cited 56% of audited Plans for inappropriate denials. CMS also cited 45% of Plans for sending denial

letters with incomplete or incorrect information, which may inhibit the ability of beneficiaries and providers to file successful appeals. Based on these audits, CMS took enforcement action against some Plans, including imposition of penalties and sanctions.

The OIG urges CMS in its Report to continue to monitor Plans, especially those with extremely high overturn rates and/or low appeal rates. The OIG also urges CMS to address persistent problems related to inappropriate denials and insufficient information in denial letters.

What should providers do? The “name of the game” for denials in the Medicare fee for service or “original” Medicare has always been appeal, appeal, appeal! As the above Report makes clear, the same applies to Medicare Advantage Plans. Both providers and beneficiaries should appeal, appeal, appeal! [CM](#)

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Elizabeth Hogue, Esquire, is an attorney who represents health care providers. She has published 11 books, hundreds of articles, and has spoken at conferences all over the country.

CMSA Task Force for Hospital Case Management

Mary McLaughlin-Davis, DNP, ACNS-BC, NEA-BC, CCM

To address the queries and requests for information received by the Case Management Society of America (CMSA) from hospital case managers across the nation, a task force of notable experts in the field was assembled to explore the current models of hospital case management practice and weigh them against the goals and expectations of our rapidly evolving hospital environment. In the process, the task force intends to provide insights on the overarching theme of care coordination as promulgated by governmental and quasigovernmental entities as well as federal, state, and private payers. The task force also will recommend best practices wherever possible to help hospital leadership embark on the road to transformation.

CMSA has been an organizing force setting the practice direction for the discipline of case management through its representation, advocacy, and education functions. CMSA promotes practice that is evidence based and discourages the use of practices which, though popular or widely accepted, are either not beneficial or are contrary to the Standards of Practice (SoP). While the increasing emphasis on care coordination by providers and payers has opened professional debate regarding the models being used in hospitals today, CMSA intends to clarify its position on hospital case management practice through a forthcoming white paper and urges hospital leaders to seek solutions that more effectively address the needs of our most vulnerable hospitalized patients.

It's no secret that the hospital industry in the midst of

While the increasing emphasis on care coordination by providers and payers has opened professional debate regarding the models being used in hospitals today, CMSA intends to clarify its position on hospital case management practice through a forthcoming white paper and urges hospital leaders to seek solutions that more effectively address the needs of our most vulnerable hospitalized patients.

The task force members from CMSA are:

- Stefani Daniels, MSNA, RN, ACM, CMAC
- Victoria Florentine, BA, RRT, CCM, AE-C
- Linda Edmond, BSMHR, LBSW, LNHA
- Gary L. Morman, DO
- Meggan Eaves, MOTR/L
- Vivian Campagna, MSN, RN-BC, CCM
- Juliet Ugarte Hopkins, MD, CHCQM
- Ellen Fink-Samnick, MSW, ACSW, LCSW, CCM, CRP
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Mary McLaughlin-Davis, DNP, ACNS-BC, NEA-BC, CCM, has been a certified case manager since 1993. She is a clinical nurse specialist for adult health and the senior director for care management for Cleveland Clinic Avon Hospital as well as Immediate Past President of CMSA National.

seismic changes. From the scale of mergers and acquisitions among hospital and nonhospital entities to the expansion of convenient ambulatory services centers, health care systems are under overwhelming pressure to improve patient outcomes and lower costs. Value-based inducements were introduced to incentivize hospital leaders to improve delivery of care processes and promote collaborative interdisciplinary interactions. The traditional private medical practice is waning because medical practices are consolidating and medical homes are created. All these changes are taking place at the speed of light.

To adapt and survive in this new marketplace, hospital leaders are scrambling to take advantage of every bit of institutional talent to make changes that reflect the new reality. As a result, hospital case management in general, and care coordination specifically, have suddenly caught the attention of hospital executives.

According to the Agency for Healthcare Research and Quality (AHRQ), the main goal of care coordination is to meet patients' needs and preferences in the delivery of

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CE I Are Healthcare Professionals Ready to Address Patients' Substance Use and Mental Health Disorders?

Deborah S. Finnell, DNS, CARN-AP, FAAN, and Glenn Albright, PhD

Sixty-five million Americans will experience a mental health or substance use disorder in their lifetime, raising their risk of disease and mortality and increasing healthcare costs.¹

Integrating behavioral health within routine care creates new opportunities for providers to assess every patient's mental health and substance use, intervene appropriately, and connect them to treatment and resources.

A number of evidence-based screening tools can be given verbally, electronically, or by paper questionnaires and can be used to identify the severity of the problem. In turn, providing screening and brief behavioral interventions like motivational interviewing are evidence-based approaches to prevent, reduce, and treat substance use disorder as well as to address mental health concerns such as depression and suicide.^{2,3}

The US Preventive Services Task Force (USPSTF) has endorsed screening and brief intervention (SBI) for adults who are at risk because of alcohol use⁴ or tobacco use.⁵ This set of clinical strategies is applicable to other health conditions and problems for which early detection and timely inter-

use can save over \$4 in future health care costs.⁶ Similarly, team-based care for depression (a condition that affects 1 in 5 Americans and accounts for more than \$200 billion per year in lost earnings),⁷ when integrated in primary care settings, has been found to save up to \$6 for every dollar invested while yielding improved patient outcomes.⁸

This approach is consistent with normalized practice for a broad range of medical conditions: screenings allow for their identification, followed by the development of a col-

laborative plan between provider and patient to address the risks associated with those conditions or behaviors, all at the point of care where the condition is identified.

Implementing SBI may raise concerns about added time in patient visits, reimbursability of services, and initial cost of implementation.⁹ Yet the recent movement toward value-based care, parity legislation, and the high prevalence of opioid use and mortality have brought renewed impetus to arm all healthcare professionals with the skills to address patients' behavioral health in primary and acute care, community health centers, pharmacies, and other settings.

As primary and acute care practitioners are increasingly integrating substance use and mental health into routine care, we sought to answer the following questions:

1. Are healthcare professionals

The findings make it clear that considerable investment in preparing the healthcare professional workforce is needed to address the behavioral health needs of patients.

ventions can be lifesaving. For instance, the USPSTF also recommends screening for depression, providing an accurate diagnosis, effective treatment, and appropriate follow-up.⁴

There are also strong economic indicators for the value of this health promotion and harm reduction approach. Research has shown that every dollar spent on SBI for alcohol

Deborah S. Finnell, DNS, CARN-AP, FAAN, Faculty Consultant, Johns Hopkins School of Nursing, has specialized in mental health and addictions for most of her career. She has had a 30-year tenure in higher education in addition to her professional practice as a registered nurse, psychiatric/mental health clinical nurse specialist, and nurse practitioner. As a fellow in the American Academy of Nursing, Dr. Finnell focuses on mental health and substance use policy-related initiatives.

Glenn Albright, PhD, Cofounder and Director of Research for Kognito, is a clinical psychologist and former chair of the Department of Psychology at Baruch College, City University of New York. His research at Kognito evaluates how game-based health simulations designed to bring about changes in health and mental health behaviors can cost effectively impact large numbers of geographically dispersed people who would benefit the most from such training.

competent in delivering this set of clinical strategies for substance use and mental health?

2. How likely are they to carry out these activities as part of routine care?
3. How many patients do they currently engage in these activities?

The Survey

Between August 2015 and September 2018, Kognito surveyed 676 healthcare professionals from over 50 organizations. Participants completed the survey immediately before enrolling in 1 of the online simulations on substance use and mental health SBI, which was implemented by their organization as a professional development activity. Participation in the activity was not mandatory. Participants were not compensated for taking the survey but were offered 1.5 to 2.0 continuing medical education (CME) credits or continuing nursing education (CNE) credits, depending on their profession. On average, participants had 10.85 years of experience as healthcare professionals.

Survey Highlights

The survey revealed significant gaps in clinicians' assessment of their own skills to identify patients who might benefit from behavioral health services and to collaborate with these patients on accessing treatment.

Below are the survey findings, organized by type of learning outcome:

Competency

See Appendix Question 1

Overall, participants reported feeling largely unprepared to conduct SBI:

- 57% don't feel adequately prepared to screen patients for substance use or mental health disorders or to provide their patients with information about the impact of substance use and mental health.
- 64% don't feel adequately prepared to use motivational interviewing to

enhance their patients' motivation to change their behavior or seek help.

- 62% don't feel adequately prepared to collaborate with their patients to create an action plan.

Behavioral Intent

See Appendix Question 2

Despite lack of preparedness, participants did report a strong likelihood to conduct SBI with patients:

- 84% are likely or very likely to provide substance use or mental health screening, BIs, and referrals to treatment to their patients.

Current Behavior

See Appendix Question 3

Participants were asked how many patients they screened, engaged in BIs, and referred to additional help in the prior 2 months:

- On average, physicians screened 17.6 patients, engaged in BI with 5.6 (32% of those screened) and referred 1.3 (7% of those screened).
- On average, nurses/nurse practitioners screened 8.5 patients, engaged in BI with 4.7 (55% of those screened), and referred 3.5 (41% of those screened).

Need and Demand for SBI Training

Overall, healthcare professionals responding to this survey report not feeling adequately prepared to address the needs of patients with potential substance use and mental health problems. Such lack of preparedness means that patients will go undetected for common behavioral health problems for which screening measures and intervention models exist and can be feasibly administered in most healthcare settings.

Also of concern is that over 60% of healthcare professionals did not feel adequately prepared to engage in motivational conversations with their patients to promote health behavior change, skills that are also relevant in

supporting patients in managing their chronic health and following treatment recommendations.

Less than half of respondents felt adequately prepared to collaborate with patients on treatment plans. The findings make it clear that considerable investment in preparing the healthcare professional workforce is needed to address the behavioral health needs of patients.

Despite their overwhelming lack of preparedness, it is encouraging that over 80% of respondents reported an intent to use these clinical skills with their patients. The level of risk identified through screening should be used to guide the intervention.

The total number of patients for whom the healthcare providers delivered any component of SBI suggests that they are provided to only a fraction of their patients. The absence of data on the total number of patients seen in the past 2 months precluded the ability to calculate the proportion of patients who were screened.

Screening

Despite this, respondents reported fairly small numbers of patients whom they screened in the prior 2 months. This low number is not surprising since a high proportion of providers reported not feeling adequately prepared to do so, though it is not known whether they were working in systems where universal screening was implemented. Further unknown is whether these providers knew what screening entails, whether they were using established screening measures or even knew such measures exist, or whether they were relying on non-evidence-based methods of detection.

Brief Intervention

On average, healthcare providers reported a smaller number of patients who received a BI than those screened.

Systematically referring patients to specialist treatment settings who could otherwise receive a brief intervention and treatment in primary care raises concerns around unnecessary costs and patient burden for specialty care settings.

The level of risk identified through screening should be used to guide the intervention. About 70% of the US population is at low risk due to abstinence or low-risk alcohol consumption. The remaining 30% of the US population falls into at-risk use (25%) or potential alcohol dependence (5%), groups that merit a BI.

What is not known from this survey is whether patients who were engaged in a BI were previously identified by a screening tool to be at a risk level that merits a BI. Providers may have delivered a BI to patients who were not screened or to patients who were screened but did not present harmful use. Further, providers may have different notions of what constitutes a BI or brief motivational counseling.

Some may believe that a BI entails giving advice and lecturing patients about alcohol, as opposed to using a collaborative communication style such as motivational interviewing.

Referral to Treatment

About 5% of the total population require a BI and a referral to a specialist for diagnostic evaluation and treatment. Not known from this survey is whether providers based the decision to refer on the level of risk identified from the screening. These providers referred approximately 25% of the number of patients they screened, more than 5 times what would be expected based on population estimates (and approximately 50% when examining adult patients only). This high rate of referral for additional treatment services may be because providers, as reported above,

do not feel adequately prepared to create an action plan, such as when a referral is indicated.

Some providers may fear upsetting patients or otherwise abdicate their role in addressing substance use as part of primary care and thus believe that referring patients to a specialist is the best approach.¹⁰

Systematically referring patients to specialist treatment settings who could otherwise receive a BI and treatment in primary care raises concerns around unnecessary costs and patient burden for specialty care settings as well as the potential for patients not receiving that treatment because of long wait times or other barriers to accessing specialty care. Since patients appear to expect more discussion about substance use with their healthcare providers,¹⁰ enhancing competency to deliver this set of evidence-based strategies is imperative.

Conclusion

Efforts have been undertaken to incorporate SBI into education for future healthcare providers including medical¹¹ and nursing providers.¹² However, as the integration of this content into curricula has occurred only recently, the healthcare professionals responding to this survey may not have had this advantage. This lack of core education may explain the gap between low preparedness but high willingness to conduct SBI reported in the survey.

At a time when drug overdoses are contributing to a reduction in life expectancy, when alcohol accounts for 1 in every 10 adult deaths in the US,¹³ and depression and suicide rates

continue to rise at an unprecedented rate,¹⁴ there is renewed impetus to treat substance use and mental health like other health conditions. This approach begins with the detection of risk in primary care with calls now to extend to those at risk because of opioid use. That is, primary care providers can be mobilized to reach the millions of Americans with opioid use disorder including identifying patients who are at risk because of opioids and providing evidence-based actions in primary care that can have an immediate life-saving effect.¹⁵

There is also evidence that people with substance use disorders are more willing to enter treatment in a primary care setting than in a specialty setting.¹⁶ For healthcare providers to keep pace with this need, they must have the knowledge and skills to address the needs of patients with behavioral health conditions as part of routine practice and on par with any physical illness. **CE I**

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APPENDIX

Question 1:**Please rate your preparedness to:**

- Screen patients for substance use and mental health disorders
- Engage patients who screen positive in a conversation about substance use and mental health
- Provide information about the impact of substance use and mental health on patients' health
- Use motivational interviewing techniques to enhance patients' motivation to lower their substance use and seek help
- Collaborate with patients to create an action plan
- Schedule a follow-up visit or refer patients to additional support services when needed

Question 2:**How likely are you to conduct substance use or mental health screening, brief interventions, and referrals?**

- Very Unlikely
- Likely
- Unlikely
- Very Likely

Question 3:**In the past two months, approximately how many patients have you:**

- Screened for substance use
- Engaged in brief motivational counseling
- Referred to additional treatment services

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CE II Case Management and Care Coordination: Best-Practice Workplace Solutions

Susan L. Jensen, PhD, RN, CCM, MSCC

Abstract

As employers seek to mitigate the impact of the cost and duration of workers' compensation cases, companies are increasingly using integrated solutions to improve employee health and productivity. A key component is early intervention by a skilled clinical professional—a professional case manager. Case managers, particularly those who are board certified, have the requisite knowledge, skills, and expertise to act in a care coordination role to ensure access to the right care and treatment at the optimal time, in pursuit of desired outcomes, especially a successful return to work. Case managers also take a holistic approach that looks at the entire person, with communication and collaboration skills that build consensus among stakeholders and increases buy-in by the injured employee. Through professional case management services, win/win solutions are pursued to meet the needs of the employee and the employer.

Introduction

Across the care continuum, professional case management is a proven solution to improve quality and efficiency in care delivery. The same holds true in workers' compensation, as employers and insurers seek ways to decrease the impact of direct and indirect costs while promoting employee health, wellness, and productivity. Within this context, the professional case manager, particularly one who is board certified, brings important skills in assessment, evaluation, and care coordination to identify the most appropriate and timely resources at every phase, from diagnosis and treatment to rehabilitation and eventual return to work and beyond.

In this article, we discuss the professional case manager's care coordination role, which includes delivering services to an employee who has become injured on the job or who

has an occupation-related illness or disability. Although workers' compensation, as a state-mandated program, is a specialized area of practice, it falls well within the overall scope of professional case management. Case management is an advanced practice within health and human services, bringing together professionals with diverse backgrounds such as nursing, social work, vocational rehabilitation, and occupational therapy.

Defining Case Management

The delivery of case management and care coordination in a workers' compensation context is encompassed by the overall definition of professional case management, as put forth by the Commission for Case Manager Certification (CCMC). As the first and largest nationally accredited organization that is responsible for board certification of case managers, CCMC has awarded its Certified Case Manager® credential to more than 35,000 case managers since 1992.^{1,2} Case management is defined as a "collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human-services needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes."¹ (Client refers to the individual receiving case management services; in workers' compensation, this person is the injured employee.)

Within employee populations, case management is a proven solution to mitigate the cost and impact of injuries and illnesses, whether occupational cases covered by workers' compensation or nonoccupational cases that fall under short-term disability. With their skills, experience, and expertise, board-certified case managers are able to ensure that employees receive the appropriate care and treatment at the right time while working toward the goal of a safe and timely return to work.

Workers' compensation case management is aligned with the overarching philosophy of case management to facilitate the individual's wellness and autonomy. The case manager provides access to "appropriate providers and resources," while ensuring that care and treatment are safe, effective,

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Case managers, particularly those who are board certified, have the requisite knowledge, skills, and expertise to act in a care coordination role to ensure access to the right care and treatment at the optimal time, in pursuit of desired outcomes, especially a successful return to work.

client-centered, timely, efficient, and equitable. “This approach achieves optimum value and desirable outcomes for all—the clients, their support systems, the providers and the payer.” One can easily recognize these values as being congruent with the typical objectives in workers’ compensation cases of maximum medical improvement and return to work, while reducing the impact of direct and indirect costs on employers.

Early Intervention

As we look at the role of the case manager in a care coordination role, we recognize that a long-standing best practice for managing serious or catastrophic workers’ compensation cases has been early intervention by a professional case manager, usually within the first or second day of the incident. This often involves an in-person visit while the employee is still hospitalized to meet with the individual and/or the family or other support system. Increasingly, particularly among large employers, the value of such early contact with the employee in all workers’ compensation cases is being viewed as a valuable intervention, although cost containment remains a priority.

Early referral to and intervention by a professional case manager contributes to positive outcomes and may keep complex or high-cost claims from escalating further. In addition, through advocacy, the professional case manager builds rapport with the employee that facilitates communication and can help diffuse ill feelings toward an employer, which may mitigate the risk of litigation. Such contact also facilitates the use of care coordination as an integral part of case management to achieve positive clinical, financial, and stakeholder satisfaction outcomes.³

Care Coordination in Workers’ Compensation Cases

Central to the care and treatment plan is care coordination. Across the broader health care spectrum, care coordination is increasingly in the spotlight as a proven means to ensure collaboration and cooperation among several providers and to establish accountability for communication and integration of a comprehensive care plan. The National Quality Forum states that care coordination is particularly

important for patients who see multiple physicians and care providers each year.⁴ While excellent care coordination may very well be the missing link in the healthcare delivery chain, equally important to consider is who provides this service within the overall treatment team. Clinical professionals such as board-certified case managers bring unique expertise to act as care coordinators.

Central to the care coordination process is assessment that looks at the whole person and his/her health issues. Even in workers’ compensation cases, the professional case manager must assess the impact of other health issues that could impact recovery from a workplace injury or illness; for example, the individual who is diabetic may face longer healing from a laceration or surgery.

In addition, research has shown that care coordination as part of professional case management can decrease claim costs by reducing delays in care and transitioning the employee to the right physician to obtain appropriate diagnosis and treatment. Moreover, board-certified case managers have the expertise to provide ongoing monitoring and case evaluation to ensure that medical progress is achieved. If progress is delayed, the case manager, in consultation with the ill or injured worker and the treatment team, recommends changes to the care plan.

Because professional case managers take a holistic view of the individual, care coordination must also take into account the full spectrum of services the injured employee needs to achieve a positive return-to-work outcome. This may involve visits to the workplace, evaluation of workstation, and/or follow up to ensure that physician-approved job modifications support the employee’s successful transition back to work. Thus, the rehabilitation component of case management and care coordination is integral in managing workers’ compensation cases.⁵

In its most recent field research, known as the case manager role and function study, the CCMC identified rehabilitation as one of the knowledge domains in which case managers in general must demonstrate competency to achieve board certification. Specific knowledge requirements within rehabilitation include workers’ compensation, assessment of physical functioning, disability compensation,

Within employee populations, case management is a proven solution to mitigate the cost and impact of injuries and illnesses, whether occupational cases covered by workers' compensation or nonoccupational that fall under short-term disability.

assistive devices, ergonomics, functional capacity evaluation, job analysis, job modifications and accommodations, and vocational aspects of chronic illness and disability.

As the role and function study shows, the professional case manager has broad knowledge of the case management process as it is practiced across the healthcare continuum. In addition, specific knowledge and expertise are more in-depth in certain practice settings to achieve outcomes related to a specific incident or care episode. At all times, though, the professional case manager maintains a holistic perspective that addresses the needs of the injured worker within the context of workers' compensation statutes, while promoting overall health and productivity. Often, health and productivity initiatives fall under the broad umbrella of a workforce management approach known as absence management.

Absence management and return-to-work

Controlling the cost and impact of workers' compensation has been in the spotlight for decades as employers have tried to rein in spiraling costs while reducing the duration of such absences. Today, many employers see workers' compensation as part of a broader workforce management program addressing all unscheduled absences (despite differences in benefits programs), whether they are due to occupational or nonoccupational causes. Depending on the employer, absence management can include workers' compensation, short-term and long-term disability, and even shorter absences covered by paid time off.

Although many large employers offer integrated health and wellness programs, with initiatives to support employees to return to the workplace as quickly as medically feasible after an illness or injury, some companies do not fully recognize the link between health and productivity. As the Centers for Disease Control and Prevention stated, "While employers understand that investing in human capital improves the company bottom line, they are only beginning to understand the impact health has on worker productivity."⁶ As a result, indirect costs of poor health in the workplace, including absenteeism or reduced work output, may be several times higher than direct medical costs. Productivity losses related to personal and family health problems have been estimated at \$1,685 per employee per

year, for a total of \$225.8 billion annually.⁶

At the same time, however, industry research has shown companies that offer initiatives to promote employee health and foster faster recovery and return to work experience lower costs and improved productivity. Given the aging of the population and the increased prevalence of chronic conditions, employers are looking for more ways to effectively promote health while reducing unscheduled absences. Here, professional case management and care coordination will play a larger part to pursue improvements in efficiency and quality of care delivery, while bringing together the right resources in support of employee goals around recovery and, whenever possible, return-to-work.

A standard among workforce management programs, particularly in workers' compensation but increasingly for nonoccupational cases, is return-to-work, which helps ease injured/ill employees back into the workforce, sometimes with modified duties or temporary assignments elsewhere in the company. Such programs allow employees to heal and become work-hardened before they are "100 percent" ready, while treatment and rehabilitation continue, with all work-related activities approved by the treating physician.

Within these initiatives, a professional case manager in a care coordination role acts as a liaison among the stakeholders. While acting as an advocate for the injured employee, the case manager works closely with a multidisciplinary treatment team, including the physician, occupational therapist, physical therapist, nurses, and other clinicians. The injured employee is always at the center, in recognition of the importance of a client-centered care and treatment plan.⁵

Summary

Across the care continuum, case management is highly individualized based on the type of injury or illness involved, the individual's medical status, and the treatment resources needed. A professional case manager who provides care coordination is able to coordinate and facilitate the delivery of the right care and treatment resources at the optimal time in pursuit of desired outcomes. Specific to workers' compensation, professional case management keeps the focus on the individual (the ill/injured employee) and his/her goals around return-to-work, which are also congruent with the

employer's objectives to control the cost of claims and reduce the duration of unscheduled workplace absences.

Given the aging of the population, the prevalence of chronic conditions, and the need for quality and cost-effective outcomes across the healthcare spectrum, including workers' compensation, the professional case manager will likely play an even larger role in the future. As the benefits of early intervention, advocacy for the individual, and emphasis on education and self-care are recognized, workers' compensation stakeholders will turn to the professional board-certified case manager to manage and coordinate the delivery of care and treatment that will truly make a meaningful difference in the lives and health of employees. **CE II**

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PharmaFacts for Case Managers



Spravato™ (esketamine) nasal spray

INDICATIONS AND USAGE

Spravato™ is indicated, in conjunction with an oral antidepressant, for the treatment of treatment-resistant depression (TRD) in adults.

Limitations of Use: Spravato is not approved as an anesthetic agent. The safety and effectiveness of Spravato as an anesthetic agent have not been established.

DOSAGE AND ADMINISTRATION

Important Considerations Prior to Initiating and During Therapy

Spravato must be administered under the direct supervision of a healthcare provider. A treatment session consists of nasal administration of Spravato and postadministration observation under supervision.

Blood Pressure Assessment Before and After Treatment

- Assess blood pressure prior to dosing with Spravato.
- If baseline blood pressure is elevated (e.g., >140 mm Hg systolic, >90 mm Hg diastolic), consider the risks of short-term increases in blood pressure and benefit of Spravato treatment in patients with TRD. Do not administer Spravato if an increase in blood pressure or intracranial pressure poses a serious risk.
- After dosing with Spravato, reassess blood pressure at approximately 40 minutes (which corresponds with the C_{max}) and subsequently as clinically warranted.
- If blood pressure is decreasing and the patient appears clinically stable for at least two hours, the patient may be discharged at the end of the post-dose monitoring period; if not, continue to monitor.

Food and Liquid Intake Recommendations Prior to Administration

Because some patients may experience nausea and vomiting after administration of Spravato, advise patients to avoid food for at least 2 hours before administration and to avoid drinking liquids at least 30 minutes prior to administration.

Nasal Corticosteroid or Nasal Decongestant

Patients who require a nasal corticosteroid or nasal decongestant on a dosing day should administer these medications at least 1 hour before Spravato.

Recommended Dosage

Administer Spravato in conjunction with an oral antidepressant (AD). Dosage adjustments should be made based on efficacy and tolerability. Evidence of therapeutic benefit should be evaluated at the end of the induction phase to determine need for continued treatment.

Recommended Dosage for Spravato

Induction Phase for Adults

Weeks 1 to 4:

Administer twice per week

Day 1 starting dose: 56 mg; Subsequent doses: 56 mg or 84 mg

Maintenance Phase for Adults

Weeks 5 to 8: Administer 56 mg or 84 mg once weekly

Week 9 and after: Administer 56 mg or 84 mg every 2 weeks or once weekly (dosing frequency should be individualized to the least frequent dosing to maintain remission/response).

Administration Instructions

Spravato is for nasal use only. The nasal spray device delivers a total of 28 mg of esketamine. To prevent loss of medication, do not prime the device before use. Use 2 devices (for a 56 mg dose) or 3 devices (for an 84 mg dose), with a 5-minute rest between use of each device.

Post-Administration Observation

During and after Spravato administration at each treatment session, observe the patient for at least 2 hours until the patient is safe to leave. Before Spravato administration, instruct patients not to engage in potentially hazardous activities, such as driving a motor vehicle or operating machinery, until the next day after a restful sleep.

Missed Treatment Session(s)

If a patient misses treatment sessions and there is worsening of depression symptoms, per clinical judgement, consider returning to the patient's previous dosing schedule (i.e., every two weeks to once weekly, weekly to twice weekly).

DOSAGE FORMS AND STRENGTHS

Nasal Spray: 28 mg of esketamine per device. Each nasal spray device delivers two sprays containing a total of 28 mg esketamine.



CONTRAINDICATIONS

Spravato is contraindicated in patients with:

- Aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial, and peripheral arterial vessels) or arteriovenous malformation
- History of intracerebral hemorrhage
- Hypersensitivity to esketamine, ketamine, or any of the excipients

WARNINGS

WARNING: SEDATION; DISSOCIATION; ABUSE AND MISUSE; AND SUICIDAL THOUGHTS AND BEHAVIORS

Sedation

- Patients are at risk for sedation after administration of Spravato.

Dissociation

- Patients are at risk for dissociative or perceptual changes after administration of Spravato.

Because of the risks of sedation and dissociation, patients must be monitored for at least 2 hours at each treatment session, followed by an assessment to determine when the patient is considered clinically stable and ready to leave the healthcare setting.

Abuse and Misuse

- Spravato has the potential to be abused and misused. Consider the risks and benefits of prescribing Spravato prior to use in patients at higher risk of abuse. Monitor patients for signs and symptoms of abuse and misuse.

Because of the risks of serious adverse outcomes resulting from sedation, dissociation, and abuse and misuse, Spravato is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Spravato REMS.

Suicidal Thoughts and Behaviors

Antidepressants increased the risk of suicidal thoughts and behavior in pediatric and young adult patients in short-term studies. Closely monitor all antidepressant-treated patients for clinical worsening, and for emergence of suicidal thoughts and behaviors. Spravato is not approved in pediatric patients.

ADVERSE REACTIONS

- Sedation
- Dissociation
- Increase in Blood Pressure
- Cognitive Impairment
- Impaired Ability to Drive and Operate Machinery
- Ulcerative or Interstitial Cystitis
- Embryo-Fetal Toxicity

DRUG INTERACTIONS

Central Nervous System Depressants

Concomitant use with CNS depressants (e.g., benzodiazepines, opioids, alcohol) may increase sedation. Closely monitor for sedation with concomitant use of Spravato with CNS depressants.

Psychostimulants

Concomitant use with psychostimulants (e.g., amphetamines, methylphenidate, modafinil, armodafinil) may increase blood pressure. Closely monitor blood pressure with concomitant use of Spravato with psychostimulants.

Monoamine Oxidase Inhibitors (MAOIs)

Concomitant use with monoamine oxidase inhibitors (MAOIs) may increase blood pressure. Closely monitor blood pressure with concomitant use of Spravato with MAOIs.

USE IN SPECIFIC POPULATIONS

Pregnancy

Pregnancy Exposure Registry

There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to antidepressants, including Spravato, during pregnancy. Healthcare providers are encouraged to register patients by contacting the National Pregnancy Registry for Antidepressants at 1-844-405-6185.

Lactation

Risk Summary

Esketamine is present in human milk. There are no data on the effects of Spravato on the breastfed infant or on milk production. Published studies in juvenile animals report neurotoxicity. Because of the potential for neurotoxicity, advise patients that breastfeeding is not recommended during treatment with Spravato.

Females and Males of Reproductive Potential

Contraception

Based on published animal reproduction studies, Spravato may cause embryo-fetal harm when administered to a pregnant woman. However, it is not clear how these animal findings relate to females of reproductive potential treated with the recommended clinical dose. Consider pregnancy planning and prevention for females of reproductive potential during treatment with Spravato.

DRUG ABUSE AND DEPENDENCE

Controlled Substance

Spravato contains esketamine hydrochloride, the (S)-enantiomer of ketamine and a Schedule III controlled substance under the Controlled Substances Act.

Abuse

Individuals with a history of drug abuse or dependence may be at greater risk for abuse and misuse of Spravato. Abuse is the intentional, non-therapeutic use of a drug, even once, for its psychological or physiological effects. Misuse is the intentional use, for therapeutic purposes, of a drug by an individual in a way other than prescribed by a health care provider or for whom it was not prescribed. Careful consideration is advised prior to use of individuals with a history of substance use disorder, including alcohol. Spravato may produce a variety of symptoms including anxiety, dysphoria,



disorientation, insomnia, flashback, hallucinations, and feelings of floating, detachment, and being “spaced out”. Monitoring for signs of abuse and misuse is recommended.

Dependence

Physical dependence has been reported with prolonged use of ketamine. Physical dependence is a state that develops as a result of physiological adaptation in response to repeated drug use, manifested by withdrawal signs and symptoms after abrupt discontinuation or significant dosage reduction of a drug. There were no withdrawal symptoms captured up to 4 weeks after cessation of esketamine treatment. Withdrawal symptoms have been reported after the discontinuation of frequently used (more than weekly) large doses of ketamine for long periods of time. Such withdrawal symptoms are likely to occur if esketamine were similarly abused. Reported symptoms of withdrawal associated with daily intake of large doses of ketamine include craving, fatigue, poor appetite, and anxiety. Therefore, monitor Spravato-treated patients for symptoms and signs of physical dependence upon the discontinuation of the drug. Tolerance has been reported with prolonged use of ketamine. Tolerance is a physiological state characterized by a reduced response to a drug after repeated administration (i.e., a higher dose of a drug is required to produce the same effect that was once obtained at a lower dose). Similar tolerance would be expected with prolonged use of esketamine.

CLINICAL STUDIES

Treatment Resistant Depression—Short-Term Study

Spravato was evaluated in a randomized, placebo-controlled, double-blind, multicenter, short-term (4-week), Phase 3 study (Study 1; NCT02418585) in adult patients 18 to 65 years old with treatment-resistant depression (TRD). Patients in Study 1 met DSM-5 criteria for major depressive disorder (MDD) and, in the current depressive episode, had not responded adequately to at least two different antidepressants of adequate dose and duration. After discontinuing prior antidepressant treatments, patients in Study 1 were randomized to receive twice weekly doses of intranasal Spravato (flexible dose; 56 mg or 84 mg) or intranasal placebo. All patients also received open-label concomitant treatment with a newly initiated daily oral AD (duloxetine, escitalopram, sertraline, or extended-release venlafaxine as determined by the investigator based on patient’s prior treatment history). Spravato could be titrated up to 84 mg starting with the second dose based on investigator discretion.

The demographic and baseline disease characteristics of patients in Study 1 were similar for the Spravato and placebo nasal spray groups. Patients had a median age of 47 years (range 19 to 64 years) and were 62% female, 93% Caucasian, and 5% Black. The newly initiated oral AD was an SSRI in 32% of patients and an SNRI in 68% of patients. In Study 1, the primary efficacy measure was change from baseline in the Montgomery-Asberg Depression

Rating Scale (MADRS) total score at the end of the 4-week double-blind induction phase. The MADRS is a ten-item, clinician-rated scale used to assess severity of depressive symptoms. Scores on the MADRS range from 0 to 60, with higher scores indicating more severe depression. Spravato plus a newly initiated oral AD demonstrated statistical superiority on the primary efficacy measure compared to placebo nasal spray plus a newly initiated oral AD.

Treatment-Resistant Depression—Long-term Study

Study 2 (NCT02493868) was a long-term randomized, double-blind, parallel-group, multicenter maintenance-of-effect study in adults 18 to <65 years of age who were known remitters and responders to Spravato. Patients in this study were responders in one of two short-term controlled trials (Study 1 and another 4-week study) or in an open-label direct-enrollment study in which they received flexibly dosed Spravato (56 mg or 84 mg twice weekly) plus daily oral AD in an initial 4-week phase.

Stable remission was defined as a MADRS total score ≤ 12 for at least 3 of the last 4 weeks. Stable response was defined as a MADRS total score reduction $\geq 50\%$ for at least 3 of the last 4 weeks and not in remission. After at least 16 initial weeks of treatment with Spravato and an oral AD, stable remitters and stable responders were randomized separately to continue intranasal treatment with Spravato or switch to placebo nasal spray, in both cases with continuation of their oral AD. The primary study endpoint was time to relapse in the stable remitter group. Relapse was defined as a MADRS total score ≥ 22 for 2 consecutive weeks or hospitalization for worsening depression or any other clinically relevant event indicative of relapse.

The demographic and baseline disease characteristics of the two groups were similar. Patients had a median age of 48 years (range 19 to 64 years) and were 66% female, 90% Caucasian, and 4% Black. Patients in stable remission who continued treatment with Spravato plus oral AD experienced a statistically significantly longer time to relapse of depressive symptoms than did patients on placebo nasal spray plus an oral AD.

In Study 2, based on depressive symptomatology, the majority of stable remitters (69%) received every-other-week dosing for the majority of time during the maintenance phase; 23% of stable remitters received weekly dosing. Among stable responders, 34% received every-other-week dosing and 55% received weekly dosing the majority of time during the maintenance phase. Of the patients randomized to Spravato, 39% received the 56 mg dose and 61% received the 84 mg dose.

Effects on Driving

Two studies were conducted to assess the effects of Spravato on driving skills; one study in adult patients with major depressive disorder (Study 3) and one study in healthy subjects (Study 4). On-road driving performance was assessed by the mean standard deviation of the lateral position (SDLP), a measure of driving



impairment. A single-blind, placebo-controlled study in 25 adult patients with major depressive disorder evaluated the effects of a single 84-mg dose of intranasal Spravato on next day driving and the effect of repeated administration of 84 mg of intranasal Spravato on same-day driving performance (Study 3). For the single dose treatment phase, an ethanol-containing beverage was used as a positive control. The SDLP after administration of single 84-mg dose of Spravato nasal spray was similar to placebo 18 hours post-dose. For the multiple dose treatment phase, the SDLP after repeated administration of 84 mg intranasal Spravato was similar to placebo 6 hours post-dose on Day 11, Day 18, and Day 25.

A randomized, double-blind, cross-over, placebo-controlled study in 23 healthy subjects evaluated the effects of a single 84-mg dose of esketamine nasal spray on driving (Study 4). Mirtazapine (30 mg) was used as a positive control. Driving performance was assessed at 8 hours after Spravato or mirtazapine administration. The SDLP 8 hours after Spravato nasal spray administration was similar to placebo. Two subjects discontinued the driving test after receiving Spravato because of a perceived inability to drive after experiencing post-dose adverse reactions; one subject reported pressure behind the eyes and paresthesia of the hands and feet, the other reported headache with light sensitivity and anxiety.

HOW SUPPLIED/STORAGE AND HANDLING

Spravato nasal spray is available as an aqueous solution of esketamine hydrochloride in a stoppered glass vial within a nasal spray device. Each nasal spray device delivers two sprays containing a total of 28 mg of esketamine (supplied as 32.3 mg of esketamine hydrochloride).

Spravato is available in the following presentations:

- 56 mg Dose Kit: Unit-dose carton containing two 28 mg nasal spray devices (56 mg total dose) (NDC 50458-028-02).
- 84 mg Dose Kit: Unit-dose carton containing three 28 mg nasal spray devices (84 mg total dose) (NDC 50458-028-03).

Within each kit, each 28 mg device is individually packaged in a sealed blister.

Storage

Store at 20° to 25°C (68° to 77°F); excursions permitted from 15° to 30°C (59° to 86°F)

Disposal

Spravato nasal spray devices must be handled with adequate security, accountability, and proper disposal, per facility procedure for a Schedule III drug product, and per applicable federal, state, and local regulations.

Spravato is manufactured by Renaissance Lakewood LLC for Janssen Pharmaceuticals, Inc. 



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Cancer. 2019 May 3. doi: 10.1002/cncr.32158.

[Epub ahead of print]

[Advanced stage at diagnosis and elevated mortality among US patients with cancer infected with HIV in the National Cancer Data Base.](#)

Coghill AE, Han X, Suneja G, et al.

BACKGROUND: People living with HIV (PLWH) are at an increased risk of developing several cancers, but to the authors' knowledge less is known regarding how HIV impacts the rate of progression to advanced cancer or death.

METHODS: The authors compared stage of disease at the time of presentation and mortality after diagnosis between 14,453 PLWH and 6,368,126 HIV-uninfected patients diagnosed with cancers of the oral cavity, stomach, colorectum, anus, liver, pancreas, lung, female breast, cervix, prostate, bladder, kidney, and thyroid and melanoma using data from the National Cancer Data Base (2004-2014). Polytomous logistic regression and Cox proportional hazards regression were used to evaluate the association between HIV, cancer stage, and stage-adjusted mortality after diagnosis, respectively. Regression models accounted for the type of health facility at which cancer treatment was administered and the type of individual health insurance.

RESULTS: HIV-infected patients with cancer were found to be more likely to be uninsured (HIV-infected: 5.0% vs HIV-uninfected: 3.3%; $P < .0001$) and were less likely to have private health insurance (25.4% vs 44.7%; $P < .0001$). Compared with those not infected with HIV, the odds of being diagnosed at an advanced stage of disease were significantly elevated in PLWH for melanoma and cancers of the oral cavity, liver, female breast, prostate, and thyroid (odds ratio for stage IV vs stage I range, 1.24-2.06). PLWH who were diagnosed with stage I to stage III disease experienced elevated mortality after diagnosis across 13 of the 14 cancer sites evaluated, with hazard ratios ranging from 1.20 (95% CI, 1.14-1.26) for lung cancer to 1.85 (95% CI, 1.68-2.04), 1.85 (95% CI, 1.51-2.27), and 2.93 (95% CI, 2.08-4.13), respectively,

for cancers of the female breast, cervix, and thyroid.

CONCLUSIONS: PLWH were more likely to be diagnosed with advanced-stage cancers and to experience elevated mortality after a cancer diagnosis, even after accounting for health care-related factors.

J Acquir Immune Defic Syndr. 2019 Apr 1. doi: 10.1097/QAI.0000000000002041. [Epub ahead of print]

[Third trimester vitamin D status is associated with birth outcomes and linear growth of HIV-exposed uninfected infants in the United States.](#)

Sudfeld CR, Jacobson DL, Rueda NM, et al.

BACKGROUND: Vitamin D status in pregnancy may influence the risk of prematurity, birth size, and child postnatal growth but few studies have examined the relationship among pregnant women living with HIV.

METHODS: We conducted a prospective cohort study of 257 HIV-infected mothers and their HIV-exposed uninfected infants who were enrolled in the 2009-2011 Nutrition sub-study of the Surveillance Monitoring for ART Toxicities (SMARTT) Study. HIV-infected pregnant women had serum 25-hydroxyvitamin D (25(OH)D) assessed in the third trimester of pregnancy and their infants' growth and neurodevelopment were evaluated at birth and approximately one year of age.

RESULTS: The mean third trimester serum 25(OH)D concentration was 35.4 ± 14.2 ng/mL with 15% of women classified as vitamin D deficient (<20 ng/mL) and 21% as insufficient (20-30 ng/mL). In multivariable models, third trimester vitamin D deficiency and insufficiency were associated with -273g (95% CI: -450, -97) and -203g (95% CI: -370, -35) lower birth weights compared to vitamin D sufficient women, respectively. Maternal vitamin D deficiency was also associated with shorter gestation (mean difference -0.65 weeks; 95% CI: -1.22, -0.08) and lower infant length-for-age z-scores at one year of age (mean difference: -0.65; 95% CI: -1.18, -0.13). We found no association of vitamin D status with

infant neurodevelopment at 1 year of age.

CONCLUSION: Third trimester maternal vitamin D deficiency was associated with lower birth weight, shorter length of gestation, and reduced infant linear growth. Studies and trials of vitamin D supplementation in pregnancy for women living with HIV are warranted.

Eur J Gastroenterol Hepatol. 2019 Feb;31(2):149-156. doi: 10.1097/MEG.0000000000001263.

[Marijuana is not associated with progression of hepatic fibrosis in liver disease: a systematic review and meta-analysis.](#)

Farooqui MT, Khan MA, Cholankeril G, et al.

BACKGROUND: An estimated 22 million adults use marijuana in the USA. The role of marijuana in the progression of hepatic fibrosis remains unclear.

AIMS: We carried out a systematic review and meta-analysis to evaluate the impact of marijuana on prevalence and progression of hepatic fibrosis in chronic liver disease.

PATIENTS AND METHODS: We searched several databases from inception through 10 November 2017 to identify studies evaluating the role of marijuana in chronic liver disease. Our main outcome of interest was prevalence/progression of hepatic fibrosis. Adjusted odds ratios (ORs) and hazards ratios (HRs) were pooled and analyzed using random-effects model.

RESULTS: Nine studies with 5976026 patients were included in this meta-analysis. Prevalence of hepatic fibrosis was evaluated in nonalcoholic fatty liver disease (NAFLD), hepatitis C virus (HCV), and hepatitis C and HIV coinfection by two, four, and one studies. Progression of hepatic fibrosis was evaluated by two studies. Pooled OR for prevalence of fibrosis was 0.91 (0.72-1.15), I=75%. On subgroup analysis, pooled OR among NAFLD patients was 0.80 (0.75-0.86), I=0% and pooled OR among HCV patients was 1.96 (0.78-4.92), I=77%. Among studies evaluating HR, pooled HR for progression of fibrosis in HCV-HIV co-infected patients was 1.03 (0.96-1.11), I=0%.

CONCLUSION: Marijuana use did not increase the prevalence or progression of hepatic fibrosis in HCV and HCV-HIV-coinfected patients. On the contrary, we noted a reduction in the prevalence of NAFLD in marijuana users. Future studies are needed to further understand the therapeutic impact of cannabidiol-based formulations in the management of NAFLD.

Am J Kidney Dis. 2019 Apr 25. pii: S0272-6386(19)30617-1. doi: 10.1053/j.ajkd.2019.02.015. [Epub ahead of print]

[Association between hypertension and kidney function decline: The Atherosclerosis Risk in Communities \(ARIC\) Study.](#)

Yu Z, Rebholz CM, Wong E, et al.

RATIONALE & OBJECTIVE: The relationship between hypertension, antihypertension medication use, and change in glomerular filtration rate (GFR) over time among individuals with preserved GFR requires investigation.

STUDY DESIGN: Observational study.

SETTING & PARTICIPANTS: 14,854 participants from the Atherosclerosis Risk in Communities (ARIC) Study.

PREDICTORS: Baseline hypertension status (1987-1989) was categorized according to the 2017 American College of Cardiology/American Heart Association Clinical Practice Guideline as normal blood pressure, elevated blood pressure, stage 1 hypertension, stage 2 hypertension without medication, or stage 2 hypertension with medication.

OUTCOMES: Slope of estimated GFR (eGFR) at 5 study visits over 30 years.

ANALYTICAL APPROACH: Mixed models with random intercepts and random slopes were fit to evaluate the association between baseline hypertension status and slope of eGFR.

RESULTS: At baseline, 13.2%, 7.3%, and 19.4% of whites and 15.8%, 14.9%, and 39.9% of African Americans had stage 1 hypertension, stage 2 hypertension without medication, and stage 2 hypertension with medication. Compared with those with normal blood pressure, the annual eGFR decline was greater in people with higher blood pressure (whites: elevated blood pressure, -0.11 mL/min/1.73 m²; stage 1 hypertension, -0.15 mL/min/1.73 m²; stage 2 hypertension without medication, 0.36 mL/min/1.73 m²; stage 2 hypertension with medication, -0.17 mL/min/1.73 m²; African Americans: elevated blood pressure, -0.21 mL/min/1.73 m²; stage 1 hypertension, -0.16 mL/min/1.73 m²; stage 2 hypertension without medication, -0.50 mL/min/1.73 m²; stage 2 hypertension with medication, -0.16 mL/min/1.73 m²). The 30-year predicted probabilities of developing chronic kidney disease stage G3a+ with normal blood pressure, elevated blood pressure, stage 1 hypertension, stage 2 hypertension without medication, or stage 2 hypertension with medication among whites were 54.4%, 61.6%, 64.7%, 78.1%, and 70.9%, respectively, and 55.4%, 62.8%, 60.9%, 76.1%, and 66.6% among African Americans.

LIMITATIONS: Slope estimated using a maximum of 5 eGFR assessments; differential loss to follow-up.

CONCLUSIONS: Compared to normotension, baseline hypertension status was associated with faster kidney function decline over 30-year follow-up in a general population cohort. This difference was attenuated among people using antihypertensive medications.

Am J Cardiol. 2018 Jan 15;121(2):205-209. doi: 10.1016/j.amjcard.2017.10.007. Epub 2017 Nov 16.

[Outcome of patients with in-hospital ventricular tachycardia and ventricular fibrillation arrest while using a wearable cardioverter defibrillator.](#)

Ellenbogen KA, Wan C, Shavelle DM.

In-hospital sudden cardiac arrests occurring during nighttime and weekend hours or within unmonitored hospital areas have been reported to have poorer outcomes than monitored cardiac arrest. This study sought to assess the outcome of in-hospital ventricular tachycardia (VT) and ventricular fibrillation (VF) arrest by time of day, day of week, and within-hospital location when using a wearable cardioverter defibrillator (WCD). We retrospectively identified and reviewed consecutive in-hospital VT/VF arrests from January 2011 to May 2015 experienced by patients wearing a WCD using the manufacturer's postmarket registry. An index shockable sudden cardiac arrest event was defined as the first arrest caused by VT/VF. Event location and clinical outcome were extracted from patient call logs. Survival analysis was performed using the Kaplan-Meier method. A total of 234 in-hospital VT/VF arrests were included (mean age = 65 ± 12 years, male = 74%); 50% had a history of congestive heart failure. The median follow-up time was 6 days (interquartile range 1-4). In the 128 (55%) daytime events (7:00 a.m. to 7:00 p.m.), 24-hour survival was 91%. The 106 (45%) nighttime events (7:01 p.m. to 6:59 a.m.) had 89% 24-hour survival ($p=0.54$). Survival outcome by monitored or unmonitored hospital locations were similar. Kaplan-Meier analyses showed no difference in 30-day survival either between weekend and weekday events (72% vs 65%, $p=0.79$), or between daytime and nighttime events (64% vs 69%, $p=0.37$). In conclusion, WCD use during in-hospital VT/VF arrest correlated with high survival rates regardless of event time or location inside a hospital. Use of a WCD appears to mitigate some of the risks associated with in-hospital VT/VF arrest.

Am J Cardiol. 2019 Apr 10. pii: S0002-9149(19)30400-X. doi: 10.1016/j.amjcard.2019.04.005. [Epub ahead of print]

[The effect of obstructive sleep apnea on 3-year outcomes in patients who underwent orthotopic heart transplantation.](#)

Afzal A, Tecson KM, Jamil AK, et al.

Despite the well-known association between obstructive sleep apnea (OSA) and cardiovascular disease, there is a paucity of data regarding OSA in orthotopic heart transplant (OHT) recipients and its effect on clinical outcomes. Hence, we sought to determine the association between OSA, as detected by polysomnography, and late graft dysfunction (LGD) after OHT. In this retrospective review of consecutive OHT recipients from 2012 to 2014 at our center, we examined LGD, i.e., graft failure >1 year after OHT, through competing risks analysis. Due to small sample size and event counts, as well as preliminary testing which revealed statistically similar demographics and outcomes, we pooled patients who had treated OSA with those who had no OSA. Of 146 patients, 29 (20%) had untreated OSA, i.e., OSA without use of continuous positive airway pressure therapy, at the time of transplantation. Patients with untreated OSA were significantly older, heavier, and more likely to have baseline hypertension than those with treated/no OSA. Although there were no differences between groups in regard to short-term complications of acute kidney injury, cardiac allograft vasculopathy, or primary graft dysfunction, there were significant differences in the occurrence of LGD. Those with untreated OSA were at 3 times the risk of developing LGD than those with treated/no OSA (hazard ratio 3.2; 95% confidence interval 1.3 to 7.9; $p = 0.01$). Because OSA is a common co-morbidity of OHT patients and because patients with untreated OSA have an elevated risk of LGD, screening for and treating OSA should occur during the OHT selection period.

Clin Lung Cancer. 2019 Apr 1. pii: S1525-7304(19)30079-8. doi: 10.1016/j.clc.2019.03.006. [Epub ahead of print]

[Node-positive segmentectomy for non-small-cell lung cancer: risk factors and outcomes.](#)

Lutfi W, Schuchert MJ, Dhupar R, et al.

BACKGROUND: Segmentectomy for well-selected early stage non-small-cell lung carcinoma (NSCLC) has been shown to have similar oncologic outcomes and survival to lobectomy. However,



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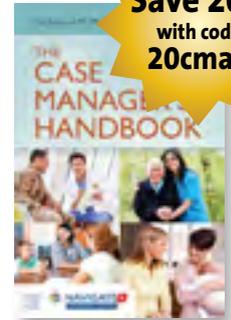
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these data are based on the presumption that the disease is node negative. Few data exist regarding the risk factors for and the outcomes of patients with disease treated with segmentectomy that is found to be node positive. We sought to determine the risk factors for and outcomes of clinical stage I NSCLC patients who are treated with segmentectomy but are determined to be node positive.

PATIENTS AND METHODS: We queried patients with clinical stage I NSCLC ≤ 3 cm within the National Cancer Data Base between 2004 and 2014 who were treated with segmentectomy or lobectomy and found to have positive nodes. Kaplan-Meier curves with log-rank tests were used to compare overall survival (OS) between segmentectomy and lobectomy. For comparison only, segmentectomy patients with pathologically node-negative disease were identified to determine predictors of node positivity after segmentectomy via multivariable logistic regression.

RESULTS: A total of 4556 patients with node-positive disease were identified, comprising 115 segmentectomy patients and 4441 lobectomy patients. Multivariable analysis identified increasing tumor size, squamous-cell histology, and increasing number lymph nodes sampled as significant predictors of node positivity after segmentectomy. There was no difference in OS between segmentectomy and lobectomy, with 3-year OS rates of 66.3% and 68.1%, respectively ($P = .723$).

CONCLUSION: There are discrete risk factors for discovering positive nodes after segmentectomy. Segmentectomy is associated with similar OS compared to lobectomy for clinical stage I NSCLC found to be node positive.

J Asthma. 2019 May 2;1-16. doi: 10.1080/02770903.2019.1614615. [Epub ahead of print]

[Disparities in complementary alternative medicine use and asthma exacerbation in the United States.](#)

Ji Kim E, Simonson J, Jacome S, et al.

Complementary and alternative medicines (CAM) are associated with poor asthma medication adherence, a major risk factor for asthma exacerbation. However, previous studies showed inconsistent relationships between CAM use and asthma control due to small sample sizes, demographic differences across populations studied, and poor differentiation of CAM types. We examined associations between CAM use and asthma exacerbation using a cross-sectional analysis of the 2012 National Health Interview

Survey. We included adults ≥ 18 years with current asthma ($n=2,736$) to analyze racial/ethnic differences in CAM use as well as the association between CAM use and both asthma exacerbation and emergency department (ED) visit for asthma exacerbation across racial/ethnic groups. We ran descriptive statistics and multivariable logistic regressions. Blacks (OR = 0.63 [0.49-0.81]) and Hispanics (OR = 0.66 [0.48-0.92]) had decreased odds of using CAM compared to Whites. Overall, there was no association between CAM use and asthma exacerbation (OR = 0.99 [0.79-1.25]) but the subgroup of 'other complementary approaches' was associated with increased odds of asthma exacerbation among all survey respondents (1.90 [1.21-2.97]), Whites (OR = 1.90 [1.21-2.97]), and Hispanics (OR = 1.43 [0.98-2.09]). CAM use was associated with decreased odds of an ED visit for asthma exacerbation (OR = 0.65 [0.45-0.93]). These associations were different among racial/ethnic groups with decreased odds of ED visit among Whites (OR = 0.50 [0.32-0.78]) but no association among Blacks and Hispanics. In summary, we found that both CAM use and the association between CAM use and asthma exacerbation varied by racial/ethnic group. The different relationship may arise from how CAM is used to complement or to substitute for conventional asthma management.

PLOS Med. 2019 Apr 29;16(4):e1002797. doi: 10.1371/journal.pmed.1002797. eCollection 2019 Apr.

[Extended prophylaxis for venous thromboembolism after hospitalization for medical illness: A trial sequential and cumulative meta-analysis.](#)

Bajaj NS, Vaduganathan M, Qamar A, et al.

BACKGROUND: The efficacy, safety, and clinical importance of extended-duration thromboprophylaxis (EDT) for prevention of venous thromboembolism (VTE) in medical patients remain unclear. We compared the efficacy and safety of EDT in patients hospitalized for medical illness.

METHODS AND FINDINGS: Electronic databases of PubMed/MEDLINE, EMBASE, Cochrane Central, and ClinicalTrials.gov were searched from inception to March 21, 2019. We included randomized clinical trials (RCTs) reporting use of EDT for prevention of VTE. We performed trial sequential and cumulative meta-analyses to evaluate EDT effects on the primary efficacy endpoint of symptomatic VTE or VTE-related death, International Society on Thrombosis and Haemostasis (ISTH) major or fatal bleeding, and all-cause mortality. The pooled num-

ber needed to treat (NNT) to prevent one symptomatic or fatal VTE event and the number needed to harm (NNH) to cause one major or fatal bleeding event were calculated. Across 5 RCTs with 40,247 patients (mean age: 67–77 years, proportion of women: 48%–54%, most common reason for admission: heart failure), the duration of EDT ranged from 24–47 days. EDT reduced symptomatic VTE or VTE-related death compared with standard of care (0.8% versus 1.2%; risk ratio [RR]: 0.61, 95% confidence interval [CI]: 0.44–0.83; $p = 0.002$). EDT increased risk of ISTH major or fatal bleeding (0.6% versus 0.3%; RR: 2.04, 95% CI: 1.42–2.91; $p < 0.001$) in both meta-analyses and trial sequential analyses. Pooled NNT to prevent one symptomatic VTE or VTE-related death was 250 (95% CI: 167–500), whereas NNH to cause one major or fatal bleeding event was 333 (95% CI: 200–1,000). Limitations of the study include variation in enrollment criteria, individual therapies, duration of EDT, and VTE detection protocols across included trials.

CONCLUSIONS: In this systematic review and meta-analysis of 5 randomized trials, we observed that use of a post-hospital discharge EDT strategy for a 4-to-6-week period reduced symptomatic or fatal VTE events at the expense of increased risk of major or fatal bleeding. Further investigations are still required to define the risks and benefits in discrete medically ill cohorts, evaluate cost-effectiveness, and develop pathways for targeted implementation of this postdischarge EDT strategy.

Dis Colon Rectum. 2019 Apr;62(4):483–490. doi: 10.1097/DCR.0000000000001308.

[Academic hospitals discharge fewer patients to postacute care facilities after colorectal resection.](#)

Kanters AE, Nikolian VC, Kamdar NS, et al.

BACKGROUND: Discharge to a nonhome destination (ie, skilled nursing facility, subacute rehabilitation, or long-term care facility) after surgery is associated with increased mortality and higher costs and is less desirable to patients than discharge to home.

OBJECTIVE: We sought to identify modifiable hospital-level factors that may reduce rates of nonhome discharge after colorectal resection.

DESIGN: This was a retrospective cohort study of patients undergoing colorectal resection in the Michigan Surgical Quality Collaborative (July 2012 to June 2015). Patient- and hospital-level characteristics were tested for association with nonhome discharge

patterns.

SETTINGS: Patients were identified using prospectively collected data from the Michigan Surgical Quality Collaborative, a statewide collaborative encompassing 63 community, academic, and tertiary hospitals.

PATIENTS: Patients undergoing colon and rectal resections were included.

MAIN OUTCOME MEASURE: The main outcome measure was hospital use patterns of nonhome discharge.

RESULTS: Of the 9603 patients identified, 1104 (11.5%) were discharged to a nonhome destination. After adjustments for patient factors associated with nonhome discharge, we identified variability in hospital use patterns for nonhome discharge. Designation as a low utilizer hospital was associated with affiliation with a medical school ($p = 0.020$) and high outpatient volume ($p = 0.028$). After adjustments for all hospital factors, only academic affiliation maintained a statistically significant relationship (OR = 4.94; $p = 0.045$).

LIMITATIONS: This study had a retrospective cohort design with short-term follow-up of sampled cases. Additionally, by performing our analysis on the hospital level, there is a decreased sample size.

CONCLUSIONS: This population-based study shows that there is significant variation in hospital practices for nonhome discharge. Specifically, hospitals affiliated with a medical school are less likely to discharge patients to a facility, even after adjustment for patient and procedural risk factors. This study raises the concern that there may be overuse of subacute facility discharge in certain hospitals, and additional study is warranted. ■

Health Technology Use Among Seniors

A 2015 survey conducted by the National Health and Aging Trends Study reported that 60% of the seniors surveyed (>7000) used at least 1 technological assistive device, most commonly for bathing, toileting, and moving around. Twenty percent used 2 or more devices, and 13% also received personal assistance. Five percent had difficulty with daily tasks but didn't have help and hadn't made other adjustments. One percent received help only.

Needs multiplied as people grew older, with 63% of those 85 and older using multiple devices and getting personal assistance compared with 23% of those between ages 65 and 74.

The problem, experts note, is that Medicare doesn't pay for most of these nonmedical services, with some exceptions. Many seniors, especially those at low income levels, go without needed assistance, even when they're enrolled in Medicaid. (Medicaid community-based services for low-income

seniors vary by state and often fall short of actual needs.)

The precariousness of their lives is illustrated in a companion report on financial strain experienced by older adults who require long-term services and supports. Slightly more than 10% of seniors with high needs experienced at least 1 type of hardship, such as being unable to pay expenses like medical bills or prescriptions (5.9%), utilities (4.8%) or rent (3.4%), or skipping meals (1.8%). (Some people had multiple difficulties, reflected in these numbers.)

These kinds of adverse events put older adults' health at risk while contributing to avoidable hospitalizations and nursing home placements. Given a growing population of seniors who will need assistance, "I think there's a need for Medicare to rethink how to better support beneficiaries," said Amber Willink, coauthor of both studies and an assistant scientist at the Johns Hopkins Bloomberg School of Public Health. ■

Quick Reference Guide to Promising Care Models for Patients With Complex Needs

Many pioneering programs have reduced avoidable utilization of care and lowered costs while improving health outcomes for adults with complex needs. The most promising models target high-risk populations and provide key elements of person-centered care, including individualized care plans, interdisciplinary care teams, active care coordination, and continuous information-sharing with providers and patients.

The [Quick Reference Guide to Promising Care Models](#) offers summary information on 28 programs for adults with complex needs, specifically:

- Target population and subpopulations served by the model
- Key features of the model associated with person-centered care
- Outcomes and impact

The guide was updated in January 2019 using the original version of the Quick Reference Guide developed in December 2016, data from a survey of promising care models conducted by the Center for Health Care Strategies for the [Better Care Playbook's State Map](#), and targeted literature searches. Models were included if they targeted adults with complex needs, provided at least one element of person-centered care, and had [strong, moderate, or promising evidence](#) on at least one outcome related to quality, utilization, or cost. Links are provided under the Models and Outcomes columns for additional information and references. In some cases, the number of sites was obtained from sources other than those listed above, which are detailed in footnotes as applicable. ■

More States Say Doctors Must Offer Overdose Reversal Drug Along With Opioids

An emerging tactic against the rising toll of opioid deaths is the requirement that physicians offer patients naloxone when they give them prescriptions for powerful opioid painkillers. California, Ohio, Virginia, and Arizona are among the states that use this tactic. The U.S. Food and Drug Administration is weighing a national recommendation to do so. ■

Two Crises In One: As Drug Use Rises, So Does Syphilis

A significant portion of syphilis transmission in heterosexuals occurs among people who use drugs, particularly methamphetamine, a new report shows. Public health officials warn that you can't treat one problem without addressing the other. ■

Drug Overdose Deaths Among Women Soar

The usual suspects—prescription opioids, synthetic opioids, antidepressants, cocaine, heroin, and benzodiazepines—accounted for a 260% increase in drug overdose deaths in women aged 30 to 64 from 1999 to 2017, according to new data from the Centers for Disease Control and Prevention (CDC). For women in that age group, the drug overdose rate increased from 6.7 deaths per 100,000 people, or 4,314 deaths total in 1999, to 24.3 per 100,000 people, or 18,110 deaths in 2017.

The CDC published its data in a recent *Morbidity and Mortality Weekly Report*. One chart shows not only how much overall drug overdoses for women in that age group increased over that time frame but also just what part prescription and synthetic opioids played in that spike. ■

Insights from Case Managers— Palliative Care *continued from page 7*

called QLife or supportive care consultations, thus removing the stigma of the word “hospice.” Some hospice providers use brand names for marketing purposes that avoid the word “hospice” and aim to show how the scope of palliative care services has evolved. As palliative care consultation services have become more mainstream, the consultation is now commonly made earlier in the intensive care unit or medical course. Patients who are candidates for hospice and palliative care are evaluated on a regular basis with regard to medical management and family support, and these patients are educated about their options.

Palliative care consultations are not

Meeting Patients’ Mental Health Needs *continued from page 2*

develop coping mechanisms.

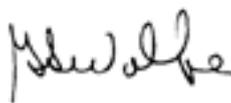
Fortunately, a number of mental disorders can be treated effectively, and prevention is a growing area of research and practice. Early diagnosis and treatment can reduce the burden of mental health disorders as well as chronic disease. Assessing and addressing mental health is important to ensure longer and healthier lives.

Assessment is key with regard to many mental health issues. What role do you as a case manager play in this situation? Because of the prevalence of mental health issues, it would be appropriate for everyone you provide case management services for to receive a screening and brief intervention regardless of the reason you are providing case management services. The real question is whether you are prepared to perform a screening. In the article titled “Are Healthcare Professionals Ready to Address Patients’ Substance

available in all health care settings. In such cases, intensivists, pulmonary specialists, nephrologists, and hospitalists discuss their patients’ prognoses. The general public is currently more accepting of hospice and palliative care because of the desire for improved comfort care at the end of life. In addition to consultations with a physician, I believe that the case management team should enlist the services of the pastoral care team or volunteers.

Case management directors may want to meet with pastoral care teams and develop a plan; many members of the pastoral care team are trained to counsel patients and discuss end of life issues. Even if the family does not want ministers, it is helpful to have these professionals or volunteers stop in daily. They can be instrumental in

Use and Mental Health Disorders”? by Drs. Deborah Finnell and Glenn Albright, published in this issue of *CareManagement*, finds that health professionals are not prepared and do not feel comfortable performing a screening and brief intervention. Case managers, like other healthcare professionals, need training and education. Remember that you are screening patients; you are not a mental health specialist. Case managers should seek training from online sources and other sources such as seminars and workshops that best meet their needs. Elevate your level of care so that your patients can be as healthy as possible.



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ACCM: Improving Case Management Practice through Education

developing a relationship with the patient and the patient’s family simply by bringing coffee or waiting with the family during medical tests. They are a friendly, supportive face even during brief periods of hospitalization. They are also great ambassadors for all stakeholders, especially if there are angry family members who need time to absorb their family member’s illness and prognosis. It may take time for the pastoral care team to develop a relationship with the family, but they often provide invaluable support. **CM**

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CMSA Task Force for Hospital Case Management

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high-quality, high-value health care. Care coordination is not a synonym for transition planning but a process that “ensures that the patients’ health care needs and preferences are known and communicated at the right time and to the right people and that this information is used to guide the delivery of safe, appropriate, and effective care.”¹ Any activity that bridges gaps between providers, care teams, and settings and provides information important to the treatment plan and patient flow leads to improved care coordination. Furthermore, case management is designed to “assist patients and their support system in managing their medical, social, and mental health conditions more efficiently and effectively.”¹ In a 1998 study, case management was defined as a “means of coordinating services” by a single case manager who is expected to assess that person’s needs, develop a care plan, arrange for suitable care to be provided, monitor the quality of the care provided, and maintain contact with the person.² Recognition of the confirmed connection between case management and care coordination energized the Task Force in its mission.

The CMSA established the Standards of Practice for Case Management (SoP) in 1995 and has revisited and updated the content⁴ times to reflect the changing health care system and the changing role of the case manager. The most recent changes in the SoP were made in 2016. CMSA emphasized the professional role of the case manager and the need to empower patients and their caregivers in important decisions regarding their care, to promote health care literacy and self-care, and to engage the patients’ participation and their transitions from the hospital.³ Key provisions in the SoP include:

- a. Identify and select patients who can most benefit from case management services.
- b. Complete health, cognitive, and social assessment.
- c. Identify problems or opportunities that would benefit from case management interventions.
- d. Collaborate with client and stakeholders to develop an individualized plan.
- e. Facilitate, coordinate, monitor, and advocate to “minimize fragmentation in the services provided and prevent the risk for unsafe care and suboptimal outcomes.”
- f. Employ ongoing monitoring to measure client’s responses.
- g. Demonstrate the benefits of case management services.³

Using these standards, the Task Force endeavored to identify what, if any, constraints exist in the hospital environment that impede the application of these practice principles. The task force then identified strategies that can

be used to ensure that hospital case management practice models are in sync with the transformation taking place throughout the hospital industry.

The task force identified the following transformation priorities for hospital case manager leaders and the hospitals’ senior administrative team:

1. Redesign scope of services

For many years, hospital case management was a hospital department charged with managing several hospital functions. But that model no longer meets the challenges of the modern acute care delivery system, population health initiatives, or the establishment of community-based partnerships that many acute care hospitals find essential to thrive in a value-based environment. New consumer expectations, new payment schemes, and new alliances demand a case management model that focuses on an enterprise-wide program of care coordination.

Care Coordination is an essential component of the SoP promulgated by CMSA³ and is also cited by the National Quality Forum,⁴ the National Healthcare Quality and Disparities Report chart book,⁵ and the Institute for Healthcare Improvement⁶ as an essential service delivery plan.⁷ Care coordination is at the heart of any new hospital case management model and leaps the brick and mortar boundaries of the acute care facility into other care facilities, community-based settings, and the patient’s home. This much broader vision can pose significant challenges when planning for the future. The hospital system requires strength and cohesiveness within the walls of the facility as well as within the larger web of the surrounding community’s infrastructure and support systems. Care coordination can no longer exist and function within a solitary hospital department located in the bowels of the facility; it must become a core competency of every hospital organization and evolve into a program where every hospital care giver provides value that results in better outcomes at lower costs.

1. Establish clear roles and responsibilities

The 2010 Affordable Care Act has put a focus on the improvement of health outcomes, specifically calling out effective case management and care coordination as activities to achieve these outcomes. By moving the case manager’s focus away from tasks and procedures as the focus of their scope of practice sharpens, opportunities will be created to meet the needs of the health care consumer and add to the value of case managers.⁸

Case management practice extends beyond the basic training of any single discipline within the health care field. Organizing for patient-centric care coordination suggests a

program comprised of diverse individuals with the skill sets, critical thinking skills, and enthusiasm to coordinate care for a selected group of patients in the hospital and across the continuum. Eligible individuals may come from many professional clinical disciplines and have strong communication and collaborative skills to engage the patient and members of the patient's care team. **CM**

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Disability Management and the Care Continuum *continued from page 6*

definition of disability. In addition, the beneficial effects of “mitigating measures” are not considered when determining if an impairment is disabling—that means even if a device or other intervention can ameliorate the impact of a disability, that does not change how the disabling condition is defined and recognized under the law.

Federal and state regulations provide a baseline of what employers can do. Some employers, particularly larger organizations, are more progressive. They build upon these rules and required programs to offer more benefits. For example, they have integrated benefits and offer return-to-work, stay-at-work, and other creative solutions that apply to all employees—those injured on the job as well as those who have nonoccupational illnesses and injuries and need accommodations and job modifications.

In today's tight labor market in particular, it is challenging for employers to recruit and retain valued employees. By offering benefits when employees become ill or injured—whether on or off the job—employers are able to preserve their human capital. Two distinctive benefit programs that advocate for and protect employees are:

1. **Workers' compensation**, a state-mandated program that applies to employers of all sizes—in some states, even for companies with as few as 1 employee. Workers' compensation covers medical costs, wage loss, and related expenses when an injury or illness arises from and in the course of performing work.
2. **Short-term and long-term disability**, providing disability compensation to individuals who are off work because of nonoccupational incidents, whether illness, injury, or the onset of a disability. Short-term disability (STD) is mandatory in 5 states (with 1 additional state pending) and voluntary in other states. When

voluntary, it is typically provided by larger employers. Employers may offer self-funded and insured disability plans that offset lost wages, generally after 7 days, with wage replacement rates that range from 50% to 70% and can last from 13 to 52 weeks. Long-term disability (LTD) plans usually collaborate and integrate with Social Security Disability offerings after 1 year.

In this complex world of laws, regulations, and employer policies and programs, CDMSs are key players who have the expertise and knowledge to serve both employers and employees. As certified professionals, disability managers can navigate the complexity of legal compliance while reducing the cost and impact of disability on employers and also advocating for employees to facilitate their return to work.

At the heart of disability management is creating pathways to help people who have perceived and documented disabilities to work without fear or judgment. **CM**

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