CareManagement

JOURNAL OF THE COMMISSION FOR CASE MANAGER CERTIFICATION | THE CASE MANAGEMENT SOCIETY OF AMERICA | THE ACADEMY OF CERTIFIED CASE MANAGERS

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Gary S. Wolfe

Navigating in Turbulent Times

By Gary S. Wolfe, RN, CCM, FCM, Editor-in-Chief

The future is before us! Although we are currently faced with uncertainties in healthcare, we understand the challenges that you, our readers, and the entire healthcare community are facing.

Without a doubt, we are in turbulent times. It seems almost everywhere you look, there is some degree of uncertainty about the future. Much of what we believe in is being questioned, discredited, or eliminated. Whether it is our work life or our personal life, everything is changing. In work, we are faced with uncertainty: Do I have a job? Will I be laid off? Will funding be cut? How can I care for more patients with fewer resources, including fewer staff? In life, we are faced with uncertainty: How do I care for the family and my relationships? Will I be able to afford groceries? How do I balance my life? How do politics and government impact my life? It is hard not to feel overwhelmed. Most of these influences are outside your control. You may feel stuck, frozen, or helpless. How do you navigate in these turbulent and chaotic times?

Here are some suggestions that I use. They are not in any order, and I use different strategies in different situations.

1. **Practice mindfulness.** Stay present every day and focus on today. Sometimes taking one day at a time is good and the best you can do.
2. **Be grateful and show gratitude.** There is so much to be grateful for. Look around and focus on the positive. Practice random acts of kindness to family, friends, and strangers. It makes you feel good.
3. **Connect with supportive friends.** Seek out friends and family who are supportive. Give yourself time to enjoy yourself. Ask for help.
4. **Set realistic goals.** Goal setting is an effective strategy when you want to accomplish something or see the light at the end of the tunnel. Set goals in a range: easy to difficult to achieve. Setting unrealistic goals is a good way to feel bad.
5. **Learn from the past.** History is important. Many things keep repeating themselves. So, learn from the past.
6. **Take care of yourself.** You must take care of yourself. Everyone does this in a different way. Figure out what your way is and do it. It could be simple, or it could be dramatic.
7. **Limit exposure to negative messages.** If the only things you hear are negative, you easily get overwhelmed and doubt yourself. Oh, believe me, there are plenty of negative messages.

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Vol. 31, No. 3, June/July2025. *CareManagement* (ISSN #1531-037X) is published electronically six times a year, February, April, June, August, October, and December, and its contents are copyrighted by Academy of Certified Case Managers, 2740 SW Martin Downs Blvd. #330, Palm City, FL 34990; Tel: 203-454-1333; Fax: 203-547-7273.

Subscription rates: $130 per year for ACCM members; $150 for institutions.

CareManagement is indexed in the CINAHL® Database and Cumulative Index to Nursing & Allied Health Literature™ Print Index and in RNdex.™

Catherine M. Mullahy

Communication and Collaboration: Which Comes First, the Chicken or the Egg?

By Catherine M. Mullahy, RN, BS, CRRN, CCM, FCM

Professional case managers are likely to agree that the most important elements in the case management process are communication and collaboration. Books have been written about both, and surely successful outcomes cannot be achieved without employing both.

Many organizations dismiss the importance of these components and mistakenly believe that individuals in nursing, social work, and other disciplines have already received education and training in these and, therefore, move along and provide educational support in the other aspects of case management—e.g., legal and ethical issues, time management, information technology, healthcare systems, resources, and so much more.

Communication and collaboration are related but decidedly different. Given the increasing complexity of our patients, the management of a wide array of medical conditions, fragmented healthcare systems, lack of effective resources, and, of course, the continuing problems with staffing shortages, we really do need to go "back to the basics" and then take a closer look at the problems that result from ineffective communication and collaboration.

To add to the complexity of communication and collaboration, and in response to the realization that breakdowns in communication are responsible for the increasing numbers of readmissions, patient safety problems, and unacceptable HCAHPS scores (Hospital Consumer Assessment of Healthcare Providers and Systems), organizations are employing systems to address and improve these processes. Collaboration systems are helpful, but effective communication also requires interpersonal skills (once again, "back to basics"). In a recent post, and despite technology, it was reported that employees are still wasting over 300 hours a year in inefficient or ineffective communication. How is that possible? I'm sure, however, that most of our readers can attest to that finding.

Many organizations dismiss the importance of [communication and collaboration] and mistakenly believe that individuals in nursing, social work, and other disciplines have already received education and training in these.

Collaboration systems provide an easy way to communicate, but exchanging messages isn't collaborating. The terms "communication" and "collaboration" are sometimes used interchangeably, which makes it harder to identify the real reason for weak, or nonexistent, collaboration. Let's take a closer look at each.

Communication is simply sharing or exchanging information. Sending an email, speaking with a colleague in the break room, or leaving voice messages are just a few ways employees communicate at work. Conversations where we work are mostly work-related but often include happenings of daily life. Communication does not always contribute to collaboration, but collaboration cannot happen without communication.

Collaboration is working with others collectively toward a common goal to create something or solve a problem. In many organizations, employees with diverse expertise collaborate to accomplish an objective more effectively. In other organizations, individuals work separately and complete tasks at the end of an endeavor instead of discussing matters, asking questions, and providing feedback along the way. Everyone applies and shares their skills to achieve something greater than any individual could achieve alone. We are familiar with and perhaps have been a member of organizations where staff in departments "work in silos" and then become amazed when we know so little about what others do.

Effective communication ensures that information is shared clearly and accurately. For healthcare professionals, effective communication is essential

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CCMC Welcomes Two New Commissioners

By MaryBeth Kurland, MPA, CAE, ICE-CCP

The Commission for Case Manager Certification (CCMC) relies on the expertise and dedication of a group of Commissioners who work closely with executive staff. Currently, 14 Commissioners volunteer their service, including two new members who recently joined to fill vacancies on the Commission.

Rosalyn Burns, BA, MEd, CCM, CCHW, is Director of Training for Medical Management and Rehabilitation Services (MMARS), which provides independent care management and coordination services to both the public and private sectors. With over 30 years in case management, Rosalyn has expertise in home- and community-based care services, workers' compensation, and disability services.

Rosalyn's interest in case management began with her studies at Coppin State University's Master of Education in Rehabilitation Counseling program. After earning her advanced degree and becoming certified in rehabilitation counseling, she also pursued the Certified Case Manager (CCM) certification.

"Being a member of a productive and healthy team gives me a feeling of accomplishment. I am honored and humbled to have been elected to serve the Commission."

Before becoming a Commissioner, Rosalyn had been volunteering with the Commission, including item writing and serving on special taskforces. "Through these experiences, I've met some of the most caring professionals and gained invaluable knowledge," she states.

Dawn Taylor, MSN, RN, CCM, is a Medical Case Manager at the Naval Medical Center in San Diego, specializing in behavioral health. With more than 38 years of experience in nursing, she has worked as a case manager for 18 years. In addition, she retired from the United States Army Nurse Corp after serving for 20 years. She received her BSN from Hampton University in Hampton, Virginia, and her MSN from Salisbury University in Salisbury, MD.

Dawn's journey into case management was through a kidney care/dialysis company and continued after she joined the Warrior Transition Battalion for the Army, while on active duty. "I loved assisting soldiers who were healing and returning to duty or who were transitioning out of the military as veterans in the community," she explains.

Before becoming a Commissioner, she became active with the Commission as a subject matter expert, reviewing questions and participating in item review for the CCM certification examination. "Being a member of a productive and healthy team gives me a feeling of accomplishment. I am honored and humbled to have been elected to serve the Commission," Dawn adds.

As these brief discussions of their backgrounds show, Rosalyn and Dawn bring to the Commission experiences in diverse care settings, such as community-based care delivery and the military. Other current Commissioners have backgrounds that include insurance, hospital-based case management, disability management, workers' compensation, vocational counseling, social work, and mental health counseling.

As the first and largest nationally accredited organization that certifies case managers and disability management specialists, the Commission believes such broad representation among its Commissioners is important. The CCM credential attests to the competency of generalist professional case managers who practice across health and human services. The CDMS credential similarly confirms the highest level of knowledge and skills related to leave and absence management in the employer space.

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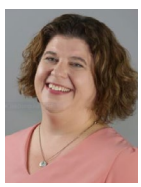

MaryBeth Kurland, MPA, CAE, ICE-CCP*, is the Chief Executive Officer of the Commission for Case Manager Certification. The Commission is the first and largest nationally accredited organization that certifies more than 50,000 professional case managers and disability management specialists. With more than 25 years of experience in the nonprofit sector, MaryBeth is a credentialing segment leader at an association management company where she oversees the strategic direction and operational excellence of credentialing programs for several associations and organizations, including CCMC.*

Case Management: Innovative Solutions, Improved Outcomes

Celebrating 35 Years of Advancing the Practice at CMSA's 2025 National Conference

By Dr. Colleen Morley, DNP, RN, CCM, CMAC, CMCN, CMGT-BC, ACM-RN, FCM, FAACM

In 2025, the Case Management Society of America (CMSA) proudly marks its 35th Anniversary—a significant milestone for the organization that has become the driving force behind the development, advancement, and recognition of the case management profession. This year's National Conference, to be held in Dallas, TX, will reflect this momentous occasion with the theme: "Case Management: Innovative Solutions, Improved Outcomes."

This theme speaks directly to the work that case managers do every day across the continuum of care—problem-solving in real time, navigating increasingly complex systems, and crafting creative, patient-centered solutions that genuinely make a difference. The 2025 conference will serve as a rallying point for professionals ready to share, learn, and lead into the next era of case management.

Honoring 35 Years of Impact

Founded in 1990, CMSA has spent more than three decades advocating for the professionalization of case management, establishing standards of practice, advancing certification, and supporting the development of leaders across various healthcare settings. The 35th Anniversary Conference will celebrate this remarkable legacy while showcasing how the field is adapting to meet today's—and tomorrow's—challenges.

Dr. Colleen Morley, DNP, RN, CCM, CMAC, CMCN, CMGT-BC, ACM-RN, FCM, FAACM, *is Immediate Past President of the Case Management Society of America National Board of Directors and principal of Altra Healthcare Consulting in CO.*

Whether you're new to the profession or an experienced leader, this conference intends to energize your practice, expand your toolkit, and connect you with peers and pioneers from across the country.

A Conference Designed for Innovation and Application

The CMSA 2025 Conference promises an agenda filled with fresh ideas, evidence-based strategies, and actionable tools. Designed to support case managers at all levels and practice settings, the sessions will focus on what matters most to today's professionals:

- Emerging Technologies and Care Delivery Models: AI, digital health, telehealth case management, and predictive analytics in population health
- Social Determinants of Health and Health Equity: Practical frameworks for addressing disparities through innovative program design
- Acute and Transitional Care Strategies: Enhancing patient outcomes and reducing readmissions through collaborative discharge planning and bundled payment models
- Leadership and Professional Growth: Empowering case managers to grow as innovators, influencers, and advocates
- Special 35th Anniversary Programming: A gala celebration, legacy reflections, and special recognitions to honor CMSA's founders and key contributors

Whether you're new to the profession or an experienced leader, this conference intends to energize your practice, expand your toolkit, and connect you with peers and pioneers from across the country.

Reimagining Outcomes Through Collaboration

With their unique practice competencies, case managers can drive improvement in clinical, financial, and humanistic outcomes. The 2025 conference will highlight how interdisciplinary collaboration, data-informed

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Disability Management Job-Task Analysis Underway

By Patricia "Patty" Nunez, MA, CRC, CDMS, CCM and Rebecca Fisco, CDMS

Every five years, a disability management field practice study is conducted, with the results used to evaluate, validate, and, where necessary, update the content of the Certified Disability Management Specialist (CDMS) certification examination. The latest field study, which is also known as a job-task analysis (JTA) or a role and function study, is currently underway.

The JTA is being conducted by the Commission for Case Manager Certification (the Commission), which administers the CDMS credential.

Field research ensures that credentials such as the CDMS and the CCM, as well as their respective certification examinations, remain relevant and reflective of the current knowledge required for competent practice.

The Commission has partnered with Data Recognition Corporation (DRC), a provider of assessment solutions, to conduct the analysis, which seeks to validate the core knowledge areas in disability management practice.

The previous JTA was conducted in 2020. At that time, the essential knowledge areas, or domains, of disability management practice were identified as:

- Disability and Work Interruption Case Management
- Workplace Intervention for Disability Prevention
- Program Development, Management, and Evaluation
- Employment Leaves and Benefits Administration

These 2020 findings provided a baseline for the 2025 JTA to determine if the essential knowledge areas should be altered, expanded, amended, replaced, or otherwise changed.

The latest study began with a panel of subject matter experts (SMEs) convened to review and propose updates to the content outline of the CDMS examination, effective in 2026. Based on the SMEs' input, a survey was sent in Spring 2025 to the disability management community. After that survey ends, the findings will be analyzed by DRC and then presented to the Commission for review. Once approved, the JTA findings will inform a new CDMS exam blueprint, starting with the 2026 examinations.

A Legacy of Field Research

The latest field survey of disability management practice is the second such evidence-based research conducted recently by the Commission. In late 2024, the Commission approved findings from a JTA survey into case management practice to support its Board Certification in case management: the Certified Case Manager (CCM) credential. (Findings of the CCM field survey will be summarized in an upcoming article.)

Field research ensures that credentials such as the CDMS and the CCM, as well as their respective certification examinations, remain relevant and reflective of the current knowledge required for competent practice. Conducted every five years, JTAs reveal insights into the field of practice at the time research is conducted and contribute to a continuum of knowledge about how the professional practice is evolving.

Over the years, disability management practice has expanded. Initially, the practice primarily addressed

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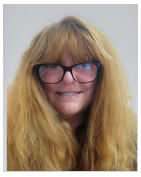

Patricia "Patty" Nunez, MA, CRC, CDMS, CCM, *is Chair of the Commission for Case Manager Certification (CCMC), the first and largest nationally accredited organization that certifies more than 50,000 professional case managers and disability management specialists. The Commission oversees the process of case manager certification with its CCM® credential and the process of disability management specialist certification with its CDMS® credential. Triple certified as a CCM, CDMS, and CRC, Patty recently retired from the Claim Vendor Management office of CNA and remains active with the Commission and as a volunteer with professional organizations and as an advocate.*

Rebecca Fisco, CDMS, *is Chair-elect of the Commission and Chair of the CDMS's JTA Taskforce. She is also Associate Director, Integrated Absence Management, at The Ohio State University.*

Legal Updates

By Elizabeth E. Hogue, Esq.

What Does OIG Say About Charity Care?

Providers that render charity care often have the best intentions, but it's important to make sure that good intentions go unpunished! What does the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services say about so-called charity care?

The information in this article is based on "General Questions Regarding Certain Fraud and Abuse Authorities" in the form of FAQs published in July of 2024.

Here's what the OIG says about charity care:

1. **Does the federal anti-kickback statute (AKS) or Beneficiary Inducement Civil Money Penalties (CMP) law prohibit providers from waiving patients' cost-sharing amounts in charity care policies?**

   According to the OIG, providers may give relief to uninsured and underinsured patients who cannot afford the costs of their care and to Medicare beneficiaries who cannot afford cost-sharing amounts under the Medicare Program. The OIG generally supports providers' efforts to provide charity care under these circumstances. In addition, the AKS and the Beneficiary Inducement CMP do not apply to cost-sharing waivers provided to uninsured persons or to persons insured solely by commercial health plans, including qualified health plans.

   With respect to federal health care program enrollees, financial assistance policies that permit providers to waive cost-sharing amounts may violate both the AKS and the Beneficiary Inducements CMP. The OIG has long-standing and consistent concerns regarding routine waivers of federal health care program enrollees' cost-sharing amounts. In particular, providers that routinely waive cost-sharing amounts as part of a financial assistance policy or otherwise for reasons unrelated to individualized, good-faith assessments of financial hardship may be held liable under the AKS, the Beneficiary Inducements CMP, or both.

   The OIG has repeatedly stated that waivers of federal health care program enrollees' cost-sharing amounts on the basis of enrollees' financial need, as long as waivers are not routine, not advertised, and made pursuant to a good-faith, individualized assessment of the enrollees' financial need are low-risk under the AKS. Likewise, the Beneficiary Inducements CMP excludes from the definition of "remuneration" under the CMP certain waivers of cost-sharing amounts offered to patients in financial need that are: (1) not offered as part of any advertisement or solicitation; (2) not routine; and (3) made following individual determinations of financial need.

2. **Can providers make patients aware of charity care policies that permit lawful waivers of federal health care program enrollees' cost-sharing amounts without violating the AKS, the Beneficiary Inducements CMP, or both?**

   Yes, providers can make patients aware of charity care policies that permit lawful waivers of federal health care program enrollees' cost-sharing amounts. Note, however, that the Beneficiary Inducements CMP exception at 42 C.F.R. §1003.110 for the waiver of coinsurance and deductible amounts contains a condition under which the exception only applies if the waiver "is not offered as part of any advertisement or solicitation." Consequently, cost-sharing waivers that otherwise satisfy this exception would no longer qualify if the waiver were offered as part of an "advertisement or solicitation."

   Whether a particular communication constitutes an "advertisement or solicitation" for the purposes of this exception depends on the facts and circumstances. Making all patients aware of financial assistance policies that permit waivers of enrollees' cost-sharing amounts, such as on providers' websites, does not necessarily raise concerns under the "advertisement or solicitation" condition. On the other hand, if providers announce on their websites that they offer "insurance only" billing to all patients as an inducement to attract patients, including federal health care program enrollees, such announcements would be "advertisements or solicitations" and would present risks under both the Beneficiary Inducement CMP and the AKS.

3. **Does the provision of free care to uninsured patients or commercially insured patients violate the AKS or the Beneficiary Inducements CMP? Does advertising the free care available to uninsured or commercially insured patients violate the AKS or the Beneficiary Inducements CMP?**

   Generally speaking, the AKS and the Beneficiary Inducement CMP do not prohibit providers from furnishing free or discounted items or services to uninsured or commercially insured patients who are unable to pay their bills. Likewise, these statutes do not prohibit providers from advertising or otherwise communicating about financial assistance policies that provide such support to uninsured or commercially insured patients.

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

4. **If providers' financial assistance policies specify that providers must conduct good faith, individualized assessments of financial need of patients who request financial assistance with their bills and after making such assessments, offer financial assistance to patients who qualify as having financial need, and if providers state on their websites and on mailed bills that patients may contact providers for additional information about potential financial assistance, are they violating the AKS or the Beneficiary Inducement CMP?**

   If providers' policies say that they give assistance to federal health care program enrollees and providers give assistance consistent with its policy, then providers can disseminate information about financial assistance policies through their websites, on posters in public areas, on their mailed bills, or through other mechanisms in a manner that is sufficiently low-risk to avoid sanctions under the AKS and other OIG authorities.

The bottom line is that providers must put charity care policies in place and apply them consistently before rendering free care.

Continuing Violence Against Field Staff in Home Care

Sadly, but not surprisingly, the violence against field staff caring for patients in their homes continues. Here's a recent example:

On February 28, 2025, a hospice nurse in Texas was accosted inside a patient's home while she was attempting to provide care. The man who accosted her inside the home followed her outside with a rifle and fired at her as she fled. The nurse was uninjured, but her car was struck by at least one bullet. Then, still armed, the man went back inside the patient's home where he stayed close to the patient while pointing his rifle at deputies. Law enforcement officers were able to communicate with him and de-escalate the tense situation. The man was booked into the county jail on a charge of aggravated assault with a deadly weapon and bond was set at $250,000.

According to a recent analysis of Bureau of Labor Statistics data, healthcare is one of the most dangerous places to work. Homecare field staff members who provide services on behalf of private duty agencies, hospices, Medicare-certified home health agencies, and home medical equipment (HME) companies may be especially vulnerable. Contributing to their vulnerability is the fact that they work alone on territory that may be unfamiliar and over which they have little control. Staff members certainly need as much protection as possible.

First, regardless of practice setting, management should develop a written policy of zero tolerance for all incidents of violence, regardless of source. This policy should include animals. The policy must require employees and contractors to report and document all incidents of threatened or actual violence, no matter how minor. Emphasis should be placed on both reporting and documenting. Employees must provide as much detail as possible. The policy should also include zero tolerance for visible weapons. Caregivers must be required to report the presence of visible weapons.

Below are some additional important actions for healthcare organizations to take that are based on the UCHealth SAFE Program:

- Encourage staff members to STOP if they feel unsafe for any reason.
- If danger is not imminent, workers should pause to generally ASSESS their environments. Staff members should think about what happened and observe what is currently happening. Is there, for example, mounting frustration or anger?
- Staff should then FAMILIARIZE themselves with the area. Who is the patient? Where is the patient? Are there any factors that might escalate behaviors? Staff members should also consider putting themselves in positions where they have a route to escape, if necessary.
- Practitioners should also ENLIST help. Getting help may, for example, include pushing panic buttons on mobile devices.

Here is what Chris Powell, Chief of Security at UCHealth, said in Becker's Hospital Review on June 4, 2024:

"You can't just talk about the shrimp and give you a good picture. We have to talk about the roux and the rice and everything else that goes into this for a good picture to be painted so people have an understanding. We want to solve this with an electronic learning or a 15-minute huddle, but we can't. This is continuous and a persistent pursuit toward educating, communicating, recognizing, responding to, reporting and recovering from workplace violence."

Every caregiver matters. The healthcare industry has lost caregivers to violence on the job in the past. Let's do all that we can to avoid similar events in the future. CM

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Traumatic Brain Injury and Seizures: Ethical Priorities in Patient-Centered Care

By Chikita Mann, MSN, RN, CCM

Traumatic brain injury (TBI) is one of the leading causes of death and disability worldwide, with over 3 million people affected annually in the United States alone. These injuries, which may result from falls, motor vehicle accidents, assaults, or workplace incidents, often lead to long-term neurological complications, one of the most serious being the development of post-traumatic seizures (PTS) or epilepsy (PTE) (Sharma et al., 2021). The onset of seizures following a TBI can significantly complicate recovery, disrupt daily functioning, and impact the individual's ability to return to work or maintain independence. For case managers, this presents a unique and complex landscape of care coordination, where neurological instability intersects with psychosocial vulnerability.

Coordinating care for individuals with PTS requires more than clinical oversight—it demands an ethically grounded approach. Patients with TBI-related epilepsy may face stigma, impaired decision-making capacity, and systemic barriers to equitable care. Ethical concerns related to autonomy, confidentiality, informed consent, and access to appropriate services are central to ensuring the dignity and well-being of these patients. Case managers must navigate these challenges while advocating for the patient's best interests, balancing safety with respect for individual rights, and ensuring that decisions are made through an inclusive, informed, and compassionate lens.

Understanding Post-Traumatic Seizures and Epilepsy

Traumatic brain injury (TBI) is the third most common cause of epilepsy and can result from either direct (primary) damage or delayed (secondary) effects on brain tissue. TBI may lead to both localized (focal) and widespread (diffuse) injury within the central nervous system (CNS), creating conditions that can trigger the development of epilepsy, a process known as *epileptogenesis*. Epileptogenesis is the term used to describe the process by which a normal brain develops epilepsy. Neuroinflammation plays a central role in the development of epilepsy (epileptogenesis) following TBI. It refers to the gradual sequence of changes in the brain, often triggered by an initial injury, such as a TBI, stroke, infection, or genetic abnormality, that ultimately leads to the onset of spontaneous, recurrent seizures (Dulla & Pitkänen, 2021; Sun et al., 2021).

Focal injuries often involve brain contusions, bleeding (hemorrhage), tissue death (infarction and necrosis), and scarring of the cerebral cortex. This scarring can disrupt normal brain connectivity, affecting synaptic plasticity and hindering recovery. A diffuse brain injury can cause widespread damage by stretching and tearing nerve fibers, harming small blood vessels, triggering inflammation in the brain, and releasing harmful molecules that can further damage brain cells (Sharma et al., 2021).

Post-traumatic seizures (PTS) are seizures that occur as a direct result of a TBI. When these seizures continue beyond the initial injury period, they may progress into PTE—a chronic neurological condition marked by recurrent, unprovoked seizures attributed to the brain injury. PTE is one of the most disabling complications of moderate to severe TBI and may occur weeks, months, or even years after the initial trauma (Kotas et al., 2024). The presence of seizures can disrupt recovery, complicate rehabilitation, and affect both psychosocial and occupational outcomes.

Post-traumatic seizures are categorized based on the timing of onset:

- Early post-traumatic seizures (ePTS) occur within the first seven days of the injury. These are often provoked by acute factors such as intracranial bleeding, swelling,

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PTE is one of the most disabling complications of moderate to severe TBI and may occur weeks, months, or even years after the initial trauma.

or metabolic imbalance. While not all patients with early seizures later develop epilepsy, they are at higher risk (Kotas et al., 2024).

- Late post-traumatic seizures (lPTS) develop after the first week and are more strongly associated with permanent changes in brain function. These seizures are considered more predictive of chronic post-traumatic epilepsy and may require long-term anticonvulsant therapy and neurological monitoring (Kotas et al., 2024).

Understanding the risk factors for PTE is critical for early identification, prevention planning, and patient education. These risk factors fall into two main categories: those related to the injury itself and those specific to the individual. Injury-related factors include the severity of the TBI, intracerebral hemorrhage, penetrating head trauma, and the occurrence of ePTS within the first week following injury. Each of these increases the likelihood of long-term epileptic activity due to disruption of normal brain structures. Individual-specific factors such as older age, a family history of epilepsy, and premorbid conditions—including alcohol use disorder or depression—can further elevate the risk of developing chronic seizures (Kazis et al., 2024; Semple et al., 2019).

Depressed mood is the most prevalent psychiatric symptom associated with epilepsy and is often perceived by patients as more debilitating than the unpredictability of the seizures themselves. Notably, approximately one in two individuals with epilepsy will experience a clinically significant depressive disorder at some point during their lifetime (Golub & Reddy, 2022; Semple et al., 2019).

Cognitive impairment is one of the most common and disabling consequences of TBI, affecting key mental processes such as attention, learning, memory, and executive functioning. Similarly, epilepsy is independently associated with a range of cognitive comorbidities, with many individuals experiencing difficulties in attention, memory (both short- and long-term), and executive function (Golub & Reddy, 2022; Semple et al., 2019).

Social dysfunction is widely recognized as one of the most persistent and disabling challenges following TBI. A substantial body of clinical research indicates that individuals with TBI are at elevated risk for impairments in social interaction, social cognition, verbal and nonverbal communication, and adaptive behavior. Individuals with these impairments often exhibit increased tendencies toward aggression and antisocial behavior. Similarly, social functioning is frequently compromised in individuals with epilepsy. Many patients report reduced participation in social activities, which is particularly pronounced among those with intractable or medically refractory epilepsy. Evidence suggests that frequent seizures significantly hinder an individual's ability to engage in community life, further contributing to isolation and diminished quality of life (Golub & Reddy, 2022; Semple et al., 2019).

Care Coordination Concepts

Care coordination for individuals with seizures that result from a TBI presents unique ethical dilemmas. The board-certified case manager must understand how the dual diagnoses of PTE and TBI can be daunting psychologically, physically, socially, and emotionally. Before analyzing the ethical complexities encountered by board-certified case managers in coordinating care, it is imperative to address the societal stigmatization associated with TBI and post-traumatic epilepsy.

Stigmatization significantly contributes to the overall burden of the condition and can also extend its impact to the families of those affected. Many people mistakenly believe that individuals with TBI or post-traumatic epilepsy are incapable of leading independent lives. There is also a misconception that these conditions always result in severe cognitive impairments. Additionally, some assume that people with these conditions are prone to violent behavior, which is not true in most cases.

For board-certified case managers, it is important to recognize two types of stigmata often faced by individuals with epilepsy. "Enacted stigma" involves direct experiences of discrimination due to societal biases, whereas "felt stigma" reflects the individual's internalized shame and fear of being judged or mistreated (Mao et al., 2022). As case managers, it is essential to recognize how both stigmas can profoundly affect individuals living with epilepsy. These effects extend beyond the neurological diagnosis and directly influence the patient's ability to engage in care, achieve independence, and participate fully in life. Both forms can significantly impact the patient's mental health, engagement in care, and overall recovery.

Approximately 60% of individuals experience a psychiatric disorder within the first 12 months following a TBI with affective conditions such as depression and anxiety being the most commonly reported.

Understanding the Impact of Enacted Stigma on Individuals with Epilepsy

Emotional and Psychological Distress

Such patients are at increased risk for experiencing emotional and psychological disturbances, including anxiety, depression, and reduced coping capacity. Patients who experience stigmatizing behaviors may develop depression, anxiety, or shame. These emotional responses can hinder communication, lower self-esteem, and decrease motivation to participate in rehabilitation or treatment planning (Mao et al., 2022).

Employment and Educational Barriers

Discrimination within the workplace and academic environments remains a significant and well-documented consequence of stigma faced by individuals with epilepsy, particularly those whose condition resulted from a TBI. These individuals may encounter implicit or explicit biases that affect their ability to access or sustain meaningful employment or educational advancement.

In professional settings, employers may be reluctant to hire or retain individuals with epilepsy due to misconceptions about productivity, safety risks, or liability. Even when hired, individuals may be placed in positions below their qualifications or denied advancement opportunities based solely on their diagnosis. Workplace policies sometimes fail to provide reasonable accommodations, such as modified schedules, seizure response plans, or safe environments, all of which are protected under the Americans with Disabilities Act (ADA). The absence of such accommodations can compromise job performance, increase workplace stress, and ultimately result in job loss or resignation.

Social Isolation and Diminished Support

Case managers should be aware that enacted stigma often leads individuals with epilepsy, particularly those recovering from a TBI, to withdraw from social interactions as a protective mechanism. Many patients avoid public settings, social events, or even close relationships due to fear of embarrassment, negative judgment, or misunderstanding related to their condition.

This withdrawal can severely reduce access to vital community and familial support systems, which are often critical to emotional recovery and long-term rehabilitation. Social isolation not only exacerbates feelings of loneliness and depression, but it may also hinder the patient's willingness to participate in treatment or engage in return-to-work and community reintegration programs.

Patients already managing the cognitive and emotional challenges of TBI are especially vulnerable to the compounded effects of social isolation. Without consistent support, they may become increasingly disengaged, further complicating care coordination and leading to poorer health outcomes.

Family Dynamics and Secondary Stigma

When coordinating care for individuals with epilepsy following a TBI, board-certified case managers must also consider the impact of secondary stigma on family members and caregivers. Secondary stigma refers to the prejudice, misconceptions, or social judgment experienced by those closely associated with the individual living with epilepsy. This often places an emotional and psychological burden on the family unit, which can directly affect the patient's recovery environment.

Family members may feel isolated, overprotective, or even ashamed due to societal perceptions of epilepsy. In some cases, caregivers may limit the patient's independence, not out of malice, but due to fear of public episodes or judgment. Over time, this overprotection can unintentionally reinforce feelings of helplessness in the patient and lead to increased dependency or strained relationships.

In addition, caregivers may experience burnout, especially if they are solely responsible for managing medical appointments, safety planning, or behavioral changes post-TBI. The emotional toll of caregiving, compounded by social stigma, can reduce their effectiveness in providing support and may lead to feelings of guilt, resentment, or fatigue.

Understanding Felt Stigma in Individuals with Epilepsy

Felt stigma refers to the internalized fear, shame, or anticipation of discrimination that individuals with epilepsy may experience, even in the absence of direct stigmatizing events. Felt stigma was associated with more frequent and recent seizures, earlier epilepsy onset, longer duration, lower education, poorer epilepsy knowledge, and younger age. For patients with TBI who develop epilepsy, this internal burden can be particularly intense due to cognitive, emotional, and social vulnerabilities following the injury (Mao et al., 2022).

A substantial body of clinical research indicates that individuals with TBI are at elevated risk for impairments in social interaction, social cognition, verbal and nonverbal communication, and adaptive behavior.

Emotional Self-Consciousness

Patients with epilepsy, especially those recovering from a TBI, often experience heightened emotional self-consciousness. Feelings of embarrassment or shame may arise when seizures occur in public or when the individual has previously encountered negative reactions from others. These emotional responses are not merely fleeting—they can become internalized and deeply affect the patient's sense of identity and self-worth.

For case managers, it is important to recognize how this internal struggle can undermine a patient's willingness to engage in recovery. Persistent feelings of vulnerability or fear of judgment may cause patients to withdraw, resist treatment, or avoid participating in therapeutic activities that involve others. Left unaddressed, emotional self-consciousness can contribute to anxiety, depression, and decreased motivation, ultimately hindering progress toward functional goals and reintegration.

Fear of Disclosure

Fear of disclosure is a common concern among patients with epilepsy, particularly those also coping with the effects of a TBI. Many individuals hesitate to share their diagnosis due to fears of being judged, misunderstood, or treated unfairly. This reluctance often stems from prior negative experiences or internalized stigma and can significantly impact both safety and access to care.

When patients choose not to disclose their condition, they may forgo necessary precautions, such as informing employers, coworkers, or educators of seizure risks and response plans. This can lead to unsafe environments, especially in work settings where physical demands or equipment pose additional hazards. Additionally, nondisclosure may result in missed opportunities for accommodations, delayed referrals to specialists, or incomplete care coordination.

Social Withdrawal

Social withdrawal is a frequent psychosocial consequence experienced by individuals with epilepsy, especially when co-occurring with TBI. Anticipated rejection or fear of stigma may cause patients to distance themselves from others, avoiding social gatherings, community involvement, and recreational activities where a seizure could occur or where they might feel judged.

This self-imposed isolation can have far-reaching effects. As patients disengage from their support networks, they often experience heightened loneliness, reduced emotional resilience, and a decreased sense of belonging—all of which can negatively influence both mental health and rehabilitation outcomes. Over time, social withdrawal may contribute to depression, diminished motivation, and reduced quality of life.

- **Use Patient-Centered Cmmunication**
  Validate and normalize feelings and normalize the experience of living with epilepsy. Avoid clinical detachment—compassion goes a long way.
- **Encourage Safe Disclosure**
  Guide patients in determining when, how, and to whom they can safely disclose their condition, especially in workplace or educational settings. Collaborate with Human Resources or disability services as needed.
- **Facilitate Peer and Psychosocial Support**
  Refer patients to support groups, peer mentoring programs, or behavioral health services. Connecting with others who have similar experiences can reduce shame and promote empowerment.
- **Incorporate Stigma Education Into Care Planning**
  Help patients and their families understand the role stigma can play in recovery. Provide educational resources that demystify epilepsy and challenge stereotypes.
- **Advocate for Rights and Accommodations**
  Be proactive in supporting the patient's access to workplace modifications, transportation, or other services that foster independence while ensuring safety.

The Ethical Responsibilities of the Case Manager

Case managers play a pivotal role in coordinating care that is not only clinically appropriate but also ethically sound. Their responsibilities extend beyond logistical coordination and into the realm of ethical decision-making, advocacy, and safeguarding patient rights. Whether supporting individuals with TBI, post-traumatic seizures, or other complex conditions, case managers are consistently called upon to navigate challenging situations involving autonomy, confidentiality, informed consent, and access to care. Upholding ethical principles—such as beneficence, nonmaleficence, justice, and respect for autonomy—is essential to

ensuring that each patient receives compassionate, equitable, and individualized support throughout their recovery journey. The foundation for the analysis of ethical principles for the board-certified case manager is found in the CCMC Code of Professional Conduct and the CDMS Code of Professional Conduct, as well as their respective licensing agency's ethical standards, which provide a strong basis for ethical behavior (CCMC,® 2023) (Table 1).

TABLE 1

PRINCIPLES OF THE CODE OF PROFESSIONAL CONDUCT FOR CASE MANAGERS

1. Board-certified case managers will place the public interest above their own at all times.
2. Board-certified case managers will respect the rights and inherent dignity of all of their clients.
3. Board-certified case managers will always maintain objectivity in their relationships with clients.
4. Board-certified case managers will act with integrity and fidelity with clients and others.
5. Board-certified case managers will maintain their competency at a level that ensures their clients will receive the highest quality of service.
6. Board-certified case managers will honor the integrity of the CCM designation and adhere to the requirements for its use.
7. Board-certified case managers will obey all laws and regulations.
8. Board-certified case managers will help maintain the integrity of the Code, by responding to requests for public comments to review and revise the code, thus helping ensure its consistency with current practice.

Advocacy and Best Interests: Navigating Employer and Insurer Limitations While Prioritizing Patient Well-Being

Advocacy is a core ethical obligation in case management practice. As advocates, case managers are entrusted with the responsibility to act in the best interest of their patients, ensuring that their voices are heard, their rights are protected, and their care is both appropriate and equitable. This role is especially critical when working with individuals living with epilepsy and TBI, who may face stigma, cognitive challenges, or barriers to accessing quality care.

In workers' compensation and disability case management, case managers often operate within systems that involve multiple stakeholders—employers, insurance carriers, third-party administrators, and healthcare providers. While collaboration among these entities is necessary, the case manager's primary ethical responsibility is to advocate for the patient's best interests and overall well-being.

Navigating the expectations of employers and insurers can present ethical challenges, especially when organizational priorities such as cost containment, return-to-work timelines, or benefit limitations may not align with what is clinically or psychosocially appropriate for the patient. In such situations, case managers must act as both facilitators and protectors—ensuring that care remains person-centered, medically necessary, and ethically sound.

Case Management Considerations

1. Uphold Patient-Centered Care Principles
Ensure that care plans reflect the patient's unique medical needs, functional goals, and psychosocial circumstances—not just administrative objectives. The patient's voice should remain central in all decision-making.

2. Navigate Conflicting Expectations Transparently
When there are conflicting goals (e.g., an employer seeking an expedited return to work vs. a physician recommending extended recovery), the case manager should serve as a neutral coordinator who presents clinical facts objectively while advocating for medically appropriate care.

3. Educate Stakeholders About Clinical Justifications
Use evidence-based guidelines and clear documentation to support recommendations that may exceed standard benefits or timelines. When advocating for exceptions or extensions, frame requests in terms of long-term cost savings and injury resolution outcomes.

4. Respect Ethical Boundaries
Do not allow pressure from external entities to compromise clinical judgment, confidentiality, or patient safety. When necessary, escalate concerns to supervisors, ethics committees, or regulatory bodies.

5. Empower Patients Through Advocacy
Help patients understand their rights, benefits, and available resources. When employers or insurers propose options that may not serve the patient's well-being, support the patient in exploring alternatives or voicing concerns.

Ethical Imperative: While employers and insurers are key partners in the care coordination process, the case manager's duty of loyalty lies with the patient. Upholding this principle ensures that advocacy remains rooted in compassion, clinical integrity, and ethical professionalism. In doing so, case managers help preserve trust and promote outcomes that are both medically effective and humanely responsive.

Patient Autonomy: Supporting Informed Decision-Making Regarding Treatment Options

Respecting and promoting patient autonomy is a foundational ethical principle in case management, particularly when working with individuals who have epilepsy

Case managers must be vigilant in ensuring that these individuals [patients who have had a TBI] are fully informed and supported in making choices that align with their personal values, goals, and level of comfort.

and a history of TBI. Autonomy involves the patient's right to make decisions about their own care, based on a clear understanding of available options, potential risks, and expected outcomes.

Patients living with epilepsy may face additional challenges in exercising autonomy, especially if they are coping with cognitive deficits, emotional distress, or external pressures from family or employers. Case managers must be vigilant in ensuring that these individuals are fully informed and supported in making choices that align with their personal values, goals, and level of comfort.

Case Management Considerations

1. Start with the Presumption of Capacity
Unless there is documented evidence to the contrary, always begin with the assumption that the patient is capable of making decisions. Respect their ability to express preferences, ask questions, and weigh risks—even if they need support in processing information.

2. Use Clear, Accessible Communication
Adapt communication to the patient's cognitive, language, and literacy levels. Use plain language, visual aids, or repetition as needed. Confirm understanding through teach-back techniques and encourage questions to support informed decision-making.

3. Encourage Participation in Goal Setting
Involve the patient in identifying meaningful goals related to treatment, rehabilitation, and quality of life. Whether it's returning to work, improving mobility, or reducing seizure frequency, centering care plans around the patient's personal priorities reinforces their autonomy and motivation.

4. Support Shared Decision-Making
Facilitate discussions between the patient, healthcare providers, and family members, ensuring the patient's preferences are always included. Guide conversations in a way that empowers the patient to be an active participant, not a passive observer.

5. Advocate for Accommodations, Not Substitutions
When cognitive or functional limitations affect decision-making, work with the care team to provide reasonable accommodations rather than remove the patient from the process. This may include breaking down choices into manageable parts, using supported decision-making models, or involving trusted support persons without overriding the patient's voice.

6. Balance Risk and Respect
Patients may make decisions that carry some level of risk. As long as they are informed and capable, case managers must respect those choices, even if they differ from provider recommendations. Risk does not automatically justify limiting autonomy.

7. Document Patient Preferences
Ensure that the patient's wishes, preferences, and values are documented in the care plan. Revisit and update these preferences regularly, especially as recovery progresses or circumstances change.

Confidentiality and Privacy: Balancing Employer, Insurer, and Patient Rights

Confidentiality is a cornerstone of ethical case management practice. Case managers are entrusted with sensitive health information and are responsible for protecting the privacy of the individuals they serve while also navigating the information needs of employers, insurers, and other stakeholders involved in the care and recovery process.

In the context of workers' compensation, particularly when managing complex cases involving epilepsy or TBI, maintaining confidentiality can be challenging. Employers and insurers may request frequent updates or detailed documentation, but case managers must ensure that any disclosures align with applicable privacy laws and ethical standards.

Case Management Considerations

1. Obtain and Respect Informed Consent
Always secure written authorization before sharing protected health information (PHI). Ensure the patient understands who will receive the information, what will be disclosed, and for what purpose. Revisit consent forms periodically to confirm they remain valid and appropriate.

2. Disclose the Minimum Necessary Information
When communicating with insurers or employers, only share information that is directly relevant to the coordination of care, functional abilities, and return-to-work planning. Avoid disclosing sensitive diagnostic details unless

explicitly authorized or medically necessary.

3. **Educate Stakeholders on Privacy Boundaries**
   Case managers may need to remind employers or adjusters of confidentiality limitations. Clarify that while updates on functional status and work capacity can be provided, personal medical details are protected unless the patient has given specific consent.
4. **Document All Disclosures**
   Maintain clear records of what information was shared, with whom, and under what authority. This transparency protects both the patient's rights and the case manager's professional integrity.
5. **Support the Patient's Right to Privacy:**
   Be mindful that individuals with epilepsy or TBI may feel particularly vulnerable or stigmatized. Assure them that their health information will be handled with care and advocate for their comfort when sensitive issues arise.

Ethical Reminder: Balancing the interests of all parties involved does not mean compromising the patient's right to privacy. The case manager's ethical duty is to serve as a trusted guardian of confidential information while facilitating appropriate and legally compliant care coordination.

Equitable Access to Care: Addressing Financial Limitations and Social Determinants of Health

One of the fundamental responsibilities of a case manager is to promote equitable access to care, ensuring that all patients, regardless of socioeconomic status or background, receive the medical and supportive services they need. This is especially critical when working with individuals affected by epilepsy and traumatic brain injury (TBI), who may face complex challenges compounded by financial hardship or adverse social conditions.

Social determinants of health (SDOH)—including housing instability, transportation barriers, food insecurity, limited education, and lack of access to healthcare services—can significantly impede a patient's ability to participate in treatment, attend appointments, or achieve meaningful recovery. Financial limitations may also restrict medication adherence, access to specialists, or eligibility for supportive equipment and therapies.

Case Management Considerations:

1. **Conduct a Comprehensive Needs Assessment:**
   Begin by identifying barriers related to finances, housing, employment, transportation, education, and caregiving responsibilities. A structured assessment can help surface unmet needs that directly influence health outcomes.
2. **Connect Patients with Community Resources:**
   Collaborate with social workers, nonprofit organizations, and public agencies to link patients with services such as transportation assistance, medication discount programs, vocational rehabilitation, food assistance, and housing support.
3. **Advocate for Alternative Funding and Entitlements:**
   Assist patients in navigating complex systems to access Medicaid, Social Security Disability Insurance (SSDI), or local/state-funded programs. Advocate with payers for exceptions when medically necessary services fall outside standard coverage.
4. **Prioritize Culturally and Linguistically Appropriate Services:**
   Ensure care coordination accounts for language preferences, cultural beliefs, and health literacy levels. Using interpreters, translated materials, and culturally competent providers can improve communication and trust.
5. **Monitor for Emerging Needs Over Time:**
   Recognize that barriers may shift throughout the course of recovery. Regular follow-ups and reassessments allow case managers to intervene early and adjust the care plan accordingly.

Ethical Imperative: Equity is not about giving everyone the same—it is about ensuring each patient gets what they need to succeed. Case managers serve as vital advocates in bridging the gap between clinical care and real-world challenges. By addressing financial limitations and SDOH, case managers help reduce disparities, improve outcomes, and promote dignity and fairness in healthcare delivery.

Beneficence and Non-Maleficence in Care Coordination for Patients with Post-Traumatic Seizures

When coordinating care for individuals experiencing post-traumatic seizures following a traumatic brain injury (TBI), case managers are ethically obligated to apply the principles of beneficence (doing good) and non-maleficence (avoiding harm). These foundational principles ensure that care is not only medically appropriate but also ethically sound and patient-centered.

Beneficence: Promoting Patient Well-Being

Beneficence refers to the ethical obligation to act in the patient's best interest by promoting their health, safety, and overall quality of life. In practice, this involves:

- Prompt referral to neurology and specialty care for accurate diagnosis and management
- Coordinating treatment plans that support both seizure control and functional goals
- Ensuring patient and caregiver education on seizure management, medication use, and safety precautions
- Advocating for support services such as vocational rehabilitation, transportation, or mental health counseling to improve long-term outcomes

Non-Maleficence: Preventing Harm

Non-maleficence emphasizes the need to avoid actions that could result in physical, emotional, or systemic harm to the patient. For individuals with seizures and TBI, this principle guides the case manager to:

- Prevent inappropriate return-to-work or driving decisions that may compromise safety
- Monitor for medication-related complications or cognitive side effects that could impair function or adherence
- Uphold confidentiality in all communications, particularly with third parties such as employers or insurers
- Ensure clear care coordination between providers to reduce treatment delays, miscommunication, or service gaps

Case Management Strategies to Address Beneficence and Non-Maleficence

To effectively uphold these ethical principles, case managers should implement the following strategies:

1. **Coordinate Interdisciplinary Communication**
   Facilitate collaboration among neurologists, therapists, primary care providers, and mental health professionals to ensure cohesive, patient-centered care. Frequent communication reduces risks associated with fragmented treatment.
2. **Educate and Empower the Patient**
   Provide clear, accessible information about treatment options, safety precautions, and symptom monitoring. Empower the patient to participate in care planning and advocate for their own needs.
3. **Promote Safety-First Decision-Making**
   Balance functional goals with safety. Engage all stakeholders—including family, providers, and employers—in developing realistic plans for return to work, driving, or independent living when seizure control is achieved.
4. **Maintain Ethical Documentation and Communication**
   Document all decisions, patient preferences, and care coordination steps thoroughly. When communicating with external parties, share only the information authorized and relevant to the coordination of care.
5. **Reassess Frequently**
   Monitor changes in the patient's condition, risk factors, or psychosocial circumstances. Update the care plan accordingly to prevent harm and promote ongoing recovery.

Ethical imperative: Beneficence and non-maleficence are not one-time considerations—they are ongoing ethical commitments. Case managers must apply these principles continuously through proactive planning, collaborative communication, and unwavering patient advocacy. By doing so, they help ensure care is not only clinically effective but also ethically grounded and aligned with the patient's best interests.

Conclusion

Caring for individuals with post-traumatic seizures following a TBI presents not only clinical challenges but also profound ethical responsibilities. Case managers are uniquely positioned to uphold ethical principles by promoting patient autonomy, advocating for equitable access to care, and ensuring safety through coordinated, compassionate interventions. By applying the core values of beneficence, non-maleficence, justice, and respect for individual rights, case managers help patients navigate complex medical, emotional, and social landscapes. Ultimately, ethical, patient-centered care is not just about managing seizures—it is about empowering individuals to recover with dignity, participate meaningfully in decisions, and reclaim their quality of life after injury. CE 1

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CE2 Approved for 1 hour of CCM, CDMS, and nursing education credit
Exam expires on December 17, 2025

Care Advocacy Within the Elder Law Firm

By Deanna Baez-Rubino, LMSW, LNHA, CECC, DCC; Raina DeDilectis, BSN RN, CECC, DCC; Brian Andrew Tully, Esq.

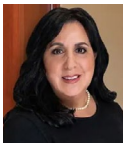
It was a crisp fall morning when Mr. Anderson stood on his front porch, about to embark on his day. He had recently returned from a wonderful vacation with his family and was planning to take his daily morning stroll around the neighborhood and end up at the deli on the corner of his block, where he would meet two of his neighbors for coffee. Unfortunately, this is not how his day began.

As he took the first step off his porch, Mr. Anderson stumbled. Unable to steady himself, he crashed to the ground. The next thing he knew, he was surrounded by emergency personnel, and all he could hear was the sound of machine alarms. He had suffered a cerebral vascular accident (CVA). He was unable to speak because a tube had been put in his throat and a large oxygen mask covered his nose and mouth. He couldn't feel anything on his entire left side, and he recalls feeling extremely terrified.

After several days in the intensive care unit, placement of a nasogastric tube was necessary, followed by a percutaneous endoscopic gastrostomy (PEG) tube for permanent feeding because he was extubated and removed from the ventilator but unable to swallow safely. He was transferred to a skilled nursing and rehabilitation center where he spent the next few months growing stronger physically and working diligently with therapy. Fortunately, he did regain some of the feeling to his left side but still required hands-on assistance for all his activities of daily living. The social workers at the facility advised the family that rehab was coming to an end, and they needed to plan for his discharge.

Mr. Anderson had a very devoted wife and supportive children. Their main goal was to get him back to the loving environment within the home he worked so hard for. They were understandably devastated and frightened by the thought of losing all he had worked for to pay for the long-term care he now required. The family knew they needed to discuss the legal and financial concerns regarding aging, but, also, they were at a loss as to what options were available to them regarding care, and what programs, if any, he qualified for. They began looking into private pay for caregivers at home and found the costs overwhelming. Not knowing what the next steps would be, they sought the guidance of an elder care attorney.

In this scenario, Mr. Anderson's family ultimately engaged a life care planning (LCP) law firm. An LCP law firm is an interdisciplinary team of elder law attorneys, care coordinators, and support staff that work together to develop an estate plan, protect assets, to determine the client's qualification for public benefits, coordinate care, provide education, offer decision-making support, advocate for high-quality care, and intervene when there are problems with care providers. The estate plan is vital to care and must include the four core basic documents every adult over the age of 18 must have a: (1) Health Care Proxy, (2) Durable Power of Attorney, (3) Last Will & Testament, and (4) Living Will. Depending on a client's situation and their financial goals, an Irrevocable Trust may also be needed. The law firm discusses all the options and strategies at length with the client and their family so that the elder care plan reflects the client's wishes and objectives.



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Life care planning is the future of elder law: it offers the traditional elder law firm services of asset protection, estate planning, and Medicaid qualification with the expanded areas of care coordination and advocacy.

What Is Life Care Planning?

Life care planning is the future of elder law: it offers the traditional elder law firm services of asset protection, estate planning, and Medicaid qualification with the expanded area of care coordination and advocacy. LCP offers a holistic approach that helps families with every aspect of caring for someone with a chronic illness. In essence, LCP legal services help people find, get, and pay for good long-term health care by bundling the legal and financial aspects of aging with long-term care services' coordination, community and nursing home advocacy, and crisis intervention. It is typically a one-year engagement, which allows the team to develop and cultivate supportive relationships with the family and clients to better assist them along their journey. As the first year of services end, families and clients can renew for continued services and on an annual basis. This concept was first introduced in the 1990s and was later adopted by multiple firms nationwide that saw the benefit of the comprehensive approach. Soon after, the firms practicing this model developed the Life Care Planning Law Firms Association (LCPLFA) to share knowledge and promote LCP as an alternative to traditional Elder Law. More can be learned about the association at www.lcplfa.org. These unique law firms are "elder-centered," which means that the elder is this primary focus, and the finances and family are secondary. The mission of the LCPLFA is to "empower LCPLFA as they provide legal, financial, and healthcare advocacy services." There are approximately 80 LCP firms nationwide at present.

An LCP provides the road map that allows an elder to achieve their desired quality of life, care and long-term care financing goals. There are three principal goals of the LCP that allow the firm to help the elder and family develop and implement this road map:

1. We help make sure that the elder gets good care, whether that care is at home or outside the traditional home setting. This is the most important of all goals because it goes to the very heart and quality of life in the later years. The LCP is focused first on the elder's good health, safety, and well-being.
2. We help the elder and involved family make the best possible decisions relating to the needed long-term care and special needs. As objective advisors, we are the resource for experience, support, and knowledge.
3. We help the elder and family find sources to pay for good long-term care. We work with all concerned through the maze of choices and options to find the best, or often, the most comfortable solution to financing the needed care, which is often through the complicated Medicaid program.

Who Benefits from Life Care Planning?

Any senior with a health condition that has the potential to impact their ability to care for themselves benefit from an LCP. Caregivers also benefit from the continual support offered through the law firm's elder care coordinator (ECC).

What Is an Elder Care Coordinator?

An ECC is a professional, such as a social worker, counselor, nurse, or gerontologists who specializes in assisting older people and their families to attain the highest quality of life given their circumstances. An ECC will:

- Help clients and families identify care problems and assist in solving them
- Assist families in identifying and arranging in-home help or other services
- Coordinate with medical and healthcare providers
- Review medical issues and offer referrals to other geriatric specialists to provide appropriate care while conserving financial resources
- Provide support, guidance, and advocacy during a crisis
- Help coordinate transfer and transportation of an older person to or from a retirement complex, assisted care living facility, or a nursing home
- Provide education
- Offer counseling and support

After the Anderson family retained the LCP law firm, the ECC and other team members immediately started work to assist Mr. Anderson's family with the rehabilitation/discharge process and to ensure the necessary care was in the home when Mr. Anderson arrived. The team and family determined that Community-based Medicaid Assistance (also called Home and Community-Based Services–HCBS) would be the best option to provide Mr. Anderson with the home care he so desperately needed. Having the cost of the care covered by Medicaid ensures the Anderson family he would be able to stay at home safely without depleting the family of their life savings. Once approved financially, his ECC then attended

An ECC is a professional, such as a social worker, counselor, nurse, or gerontologist, who specializes in assisting older people and their families to attain the highest quality of life given their circumstances.

the necessary Medicaid assessments and advocated for Mr. Anderson. The result was a weekly award of 168 hours of home health aide services. Due to the complexity of his case and the presence of a PEG tube feeding, traditional home care was not an option. With extensive education and ECC guidance, his children learned how to administer medications and feedings, and ultimately were able to be enrolled as Consumer Directed Personal Assistance Program workers under the Medicaid program, allowing them to be financially compensated for their caregiving work. This was a hardship for his children because they needed to apply for Family and Medical Leave Act (FMLA) leave from their employment to ensure their father was receiving the safe care he needed at home. Additionally, the ECC was able to assist with obtaining necessary durable medical supplies and coordinate other home care services, such as transportation, home visit doctors, physical, occupational, and speech therapy as well as delivery of personal protective garments and a life alert system.

Remarkably, through extensive testing and work with speech therapy, Mr. Anderson was diagnosed with a condition called Zenker's dysphagia. Fortunately, this is a repairable condition, and once he was stable enough to undergo the necessary procedure, the repair permitted him to eventually have the PEG tube removed and resume a normal diet.

While dealing with the complex medical concerns of the case, Mr. Anderson's ECC knew that the services were limited. The awarded hours were temporarily placed and were in danger of being reduced by his Medicaid Managed Long Term Care Plan. She decided to explore other options for him and ultimately guided the family to apply for a waiver program for individuals who have suffered a traumatic brain injury. Once the PEG tube and feedings were no longer a concern, the ECC assisted the family with finding a reputable home care agency under his Medicaid benefit to provide the personal care assistance who would allow the family to return to work.

Two years have passed since Mr. Anderson's CVA. The family has continued to annually renew the LCP services with the elder care law firm and continue to work regularly with the ECC to maintain the needed care hours and advocate for more care when needed. In addition, the legal team also continues to assist by helping Mr. Anderson maintain financial and legal eligibility for the Medicaid program and handle the annual Medicaid recertifications. They have expressed gratitude for all the hard work and dedication and state they would not have been able to keep their husband and father at home without the comprehensive support and guidance along the way.

ECCs working in an LCP law firm must continue to educate themselves and remain aware of new innovations in care management. The LCPLFA offers a certificate in ECC, in collaboration with The Stockton Center on Successful Aging at the Richard Stockton College of New Jersey. This program affords ECCs within an LCP firm to receive comprehensive training of the multifaceted and complex challenges involved with the role of ECC. This certification comprises a 15-week online program that is designed to provide the tools and support needed to promote best practices. The course works to enrich the ECC's abilities to help clients and families identify care problems and assist in solving them. It is not necessary to complete the course to perform the role of an ECC; however, completion provides professional recognition for their role within the law firm and the community as well as a solid foundation in the law behind LCP and community caregiving, knowledge of the aging process, public benefits, appropriate treatment options, and referrals.

Elder care coordinators function in various roles across the continuum of care within the law firm. When an LCP retains a new client, they set a meeting with the client and their family within their own environment to discuss care concerns, assess their current situation, develop goals and make recommendations. The clients are provided the ECC's contact information, and depending on the client's individual circumstances, schedule additional meetings. For clients at home, there may be evaluations for care qualifications through their long-term care insurance or with an independent Medicaid assessor at the state level. The ECC attends the meetings with the client as an advocate. For clients placed in facilities, ECCs can participate in care plan meetings and provide the much-needed support and guidance the families require. Throughout the initial year of engagement, the ECC is in regular contact with the client and family and is continually assessing the care, evaluating the plan and modifying as needed, and providing resources and support. Given the multitude of circumstances that may arise for a client regarding their health, the ECC's goal is to hold their client's hand and assist with referrals for falls, hospitalizations, rehab stays,

An LCP model functions on an annual engagement, allowing clients to be in contact with their trusted team and not be billed per interaction, which ensures that the clients communicate their concerns and needs on a regular basis, and team intervention is immediate.

day programs, and community resources. Moreover, there are times when a client's previously authorized care comes under scrutiny, and Medicaid then looks to reduce the benefit. The ECCs, in turn, assist the families in the appeal process and advocate for the needed care.

When the initial year ends, clients can renew their annual services with the LCP who provides an additional year of assistance and access to the ECCs and legal team at the firm. This ongoing relationship with the clients allows the firm and ECC to continually assess, evaluate, and adjust the plan, as needed, to ensure that the client's and family's goals are at the forefront and are the deciding factor when it comes to care.

The LCP model is unique and holistic in contrast to a traditional fee-for-service elder law model, in which clients pay work done on an hourly or transactional basis. An LCP model functions on an annual engagement, allowing clients to be in contact with their trusted team and not be billed per interaction, which ensures that the clients communicate their concerns and needs on a regular basis, and team intervention is immediate.

Elder care coordinators are an integral part of the success of clients achieving their financial and health care goals. ECCs attend ongoing educational programs and are members of professional networking groups and organizations such as the Case Management Society of America (CMSA) and National Aging in Place Council (NAIPC). In addition to the clinical aspect of helping clients, a vital aspect of the ECCs' role is networking and providing education to community programs, hospitals, caregiver support groups, skilled nursing/rehabilitation facilities, and other organizations, which helps to inform and provide resources not only for the community but to clients as well. LCPs receive referrals from a multitude of sources, both community and other senior professionals, but the greatest referral comes from clients who are happy with the provided services and then refer to their friends and family.

In conclusion, the LCP uses an elder care continuum approach that connects the client's long-term care concerns and needs as they age to the knowledge and expertise of an elder care law firm and an ECC with the purpose of helping them find, get, and pay for good care.

For those looking for more information about what LCP law firms are in their area, they can search at www.lcplfa.org.

"My family and I had a great experience with [our LCP law firm]. They were with us from beginning to end, helping us with a trust and Medicaid. Our questions and concerns were answered immediately. Everyone [was] so friendly and knowledgeable. The whole process with Medicaid was overwhelming and daunting, and the staff were with us every step of the way. Big shout out to our ECC. She was so kind and understanding and answered all our questions and concerns. We would highly recommend our LCP law firm."

–L.C., May 2024 CE2

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How Can Care Managers Help to Reduce Hospital Length of Stay?

By Laura Ostrowsky, RN, CCM MUP, FCM

There was a time when length of stay (LOS) wasn't an issue. Hospital beds were widely available, and hospitals were paid on a per diem basis. Patients were admitted for sleepovers before procedures, and insurance companies rarely denied excess days. Those days are long gone. In 1985 Medicare changed their payment methodology from per diem to case-based payment via the Diagnosis Related Group (DRG) case payment system for most acute care hospitals. Each DRG had an average length of stay (ALOS), and payment was based on that average. There were exceptions for specialty care, acute rehabilitation, and psychiatric hospitals, which continued to receive per diem reimbursement. Even for those paid on a per diem basis, payment for every day of stay was and is no longer a given. Each day must be defensible, meeting medical necessity and appropriateness criteria. Longer stays require meticulous justification. For case-based payment, justification for each day of stay may not be needed, but the urgency to minimize days remains because the provided care must fall within a budget (case payment amount), or money is lost. It's a matter of fiscal survival.

But it's not just about money. There are risks to staying in the hospital longer than necessary. Nosocomial or hospital-acquired infections are a real danger. According to the CDC, "on any given day, 1 in 31 hospital patients has a healthcare associated infection" (CDC November 25, 2024). Other risks are hazards related to immobility.

According to the American Hospital Association (2025), there were 913,136 hospital beds in the U.S. as of January 2025. This is a steep drop from 1975 when there were 1.5 million beds. (Yang) This drop can be attributed to decreasing LOS, the movement of care to the ambulatory setting, and the elimination and merger of many hospitals across the country. The AHA further reports there are currently 6,093 hospitals in the U.S., down from 7,156 in 1985 (2025). In some regions there are bed shortages, leading to high census days, long waits in emergency departments (EDs), and waits for scheduling elective surgery. The resulting high census means hospitals are running close to, at, or even over capacity. How can a hospital run a census over 100%? Easily—admitted patients in the ED are waiting for a bed to open. Patients in post-op/recovery are awaiting transfers to inpatient beds.

Census numbers sometimes, but rarely, run as high as 110%, although 101% to 104% is quite common at many hospitals.

Lowering LOS is not arduous, but it requires constant attention and adherence to utilization management (UM) principles. UM is about respecting and conserving resources and using them appropriately. We have limited resources in healthcare: beds, staff, equipment, appointment slots, and money, to name a few. Every day of stay must be necessary and appropriate, and every test justified. It's about the overriding principles of UM and care management fundamentals—the right care, in the right place (level of care), at the right time.

A historical review of hospital LOS shows an average LOS in 1980 of 7.35 days. By 1987, soon after the implementation of DRGS, it had dropped to 5.71. (CDC December 6, 2024) ALOS in the U.S. is currently 4.5 days. (Alis 2025) The drop from 1987 is not huge, but keep in mind that many formerly short stays for elective surgeries and invasive procedures have shifted to the ambulatory setting, eliminating stays that brought down the average number. Observation status was another contributor or subtractor, eliminating many one- and two-day stays from the equation. To determine with accuracy if ALOS is still dropping, drilling down by DRG, diagnosis, and/or procedure is necessary; otherwise, the numbers

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For case-based payment, justification for each day of stay may not be needed, but the urgency to minimize days remains because you must provide the care within a budget (case payment amount) or lose money on the case.

are skewed by change in practice. Only sicker, more acute, unstable, and complicated patients are now treated on an inpatient basis.

How to Reduce LOS

So now you know why LOS reduction is important, but how can it be accomplished? Opportunities to decrease LOS and to free up beds can be divided into two categories: shortening patient stays and avoiding admissions. Early work on LOS reduction was easy: eliminate preop days and raise awareness of the need to trim unnecessary days. The introduction of technological innovations like minimally invasive and noninvasive procedures shortened recovery time and even eliminated some admissions altogether. That was the low hanging fruit; further progress will require inquiry and analysis.

Identify Avoidable Days

The first step is to identify avoidable days in a stay. These are days that are not necessary to the overall care. Avoidable days usually fall at the end of the stay, but they can occur any time during a hospital admission. They are defined as any delays during the stay that are not clinical. If a patient becomes unstable, for instance, a delay in surgery might be warranted. If the surgery is delayed due to an administrative or systems reason (operating room [OR] scheduling, staff availability), it is not justified and is unnecessarily contributing to the overall patient stay.

Avoidable days can occur early in the stay when a patient is admitted emergently, especially on weekends or holidays, and testing or procedures are delayed until the beginning of the work week. Hospitals may be open 24/7, but care and availability of services are not always readily available. Further analysis can quantify and categorize avoidable days.

The first step is creating codes that identify reasons for the delay/extended stay. These are some examples:

- Unnecessary preop/preprocedure day
- Delay due to lack of availability of:
  - OR time
  - Consultant
  - Diagnostic procedure
  - Appropriate discharge service(s)
  - Rehab/physical therapy/occupational therapy (PT/OT)
  - Other (must be specified)
- Inappropriate admission
- Outpatient procedure
- Delay caused by patient/family refusing discharge
- Physician and CM disagreement on timing of discharge

For the purposes of analysis, you may want to categorize your codes into "buckets." There are no hard and fast rules for the number of categories or codes. You don't want to have too many or create categories and codes that are too narrow or specific, because it will be harder to identify patterns and trends. Four categories and codes are a jumping off point. Make sure they are relevant to your practice.

- Front-end delays
  - Timing of admission
  - Inappropriate admission
  - Failure to prepare patient in advance of admission
- Discharge delays
  - Delay in discharge planning
  - Unavailability of discharge services—skilled nursing facility beds, homecare services
  - Physician reluctance to discharge
  - Patient/family refusal of discharge
- Systems delays
  - Equipment, beds
  - Slots for OR diagnostics, and others
  - Sequencing of diagnostics
  - Medical vs surgical delays

Staff need to collect or code this information during their reviews, and reports should be run regularly. Collection and coding take some time, but running reports both monthly and cumulatively, and then slicing and dicing the data, will generate patterns. Quarterly reports with comparison over time can be used to identify problems and to monitor interventions. Drilling down by service or nursing unit, as well as by practitioner, provides specific information. The information is there for the taking, but it must be collected and analyzed.

Most hospitals have a variety of standard reports. Review them and identify those that complement the work you are doing. Hospitals and departments can often provide you with LOS reports by service, unit, or practitioner. Work with IT to create a standard weekly report of patients in-house over 10 days. Pick the LOS target and then study these patients to look for root causes of longer stays, trends, and patterns. Identify them and explore ways to intervene. This

Pick the LOS target and then study these patients to look for root causes of longer stays, trends, and patterns. Identify them and explore ways to intervene. This information can be used to focus reviews, expedite discharge planning, and work with individual services or practitioners to change practice.

information can be used to focus reviews, expedite discharge planning, and work with individual services or practitioners to change practice. The longest-stay patients are often difficult to discharge due to complicated plans requiring extensive planning or limited placement options. These issues can be resolved by working with specific home care and infusion companies to leverage expertise and develop agreements with skilled nursing and rehabilitation facilities. Patients on ventilators are a particular long-stay problem because physicians try to wean them in-house and delay discharge planning until they have exhausted their efforts. Our case management staff were able to work with the medical staff to apply to pulmonary rehabilitation facilities as soon as the need was established, while also beginning the weaning process in-house. Once a facility accepts the patient, they are transferred to those facilities, which will continue weaning efforts or identify chronic care needs. These efforts result in significant LOS reductions.

The avoidable-days reports can provide further ideas for LOS reduction. Our hospital identified patients being admitted or staying longer than necessary because of delays in peripherally inserted central catheter (PICC) line placements or waiting for other procedures or interventions that weren't available on weekends. Increasing the number and type of practitioners who could insert PICCs prevented unnecessary admissions and in some cases cut a day or two off the LOS. Providing PT on weekends also helps to lower LOS and, more importantly, can improve the quality of care.

Most avoidable days come at the end of the stay. Assessment for potential discharge needs must take place on admission. Needs may change or evolve during the stay, and that's why reviewing, reassessing, and updating plans are important as patients' conditions and needs change. Often patients or attending physicians want to refer to acute rehab, but the patient is not meeting acute criteria or is borderline. Rather than argue with the family or staff, CMs can apply concurrently to both levels of facilities, and the post-acute providers will decide based on acceptance or rejection of the application. There is no time lost waiting for a rejection before initiating application to a different level of care. If a patient is not ready to accept home or inpatient hospice, CMs can apply to providers who offer both options. This forward-thinking dual planning can evolve when the plan changes or the patient requires seamless transition to the next level of service while remaining with the same agency. When a patient wants home hospice, and CMs are concerned that the required care would be too complicated for home care, they can explain their concerns, comply with patient wishes, and create a backup plan of inpatient hospice ready for implementation. Patients are informed of the backup plan and told to call if a change of plan is needed. This information would also be provided to the ED so that if the patient presents, transfer to an inpatient facility can be immediate, and admission is not needed. Choice of providers may be limited by insurance networks, but, whenever possible, a provider who can modify the plan as the patient's condition changes is the best solution for both continuity of care and patient satisfaction.

Short stays may also be amenable to LOS reduction. I worked with three surgical services to identify one to two procedures each that had variables in LOS. On review it was determined that standardizing practice, order sets, and patient education could provide a care plan that reduced current stays by one to two days. This is an updated version of the old clinical pathway approach. Our CMs took it a step further, creating an inclusive interdisciplinary team of everyone involved in care from the ambulatory care visit, where the decision to have the specific elective procedure was made, through preop testing and teaching, admission, postop, discharge, and follow-up. The patient was included in the plan as a full team member and knew what to expect at each step, thus managing concerns and expectations about care and the short stay. In our facility, the most successful service embraced standardization and a team approach and reduced average LOS for the specified procedure by one-and-a-half days.

Managing patient and staff expectations means communicating regularly, updating everyone on the plan and timing, and including the patient as a team member. We don't want to blindside patients with sudden changes or precipitous discharges. Blindsiding patients doesn't promote patient satisfaction or engagement and often leads to disputes and delays in discharge (i.e., avoidable days).

Preventing unnecessary or inappropriate admissions frees up beds and minimizes payer denials. Interventions to achieve this goal include the inclusion of a CM in the ED and outpatient clinics. The emergency department CM can implement home care to maintain patient safety in the home and

Patient flow committees need to be inclusive and multidisciplinary, representing front and back of house services.

prevent admissions for what constitutes discharge planning. That's why limiting term and practice of discharge planning has been replaced with the concept of transition planning. This planning applies in the outpatient areas as well as where services can be implemented to preserve patient independence and prevent admission.

For patients requiring admission, the ED and ambulatory setting CMs can jumpstart the transition planning process in the ED, assessing continuing needs and collecting contact information from companions/significant others accompanying the patient to the ED. This information is provided to the inpatient team, including the CM, and can help expedite the process of coordinating a safe discharge plan. The CM in the ambulatory setting can also begin transition planning for patients electively or even emergently admitted from the clinic.

Another source of information about LOS and appropriateness of admissions is payer denials. We had an aggressive appeals program and overturned most denials; however, review of reasons for denial provides information on opportunities to eliminate days and prevent admissions as well as to identify necessary documentation that can prevent the denial in the first place.

Improving Patient Flow

Patient flow is another concept designed to save time, increase efficiency, and smooth transitions. It focuses on time and motion studies, patient tracking, bed boards, OR turnaround time, time to admission, and room cleaning postdischarge. Managing patient flow is basically a logistical or business approach. The clinical perspective is not always well-represented, and the approach is fragmented and reactive. It looks at bed assignment and turnaround times but not the whole picture. When first introduced, patient flow committees rarely included case management. Patient flow saves minutes, hours, and large parts of days, but case management saves entire days. One major thrust of patient flow committees has been to get patients out earlier in the day, which is important to make room for elective admissions and patients arriving in the ED late in the day and overnight. This approach fails to recognize that in a 24/7 institution, a late discharge of a patient might be one in which the patient would have gone home tomorrow, *not early in the day but a day early.* Physicians were concerned with being blamed for discharging their patients late in the day and would hold them over to get credit for an early discharge a day later. There are many patients that need a final infusion, a last set of lab results, a treatment or an intervention before they can be discharged. That is no reason to keep them for another day. Case management looks at the big picture.

Patient flow committees need to be inclusive and multidisciplinary, representing front and back of house services. Committee membership selection is important. As much as possible, those on the committee should include professionals who believe in the concept of performance improvement and are open to hearing perspectives from other disciplines. The goal is consensus-driven decision-making. The members will be the spokespeople or ambassadors for the process and will obtain cooperation from practitioners and involved staff in data collection and buy-in with proposed changes.

Another focus of these committees is daily census. My hospital often ran a census in the high 90% and was over 100% census during several days on most weeks in the years leading up to the pandemic. The committee drafted high census guidelines and sent out census alerts at thresholds of 95% and over. This is a *reactive* approach to daily census and LOS and should be used cautiously. The census should NEVER drive the decision to discharge a patient. Discharge is a clinical decision; thus, stability and a safe discharge plan should be the driver of the decision. This applies whether the census is 105% or 75%. You don't let a patient stay for convenience when a plan is in place and they are clinically appropriate for discharge or transfer to another level of care, even if the hospital is empty. You also don't discharge a patient with inadequate follow-up or planning before it is appropriate. Doing so could trigger a readmission and is endangering the patient. Adherence to UM principles will maximize patient flow and appropriate care.

Our hospital's committee spent time analyzing the census over time. They looked at peaks and flows, OR capacity and scheduling, and a larger approach vs fragmented approach. The census tended to drop off on the weekends and then begin to build from Monday forward. Wednesday, Thursday, and Friday tended to have the highest census. Friday's census would start high but become manageable by afternoon. An attempt was made to think differently to flatten out the census. Why not use those empty beds and OR slots on Friday and Saturday? We started by scheduling elective short stay cases (those with an expected LOS of two to three days) for

Friday and Saturday. These patients would be discharged Sunday to Tuesday, creating a shift in the weekday census and decompressing the mid and end of week bottleneck.

Identification of appropriate cases is institution specific. You need to carefully review with clinical staff and identify practitioners and procedures able to adapt to this schedule. This is an opportunity to create comprehensive standardized treatment plans with order sets to minimize LOS and maximize efficiency and quality of care; it is a great example of a proactive big picture approach to LOS reduction and patient flow.

Every institution is different; the strategies are the same but the focus changes depending on case mix and specialties. I worked in an oncology specialty hospital, so in addition to the strategies I have described thus far, we also looked at the use of palliative care to manage symptom burden both inpatient and outpatient, identification and timing of hospice referral, and inpatient mortality and admissions during the last six months of life. We performed both concurrent and retrospective reviews. One focus of admissions near end of life was the identification of discharge or transition plans. We found that referral to hospice took place following the last admission, yet many of these patients met hospice criteria during previous stays. To identify timeliness for hospice referral, I worked with our hospice providers to identify LOS in hospice. The results were clear. One-third of our patients referred to hospice died within a week of admission, many in as little as one to three days. We had a problem. Over the next two years we worked with clinical staff, educating them on hospice criteria and raising awareness with all members of the interdisciplinary team. Nurse CMs and social workers held grand rounds and inservice education sessions on hospice criteria and goals of care. CMs used a surprise question when trying to identify readiness for hospice. The question to the medical staff who felt patients weren't ready for hospice is a simple one. "Is it your expectation that this patient will be alive in 6 months?" When the answer was no, the CM would then explain hospice criteria and after discussion sometimes there would be a referral to home hospice. Two years later the number of patients who died within one week of hospice referral had dropped to just over 20%.

I have provided you with suggestions, strategies, examples, and anecdotes from four decades of largely successful LOS-reduction efforts. Most apply to any institutional setting while some are specialty specific. All are food for thought. Identify the metrics, then collect and analyze them. Utilize standard reports, create new ones. there is no shortage of data. Sometimes they reveal exactly what you suspect; other times surprises will emerge. Analytics are the future for healthcare and for case management. Leverage this information to make an impact on your practice, institution and the future direction of healthcare. CE 3

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Case Management: Innovative Solutions, Improved Outcomes

continued from page 5

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ETHICS CEU

Traumatic Brain Injury and Seizures: Ethical Priorities in Patient-Centered Care

continued from page 16

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Disability Management Job-Task Analysis Underway

continued from page 6

workplace injuries, illnesses, and disabling conditions; later, it began to encompass nonoccupational causes of unplanned absences. Today, integrated absence management helps support the productivity of employees affected by short-term and long-term absences due to both occupational and nonoccupational illnesses, injuries, and disabling conditions. The emphasis is on assisting individuals in pursuing their goals, including return-to-work (RTW) and stay-at-work (STW) strategies as they recuperate and heal.

For both the CDMS and the CCM credentials, conducting field surveys at regular intervals is a required aspect of being nationally accredited by the National Commission for Certifying Agencies (NCCA). NCCA is the accrediting body of the Institute for Credentialing Excellence (ICE). It is also important to note that NCCA was created to ensure the health, welfare, and safety of the public by credentialing certification programs that assess professional competence.

After results of the disability management JTA are analyzed, reviewed, and approved, the Commission will announce updates to the CDMS certification examination, as well as potential changes to eligibility criteria (if any). We encourage readers to watch for upcoming CDMS Spotlight columns on the JTA and the CDMS certification. CM

CCMC Welcomes Two New Commissioners

continued from page 4

We welcome Rosalyn and Dawn to the Commission and thank all of our dedicated Commissioners for their service. CM

Communication and Collaboration: Which Comes First, the Chicken or the Egg? *continued from page 3*

when explaining treatment options and care plans to patients. Case managers often face challenges obtaining timely and accurate patient information because it comes from various sources and stakeholders, including:

- Patients
- Insurance companies
- Healthcare providers and medical teams
- Caregivers and family members

Developing or sharpening the following communication skills can improve the collaboration between patients, providers, and stakeholders:

- Empathy
- Active listening
- Feedback
- Rapport
- Speaking with clear, concise language

In essence, communication provides the means to share information, while collaboration uses that information to work together toward a common goal. Our role as case managers is to advocate for our patients' needs and ensure they have fair access to treatment, services, procedures, and medications. Forming collaborative partnerships and exploring alternative funding sources can help improve our patients' access to cost-effective resources, which will hopefully improve their outcome and their satisfaction with their experience in a patient-centered care model.

As we begin the summer months, enjoy this special time with your family and friends and reflect on the success you have achieved making a difference…one patient at a time!

Warmest regards, Catherine

Catherine M. Mullahy, RN, BS, CRRN, CCM, FCM, *Executive Editor*
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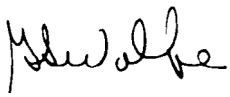
Navigating in Turbulent Times *continued from page 2*

It may mean limiting the news. Don't buy into negativity.

8. **Stay connected to your values.** To feel good about yourself, you must honor your values. Don't be put down for who or what you are or what you believe. Your values are an important part of your life.

In this chaotic and turbulent world, you must accept uncertainty by building resilience. It is not easy, and it takes work. We each react to uncertainty differently. A firm foundation will help you balance all aspects of your life. When you have inner harmony, you feel more confident, more adaptable and at peace. Even in this chaotic and turbulent world, you will survive. A lot of how well you survive is up to you!



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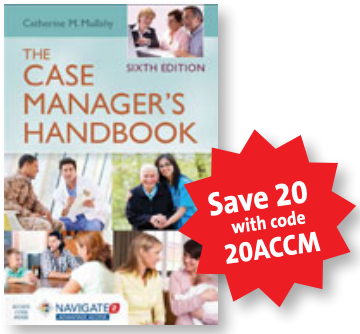

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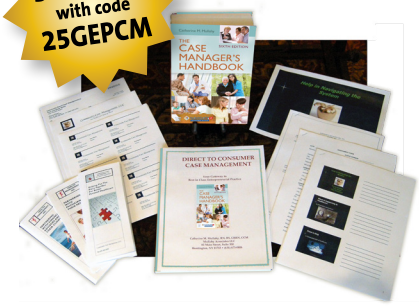

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JOURNAL OF THE COMMISSION FOR CASE MANAGER CERTIFICATION, THE CASE MANAGEMENT SOCIETY OF AMERICA, & THE ACADEMY OF CERTIFIED CASE MANAGERS

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Vol. 31, No. 3, June/July 2025.
CareManagement (ISSN #1531-037X) is published electronically six times a year, February, April, June, August, October, and December, and its contents are copyrighted by Academy of Certified Case Managers, Inc., 2740 SW Martin Downs Blvd. #330, Palm City, FL 34990;
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