

CareManagement

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While clinicians are trained experts in identifying and diagnosing disease and other conditions that impact health outcomes, there are often gaps between what they can provide and what patients with health complexity require for optimal outcomes. Outcome-focused complex care management can help bridge that gap because case managers “assist” and “support” patients with clinical and nonclinical challenges to get better.

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Gary S. Wolfe

National Case Management Week is October 11–17, 2020

Case Managers
can _____.

National Case Management Week is an opportunity to recognize the many contributions that case managers make toward improving their clients' health. The Case Management Society of America first recognized National Case Management Week in 1998. Many organizations were asked to join in this celebration. Case managers foster case management growth and development, impact health care policy, and provide evidence-based tools and resources.

Case managers work within the continuum of care as patient advocates; they assess patients' needs and goals to deliver effective and efficient care. In 2020, case managers have risen to the challenges of a "new normal" in the COVID-19 pandemic. What we do is the same but how we do it is different.

Case managers have a lot to be proud of. Case management is a recognized component of health care delivery, and every health care organization now employs case managers. The demand for case managers is great! The case management body of knowledge continues to grow, and best practices are identified.

What are your plans for National Case Management Week? Some suggestions:

- Thank your fellow case managers

- Announce National Case Management Week on your social media
- Send cards to your fellow case managers
- Host a Zoom celebration
- Enlist the support of your community to celebrate National Case Management Week
- Do something special for yourself
- Educate your patients about National Case Management Week
- Ask your employer to recognize case managers
- Ask your local and state government to recognize National Case Management Week

You are only limited by your imagination. Start thinking! Start celebrating!

I honor, applaud, and thank each and every case manager. Continue to dedicate yourself to making a difference in people's lives.

Congratulations!

Gary S. Wolfe, RN, CCM
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CareManagement

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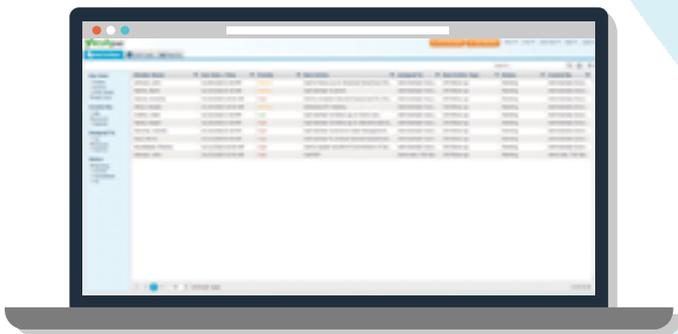


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Catherine M. Mullahy

Another Celebration and a Story to Tell!

As we celebrate another National Case Management Week, I think back on where we have been and where we will be going. Much has changed over the years that I have been in case management, yet thankfully many of the processes, core components, and essential activities remain the same. It's reassuring that, when change seems to be the "new normal," especially in the midst of this continuing pandemic, that our evidence-based processes are used by knowledgeable, caring professionals and that the results of our interventions can be assured.

When we examine the definition of case management created by the Case Management Society of America and subsequently aligned by one created by the Commission for Case Manager Certification, we understand why the definition continues to underscore the significance of that process. When the certified case manager credential was introduced and soon became the "gold standard" for accountable case management professionals, the various role and function studies that have been conducted every 5 years have never demonstrated a need to change that definition.

While technology, practice settings, and other factors have advanced treatment of the complex high cost: high need conditions most often targeted by case management programs, the process applied by case managers has essentially remained unchanged. Regardless of each patient's age, gender, medical conditions, and

social determinants of health as well as where that individual may be across the ever-expanding continuum of care, the evidenced-based process should be used that enables case managers to gather the necessary information and create a plan that meets patient-specific goals. Concurrently, that plan also is designed to promote outcomes that are congruent with "quadruple aim" goals of improving the health of populations, enhancing the patient care experience, reducing the per-capita cost of health care, and improving staff engagement and satisfaction.

So, just where will we be heading in the future? It's not enough to just have a presence during National Case Management Week, when the balloons, celebratory decorations, and happy memories give recognition to the achievements of case managers. It is important to develop a strategy to ensure our future.

We have often spoken about the need to tell the "story" of case management. CareManagement invites our readers to contribute continuing education articles to maintain our respective licenses and professional certification while adding to the body of knowledge that supports our profession. CareManagement serves as the "voice" of case managers. The case management community is as diverse as the patient population that receives the care and intervention case managers provide. Most of us are working in organizations that recognize case management as a necessary component of the departments providing and/or paying for patient care and

services. Regrettably, many of those organizations don't have the kind of understanding that would allow them to recognize the real contributions case managers make. While that is the unfortunate reality and challenge, it also affords an opportunity for case managers to "tell the story" of case management.

The Case Manager Insights column is your opportunity to begin to communicate your story, using your words. We invite you to read this issue's case management story. Responding to the impact of the COVID-19 pandemic on an indigent population in Fort Worth, Texas, an integrated department of RN and social worker case managers created and implemented a COVID home monitoring program with direction from physicians. The program was so newsworthy that it gained the attention of the local media. We can and, in fact, must create these types of programs and communicate their success in a way that will resonate with others inside and outside our organizations. Case managers can be the leaders in these communication initiatives. Case managers can tell their stories one patient at a time. I hope you will accept our invitation.

Catherine M. Mullahy

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What Ethical Principles Mean

Vivian Campagna, MSN, RN-BC, CCM

The [Code of Professional Conduct](#) for case managers, published by the Commission for Case Manager Certification (CCMC), is an invaluable resource for ensuring that board-certified case managers adhere to the highest levels of ethical and professional standards. Regular review of the Code is recommended for all

Of particular importance are the ethical principles defined in the Code and how they apply to case management practice. By becoming more familiar with each of the principles, and how they influence ethical case management practice, case managers will be supported as they navigate complex situations with multiple stakeholders.

us to do good. Case managers have the ethical duty to act in the best interest of the individual for whom they advocate. Beneficence compels case managers to be “of benefit” to the individuals they serve and show compassion.

- **Justice:** Grounded in fairness and equality, justice applies to access to resources and treatment by others.

Of particular importance are the ethical principles defined in the Code of Professional Conduct and how they apply to case management practice. By becoming more familiar with each of the principles, and how they influence ethical case management practice, case managers will be supported as they navigate complex situations with multiple stakeholders.

case managers, no matter how long they have been in practice.

The primary purpose of the Code is to protect consumers, the individuals (or “clients”) who receive case management services and their families/support systems. As the Code states, “Board-Certified Case Managers (CCMs) understand and commit to quality outcomes for clients, appropriate use of resources, and the empowerment of clients in a manner that is supportive and objective.”

Vivian Campagna, MSN, RN-BC, CCM, is the Chief Industry Relations Officer for the Commission for Case Manager Certification, the first and largest nationally accredited organization that certifies over 48,000 professional case managers and nearly 2,300 disability management specialists. Vivian has been involved in case management for more than 25 years and has been a volunteer for the Commission in various capacities, including as Chair, before joining in a staff role.

- **Advocacy:** The ethical foundation for case management practice is advocacy, with the case manager’s primary responsibility being to the client. Advocacy for clients (known as patients in many care settings) entails ensuring that individuals receive the right care at the right time to support their goals.
- **Autonomy:** This principle is perhaps the most important. In fact, advocacy and promotion of autonomy cannot be separated from professional practice. Autonomy is the agreement to respect another’s rights to self-determine a course of action. Independent decision-making is facilitated through the sharing of unbiased information so that individuals can make their own decisions, such as whether to give consent to a plan of treatment or to receive treatment in a particular setting.
- **Beneficence:** This principle compels

This principle is particularly important in ensuring fair allocation of goods or services that may be in short supply.

- **Nonmaleficence:** As a governing principle, nonmaleficence means to not intentionally cause harm or injury—with the understanding that harm can be caused by acts of omission or commission. Case managers must understand the obligation that, though harm may occur, the harm to reach a beneficial outcome should not outweigh the benefit.
- **Veracity:** As truth-telling, veracity has a significant role in health care. Individuals interacting with the health care system must be able to assume that they are being told the truth, which is the basis of a trusting relationship. Likewise, providers also expect to receive truthful information from individuals and their families/support systems.

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How Remote Working Opens Doors for People with Disabilities

Patty Nunez, MA, CRC, CDMS, CCM

There are people with disabilities—physical, emotional, or psychological—who may find it challenging to report to a workplace for a full day of work every day. Historically, such limitations have kept people from exploring work opportunities because, in the minds of many employers, most jobs could only be performed in the workplace. Work-from-home assignments traditionally were limited and often by “special

arrangement” to allow some flexibility to work remotely.

The pandemic, however, has changed this perception, as working from home has become the norm for many workers and telecommunication/teleconference technologies are widely embraced. As a result, companies are rethinking remote working as a solution for the future. A [University of Chicago study](#), for example, found that about one-third of jobs can plausibly

be performed remotely for the long term.

For people with disabilities, greater acceptance of remote working and improved technology open the door to more opportunities to seek employment or return to work after a life-altering injury or illness. The result would be a more diverse and inclusive workforce, which carries widespread benefits from more significant innovation to more empathy and acceptance.

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Canaries in the Coal Mine

Jose Alejandro, PhD, RN, FAAN

My father was part of the silent majority. As a child living through the Great Depression, he understood that our world could be turned upside down. He was taught to do more with less. Not once did he complain about how COVID impacted him. “It happens, hijo (son). Life repeats itself.” My father learned about systems thinking from the school of

Research demonstrates how social determinants of health can dramatically spread infectious diseases.²

In 2013, the Institute of Medicine noted that “we lacked a coordinated public health system.” They noted that the US public health infrastructure was fragmented and that our system lacked the ability to effectively communicate.³ Looking back further to 1988, the Institute of Medicine’s report on

Whether a formal or informal leader, you have been charged with leading the way through chaos both as a professional and as a layperson within your personal life. Your case management and leadership competencies have been shaken up and are continuously challenged. This is truly the best time to take a moment to reflect and reconnect your passion to purpose. It is important that we recognize

Stepping back to reflect on what is happening around us provides an opportunity to move into a “learning mindset.” A learning mindset explores possibilities and considers how professional case managers can improve practice that can prepare and equip us for future change and challenge. The CMSA Standards of Practice for Case Management (2016), continuous learning, professional development, and your experience provide you with an array of tools to assist you through this transitional time.

hard knocks. He was a very proud man who raised 13 children. He didn’t get the opportunity to attend college, but he did instill in us the importance of doing what is right.

Before the COVID-19 epidemic there were many warning signs (canaries in the coal mine) about our lack of preparation in dealing with an infectious disease outbreak. Florence Nightingale noted that poor “living conditions” were the largest threat during the 1918 flu epidemic.¹

Jose Alejandro, PhD, RN, FAAN, is the Immediate Past President of CMSA, Director of Care Management at UC Irvine Health, and Assistant Professor of Nursing at Mount St. Mary’s University in Los Angeles. Jose also serves as the Treasurer for Sigma Theta Tau International and serves on the board of directors for the American Academy of Nursing.

“The Future of Public Health” noted that our public health system was in a precarious position and in disarray.^{4,5} We had plenty of notice that we were not prepared for a major public health event like COVID-19.

As a case manager, COVID-19 continues to impact you from both a personal and professional practice perspective. The pandemic has challenged us to do more with less and to think outside of the box. We have firsthand experience of rationing in health care and dealing with shortages of common household items. At times it feels overwhelming, enduring, painful, and emotionally draining. Rosa and colleagues warn us to be prepared for “rising moral residue.”⁶ The choices and decisions we have made, amid the pandemic, may result in ethical injuries to our psyche.

and tackle the early stages of burnout through professional development.⁷

Stepping back to reflect on what is happening around us provides an opportunity to move into a “learning mindset.”⁸ A learning mindset explores possibilities and considers how professional case managers can improve practice that can prepare and equip us for future change and challenge. The CMSA Standards of Practice for Case Management (2016),⁹ continuous learning, professional development, and your experience provide you with an array of tools to assist you through this transitional time.

As a case management professional, you understand the importance of building and maintaining trusting relationships. These relationships build a network that is rich in knowledge and experience.

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COVID-19? Care Management to the Rescue!

Devon Armstrong, MSN, RN-BC, CCM

COVID-19

disrupted the natural order of operations at JPS Health Network in March 2020. Operational leaders were tasked with determining methods in which hospital beds could be conserved for the looming surge threat of COVID-19-positive patients requiring hospitalization.¹ Studies

projected that 1 in 5 patients diagnosed would require hospitalization. In short order, a strategy was developed to discharge COVID-19-positive patients from the hospital to their home earlier than usual with home oxy-

gen, a pulse oximeter, and high touch contacts from registered nurse case managers (RN CMs) and social workers under licensed physician supervision. This strategy led to the birth of the Outpatient Case Management (OPCM) COVID Home Monitoring Program. What was designed to be an oxygen program where patients with COVID-19 were weaned off oxygen at home quickly flourished as a robust partnership between the RN CMs and the social workers delivering exceptional home monitoring and support to our patients who were recovering from COVID-19 at home. Care management serves a valuable role during this pandemic.²

Devon Armstrong, MSN, RN-BC, CCM, is the Director of Outpatient Case Management at JPS Health Network in Fort Worth, Texas.

The OPCM COVID Home Monitoring Program yielded hospital bed days saved and reduced emergency department visits as well as hospital admissions and readmissions, allowing the network to focus on patients who were severely ill with non-COVID conditions that required admission to the hospital.³ The program also

The Outpatient Case Management COVID Home Monitoring Program was designed to be an oxygen program where patients with COVID-19 were weaned off oxygen at home but quickly flourished as a robust partnership between registered nurse case managers and social workers who delivered exceptional home monitoring and support to patients who were recovering from COVID-19 at home.

captured the attention of two local news stations and hospital executives in the Dallas-Fort Worth area. This exposure allowed us to expand our program by also enrolling patients who had never been hospitalized. Providing services from RN CMs and social workers is not a new concept; what is unique is being able to partner and provide holistic care during a global pandemic. It was the partnership that contributed to the patient outcomes yielded with this program. The RN CMs provided clinical care, contacting patients often twice daily if they required oxygen to discuss their symptoms, answer questions, titrate their oxygen, connect them to primary care, and coordinate timely interventions to promote optimal recovery, including chronic disease management education. More than

half of these patients were already medically complex and not engaging with a primary care provider. COVID-19 only further complicated their health. These patients were terrified of being diagnosed with a virus that science is still learning about. They heard stories of people losing their life to the novel virus, and they were

often isolated in their homes without their friends and family for days and weeks. We are often the only contact that patients have daily. We give them hope, support, encouragement, and answers! Our social workers call each enrollee to complete

an initial psychosocial assessment, and information gleaned from that assessment allows the social worker to create a plan addressing the social determinants of health.

JPS Health Network is located in the zip code with the lowest life expectancy in Texas; as the only public hospital in Tarrant County, we serve a largely indigent population.⁴ Before the COVID pandemic, many of our patients were financially unstable and lacked basic necessities such as food, transportation, medical care, and stable housing. COVID heightened these issues. Patients in our program are disproportionately essential workers, and, in many instances, the sole breadwinner for their household. Fourteen days of quarantine for sole breadwinners with no access to paid time off or short-term

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Discharge Planners Must Stop Accepting Kickbacks and Managers Must Monitor Receipt

Elizabeth Hogue, Esq.

Case managers/discharge planners have recently come under fire from fraud enforcers for violations of the federal anti-kickback statute. This statute generally prohibits anyone from either offering to give or actually giving anything to anyone in order to induce referrals. Case managers/discharge planners who violate the anti-kickback statute may be subject to criminal prosecution, which may result in prison sentences, among other consequences.

Federal Criminal Complaints were recently filed against thirty defendants in the San Francisco area who were charged in a “patients-for-cash” kickback scheme. The complaints centered on Amity Home Health Care, the largest home health care provider in the Bay Area, and Advent Care, Inc., a hospice. Under the leadership of Ridhima “Amanda” Singh, Chief Executive Officer, the federal government claims that Amity and Advent paid kickbacks to discharge planners/case managers at hospitals and social workers at skilled nursing facilities (SNFs), among others, in exchange for referrals.

The Criminal Complaints say that discharge planners/case managers in hospitals and SNFs received the following in exchange for referrals of home health and hospice patients:

- Cash periodically delivered in envelopes

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

- Gift cards ranging in value from \$2,000 to \$5,000
 - Handbags from Gucci, Louis Vuitton, and Nordstrom
 - All-expenses-paid trips to Napa, California
- These alleged payments and gifts clearly violate the federal anti-kickback statute.

Case managers/discharge planners who violate the anti-kickback statute may be subject to criminal prosecution, which may result in prison sentences, among other consequences.

Most recently, a registered nurse (RN) in California pled guilty to conspiring with owners of home health agencies to pay and receive illegal kickbacks in exchange for referrals of Medicare patients. The RN, who was a case manager at a nonprofit hospital, used his position as a discharge planner to steer Medicare patients to home health agencies who paid kickbacks to him.

The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS), the primary enforcer of fraud and abuse prohibitions, says that discharge planners cannot accept the following from providers who want referrals:

- Cash
- Cash equivalents, such as gift cards or gift certificates
- Non-cash items of more than nominal value

- Free discharge planning services that case managers/discharge planners are obligated to provide
- The services provided by discharge planners/case managers are extremely important and are valued by many patients and their families, but the credibility and trustworthiness of discharge planners/case managers is destroyed when discharge planners/case managers make referrals based on kickbacks received.

Now a word to managers and all the way up the chain of command to CEOs. Whether or not you know that case managers/discharge planners are accepting kickbacks, the OIG may also hold you responsible. The OIG has made it clear that your job is to monitor and to be vigilant. If you knew or should have known, you may be responsible. A good starting point is to put a policy and procedure in place that requires discharge planners/case managers to report in writing anything received from post-acute providers. Or how about a policy and procedure that prohibits all gifts?!

Now a word to post-acute marketers. Don't give kickbacks to discharge planners/case managers! It's simply not true that you must give kickbacks in order to get referrals. The proverbial bottom line is: Do you like the color orange? Is orange your preferred fashion statement?

Please stop now! [CM](#)

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Social Media Will Bite You!

Elizabeth Hogue, Esq.

Many of us appreciate social media, especially while sheltering at home. It is a convenient way to stay in touch with others and to obtain information. But...care is needed! A reminder: healthcare providers cannot

outside as well and what we do.”

The City Commissioner and member of the hospice board of directors, who also happens to be a person of color, added that, “All of these families, whose relatives are at the end stages of their life...we want to be sure that

conclude that they cannot expect appropriate care from certain providers because of their staff members’ social media posts.

Be ever mindful of these concerns! **CM**

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Healthcare providers cannot share information about patients on social media without first securing their permission. Further, information cannot be posted on social media that allows for patient identification, even if patients are unnamed. The best practice is not to post any patient information online at all.

share information about patients on social media without first securing their permission. Further, information cannot be posted on social media that allows for patient identification, even if patients are unnamed. The best practice is not to post any patient information online at all.

For instance, the CEO/President of a Western Kentucky hospice was recently suspended as a result of her Facebook posts. According to members of the hospice’s board of directors, the CEO/President posted a number of racially charged comments on her Facebook page. Three of her posts were shared with news outlets by members of the board. The CEO/President acknowledged that she created one of the Facebook posts, but says the other two were the work of hackers.

A representative of the local Human Relations Commission said, “Obviously you are representing hospice. A lot of times we don’t realize that our positions affect not only where we work, but

those people are taken care of with the utmost respect and courtesies that we could offer.”

There you have it! Staff members certainly have the right to freedom of speech. However, based upon the above remarks, there is something more at play when it comes to healthcare providers.

The public often views staff members of providers as representatives of their employers. Providers and their staff members are frequently respected and esteemed in their communities. When social media is used inappropriately, community members are likely to attribute inappropriate posts to the providers with whom those who post are associated. So, when staff members use social media, they must be mindful of the effects on patients and providers.

In addition, as indicated above, inappropriate posts may interfere with patients’ willingness to accept care from providers. What a shame to think that patients and their families might

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CareManagement welcomes articles that explain, illuminate, interpret, and advance case management in all practice settings. Topics include case management models and trends, care plans, business and legal aspects of case management, medical treatments and medications, case management education, outcomes measurement, developments in certification and legislation, ethical issues, advancements in managed care, and new products and equipment.

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- The first page of the manuscript (the title page) should include manuscript title and a mini-abstract of 2–3 sentences summarizing the manuscript—please do not put author’s names on the title page
- Suggested manuscript length is 2,500 to 3,000 words

Please send manuscripts or inquiries to:
Catherine Mullahy at cmullahy@academycm.org.

CE I Attachment Theory for Case Managers

Thomas L. Blakely, LMSW, PhD

The purpose of this article is to describe how attachment theory may be useful for case managers at all levels and for all ages in the delivery of health care. Case managers are caring people who may become attachment figures for vulnerable individuals who need case management, and there is a connection between attachment theory and case management.

The word *care* suggests an orientation for case managers in which attachment is a concept. The first sustained and psychological contact a newborn child has is with their mother through the act of feeding, either breastfeeding or bottle feeding. This is the beginning of the attachment process that occurs in the child-mother relationship. Representations of this attachment experience develop in the mind. They are the foundation for a person to reach out to a case manager as an attachment figure later in life when adverse health circumstances occur. Attachment develops self-esteem.¹ Case managers as attachment figures can also do this.

According to the Case Management Society of America (CMSA), “Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost.”²

Case managers, along with other health care providers, are involved in palliative care. According to the Medline Plus Medical Encyclopedia, “The goal of palliative care is to help people with serious illnesses feel better. It prevents or treats symptoms and side effects of disease and treatment. Palliative care also treats emotional, social, practical and spiritual problems that illnesses can bring up. When the person feels better in these areas, they have an improved quality of life.”³ Attachment theory may be helpful in the delivery of palliative care.

An intricate process of close interpersonal relationships is required for both types of care. These relationships may be enhanced if the participants understand their dynamics. Knowing why some relationships not only are not effective in carrying out a process but may damage it beyond repair is important. Attachment theory provides insight into these problems and clarifies them so process outcomes are considerably improved.

Attachment Theory

John Bowlby and Mary Ainsworth originated attachment theory.⁴ Attachment theory is a reconstruction of Sigmund Freud’s psychoanalytic theory that was based on psychological problems of adults that could be traced to abusive or dysfunctional childhood relationships. He borrowed from neo-Freudian object relations theory and other frameworks to create attachment theory that explained why childhood relationships with parents had a long-lasting effect on personality. He also believed that attachment to a primary attachment figure is instinctual. It is unidirectional and inherently sought by the child. The mother usually is the primary attachment figure, and the father and siblings are secondary attachment figures whose negative or unavailable response to a child may be damaging to personality development and self-esteem.⁵ The primary attachment figure is a safe base, a special person to whom the child can turn to for protection and emotional support.⁶

The primary focus of attachment theory is the relationship between attachment figures and the child and how these relationships affect a child’s personality development. The child attaches to the mother. When the mother is responsive by providing loving and nurturing care, a secure attachment style will be established based on the mental representations of the nurturing experience. The nurturing provided by the primary attachment figure leads a person to believe that s/he is worthy of care and others, such as a case manager, will provide it when needed.

Research results suggest that the child’s attachment style stabilizes over time and is carried forward to adult life.^{7,8} Connecting this to case management, a case manager with a secure attachment style also may be a safe base for a client. As such, a case manager is in a position of providing safety and protection that promotes recovery from illness or emotional distress.

Most children develop a secure attachment style that likely

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Attachment theory may be useful for case managers at all levels and for all ages in the delivery of health care. Case managers are caring people who may become attachment figures for vulnerable individuals who need case management.

will be lifelong. When this attachment process is thwarted for some reason, such as when the mother is unavailable or incapable, the child develops an insecure attachment style that also will likely be lifelong. Case managers may find it difficult to help clients who have an insecure attachment style. Being able to assess a client's attachment style is a skill every case management professional should have.

Attachment Behavioral System, Attachment Styles, and Working Models

Knowledge of these concepts enables case managers to assess a client's attachment style. Everyone has an attachment behavioral system. This system is activated by environmental or relational threats. It is present throughout life. It organizes adaptive behavior to manage threats. Perceived threats cause a person to seek closeness to an attachment figure. Attainment of closeness and protection brings relief and security and the deactivation of the attachment behavioral system. The memory of nurturing and protection provided by the primary attachment figure creates mental representations of the self as worthy of care and of protective figures as caring. These representations become the foundation for working models that lead to an attachment style. Positive working models also can be used to self-soothe at other times when threats are ominous.

A person's behavioral response to threats is determined by processing information, monitoring the response of attachment figures, and adjusting behavior to adapt to the situation. Both children and adults seek out a primary attachment figure as a response when threatened. An attachment figure may change depending on circumstances and maturity. For example, a wife may become primary attachment figure for her husband, and if a mother were to die a stepmother could become the primary attachment figure for a child. Likewise, a case manager may become an attachment figure for a client. This attachment may be helpful to the case manager because the client may be more cooperative in carrying out a case management plan. It may be helpful to a client if the case manager is a safe base, especially at a vulnerable time.

Attachment styles are an adaptation to the success or failure of attachment. The secure style results from positive attachment. There are three insecure styles: anxious avoidant, anxious ambivalent, and disorganized.⁹ Bartholomew

and Horowitz¹⁰ retained the term secure and labeled ambivalent as preoccupied and avoidant as fearful. These latter terms may convey a clearer meaning for some readers, although the meanings in both sets are the same.

Fortunately, most children and adults have a secure style. Their adaptation to life's challenges is successful, and thus social functioning is normative. For the purposes of this paper, adaptation is the successful management of drives, instincts, and interpersonal relationships. Social functioning is normative social behavior that is acceptable to observers.

The secure attachment style is characterized by a positive view of self and others. The primary attachment figure was sensitive and responsive to the child's emotional needs. The ambivalent or preoccupied insecure style is characterized by a negative view of self and a positive view of others. The primary attachment figure was inconsistent in nurturing, meaning alternately attentive and inattentive, which may be seen in the word ambivalent. The avoidant or dismissive insecure style is characterized by a positive view of self and a negative view of others. The primary attachment figure's care was confusing to the child.

The behavior of persons with a secure style is normative, meaning that social functioning also is normative and that behaviors are readily accepted by observers. When attachment figures are not readily available and stress is not relieved, security is undermined. Negative working models of self and others are formed. The probability of later emotional problems is increased.

Observed behavior of persons with an ambivalent insecure attachment style may include seeking affection and attention, fear of rejection, and self-devaluation to seek sympathy. The observed behavior of persons with an avoidant insecure attachment style may include a lack of self-awareness, difficulty maintaining a sense of self-worth, an unrealistic view of self, denial of weakness, and inability to accept positive feedback. The observed behavior of persons with a disorganized insecure attachment style may include a lack of a plan for responding to the unpredictable behavior of parents, generalized fear that followed traumatic experiences, lack of ability to self-soothe, and possibly serious psychiatric problems.¹¹

Working models are the processes of attachment style. They are representations of childhood experiences with

A case manager with a secure attachment style also may be a safe base for a client. As such, a case manager is in a position of providing safety and protection that promotes recovery from illness or emotional distress.

attachment figures. Children who receive a prompt response from a loving adult when they feel bad learn that their behaviors are linked with the positive behaviors of the attachment figure. From this they learn they are deserving of love and that others will help and protect them. If there is an uncaring response from an attachment figure, they learn a working model that the attachment figure is rejecting. This leads to a feeling of not being worthy of care and that others may not be helpful or supportive in time of need. Working models tend to stabilize over time. They affect individuals' response to interpersonal relationships and the social environment.¹²

A case management plan can be affected by a person's working models. Because they are based on mental representations of childhood experiences, a person with either an anxious ambivalent or anxious avoidant insecure attachment style may not feel worthy of a case manager's care or may feel that a case manager is not capable or willing to provide it. These feelings persist and may make the delivery of care difficult.

Attachment Theory for Case Management

The social position of both the nurse and the patient may be affected by attachment theory. Social position is a concept in social role theory. A social position may be ascribed or achieved.

The social position or status of both the case manager and a recipient of services may be affected by attachment style. Social position or status is a sociological concept in role theory.¹³ There are two types of position or status: achieved and ascribed. An achieved status is one that is acquired on the basis of merit. It is earned based on a person's skills, abilities, and efforts. Being a case manager, lawyer, or physician is an achieved status. An ascribed status is something people are either born with or have no control over. Examples of ascribed status include sex, race, and age.

Each social position or status has accompanying social role behaviors. A case manager's role behavior is managing care. The status of a patient is one who is ill. The role behavior may be accepting the sickness and treatment, complaining about being sick, expressing anger and resentment about the condition, or other appropriate or inappropriate behaviors.

If both the case manager and client have a secure attachment style and positive working models, the status of the relationship will be positive. Other things being equal, case management will go smoothly and the outcomes likely

will be positive. The client will attach to the case manager as a caring person, will respond to care and direction, and will believe that good care will be provided.

Learning the attachment style of a potential case manager as part of the employment process may be helpful in avoiding problems with clients when the case manager has either an anxious ambivalent or anxious avoidant insecure attachment style. Blakely et al.¹⁴ described a preemployment process that determined the attachment capacity of mental health workers applying for a case management position at a mental health agency that could be used to screen case management applicants for most case management agencies. The behavior of persons with insecure attachment styles is not conducive to meeting a client's attachment needs.

When clients have an insecure attachment style, their working models may be the reason for a negative or troublesome reaction to care. Case managers need to know that this reaction is part of a client's attachment style and not take any client negativity personally. When case managers continue caring for clients with their secure attachment style, over time clients may, through identifying a case manager as an attachment figure, reinterpret past difficult developmental experiences and learn a new positive perspective characteristic of a secure attachment style. This may result in improved adaptation and social functioning that will contribute to an easier application of a case management plan and better care outcomes.

The case manager may readily be an attachment figure for a client as he/she can be a safe base. Clients are in a vulnerable state when they are in need of case management. Their instinct is to reach out to an attachment figure that is a caregiver. When the case manager is caring and nurturing, the client's attachment behavioral system will respond positively with a client learning that he/she is worthy of care and that the case manager will provide it. Having this replacement attachment figure may generate a sense of hope in a client that is a factor in recovery from illness or distress.

Case Management Intervention

Assuming that a case manager has a secure attachment style, the following are suggestions about incorporating attachment theory into a case management plan for clients who have an insecure attachment style.

Initially, the case manager should observe the client's

behavioral response. These observations should occur over time to ensure they are accurate. Look for physical and verbal signs of anxiousness such as handwringing, facial tics, sweaty palms, heartbeat rate, hesitant eye contact, excessive talking, frequent bathroom visits, or other signs with which a case manager may already be familiar. The behaviors of individuals with either an ambivalent or avoidant attachment style were described previously in this article. Listen to what the client says and watch for behavior that indicates inner feelings. Listen with your intuitive mind for signals about a client's need for attention and affection, fear of rejection, and devaluation of self to seek sympathy that are indications of an anxious ambivalent attachment style. Look for signals about a lack of self-awareness, difficulty maintaining a sense of self-worth, an unrealistic view of self, a denial of weakness, and an inability to accept positive feedback as these are indications of an anxious avoidant attachment style. Observe how a client interacts with others as these behaviors may provide clues about feelings.

Occasions may arise when the case manager can talk with a patient about family relationships with parents and siblings. Information about how the client related to them, especially their mother, will help with assessment of attachment style. It is likely that clients transfer expectations of behavior to the case manager so he/she should reflect on his/her feeling responses to avoid negative countertransference. If it appears that clients are responsive, a case manager might explain working models as a basis for relating to others. This could lead to a client's recognizing that interpretations of earlier emotional exchanges with significant others that may have laid a foundation for current views of self and others are not accurate.

The techniques case managers may use are entitled reflective listening¹⁵ and "validation."¹⁶ Reflective listening is listening accurately to what a client verbalizes and in addition hearing the feeling behind the verbalizations and responding with feedback about the feeling. For example, if a client says, "I wish my wife were more considerate of my feelings," a case manager might respond "I think I hear you saying you would feel better if your wife showed you that she considers your feelings." If this response is inaccurate, the client will tell you.

Validation occurs when reflective listening is accurate. Hearing a client's feelings promotes a client's self-esteem. A client feels more important and recognized. These feelings increase attachment that increases the strength of the client-case manager relationship.

If a case manager can help a client to recognize nonfunctional working models, that may generate a new perspective on interpersonal relationships. This may have a positive effect on the delivery of care, recovery, and improved health. It takes a lot of energy to be ill or distressed. A level of energy is endowed to individuals at conception. The level may be higher

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CE II Delivery Model for Outcome-Producing Care Management in Patients with Health Complexity

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Introduction

While clinicians are trained experts in identifying and diagnosing disease and other conditions that impact health outcomes, there are often gaps between what they can provide and what patients with health complexity require for optimal outcomes. Outcome-focused complex care management can help bridge that gap because case managers “assist” and “support” patients with clinical and nonclinical challenges to get better.¹ Case managers do not treat patients, rather they assist and support patients as they weather complicated health problems and life situations. Clinicians, on the other hand, generally restrict their activities to improving

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illness-based outcomes. They do not help patients find housing, money for medications, or solutions to other impairing social determinants of health (SDOH) unless these problems are directly related to the treatment of an illness. Even then, because of time constraints, most practitioners rely on other health care support team members to deal with non-illness related contributors to poor health outcomes.

Methods

We review the current state of research about case management and discuss the use of biopsychosocial and health system case management to systematically and progressively improve outcomes for patients with health complexity. Perhaps, more importantly, we lay out an implementable multifaceted approach with outcome measurement capabilities that can be used to improve health and cost outcomes for both adults and children with high need: high cost (HNHC).

Observations

Background

It may be surprising to learn that the variations and types of case management are still poorly defined even though the field of case management had its origins in the 1960s.² In fact, many reviews evaluating case management efficacy in creating health improvement and cost savings show limited impact.²⁻⁷ There are numerous “brands” of case management with differing names delineating what they

do, eg, discharge management, disease management, behavioral health (BH) management, patient navigation, health care coaching, and disability management. Only a small number have demonstrated improved health outcomes or cost savings.^{8,9} Even case management in patients with health complexity does not uniformly demonstrate value because the definitions of what constitutes “health complexity” vary widely or the type of assistance and support provided is inconsistent from program to program.

Payers and care delivery systems also contribute to the limited case management outcome metrics reported because they segregate payment and support for BH from medical care despite the fact that BH conditions are consistently seen in up to 80% of patients with health complexity.^{10,11} Thus, BH issues, with the occasional exception of depression and substance use disorders, do not generally constitute reasons for assistance in medical models of case management despite their now well-documented contribution to poor health outcomes and high cost, especially in complex patients.¹²⁻¹⁴

Similarly, patients receiving BH case management are expected to have their medical problems addressed in the medical setting, though most often without cross-disciplinary communication. During the past 10 years, the attitude towards segregated payment and delivery has changed because of the significant added health care cost burden, especially for complex

While clinicians are trained experts in identifying and diagnosing disease and other conditions that impact health outcomes, there are often gaps between what they can provide and what patients with health complexity require for optimal outcomes. Outcome-focused complex care management can help bridge that gap because case managers “assist” and “support” patients with clinical and nonclinical challenges to get better.

patients.¹⁰ Making changes to integrate medical and BH services nonetheless remains challenging when two reluctant, segregated payers are involved. Unfortunately, few organizations have taken steps to consolidate medical and BH case management programs.

Finally, and importantly, social and health system issues play a significant role in the persistent poor health outcomes seen in complex patients. Although these are receiving increased attention as studies related to SDOH are published,^{15,16} these issues are rarely addressed adequately in the health care setting where patients typically receive care. Health system issues (eg, patient’s access to health insurance, communication and coordination of providers with each other, or the patient-provider relationship) receive even less attention than SDOH dimensions (eg, housing, transportation, or food insecurity). Most health care organizations and health care professionals categorize these issues as being outside the realm of their responsibility and few of them believe that they can impact the social or health system determinants of their patients’ health. This is true even though these issues may critically influence outcome, regardless of the medical severity level.

Health Complexity—High Need: High Cost Patients

Adults and children with HNHC fall into the same category as those identified with health complexity. In essence, patients whose needs do not match

the capacity of health care services to support them (ie, complex patients)¹⁷ typically spend more on health care (Table 1) because they have difficulty in effectively accessing the services they truly need, including BH and nonclinical services.^{1,10,18} For purposes of this article, health complexity and HNHC will be used interchangeably.

The average annual cost of care is approximately \$110,000 for the top 1% of individuals in the United States and is approximately \$50,000 for the top 5%.¹⁸ In a closer look at HNHC patients, over half of patients falling into the top 10% each year continue to demonstrate high health care service use in subsequent years.¹⁹ Few patients with HNHC appear to return to average annual population health care costs, at least not in the short term.

Notably, 60% to 80% of HNHC patients have comorbid medical and BH conditions.¹⁰ Numerous studies

show that four-fifths of the cost doubling documented in HNHC health care relates to excess medical service use rather than to BH care.¹³ Thus, despite an excess of BH conditions among such patients, they tend not to get care in the BH sector but rather use high amounts of medical care in the medical sector. Unless access to and use of BH care is established in the medical setting where 70% of BH patients exclusively go for “all” health issues, then drivers of HNHC will not be corrected. Chronic illness and high cost will persist.

Most physicians are unaware of data related to this small percentage of patients who use such an enormous amount of the health care dollar. In fact, the bottom (least costly) 80% of patients average less than \$300 in annual health care costs.¹⁸ Thus, targeting the costliest 10% of patients works as a means to identify those in whom complex case management assistance should be considered, though other factors logically inform the selection of the best candidates.

Unfortunately, most hospitals, clinic systems, and medical health plans do not use annual cost of patients’ care to determine who might benefit most from case management. Health insurance and care delivery system contracts, influenced by purchasers of care (employers and government agencies), often attempt to provide the same level of “cookie cutter” case management assistance to an entire population, as opposed to providing a

TABLE 1
COST OF ANNUAL HEALTHCARE FOR THE HIGHEST NEED PATIENTS

| PERCENTAGE OF POPULATION | PERCENTAGE OF HEALTHCARE SPEND |
|--------------------------|--------------------------------|
| Top 1% | 22% |
| Top 5% | 50% |
| Top 10% | 66% |
| Top 15% | 76% |
| Top 20% | 82% |
| Top 50% | 97% |
| Lower 50% | 3% |

Table adapted from Mitchell.¹⁸

TABLE 2 ADULT VALUE-BASED INTEGRATED CASE MANAGEMENT COMPLEXITY ASSESSMENT GRID

| | | | | | | | | | |
|----------------------|---|-------|------------------------|----------------------------------|-------|----|------------------------------|-------|---|
| Name | Pearson, Randy | | Date of Birth | 5/15/XX | | | | | |
| ID # | 1234 | | Gender | M | | | | | |
| Opening date | 9/9/XX | | VB-ICM-CAG score | 34 | 14 | | | | |
| Time stamped | 10/25/XX | | Legal guardian name(s) | Pearson, Randy | | | | | |
| VB-ICM manager | Johnson, Ella | | VB-ICM manager team | High need: High cost | | | | | |
| VB-ICM program | Health complexity | | Book of business | State health plan | | | | | |
| Assessment Reason: | Hepatitis C with multiple complications; substance use disorder; recent release from jail; type 2 diabetes; poor compliance | | | | | | | | |
| Date | HEALTH RISKS AND HEALTH NEEDS | | | | | | | | |
| Name | HISTORICAL | | | CURRENT STATE | | | VULNERABILITY | | |
| | Complexity Item | Score | | Complexity Item | Score | | Complexity Item | Score | |
| | I = initial; FU = follow up | I | FU | FU date = 1/5/XX+1 | I | FU | | I FU | |
| Biological domain | Chronicity | 3 | 2 | Symptom severity/impairment | 2 | 1 | Physical illness-life threat | 3 | 1 |
| | Diagnostic dilemma | 0 | 0 | Diagnostic/therapeutic challenge | 3 | 2 | | | |
| Psychological domain | Coping with stress | 1 | 1 | Treatment adherence | 2 | 0 | Behavioral-adherence threat | 2 | 0 |
| | Behavioral health history | 2 | 1 | Behavioral health symptoms | 2 | 0 | | | |
| Social domain | Job and leisure | 1 | 1 | Social determinants | 0 | 0 | Social system threat | 1 | 1 |
| | Relationships | 0 | 0 | Social support | 1 | 1 | | | |
| Health system domain | Access to care | 2 | 1 | Getting health services | 2 | 0 | Health system threat | 3 | 1 |
| | Treatment experience | 1 | 1 | Coordination of care | 3 | 0 | | | |

Abbreviations: FU = follow-up; I = initial; M = male; VB-ICM-CAG = value-based integrated case management complexity assessment grid; XX = year.

more targeted and integrated level of complex case management to individuals with demonstrated HNHC. There is a lack of adequate focus on chronically ill patients with the greatest cost.

Providing the same level of case management to an entire population actually prevents the delivery of effective complexity-based case management by diluting the effort of case management to address the needs of a large number of noncomplex patients. Two recent studies on complex case management interventions illustrate the point that generic case management interventions do not necessarily impact outcomes and cost of care for patients unless those interventions target appropriate patients and address their biopsychosocial and health system needs in an integrated way.^{20,21}

Adult and Pediatric Integrated Case Management Training

Training in case management remains uncommon even when case managers work with complex patients, whether adults or children, despite the fact that multiple factors play a role in high health care service use and poor outcomes.¹ Importantly, nonclinical factors, such as homelessness, lack of family or social support, or the financial inability to pay for needed medications or treatments, can be as or more important than clinical barriers to improvement. It is essential for case managers to receive specific training that addresses the types of barriers complex patients may experience, how to prioritize these barriers for correction, and how to help HNHC patients find solutions that lead to better health

outcomes and lower cost. Table 2 is an example of an adult complexity grid that can be used to document broad-based barriers to improvement that case managers can use to assist HNHC patients.¹ It was derived from formative work by researchers in Europe on the INTERMED.²² The grid documents biological and psychological as well as social and health system barriers to improvement and examines factors across historical, current, and outcome vulnerability contexts that can be used to improve health and life outcomes.

Finally, it is important to remember that children present with different types of problems than adults, though some challenges may be similar. Thus, training case managers in how to assist children/youth and their parents/guardians can lead to improved health

TABLE 3 VALUE-BASED PEDIATRIC INTEGRATED CASE MANAGEMENT COMPLEXITY ASSESSMENT GRID

| | | | | | | | | | |
|----------------------|---|-------|----|----------------------------------|----------------------------|----|---|-------|---|
| Name | McGlynn, Darren | | | Date of Birth | 1/1/XX | | | | |
| ID # | 1234 | | | Gender | M | | | | |
| Opening date | 2/22/XX | | | VB-PICM-CAG score | 57 | 22 | | | |
| Time stamped | 9/1/XX | | | Legal guardian name(s) | McGlynn, Paul; Rath, Karen | | | | |
| VB-PICM manager | Terry, Ruth | | | VB-PICM manager team | Pediatric Medicaid | | | | |
| VB-PICM program | VB-PICM | | | Book of business | Emblem insurance | | | | |
| Assessment Reason: | Uncompensated cystic fibrosis, fatigue, school nonattendance; autism spectrum disease; unemployed parents; possible child abuse | | | | | | | | |
| Date | HEALTH RISKS AND HEALTH NEEDS | | | | | | | | |
| Name | HISTORICAL | | | CURRENT STATE | | | VULNERABILITY | | |
| | Complexity item | Score | | Complexity item | Score | | Complexity item | Score | |
| | I = initial; FU = follow up | I | FU | FU date = 9/1/XX | I | FU | I | FU | |
| Biological domain | Chronicity | 2 | 1 | Symptom severity/impairment | 3 | 1 | Physical illness-life threat | 3 | 1 |
| | Diagnostic dilemma | 1 | 1 | Diagnostic/therapeutic challenge | 3 | 1 | | | |
| Psychological domain | Coping with stress | 2 | 1 | Treatment adherence | 3 | 0 | Behavioral-developmental-adherence threat | 2 | 1 |
| | Behavioral health history | 2 | 1 | | | | | | |
| | Developmental history | 3 | 2 | Behavioral health symptoms | 2 | 1 | | | |
| | Adverse developmental events | 3 | 2 | | | | | | |
| Social domain | School functioning | 3 | 2 | Social determinants | 1 | 1 | Family-school-social system threat | 2 | 1 |
| | Family and societal relationships | 2 | 1 | Child/youth support | 0 | 0 | | | |
| | Caregiver/parent health and function | 3 | 2 | Caregiver/family support | 2 | 0 | | | |
| | | | | School and societal issues | 3 | 0 | | | |
| Health system domain | Access to care | 0 | 0 | Getting health services | 3 | 0 | Health system threat | 3 | 0 |
| | Treatment experience | 3 | 2 | Coordination of care | 3 | 0 | | | |

Abbreviations: FU = follow-up; I = initial; M = male; VB-PICM-CAG = value-based pediatric integrated case management complexity assessment grid; XX = year.

outcomes and the use of fewer medical or behavioral services during childhood and as children enter adulthood. Table 3 is an example of a slightly different risk-based complexity grid that specifically addresses the clinical barriers that children and adolescents face.¹

Outcome Measurement

Some case management programs are designed specifically to improve costs in HNHC patients by providing specific case management support that would decrease emergency department use or repeated inpatient admissions. While there is good

evidence that many of these programs deliver case management services that produce cost saving, there is no certainty that decreased service use will endure after completion of the research project or that the underlying clinical and functional issues leading to HNHC are corrected. Since a substantial portion of complex patients continue to demonstrate high service utilization during the years after an index period,¹⁹ using a model of case management that measures outcomes can be particularly helpful in guiding the delivery of future case management services.

Creating A Useable Value-Based Model of Integrated Case Management for Complex Patients

Preliminary Steps

While the model of case management used for complex patients is important, there are a number of health system-based issues that may need to be clarified and corrected before a value-based “integrated” case management (VB-ICM) program can be effectively initiated. These include: 1) payment for BH services from medical claim dollars; 2) a single electronic health record system for medical and BH

TABLE 4 CORE FEATURES OF AN IMPLEMENTABLE VALUE-BASED INTEGRATED CASE MANAGEMENT MODEL

| VB-ICM Stages | Activities | Personnel Involved |
|--|--|---|
| I. Patient selection and enrollment | Triage for complex HNHC patients in served population | Enrollment specialist |
| | Obtain consent to participate in the VB-ICM program | |
| | Transfer patient to a VB-ICM manager with a new case opening (warm handoff from enrollment specialist to the VB-ICM manager) | |
| II. VB-ICM assessment and plan | Develop an open, positive relationship with the HNHC patient during the assessment interaction | VB-ICM manager and patient |
| | Complete a "defined" biopsychosocial and health system assessment using an interactive dialogue | |
| | Document prioritized barriers to improvement and create "big picture" VB-ICM goals (clinical, functional, economic, satisfaction, and quality of life [Table 5]); build a care plan with the patient | |
| III. VB-ICM implementation | Share the patient's barriers, big picture goals, and care plan with the patient's practitioners | VB-ICM manager, patient, and clinical practitioner |
| | Address "dangerous" and "improvement preventing" issues immediately | |
| | Work on high priority (and connected) barriers first, then move to lower priority barriers over time (iterative) | |
| | Document changes from baseline on the patient's care plan and big picture goal sheet (Table 5) until decreased "vulnerability" allows the patient to return to standard care | |
| IV. Graduation | Prepare the patient for graduation from VB-ICM several weeks in advance | VB-ICM manager, patient, and clinical practitioners |
| | Update changes (see color codes on Tables 2 and 3) on the care plan and document progress in achieving big picture goals (share outcomes with the patient and the patient's clinicians) | |
| | Discuss continued risks with primary caregivers | |
| | Discharge patient from VB-ICM assistance and support back to standard care | |
| V. Outcome measurement and program improvement | Transfer each patient's big picture outcomes to organizational "group" data sheets and analyze | VB-ICM program analyst, VB-ICM leadership |
| | Update program based on outcome findings | |

Abbreviations: HNHC = high need: high cost; VB-ICM = value-based integrated case management.

services; 3) biopsychosocial and health system training in assistance and support practices for adult and youth VB-ICM managers; 4) VB-ICM "pod" assignments that span all treatment settings and support real-time dashboards and patient registries; and 5) active weekly or biweekly assistance by program medical directors.

Since the 1980s, medical and BH services have been delivered by separate and siloed payment systems.¹⁰ This began since the variance in BH treatments, such as years in the hospital for psychodynamic therapy versus weeks in the hospital followed with outpatient treatment for biologically based intervention, was

so large that medical payers chose to separate BH services from medical and let a new set of "BH payers" correct the variance. Although the variance in BH care was largely equalized by the end of the 1990s, a BH payer system was now well established and owners of this system were reluctant to give up their income-producing capacity through aggressive management of segregated BH care and cost. They argued that they could create more effective clinical BH programs and that they could protect sensitive BH issues from view by medical practitioners.

At that time, the understanding of the impact of BH conditions on total medical costs was in its infancy. In addition, there was inadequate appreciation that sensitive information was handled on the medical side of care just as much as on the BH side (eg, sexually transmitted infections, infertility, family violence). Furthermore, few realized that 70% of patients with BH issues refuse to go for treatment in the BH setting. Nonetheless, we have been saddled with separate and largely noncommunicating medical and BH systems since that time. This, of course, contributes substantially to poor BH care access in the medical setting and a lack of communication between medical and BH practitioners.

Another area in which complex VB-ICM services would function better with correction of core care delivery practices relates to how VB-ICM managers are trained and deployed. No two complex patients are the same, although their complexity can be captured and prioritized as long as the VB-ICM managers know how to document barriers to improvement in all health risk areas. This is why integrated case management training is so important. It also informs how VB-ICM will function in the health care setting. For complex VB-ICM, the relationship between the VB-ICM

EXAMPLE OF MEASURED CLINICAL, FUNCTIONAL, ECONOMIC, SATISFACTION, AND QUALITY-OF-LIFE OUTCOMES FOR A PATIENT IN VALUE-BASED INTEGRATED CASE MANAGEMENT FOR 4 MONTHS

TABLE 5

| Patient-Centered Value-Based Integrated Case Management | | | | |
|--|-------------------|-----------------------|--------------------|----------|
| Name and Case #: | Pearson, Randy | 1234 | | |
| VB-ICM manager name and team name: | Johnson, Ella | High need: high cost | | |
| VB-ICM program | Health complexity | | | |
| Book of business | State health plan | | | |
| Measure | Baseline | Follow-Up Assessments | | |
| Time period | 9/9/XX | 10/25/XX | 12/1/XX | 1/5/XX+1 |
| INDIVIDUAL'S MEASURES | | | | |
| Hepatitis control (bilirubin level [mg/dL]) | 17.2 | 9.4 | 2.1 | 0.8 |
| No. of days driving a truck (days worked/week) | 0 | 0 | 4 job applications | 4/week |
| Satisfaction with health (VAS 1 to 10) | 1 | 8 | 8 | 10 |
| No. of days feeling healthy (days/last month) | 0 | 15 (better) | 25 | all |
| VB-ICM MANAGER'S MEASURES | | | | |
| VB-ICM-CAG score | 34 | 19 | 16 | 14 |
| Clinical I—HbA1c (percent) | 9.2 | | | 7.8 |
| Clinical II—recreational substance use (drinks/hits per day) | 12 | 0 | 0 | 0 |
| Functional I—attends child's functions (#/month) | 0 | 3 | 8 | most |
| Functional II—sporting events (hours/week) | 0 | 0 | 2 | 5 |
| Economic I—emergency department visits (visits/month) | 4 | 0 | 0 | 0 |
| Economic II—money legally earned (dollars earned/week) | \$0 | \$0 | odd jobs | \$475 |

Abbreviations: VAS = visual analog scale; VB-ICM-CAG = value-based integrated case management complexity assessment grid.

manager and the patient is key to a patient's willingness to change; thus, any VB-ICM handoff is to be discouraged even when a change in treatment venues occurs (eg, from inpatient to outpatient care or from the medical to the BH setting).

Value-Based Integrated Case Management
We finally arrive at the creation of an outcome-producing approach

to VB-ICM designed for complex (HNHC) patients.¹ Table 4 summarizes the components of such a system, which is largely based on accumulated research findings. Such an approach can be deployable by care delivery systems, government programs, medical health plans, and the military and lead to improved measurable outcomes for an organization's most challenging patients.^{3-5,23}

Patient Selection & Enrollment

In well-developed programs, patient identification and recruitment should be handled by supervised nonprofessionals who understand the type of people who benefit the most from complexity-based VB-ICM. In almost all situations, there will be more patients for whom VB-ICM is requested than there are VB-ICM managers to assist them. Enrollment specialists should be well versed in the complexity criteria used by their organization and use this knowledge to recruit and assign appropriate candidates for program participation. All enrollment specialists and their supervisors are also aware of the need not to over assign cases to individual VB-ICM managers. VB-ICM managers typically carry no more than 20, but occasionally up to 40, cases at any one time because of HNHC patients' complex needs.

I. VB-ICM Assessment and Plan

Once the case manager has been assigned a new case, they will score the biopsychosocial and health system complexity assessment (see Table 2 or 3), remembering that this will be done using a guided "dialogue" between the patient and the VB-ICM manager. This process is intended to allow a relationship to develop. The interview is not a series of staccato questions. Although the assessment findings are an important component of the initial interview, it is the relationship between the VB-ICM manager and the patient that leads to a patient's willingness to change. Thus, the time used in the initial interview is considered critical in outcome-based VB-ICM.

At the completion of the VB-ICM assessment, big picture goals will also be documented. These goals serve three purposes: 1) they allow the patient to identify personal clinical and functional goals that they would like to accomplish during their time in VB-ICM, 2) they allow the VB-ICM

manager to add more broad-based goals to the patient's goals, and 3) they form the basis for outcomes measured during the course of VB-ICM. Big picture goals allow organizations to understand the value they bring to complex patients via VB-ICM and to measure successes and failures, which guide program evolution.

II. VB-ICM Implementation

Outcome producing VB-ICM, as described here, is an iterative process. It can be provided during face-to-face encounters, through internet communication, or telephonically. All of these have evidence of benefit, though some patients respond better to one form of communication than another. On average VB-ICM, even in complex patients, lasts no more than 3-4 months, although this varies by individual need and the population served. For instance, in some populations, the level of complexity and the poor availability of patient resources may lead some patients to enter and remain in VB-ICM for extended periods.

VB-ICM assistance starts with the most critical or dangerous areas uncovered for the patient (eg, suicidality) or indicate problems in the patient's life (eg, homelessness) that, unless corrected, will prevent other needed health-related changes from occurring. Thus, these eminent needs are addressed first. While these needs are being addressed, assistance with other complexity (color)-coded (red [highest] to green [lowest]) barriers can also be initiated (Tables 2 and 3). However, it is important not to overwhelm either the VB-ICM manager or the patient, especially since the entire VB-ICM process will likely take months to complete.

Some case management programs suggest that patients should be active in their own improvement process from

the beginning. Our experience is that the VB-ICM manager must take a more active role at the start, while still using a collaborative goal-oriented style of communication consistent with the spirit of motivational interviewing.²⁴ Then, gradually the VB-ICM manager will turn responsibility over to the patient as initial gains and milestones are achieved. This communicates to the patient that the VB-ICM manager is engaged and caring but gradually turns

The average annual cost of care is approximately \$110,000 for the top 1% of individuals in the United States and is approximately \$50,000 for the top 5%. In a closer look at high need: high cost patients, over half of patients falling into the top 10% each year continue to demonstrate high health care service use in subsequent years.

more assignments over to the patient so that they have the needed skills to maintain health and life stability after graduation from VB-ICM.

As the VB-ICM manager works with the patient, they should be capable of seeing a snapshot of the patient's original and follow-up complexity picture (Tables 2 and 3). This allows the VB-ICM manager to better monitor the changes that have occurred and anticipate the challenges that remain. Thus, the VB-ICM manager and the patient can plan ahead for anticipated graduation and return to standard care by their primary care and specialty medical doctors. VB-ICM managers routinely update their initial assessment findings in various problem areas as they work with patients.

Finally, the VB-ICM manager also updates big picture goals as defined

by the VB-ICM manager and the patient. (Table 5).¹ Big picture goals are different than care plan objectives in that they represent what the patient and VB-ICM manager together had identified, in a person-centered way, to be the larger goals to achieve during the course of the VB-ICM episode of care. For big picture goals to be achieved, care plan objectives have to be reached as well, although it is the big picture goals that motivate the patient to change. These may relate to health issues (eg, decrease in the number of headaches per week), or they could relate to health-related issues (eg, being able to attend the patient's daughter's future piano recitals). Not only do these big picture goals provide motivation for the patient to make changes, they will also be used to document and compare outcomes (Table 5).

III. Graduation

All forms of complexity-based VB-ICM should be oriented toward goal attainment and return to usual care by the patient's primary care clinicians. Even though many complex patients fall into the designation of HNHC patients, with adequate interventions many of them will stabilize and return to usual care. For successful graduation to occur, however, it is necessary to prepare both the patient and their clinicians for the transition back to standard care as they get close to health stabilization. This usually means completing a summary of the changes and progress in the care plan, sharing the improvements that occurred in big picture goals, and highlighting continued issues that need attention as the patient transfers back to standard care.¹⁰ Each of these will make it possible for the clinical care team to support the patient moving forward.

continues on page 36

PharmaFacts for Case Managers



Kesimpta® (ofatumumab) injection, for subcutaneous use

INDICATIONS AND USAGE

Kesimpta is indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

DOSAGE AND ADMINISTRATION

Assessments Before First Dose of Kesimpta *Hepatitis B Virus Screening*

Before initiating Kesimpta, perform Hepatitis B virus (HBV) screening. Kesimpta is contraindicated in patients with active HBV confirmed by positive results for hepatitis B surface antigen [HBsAg] and anti-HBV tests. For patients who are negative for HBsAg and positive for hepatitis B core antibody [HBcAb+] or are carriers of HBV [HBsAg+], consult liver disease experts before starting and during treatment with Kesimpta.

Serum Immunoglobulins

Before initiating Kesimpta, perform testing for quantitative serum immunoglobulins. For patients with low serum immunoglobulins, consult immunology experts before initiating treatment with Kesimpta.

Vaccinations

Because vaccination with live-attenuated or live vaccines is not recommended during treatment and after discontinuation until B-cell repletion, administer all immunizations according to immunization guidelines at least 4 weeks before initiation of Kesimpta for live or live-attenuated vaccines, and whenever possible, at least 2 weeks before initiation of Kesimpta for inactivated vaccines.

Recommended Dosage

The recommended dosage of Kesimpta is:

- Initial dosing of 20 mg by subcutaneous injection at Weeks 0, 1, and 2, followed by
- Subsequent dosing of 20 mg by subcutaneous injection once monthly starting at Week 4

Missed Doses

If an injection of Kesimpta is missed, it should be administered as

soon as possible without waiting until the next scheduled dose. Subsequent doses should be administered at the recommended intervals.

Administration Instructions

Administer by subcutaneous injection only. Kesimpta is intended for patient self-administration by subcutaneous injection. Administer Kesimpta in the abdomen, thigh, or outer upper arm subcutaneously. Do not give injection into moles, scars, stretch marks, or areas where the skin is tender, bruised, red, scaly, or hard. The first injection of Kesimpta should be performed under the guidance of a healthcare professional. Kesimpta Sensoready® pens and syringes are for one-time use only and should be discarded after use. See Instructions for Use for complete administration instructions.

Preparation of Kesimpta

The Kesimpta “Instructions for Use” for each presentation contains more detailed instructions on the preparation of Kesimpta. Before administration, remove Kesimpta Sensoready pen or Kesimpta prefilled syringe from the refrigerator and allow Kesimpta to reach room temperature for about 15 to 30 minutes. DO NOT remove the needle cover while allowing the prefilled syringe to reach room temperature. Parenteral drug products should be inspected visually for particulate matter and discoloration before administration, whenever solution and container permit. Do not use if the liquid contains visible particles or is cloudy

DOSAGE FORMS AND STRENGTHS

Kesimpta is a clear to slightly opalescent and colorless to slightly brownish-yellow solution available as follows:

- Injection: 20 mg/0.4 mL in a single-dose prefilled Sensoready Pen
- Injection: 20 mg/0.4 mL in a single-dose prefilled syringe

CONTRAINDICATIONS

Kesimpta is contraindicated in patients with

- Active HBV infection

ADVERSE REACTIONS

The following clinically significant adverse reactions are reported:

- Infections
- Injection-related reactions
- Reduction in immunoglobulins



DRUG INTERACTIONS

Immunosuppressive or Immune-Modulating Therapies

Concomitant usage of Kesimpta with immunosuppressant drugs, including systemic corticosteroids, may increase the risk of infection. Consider the risk of additive immune system effects when coadministering immunosuppressive therapies with Kesimpta. When switching from therapies with immune effects, the duration and mechanism of action of these therapies should be taken into account because of potential additive immunosuppressive effects when initiating Kesimpta.

USE IN SPECIFIC POPULATIONS

Pregnancy Risk Summary

There are no adequate data on the developmental risk associated with the use of Kesimpta in pregnant women. Ofatumumab may cross the placenta and cause fetal B-cell depletion based on findings from animal studies. Transient peripheral B-cell depletion and lymphocytopenia have been reported in infants born to mothers exposed to other anti-CD20 antibodies during pregnancy. B-cell levels in infants following maternal exposure to Kesimpta have not been studied in clinical trials. The potential duration of B-cell depletion in infants exposed to ofatumumab in utero, and the impact of B-cell depletion on the safety and effectiveness of vaccines, are unknown. Avoid administering live vaccines to neonates and infants exposed to Kesimpta in utero until B-cell recovery occurs. Following administration of ofatumumab to pregnant monkeys, increased mortality, depletion of B-cell populations, and impaired immune function were observed in the offspring, in the absence of maternal toxicity, at plasma levels substantially higher than that in humans. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively. The background risk of major birth defects and miscarriage for the indicated population is unknown.

Lactation Risk Summary

There are no data on the presence of ofatumumab in human milk, the effects on the breastfed infant, or the effects of the drug on milk production. Human IgG is excreted in human milk, and the potential for absorption of ofatumumab to lead to B-cell depletion in the infant is unknown. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Kesimpta and any potential adverse effects on the breastfed infant from Kesimpta or from the underlying maternal condition.

Females and Males of Reproductive Potential Contraception

Females of childbearing potential should use effective contraception while receiving Kesimpta and for 6 months after the last treatment of Kesimpta.

Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

Geriatric Use

Clinical studies of Kesimpta did not include sufficient numbers of geriatric patients to determine whether they respond differently from younger subjects.

CLINICAL STUDIES

The efficacy of Kesimpta was demonstrated in two randomized, double-blind, double-dummy, active comparator-controlled clinical trials of identical design, in patients with relapsing forms of MS [Study 1 (NCT02792218) and Study 2 (NCT02792231)]. Both studies enrolled patients with at least one relapse in the previous year, 2 relapses in the previous 2 years, or the presence of a T1 gadolinium-enhancing (GdE) lesion in the previous year. Patients were also required to have an Expanded Disability Status Scale (EDSS) score from 0 to 5.5.

Patients were randomized to receive either Kesimpta, 20 mg subcutaneously on Days 1, 7, and 14, followed by 20 mg every 4 weeks thereafter starting at Week 4 with a daily oral placebo, or the active comparator, teriflunomide, at a dose of 14 mg orally once daily with a placebo administered subcutaneously on Days 1, 7, 14, and every 4 weeks thereafter. The treatment duration for an individual patient was variable based on when the end of study criteria were met. The maximal duration of treatment for an individual patient was 120 weeks. Neurologic evaluations were performed at baseline, every 3 months during blinded treatment, and at the time of a suspected relapse. Brain MRI scans were performed at baseline, 1 and 2 years.

In Study 1, a total of 927 patients were randomized to receive Kesimpta (n = 465) or teriflunomide (n = 462). Of those randomized to Kesimpta, 90% completed the study; of those randomized to teriflunomide, 81% completed the study. Demographics and disease characteristics were balanced across treatment arms. The mean age was 38 years, 89% were White, and 69% were female. The mean time since MS diagnosis was 5.7 years and the median EDSS score at baseline was 3.0; 60% had been treated with a non-steroid therapy for MS. At baseline, the mean number of relapses in the previous year was 1 and the mean number of T1 GdE lesions on MRI scan was 1.5.

In Study 2, a total of 955 patients were randomized to receive Kesimpta (n = 481) or teriflunomide (n = 474). Of those randomized to Kesimpta, 83% completed the study; of those randomized to teriflunomide, 82% completed the study. Demographics and disease characteristics were balanced across treatment arms. The mean age was 38 years, 87% were White, and 67% were female. The mean time since MS diagnosis was 5.5 years and the median EDSS score at baseline was 2.5; 61% had been treated with a non-steroid therapy for MS. At baseline, the mean



number of relapses in the previous year was 1.3, and the mean number of T1 GdE lesions on MRI scan was 1.6.

In both studies, Kesimpta significantly lowered the annualized relapse rate compared with teriflunomide.

Kesimpta significantly reduced the risk of 3-month confirmed disability progression compared with teriflunomide.

Kesimpta significantly reduced the number of T1 GdE lesions and the rate of new or enlarging T2 lesions in both studies.

HOW SUPPLIED/STORAGE AND HANDLING

How Supplied

Kesimpta (ofatumumab) injection is a preservative-free, clear to slightly opalescent and colorless to slightly brownish yellow solution for subcutaneous administration, which is supplied as follows:

- Kesimpta Sensoready Pen: Carton of one 20 mg/0.4 mL single-dose prefilled Sensoready Pen
- Kesimpta Prefilled Syringe: Carton of one 20 mg/0.4 mL single-dose prefilled syringe

Storage and Handling

Kesimpta Sensoready pens and prefilled syringes must be refrigerated at 2°C to 8°C (36°F to 46°F). Keep the product in the original carton to protect from light until the time of use. Do not freeze. To avoid foaming, do not shake.

Kesimpta is manufactured by Novartis Pharmaceuticals Corporation.

Onureg (azacitidine) tablets, for oral use

INDICATIONS AND USAGE

Onureg is indicated for continued treatment of adult patients with acute myeloid leukemia who achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy and are not able to complete intensive curative therapy.

DOSAGE AND ADMINISTRATION

Important Administration Information

Do not substitute Onureg for intravenous or subcutaneous azacitidine. The indications and dosing regimen for Onureg differ from that of intravenous or subcutaneous azacitidine.

Recommended Dosage

The recommended dosage of Onureg is 300 mg orally once daily with or without food on Days 1 through 14 of each 28-day cycle. Continue Onureg until disease progression or unacceptable toxicity.

Administer an antiemetic 30 minutes before each dose of Onureg for the first 2 cycles. Antiemetic prophylaxis may be omitted after 2 cycles if there has been no nausea and vomiting. If the absolute neutrophil count (ANC) is less than 0.5 Gi/L on Day 1 of a cycle, do not administer Onureg. Delay the start of the cycle until the ANC is 0.5 Gi/L or more.

Instruct patients on the following:

- Do not split, crush, or chew Onureg tablets.
- Take a dose about the same time each day.
- If a dose of Onureg is missed, or not taken at the usual time, take the dose as soon as possible on the same day, and resume the normal schedule the following day. Do not take 2 doses on the same day.
- If a dose is vomited, do not take another dose on the same day. Resume the normal schedule the following day.

Onureg is a hazardous drug. Follow applicable special handling and disposal procedures.

Monitoring and Dosage Modifications for Adverse Reactions

Monitor complete blood count every other week for the first 2 cycles and before the start of each cycle thereafter. Increase monitoring to every other week for the 2 cycles after any dose reduction for myelosuppression. The recommended dosage modifications for adverse reactions are available in the full prescribing information.

CONTRAINDICATIONS

Onureg is contraindicated in patients with known severe hypersensitivity to azacitidine or its components.

WARNINGS AND PRECAUTIONS

Risks of Substitution with Other Azacitidine Products

Because of substantial differences in the pharmacokinetic parameters, the recommended dose and schedule for Onureg are different from those for the intravenous or subcutaneous azacitidine products. Treatment of patients using intravenous or subcutaneous azacitidine at the recommended dosage of Onureg may result in a fatal adverse reaction. Treatment of patients using Onureg at the doses recommended for intravenous or subcutaneous azacitidine may not be effective.

Do not substitute Onureg for intravenous or subcutaneous azacitidine.

Myelosuppression

New or worsening Grade 3 or 4 neutropenia and thrombocytopenia occurred in 49% and 22% of patients who received Onureg, respectively. Febrile neutropenia occurred in 12%. A dose reduction was required for 7% and 2% of patients because of neutropenia and thrombocytopenia, respectively. Less than 1% of patients discontinued Onureg because of either neutropenia or thrombocytopenia. Monitor complete blood counts and modify the dosage as recommended. Provide standard supportive care, including hematopoietic growth factors, if myelosuppression occurs.

Increased Early Mortality in Patients with Myelodysplastic Syndromes

In AZA-MDS-003 (NCT01566695), 216 patients with red blood cell transfusion-dependent anemia and thrombocytopenia due to myelodysplastic syndromes were randomized to Onureg or placebo. One-hundred and seven patients received a median of 5 cycles of Onureg 300 mg daily for 21 days of a 28-day cycle.



Enrollment was discontinued early because of a higher incidence of early fatal and/or serious adverse reactions in patients who received Onureg compared with placebo. The most frequent fatal adverse reaction was sepsis. The safety and effectiveness of Onureg for treatment of myelodysplastic syndromes have not been established. Treatment of patients with myelodysplastic syndromes with Onureg is not recommended outside of controlled trials.

Embryo-Fetal Toxicity

Based on the mechanism of action and findings in animals, Onureg can cause fetal harm when administered to a pregnant woman. Azacitidine administered to pregnant rats via a single intraperitoneal dose less than the recommended human daily dose of oral azacitidine on a mg/m² basis caused fetal death and anomalies. Advise pregnant women of the potential risk to a fetus. Advise females of reproductive potential to use effective contraception during treatment with Onureg and for at least 6 months after the last dose. Advise males with female partners of reproductive potential to use effective contraception during treatment with Onureg and for at least 3 months after the last dose.

ADVERSE REACTIONS

The following clinically significant adverse reactions are described elsewhere in the labeling:

- Myelosuppression

USE IN SPECIFIC POPULATIONS

Pregnancy Risk Summary

Based on its mechanism of action and findings in animals, Onureg can cause fetal harm when administered to a pregnant woman. There are no available data on Onureg use in pregnant women to evaluate for a drug-associated risk. Azacitidine was teratogenic and caused embryo-fetal lethality in animals at doses less than the recommended human daily dose of oral azacitidine on a mg/m² basis. Advise pregnant women of the potential risk to the fetus. The estimated background of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Lactation Risk Summary

There are no data regarding the presence of azacitidine in human milk or the effects on the breastfed child or milk production. Because of the potential for serious adverse reactions in the breastfed child, advise women not to breastfeed during treatment with Onureg and for 1 week after the last dose.

Females and Males of Reproductive Potential

Onureg can cause embryo-fetal harm when administered to pregnant women.

Pregnancy Testing

Pregnancy testing is recommended for females of reproductive potential before starting Onureg.

Contraception

Advise females of reproductive potential to use effective contraception during treatment with Onureg and for at least 6 months after the last dose.

Advise males with female partners of reproductive potential to use effective contraception during treatment with Onureg and for at least 3 months after the last dose.

Infertility

Based on animal data, Onureg may impair male or female fertility.

Pediatric Use

The safety and effectiveness of Onureg in pediatric patients have not been established.

Geriatric Use

Of the 238 patients in QUAZAR (NCT01757535, a multicenter, randomized, double-blind, placebo-controlled study) who received Onureg, 72% were 65 years of age or older, while 12% were 75 years of age or older. No overall differences in safety or effectiveness of Onureg were observed between these patients and younger patients.

Renal Impairment

Monitor patients with severe renal impairment (creatinine clearance [CL_{cr}] 15 to 29 mL/min calculated by Cockcroft-Gault formula) more frequently for adverse reactions and modify the Onureg dosage for adverse reactions. No dose adjustment of Onureg is recommended for patients with mild to severe renal impairment (CL_{cr} 15 to 89 mL/min).

Hepatic Impairment

Onureg has not been studied in patients with preexisting severe hepatic impairment (total bilirubin > 3 × ULN). A recommended dosage of Onureg has not been established for patients with moderate hepatic impairment (total bilirubin > 1.5 to 3 × ULN). No dose adjustment of Onureg is recommended for patients with mild hepatic impairment (total bilirubin ≤ ULN and AST > ULN, or total bilirubin 1 to 1.5 × ULN and any AST).

CLINICAL STUDIES

The efficacy of Onureg was evaluated in QUAZAR. Eligible patients were ages 55 years or older, had AML, and were within 4 months of achieving first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) with intensive induction chemotherapy. Patients may have received consolidation. Patients were excluded if they were candidates for hematopoietic stem cell transplantation at the time of screening.

A total of 472 patients who completed induction with or

[continued on page 34](#)



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

AIDS Res Hum Retroviruses. 2020 Aug 24.doi: 10.1089/AID.2020.0107. Online ahead of print.

[Reasons people living with HIV might prefer oral daily antiretroviral therapy, long-acting formulations, or future HIV remission options](#)

Dube K, Campbell DM, Perry KE, et al.

BACKGROUND: A growing body of research is beginning to elucidate reasons people living with HIV (PLWHIV) might prefer oral daily antiretroviral treatment (ART) compared to emerging long-acting ART (LA-ART) or HIV remission strategies under investigation. Our objective is to provide qualitative insights into the reasons why PLWHIV might prefer one of these HIV control therapies over the others.

METHODS: From May-August 2018, we implemented a semi-structured, cross-sectional survey of PLWHIV in the United States to better understand patient preferences around various HIV treatment and remission options. Using free text, respondents were asked to explain why they preferred one HIV control option over the other two. We analyzed responses to the open-ended survey questions on reasons for preferring oral daily ART versus LA-ART versus HIV remission strategies using conventional content analysis.

RESULTS: The results showed that PLWHIV preferred oral daily ART because of its familiarity and known safety and efficacy profile, while those who preferred LA-ART would value the convenience it offers. Lastly, HIV remission strategies would be preferred to avoid taking ART altogether.

CONCLUSIONS: The qualitative results provide insights into reasons why PLWHIV in the United States might prefer oral daily ART versus novel therapies. More importantly, they provide information to better align HIV virologic control strategies with end-user perspectives. To make informed choices around evolving HIV therapeutics, PLWHIV and HIV care providers would benefit from decision tools to better assess options and trade-offs. More research is needed on how best to effectively support PLWHIV and HIV care providers in shared decision-making.

AIDS. 2020 Aug 10.doi: 10.1097/QAD.0000000000002666. Online ahead of print.

[Characteristics and outcomes of COVID-19 in patients with HIV: a multi-center research network study](#)

Hadi YB, Naqvi SFZ, Kupec JT, et al.

OBJECTIVE: We studied clinical outcomes of COVID-19 infection in patients living with HIV (PLH) in comparison to non-HIV population.

DESIGN: Analysis of a multicenter research network TriNETX was performed including patients >10 years of age diagnosed with COVID-19.

METHODS: Outcomes in COVID-19 positive patients with concurrent HIV (PLH) were compared to a propensity matched cohort of patients without HIV (non-PLH).

RESULTS: 50,167 patients with COVID-19 were identified (49,763 non-PLH, 404 PLH). PLH were more likely to be males, African American, obese, and have concurrent hypertension, diabetes, CKD, and nicotine dependence compared to non-PLH cohort (all p values <0.05). We performed 1:1 matching for BMI, diabetes, hypertension, chronic lung diseases, chronic kidney disease, race, history of nicotine dependence and gender. In unmatched analysis, PLH had higher mortality at 30 days (RR 1.55, 95% CI: 1.01-2.39) and were more likely to need inpatient services (RR 1.83, 95% CI: 1.496-2.24). After propensity score matching, no difference in mortality was noted (RR 1.33, 95% CI: 0.69-2.57). A higher proportion of PLH group needed inpatient services (19.31% vs 11.39%, RR 1.696, 95% CI: 1.21-2.38). Mean CRP, ferritin, ESR and LDH levels after COVID-19 diagnosis were not statistically different and mortality was not different for PLH with history of anti-retroviral treatment.

CONCLUSION: Crude COVID-19 mortality is higher in PLH; however, propensity matched analyses revealed no difference in outcomes, showing that higher mortality is driven by higher burden of comorbidities. Early diagnosis and intensive surveillance are needed to prevent a 'Syndemic' of diseases in this vulnerable cohort.

Am J Cardiol. 2020 Jun 1;125(11):1638-1643.doi: 10.1016/j.amjcard.2020.03.002. Epub 2020 Mar 15.

[Development of a risk score for atrial fibrillation in adults with diabetes mellitus \(from the ACCORD Study\)](#)

Yang P, Zhao Y, Wong ND.

We aimed to develop a novel risk score predicting 5-year atrial fibrillation (AF) risk for diabetes mellitus (DM) patients. We included subjects from the Action to Control Cardiovascular Risk in Diabetes study cohort without AF at baseline. Potential risk factor and demographic predictors were collected at baseline and incident AF was defined from ECG during follow-up. A 5-year risk score for incident AF was developed using Cox regression with internal validation. We studied 9,240 subjects with DM (62% male, mean age 62.6 years) of which 1.8% (n = 165) developed AF over a median follow-up of 4.9 years. Subjects developing AF were more likely male, of white ethnicity and with more obesity and poorer kidney function, but with lower diastolic blood pressure and low density-lipoprotein cholesterol. In the risk prediction model, age, gender, race, body mass index, heart failure, diastolic blood pressure, triglycerides, hemoglobin A1c, duration of DM, serum creatinine and hypertension medication were included as important predictors. The Harrell's C-statistic was 0.79 with excellent internal calibration (goodness-of-fit test p = 0.99 and calibration slope = 1.01). Our risk model may be useful for assess future AF risk in DM patients.

Am J Respir Crit Care Med. 2020 Aug 21. doi: 10.1164/rccm.202006-2309OC. Online ahead of print.

[Aerosol generation from the respiratory tract with various modes of oxygen delivery](#)

Gaeckle NT, Lee J, Park Y, et al.

RATIONALE: Aerosol generation with modes of oxygen therapy such as high flow nasal cannula and non-invasive positive pressure ventilation is a concern for health care workers during the SARS-CoV-2 pandemic. The amount of aerosol generation from the respiratory tract with these various oxygen modalities is unknown.

OBJECTIVES: To measure the size and number concentration of particles and droplets generated from the respiratory tract of humans exposed to various oxygen delivery modalities.

METHODS: 10 healthy participants with no active pulmonary disease were enrolled. Oxygen modalities tested included non-humidified nasal cannula, face mask, heated and humidified high flow nasal cannula, and non-invasive positive pressure ventilation.

Aerosol generation was measured with each oxygen mode while participants performed maneuvers of normal breathing, talking, deep breathing, and coughing. Testing was conducted in a negative pressure room. Particles with a diameter between 0.37 and 20 μm were measured using an aerodynamic particle spectrometer.

MEASUREMENTS AND MAIN RESULTS: Median particle concentration ranged from 0.041 to 0.168 particles/cm³. Median diameter ranged from 1.01 to 1.53 μm . Cough significantly increased the number of particles measured. Measured aerosol concentration did not significantly increase with the use of either humidified high flow nasal cannula or non-invasive positive pressure ventilation. This was the case during normal breathing, talking, deep breathing, and coughing.

CONCLUSIONS: Oxygen delivery modalities of humidified high flow nasal cannula and non-invasive positive pressure ventilation do not increase aerosol generation from the respiratory tract in healthy human participants with no active pulmonary disease measured in a negative pressure room. This article is open access and distributed under the terms of the [Creative Commons Attribution Non-Commercial No Derivatives License 4.0](#).

Hypertension. 2020 Aug 24;HYPERTENSIONAHA12015205. doi: 10.1161/HYPERTENSIONAHA.120.15205.

Online ahead of print.

[Pathophysiology of diuretic resistance and its implications for the management of chronic heart failure](#)

Wilcox CS, Testani JM, Pitt B.

Diuretic resistance implies a failure to increase fluid and sodium (Na⁺) output sufficiently to relieve volume overload, edema, or congestion, despite escalating doses of a loop diuretic to a ceiling level (80 mg of furosemide once or twice daily or greater in those with reduced glomerular filtration rate or heart failure). It is a major cause of recurrent hospitalizations in patients with chronic heart failure and predicts death but is difficult to diagnose unequivocally. Pharmacokinetic mechanisms include the low and variable bioavailability of furosemide and the short duration of all loop diuretics that provides time for the kidneys to restore diuretic-induced Na⁺ losses between doses. Pathophysiological mechanisms of diuretic resistance include an inappropriately high daily salt intake that exceeds the acute diuretic-induced salt loss, hyponatremia or hypokalemic, hypochloremic metabolic alkalosis, and reflex activation of the renal nerves. Nephron mechanisms include tubular tolerance that can develop even during the time that the renal tubules are exposed to

a single dose of diuretic, or enhanced reabsorption in the proximal tubule that limits delivery to the loop, or an adaptive increase in reabsorption in the downstream distal tubule and collecting ducts that offsets ongoing blockade of Na⁺ reabsorption in the loop of Henle. These provide rationales for novel strategies including the concurrent use of diuretics that block these nephron segments and even sequential nephron blockade with multiple diuretics and aquaretics combined in severely diuretic-resistant patients with heart failure.

Hypertension. 2020 Aug 24;HYPERTENSIONAHA12015300. doi: 10.1161/HYPERTENSIONAHA.120.15300.

Online ahead of print.

[Effects of intensive versus standard office-based hypertension treatment strategy on white-coat effect and masked uncontrolled hypertension: from the SPRINT ABPM Ancillary Study](#)

Ghazi L, Cohen LP, Munter P, et al.

Guidelines recommend using out-of-office blood pressure (BP) measurements to confirm the diagnoses of hypertension and in the titration of antihypertensive medication. The prevalence of out-of-office BP phenotypes for an office systolic/diastolic BP goal <140/90 mm Hg has been reported. However, the prevalence of these phenotypes when targeting an office systolic/diastolic BP goal <120/80 is unknown. The SPRINT (Systolic Blood Pressure Intervention Trial) Ambulatory BP Ancillary study evaluated out-of-office BP using ambulatory BP monitoring in 897 participants 27 months after randomization to intensive versus standard BP targets (office systolic BP <120 versus <140 mm Hg). We used office and daytime BP to assess the proportion of participants with white-coat effect (standard target: office BP \geq 140/90 mm Hg and daytime BP <135/85 mm Hg versus intensive target: office BP \geq 120/80 mm Hg and daytime BP <120/80 mm Hg) and masked uncontrolled hypertension (standard target: office BP <140/90 mm Hg and daytime BP \geq 135/85 mm Hg versus intensive target: office BP <120/80 mm Hg and daytime BP \geq 120/80 mm Hg) in each treatment arm. The prevalence of white-coat effect and masked uncontrolled hypertension was 9% and 34%, in both treatment groups. Among participants with uncontrolled office BP, white-coat effect was present in 20% and 23% in the intensive and standard groups, respectively. Among participants with controlled office BP, masked uncontrolled hypertension was present in 62% and 56% in the intensive and standard groups, respectively. In conclusion, a more intensive BP target resulted in a similar proportion of patients with white-coat effect and masked uncontrolled hypertension compared with a standard target.

Circ Heart Fail. 2020 Apr;13(4):e006666. doi: 10.1161/CIRCHEARTFAILURE.119.006666. Epub 2020 Apr 8.

[Clinical outcomes and quality of life with an ambulatory counterpulsation pump in advanced heart failure patients: results of the Multicenter Feasibility Trial](#)

Uriel N, Jeeyanandam V, Imamura T, et al.

BACKGROUND: The NuPulseCV intravascular ventricular assist system (iVAS) provides extended duration ambulatory counterpulsation via a durable pump placed through the distal subclavian artery.

METHODS: We performed a prospective, single-arm, multicenter, US Food and Drug Administration-approved feasibility trial of iVAS therapy as a bridge to transplant or decision following the FIH (First-In-Human) trial.

RESULTS: Forty-seven patients were enrolled, and 45 patients (median 61 years old, 37 males, and 30 listed on United Network of Organ Sharing) received iVAS support for median 44 (25-87) days. There were no intraoperative complications. Success was defined as survival or transplant on iVAS therapy free from disabling stroke. Outcome success at 30 days (the primary end point of this study) and at 6 months was 89% and 80%, respectively. During 6 months of iVAS support, 2 patients died and 2 patients experienced disabling neurological dysfunction. Six-minute walk distance, 2-minute step test, and Kansas City Cardiomyopathy Questionnaire score improved during 4-week iVAS support.

CONCLUSIONS: This feasibility trial demonstrated promising short-term outcomes of iVAS therapy with improved functional capacity and quality of life during the therapy

Chest. 2020 Aug 21;S0012-3692(20)34274-4. doi: 10.1016/j.chest.2020.08.2053. Online ahead of print.

[Computed tomography imaging and comorbidities in chronic obstructive pulmonary disease: beyond lung cancer screening](#)

Singhvi D, Bon J.

Comorbidities significantly contribute to morbidity, mortality, and health care costs in individuals with chronic obstructive pulmonary disease (COPD). Comorbidity prevalence does not always correlate with lung disease severity and the elevated risk of certain comorbidities is often independent of shared risk factors such as tobacco burden. While COPD management guidelines recognize the importance of identifying and treating comorbidities as part of

the comprehensive management of COPD patients, little guidance is provided regarding best screening practices. Whereas universal comorbidity screening in COPD patients is likely not cost-effective, targeted early screening and treatment in those at highest risk may have a significant impact on COPD outcomes. Recent studies suggest that certain radiographic features on thoracic imaging may serve as surrogate markers of comorbidity in patients with COPD. This review evaluates these studies in the context of the growing availability of chest CT scans in the lung cancer screening era and discusses how chest CT imaging can be leveraged to identify those COPD patients at highest risk for comorbid disease.

Lung Cancer. 2020 Aug 7;148:79-85. doi: 10.1016/j.lungcan.2020.07.036. Online ahead of print.

[Improving identification of candidates for lung cancer screening in a high risk population](#)

Waddle MR, Ko SJ, May J, et al.

BACKGROUND: Low dose computerized tomography (LDCT) has been shown to reduce lung cancer specific mortality by 20%. Despite U.S. Preventive Services Task Force (USPSTF) endorsement, screening of appropriate patients in the U.S. remains low, at 1.9%. The goal of this study was to assess the number and type of patients that would qualify for lung cancer screening based upon recommendations by various guidelines.

METHODS: We prospectively collected a patient reported questionnaire, including smoking history, family history, exposure history, and demographics, from April–October 2017 from new consults in the Department of Radiation Oncology and Otolaryngology (ORL). Patients smoking status and patient factors were collected and reported. Patients qualifying for screening by USPSTF, the National Comprehensive Cancer Network (NCCN), and Tammemagi scoring criteria were identified. Multivariate analysis assessed the factors associated with positive criteria for screening and the sensitivity of each criterion was calculated.

RESULTS: There were 546 new consults during the study period and 528 successfully completed the questionnaire. A total of 104/528 (20%) patients who completed questionnaires qualified for screening based on any guideline. After exclusion of active lung cancer (n = 19), poor prognosis (n = 24), and CT as part of surveillance (n = 16), 45 (8.5%) patients would require LDCT. Of the entire population, 10%, 11% and 18% of patients qualified based on USPSTF, NCCN, and Tammemagi, which was reduced to 4.9%, 5.3%, and 7.8%, respectively after exclusions. Patients with head and neck cancer (40%), skin cancer (27%), and prostate

cancer (11%) accounted for the majority of patients eligible for screening after exclusions. The sensitivity of the USPSTF, NCCN, and Tammemagi criteria in patients with a diagnosis of lung cancer (n = 26) was 38.5% (CI95 20.2%-59.4%), 46.2% (CI95 26.6%-66.6%), and 61.5% (CI95 40.6%-79.8%), respectively.

CONCLUSIONS: We successfully identified 9% of an oncology population at consultation who could benefit from lung cancer screening in survivorship. Distribution of a written or electronic questionnaire at consultation is a simple, low cost, effective method of identifying patients who would benefit from LDCT.

Am J Nephrol. 2019;50(1):48-54. doi:10.1159/000500706. Epub 2019 Jun 5.

[Albuminuria testing by race and ethnicity among patients with hypertension with and without diabetes](#)

Lee J, Chu C, Guzman D, et al.

BACKGROUND: Detection of chronic kidney disease (CKD) with urine albumin-to-creatinine ratio (UACR) among patients with hypertension (HTN) provides an opportunity for early treatment, potentially mitigating risk of CKD progression and cardiovascular complications. Differences in UACR testing patterns among racial/ethnic populations at risk for CKD could contribute to known disparities in CKD complications.

METHODS: We examined the prevalence of UACR testing among low-income adult primary care patients with HTN, defined by a new administrative code for HTN or 2 clinic blood pressures >140/90 mm Hg between January 1, 2014, and January 1, 2017, in one public health-care delivery system with a high prevalence of end-stage kidney disease among race/ethnic minorities. Logistic regression was used to identify odds of UACR testing within 1 year of an HTN diagnosis, overall, and by racial/ethnic subgroup, adjusted for demographic factors, estimated glomerular filtration rate, and HTN severity. Models were also stratified by diabetes status.

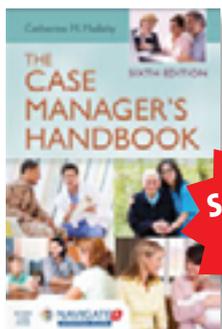
RESULTS: The cohort (n = 16,414) was racially/ethnically diverse (16% White, 21% Black, 34% Asian, 19% Hispanic, and 10% other) and 51% female. Only 35% of patients had UACR testing within 1 year of an HTN diagnosis. Among individuals without diabetes, odds of UACR testing were higher among Asians, Blacks, and Other subgroups compared to Whites (adjusted OR [aOR] 1.19; 95% CI 1.00-1.42 for Blacks; aOR 1.33; 1.13-1.56 for Asians; aOR 1.30; 1.04-1.60 for Other) but were not significantly different between Hispanics and Whites (aOR 1.17; 0.97-1.39). Among individuals with diabetes, only Asians had higher odds of UACR testing



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compared to Whites (aOR 1.35; 1.12-1.63).

CONCLUSIONS: Prevalence of UACR testing among low-income patients with HTN is low in one public health-care delivery system, with higher odds of UACR testing among racial/ethnic minority subgroups compared to Whites without diabetes and similar odds among those with diabetes. If generalizable, less albuminuria testing may not explain higher prevalence of kidney failure in racial/ethnic minorities.

Ann Surg Oncol. 2020 Aug 25. doi: 10.1245/s10434-020-09049-6. Online ahead of print.

Association of living in urban food deserts with mortality from breast and colorectal cancer

Fong AJ, Lafaro K, Ituarte PHG, et al.

BACKGROUND: Food deserts are neighborhoods with low access to healthy foods and are associated with poor health metrics. We investigated association of food desert residence and cancer outcomes.

METHODS: In this population-based study, data from the 2000-2012 California Cancer Registry was used to identify patients with stage II/III breast or colorectal cancer. Patient residence at time of diagnosis was linked by census tract to food desert using the USDA Food Access Research Atlas. Treatment and outcomes were compared by food desert residential status.

RESULTS: Among 64,987 female breast cancer patients identified, 66.8% were <65 years old, and 5.7% resided in food deserts. Five-year survival for food desert residents was 78% compared with 80% for non-desert residents ($p < 0.0001$). Among 48,666 colorectal cancer patients identified, 50.4% were female, 39% were >65 years old, and 6.4% resided in food deserts. Five-year survival for food desert residents was 60% compared with 64% for non-desert residents ($p < 0.001$). Living in food deserts was significantly associated with diabetes, tobacco use, poor insurance coverage, and low socioeconomic status ($p < 0.05$) for both cancers. There was no significant difference in rates of surgery or chemotherapy by food desert residential status for either diagnosis. Multivariable analyses showed that food desert residence was associated with higher mortality.

CONCLUSION: Survival, despite treatment for stage II/III breast and colorectal cancers was worse for those living in food deserts. This association remained significant without differences in use of surgery or chemotherapy, suggesting factors other than differential care access may link food desert residence and cancer outcomes.

J Hepatol. 2020 Aug 19;S0168-8278(20)30547-X. doi: 10.1016/j.jhep.2020.08.017. Online ahead of print.

Simultaneous splenectomy improves outcomes after adult living donor liver transplantation

Yoshizumi T, Itoh S, Shimokawa M, et al.

BACKGROUND AIMS: Small-for-size graft (SFSG) syndrome is a main causes of graft loss in living donor liver transplantation (LDLT). Splenectomy (Spx) is an option to prevent this catastrophic complication, but its effect remains controversial. To date, there has been no prospective randomized study to clarify the impact of Spx. The aim of this study was to compare graft function and long-term outcomes of Spx with no portal flow modulation during LDLT between two matched groups.

METHODS: Three hundred and twenty patients were divided into two groups: with Spx ($n=258$) and without Spx ($n=62$). To overcome selection bias, one-to-one matching using propensity score matching (PSM) was performed ($n=50$, in each group)

RESULTS: Recipients with simultaneous Spx showed better graft function on post-operative-day (POD) 7, 14 and lower sepsis frequency within 6 months after LDLT, and better graft survival rates compared with those without Spx before matching. After PSM, recipients with simultaneous Spx showed lower early graft dysfunction frequency on POD 7 ($p=0.04$), lower SFSG syndrome frequency ($p=0.01$), lower serum total bilirubin levels ($p=0.001$), and lower international normalized ratio ($p=0.004$) on POD 14, lower sepsis ($p=0.02$) frequency within 6 months after LDLT, and better graft survival rates ($p=0.04$) compared with those without Spx. Univariate analysis revealed that without Spx (hazard ratio=3.06, 95% confidence intervals:1.07 - 11.0, $p=0.037$) was the only risk factor for graft loss after LDLT.

CONCLUSIONS: Simultaneous Spx may prevent SFSG syndrome and is a predictive factor for graft survival after LDLT. Simultaneous Spx is recommended when a small graft (GW/SLW 35% or less) is predicted preoperatively, or for patients with portal hypertension or high portal pressure (above 20 mm Hg) after reperfusion in LDLT. ■

How Remote Working Opens Doors for People with Disabilities

[continued from page 7](#)

As [research](#) has shown, there are many benefits to hiring people with disabilities, such as improved profitability, lower turnover, greater loyalty, and increased employee reliability. Employees with disabilities

it may not matter when it's performed.

Consider the example of someone with severe physical limitations who needs an attendant to help with activities of daily living such as dressing. Getting ready for work in the morning can, by itself, be physically taxing. When coupled with a commute with accessibility challenges, reporting to a work environment every day could

To capture such possibilities, case managers need to become aware of our biases and ingrained thinking. If we come in with low expectations, what does that do for our clients for whom we advocate? It's our ethical obligation to be open to and explore a wide range of possibilities, to encourage our clients, and, whenever possible, to help facilitate them.

For people with disabilities, greater acceptance of remote working and improved technology open the door to more opportunities to seek employment or return to work after a life-altering injury or illness. The result would be a more diverse and inclusive workforce, which carries widespread benefits from more significant innovation to more empathy and acceptance.

are no different than other employees: having employment opportunities and responsibilities lead to improved quality of life, enhanced self-confidence, and a sense of community.

Pursuing these positive outcomes can be life changing for people with disabilities. For example, someone with chronic fatigue syndrome or another medical condition that requires periodic rest may find it challenging to spend the entire workday in an office environment. Working from home offers positive alternatives, such as being active in the morning and later in the day, with a rest in between. As long as the required work is completed,

be prohibitive. Working from home may be a solution. Virtual work allows more individuals with disabilities to become contributing members of society (while also receiving other benefits to which they are entitled to pay for care and other resources).

Case managers and disability managers need to think more broadly. Just because a particular diagnosis or the presence of severe disability was an obstacle in the past does not automatically mean that this severe disability is an obstacle in today's world given current technology and acceptability of work-from-home arrangements.

There will always be obstacles, but technology and the success of widespread remote working during the pandemic have created a shift in thinking. For people with disabilities, this should lead to more possibilities and opportunities to pursue. 

Patty Nunez, MA, CRC, CDMS, CCM, is a Commissioner of the Commission for Case Manager Certification, a nationally accredited organization that certifies more than 46,000 certified case managers (CCMs) and 2,600 certified disability management specialists (CDMSs). Patty is a director within the Claim Supply Management office of CNA and is based in Orange County, California.

What Ethical Principles Mean

[continued from page 6](#)

While ethical principles apply to every aspect of case management practice, they are especially important when it comes to decision making. Being able to make a decision raises the issue of capacity, which is a determination by a clinician about the ability of an individual to weigh

various options as they make decisions and to understand the information and the implications of their decisions. Capacity is issue-specific, and an individual can be determined to have the capacity to make some decisions but not others. For example, an individual could be identified as having the capacity to sign an advance directive while, at the same time, not having the capacity to understand the

benefits and risks to sign a consent for surgery.

It is the case manager's duty and obligation to ensure that individuals are given every opportunity to make autonomous decisions for themselves when they are able. To carry out this responsibility, case managers need to understand the principles of ethical practice as defined by the Code and to refer to them frequently. 



PharmaFacts for Case Managers

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without consolidation therapy were randomized 1:1 to receive Onureg 300 mg (n=238) or placebo (n=234) orally on Days 1 through 14 of each 28-day cycle. Randomization was stratified by age at time of induction therapy (55 to 64 vs. \geq 65 years), cytogenetic risk category at time of induction therapy (intermediate risk vs. poor risk), history of MDS/CMML (yes vs. no), and received consolidation therapy following induction therapy (yes vs. no).

The efficacy of Onureg was established on the basis of overall survival (OS). The trial demonstrated a statistically significant improvement in OS for patients randomized to Onureg compared to placebo. A subgroup analysis showed consistency in the OS benefit for patients in either CR or CRi.

HOW SUPPLIED/STORAGE AND HANDLING

How Supplied

Onureg tablets are available as:

- 200 mg: pink, oval, film-coated tablets with debossed “200” on one side and “ONU” on the other side.
- 300 mg: brown, oval, film-coated tablets with debossed “300” on one side and “ONU” on the other side.

Storage

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

Keep bottle tightly closed. Store and dispense in the original bottle (with two desiccant canisters).

Handling and Disposal

Onureg is a hazardous drug. Follow applicable special handling and disposal procedures. If powder comes in contact with skin, immediately and thoroughly wash with soap and water. If powder comes in contact with mucous membranes, immediately flush the area with water.

Onureg is manufactured by the Celgene Corporation, A Wholly Owned Subsidiary of Bristol-Myers Squibb.

Please see product insert for full prescribing information on all medications.

COVID-19? Care Management to the Rescue! *continued from page 9*

disability benefits is the beginning of financial devastation for many COVID patients. Patients who discuss their symptoms with the RN CM and who should be focused on recovery are often dealing with the stress of financial ruin as well as grief and loss. The social workers connected our patients and families to chaplain services for those who needed help processing grief and loss. They spent hours helping patients to apply for SNAP benefits to address their hunger and determining how to tap into CARES funds.

One of the most powerful patient stories is that of a gentleman who was enrolled in our program for several days. After speaking with the RN CM twice daily, his condition worsened. He was admitted to the intensive care unit because of COVID-19 and died. He had two minor children, and his wife never worked outside of the home. His wife was uncertain how to navigate life after her husband died. Our social

worker provided support to the family for weeks after the patient died. She connected them with food donations centers before helping them apply and get approval for SNAP benefits. The City of Ft. Worth helped with rent for 3 months, which allowed the family time to begin processing their grief and planning for their future without their husband and father. This process wasn't easy and it was time consuming, but it separated us from other case management programs.

Did the OPCM COVID Home Monitoring program wean patients off oxygen as it was originally designed and conserve hospital bed capacity? Yes, but what we have done and continue to do is far more than that. We help patients become whole again. We don't just identify issues, document them, and move on; we identify the need and determine how to meet that need because that is what we do as a care management team—RN CMs and social workers together!

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Podcast: <https://directory.libsyn.com/episode/index/show/jpshealthnetwork/id/16103561>

CE I Attachment Theory for Case Managers

continued from page 15

or lower than average. Any event that requires extra energy to maintain balance in the mental and physical system detracts from the amount of available energy. For a person who is ill or distressed, any resolution of insecure attachment issues means more energy is available to fight illness and maintain health.

Summary and Recommendations

Case management is both mental and physical; the mind and body are integrally related.¹⁷ This is a basis for case managers to become knowledgeable about attachment theory and use it when developing care plans. In this article on attachment theory, attachment styles and working models were described. The case manager as a care provider was identified as a potential attachment figure for clients. This phenomenon may be significant in case planning because a patient may learn through this positive attachment relationship that changes in working models are possible. Changing working models through rethinking and relearning the errors in assumptions that followed difficult emotional experiences can result in a changed perspective that results in learning a secure attachment style.

Suggestions were provided for case managers to interact with recipients of service. They focused on observations of behavior for an accurate assessment of a client's attachment style. Reflective listening and validation were suggested techniques that could be used in interactions with clients so they can learn a secure attachment style.

Attachment theory should be a part of case management education curricula. A specific course that explores attachment theory in depth and how to use it in interactions with clients should be offered. For a case manager who is already practicing, continuing education in attachment theory is available at several universities. A consultant who specializes in attachment theory may be employed by case management agencies to provide education and to monitor applying the theory.

Case managers need to be aware that they can become attachment figures. This is an important social position. The social role behaviors of the position have mental and physical components

as knowledge of each are part of a management care plan. With this knowledge, case managers have the potential to provide a service that may result in improved delivery of care, recovery from illness or distress, and improved general health. **CE I**

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IV. Outcome Measurement & Program Improvement

Virtually all comprehensive case management programs are interested in measuring participating patient outcomes. This is less crucial for case management programs that have a more specific focus, eg, discharge management, health care counseling, or patient navigation. These narrowly focused case management programs typically are less concerned with measuring the overall health improvement of the patient. In these models, outcomes are either not generally expected or are very focused, based on the published literature. However, in more-comprehensive programs that typically address the needs of patients with health complexity, the case manager is more interested in the outcomes of their patients in a holistic way and across different treatment settings as opposed to focusing narrowly on their use of such things as emergency department services or readmission rates. Documenting patient-centered “big picture” goals as illustrated in Table 5 is an important component of engaging patients in an outcome-oriented VB-ICM and progress-monitoring process.

By developing the methodology to document these big picture outcomes while capturing data points in useable worksheets, an analyzable database can be created. The data should demonstrate where and how a specific VB-ICM program or a set of interventions impacts the care of individuals with health complexity along the path to improved health, lower cost, and a better life.

Discussion

A well implemented and well managed comprehensive VB-ICM program, as defined above, could help achieve the quadruple aim²⁵ of improving care, decreasing cost, and providing a better experience for the patients involved as well as supporting more purpose and joy in work for VB-ICM managers and other providers of care. **CE II**

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Canaries in the Coal Mine

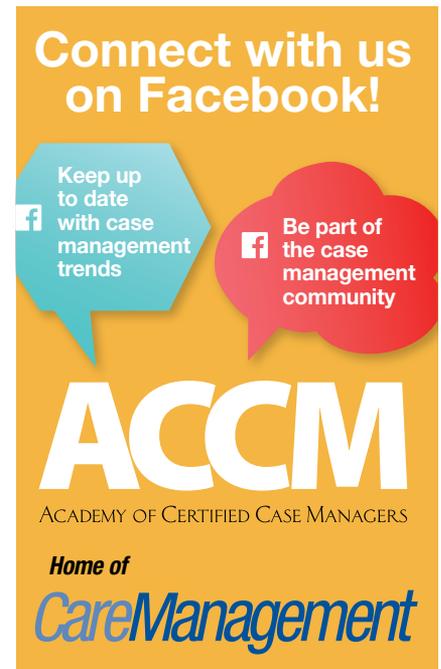
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Our CMSA network can help you discover new strategies to improve your practice and your resiliency. It is important to remember that the essential components of resiliency are self-kindness, common humanity, and mindfulness.¹⁰ We might equate it to “paying it forward” by taking care of ourselves and supporting the needs of others.

Throughout history, infectious diseases have wreaked havoc on our global community. Before the professional role of case management was established, clinicians had to develop and implement strategies to appropriately place individuals with an infectious disease. Today, case managers have an important role of helping us navigate through this storm. **CM**

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