

CareManagement

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Gary S. Wolfe

Culturally Sensitive Care for the LGBTQ+ Patient

Culturally sensitive care is a continuing issue that needs to be addressed by the case manager. As society continues to evolve, we are confronted with the challenges of culture. Culture refers to mostly intangible aspects of life including values, beliefs, social forms, material traits, communica-

LGBTQ+ patients have a lower rate of health insurance coverage and fewer LGBTQ+ people have a regular healthcare provider than their heterosexual counterparts. The ramifications of not providing culturally sensitive care to the LGBTQ+ patient can be dire.

Have you either explicitly or implicitly

LGBTQ+ individuals experience significant health disparities caused by a combination of barriers to care and minority status. Case managers can make a difference in improving care for the LGBTQ+ patient, although this will take time. The beliefs and values each case manager has come into play when providing culturally sensitive care.

tion, and characteristic features of everyday life that people share in common and define them in a particular group. Case managers are confronted with many cultures when managing their caseload. A patient's culture has a direct impact on their healthcare and outcomes.

Although more and more individuals have recently been expressing their gender and sexuality outside previously established norms (eg, not identifying as heterosexual or with sex assigned at birth), many case managers practicing today lack basic education about LGBTQ+ patients and there are major differences in case managers' knowledge about LGBTQ+ individuals depending on where they practice.

It is estimated that at least 10 million people identify as LGBTQ+ in the United States, but because of LGBTQ+ fluidity, this is not a static number. According to the U.S. Department of Health and Human Services, LGBTQ+ individuals are at higher risk than the general population for substance abuse, obesity, mental health disorders, sexually transmitted diseases, sexual abuse, and suicide. Generally,

showed bias when it comes to the LGBTQ+ patient? This question may take some soul searching. Everyone knows the "right" answer would be "no," but when we ask this question to an LGBTQ+ patient we would get a different answer. Case managers may not intend to be isolating or insensitive, but because of our lack of understanding, we may come across that way. LGBTQ+ patients are quick to pick up on that and can be reluctant to seek follow-up care.

There are steps the case manager can take to become culturally sensitive to the LGBTQ+ patients:

- Use culturally sensitive language
- Become familiar with key terms and concepts
- Get the full context; don't make assumptions
- Understand the nuances of LGBTQ+ culture
- Practice empathy and establish trust
- Ask questions, some of which may make you uncomfortable

LGBTQ+ individuals experience significant health disparities caused by a

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Catherine M. Mullahy

Striking a Balance

As we move toward what hopefully will be better times this year, the past year made us realize what truly matters most. We continue to cope with the realities of the pandemic, and, sadly, perhaps the loss of some of our colleagues, friends, and family, but we also have the promise of

enough, and what should be the decision-making process to determine that? Understanding the issues is part of the case management process, to be sure, but the complexity of some patients, especially when it seems that *all* our patients are complex, can be overwhelming. Accepting that case management is essentially a risk-management

importance of culturally appropriate care for those in the LGBTQ+ communities, introduce a truly innovative COVID-19 family action plan created by a children's hospital serving a high-risk and complex pediatric population from newborns through adolescents, and explore how depression in the geriatric population differs from that

Articles in this issue explore the importance of culturally appropriate care for those in the LGBTQ+ communities, introduce a truly innovative COVID-19 family action plan created by a children's hospital serving a high-risk and complex pediatric population from newborns through adolescents, and explore how depression in the geriatric population differs from that in other age groups

spring, the season of new beginnings, and the enjoyable days of summer to look forward to. And now many of the celebrations that accompany these special times of the year will happen in a close-to-normal environment. Days to honor moms and dads, graduations, family reunions, concerts, fairs, and so much more! It's challenging to keep everything in perspective, especially as we try to strike that sometimes elusive work-life balance. We do need, however, to look forward to these occasions and to take the time to truly engage not only with family and friends but to nourish our inner selves so that we can return to our professional responsibilities with renewed energy.

As professionals, we remain committed to providing the best that we can for our patients, although we all too often take unfinished business home with us. What can we do when so much remains on our increasingly longer to do list? How do we decide just what to do, when is enough *really*

strategy (ie, identifying, assessing, and managing risk factors such as medical, behavioral, and of course the increasingly important social determinants of health), the experienced case manager will be able to ascertain which of those require immediate attention and which can be delegated to others on the team. Ahhh, yes...the team. Who is on that team? Are case managers the leaders on those teams or are we hoping that someone else steps up to provide vision and collaborative synergy? When we don't get the results we're seeking, it's all too easy to blame others, but effective leaders in case management can not only envision success but can create and communicate the pathway that will optimize the potential to achieve success.

In this issue, there are several compelling illustrations of collaboration, communication, and the leadership characteristics that underscore the contributions that case managers make. Articles in this issue explore the

in other age groups. The perspective, expertise, and leadership demonstrated by the authors will not only engage you but will encourage you to explore new solutions to complex problems.

Although these articles provide you with CE opportunities, you should keep yourself updated by reading the columns. CARF considers the importance of participating in the process of updating standards and suggests that professionals should be engaged in the creation of these standards as well as in the review process. CMSA has embraced many changes that members and the organization have encountered, refers to 2021 as the "changing year," and encourages readers to join the organization and participate in its diverse initiatives. CDMS examines the challenges facing an aging workforce, including those in case management. Finally, the VHA has its second column in this issue and discusses its innovative and successful program as individuals

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Change!

Melanie A. Prince, MSN, BSN, NE-BC, CCM, FAAN

Last issue, I wrote about the beginning of spring and used the analogy of seasonal crop rotations to describe how the Case Management Society of America (CMSA) will approach a new era in association benefits, services, and products. Internal and external forces are changing how we support the incredible case management professionals across the country and, indeed, around the world. The idea of CHANGE evokes a myriad of responses, from anxiety, fear, and confusion, and sometimes anger to excitement, relief, revitalization, and transformation. With a 30-year military career that served CHANGE on a silver, bejeweled platter, I have evolved into a Cheerleader for Change and recently embarked on a renewed study into the science and art of change management.

Change is represented by many models. There are change theory models specific to health care, family, transitions, organizations, and general theories. One of my favorite theorists is Kurt Lewin, who developed the Change

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has diverse experience in population health; case, disease and utilization management; public policy; trauma/violence prevention and organizational leadership. Melanie is a certified professional case manager and nurse executive and has master's degrees in nursing case management and military strategic studies.

Theory of Nursing and Lewin's Change Theory. He describes three steps in his change model: unfreezing, changing, and refreezing. "The process of change entails creating the perception that a change is needed, then moving toward the new, desired level of behavior and

hard to exist within the constraints of safety, infection control, and personal protection. There was a lot of change to restore a sense of "sameness."

This year, 2021, may be viewed as the "changing year." The world is moving toward new ways of existing. As the

CMSA is excited to use technology to create energetic and engaging experiences for case managers to hone their skills and network with other professionals. The staff is hard at work transforming these ideas into actionable initiatives and programs, and our ability to network and collaborate on educational programs with international organizations adds to the excitement of new possibilities. Virtual formats have been and will continue to be great options!

finally, solidifying that new behavior as the norm." (Lewin's 3-Stage Model of Change: Unfreezing, Changing & Refreezing). While Lewin's Change Theory is applied to healthcare disciplines, businesses, organizations, and academia, I considered the theory for CMSA in the context of the 2020 pandemic environment and beyond.

The 2020 year of COVID-19 pandemic reflected the unfreezing step of Lewin's Change Model. As the world responded to the crises, many entities realized that a change was needed to continue our daily lives in spite of the pandemic. We tried to accommodate and sustain life as we knew it. Virtual graduations, weddings, birthdays, and family events were created to mimic "how we have always done it." Restaurants built seating pods and companies installed plexiglass barriers to maintain the experience of how "things were normally done." The world worked very

pandemic dissipates and we become more experienced in maintaining our way of life with the ebbs and flows of protection requirements, we can take the time to analyze last year's unfreezing. Many entities are evaluating the changes that were put in place last year. Organizations are seeking answers to "should we go back to pre-COVID norms" or "adopt some of the changes we implemented last year as permanent alternatives?" I view this year as a time for reflective transformation of strategy, operational, and tactical organizational practices for CMSA.

CMSA is in its changing year. In addition to the many revisions in how we supported case managers during the height of the pandemic last year, we also studied best practices in association management to position the society for agility and flexibility in 2021 and beyond. For example, we look

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What Can Discharge Planners/Case Managers Accept from Providers Who Want Referrals?

Elizabeth Hogue, Esq.

Discharge planners, case managers, and social workers certainly cannot accept cash payments from providers in exchange for referrals of patients. But what can they accept from providers who want referrals? What about non-cash items that have a relatively low value? What about acceptance of referrals to provide services in the evenings and on weekends on behalf of providers who receive referrals from discharge planners/case managers?

The key source that must be considered to answer these questions is

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, the primary enforcer of fraud and abuse prohibitions, has clearly stated that discharge planners/case managers may not accept and post-acute providers may not give cash or cash equivalents, including gift cards and gift certificates.

a federal statute that prohibits illegal remuneration or kickbacks in the Medicare and Medicaid and other federal and state health care programs. This federal statute makes it a crime for providers to offer to give or actually give anything to anyone in order to induce referrals.

Providers who are not Medicare-certified or do not participate in the Medicare program, such as so-called “private” providers, such as private duty home care agencies, may be tempted to ignore this statute. Providers must remember

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30-Day Hospital Readmission Rate A Flawed but Important Metric

The 30-day hospital readmission rate has become an important quality-of-care metric. In this white paper, MCG Managing Editor, William Rifkin, MD, FACP, explores the extent to which readmissions are preventable and the correlations between appropriate hospital admissions and readmission rates.

[Read the White Paper](#)



Key Aspects of the Practice of Hospital Case Management

Elizabeth Hogue, Esq.

The Case Management Society of America (CMSA) published Standards of Practice for Case Management (SOPs) in 1995 and revised them most recently in 2016. Key provisions of the SoPs include:

- Identification and selection of patients who can most benefit from case management services
- Completion of health, cognitive, and social assessments
- Identification of problems or opportunities that would benefit from case management interventions
- Collaboration with clients and stakeholders to develop individualized plans
- Facilitation, coordination, monitoring, and advocacy to minimize fragmentation in services provided and prevent risks of unsafe care and suboptimal outcomes
- Ongoing monitoring to measure patients' responses
- Demonstration of the benefits of case management services

CMSA recently published "The Practice of Hospital Case Management: A White Paper" to provide more details about the provision of case management services in hospitals. Both case managers and post-acute providers need to know about this White Paper because it provides information about what both should be focused on in

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terms of working together.

The White Paper places emphasis on coordination of care as the future of case management services in hospitals, as follows:

"A new value-based marketplace calls for a new vision of case management that eschews tasks and instead focuses on activities that promote a safe, coordinated journey across the continuum for the most vulnerable patients. Ticking off prescribed

According to the CMSA White Paper, the overarching responsibility of case managers as care coordinators is advocacy on behalf of patients.

checkboxes is replaced by thoughtful engagement and purposeful planning by individual case managers based on the needs of their patients. Indeed, it could be argued that the generic principle of case management is to ensure coordination of a patient's case through the assignment of a case manager. Creating a vision of that coordinated journey is a practical approach that will serve as the impetus to align future initiatives, inspire participation and generate new ideas..."

The White Paper goes on to define coordination as: "a deliberate and longitudinal organization of safe, efficient and appropriate care and services for selected patients with multiple needs as they move through the case

continuum from acute care to community settings..."

Specifically, both case managers and post-acute providers must focus on care that is:

- Safe
- Effective
- Timely
- Patient-centered
- Efficient
- Equitable

Based upon the above, case managers must become care coordinators in partnership with post-acute providers.

According to the White Paper, the overarching responsibility of case managers as care coordinators is advocacy on behalf of patients. Although the authors of the White Paper acknowledge the difficulties of advocacy on behalf of patients in hospitals, both the White Paper and the SOPs described above emphasize that this obligation of case managers remains paramount.

This new guidance from CMSA makes it clear that hospital case managers must retool into care coordinators. Partnerships between hospital case managers and post-acute providers are essential to accomplish this transition. Post-acute providers must "step up to the plate" to work with hospital case managers to achieve this goal. [CM](#)

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“Push Pause”: A Campaign of Gratitude for Case Managers

By MaryBeth Kurland, CAE

Throughout the pandemic, professional case managers faced pressure and uncertainty in every care setting, from hospitals to telehealth. Like health and human services professionals everywhere, case managers had to face an unknown pathogen and quickly learn all they could about treatment and prevention protocols.

At the same time, many faced significant [personal challenges](#), as well. According to a survey conducted early in the pandemic by the Commission for Case Manager Certification, nearly one-third (30.5%) of respondents lost income or had their incomes reduced as a result of the pandemic. Another 21.5% of respondents suffered health issues, 20.9% reported mental health issues, 16.6% had food scarcity issues, and 5.3% lost loved ones.

Despite these burdens, case managers rose to the challenge—and continue to do so. The [case management response](#) to COVID-19 has underscored the importance of individual care plans, care coordination, and transitions of care to address the needs of individuals with the disease, particularly those at higher risk because of comorbidities. But there has been a cost borne by case managers, as well as other clinicians and medical professionals, who are facing fatigue and [burnout](#). It's time to “[Push Pause](#).” To show appreciation for all that case managers have done and continue to do, the Commission launched a campaign of self-care and wellness. These offerings, circulated via social media and

on the [Commission's website](#) starting in late 2020, remind case managers of the importance of stopping to breathe, reflect, and restore themselves.

The feedback from our case man-

To show appreciation for all that case managers have done and continue to do, the Commission launched a campaign of self-care and wellness. These offerings, circulated via social media and on the Commission's website starting in late 2020, remind case managers of the importance of stopping to breathe, reflect, and restore themselves.

agement community has been so positive that we wanted to share a sampling of the Push Pause segments. It's a reminder for all of us that stresses mount, challenges increase, and so many people are counting on us, the pause we need is only a click away. Here is some advice from the [Push Pause](#) self-care and wellness experts:

- Dr. Chantise Sims-Holliman, author, speaker, educator, and resilience coach: “Isn't it funny that we know how to push pause on a video, we know how to push pause on our remote control? ... But when it comes time to push pause for ourselves, well, we don't do that good of a job.”
- April Lewis, keynote speaker and

mental fitness coach: “There is so much power in silence. In your silence, you are giving yourself self-care, and self-care is what you need now more than ever so you can continue to show up and serve and help everyone you are responsible for.”

- Wendy Lynch, PhD, researcher, speaker and author: “Ask yourself the question, ‘If I could create a wonderful pause later in my day, what would I most look forward to?’ When you design that answer, you're giving yourself a gift.”

It's so easy for all of us to get caught up in our day-to-day responsibilities. This is especially true of case managers who are often juggling large case loads and trying to help as many people as they can. But we cannot deplete ourselves in the process.

To truly serve others and support our colleagues, as well as take care of those who are in our lives, we need to be good to ourselves. For that, pushing pause is critical. **CM**

MaryBeth Kurland, CAE, is CEO of the Commission for Case Manager Certification, the first and largest nationally accredited organization that certifies more than 50,000



professional case managers and 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.

Helping “Jerry” Return Home

Cassandra Wadlington, MSM, MSN, BSN, RN, ACNE, CEN, TNS

In my job at a major acute care hospital, I learned of a developmentally delayed patient with minor physical disabilities who had been abandoned by his family. He had been hospitalized for many months. Jerry was initially admitted for “seizures” in early February 2020. I realized I needed to investigate and uncover the back story.

Upon speaking to the emergency contact/next of kin, a sister, I discovered that in fact Jerry wasn’t abandoned. However, due to the sister not being a United States Citizen and her living situation with friends, she could not assume responsibility for her brother. She also informed me that Jerry was not a US Citizen; he was from a Caribbean Island where he still had family. The sister relayed that Jerry, her half-brother, was brought to the United States by their father. She happened to meet Jerry when visiting her father one day. Jerry had been living with their father and Jerry’s step-mother until both parents passed away. Then Jerry was cared for by other family members until they too passed away.

I reviewed the chart and learned that Jerry was alert and oriented, and able to answer questions appropriately. I went to visit him and had a conversation, which showed me he had some developmental delay, but was appropriate and answered all of my questions



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fully. He was able to provide the name of his mother, father, and sisters, and said that he wanted to return to his island home and “all the good food.” I contacted his sister to see if she would be returning soon and suggested that we might help make arrangements for him to return with her. She was hesitant, and then refused, saying she

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would be returning, but not soon.

Because there was no medical reason for his continued hospitalization, I contacted the island nation’s consulate in the US for assistance. I was referred to the Consul General at the Embassy in Washington DC. The Consul took the call and confirmed Jerry’s citizenship and agreed to assist with locating family on the island to accept and support him upon his repatriation.

After locating an elderly cousin who still lived there, we learned that Jerry’s mother had also passed away and no other siblings could be located. The cousin was unable to care for him due to her age, physical disability and financial constraints. With this information,

I understood that I needed to learn if there were any facilities that could care for Jerry on the island.

The only assisted living facilities there are for the elderly. There is nothing for the developmentally delayed. It was now September, Jerry was stable, ready for discharge, and asking to go back home because he liked it there. I continued working with the embassy as well as with his sister.

Then one day, I was informed by the embassy that there was a retired medical worker willing to care for Jerry on the island, and that the embassy was making arrangements for Jerry to go home. The only thing stalling his trip home was the COVID-19 pandemic, which had stopped all flights between the island and the US until October 1, 2020.

Due to his disability the decision was made that someone would have to accompany Jerry on the trip home. I was chosen for the task. While waiting for the day of departure, I had multiple visits with Jerry to keep him informed of what was happening and to ensure his comfort level with the discharge plan and with me as a traveling companion. We also kept his sister informed of Jerry’s status and discharge plan.

Working with the embassy and the Minister of Health on the island, we coordinated Jerry’s new residence and finalized the plans for who would provide care once he was repatriated. Jerry was provided with a donated ticket, clothing (purchased and donated by the staff at the hospital), a 6-month supply of medication, a wheelchair, and personal protective equipment.

On October 3, 2020 Jerry was discharged and I traveled with him. Upon

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The Importance of Participation in CARF Field Reviews of Standards

Christine M. MacDonell, FACRM

Case managers have the unique opportunity to work across all health and human services. They bring a wealth of knowledge and competencies to a variety of provider settings and their own businesses. They serve populations with physical disabilities, behavioral health needs, intellectual disabilities, addictions, and pediatric and geriatric concerns. Case management services are in every CARF-accredited program area in a role as a person who coordinates services. In many of the standards manuals there are specific program-level case management standards.

CARF's standards development process could be enriched with more case managers participating in what CARF calls "field review." When developing a new set of standards or revising an existing set of standards, CARF implements a variety of steps that case managers could consider participating in.

First, we are always looking for feedback from individuals working in the field to alert us to changes,



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Tucson, Arizona. She is part of the medical rehabilitation team responsible for the training of CARF surveyors and for the development and revision of CARF standards.

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new evidence, practice guidelines, or new approaches in any of the areas we accredit in. This information comes from payers, trade associations, individual providers, CARF-accredited programs, and CARF surveyors.

Our next step is to decide whether a new set of standards should be developed or if an existing set needs to be revised and updated. If this is the direction we take, we then invite the "field" (providers, consumers, payers, surveyors, national and international level individuals) to participate in an International Standards Advisory Committee (ISAC). The ISAC is usually 12-15 individuals who represent these areas. The most recent work of an ISAC was on the revision of Interdisciplinary Pain Rehabilitation (IPR) Program standards.

The IPR ISAC was unusual in how it was conducted because of COVID-19. Just like many of you who may have turned to telehealth to provide your

services, we developed a virtual ISAC system. The normal process is a 3-day meeting where the experts identify where a particular set of standards could be revised, improved, and enhanced. The virtual ISAC was over a 7-week process with 1-hour sessions every other week and homework for each of those sessions. The homework was reviewed and discussed to make the changes. Just like in a normal ISAC process, on the last session they received their work in the form of a set of standards for a final review.

The next step is a review of the proposed set of standards by CARF's International Advisory Council (IAC), which is comprised of trade associations from the different areas CARF accredits in and individuals interested in the quality standards that CARF produces. Their review generates comments that are considered for changes before general field review occurs.

All case managers are welcome to participate in field review. Every year there are a variety of these field reviews. They are posted on the [CARF website](#) and all are welcome and encouraged to participate. It is an easy process. We ask for some demographic information and we use SurveyMonkey to list each standard; you tell us whether you are very satisfied, satisfied, dissatisfied, or very dissatisfied with the proposed standard. We leave room for all comments, especially for feedback when you do not agree. We listen and respond to field review. Changes come about from this process. All responses

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Innovations in Transitions of Care from the Military to VA

Jennifer Perez, LICSW, Kathleen Dinegar, LICSW, Adrienne Weede, LCSW, and Janet Belisle, MHA, RHIA, FACHE

The Department of Veterans Affairs (VA) mission is to care for those who have borne the battle, and for many of our nation's veterans, this begins with ensuring their access to care and benefits. Among the newest generation of veterans, men and women experience organizational, logistical, and social barriers to care, including challenges with system navigation. Furthermore, advances in battlefield health care delivery and protective gear have improved survival rates among post-9/11 era veterans compared with veterans from other eras. An increase in the number of veterans with service-connected injuries underscores the need for health care services following separation from military service.

Transitioning from the Military

The VA has taken dramatic steps to reduce recently separated veterans' barriers to care and fulfill its mission through post-9/11 transition and case management (TCM). Its origins date back to 2003 with the first VA Liaison for Health Care stationed at Walter Reed Army Medical Center to coordinate severely ill and injured combat veterans' transition of care from the

Department of Defense (DoD) to the VA health care system. The proven effectiveness of a single VA Liaison led to a program expansion with 43 VA Liaisons onsite at 21 military treatment facilities (MTFs) and five virtual VA Liaisons, providing transition assistance to MTFs without an onsite VA Liaison.

VA Liaisons, who are co-located with DoD case managers at MTFs, provide the consistency, consultation,

and collaboration that is needed as service members prepare to leave a military installation and enter civilian life. VA Liaisons, licensed clinical social workers, and registered nurses meet directly with service members to assess their individual health and wellness needs and provide education about VA care, services, and benefits. This one-to-one support ensures that VA care is personalized and patient



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Transition and Case Management (TCM), since 2016 and is the principal advisor on VA Transition and Case Management Services within the Veterans Health Administration. She leads all aspects of the VA Liaison and Post 9/11 Military2VA Case Management Programs nationally at the VISN and facility level.



Kathleen Dinegar, LICSW, has been serving as the National Program

Manager, VA Liaison Program, since October 2016. Ms. Dinegar has programmatic oversight of 43 VA Liaisons for Healthcare stationed at 21 Department of Defense Military Treatment Facilities (MTFs), 5 VA Liaisons serving all other DoD MTFs virtually, and 5 VA Liaisons serving academic medical centers involved in public-private partnerships with VHA.



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VA Liaisons, licensed clinical social workers, and registered nurses meet directly with service members to assess their individualized health and wellness needs and provide education about VA care, services, and benefits. This one-to-one support ensures that VA care is personalized and patient driven as well as tailored to the unique needs of each veteran.

driven as well as tailored to the unique needs of each veteran. By embedding VA Liaisons in MTFs who initiate service members' transition of care before military separation, VA and DoD have developed a collaborative transition of care model that is proactive, safe, and high quality. Since the program's inception, VA Liaisons have coordinated over 130,000 service members' transitions from DoD to VA.

The Value of Connection

VA Liaisons bridge the gap for service members by facilitating their easy access to VA care and transition resources. Through early engagement and assessment, vulnerable service members who may be at risk for suicide or homelessness are identified and receive an expedited VA registration and connection to the post-9/11 Military2VA (M2VA) case management program. Located at every VA medical center (VAMC), M2VA case management programs serve as the main point of contact for the VA Liaison, DoD, and Veterans Benefits Administration programs. The teams serve transitioning service members and post-9/11 veterans by providing proactive outreach and clinical case management services, which include screening, assessing, care planning, care coordinating, and monitoring. Post-9/11 era veterans with health and/or social complexities are assigned to an M2VA case manager who partners with them to create a whole health care plan that is inclusive of the veteran's social determinants of health. As a recently separated veteran navigates

the VA health care system, the M2VA case manager oversees their holistic care coordination needs and supports their community reintegration. In fiscal year 2020, post-9/11 M2VA case management teams screened over 175,000 veterans—93% of whom engaged in VA healthcare for the first time—and provided ongoing case management to over 40,000 veterans.

Bridging the Gap through Strategic Partnerships

Building on resounding success, VA replicated this transition of care model by placing VA Liaisons at Warrior Care Network sites and the Marcus Institute for Brain Health. The Warrior Care Network is an innovative first-of-its-kind collaboration between the VA, Wounded Warrior Project,[®] and four nationally recognized academic medical centers of excellence: Emory Healthcare, Massachusetts General Hospital, Rush University Medical Center, and UCLA Health. These academic medical centers offer specialized clinical services to veterans and their families with posttraumatic stress disorder, traumatic brain injury, and comorbid conditions. The Marcus Institute for Brain Health offers intensive outpatient care for complex patients with a history of mild-moderate traumatic brain injury and associated psychological health conditions. VA Liaisons continue providing state-of-the-art transition assistance to veterans participating in these intensive outpatient programs and assist them with re-engaging in VA care.

The VA's approach to leveraging partnerships is to engage service members and veterans and to ensure their access to care during transition, which exemplifies its mission. By establishing an early connection with the VA, service members and veterans are able to seamlessly transition with the confidence that the VA is ready to serve them and deliver the world-class care they have earned. For more information, please visit www.oefoif@va.gov.

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Culturally Sensitive Care for LGBTQ+ Individuals: Considerations for Case Managers

Abigail Mitchell, DHEd, MSN, MBA, RN, CNE, FHERDSA

Introduction

Case management is a needed puzzle piece for the integration of health care for support and services for a variety of populations. Case management emerged in the 1960s in response to the deinstitutionalization of large number of patients with severe mental health conditions. In the 1970s and 1980s, the cost of health care increased and health services became decentralized, increasing the role of case managers. Case managers have played various roles since the 1990s (Lukersmith, Millington, Carulla, 2016). Case management is important because of our fragmented care delivery systems, lack of insurance and payment structures, lack of access, lack of availability, and lack of acceptability.

Being culturally competent is a necessity for case managers. Culturally competent case managers value diversity and respect an individual's differences regardless of race, religion, and or ethnocultural background. In today's health care environment, another diverse population must be considered for "competency." Case management is essential for the LGBTQ+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual) because they face many challenges including discrimination and bias. Case management can vary in different service sectors, different settings, and within different community settings. Case management supports the missing puzzle piece for the integration of health care and social services for LGBTQ+ individuals, and case managers support LGBTQ+ patients with complex health conditions who face health disparities.

Understanding the history of the LGBTQ+ community in the United States is essential in bringing context to this diverse population. In 1969 the Stonewall riots became the historic launching point for gay rights. In 2003, the Supreme Court voted down sodomy laws across the country with their decision regarding Lawrence vs Texas. In 2013, the Supreme Court decision regarding United States vs Windsor led to same sex couples being allowed to share the same federal benefits as opposite sex couples. In 2015 the Supreme Court decision regarding Obergefell vs Hodges led to same-sex marriage becoming legal in all 50 states.

The DSM (Diagnostic and Statistical Manual of Mental Disorders) has been revised to improve patient treatments and outcomes. In DSM-I (1952), homosexuality is listed as

a sociopathic personality disturbance. In DSM-II (1968), homosexuality continues to be listed as a mental disorder. In DSM-II (1974), homosexuality is no longer listed as a disorder. The diagnosis is replaced with the category of sexual orientation disturbance. In DSM-III (1980), the diagnosis of ego-dystonic homosexuality replaces the DSM II category of sexual orientation disturbance and introduces gender identity disorder. In DSM III-R (1987), ego-dystonic homosexuality is removed and replaced by sexual disorder not otherwise specified. DSM-V (used today) includes a separate nonmental disorder diagnosis of gender dysphoria to describe people who experience significant distress with the sex and gender they were assigned at birth (Cabaj, 2021).

International Classification of Diseases, 10th Revision (ICD-10) still uses the outdated term of gender identity disorder (F64.0 is a code that covers transsexualism, F64.1 covers dual role transvestism, F64.2 covers gender identity disorder of childhood, F64.8 covers other gender identity disorders, and F64.9 covers gender identity disorder, unspecified).

Overview:

It is estimated that 9 million LGBTQ+ individuals live in the United States and that more than 650,000 are same sex couples. Adults who identify as LGBTQ+ make up 4.5% of the population. Suicide is a leading cause of death for the LGBTQ+ population: 30% of gay youth attempt suicide by the age of 15, with 1,500 succeeding every year. Twenty percent of homeless youth are LGBTQ+. Forty-four percent of lesbian women and 61% of bisexual women report rape, physical violence, and stalking as compared with 26% of gay men and 37% of bisexual men (www.ncadv.org). People who identify as LGBTQ+ are members of every community and include

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Being culturally competent is a necessity for case managers. Culturally competent case managers value diversity and respect an individual's differences regardless of race, religion, and or ethnocultural background.

people of all ages, ethnicities, races, and different socioeconomic backgrounds. LGBTQ+ individuals live in a few concentrated metropolitan areas that include Seattle, Washington (12.9%), Atlanta, Georgia (12.8%), and San Francisco, California (15.4%) (sexualdiversity.org). Healthy People 2020 reported that the LGBTQ+ population is considered a vulnerable population because of many health disparities. Healthy People 2030 includes 3 types of objectives: core, developmental, and research that will be implemented and maintained throughout the decade. Social determinants of health have a huge impact on the health, well-being, and quality of life of the LGBTQ+ population. A goal of Healthy People 2030 is to improve the health, safety, and well-being of the LGBTQ+ population (<https://health.gov/healthypeople>). The U.S. Department of Health & Human Services (HHS) started actively working to improve the health, safety, and well-being of the LGBTQ+ population in response to the many social and health inequities that were prevalent in the community in 2017 (<https://www.hhs.gov/>). For continuity and simplicity, this article uses the term LGBTQ+ to indicate the full spectrum of minority gender identities and sexual orientations.

Disparities

Research shows that the LGBTQ+ population have difficulty accessing health care services and obtaining health insurance and that they have lower rates of routine follow-up visits for chronic health conditions and routine screenings. According to the HHS, individuals who identify as LGBTQ+ are at a higher risk of substance use and abuse; obesity; mental health disorders; sexually transmitted diseases; physical, psychological, and sexual abuse; and suicide than heterosexual individuals. Lesbians and bisexual women are at higher risk for colon, ovarian, and breast cancer. Gay men are at higher risk for prostate and testicular cancer. LGBTQ+ individuals are less likely than heterosexual and cisgender people to seek preventive care. Several studies have suggested that homophobia contributes to substandard health care for gays, lesbians, and bisexuals that leads to decreased life expectancy compared with the heterosexual population (Dean, Guidry-Grimes, 2016). A report from the Centers for Disease Control and Prevention (2017) found that health disparities exist among an estimated 2.6 million sexual minority students. Sixty-three percent feel sad or hopeless, 48% have seriously considered suicide, 33% felt bullied,

and 23% reported using illicit drugs (<https://cdc.gov>). Discrimination and bias have contributed to poor physical health and outcomes for all age groups of the LGBTQ+ community. Many individuals in the LGBTQ+ community have been discriminated against and marginalized by health care professionals (Dean, Guidry-Grimes, 2016). While there are many factors contributing to health care avoidance such as fear, stress, and discrimination, case managers can improve the patient experience and promote patient health outcomes. A LGBTQ+ patient may present with complex issues or be at higher risk for the following:

- Intimate partner violence
- Eating disorders including obesity
- Mental health disorders such as anxiety and depression
- Sexual and reproductive health issues
- Smoking, alcohol, and opioid use along with other substance abuse
- Cardiovascular health problems
- Increased risk of certain cancers
- Hormonal imbalances
- Metabolic syndrome

Barriers to health care

In 2016, President Obama's administration issued a regulation clarifying that Section 1557 of the Affordable Care Act (ACA), which prohibits sex discrimination in health care, also prohibits discrimination against LGBTQ+ people. This bill is the first federal civil rights law to prohibit discrimination based on sex in health care, and it extends nondiscrimination protections to individuals enrolled in coverage through the health insurance marketplace and other health coverage plans (www.hhs.gov/). In 2019, the HHS rule changed under President Trump. The rule would allow the health care industry to legally discriminate against people who are LGBTQ+ by denying them health care, including lifesaving procedures that have nothing to do with their sexual orientation or gender identities (Slisco, 2020). On May 10, 2021, the U.S. Department of Health and Human Services announced that the Office for Civil Rights will interpret and enforce Section 1557 and Title IX's prohibitions on discrimination based on sex to include: (1) discrimination on the basis of sexual orientation; and (2) discrimination on the basis of gender identity. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or

Case management is essential for the LGBTQ+ community because they face many challenges including discrimination and bias.

disability in covered health programs or activities. The update was made in light of the U.S. Supreme Court's decision in *Bostock v. Clayton County* and subsequent court decisions. President Biden signed an executive order in January 2021 that directed federal agencies to comply with federal antidiscrimination statutes covering sex discrimination. On February 25, 2021, the House passed the Equality Act, a landmark LGBTQ+ rights bill that prohibits discrimination based on sexual orientation and gender identity in numerous areas such as employment, housing, education, public accommodations, credit, and jury service. Protection at the various state levels are lacking. In 10 states, transition-related health care is excluded from Medicaid coverage, limiting options for low-income transgender patients.

Various reports have shown that LGBTQ+ individuals have difficulties finding hormone replacement therapy, HIV prevention and treatment options, fertility and reproductive services, and primary care physicians who are welcoming (hrw.org). In addition, LGBTQ+ individuals have been refused services because of their sexual orientation or gender identity. In 2017, a nationally representative survey reported that 8% of lesbian, gay, and bisexual respondents and 29% of transgender respondents reported that a health care provider refused to see them based on their sexual orientation or gender identity (www.hhs.gov/). Other issues that LGBTQ+ individuals encounter include a lack of informed care, inappropriate name or pronoun use, intake forms not asking the right information (which is offensive), and confidentiality/privacy not always respected.

Communication

It is important to create a health care environment that is inclusive of all patients regardless of SOGI (sexual orientation and gender identity), language, religion, socioeconomic status, and sociocultural and other factors. Poor communication can lead to improper care and a risk of explicit discrimination. Case managers may unintentionally convey awkwardness and discomfort that could hurt the patient relationship. In today's environment, gender and sexuality are fluid and therefore a variety of vocabulary and terms exist to describe and refer to individuals with diverse SOGI. It is important for any case manager to be aware of the current vernacular in order to treat patients with respect and sensitivity. If case managers do not know if their patient identifies

as LGBTQ+ and/or if they do not know their patients' SOGI status, important preventive and therapeutic services may not be offered (Streed, Grasso, Reisner, Mayer, 2020).

Conscientious efforts to use patients' preferred names and pronouns is an easy way of creating a welcome and inviting environment. This can be accomplished by asking the patient their preferred name and preferred pronoun and by then documenting this communication into the medical record for the other health care provider that will be accessing the record to provide care. Creating a safe environment is important. Case managers can establish trust and rapport with LGBTQ+ patients, even when seeking out questions such as sexual behavior, identity, and attraction. To make patients feel normal, ask the same questions you would ask any other patient. Ask open-ended questions because you should not assume anything about their relationships, partners, or sexual behavior. For example, ask the patient "Do you have sex with men, women, or both?" Also ask the patient, "How do you identify yourself?" The case manager should be sensitive to patients who are in transition and ask how they would like to be addressed and what the appropriate pronoun would be. Case managers should be aware of issues pertinent to LGBTQ+ patients such as legal rights as parents and partners, aging, adolescence, parenting and creating families, reproduction or adoption, coming out, and health barriers (Levitt, Klingenstein, Reiss, 2020).

Understanding the Acronym, Language, and Identity

Because of the long history of discrimination against LGBTQ+ people in health care settings, nondiscrimination and employment policies should include the terms "sexual orientation," "gender identity," and "gender expression." Table 1 provides terms and definitions related to sexual orientation and gender identity. Even though the discussion of SOGI is more commonplace today than in the past, there is still a lack of education and awareness of how to appropriately and openly communicate with this population (Pilgram, 2017). Increased education and awareness about the diversity in the LGBTQ+ community and a good understanding of the complex acronyms and language that a person may use to self-identify will help reduce the stigma of being a member of the LGBTQ+ community and avoid unintended discrimination by health care providers such as case managers (Lee & Kanji, 2017).

LGBTQ+ patients lack trust in the health care system,

TABLE 1 TERMS AND DEFINITIONS*

Aromantic	People who do not experience romantic attraction
Asexual	Broad spectrum of sexual orientation. Does not experience sexual attraction or desire
Binary system	A system comprised of two opposing parts. Male/female system for sex, and man/woman is a binary system for gender
Bioromanticism	Capable of feeling romantic connection with people of both similar and different genders
Bisexual	A person whose primary sexual and affectional orientation is towards people of the same and other genders
Cisgender	Person whose gender identity matches the sex of their body and the gender they were assigned at birth
Demisexual	Attracted only to people when there is an emotional connection
Gay	A sexual and affectional orientation toward people of the same gender
Gender fluid	Gender identity that shifts; it may or may not be binary. A gender fluid person may feel like a man some days and like a woman other days
Gender identity	A person's internal sense of self and how they fit into the world
Gender nonconforming	A person whose gender identity differs from that which was assigned at birth but may be more complex, fluid, multifaceted or otherwise less clearly defined than a transgender person
Intersex	An umbrella term used to describe a wide range of natural body variations that do not fit neatly into conventional definitions of male or female.
Lesbian	A woman whose primary sexual and affectional orientation is toward people of the same gender
Pansexual	Can be attracted to any sex or gender or can be referred as omniseuxals or as being gender blind
Polyamorous	Intimate relationships with more than one partner with consent from all partners
Queer	Some people may use queer, or more commonly genderqueer, to describe their gender identity and/or gender expression. Once considered a pejorative term, queer has been reclaimed by some LGBTQ+ individuals to describe themselves; however, it is not a universally accepted term even within the LGBTQ+ community.
Questioning	Sometimes, when the Q is seen at the end of LGBT, it can also mean questioning. This term describes someone who is questioning their sexual orientation or gender identity.
Sexual orientation	A person's sexual identity in relation to the gender to which they are attracted; the fact of being heterosexual, homosexual, or bisexual.
Transgender	A person whose gender identity differs from the sex that was assigned at birth
Transgender female/woman	Someone with female gender identity and a male sex assigned at birth
Transgender male/man	Someone with male gender identity and a female sex assigned at birth

*Please note that this chart may not be all inclusive.

TABLE 2 RESOURCES FOR MORE INFORMATION ON LGBTQ+

Centers for Disease Control and Prevention	https://cdc.gov
The Fenway Institute and the National LGBT Health Education Center	https://fenwayhealth.org/the-fenway-institute/
National Resource Center on LGBTQ Aging	https://www.lgbtagingcenter.org
LGBTQIA+ Health Education Center	https://www.lgbthealtheducation.org/resources
LGBTQ Youth Resources	https://www.cdc.gov/lgbthealth/youth-resources.htm
National Resources-Office of LGBTQ	https://www.vanderbilt.edu/lgbtqi/resources/national-resources
U.S. Department of Health & Human Services	https://hhs.gov

Case management supports the missing puzzle piece for the integration of health care and social services for LGBTQ+ individuals, and case managers support LGBTQ+ patients with complex health conditions who face health disparities.

which in return impacts patient outcomes. Being aware and using resources to guide case managers is beneficial for all of those involved in caring for LGBTQ+ patients. There are many resources for information on LGBTQ individuals. Table 2 includes a few of the easier ones to navigate.

Gaining Competence Using Education and Training

To provide compassionate and quality health care to LGBTQ+ individuals, health care professionals, including case managers, should expand their knowledge about the community. Despite the current openness of homosexual relationships, most clinicians and people in general are uncomfortable interacting with this community because of a lack of guidance. Organizational policies and training (listing sexual orientation and gender identity/expression in patient and employee nondiscrimination policies) do not often explicitly mention the importance of providing culturally responsive care for LGBTQ+ individuals and they do not evaluate trainee competence (Baldwin, 2017). For change to be implemented, health care providers such as case managers should be held accountable and take leadership roles in initiating organizational change. This can be achieved by identifying organizations' strengths and weaknesses so that they can direct their attention toward making progress in deficient areas (Baldwin, 2017). The Fenway Institute (2012) noted that effectively serving LGBTQ+ patients requires clinicians to understand the cultural context of their patients' lives, modify practice policies and environments to be inclusive, educate themselves about the health issues of importance to their patients, and reflect on personal attitudes that might prevent them from providing the kind of affirmative care that LGBTQ+ people need.

Strategies

Case managers in all areas should take the time to increase personal and professional preparedness to improve outcomes for the LGBTQ+ population. The following are a few questions you can ask yourself to ensure culturally competent services: How do I feel about LGBTQ+ patients? Are our services available to LGBTQ+ patients? Are our services appropriate for and acceptable to LGBTQ+ patients? Have we made our services welcoming to LGBTQ+ patients? Case managers need to be mindful of biases. Educate yourself as case managers but also educate the health care providers on

your team. Develop policies to promote objective decision making and provide guidance and continue to educate yourself about LGBTQ+ patients to improve outcomes. Health care organizations should display posters, pamphlets, and information on the organization's website geared towards LGBTQ+ patients (Panganiban & O'Neil, 2021). The Fenway Institute works to make life easier for LGBTQ+ individuals by providing education and training and has developed a toolkit for collecting information about sexual orientation and gender identity in clinical settings. Their resources include webinars, publications, videos, and other up-to-date resources (<https://www.lgbtqihealtheducation.org/>).

Conclusion

Case managers' tasks are now performed by people from various disciplines for people with different problems in diverse populations such as the LGBTQ+ (Lukersmith, Millington, Carulla, 2016). The objective of case managers is to provide a service delivery approach to ensure that cost-effective care is provided. This can be done by providing alternatives to institutionalization, by providing access to proper treatment, by coordinating services, and by improving patient outcomes. Studies suggest that, with proper training and education, case managers can decrease disparities for LGBTQ+ patients. Improving the case manager and LGBTQ+ patient relationship by creating a warm, knowledgeable, and inclusive environment will allow for increased trust. Increased knowledge and implementation of knowledge may eliminate the stress and trauma that LGBTQ+ individuals feel when working with case managers. Case managers must be aware of the needs of the LGBTQ+ community. **CE**

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COVID-19 Family Action Plan: Supporting Families of Children with Chronic Health Conditions and Medical Complexities

Diana Dobbins Johnson, RN, MSN, CCM, and Margie Farrar-Simpson, MSN, RN, PNP-BC, NE-BC, CCM

When the COVID-19 pandemic emerged in spring 2020, leaders of the Children's National Hospital's Clinical Resource Management (CRM) department in Washington, DC, identified the need to prepare a tool for families with children in the community to prevent them from becoming infected with COVID-19 and to make provisions in the event someone in the family became infected with COVID-19. School systems and workplaces in the Washington, DC, metro area were transitioning to distance/virtual learning from in-person learning and to telework when possible with the exception of essential employees. Stay-at-home orders were put in place to encourage people to stay home to stop the spread of COVID-19 and to stay safe. Cases were just beginning to be identified in our area, and COVID-19 was newly identified as a worldwide pandemic.

The primary populations served by the Ambulatory Case Management (ACM) are children, adolescents, and young adults from newborns to 22 years old from the DC metropolitan area which includes Washington, DC, Maryland, Virginia, and West Virginia. The team is comprised of a nurse manager, nurse, social work case managers, and community health coordinators serving medically complex specialty and primary care populations. The ACM team coordinates care across the health care continuum within Children's National Hospital and the greater community. The ACM program provides support to children in several subpopulations. Figure 1 shows a snapshot of population data from the ACM patient subpopulations in February 2021. One population includes children with medical complexity, defined at Children's National Hospital as those who have a diagnosis that affects 3 or more body systems and have an additional high-risk criterion. A second patient population is children who have 3 or more chronic conditions who are beneficiaries of DC Medicaid or one of the DC managed care organizations. Finally, we have a specialty population inclusive of hematologic disorders, oncology, genetic diseases, and colorectal diseases. Our emergency department (ED) population focus is on those seen in the ED for low acuity, nonurgent conditions (eg, asthma, fever, rash, sore throat). Many of these children and families receive government benefits such as Medicaid,

some have commercial coverage, and some families of children with disabilities receive Medicare.

Many of the children supported by the ACM team have chronic health conditions and medical complexities, including technology dependence (eg, gastrostomy tube, tracheostomy, ventilator dependence, or genetic disorders requiring weekly intravenous infusions). Thus, it was critical to keep them as safe as possible during this pandemic. In the early stages of the pandemic, the ACM team members contacted each of their assigned families via phone to review the COVID-19 guidelines and to inquire about any social determinants of health needs. It became apparent that many families were concerned about social determinants of health (ie, food insecurity, lost wages, virtual learning) as stay-at-home orders were in place, and these concerns needed to be included in the family action plan. Within our health system, community-based testing demonstrated racial, ethnic, and socioeconomic disparities in COVID-19 infection, with higher rates among minority and socioeconomically disadvantaged children (Goyal et al., 2020).



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Margie Farrar-Simpson, MSN, RN, PNP-BC, NE-BC, CCM, is the Manager of Ambulatory Case Management at Children's National Hospital and provided leadership, oversight, and editorial review of the Coronavirus (COVID-19) Family Action Plan. She has over 20 years of experience in the ambulatory setting as a board-certified pediatric nurse practitioner and a leader in ambulatory case management. She received her bachelor of science and master of science in nursing, and she received a pediatric nurse practitioner postgraduate certificate from the University of Virginia.



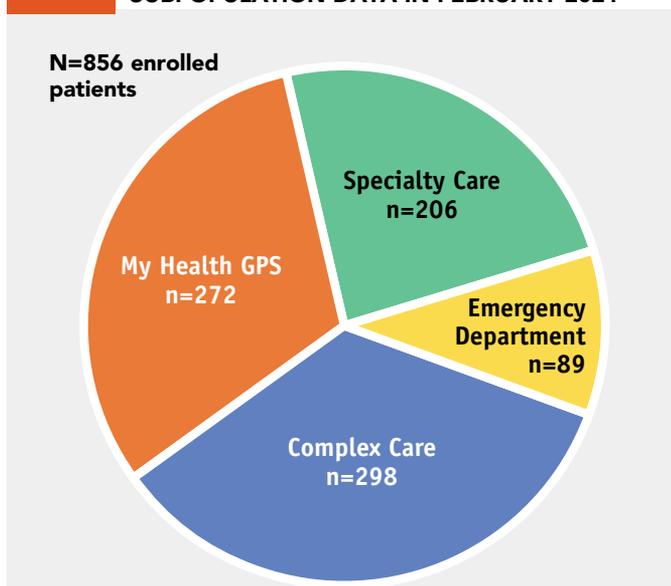
The primary objective of developing the COVID-19 Family Action Plan was to educate families of children with chronic health conditions and those with medical complexity, many of whom are technology dependent, in the Ambulatory Case Management Program about COVID-19 prevention.

Objective

Members of the ACM program at Children's National Hospital led the development of this tool. The primary objective of developing the COVID-19 Family Action Plan was to educate families of children with chronic health conditions and those with medical complexity, many of whom are technology dependent, in the ACM Program about COVID-19 prevention. Beyond our health system, we planned to disseminate the tool to the pediatric community at large to prevent them from becoming infected with the COVID-19 virus. We designed the tool to provide guidance for medical providers in the home who were caring for the family's child and to provide a plan if someone in the family became infected. The tool can help a family create a plan to ensure all household family members are aware of the preventative guidelines and can receive appropriate care and that family members can proactively plan for healthcare needs and identify any social determinants of health (eg, food, housing, employment support) if a caregiver or other family member became infected with the virus.

With stay-at-home orders, it was important to connect families to local resources that were identified through screening for social determinants of health. Foster et al. (2020) found that over half of families with chronic disease in a case management program reported a social determinant of health concern, and individuals with food insecurity had higher rates of ED utilization. Using a web-based national resource platform, Aunt Bertha, we were able to identify resources and programs in the family's area that could be easily accessed. As the national resource platform has email and text capabilities, this enhanced sharing of resource information with families. Our team also worked with the public school system to connect and obtain needed educational tools for our patients/students. Finally, as our families shared with us, it was important for caregivers to have a list of local resources and reference links so that they could stay informed of updates and changes related to COVID-19. Links to local DC, Virginia, and Maryland COVID-19 sites and the Centers for Disease Control and Prevention (CDC) website were included on the tool.

FIGURE 1 AMBULATORY CASE MANAGEMENT PATIENT SUBPOPULATION DATA IN FEBRUARY 2021



Methods

Five staff members of the ACM team of CRM volunteered to create, assemble, and develop the Children's National Hospital's Coronavirus (COVID-19) Family Action Plan. The team, consisting of 3 nurse case managers and 2 community health coordinators, began by searching for similar tools created by other pediatric and healthcare institutions. Although there were COVID-19 tools available (Gray et al., 2020), the team began gathering ideas to create a tool that would be targeted to meet the needs of the Children's National Hospital patient population.

The Children's National Hospital's Coronavirus (COVID-19) Family Action Plan was developed with the familiar theme of a stop light (green, yellow, red) and modeled after the hospital's Asthma Action Plan. Using this framework, parents/caregivers could easily recognize the 3 zones to focus on COVID-19 prevention, they could respond to an exposure (whether it was the child or another family member), and they could minimize transmission when someone became infected with COVID-19. The importance of the use of visual

The Children’s National Hospital’s Coronavirus (COVID-19) Family Action Plan was developed with the familiar theme of a stop light (green, yellow, red) and modeled after the hospital’s Asthma Action Plan. Using this framework, parents/caregivers could easily recognize the 3 zones to focus on COVID-19 prevention, they could respond to an exposure (whether it was the child or another family member), and they could minimize transmission when someone became infected with COVID-19.

reinforcement and readability were taken into consideration (Hamaguchi et al., 2020). The tool was created to meet the standard of being readable at a sixth grade level, which is the standard for patient/family education materials (Mishra et al., 2020).

Additionally, many of these patients are technology-dependent and may have other medical providers (eg, a private duty nurse or home health aide) coming into their homes to provide care. It was important that the caregivers in the home be assured that all members of the household were following preventative measures around COVID-19. One of our team’s primary goals was to provide information to empower parents/caregivers so that they would be able to speak to those individuals coming into their homes and to ensure that infection control expectations were maintained.

The first draft of the tool was reviewed and edited by the manager of the ACM team, the Vice President of Revenue Cycle and Care Management, and the Director of Infection Control/Epidemiology for accuracy of the COVID-19 guidelines. The Patient/Family Education manager provided input on completion, readability, and health literacy. We also asked 6 families within the ACM Program who had children with different diagnoses, care needs, ages, and backgrounds to review the tool and provide feedback. They were asked if the tool was helpful, if it was easy to understand, if they would follow the recommendations, and if additional information would be helpful. Parents/caregivers offered invaluable input into the development of this resource.

Overall, the feedback was that the tool was helpful, that they would follow the recommendations, and that the tool was well designed. Suggestions included tailoring the section to call the doctor with the individual family’s primary care provider’s phone number and making the yellow section clearer; the feedback also indicated that the plan to be isolated was confusing. Other recommendations were to include guidance in the green zone about “well visits” and the steps families should take before/during/after and to add information about medical devices (ie, oxygen, walkers) in the yellow zone. Families thought some of the words may have been too complex (before review for grade level) and wondered whether the tool would be mailed or emailed to families.

One concern was that families without internet access may not receive the tool. All recommendations were reviewed, and necessary adjustments were made. The final tool incorporated family feedback and was adjusted to the recommended sixth-grade reading level. Final wording and structure were completed with the Revenue Cycle and Care Management project manager, and the resulting tool was translated into Spanish for wider distribution. Figures 2 and 3 are the COVID-19 Family Action Plan in [English](#) and [Spanish](#).

Results

The COVID-19 Family Action Plan was developed in English and Spanish and was distributed in December 2020 via email to 554 families. Families were encouraged to keep the tool in a common area for all family members to view and read. Additionally, for one subpopulation in our target population, staff of the My Health GPS, a Home Health II program, were required to report COVID-positive patients to the local health jurisdiction on a monthly basis. These patients and their families used the tool to manage COVID-19 symptoms in household members. In addition, they were assessed for social determinants of health needs per the tool. Other staff members used the tool in the community to assist with planning if a family/household member was COVID-19 positive. The planning included identifying a room for isolation, storing extra food, using paper products to provide meals to the individual, and reaching out to neighbors proactively for assistance if other caregivers became ill. Additional anticipatory guidance included creating a list of important phone numbers that the infected household member could use for ease of communication.

The tool was used creatively with a Spanish-speaking family who did not have an email address but who could share a picture. A bilingual staff member was able to be educated via phone as the family took notes. The tool was also shared by some staff members with new families when enrolling in ACM. Some families indicated that they would have liked to have the tool earlier when members of their family contracted COVID-19. The tool has been shared with 7 primary care practices in the District of Columbia, 3 managed care organizations, and a local Maryland department of health, and

The COVID-19 Family Action Plan can help a family create a plan to ensure that all household family members are aware of the preventative guidelines and how to receive appropriate care, can proactively plan for healthcare needs, and can identify any social determinants of health (eg, food, housing, employment support) if a caregiver or other family member became infected with the virus.

it was also included on our internal departmental web page. Our next step for this project includes developing a quality improvement survey to obtain feedback from caregivers in the home on the efficacy of the tool.

Discussion

The COVID-19 Family Action Plan proved to be a useful tool for our complex and chronic patient population. Our primary goal of creating the tool was to provide needed education to families and caregivers, to provide anticipatory guidance if someone in the family tested positive for the virus, and to connect families to resources given the financial impact of the pandemic on families.

Children's National Hospital is celebrating 150 years of caring for children in the community. As one of the top children's hospitals in the nation, our mission is to excel in care, advocacy, research, and education. One way we accomplish our mission is by leading the creation of innovative solutions to pediatric health challenges. The tool created by our team was the result of an identified need to provide accurate information and guidance to families of children with chronic and complex needs in a global pandemic. Our team was dedicated to providing much-needed information about a new, scary virus to a vulnerable patient population, those with chronic and complex health needs. In a time of so much uncertainty in the world, we knew parents would trust information from Children's National Hospital and wanted to provide guidance to keep patients and families safe and healthy in the midst of a pandemic. The COVID-19 Family Action Plan was a valuable contribution for the vulnerable pediatric population we serve, for medical providers in the home setting, and for family members and the community at large.

Conclusion

The effectiveness of COVID-19 Family Action Plan was due to input from clinical and nonclinical team members involved in the creation of this tool. Our unique skill sets and expertise complemented each other in developing the tool to include health information as well as in identifying social determinants of health and connecting families to resources. Starting from a simple idea, this team created an impactful

tool to educate, empower, and keep patients and families safe and healthy. The organization's core values of compassion, commitment, and connection are demonstrated daily by the members of the ACM team as our relationship with patients, families, medical teams, and programs in the community is visible each day in all interactions. Our goal is to help children and their families grow up stronger. **CE II**

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Spotlight on Geriatric Patients: Part I:

Depression and Cognitive Impairment in the Geriatric Population

Chikita Mann, MSN, RN, CCM

Appropriate care for the geriatric population is a growing concern. The number of individuals over the age of 65 in the United States (US) has risen to more than 54 million per the U.S. Census Bureau, and it is anticipated that the geriatric population will account for 20.2% of the US population by 2050 (Ortman, Velkoff, & Hogan, 2014). This increase in the geriatric population has presented new and unaddressed concerns regarding mental health resources and testing for this group. Geriatric psychiatry is a new specialty within American medicine. Mental health resources and specialized psychiatric care for geriatric clients are sorely lacking. Mental health disorders are on the rise, partially because of isolation and social distancing associated with COVID-19. Attention to late-life depression (LLD) as well as treatment and prevention of depression is imperative. Depression is a worldwide public health issue.

Depression can be complicated by cognitive impairment, which can occur simultaneously in patients. Research has shown that depression can be a prodromal symptom of or risk factor for dementia. Geriatric depression, which has increased mortality rates caused by medical illness, results in increased health care costs.

The purpose of this article is to explore how depression in geriatric clients differs from that in other age

groups. The article also discusses the prevalence and causes of cognitive impairment and how it can lead to the development of depression. This will allow us to gain an understanding of how cognitive impairment and depression correlate with each other. The unique ethical dilemmas that a board-certified case manager could encounter will be addressed, along with considerations for care coordination for the geriatric client.

Late-Life Depression

One of the most common chronic diseases in the general population is depression (McCall & Kintziger, 2013). Late-life depression is defined as depression occurring in individuals older than 60–65 (Aziz & Steffens, 2013). It is often underrecognized, undertreated, and misdiagnosed. The symptomatology of LLD differs greatly from early-onset depression. Individuals with LLD are less likely to have a family history of depression, whereas those with early-onset depression have a familial history of depression. Late-life depression manifests differently in geriatric clients. Symptoms include apathy, weariness, guilt, anger, fearfulness, poor appetite, and hopelessness (Aziz & Steffens, 2017). Common physical symptoms that could be indicators of depression are bowel irregularities, decreased sexual interest, slowed or decreased speech, digestive issues, and disheveled appearance (Smith et al., 2015)

Depression in the elderly can present in three different ways. It can manifest as a recurrence from earlier life or it can develop late in life. It could also be a result of medication interactions or adverse effects.

For some individuals, depression can be considered as a cognitive disorder because it can affect one's working memory, ability to focus and handle emotions, sustain attention, and processing speed. Cognitive deficits occur more with LLD, which supports theories that vascular disease and neurodegenerative disorders could be contributing factors to developing LLD. Among those complaints are working memory issues, learning difficulties, selective attention, and altered memory retrieval (Aziz & Steffens, 2017). The chances of developing LLD is higher in individuals who have been diagnosed early in life with depression. Depression can occur



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multinational property and casualty insurer and carrier. The views and opinions expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Commission for Case Manager Certification.

Appropriate care for the geriatric population is a growing concern. The number of individuals over the age of 65 in the US has risen to more than 54 million per the US Census, and it is anticipated that the geriatric population will account for 20.2% of the US population by 2050.

as an interaction of biological and psychosocial factors. We briefly discuss how these factors can contribute to depression in the geriatric client.

Biological

Cognitive impairments related to processing speed, memory, and executive functioning usually are concomitant with the diagnosis of LLD. The most common manifestations of executive dysfunction are disorganization, impaired concentration, difficulty shifting attention, and a tendency to dwell on irrelevant information. Other symptoms include reduced verbal fluency and psychomotor retardation. Cognitive deficits are primarily caused by frontal lobe structural and functional abnormalities. (Aziz & Steffens, 2013).

Geriatric clients are likely to have significant comorbidities, particularly cardiovascular and cerebrovascular diseases such as strokes and aneurysms, that increase the risk of LLD. It has been hypothesized that there is a reciprocal relationship between depression and vascular disease (Barnes et al., 2012). Research has shown a correlation between depression and medical conditions that cause chronic inflammation in the body (ie, autoimmune and endocrine diseases) (Sonsin-Diaz et al., 2020). Various research has shown that geriatric clients with basal ganglia disorders or neurodegenerative diseases (ie, Parkinson's disease, Huntington's disease, multiple sclerosis, and Alzheimer's disease) have an increased risk of developing LLD. In fact, major depressive disorders have been found to be common among patients with dementia. Other common

comorbidities associated with LLD are cancer, functional impairments, chronic pain, hypertension, arthritis, and chronic obstructive pulmonary disease (Byers & Yaffe, 2012; Aziz & Steffens, 2013; McCall & Kintziger, 2013; Smith, Haedtke, & Shibley, 2015). Another surprising yet common contributor to the development of LLD are medications that are taken to treat another health condition.

Psychosocial Factors

Individuals with low educational level, low income, and no health insurance are more likely to have higher rates of depression. Other psychosocial factors include stressful life events such as dealing with the loss of a spouse, divorce, and forced relocation (ie, to live with other family members). Social factors that increase the chances of developing LLD are forced retirement, female gender, living in an institution (eg, nursing home or assisted living), and lack of social support (Smith et al., 2015). Elderly caregivers also are at increased risk for developing depression.

Treatment options

Effective treatment for LLD depends on the geriatric client being diagnosed accurately. If the client has been diagnosed with depression, there are pharmacological and/or nonpharmacological treatment options. The Expert Consensus Guidelines recommend that antidepressant drug therapy should be combined with psychosocial intervention. One class of medications that has been effective for geriatric clients is selective serotonin reuptake inhibitors. Sertraline, paroxetine, and duloxetine

are first-line treatment for LLD (Beyer & Johnson, 2018).

Electroconvulsive therapy (ECT) has been effective in treating depression in geriatric clients. It is indicated for psychotic depression, severe nonpsychotic depression, and inability to respond to antidepressants. Both continuation and maintenance ECT have proven to be effective with geriatric clients. The major issue with ECT is adverse cognitive effects (Kerner & Prudic, 2014).

Nonpharmacological treatment is gaining popularity in the treatment of depression. One option is cognitive remediation training. With this training, the therapist helps the geriatric client develop new problem-solving strategies. It involves computerized cognitive training, building new problem-solving skills, and transferring the new cognitive changes into clients' daily lives. Cognitive remediation training can enhance interpersonal relationship skills and correct communication deficiencies (Douglas, Milanovic, Porter, & Bowie, 2020; Morimoto et al, 2012). Another treatment for major depressive disorder is Treatment with Exercise Augmentation for Depression (TREAD). Patients' psychomotor processing and executive functioning as well as attention and visual memory have improved with therapy (Chakrabarty, Hadjipavlou, & Lam, 2016). Other recommended psychotherapies are Problem Solving Therapy for Executive Dysfunction (PST-ED), Problem Adaptive Therapy (PATH), Interpersonal Psychotherapy for Mild Cognitive Impairment (IPT-CI), and Engage (Morimoto, Kanellopoulos, Manning, & Alexopoulos, 2015).

Depression in the elderly can present in three different ways. It can manifest as a recurrence from earlier life or it can develop late in life. It could also be a result of medication interactions or adverse effects.

Mild Cognitive Impairment

Cognition is the process of gaining knowledge and insight. It has a complementary relationship with emotion and affects one's quality of life. Cognition involves attention, working memory, psychomotor speed, declarative memory, planning, and decision making. Divided attention, verbal fluency, learning, and reaction time tend to decline with normal aging. Cognitive deficits are defined as impairment in language, attention, judgment, and memory. Cognitive decline can range from mild cognitive impairment to dementia. For this article, we will focus on mild cognitive impairment.

Mild cognitive impairment is estimated to occur in 14%–18% of individuals aged 70 and older. It was previously believed that mild cognitive impairment was primarily associated with memory impairment, but research has shown that there can be impairment in the nonmemory cognitive domains (attention, visuospatial, language). Geriatric clients often have physical frailty and cognitive impairment, which can increase their chances of developing depression (Jongsiriyanyong & Limpawattana, 2018). The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) provides different categories for specific cognitive domains: perceptual-motor, executive function, language, social, complex attention, and learning and memory (McDonald, 2017). Mild cognitive impairment does not hinder independent living, but geriatric clients may need assistance with some activities such as managing medications or money. Cognitive decline can also

interfere with language skills, which can hinder a geriatric client's ability to articulate their thoughts and feelings.

Risk factors for mild cognitive impairment are classified as nonmodifiable and modifiable. Nonmodifiable risk factors are those such as gender, genetics, and age. Modifiable risk factors include neuropsychiatric conditions (depression and anxiety), vascular (ie, hypertension, diabetes, stroke), cardiovascular disease outcomes (congestive heart failure, coronary artery disease), and systemic inflammation (Roberts & Knopman, 2014).

Treatment for cognitive impairment is centered around lowering cardiovascular risk factors and stroke prevention. Aerobic activity has been found to decrease the acceleration of cognitive decline. Social engagement and mental activity may help lower the risk of additional cognitive decline (Langa & Levine, 2014). Cognitive rehabilitation is another treatment option because geriatric clients can engage in cognitively stimulating activities.

Intersection of Depression and Mild Cognitive Impairment

In geriatric clients, depression and cognitive impairment often present simultaneously. Deficits in memory, processing speed, flexible thinking, and self-control are common in depression. Geriatric clients with depression usually perform poorly on word list memory and recall. Cognitive impairment and depression may have a common cause such as vascular disease (Morimoto, Kanellopoulos, Manning, & Alexopoulos, 2015). In addition, cognitive dysfunction is linked to

poor psychosocial functioning, which can in turn increase the chances of developing depression (Chakrabarty, Hadjipavlou, & Lam, 2016).

Ethical Challenges

There are ethical challenges associated with working with geriatric clients with depression and cognitive impairment. One ethical principle that often brings conflict between a geriatric client and their treating providers is that of privacy and confidentiality. The geriatric client may decide that they do not want their family members to know about their depression and/or cognitive impairment diagnoses. This can become an issue, however, if the client's safety or someone else's safety becomes compromised. This could conflict with the ethical principle of nonmaleficence—avoiding causation of harm. This can prove to be a difficult situation if the geriatric client is insistent on driving. In these types of situation, the board-certified case manager should find out whether the geriatric client has a health care power of attorney.

Autonomy is another ethical principle that can be a cause for concern. This principle includes the client being able to make his/her own decisions about their health care and even the right to refuse treatment. It also includes the concept of informed consent. Clients with cognitive impairment and depression may still have the ability to make medical decisions, but the following questions should be asked: Did the client understand the benefits and risks of the proposed treatment? Did the client understand the consequences of not complying with proposed treatment?

Was the client able to effectively communicate his/her wishes? Facilitating effective communication between the geriatric client, treating providers, and others involved in coordinating care can help maximize the client's autonomy (Dunn, Alici, & Roberts, 2015; Tampi, Young, Balachandran, Dasarathy, & Tampi, 2018).

Geriatric clients with depression and cognitive impairment are vulnerable and may be subjected to ageism. This would require the ethical principle of justice to be used by everyone who is involved in care coordination for this client. Ageist attitudes and lack of geriatric knowledge can result in mental health professionals declining to work with geriatric clients. Ageist attitudes among health care professionals can lead to misdiagnoses, withholding of treatment options, and limited access to treatment (Burnes et al., 2019). Because of the stigma of aging, many geriatric clients may not disclose symptoms of depression and cognitive impairment and may not comply with psychotherapy and/or pharmacological treatment for depression. As board-certified case managers, we must be courageous in dealing with biases and stereotypical views of the elderly from peers, other health care professionals and, sometimes, family. We must also be willing to deal with our own biases and prejudices (Burnes et al., 2019; O'Connell, Sommer, & Dunn, 2017).

Considerations for Care Coordination

We will now discuss the different parts of the case management process for dealing with geriatric patients with depression and cognitive impairment.

Advocacy. The geriatric population is in dire need of advocates who will be a voice for their unique medical and psychosocial needs. As board-certified case managers, we can advocate for this population. Our first responsibility as an advocate is to educate ourselves

about geriatric depression and mild cognitive impairment and its effect on the daily lives of geriatric patients. Our second responsibility as an advocate is to be involved in assisting primary care physicians in choosing other health care providers who specialize in geriatric patient care. Finally, being an advocate for the geriatric client means educating oneself about mental health care resources and educating others involved in their care about these resources. Coordinating care for the geriatric client with depression and mild cognitive impairment must be a collaborative effort. All involved should know how comorbid medical illnesses can complicate the identification and management of depression in the geriatric client. The board-certified case manager may have to remind treating providers that some symptoms related to chronic medical conditions could be indicative of depression (Maurer, Raymond, & Davis, 2018).

Assessment. The past and current medical history of the geriatric client can provide insight into risk factors that predispose the client to cognitive impairment and depression. The board-certified case manager can provide a holistic view of how the geriatric client's psychosocial and medical status can play an interdependent role in the client's well-being. The geriatric client may present with communication difficulties and multiple comorbidities. For instance, an elderly client could have recently had a stroke and develop depression. The geriatric client could have an undiagnosed illness such as a urinary tract infection. The cognitive decline could affect the elderly client's ability to effectively communicate and be aware of the development of depression. Therefore, an accurate assessment is important because a great number of elderly clients have been misdiagnosed as being in the early phases of dementia when they were suffering cognitive

impairment from a cerebrovascular accident. Another factor could be cultural: the geriatric client may not speak English as their first language and may be hindered in their ability to express cognitive difficulties.

With regard to cognitive impairment, the board-certified case manager should include questions about possible falls. Falls are common for those aged 65 and older. Cognitive impairment can increase the risks for falls (Tricco et al, 2019). Traumatic brain injuries can result from falls and can be a precursor to the development of cognitive impairment (Li, Risacher, McAllister, & Saykin, 2016). Geriatric clients will often not disclose that they have fallen because of feelings of shame and guilt. Sleep disturbances are also a risk factor in the development of cognitive impairment.

Another challenge with assessment is that it may require conversations with family members who may or may not fully understand how the geriatric client should be involved in decision making. The board-certified case manager may need to be the person who must explain the geriatric client's condition to the family. This can be an uncomfortable situation if there is estrangement between the geriatric client and family members. This could also be an opportunity to explain to the geriatric patient's family how their family member's self-esteem and confidence could be improved if they continue to be involved in their health care decisions.

Polypharmacy is a common health concern with geriatric clients, and thus medication reconciliation must be a prime concern for the board-certified case manager. How many medications is the geriatric client taking? Are they taking them properly? Could medication interactions be a source of cognitive impairment and/or depression? Who are the different providers prescribing medications for the geriatric client? Are they aware that the geriatric client is obtaining prescriptions from other providers?

There are ethical challenges associated with working with geriatric clients with depression and cognitive impairment. One ethical principle that often brings conflict between a geriatric client and their treating providers is that of privacy and confidentiality. The geriatric client may decide that they do not want their family members to know about their depression and/or cognitive impairment diagnoses.

A health care power of attorney and advance care planning should be discussed with caregivers and spouses. This can present an ethical predicament regarding autonomy, privacy, and confidentiality. The geriatric client may feel they are more than capable of making their own decisions and may be resistant to including family members in these discussions. The board-certified case manager must keep in mind that geriatric clients may be afraid of losing control over their lives, which could be why they are resistant to involving family members.

The board-certified case manager has several tools for assessing geriatric clients for depression and/or cognitive impairment. One tool is the Geriatric Depression Scale (Maurer, Raymond, & Davis, 2018). Other tools are the Hamilton Depression Scale and Beck Depression Inventory (Ellison, Kyomen, & Harper, 2012). Cognitive impairment evaluations can identify different aspects of cognitive impairment. Assessments may also be made with the Mini-Mental State Examination, Montreal Cognitive Assessment, Executive Interview, and the Frontal Systems Behavior Scale (Morimoto et al, 2015). The board-certified case manager could discuss the benefits of a neuropsychological evaluation with the client's primary care physician.

Care Coordination. As stated before, a collaborative approach is necessary for geriatric clients with depression and/or cognitive impairment. The geriatric client often has different providers, so it would be beneficial for the board-certified

case manager to facilitate communication between these different providers. The case manager could also function as a liaison between the family and all treating providers and could provide education to all involved because the needs of the geriatric client are unique.

The board-certified case manager should also be knowledgeable about different resources that can be used to coordinate care for the geriatric client. Formal agencies include home health agencies, mental health centers, and Area Agencies on Aging. Friends, family caregivers, faith-based organizations, and informal resources can be a source of social interaction with the geriatric client.

Conclusion

Treatment for the geriatric client can be complicated. Specialized knowledge of the geriatric client is required, as is an understanding of the complex interactions between comorbidities, cognition, functioning, and depression. Depression and cognitive impairment can cause considerable stress for the geriatric client and those involved in their care. It is important to ensure that geriatric clients are diagnosed correctly so that an appropriate course of treatment can be provided. It can be difficult for board-certified case managers to find all the providers involved in caring for their geriatric clients. Facilitating communication with family and treatment providers is necessary to ensure appropriate care for these vulnerable clients. **CE III**

Part II will appear in the August/September 2021 issue and will examine dementia.

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PharmaFacts for Case Managers



Zegalogue® (dasiglucagon) injection, for subcutaneous use

INDICATIONS AND USAGE

Zegalogue® is indicated for the treatment of severe hypoglycemia in pediatric and adult patients with diabetes aged 6 years and above.

DOSAGE AND ADMINISTRATION

Administration Instructions

Zegalogue autoinjector and prefilled syringe are for subcutaneous injection only.

Instruct patients and their caregivers on the signs and symptoms of severe hypoglycemia. Because severe hypoglycemia requires the help of others to recover, instruct the patient to inform those around them about Zegalogue and its Instructions For Use. Administer Zegalogue as soon as possible when severe hypoglycemia is recognized.

Instruct the patient or caregiver to read the Instructions For Use at the time they receive a prescription for Zegalogue. Emphasize the following instructions to the patient or caregiver:

- Administer Zegalogue according to the printed instructions on the protective case label and the Instructions For Use.
- Visually inspect Zegalogue prior to administration. The solution should appear clear, colorless, and free from particles. If the solution is discolored or contains particulate matter, do not use.
- Administer the injection in the lower abdomen, buttocks, thigh, or outer upper arm.
- Call for emergency assistance immediately after administering the dose.
- If there has been no response after 15 minutes, an additional dose of Zegalogue may be administered while waiting for emergency assistance.
- When the patient has responded to treatment, give oral carbohydrates to restore liver glycogen and prevent recurrence of hypoglycemia.
- Do not attempt to reuse Zegalogue. Each Zegalogue device contains a single dose of dasiglucagon and cannot be reused.

Recommended Dosage

The recommended dose of Zegalogue in adults and pediatric patients aged 6 years and older is 0.6 mg administered by subcuta-

neous injection into the lower abdomen, buttocks, thigh, or outer upper arm.

If there has been no response after 15 minutes, an additional 0.6 mg dose of Zegalogue from a new device may be administered.

DOSAGE FORMS AND STRENGTHS

Zegalogue injection is a clear, colorless solution available as:

- 0.6 mg/0.6 mL single-dose autoinjector
- 0.6 mg/0.6 mL single-dose prefilled syringe

CONTRAINDICATIONS

Zegalogue is contraindicated in patients with:

- Pheochromocytoma because of the risk of substantial increase in blood pressure
- Insulinoma because of the risk of hypoglycemia

WARNINGS AND PRECAUTIONS

Substantial Increase in Blood Pressure in Patients with Pheochromocytoma

Zegalogue is contraindicated in patients with pheochromocytoma because glucagon products may stimulate the release of catecholamines from the tumor. If the patient develops a substantial increase in blood pressure and a previously undiagnosed pheochromocytoma is suspected, 5 to 10 mg of phentolamine mesylate, administered intravenously, has been shown to be effective in lowering blood pressure.

Hypoglycemia in Patients with Insulinoma

In patients with insulinoma, administration of glucagon products may produce an initial increase in blood glucose; however, Zegalogue administration may directly or indirectly (through an initial rise in blood glucose) stimulate exaggerated insulin release from an insulinoma and cause hypoglycemia. Zegalogue is contraindicated in patients with insulinoma. If a patient develops symptoms of hypoglycemia after a dose of Zegalogue, give glucose orally or intravenously.

Hypersensitivity and Allergic Reactions

Allergic reactions have been reported with glucagon products; these include generalized rash, and in some cases anaphylactic shock with breathing difficulties and hypotension. Advise patients to seek immediate medical attention if they experience any symptoms of serious hypersensitivity reactions.



ADVERSE REACTIONS

- Hypersensitivity and Allergic Reactions

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary

There are no available data on dasiglucagon use in pregnant women to evaluate for a drug-associated risk of major birth defects, miscarriage or adverse maternal or fetal outcomes.

Untreated hypoglycemia in pregnancy can cause complications and may be fatal.

In animal reproduction studies, daily subcutaneous administration of dasiglucagon to pregnant rabbits and rats during the period of organogenesis did not cause adverse developmental effects at exposures 7 and 709 times the human dose of 0.6 mg based on AUC, respectively.

Lactation

Risk Summary

There is no information on the presence of dasiglucagon in either human or animal milk, or the effects of the drug on the breastfed infant or milk production. Dasiglucagon is a peptide and would be expected to be broken down to its constituent amino acids in the infant's digestive tract and is therefore unlikely to cause harm to an exposed infant.

Pediatric Use

The safety and effectiveness of Zegalogue for the treatment of severe hypoglycemia in patients with diabetes have been established in pediatric patients aged 6 years and above. Use of Zegalogue for this indication is supported by evidence from a study in 42 pediatric patients with type 1 diabetes.

The safety and effectiveness of Zegalogue have not been established in pediatric patients younger than 6 years of age.

Geriatric Use

Clinical studies of Zegalogue included too few patients 65 years of age and older to determine whether these patients respond differently from younger adult patients.

CLINICAL STUDIES

Three randomized, double-blind, placebo-controlled, multicenter trials were conducted in patients with type 1 diabetes. Two trials (Trial A and Trial B) were conducted in adult patients, and one trial (Trial C) was conducted in pediatric patients aged 6 to 17 years. In all 3 trials, patients were randomized to Zegalogue 0.6 mg, placebo, or (in Trials A and C) glucagon for injection 1.0 mg. Zegalogue and the comparators were administered as single subcutaneous injections following a controlled induction of hypoglycemia using intravenous administration of insulin. During this procedure, a plasma glucose concentration of <60 mg/dL was targeted in Trials A and B, whereas the target was <80 mg/dL in Trial C.

The primary efficacy endpoint for all 3 trials was time to plasma glucose recovery (treatment success), defined as an increase in blood glucose of ≥ 20 mg/dL from time of administration, without additional intervention within 45 minutes. In Trials A and B, plasma glucose values were collected and assessed at pre-dose, and at 4, 6, 8, 10, 12, 15, 17, 20, 25, 30, 40, 45, 50, 60, 75, and 90 minutes after treatment. Trial C assessed plasma glucose at the same timepoints as did Trials A and B, with the exception of the 25, 40, 50, 75, and 90-minute post-treatment timepoints. The primary hypothesis test was superiority of Zegalogue versus placebo. There was no formal hypothesis test of Zegalogue versus glucagon for injection.

Trial A, NCT03378635: A total of 170 patients were randomized 2:1:1 to Zegalogue, placebo, and glucagon for injection, stratified by injection sites (abdominal region, buttocks, thigh). The mean age of the patients was 39.1 years (96% were <65 years), and the mean duration of diabetes was 20.0 years; 63% were male; 92% were White. The mean baseline plasma glucose was 58.8 mg/dL. The median time to plasma glucose recovery was statistically significantly shorter for Zegalogue (10 minutes) versus placebo (40 minutes). The median time to plasma glucose recovery was numerically similar between Zegalogue (10 minutes) and glucagon for injection (12 minutes).

Trial B, NCT03688711: A total of 45 patients were randomized 3:1 to Zegalogue and placebo stratified by injection sites (buttocks, deltoid). The mean age of the patients was 41.0 years (95% were < 65 years), and the mean duration of diabetes was 22.5 years; 57% were male; 93% were White. The mean baseline plasma glucose was 55.0 mg/dL. The median time to plasma glucose recovery was statistically significantly shorter for Zegalogue (10 minutes) versus placebo (35 minutes).

Pediatric Patients

Trial C, NCT03667053: Pediatric patients aged 6 to 17 years and weighing ≥ 20 kg, were randomized 2:1:1 to Zegalogue, placebo, and glucagon for injection, stratified by injection sites (abdominal region, thigh) and age groups (6-11 years and 12-17 years). A total of 42 patients were randomized. The mean age was 12.5 years (range 7 to 17 years), and the mean duration of diabetes was 5.9 years; 56% were male; 95% were White. The mean baseline plasma glucose was 72.0 mg/dL. The median time to plasma glucose recovery was statistically significantly shorter for Zegalogue (10 minutes) versus placebo (30 minutes). The median time to plasma glucose recovery was numerically similar between Zegalogue (10 minutes) and glucagon for injection (10 minutes).

HOW SUPPLIED/STORAGE AND HANDLING

How Supplied

Zegalogue injection is a clear, colorless solution supplied as single-dose autoinjector or single-dose prefilled syringe 0.6mg/0.6mL.



Recommended Storage

Store Zegalogue in a refrigerator, 2°C to 8°C (36°F to 46°F). Keep away from the cooling element. Do not freeze.

Zegalogue can be kept at room temperature between 20°C to 25°C (68°F to 77°F) for up to 12 months. Record the date when the product was removed from the refrigerator in the space provided on the protective case. Do not return the product to the refrigerator after storing at room temperature. Store in the provided protective case and protect from light.

Discard Zegalogue after the end of the 12-month period at room temperature storage, or after the expiration date stated on the product, whichever occurs first.

The inside of the gray cap on Zegalogue autoinjector contains dry natural rubber (a derivative of latex).

The inside of the gray needle cover on Zegalogue prefilled syringe contains dry natural rubber (a derivative of latex).

Zegalogue is manufactured by Zealand Pharma A/S.

Ponvory™ (ponesimod) tablets, for oral use

INDICATIONS AND USAGE:

Ponvory is a sphingosine 1-phosphate receptor modulator indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

DOSAGE AND ADMINISTRATION

- Assessments are required prior to initiating Ponvory
- Titration is required for treatment initiation
- The recommended maintenance dosage is 20 mg taken orally once daily
- First-dose monitoring is recommended for patients with sinus bradycardia, first- or second-degree [Mobitz type I] atrioventricular (AV) block, or a history of myocardial infarction or heart failure

Dosage Forms and Strengths

Tablets: 2 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7 mg, 8 mg, 9 mg, 10 mg, and 20 mg

CONTRAINDICATIONS

- In the last 6 months, experienced myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure requiring hospitalization, or Class III/IV heart failure
- Presence of Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, unless patient has a functioning pacemaker

WARNINGS AND PRECAUTIONS

Infections: Ponvory may increase the risk of infections. Obtain a complete blood count (CBC) before initiating treatment. Monitor for infection during treatment and for 1-2 weeks after discontinuation.

Do not start Ponvory in patients with active infection.

Bradycardia and Atrioventricular Conduction Delays: Ponvory may result in a transient decrease in heart rate; titration is required for treatment initiation. Check an electrocardiogram (ECG) to assess for preexisting cardiac conduction abnormalities before starting Ponvory. Consider cardiology consultation for conduction abnormalities or concomitant use with other drugs that decrease heart rate.

Respiratory Effects: May cause a decline in pulmonary function. Assess pulmonary function (e.g., spirometry) if clinically indicated.

Liver Injury: Discontinue if significant liver injury is confirmed. Obtain liver function tests before initiating Ponvory.

Increased Blood Pressure (BP): Monitor BP during treatment.

Cutaneous Malignancies: Periodic skin examination is recommended.

Fetal Risk: Women of childbearing potential should use effective contraception during and for 1 week after stopping Ponvory.

Macular Edema: An ophthalmic evaluation is recommended before starting treatment and if there is any change in vision while taking Ponvory. Diabetes mellitus and uveitis increase the risk.

ADVERSE REACTIONS

Most common adverse reactions (incidence at least 10%) are upper respiratory tract infection, hepatic transaminase elevation, and hypertension.

DRUG INTERACTIONS

Vaccines: Avoid live attenuated vaccines during and for up to 1–2 weeks after treatment with Ponvory.

Strong CYP3A4 and UGT1A1 Inducers: Coadministration with Ponvory is not recommended.

USE IN SPECIFIC POPULATIONS

Hepatic Impairment: Ponvory is not recommended in patients with moderate or severe hepatic impairment (Child-Pugh class B and C).

CLINICAL STUDIES

The efficacy of Ponvory was demonstrated in Study 1, a randomized, double-blind, parallel group, active-controlled superiority study in patients with relapsing forms of MS (NCT02425644). Patients were treated for 108 weeks. This study included patients who had an Expanded Disability Status Scale (EDSS) score of 0 to 5.5 at baseline, had experienced at least one relapse within the year prior, or two relapses within the prior 2 years, or who had at least one gadolinium-enhancing (Gd-enhancing) lesion on a brain MRI within the prior 6 months or at baseline. Patients with primary progressive MS were excluded.

Patients were randomized to receive either once daily Ponvory, beginning with a 14-day dose titration. Neurological evaluations

[continues on page 37](#)



LitScan for Case Managers reviews medical literature and reports abstracts that are of particular interest to case managers in an easy-to-read format. Each abstract includes information to locate the full-text article if there is an interest. This member benefit is designed to assist case managers in keeping current with clinical breakthroughs in a time-effective manner.

Clin Infect Dis. 2021 Apr 20;ciab336.

[Mortality trends in risk conditions and invasive mycotic disease in the United States, 1999-2018](#)

Ravens Em Norris KA, Codero JF.

BACKGROUND: Invasive fungal infections (IFIs) in the United States are chronically underdiagnosed and a lack of coordinated surveillance makes the true burden of disease difficult to determine. The purpose of this analysis was to capture mortality-associated burden of risk conditions and fungal infections.

METHODS: We analyzed data from the National Vital Statistics System from 1999-2018 to estimate the mortality attributed to risk conditions and related fungal disease.

RESULTS: The number of risk conditions associated with fungal disease is steadily rising in the United States with 1,047,422 diagnoses at time of death in 2018. While fungal disease decreased substantially from 1999 to 2010, primarily due to the control of HIV infection, the number deaths with fungal diagnosis has increased in the non-HIV cohort, with significant increases in patients with diabetes, cancer, immunosuppressive disorders, or sepsis.

CONCLUSION: The landscape of individuals at risk for serious fungal diseases is changing, with a continued decline in HIV-associated incidence, but increased diagnoses in patients with cancer, sepsis, immunosuppressive disorders, and influenza. Additionally, there is an overall increase in the number of fungal infections in recent years, indicating a failure to control fungal disease mortality in these new immunocompromised cohorts. Improvement in prevention and management of fungal diseases is needed to control morbidity and mortality in the rising number of immunocompromised and at-risk patients in the United States.

Clin Infect Dis. 2021 Apr 16;ciab317.

[Impact of convalescent plasma therapy on SARS CoV-2 antibody profile in COVID-19 patients](#)

Tang J, Grubbs G, Lee Y, et al.

Convalescent plasma (CP) have been used for treatment of COVID-19, but their effectiveness varies significantly. Moreover, the impact

of CP treatment on the composition of SARS-CoV-2 antibodies in COVID-19 patients and antibody markers that differentiate between those who survive and those who succumb to the COVID-19 disease are not well understood. Herein, we performed longitudinal analysis of antibody profile on 115 sequential plasma samples from 16 hospitalized COVID-19 patients treated with either CP or standard of care, only half of them survived. Differential antibody kinetics was observed for antibody binding, IgM/IgG/IgA distribution, and affinity maturation in 'survived' vs. 'fatal' COVID-19 patients. Surprisingly, CP treatment did not predict survival. Strikingly, marked decline in neutralization titers was observed in the fatal patients prior to death, and convalescent plasma treatment did not reverse this trend. Furthermore, irrespective of CP treatment, higher antibody affinity to the SARS-CoV-2 prefusion spike was associated with survival outcome, while sustained elevated IgA response was associated with fatal outcome in these COVID-19 patients. These findings propose that treatment of COVID-19 patients with convalescent plasma should be carefully targeted, and effectiveness of treatment may depend on the clinical and immunological status of COVID-19 patients as well as the quality of the antibodies in the convalescent plasma.

AIDS. 2021 May 1;35(Suppl 1):S39-S51.

[Utilizing electronic health record data to understand comorbidity burden among people living with HIV: a machine learning approach](#)

Yang X, Zhang J, Chen S, et al.

OBJECTIVES: An understanding of the predictors of comorbidity among people living with HIV (PLWH) is critical for effective HIV care management. In this study, we identified predictors of comorbidity burden among PLWH based on machine learning models with electronic health record (EHR) data.

METHODS: The study population are individuals with a HIV diagnosis between January 2005 and December 2016 in South Carolina (SC). The change of comorbidity burden, represented by the Charlson Comorbidity Index (CCI) score, was measured by the score difference between pre- and post-HIV diagnosis, and

dichotomized into a binary outcome variable. Thirty-five risk predictors from multiple domains were used to predict the increase in comorbidity burden based on the logistic least absolute shrinkage and selection operator (Lasso) regression analysis using 80% data for model development and 20% data for validation.

RESULTS: Of 8253 PLWH, the mean value of the CCI score difference was 0.8 ± 1.9 (range from 0 to 21) with 2328 (28.2%) patients showing an increase in CCI score after HIV diagnosis. Top predictors for an increase in CCI score using the LASSO model included older age at HIV diagnosis, positive family history of chronic conditions, tobacco use, longer duration with retention in care, having PEBA insurance, having low recent CD4+ cell count and duration of viral suppression.

CONCLUSION: The application of machine learning methods to EHR data could identify important predictors of increased comorbidity burden among PLWH with high accuracy. Results may enhance the understanding of comorbidities and provide the evidence-based data for integrated HIV and comorbidity care management of PLWH.

Infect Control Hosp Epidemiol. 2021 Apr 19;1-24.

[The role of procalcitonin in antibiotic decision-making in Covid-19 infection](#)

Fabre V, Karaba S, Amoah J, et al.

OBJECTIVE: To evaluate the role of procalcitonin (PCT) in antibiotic decisions for COVID-19 patients at hospital presentation.

DESIGN, SETTING AND PARTICIPANTS: Multicenter retrospective observational study of patients 18 years hospitalized due to COVID-19 at the Johns Hopkins Health system. Patients who were transferred from another facility with >24 hours stay and patients who died within 48 hours of hospitalization were excluded.

METHODS: Elevated PCT values were determined based on each hospital's definition. Antibiotic therapy and PCT results were evaluated for patients with no evidence of bacterial community-acquired pneumonia (bCAP) and patients with confirmed, probable, or possible bCAP. The added value of PCT to clinical criteria in detecting bCAP were evaluated with receiving operating curve characteristics (ROC).

RESULTS: 64% (611/962) of patients received a PCT. ROC curves for clinical criteria and clinical criteria plus PCT were similar (at 0.5ng/ml and 0.25ng/ml). By bCAP group, median initial PCT values were 0.58 ng/mL (IQR 0.24, 1.14), 0.23 ng/mL (IQR 0.1, 0.63) and 0.15 ng/mL (IQR 0.09, 0.35) for proven/probable, possible, and no bCAP groups. Among patients without bCAP, an elevated CT was associated with 1.8 additional days of CAP therapy (95% CI 1.01 2.75, $P < 0.01$) compared to patients with a negative PCT after adjusting for potential confounders. Duration of CAP therapy was

similar between patients without a PCT ordered and a low PCT for no bCAP and possible bCAP groups.

CONCLUSIONS: PCT may be abnormal in COVID-19 patients without bCAP and may result in receipt of unnecessary antibiotics.

Circ Heart Fail. 2021 Apr;14(4):e008335.

[Trends in 30- and 90-day readmission rates for heart failure](#)

Khan MS, Sreenivasan J, Lateef N, et al.

BACKGROUND: The impact of hospital readmission reduction program (HRRP) on heart failure (HF) outcomes has been debated. Limited data exist regarding trends of HF readmission rates beyond 30 days from all-payer sources. The aim of this study was to investigate temporal trends of 30- and 90-day HF readmissions rates from 2010 to 2017 in patients from all-payer sources.

METHODS: The National Readmission Database was utilized to identify HF hospitalizations between 2010 and 2017. In the primary analysis, a linear trend in 30-day and 90-day readmissions from 2010 to 2017 was assessed. While in the secondary analysis, a change in aggregated 30- and 90-day all-cause and HF-specific readmissions pre-HRRP penalty phase (2010-2012) and post-HRRP penalties (2013-2017) was compared. Subgroup analyses were performed based on (1) Medicare versus non-Medicare insurance, (2) low versus high HF volume, and (3) HF with reduced versus preserved ejection fraction (heart failure with reduced ejection fraction and heart failure with preserved ejection fraction). Multiple logistic and adjusted linear regression analyses were performed for annual trends.

RESULTS: A total of 6 669 313 index HF hospitalizations for 30-day, and 5 077 949 index HF hospitalizations for 90-day readmission, were included. Of these, 1 213 402 (18.2%) encounters had a readmission within 30 days, and 1 585 445 (31.2%) encounters had a readmission within 90 days. Between 2010 and 2017, both 30 and 90 days adjusted HF-specific and all-cause readmissions increased (8.1% to 8.7%, P trend 0.04, and 18.3% to 19.9%, P trend < 0.001 for 30-day and 14.8% to 16.0% and 30.9% to 34.6% for 90-day, P trend < 0.001 for both, respectively). Readmission rates were higher during the post-HRRP penalty period compared with pre-HRRP penalty phase (all-cause readmission 30 days: 18.6% versus 17.5%, $P < 0.001$, all-cause readmission 90 days: 32.0% versus 29.9%, $P < 0.001$) across all subgroups except among the low-volume hospitals.

CONCLUSIONS: The rates of adjusted HF-specific and all-cause 30- and 90-day readmissions have increased from 2010 to 2017. Readmissions rates were higher during the HRRP phase across all subgroups except the low-volume hospitals.

Circ Res. 2021 Apr 22.

[NAD[±] repletion reverses heart failure with preserved ejection fraction](#)

Tong D, Schiattarella GG, Jiang N, et al.

RATIONALE: Heart failure with preserved ejection fraction (HFpEF) is a mortal clinical syndrome without effective therapies. We recently demonstrated in mice that a combination of metabolic and hypertensive stress recapitulates key features of human HFpEF.

OBJECTIVE: Using this novel preclinical HFpEF model, we set out to define and manipulate metabolic dysregulations occurring in HFpEF myocardium.

METHODS AND RESULTS: We observed impairment in mitochondrial fatty acid oxidation associated with hyperacetylation of key enzymes in the pathway. Down-regulation of sirtuin 3 and deficiency of NAD⁺ secondary to an impaired NAD⁺ salvage pathway contribute to this mitochondrial protein hyperacetylation. Impaired expression of genes involved in NAD⁺ biosynthesis was confirmed in cardiac tissue from HFpEF patients. Supplementing HFpEF mice with nicotinamide riboside or a direct activator of NAD⁺ biosynthesis led to improvement in mitochondrial function and amelioration of the HFpEF phenotype.

CONCLUSIONS: Collectively, these studies demonstrate that HFpEF is associated with myocardial mitochondrial dysfunction and unveil NAD⁺ repletion as a promising therapeutic approach in the syndrome.

Ann Thorac Surg. 2021 Apr 12;S0003-4975(21)00674-3.

[A tale of two centrifugal flow ventricular assist devices as bridge to heart transplant](#)

Alwair H, Whitehouse K, Slaughter MS, et al

BACKGROUND: Use of continuous flow left ventricular assist devices (CFVAD) has previously increased over the years as bridge to transplant (BTT). The Heartware HVAD and HeartMate III (HM3) are currently approved centrifugal flow devices used for BTT. We sought to evaluate outcomes of the patients listed and transplanted after receiving these two devices.

METHODS: The United Network of Organ Sharing (UNOS) thoracic transplant database was queried after August 23, 2017 till December 2018 to identify patients aged > 18 years listed for HTx and supported by either HVAD or HM3. Patient characteristics were evaluated at time of listing and transplant. Primary study end point was 1-year mortality after LVAD implantation. Non-parametric tests were used to evaluate the device groups.

RESULTS: There were 569 patients listed for HTx during the study period of which 226 had HM3 and 343 HVAD. The HM3

group had more men (82% v. 74%, $p=0.02$), diabetics (38% v. 29%, $p=0.02$) and had a higher BMI (28 vs. 27, $p=0.04$) at listing. Between HM3 and HVAD groups, the 1-year mortality was 20% v. 17% respectively (log-rank $p=0.28$, Figure 1). The post-transplant survival at 1-year was 97% and 94% respectively for the HM3 and HVAD groups ($p=0.1$).

CONCLUSIONS: In relatively well-matched group of patients listed for heart transplant with a centrifugal flow LVAD the 6 month and 1-year mortality on the waitlist as well as post transplant were not statistically different. Additional real-world experience or a randomized trial would be needed to determine if one is superior.

Am J Hypertens. 2021 Apr 20;hpab053.

[Race/ethnic differences in atherosclerotic cardiovascular disease risk factors among patients with hypertension: analysis from 143 primary care clinics](#)

Khatib R, Glowacki N, Lauffenburger J, et al.

BACKGROUND: While it is known that sex and race/ethnic disparities persist for atherosclerotic cardiovascular disease (ASCVD), disparities in risk factor control have not been well-described in primary care where ASCVD can be prevented.

METHODS: Adult patients with a hypertension diagnosis without ASCVD were included in this analysis of electronic health records from a large US healthcare system from 2018. Patients were categorized based on risk factor control defined as blood pressure <130/80 mmHg; statin prescription among patients with indications, HbA1c of <7%, and not smoking. Multivariable Poisson regressions were developed to explore associations with race/ethnicity. Results are presented as relative risk (RR), 95% confidence intervals (CI).

RESULTS: Among 5,227 patients, 55.8% women and 60.0% men had uncontrolled blood pressure, 47.3% women and 46.4% men with statin therapy indication did not have a prescription, 34.9% women and 40.9% men had uncontrolled HbA1c values, and 9.3% women and 13.7% men were smokers. African Americans were more likely to have uncontrolled blood pressure (women: RR1.18, 95%CI 1.07-1.30; men: RR1.20, 95%CI 1.05-1.34) and more likely to lack a statin prescription (women: RR1.23, 95%CI 1.05-1.45; men: RR1.25, 95%CI 1.03-1.51) compared to Caucasians. Differences in HbA1c control were not statistically significant among Hispanic/Latino compared to Caucasians (women: RR1.28, 95%CI 0.86-1.90; men: RR1.20, 95%CI 0.72-1.97).

CONCLUSIONS: Disparities in controlling ASCVD risk factors in primary care persist and were not fully explained by demographic or clinical characteristics. Monitoring changes in disparities is important to ensure equity as interventions to prevent ASCVD in primary care are developed and implemented.

Proc Natl Acad Sci U S A. 2021 Apr 6;118(14):e2022928118.

[Signatures of immune dysfunction in HIV and HCV infection share features with chronic inflammation in aging and persist after viral reduction or elimination](#)

Lopez Angel CR, Pham EA, Du H, et al.

Chronic inflammation is thought to be a major cause of morbidity and mortality in aging, but whether similar mechanisms underlie dysfunction in infection-associated chronic inflammation is unclear. Here, we profiled the immune proteome, and cellular composition and signaling states in a cohort of aging individuals versus a set of HIV patients on long-term antiretroviral therapy or hepatitis C virus (HCV) patients before and after sofosbuvir treatment. We found shared alterations in aging-associated and infection-associated chronic inflammation including T cell memory inflation, up-regulation of intracellular signaling pathways of inflammation, and diminished sensitivity to cytokines in lymphocytes and myeloid cells. In the HIV cohort, these dysregulations were evident despite viral suppression for over 10 y. Viral clearance in the HCV cohort partially restored cellular sensitivity to interferon- α , but many immune system alterations persisted for at least 1 y posttreatment. Our findings indicate that in the HIV and HCV cohorts, a broad remodeling and degradation of the immune system can persist for a year or more, even after the removal or drastic reduction of the pathogen load and that this shares some features of chronic inflammation in aging.

BMC Cancer. 2021 Apr 14;21(1):402.

[Understanding the patient journey to diagnosis of lung cancer](#)

Zhang Y, Simoff MJ, Ost D, et al.

OBJECTIVE: This research describes the clinical pathway and characteristics of two cohorts of patients. The first cohort consists of patients with a confirmed diagnosis of lung cancer while the second consists of patients with a solitary pulmonary nodule (SPN) and no evidence of lung cancer. Linked data from an electronic medical record and the Louisiana Tumor Registry were used in this investigation.

MATERIALS AND METHODS: REACHnet is one of 9 clinical research networks (CRNs) in PCORnet®, the National Patient-Centered Clinical Research Network and includes electronic health records for over 8 million patients from multiple partner health systems. Data from Ochsner Health System and Tulane Medical Center were linked to Louisiana Tumor Registry (LTR), a statewide population-based cancer registry, for analysis of patient's

clinical pathways between July 2013 and 2017. Patient characteristics and health services utilization rates by cancer stage were reported as frequency distributions. The Kaplan-Meier product limit method was used to estimate the time from index date to diagnosis by stage in lung cancer cohort.

RESULTS: A total of 30,559 potentially eligible patients were identified and 2929 (9.58%) had primary lung cancer. Of these, 1496 (51.1%) were documented in LTR and their clinical pathway to diagnosis was further studied. Time to diagnosis varied significantly by cancer stage. A total of 24,140 patients with an SPN were identified in REACHnet and 15,978 (66.6%) had documented follow up care for 1 year. 1612 (10%) had no evidence of any work up for their SPN. The remaining 14,366 had some evidence of follow up, primarily office visits and additional chest imaging.

CONCLUSION: In both cohorts multiple biopsies were evident in the clinical pathway. Despite clinical workup, 70% of patients in the lung cancer cohort had stage III or IV disease. In the SPN cohort, only 66% were identified as receiving a diagnostic work-up.

Clin Transplant. 2021 Apr 18;e14317.

[Obesity is a risk factor for progression to kidney transplant waitlisting after liver transplantation](#)

Locke JE, Shelton B, Orandi B, et al.

BACKGROUND: Non-alcoholic steatohepatitis has emerged as a leading cause of cirrhosis, and obesity-associated comorbidities, including renal disease have increased in prevalence. Obesity predisposes the kidney to hyperfiltration injury, potentially impairing acute kidney injury recovery. Identification of patients at risk for renal dysfunction is impeded by poor performance of renal function estimating equations among cirrhotics. To better understand obesity among cirrhotics and renal disease progression, we examined likelihood of kidney transplantation (KT) waitlisting after liver transplant alone (LTA) by obesity class. **Methods:** 68,607 LTA recipients were identified in SRTR (2005-2018). Fine and Gray competing risks models were used to analyze likelihood of KT waitlisting. **Results:** 27.4% of recipients were obese (BMI>30kg/m²) and were 10% more likely to require KT waitlisting (aHR: 1.10, 95%CI: 1.01-1.20). Risk was highest among recipients with Classes II and III obesity (BMI: >35kg/m²) (aHR: 1.37, 95%CI: 1.17-1.56). Moreover, recipients with Classes II and III obesity were 57% more likely to require KT waitlisting within one year post-LTA (aHR: 1.57, 95%CI: 1.18-2.10) compared to non-obese recipients.

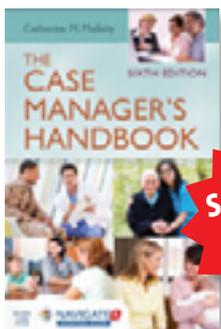
DISCUSSION: These findings suggest obesity was a risk factor for renal recovery failure and/or renal disease progression post-LTA and may confound identification of renal dysfunction and/or prediction of renal recovery among cirrhotics. ■



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Culturally Sensitive Care for LGBTQ+ Individuals: Considerations for Case Managers *continued from page 16*

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COVID-19 Family Action Plan: Supporting Families of Children with Chronic Health Conditions and Medical Complexities *continued from page 20*

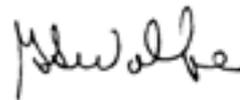
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Culturally Sensitive Care for the LGBTQ+ Patient *continued from page 2*

combination of barriers to care and minority status. Case managers can make a difference in improving care for the LGBTQ+ patient, although this will take time. The beliefs and values each case manager has come into play when providing culturally sensitive care. Every patient has a right to the best possible care, which includes culturally sensitive care.

In this issue of *CareManagement*, we are publishing a continuing education article titled "Culturally Sensitive Care for the LGBTQ+ Patient: Considerations for Case Managers" by Abigail Mitchell, DHed, MSN, MBA, RN, CNE, FHERDSA. Reading this article will help case managers provide culturally sensitive care for the LGBTQ+ patient.



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ACCM: Improving Case Management Practice through Education

Depression and Cognitive Impairment in the Geriatric Population

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Helping “Jerry” Return Home

continued from page 8

clearing customs, Jerry was able to visit with his cousin who had been brought to the airport by friends, and was introduced to his new caregiver and the Minister of Health. The embassy had made the family arrangements once the arrival date was set. Jerry and his cousin recognized each other and both were smiling and hugging in the airport. The cousin was provided with the contact information for Jerry in his new living situation, prior to Jerry's departure to his new home.

Since the trip, I have inquired about Jerry, and learned through my contact at the embassy that he continues to do well. **CM**

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The Importance of Participation in CARF Field Reviews of Standards

[continued from page 9](#)

are reviewed and considered.

The field review for the IPR standards were in field review in May 2021. In June 2021 we will finalize the standards and begin to again work with the ISAC members to develop examples for the standards. The IPR standards will be in the 2022 CARF Medical Rehabilitation Standards Manual that will be published in January 2022. Those standards go into effect July 1, 2022, through June 30, 2023.

Interdisciplinary pain rehabilitation is beginning to gain traction again since the opioid crisis. Although there has been long-time empirical support for interdisciplinary pain programs that improve function and quality of life, access to these types of programs diminished when pain centers with

injections, opioids, and single procedures became an avenue that payers saw as advantageous. This return to IPR has now begun to turn around, and payers are looking for the programs working with those with persistent pain. CARF provides the tools for these programs to speak to their durable results and return to a better level of participation in life roles for individuals with persistent pain issues.

This is one example of a field review process. We know how critical case management is. Your industry has a bird's eye view of the needs of individuals in health and human services. CARF looks forward to your future participation in our standards development process. Please contact me for any further information you may require about participation in field review or standards development. **CM**

Striking a Balance [continued from page 3](#)

transition from the Military to the Veterans (M2VA) healthcare systems.

As we look forward to sunnier skies, relaxing days, and the opportunity to reconnect with family and friends, we hope that you will be able to hit the sweet spot of the life-work balance. If we flip the work-life to life-work... maybe that might work.

Catherine M. Mullahy

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**We *can* make a difference...
one patient at a time.**

What Can Discharge Planners/Case Managers Accept from Providers Who Want Referrals? [continued from page 5](#)

that the fraud and abuse prohibitions also apply to companies that participate in Medicaid programs, including Medicaid waiver programs, as well as other federal and state health care programs, such as Tri-Care or the VA.

In addition, even if providers who want referrals do not accept payments from any federal or state health care programs, the case managers, discharge planners, and social workers who make referrals often work for organizations that do. They must comply, therefore, with fraud and abuse prohibitions and providers of all types should assist them to do so.

Case managers and providers who violate this federal statute may be guilty of criminal conduct and may go to jail or be forced to pay large amounts of money in the form of fines or civil

monetary penalties. They may also be excluded from participation in the Medicare/Medicaid and other state and federal health care programs. Case managers who are licensed registered nurses (RNs) or Medical Social Workers (MSWs) also face loss of licensure.

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, the primary enforcer of fraud and abuse prohibitions, has clearly stated that discharge planners/case managers may not accept and post-acute providers may not give cash or cash equivalents, including gift cards and gift certificates. The OIG has not, however, provided any specific guidance to about what items of non-cash nominal value may be accepted by case managers/discharge planners from providers who receive referrals.

Until specific guidance on these issues is provided by the OIG, providers and case managers may decide to apply

limits in the final regulations under the Stark laws, even though the Stark laws technically apply only to physicians.

Specifically, the Stark regulations indicate that non-cash items of nominal value may be provided within reasonable limits. The regulations further state that as long as all of the following criteria are met, nonmonetary items of nominal value will not violate the Stark laws:

- The annual aggregate value of nonmonetary gifts does not exceed \$429.00 for 2021.
- Providers that give nonmonetary compensation must make it available to those similarly situated, regardless of whether they refer patients to the provider for services.
- The compensation is not determined in any way that takes into account the volume or value of referrals to the provider.

At least in theory, providers and case managers could comply with the [continues on page 38](#)



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were performed at baseline, every 3 months during the study, and at the time of a suspected relapse. Brain MRI scans were performed at baseline and at Weeks 60 and 108.

The primary endpoint was the annualized relapse rate (ARR) over the study period. Additional outcome measures included: 1) the number of new Gd-enhancing T1 lesions from baseline to Week 108, 2) the number of new or enlarging T2 lesions (without double-counting of lesions) from baseline to Week 108, and 3) the time to 3-month and 6-month confirmed disability progression. A confirmed disability progression was defined as an increase of at least 1.5 in EDSS for patients with a baseline EDSS score of 0, an increase of at least 1.0 in EDSS for patients with a baseline EDSS score of 1.0 to 5.0, or an increase of at least 0.5 in EDSS for patients with a baseline EDSS score at least 5.5, which was confirmed after 3 months and 6 months.

A total of 1133 patients were randomized to either Ponvory (N=567) or teriflunomide 14 mg (N=566); 86.4% of Ponvory-treated patients and 87.5% of teriflunomide 14 mg-treated patients completed the study as per protocol. At baseline, the mean age of patients was 37 years, 97% were White, and 65% were female. The mean disease duration was 7.6 years, the mean number of relapses in the previous year was 1.3, and the mean EDSS score was 2.6; 57% of patients had not received any prior non-steroid treatments for MS. At baseline, 42.6% of patients had one or more Gd-enhancing T1 lesions (mean 2.0) on their baseline MRI scan.

The ARR was statistically significantly lower in patients treated with Ponvory than in patients who received teriflunomide 14 mg. The number of Gd-enhancing T1 lesions and the number of new or enlarging T2 lesions were statistically significantly lower in patients treated with Ponvory than in patients who received teriflunomide 14 mg.

There was no statistically significant difference in the 3-month and 6-month confirmed disability progression outcomes between Ponvory- and teriflunomide 14 mg-treated patients over 108 weeks.

A similar effect of Ponvory on the ARR and secondary MRI outcomes compared to teriflunomide 14 mg was observed in exploratory subgroups defined by age, gender, prior non-steroid therapy for MS, and baseline disease activity.

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Maintenance Dosage Bottle: 20 mg-yellow

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

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- Number all pages of manuscript including reference list, tables, and figure legends
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Please send manuscripts or inquiries to:

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Change! *continued from page 4*

forward to an expanding and more innovative online presence for education, training, and professional development. If there can be a silver lining from “unfreezing” in response to the pandemic, it is the ability to connect to many people in real time and at lower cost, achieving amazing results. Virtual engagement literally allows us to meet case managers where they are. We plan to build upon the capability to connect with each other and will cement online interconnectivity using diverse technical formats. CMSA is excited to use technology to create energetic and engaging experiences for case managers to hone their skills and network with other professionals. We have been able to increase our capacity to host numerous informational sessions to “hear the voice” of our members. The staff is hard at work transforming these ideas into actionable initiatives and programs, and our ability to network and collaborate on educational programs with international organizations adds to the excitement of new possibilities. Virtual formats have been and will continue to be great options!

We are refining our member benefits during this “changing year” so that we can solidify (refreeze) these changes within our 5-year strategic plan. CMSA is reimagining how we support and celebrate professional case managers in their practice and leadership development.

CMSA will launch numerous programs this year. Some of them were revealed at the recent CMSA Annual Conference and Membership meeting held June 7–10, 2020. If you were an attendee but did not have the opportunity to hear about all of the exciting new offerings...not to worry! Access to the conference information is available through August 31, 2021. Take advantage of the on-demand programs. Review the announcements about the fresh and cutting-edge CMSA member benefits and educational programs that will not only help you do your jobs better but also elevate your professional careers to new heights. If you are not a member, consider joining the association for access to a plethora of dynamic and engaging care management colleagues, a library of outstanding career support tools and information, and a cadre of organizations that support our professional development. To get an idea of how membership in CMSA makes a significant difference in your career and personal journeys, I invite you to visit our website often as a dynamo technical team works behind the scenes to constantly enhance the website’s content and experience.

<https://cmsa.org/>. The website is a great place to stay up-to-date on the variety of new programs we will continue to launch throughout the year. Let us hear from you. There are many ways to connect. Work within your local chapters and share ideas with chapter

presidents who collaborate on a regular basis via the Chapter Presidents’ Coffee Connect. Participate in the CMSA blog and social media platforms. Send us a video or audio message to celebrate a hero or a Monday Mindfulness tip to share with others. This is the National Staff and Board of Directors’ efforts to ensure your voices are heard and our association benefits from the collective power of our members.

Change can reveal what is good and should remain, while also inspiring new ways to succeed in our personal and professional lives. CMSA has a plethora of leaders who are demonstrating how change can be transformational on the local and national levels. We have reconnected with past Presidents to merge the wisdom of the past with the promise of the future as CMSA continues to elevate and evolve into an association that develops the case manager professional and advances the practice of case management around the world. Yes, CMSA is in its changing year...wait until you see how we “refreeze”! Let’s continue what we started at the annual conference and stake our new claims in case management! **CM**

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What Can Discharge Planners/Case Managers Accept from Providers Who Want Referrals? *continued from page 36*

requirements of the Stark laws regarding nonmonetary compensation to physicians but still violate the kickback statute described above.

It seems unlikely, however, that the OIG will conclude that case managers/discharge planners received kickbacks

and rebates if the requirements of the Stark regulations described above are met. In other words, compliance with the requirements of the final Stark regulations may provide protection to case managers/discharge planners and providers with regard to nonmonetary compensation received from providers by case managers, even though they may not technically apply.

Providers and case managers

should, of course, monitor developments regarding this issue. The temptations are many, but there is a great deal to lose! **CM**

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