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By Bert Burns and Lisa Wells; Leslie Burke, BSN, RN, CRRN; and Colleen Fulton, MSPT




When Bert Burns suffered a spinal cord injury (SCI) in his 20s, he was able to realize dreams that he never would have before being injured. With the help of his case managers and other medical professionals, Bert became a gold-medal winning wheelchair athlete, a husband and father of two, the founder of UroMed, one of the largest urology medical supply companies in the country, and a motivational speaker for a program called Life After Spinal Cord Injury. Hear from Bert and case managers what it takes to prosper after a traumatic injury and how case managers can provide the best support to patients.

12 Case Management for People Living with HIV/AIDS

By Carolyn Ross-Friend, RN, MHA, ACRN, CCM; Alyson Schuster, MPH, MBA; and Melissa Sherry, BS

Case management for HIV/AIDS patients is unique because of the complicated nature of the disease itself, as well as the many comorbidities and social problems that often coexist. Case managers at Johns Hopkins Healthcare LLC require the patient to take an active role in care planning and goal setting. The role of the case manager includes education, advocacy, and removal of barriers so the patient can navigate the health care system and use services appropriately. Sharing several case studies as illustrations, the authors outline complex problems, interventions, and outcomes involved in helping patients take control of their health.

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Gary S. Wolfe

Patient Adherence: A Challenge for the Case Manager

A recent report by the World Health Organization revealed that 50% of patients with chronic diseases in developed countries do not take their medications as prescribed. Poor medication adherence leads to increasingly poor health outcomes for patients and has a significant negative economic impact on health care resources. Another study by Express Scripts, an independent prescription-filling company, reports that Americans may waste as much as \$258 billion a year in health care costs by not taking prescribed medications because of missed doses that lead to emergency department visits, increased physicians' visits, and in-patient hospitalization. A similar study conducted by Harvard University and Brigham and Women's Hospital cited \$290 billion in waste due to not taking medications as prescribed. Poor adherence is a major contributor to preventable deaths and reduced quality of life. Researchers also found that more than half of people who believe they are taking their medications properly are not. The problem of poor patient adherence has been extensively researched, but the rates of nonadherence have not changed much in the past three decades.

Medications don't work if patients don't take them, and people often don't take them the way they are supposed to. There are many reasons people don't take their medications: they forget to refill their prescriptions, forget to take them, feel they don't need them, or find them too expensive. These are some of the challenges case managers must deal with daily. The case manager plays a unique and important role in assisting patients' healthy behavior changes.

An adherence model should incorporate the following three categories:

Information: Many patients are incapable of understanding the health

information they receive. Communicate effectively with patients. Listen to patients and give them full attention. Build trust and encourage patients to participate in decision making and be partners in their own health care. To be adherent, patients must be engaged in the process.

Motivation: Patients only follow treatments they believe in. Motivating patients to follow treatment recommendations is important. Patients' understanding of their condition and treatments is positively related to adherence; adherence, satisfaction, recall, and understanding are all related to the amount and type of information given. Help patients to believe in the efficacy of their treatment. Elicit, listen to, and discuss any negative attitudes toward treatment. Determine the role of the patient's social system in supporting or contradicting elements of the regimen. Help patients commit to adherence and believe that they are capable of following their treatment regimen. Be aware of and sensitive to patient's cultural beliefs and practices, and view treatment through a cultural lens to make sure that recommendations do not conflict with cultural norms.

Strategy: Concrete barriers, such as the cost of medications, mental health issues, and complex treatment regimens, represent a common set of obstacles to adherence. Patients need a workable strategy to follow treatment recommendations. Identify resources to provide financial aid or discounts. Identify individuals who can provide concrete assistance. Provide written instructions and reminders. Have patients sign a behavioral contract. Offer links to support groups. Provide electronic reminders or follow-up phone calls. Simplify the pill regimen.

There must be ongoing evaluation of patient adherence. Doctors uniformly

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State Agency Discovers Many Benefits to In-house Employment Services

For several years, the Tennessee Division of Rehabilitation Services (TN DRS) contracted with community rehabilitation providers for job placement services for job seekers with disabilities. Originally, outsourcing this service was believed to be a cost-savings measure. However, after TN DRS spent millions of dollars on contracted services with unsatisfactory results, agency staff members agreed to bring employment services back in house. In 2005, TN DRS formed a committee to determine how best to return employment services to the agency. Representatives from the East Tennessee Rehabilitation Network (ETRN), who served on the committee, volunteered to initiate a pilot project to determine if they could effect change to clients by providing employment services in their catchment area. With that move, the Project Employment by Team Effort—or PETE for short—was born.

PETE

The first step in the project was to form a regional employment team comprising ETRN staff members and others. Until then, employment efforts rarely involved sharing resources across county lines. PETE members agreed early on that a goal of the project was to share job leads, candidates, and other resources in a multi-county region for the purpose of expanding opportunities and areas of influence. To share information across county lines, employment team members developed a database that PETE members could access on the state's network. Essential components in building the PETE database included:

- A job-ready candidate pool

- Information about area employers
- A query to match candidates with employers

Using the database, ETRN employment counselors could search for job-ready candidates by areas of vocational interest. When job candidates spoke to their employment counselor about a particular company, the counselor could access information specific to that employer and determine if an ETRN staff member had an existing relationship with the employer to enable a single point of contact.

Mobile Services

Another initiative of PETE included mobile services to isolated areas not previously served. Employment team members traveled to rural locations and conducted mobile job-readiness assessments and training with clients there. An Eat Lunch with an Employer Series (Eat LES) was developed to educate referring vocational rehabilitation counselors about the dual customer model—clients and employers. Each month, agency staff members were invited to hear the perspective of an employer in a different industry, including health care, manufacturing, and retail. Over a brown-bag lunch, an employer presented its hiring needs, hiring preferences, and the qualifications it seeks in job candidates. Business needs, based on the needs of employers, would have to be met if the agency was to be successful in assisting persons with disabilities in going to work.

Standard Operating Procedures

As the PETE project progressed, a need became evident to identify standard operating procedures, including a description of each stakeholder's role

in the employment process—job seeker, referring counselor, employment counselor, and employer. An operating procedure protocol was developed with input from all parties affected by the project. Training was then conducted with agency staff. Within a year, the pilot project was producing results not matched in other parts of the state. Indeed, regions of the state that were involved in PETE have led the state in successful employment outcomes for four out of the past five years. The byproducts of the PETE program have been positive. For example:

- The Rehabilitation Services Administration established a master's degree in rehabilitation counseling as a professional standard for vocational rehabilitation counselors in state agencies. In the PETE catchment area, 74% of professional staff members meet the national standard, compared to 45% in TN DRS overall.
- When TN DRS received a grant to provide Spanish in the workplace, all members of the PETE employment team volunteered to complete a semester of Spanish language classes to help expand services to the state's underserved Latino population.

The best way to help individuals with disabilities achieve employment is to remove all barriers within the agency by pooling resources, knowledge, and talent. The strength of PETE has been the teamwork that the project fostered. PETE continues to grow and has proved itself as a national model of promising practices. **CM**

For more information, contact Michele Keffer, Tennessee Rehabilitation Center, at (423) 639-5148 or Michele.Keffer@tn.gov.

Encouraging Face-to-Face Encounters With Home Health Patients

By Elizabeth E. Hogue, Esq.

Section 6407 of the Affordable Care Act (ACA) requires a face-to-face encounter between patients and their physicians for certification of eligibility for Medicare home health services. Certifying physicians must document that they or nonphysician practitioners working with physicians have seen patients. The encounter must occur within 90 days prior to the start of home care services or within 30 days after the start of home care. Documentation of encounters must be present on certifications for patients that begin on or after January 1, 2011. The Centers for Medicare & Medicaid Services (CMS) informed agencies that they would not enforce these requirements until April 1, 2011. CMS has addressed the issue of the role of discharge planners/case managers in Frequently Asked Questions (FAQs).

First, the FAQs seem to allow discharge planners/case managers to extract information from physicians' own medical record entries to complete the required documentation. These entries must include how the patients' clinical condition, as seen during encounters with the patient, supports homebound status and the need for skilled care.

In addition, the FAQs clearly state that hospitalists, even though they may not supervise home health services after discharge, may document their encounters with patients that meet applicable requirements. Guidance

Elizabeth E. Hogue is a health care attorney and consultant in Washington, DC.

from CMS thus far seems to permit discharge planners/case managers to assist hospitalists with the completion of documentation of their encounters that meet applicable requirements. By the same token, CMS has emphatically stated that home health agency staff may not complete documentation or even assist physicians to complete it.

Anecdotally, it appears that some discharge planners/case managers do not understand that all Medicare-certified home health agencies must ensure that the encounters and documentation described above are completed as required. Consequently, they may have told agencies that inform them of these requirements that they will not receive referrals based on their perception that these agencies are imposing something that is not required by all agencies or that is required of those agencies only.

Commitment to Quality Care

The key question may be: Why should discharge planners/case managers assist home health agencies to ensure that face-to-face requirements are met?

First, patients who do not have face-to-face encounters, preferably prior to admission, cannot receive home health services. Discharge planners/case managers are deeply committed to quality care for all patients. Appropriate post-acute care, including home care services, is essential to quality patient care. Based on their commitment, case managers/discharge planners have a vested interest in making sure that patients receive home health services.

In addition, although it is a cliché, patients are certainly going home "quicker and sicker." Case managers/discharge planners have potential liability for inappropriate or premature discharges from hospitals. An effective way to manage this risk is to help ensure that patients get home care services.

Case managers/discharge planners also have an obligation under revised National Standards of Practice for case managers published by the Case Management Society of America (CMSA) in 2010 to assist with face-to-face encounters. One of the overarching requirements of these Standards is "Focusing on transitions of care, which includes a complete transfer to the next care setting provider that is effective, safe, timely and effective."

In addition, case managers/discharge planners must demonstrate compliance with H. Standard: Facilitation, Coordination and Collaboration Through Evidence of Transitions of Care.

A transfer of care, includes:

- A transfer to the most appropriate health care provider/setting
- The transfer is appropriate, timely, and *complete*.
- Documentation of collaboration and communication with other health care professionals, especially during each transition to another level of care within or outside of the client's current setting.

State Boards of Nursing will certainly apply these national standards of care to any allegations of

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**Congratulations to the winners of the CCMC/ACCM "Get a Candidate" contest!
The winners are Grace Davenport-Bishop and Sandra Edwards, both from Kingsport, TN.**

Commission for Case Manager Certification Unveils Knowledge Framework to Advance Policy and Workforce Development

Framework is foundational to the Commission's Case Management Body of Knowledge™

The Commission for Case Manager Certification (the Commission) today unveiled a Case Management Knowledge Framework that all partners in health care quality may freely use. It is designed to help them identify training needs of professional case managers as they take expanded roles in new models of care. The announcement was made in light of the critical role care coordination plays in accountable care organizations, medical homes and other advanced primary care models.

The Centers for Medicare & Medicaid Service's March 31 release of the proposed rule for accountable care organizations (ACOs) identified care coordination as one of five domains for quality measures required in the new model. The April 11 Department of Health and Human Services announcement of the new Partnership for Patient Safety initiative introduced new funding for hospital-based patient transition programs with the goal of reducing hospitalizations by 20% over 3 years.

The Commission for Case Manager Certification (www.ccmcertification.org) is the first and largest nationally accredited organization that has certified more than 30,000 professional case managers. The Commission is a nonprofit, volunteer organization that oversees the process of case manager certification with its CCM® credential. The Commission is positioned as the most active and prestigious certification organization supporting the case management.

CMS' Innovation Center, in coordination with the Federal Coordinated Health Care Office, announced April 14 that 15 states will receive \$1 million each to participate in the State Demonstrations to Integrate Care for Dual Eligible Individuals. The intent of this initiative is to develop person-centered models of care that fully coordinate primary, acute, behavioral, and long-term supports and services for dual-eligible patients. Case management plays a critical role in achieving these goals and is called for as a tool to both lower costs and improve patient care.

"The Case Management Knowledge Framework is an important contribution to both the health care policy community and those organizations that represent the professional case manager," said Annette C. Watson, RN-BC, CCM, MBA, the Commission's chair. "The Knowledge Framework will allow organizations like the Case Management Society of America, the National Social Workers Association, community health organizations, primary care groups and academic leadership to create a standardized, structured way to train a new cadre of professionals. It offers a detailed and structured description of the process, interwoven with the foundational knowledge domains of case management."

The Commission also introduced its new product, the Case Management

Body of Knowledge™ (CMBOK™). The product is built upon the Case Management Knowledge Framework and educates the user on seven knowledge domains: case management concepts; principles of practice; health care management and delivery, health care reimbursement, psychosocial aspects of care, rehabilitation, and professional advancement and development. Within those domains are structured 38 subdomains, more than 350 specific knowledge topics, and nine major phases in the case management process.

CMBOK offers the foundational knowledge a professional case manager must possess to work independently and effectively. It is the first comprehensive, Web-based, peer-reviewed, online knowledge resource available today. In light of the current and critical need to educate today's workforce, the Commission is offering 1,000 free subscriptions at the June 1 launch of the CMBOK for those board-certified case managers who supervise, train and teach case managers in the private, public and academic settings. The Commission will also offer a block of subscriptions to the 15 states chosen to participate in the CMS State Demonstrations to Integrate Care for Dual Eligibles initiative to expand their knowledge of case management as it applies to this important effort. Subscribers to the CMBOK will be able to obtain continuing education credit

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Bringing the Disability Management Conversation Online

By **Carla Rea DeFlorio, CAE** CEO, Certification of Disability Management Specialists Commission

As we look at the disability management community today, one of the striking features is how professionally diverse it is. From the traditional disciplines of rehabilitation counseling and occupational nursing, disability management has spread to encompass human resources, benefits and leave administration, safety, risk, and related roles. In many cases, professionals are handling disability management responsibilities (such as administration of policies and programs for workers' compensation or short-term/long-term disability) that have been added to their job descriptions.

How can such a diverse community be brought together? To answer this question, the Certification of Disability Management Specialists Commission (CDMS Commission) undertook a major rebranding effort over a year ago. Our new logo features a spectrum of colors that represent the individual disciplines coming together in a rich array of expertise and knowledge in a dynamic and growing field.

Now, we're taking active steps to put the vision of our brand into action. One way is a newly launched CDMS group on LinkedIn.com, which is the premier Website for business networking. The group has grown quickly to

Carla Rea DeFlorio, CAE, is the CEO of the Certification of Disability Management Specialists Commission (www.CDMS.org), which is the only nationally accredited organization that certifies disability management specialists.

include those who hold the Certified Disability Management Specialist (CDMS) certification, prospective certificants, those who have earned the new Associate Disability Management Specialist (ADMS) designation, and those who are interested in learning more about the field. Group members come from a number of disciplines

Our vision is that, in time, the CDMS group on LinkedIn.com will become the go-to place online for disability management issues, with a robust community of professionals willing to share their expertise and build our collective body of knowledge.

including human resources, occupational health, rehabilitation counseling, safety, absence management, and wellness, as well as from other disability management organizations.

The purpose of the LinkedIn.com community is to foster conversations related to disability management by establishing a forum for people to connect with their questions and suggestions, as well as to share their experiences. Our vision is that, in time, the CDMS group on LinkedIn.com will become the go-to place online for disability management issues, with a robust community of professionals willing to share their expertise and build our collective body of knowledge.

Establishing an online community

also allows the CDMS Commission to reach out to a younger demographic for which social media, online networking, and mobile apps are the norm. We also envision that the LinkedIn group will provide an opportunity for "dual mentoring" between younger and seasoned members of the community. Already, we're seeing signs of an exchange of knowledge, from best practices in the field to uses of technology.

The response to the LinkedIn.com community has been positive, enabling people to connect on the common ground of disability management. Regardless of their backgrounds or job titles, the CDMS community welcomes their questions, responses, and overall participation. For that reason, the CDMS group on LinkedIn.com recently became an "open community," which enables the cyber world to see and share in the discussion, rather than limiting it to members of the group. The group's status as an open community also allows visibility on search engines and for discussions to be shared on Twitter and Facebook.

The CDMS Commission welcomes anyone with an interest in disability management to join and participate in the community. Come, be part of the conversation about disability management today. By participating, we have a unique opportunity to share, to learn, and to grow together. **CM**

The CDMS Commission is the only independent and nationally accredited organization that certifies disability management specialists.

Managing the Care Complexity of Spinal Cord Injury

Spinal cord injury (SCI) affects about 265,000 Americans, with an annual incidence of about 40 cases per 1 million Americans or 12,000 cases per year. Most (81%) of Americans with SCI are male, and about half (56%) occur in people who are ages 16 to 30. The average age at injury is 41 years. Common causes are motor vehicle accidents (40%), falls (28%), violence (most often gunshot wounds; 15%), and sports injuries (8.5%). Other causes of SCI are rheumatoid arthritis or osteoporosis that weakens the spine or causes spinal stenosis.¹

Individuals with tetraplegia have injury to the cervical region and associated loss of muscle strength in all four extremities. (Tetraplegia is the term that has replaced quadriplegia.) Those who have paraplegia have lesions in the thoracic, lumbar, or sacral regions of the spinal cord. Since 2005, the most common hospital discharge reported among those with spinal cord injury is incomplete tetraplegia (40%). Those with complete paraplegia and incomplete paraplegia comprise 22% of discharges each, and complete tetraplegia affects about 16% of discharged patients. Less than 1% of all people with SCI experience complete neurologic recovery at discharge.¹

The lifetime costs of SCI vary according to the severity of injury. In 2010, the average estimated lifetime costs of care for a 25-year-old injured person are \$1.5 million for those with incomplete motor function at any level up to \$4.4 million for those with high tetraplegia (injury in C1-C4). Life

expectancy for persons with SCI continues to increase but is still somewhat below that of persons without SCI. Mortality rates are highest in the first year after injury, particularly for those who are severely injured. The leading cause of death has been renal failure, but significant advances in urologic management have decreased the risk of renal failure. Today, pneumonia and septicemia have the greatest effect on life expectancy for persons with SCI.¹

Symptoms

Symptoms vary depending on the location of the injury. Weakness and sensory loss occur at or below the point of injury, and severity of symptoms depends on whether the cord is completely or partially injured. Symptoms of SCI may be on one or both sides of the body and may include:

- Loss of normal bowel and bladder control
- Numbness
- Sensory changes
- Spasticity
- Pain
- Weakness
- Paralysis
- Breathing difficulties (with cervical spine injuries)

The extent of injury is defined by the ASIA Impairment Scale²:

- A = Complete, no sensory or motor function is preserved in sacral segments S4-S5
- B = Incomplete, sensory but not motor function is preserved below the neurologic levels and extends through S4-S5

C = Incomplete, motor function is preserved below the neurologic level and most key muscles below the neurologic level have muscle grade less than 3

D = Incomplete, motor function is preserved below the neurologic level and most key muscles below the neurologic level have muscle grade greater than or equal to 3

E = Normal, sensory and motor functions are normal

Muscle strength is graded using the Medical Research Council (MRC) scale of 0-5²:

- 5 = normal power
- 4+ = submaximal movement against resistance
- 4 = moderate movement against resistance
- 4- = slight movement against resistance
- 3 = movement against gravity but not against resistance
- 2 = movement with gravity eliminated
- 1 = flicker of movement
- 0 = no movement

Rehabilitation of Patients With SCI

Rehabilitation involves extensive physical therapy, occupational therapy, and other rehabilitation therapies. Recovery of some movement or sensation that occurs within 1 week usually means there is a good chance of recovering more function; losses that remain after 6 months are more likely to be permanent. Complications of SCI beyond paraplegia and tetraplegia include blood pressure changes, chronic kidney disease, deep vein thrombosis, pulmonary infections, skin breakdown, contractures, injury to numb areas, ►

urinary tract infections, loss of bladder and/or bowel control, impotence, muscle spasticity, pain, paralysis of breathing muscles, pressure ulcers, and shock.

The re-evaluation of patients with SCI must be ongoing and comprehensive and should include a multidisciplinary staff. Comprehensive specialty re-evaluation includes³:

- Review of records and history-taking as necessary
- SCI physical examination
- Nursing evaluation of bowel and bladder complications, medications, and skin condition
- Urologic studies, blood work and analysis
- Physical and occupational therapy evaluations for motor/sensory changes, posture, transfers, activities of daily living and functional tests, equipment evaluation and minor repairs or adjustments
- Psychosocial evaluation and counseling
- Consultations with other physician specialists as necessary (neurosurgical consults, skin, respiratory, etc)
- Radiological studies
- Team consultation with the patient, family, staff, and case manager with evaluation results, and recommendations
- Other services such as driving evaluations, van clinic, etc

evaluations, van clinic, etc

Case managers working with patients with SCI are tasked with coordinating the complex physical, social, and psychological needs of these patients and their families. Effective case management focuses on available resources to assist the individual and works to avoid overlap of services or provision of unwanted help and equipment. Most importantly, case managers must ensure that gaps in service are eliminated. The following article is an interview with Bert Burns, who has lived and prospered with SCI for many years. Perspectives of two case managers are also provided.

Life After Spinal Cord Injury: Bert Burns' Perspective

When Bert Burns suffered a life-changing injury in his 20s after being thrown from his car during an accident, no one would have blamed him if he decided life as he knew it was over. Facing his future as a quadriplegic, he could have easily viewed the outcome as the end rather than a beginning.

With the help of his case manager and other medical professionals, Bert discovered his spinal cord injury (SCI) to be a blessing in disguise, allowing him to realize dreams that he never would have had before being injured.

After completing rehabilitation, Bert went on to:

- Meet the love of his life, Joy, and raise two beautiful children with her;
- Compete as a wheelchair athlete on a global scale for 15 years. He won many gold medals in international wheelchair racing events over the years. Bert also won one gold medal in a 4x400 relay in wheelchair racing at the 1992 Paralympics;
- Create and lead UroMed, one of the largest urology medical supply companies in the country; and
- Positively influence hundreds of disabled youth and adults over the last 20 years through a motivational speaking program called Life After Spinal Cord Injury.

Bert shares his perspective below about his struggles and successes, and the type of support that his case manager provided along his road to recovery.

Q: How instrumental was your case manager in your rehabilitation and resuming an active life?

A: I worked closely with my case manager with getting involved in life again. One of the most instrumental aspects of her help was the way she assisted me in contacting provider and payor sources

to pay for things my insurance would not cover. For instance, my case manager helped me find a vocational rehabilitation center in Florida that adapted my car and paid for my hand controls so I could drive.

My case manager also helped me find the correct people at my university to help pay for my school and books, along with



Bert Burns, gold-medal winning wheelchair racer.

ensuring my accessibility to the campus and class locations. This was critical to my success. After my injury, I knew I had to get an education. It was hard enough to find a job while walking. Wheeling around, I needed all the options I could get.

I changed my major in college from business major to therapeutic recreation just

because I saw how much my recreation therapist helped me. After graduating with a degree in therapeutic recreation, I wanted to work with folks with SCI. Most people at rehabilitation hospitals saw my wheelchair as an advantage for that kind of role, so I used that to my favor to move into a successful career.

Q: From your perspective, what was most important to you in terms of achieving your recovery?

A: I was very fortunate to have a great team of rehabilitation professionals including a case manager, physical therapists, occupational therapists, and recreational therapists. However, the most helpful resource besides health care professionals was peer support. This is an area where a lot of rehabilitation centers get their case managers involved. Whether it be kids or any other kind of peer—it's a great way to give a patient a better perspective on any new injury, and here's why.

It's so easy for you as a therapist to tell me something, but because you're walking, in the back of my mind I'm thinking, "You're AB [able-bodied]." But when you hear the same advice from someone with a similar disability, it is a lot more credible and seems more achievable.

My rehabilitation center had an excellent peer support program and my therapist introduced me to a former patient who was similar to me in age and injury level. Being able to talk with this person one-on-one helped me realize I could make it and succeed in a wheelchair.

That's also why we started the Life After Spinal Cord Injury program, so I could continue to visit rehab centers to assist case managers and therapists in providing examples and real world advice from someone that the patient can identify with.

Because I am a trained recreation therapist and I happen to be in a wheelchair, I have instant credibility with patients. When I was working in the field, I'd roll in the room and say "We're going to go play basketball

today!" And they couldn't tell me no. I'd say, "If I can do it, you can do it. Let's go."

In 2010, the Life After Spinal Cord Injury program helped more than 600 medical professionals, patients, former patients, and family members with information, advice, and encouragement. We hope to double that number in 2011 as we continue to provide peer support assistance nationwide.

Q: How did you become accustomed to getting around on your own again?

A: One of the major areas that my rehabilitation program stressed was community reintegration. Our therapeutic recreation department took us on two to three outings per week. This enabled me to see that getting around in a wheelchair was possible every day. I went to restaurants, movie theaters, even dance clubs, and realized all of those places were accessible. It also helped to learn how other people received me now that I was in a wheelchair. This was a very good, safe way of getting back out into the real world for the first time.

Q: How can case managers and other health care providers best meet a patient's needs in terms of medical care?

A: Depending on the patient's injury level, making them as independent as possible, as quickly as possible. If he's not able to be independent himself, teach family and friends how to help.

In addition to providing onsite medical care, anything you can do to help patients learn about ways to care for themselves after they leave your facility will be ideal. For example, I had three things set up in my home when my wife and I had children that made it a lot easier and more accessible for me to be an involved parent:

Accessible sleep areas: When our twins were newborns, they slept in a Pack 'n Play that we kept in our large walk-in closet. I put boxes in the bottom, with pads and covers on top, so the babies were elevated. That way I could reach them more easily from a



Bert Burns speaking with patients at MetroHealth Rehabilitation Center.

wheelchair level.

Custom changing table: We made a table that would let me roll up under it so I could reach the babies, pick their legs up and take care of business.

Modified cribs: We adapted their cribs by extending the legs so I could roll up under the crib. And we had the doors modified so they would open outward instead of sliding up. I'd open it like a regular door and slide the baby off onto my lap.

Q: What advice would you give for a patient's psychological needs?

A: Though the medical needs are very important, the psychological needs are probably more important in terms of patients' acceptance of their new life in a wheelchair. The time it takes to accept the change is different for each individual. So the quicker you can help someone accept their disability, the quicker they can get on with their life. You don't need to convince the patient to ever say, "I'm going to be in a wheelchair forever," but what you want them to say is, "I'm in a wheelchair now, and for as long as I am, I'm going to be the best 'wheelchair person' I can be."

Q: What is key to a patient's social and family needs?



Bert Burns actively leads UroMed employees in serving customers who have experienced injuries like his.

A: I was very fortunate to have good family and friend support. In fact, the three biggest things that have contributed to my success in life are:

- The ongoing support of family and friends
- God
- Getting involved in things like sports that helped me strive toward goals, build confidence, and realize accomplishments

If the patient has a high amount of family/friend involvement, it helps tremendously. It shows patients that they are being accepted by the people that matter most to them.

The good thing about the Internet today is that a whole new world of friends are out

there for a patient who is adjusting to a disability. That's one of the reasons we started a Facebook page for the Life After Spinal Cord Injury program. On Facebook, we have built a networking community of more than 1300 friends that include SCI survivors, health care professionals, and supportive friends and family. If you'd like to join our group online, please visit: <http://tinyurl.com/LASCIpage>.

Q: Do you have any parting words of advice for case managers?

A: Our Life After SCI programs are always open to health care providers and clinicians to help them get a better

perspective on life in a wheelchair. Listening to the questions that people ask during the program can help you improve relationships with patients. A lot of health care professionals treat their patients for two to three months and don't ever see them again. You have a short span of time to help these people, and the more practical advice you can relay, the better. Please contact us at www.uromed.com or e-mail Lisa Wells at lwells@uromed.com if you would like to host a Life After SCI program at your facility! Our motivational program is free and I'd be glad to lend a hand!

Q: Do you have any parting words of advice for other people who are recovering from spinal cord injury?

A: For those of us using a wheelchair now, it's not fair. Just because today something might not be possible, doesn't mean that next week, next month, next year that it might not be. Always keep striving!

And remember, once you go home from rehab, you have two choices to make. If you go home and say "Life sucks," it will. Or you can go home and say, "These are the cards I was dealt, and I'm going to make the most of them." If that's the choice you make, you'll be OK.

Case Manager Perspective

Leslie Burke, BSN, RN, CRRN

Ensuring that patients will participate in their recovery after a disabling illness or injury can be a difficult task initially. Case managers working with the patient must have a knowledge of their disabilities, be proactive and self-directed, and have a holistic approach in the caring for the patient.



However, case managers can

ensure that patients participate in their recovery by providing education, identifying care needs for training, and coordinating services and support to patients, family, and staff in the inpatient rehabilitation setting. The education the patient receives should be individualized and specific to the injury, which allows the patient to be better informed on how to care for the condition, which may include medication management, nutritional management, bowel and bladder management, skin care, and self-care as a

few examples.

A case manager also collaborates with interdisciplinary team members to ensure that the family is well trained to care for the patient at discharge, usually addressing the same issues. If patients have more knowledge, they can better advocate for themselves to ensure they are receiving the appropriate medical care, supplies, and equipment needed for their care.

Coordination of services includes making the appropriate referrals for continued therapy in the various

settings, such as home health or outpatient; consulting various services to meet medical care needs such as monitoring of labs; providing wound care; providing nutritional or enteral feedings; collaborating with the social work team to ensure the patient has the resources to procure recommended services; and ordering medical supplies that may be needed, such as urological supplies, tracheostomy supplies, and wound care supplies.

Case managers advocate for their patients by making sure the appropriate information about their condition and care is given to the patients and families, by being “a voice” for the patient when they feel they are not heard, encouraging a sense of independence in the patient, and promoting involvement. If patients are involved in the goal setting, they tend to be more invested in their care and are better able to direct their care.

Case managers can best meet the medical care needs of patients with a SCI or other disabilities by ensuring continuity of care upon discharge and connecting patients and their families

with community resources to receive continued aftercare services. This is especially true when dealing with the indigent population.

For example, when a patient with no insurance was being discharged and needed monitoring of labs for medication management, oxygen and other respiratory supplies, enteral feedings, and continued therapies, the nutritional support team within the facility was consulted to order the feedings, using funds allocated by the facility, and to educate the patient and family on how to administer the feedings. The respiratory supplies were ordered using the same funding. The patient was also able to be scheduled for continued therapies at an outside facility that can provide scholarship assistance to patients without insurance, despite this being a program of very limited resources. One way to ensure continuity, in particular, is to make sure the patient has a primary care physician so that all pertinent information is relayed and the patient can be followed to avoid recidivism when possible.

A case manager in the inpatient

setting also helps to meet the psychological needs of the patients and families in adjusting to injury and illness and the discharge home. The case manager collaborates with team members, especially social work to identify additional gaps in service delivery and caretaker concerns. The patient’s anxiety levels tend to increase as the time to discharge gets closer, and that is when the case manager can step in to ensure that the patient has the knowledge, appropriate training, and equipment/supplies needed for a smooth transition and continuity of care. Providing support in the preparation of discharge to the community is an important step in ensuring a smooth transition home and quality self-care after discharge, while also decreasing anxiety and providing some sense of control to the patient.

Leslie, BSN, RN, CRRN, is an RN Care Coordinator for a 41-bed inpatient rehabilitation unit that treats patients with traumatic brain injury (TBI), SCI, and general rehab needs at Virginia Commonwealth University Medical Center in Richmond, Virginia.

Case Manager Perspective

Colleen Fulton, MSPT



In today’s ever-changing medical environment, it is essential to have a central person helping to coordinate care. A traumatic injury is life changing and there are many different medical professionals involved to ensure that a patient has a smooth recovery and positive re-entry into the community and home setting. In most acute rehabilitation settings, there is one person who coordinates care: a case manager.

Case managers are integral team members involved in helping patients with a plethora of diagnoses including but not limited to SCIs. Case managers help patients return home safely and with the appropriate equipment and follow up. Case managers serve as a liaison between the patient, family, physicians, therapists, social workers, external case managers with third party payors, durable medical equipment companies, and therapy locations. Case managers help to centralize and coordinate care and ensure that the patient has access to resources in the community.

Discharge planning occurs right

from admission. Case managers ensure that families are prepared for discharge and know what the expectations will be when they are no longer in the acute rehabilitation setting. Care conferences are held to help the patient and family prepare for what lies ahead after discharge. Case managers are responsible for coordinating care among disciplines, reviewing goals and recommendations, providing letters of medical necessity for equipment or medications, and finding resources for home modifications.

In essence, a case manager is the cog that keeps the wheels turning. For
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Case Management for People Living With HIV/AIDS

Carolyn Ross-Friend, RN, MHA, ACRN, CCM; Alyson Schuster, MPH, MBA; and Melissa Sherry, BS

The Case Management Society of America (CMSA) defines case management as “a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual’s health needs, using communication and available resources to promote quality, cost-effective outcomes.”¹ While this definition encompasses many of the jobs of case management, those who are HIV positive or AIDS defined (HIV/AIDS) require a broader definition of case management. Case management for HIV/AIDS patients requires greater consideration of the social and environmental challenges that tend to perpetuate ongoing struggles. Case managers must be experts in social services, empathetic advice givers, motivational health coaches, and proficient educators in order to tackle the complicated health and social issues that accompany HIV/AIDS.

Johns Hopkins Healthcare LLC (JHHC) administers Priority Partners, a Medicaid Managed Care Organization (MCO), Johns Hopkins Employer Health Plans (EHP), a self-funded MCO, and US Family Health Plan (USFHP), a Department of Defense Tricare MCO. JHHC provides case management to those who have HIV/AIDS. Maryland Medicaid mandates case management for special needs groups that include those living with HIV/AIDS, although acceptance by the Medicaid, EHP, and USFHP members is voluntary. The goal of JHHC’s case

management program for HIV/AIDS patients is to promote self-management; however, due to the complexity of the disease, the case management process can be ongoing. A multidisciplinary, holistic approach provides the best possible outcomes for members; this is where a case management team can have a significant impact. In this article, we provide background on HIV/AIDS and the complexities of case management for this population, and then present three case examples of HIV/AIDS members who had case management.

HIV/AIDS

HIV/AIDS is a viral infection that attacks and destroys CD4 cells, the disease-fighting cells of the immune system. This leaves the body in a weakened state unable to fight against infections and cancers. Acquired immune deficiency syndrome (AIDS) is the final stage of HIV disease diagnosed by a CD4 count under 200, a CD4 percentage less than 14%, or the development of opportunistic infections such as candidiasis (thrush), pneumocystis pneumonia, and cytomegalovirus (CMV). A normal CD4 can range from 500 to 1,000 and more. The viral load (VL) indicates how much of the HIV virus is in the blood. A lower VL count is associated with a better outcome and a higher VL count is associated with a faster progression to AIDS. These counts are used to determine the stage of disease and if the medications are working.² Risk factors for HIV include unprotected sex and sharing injection

drug equipment. Additionally, HIV can be passed from mother to child through pregnancy, childbirth, and breastfeeding. The risk from the blood supply is extremely low because of screening.³

Case Management for HIV/AIDS Patients

Case management for HIV/AIDS patients is unique because of the complicated nature of the disease itself, as well as the many comorbidities and social problems that often coexist. In the Priority Partners and EHP population, the majority of the members with HIV/AIDS are urban-dwelling African Americans. While African Americans represent only 12% of the US population, the Centers for Disease Control and Prevention (CDC) reports that African Americans carry a disproportional HIV/AIDS burden.⁴ This requires case managers to consider the social and environmental factors that lead to the spread or progression of HIV/AIDS within the African American community.

Our approach to case managing members is multidisciplinary and requires the member to take an active role in care planning and goal setting. The HIV/AIDS team consists of an

The authors are all employed by Johns Hopkins HealthCare. Carolyn Ross-Friend, RN, MHA, ACRN, CCM, is an advance practice case manager; Alyson Schuster, MPH, MBA, is a research associate; and Melissa Sherry, BS, is a research coordinator.

Often the need for social services takes precedence because basic needs like food and shelter must be met before a person can become engaged in his or her health care.

advanced practice nurse case manager, nurse case managers, resource coordinator, capitation specialist, and case management assistant, all of whom have access to a team of social workers. When a member is opened into case management, the case management assistant notifies the primary care provider (PCP) that the patient is enrolled. While in case management, the case manager communicates with the PCP and necessary specialty providers such as infectious disease, cardiology, and orthopedics. On average a nurse case manager in our HIV case management program has a 50-member caseload.

Case management roles include education, advocacy, and removal of barriers so members can navigate the health care system, appropriately use services, and eventually self-manage their care. The complexity of HIV/AIDS means many members have comorbidities such as hepatitis C, hypertension, diabetes, cancers, COPD, or asthma. There has been an increase in age-related comorbidities because better medications are allowing members to live longer.⁵ In addition to the disease, issues such as chaotic lifestyles, substance abuse, mental health issues, domestic violence, family issues, homelessness, and the stigma associated with HIV/AIDS exist. Often the need for social services takes precedence because basic needs like food and shelter must be met before a person can become engaged in his or her health care. By addressing non-health-related needs, case managers are able to convey compassion, build trust, and strengthen the case manager/member relationship. Removing obstacles allows members to be active participants in their own

health and improve their quality of life.

Resources

Linking members to resources is an important case management role. These can be referrals to the appropriate agency or community resource, or providing proof of HIV status needed to access services. There are many services unique to the HIV/AIDS population. For instance, the Ryan White Care Act provides funding and services for people living with HIV/AIDS. This includes counseling, medical and dental services, medications, housing, transportation, and other services not covered under Medicaid.² This Act primarily funds the Maryland AIDS Drug Assistance Program (MADAP).⁶ Many local health departments and community agencies provide similar services, while Housing and Urban Development (HUD)-Housing Opportunities for People with AIDS (HOPWA) is a federal program dedicated to finding housing for this population.

Because of the recent economic downturn, however, there has been an increase in need and a decrease in services that are available, which require case managers to stay up to date on what is available and creatively problem-solve for their clients. Efforts to obtain services often come with long periods on the phone and/or involved applications requiring a paper trail of supporting documents. For example, a housing application can be more than a 20-page document. Thus HIV/AIDS case managers must be persistent to obtain services on behalf of their members. Many credible Websites and organizations provide information and resources that can help.

Challenges

HIV/AIDS case management present many challenges. Often members have a lack of knowledge regarding HIV/AIDS and are unaware of the significance of the CD4 and VL counts. A major obstacle is medication adherence.⁷ Medication regimens include at least one medication from three classes of antiretroviral medications to fight the HIV/AIDS on different levels. The pill burden has improved over the years; however, research shows that to be effective, the medication needs to be taken over 90% of the time.⁸ The side effects can be a deterrent, and nonadherence can result in drug resistance, rendering that class unusable. Encouraging members to follow through with immunizations such as hepatitis B vaccine, flu shots, and pneumonia shots, as well as age-appropriate screenings decreases complications and improves outcomes. In addition, maintaining contact can be problematic. Members' telephones are frequently disconnected, so case managers promote the use of Safelink, a recent government-sponsored program that provides free cell phones to people based on income. This has been instrumental in maintaining contact.

The following are three case examples convey the complexity of the involvement that case management has with managing this population. Initials, ages, and minor facts were altered to protect anonymity.

Case 1

DR, a 48-year-old African American man, was diagnosed with HIV around 1986. Past medical history included asthma, hepatitis C, above-knee

amputation, endocarditis, intravenous drug use, and methicillin-resistant *Staphylococcus aureus* (MRSA) abscesses. Initially referred to case management in 2003, case managers were unable to maintain contact with him. DR agreed to case management with the current case manager in January 2007 after the case manager was able to meet this member in person to discuss the program and establish a personal relationship. During the year prior to case management enrollment, DR had frequent hospital admissions and emergency department (ED) visits and often was late or missed scheduled medical appointments. DR's CD4 was 295, viral load was 66,032 and he had not been on HIV medication for several years. He took oxycodone and morphine for stomach abscesses. Over the 2 months prior to enrollment, DR had lost 10 pounds. DR had been abandoned in infancy and endured physical and sexual abuse as a child in foster care. At enrollment he lived with his elderly foster mother and received Social Security Income (SSI).

Problems

- Member is habitually late or no show for medical appointments and clinic threatens to discharge him
- Inconsistent care—uses emergency department (ED) frequently
- Frequent hospitalization
- Poor dentition
- Weight loss
- Heroin addiction
- Not on HIV medications
- Using someone else's nebulizer

Interventions

- Formulated a plan of care that both the case manager and member agreed upon
- Arranged for member:
 - Changed primary care to HIV/AIDS specialty clinic affiliated with a major hospital. This site offered more services including support services, lab and pharmacy on site,

social workers, mental health, and substance abuse services.

- Connected member with methadone program and mental health treatment
- Dental care from dentist who receives Ryan White funds
- Food delivery by Moveable Feast
- Educated member on:
 - Disease process, appropriate labs, immunizations, preventative services
 - Importance of keeping and being on time for appointments
 - Ways to avoid the emergency department and hospitalizations
 - Community resources
 - Maintaining contact with case manager
 - Medication compliance—how to get a nebulizer and why he needed HIV medications

Outcomes

- With coaching from the case manager, DR started taking responsibility for his care by making and keeping appointments. PCP/infectious disease (ID) specialist referred DR to psychiatrist in the clinic and he started HIV medications through an adherence program.
- Moveable Feast provided three meals a day, as well as Ensure. DR has gained weight.
- In 2010 DR had no hospital admissions or ED visits compared to 10 hospital admissions and 16 ED visits in 2007. His CD4 in 2007 was 292 and VL 66,032, which improved in 2010 to CD4 427 and VL less than 50.
- DR had an increase in his knowledge, skills, and confidence to self-manage his health, as measured by the Patient Activation Measure (PAM).⁹

After making great strides in improving the health and social functioning of DR, DR suffered a setback when he lost his housing. He was in a shelter for several months at one point with a broken electric wheelchair.

Henry et al¹⁰ report, “people living with HIV/AIDS who experience homelessness have competing priorities (eg, food, security of property) and experience complex health-related issues (eg, comorbidities, transportation to clinics) that may interfere with utilizing health care. Because of the chaos in his life and environment, DR began missing appointments and not taking his medications. The vulnerability he experienced took a toll on his health and his spirits. However, case management intervened and facilitated moving DR to a medically fragile transitional housing facility. Stable housing, getting basics needs met, supportive services, and proper medical care resulted in DR experiencing a sense of security that allowed him to focus on personal goals and growth. He attended various trainings related to HIV/AIDS and completed a leadership and advocacy program, which certified him to counsel and test people with HIV/AIDS. He obtained life skills and subsequently moved to his own apartment. DR now serves on the MCO's Consumer Advisory Board. This case illustrates the revolving needs and setbacks or up and downs common in case management, but also that despite these hurdles case management can have a significant impact on members' quality of life.

Case 2

TS was a 51-year-old woman from the Caribbean and new to managed care. Newly diagnosed with AIDS when admitted to a hospital with CMV retinitis, pancytopenia, cachexia, candida, and mid-esophageal ulcer, her CD4 was only 15 and VL, 199. TS did not know how she contracted HIV, but mistakenly thought it was from a recent blood transfusion. TS had no income and was in the process of applying for SSI when she entered case management. She received Medicaid and food stamps. Prior to admission, TS was living with her mother and family, but could not

Stigma and denial still associated with the disease make self-management difficult.

go back because of the stigma. TS's sons paid her rent and utilities.

Problems

- Lack of information regarding HIV/AIDS and insurance benefits
- Impaired vision
- Ran out of medicine for CMV retinitis
- No PCP
- Needs assistance with activities of daily living (ADLs)
- Needs assistance with paperwork
- Needs food—should not cook because of limited vision and weakness
- Needs durable medical equipment (DME)
- Needs transportation
- Member in denial

Interventions

- Formulated a plan of care that both the case manager and member agreed upon
- Arranged for member:
 - Information on in-network neurologist and ID specialist
 - Refills for ophthalmic solution
 - Completion of SSI Forms
 - Mental health referral
 - Food delivery by Food & Friends
 - Resolution of unpaid hospital bill issue
 - Personal assistance from local health department
 - Prescriptions for physical therapy, shower chair, and cane
 - Completion of Metroaccess, a transportation form
- Educated member on:
 - Disease process, appropriate labs, immunizations, preventative measures
 - Medications including highly active antiretroviral therapy (HAART) and prophylaxis medications

Outcomes

- TS was empowered to speak openly about her disease and ask case manager and doctor questions.
- Food & Friends delivered Ensure and three meals a day to TS.
- Personal assistance was provided through the local health department to assist with light cleaning and ADLs.
- Social Security Disability was approved.
- Transportation was approved.
- TS's vision improved with surgery and medication.
- TS kept all appointments including follow-ups with ID and mental health.
- Disease status improved with original CD4 15 to 197 and VL from 197 to undetected.
- TS was adherent with medication.
- TS reached and maintained ideal weight.

Eventually TS's eligibility was terminated because of receipt of federal Medicaid coverage. However, at that point she was medically stable and had the social support she needed. This example illustrates the stigma and denial still associated with the disease that make self-management difficult. It also demonstrates the complexity and amount of paperwork required to deal with the complex health and social issues involved with HIV/AIDS.

Case 3

LH was 24 years old and diagnosed with HIV at age 19. She was also diagnosed with type 1 diabetes at age 7, hypertension, and high cholesterol. Her CD4 was 218 and VL was 35,718. LH worked fulltime and had a 2-year-old child with multiple medical problems. LH was a very pleasant and personable young lady. She had received

care at an adolescent clinic so she and her child could be seen together. The adolescent clinic, which was not solely dedicated to HIV/AIDS patients, allowed HIV patients to stay until age 25, and provided a great deal of ancillary and comprehensive services. LH was transitioned to the adult clinic, which provided many services, but had different expectations of the patients and was perceived as a less friendly environment. The transition seemed to be going well as the ID specialist from the adolescent clinic treated LH at the adult clinic as well. However, maintaining contact with LH became a challenge. This may be in part because the member felt that by going to a dedicated HIV/AIDS clinic within the hospital where she worked could lead to coworkers finding out about her HIV status.

Problems

- Difficult transition from adolescent clinic to adult HIV/AIDS clinic
- Missed many appointments
- Difficulty in communicating and maintaining contact; member denied getting letters and voice messages
- Multiple comorbidities
- Failure to complete paperwork for copay waivers even after many reminders
- Multiple stressors, including a sick child, fulltime employment, and low income

Interventions

- Formulated a plan of care that both the case manager and member agreed upon
- Agreed to communicate via text and e-mail based on member's preference

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VA Offers Education Reimbursement for CCM® Exam

The Commission for Case Manager Certification's prestigious board-certified CCM® designation is now within closer reach for thousands of professionals who have served in the military or reserves, as well as their dependents. Payment for CCMC's certification exam has been approved by the US Department of Veterans Affairs (VA) as reimbursable under the GI Bill for licensing and certification.

"VA recognition demonstrates the CCM's value as a marker for high-quality, safe, efficient and effective case managers," said Patrice V. Sminkey, RN, the Commission's chief staff executive. "Earning the CCM is a major step in professional development for case managers and opens the door for advancement

opportunities. It is appropriate that our men and women who have served in the military may now receive reimbursement for taking the exam that will help them advance their careers and better serve patients."

The CCM is also an approved certification for the Magnet Recognition Program. The Magnet Recognition Program recognizes health care organizations that provide nursing excellence. Recognition of the CCM aids facilities in achieving Magnet status. "The CCM is broadly recognized among employers, and earning the CCM positions the board-certified case manager for distinction in a variety of settings," Sminkey said.

Models of care such as the patient-centered medical home (PCMH) and

accountable care organizations (ACOs) emphasize core activities of the case manager such as care coordination. These models align with CCMC's philosophy that everyone benefits when clients reach their optimum level of wellness, self-management, and functional capability: the clients being served; their support systems; the health care delivery systems; and the various payer sources. Case managers play a critical role in ensuring coordinated care in the new team-based health care models.

The VA's approval of the CCM certification exam means that veterans, reservists, and their dependents who are case managers are eligible for reimbursement for the cost of the exam under the GI Bill, a \$325 value. ■

NOTICE OF ANTI-KICKBACK STATUTE

On May 20, 2011, the Office of Inspector General (OIG) posted Advisory Opinion 11-06, which makes it clear that post-acute providers that pay hospitals to participate in e-discharge planning systems likely violate the federal anti-kickback statute. Hospitals utilizing such systems that require post-acute providers to "pay to play" also likely violate the federal anti-kickback statute.

Some hospitals use e-discharge planning systems that require post-acute providers to pay fees to receive referrals electronically through systems implemented by hospitals. Providers who do not pay the required fees receive notice of possible referrals via fax. The OIG says that post-acute providers who elect not to pay to participate in e-discharge

planning systems are significantly disadvantaged and may be effectively eliminated from any chance of receiving referrals because they are unable to communicate in a timely manner with hospital discharge planners regarding referrals. This is because hospitals often discharge patients to post-acute providers on a first-come, first-served basis.

The OIG also stated that some post-acute providers cannot afford to pay to participate in e-discharge systems in order to remain competitive. Such providers, therefore, risk substantial loss of business. Providers that pay to participate in e-discharge systems probably face pressure to recoup the costs associated with participation. These pressures could create incentives to, among other

things, prolong patient stays; provide separately billable, unnecessary services; or upcode. All of these activities could result in increased costs to federal health care programs.

Hospitals and post-acute providers are now clearly on notice regarding continued use and participation in such systems. Hospitals may, of course, continue to use e-discharge systems so long as post-acute providers participate without paying to do so. Post-acute providers currently participating in e-discharge planning systems for which they have paid or are paying fees to participate should discontinue payments immediately. ■

Telepsychiatry Shown to Reduce Costs and Improve Care

Twenty-five hospitals in South Carolina are participating in a statewide telepsychiatry consulting service to help provide better care for patients who seek care in emergency departments (EDs), many of which do not have a psychiatrist on staff. In this program, psychiatrists assess ED patients remotely via live video link on a video cart that is rolled into the patient's room. The patient and psychiatrist can see each other and talk. The psychiatrist is prepped before the video session with the patient's history, lab test results, and other pertinent findings. The assessment takes about 30 minutes. The result may be a recommendation for hospitalization or scheduling of outpatient visits through the local mental health department.

The program, which is available 16 hours a day, has shortened ED visits and reduced hospital admissions for more than 6000 mental health patients. Hospital admissions declined from 12% of ED patients with psychiatric problems to 8%, and average ED stays from 4 to 3 days. About 85% of patients with severe mental illnesses in the telepsychiatry group received outpatient follow-up care within 30 days, compared with 22% in the control group.

Costs are lower for these patients as well. Medicaid telepsychiatry patients had median charges of \$2000, about \$800 less than Medicaid patients not receiving telepsychiatry. The cost difference was even greater in other payer groups.

This year another 15 hospitals will enroll in the program. ■

Case Management for People Living With HIV/AIDS *continued from page 15*

- Arranged for member:
 - Meeting with member, nurse case manager, and social worker at the adolescent clinic to help our case manager form a relationship with the member before her transition
 - Ways to get copays for medication waived
 - Option to transfer to another clinic
 - Option to connect to mental health and social services
- Educated member on:
 - Methods of taking responsibility for care such as, making appointments, getting prescriptions filled and obtaining preventative screenings

Outcomes

- Continued to investigate and remove barriers to care
- Continued to work with provider towards resolution of issues as they arose

This case illustrates the challenges associated with new members who are difficult to help because of communication barriers and shows the challenges of transitioning a member from adolescent to adult HIV care. Communication with LH and providers was critical to removing the barriers to care. Typically, members who are hard to contact will call when they need help, and it is hoped that LH eventually will be more open to case management.

Conclusion

Case management for HIV/AIDS is complicated by the social and environmental issues faced by those with HIV/AIDS. As evidenced by the case examples, it is possible to improve health by dealing with the basic needs that people have so that they can have the time and resources to devote to their health. To be a successful case manager with HIV/

AIDS patients, both empathy and persistence are required. However, for case management to be successful, the member must be an active participant in the decision-making process. Finally, health care reform and changes to State Waiver programs may increase the number of people with HIV who are eligible for case management. These new people may require different or additional resources and case managers will have to use their skills and creativity to manage this larger population. **CEU**

Exam starts on page 18

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Exam 1

Managing the Care Complexity of Spinal Cord Injury

1. **Approximately how many spinal cord injuries are there in the United States each year?**
 a. 9,000 b. 12,000 c. 15,000 d. 18,000
2. **Common causes of spinal cord injuries include:**
 a. Motor vehicle accidents
 b. Falls
 c. Violence
 d. Sports injuries
 e. All of the above
3. **In 2010, the average estimated lifetime cost of care for a 25-year-old injured person was:**
 a. \$1 million b. \$1.5 million c. \$2 million d. \$2.5 million
4. **Tetraplegia is defined as an injury to the cervical region with associated loss of muscle strength in all four extremities.**
 a. True b. False
5. **Recovery of some movement or sensation within this timeframe means there is a good chance of recovering more function:**
 a. One week b. Two weeks c. Three weeks d. Four weeks
6. **Complications of spinal cord injury beyond paraplegia and tetraplegia include:**
 a. Blood pressure changes
 b. Chronic kidney disease
 c. Deep vein thrombosis
 d. Skin breakdown
 e. All of the above
7. **The case manager is an important liaison between payors and providers to ensure needed services, supplies, and equipment are paid for.**
 a. True b. False
8. **Peer support from people who are similar in age and injury level are helpful for motivating patients with spinal cord injury and allowing them to realize there is life after injury.**
 a. True b. False
9. **The case manager plays a key role in coordinating education for those with spinal cord injury. Education should include:**
 a. Self-care
 b. Medical management
 c. Nutritional management
 d. Bowel and bladder management
 e. Skin care
 f. All of the above
10. **Part of the case manager's responsibility is to ensure that the discharge of the spinal cord injured patient is safe and proficient.**
 a. True b. False

Exam 2

Case Management for People Living with HIV/AIDS

1. **The goal of JHHC's case management program for HIV/AIDS patients is to promote self-management.**
 a. True b. False
2. **AIDS is the final stage of HIV disease diagnosed by:**
 a. A CD4 count under 200
 b. A CD4 percentage less than 14%
 c. The development of opportunistic infections
 d. All of the above
3. **Measurement of viral load is used to determine the state of the disease and whether medications are working.**
 a. True b. False
4. **Case management for HIV/AIDS patients is unique because of the complicated nature of the disease itself, as well as the many comorbidities and social problems that often coexist.**
 a. True b. False
5. **African Americans carry a disproportional HIV/AIDS burden, yet they represent what proportion of the US population?**
 a. 10% b. 12% c. 15% d. 18%
6. **Case management requires a multidisciplinary team and an active role of the individual with HIV/AIDS in care planning and goal setting.**
 a. True b. False
7. **Case management roles include:**
 a. Education
 b. Advocacy
 c. Removal of barriers
 d. Linking resources
 e. All of the above
8. **For patients with HIV/AIDS, the need for social services often takes precedence because basic requirements like food and shelter must be met before a person can become engaged in his or her health care.**
 a. True b. False
9. **The case manager working with patients with HIV/AIDS must be aware of the unique resources available to support the patient.**
 a. True b. False
10. **Medication adherence is important. Research shows that to be effective HIV/AIDS medications must be taken what percentage of the time?**
 a. 80% b. 85% c. 90% d. 95%

These educational manuscripts have been approved for 2 hours of CCM and CDMS education credit each by The Commission for Case Manager Certification and the Certification of Disability Management Specialists Commission. Provider #00059431. The answer sheet for these tests must be received by September 30, 2011. Expired exams cannot be returned. Faxed exams cannot be accepted. You may submit one or both exams; credits will be granted accordingly.

Exam 1: Managing the Care Complexity of Spinal Cord Injury

Please indicate your answer by filling in the letter:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____

Exam 2: Case Management for People Living with HIV/AIDS

Please indicate your answer by filling in the letter:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____

Continuing Education Program Evaluation

Please indicate your rating by circling the appropriate number using a scale of 1 (low) to 5 (high).

1. The article was clear and well organized.
2. The topic was both relevant and interesting to me.
3. The amount and depth of the material was adequate.
4. The quality and amount of the graphics were effective.
5. I would recommend this article.
6. This has been an effective way to present continuing education.
7. Additional comments:

Exam 1:

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Exam 2:

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PharmaFacts for Case Managers



New Approvals

Dificid (fidaxomicin)

The Food and Drug Administration (FDA) has approved Dificid (fidaxomicin) tablets for the treatment of *Clostridium difficile*-associated diarrhea (CDAD).

The safety and efficacy of Dificid were demonstrated in two trials including 564 patients with CDAD that compared Dificid with vancomycin, a common antibiotic used to treat CDAD. The clinical response was similar in the Dificid group compared with the vancomycin group in both studies. In some patients with CDAD, symptoms can return. In the Dificid trials, a greater number of patients treated with Dificid had a sustained cure 3 weeks after treatment ended versus those patients treated with vancomycin.

Dificid, a macrolide antibacterial, should be taken two times a day for 10 days with or without food.

To maintain the effectiveness of Dificid, and to reduce the development of drug-resistant bacteria, the drug should be used only to treat infections that are proven or strongly suspected to be caused by *C difficile*.

The most common side effects reported with Dificid included nausea, vomiting, headache, abdominal pain, and diarrhea. People at risk of developing the bacterial infection include elderly people, patients in hospitals or nursing homes, and people taking antibiotics for another infection. The most effective way to prevent CDAD is thorough handwashing with soap and warm water.

Indications and Usage

Dificid is a macrolide antibacterial drug indicated in adults (18 years of age and older) for treatment of *C difficile*-associated diarrhea.

Dosage is one 200-mg tablet orally twice daily for 10 days with or without food. The drug is available in a film-coated 200-mg tablet.

Warnings and Precautions

Dificid should not be used for systemic infections. It should be used only for infection proven or strongly suspected to be caused by *C difficile*.

Pediatrics: The safety and effectiveness of Dificid has not been studied in patients younger than 18 years of age.

Incivek (telaprevir)

The FDA has approved Incivek (telaprevir) tablets for a broad group of people with genotype 1 chronic hepatitis C with compensated liver disease (some level of damage to the liver but the liver still functions), including cirrhosis (scarring of the liver). Incivek (pronounced in-SEE-veck) is an oral medicine that acts directly on the hepatitis C virus protease, an enzyme essential for viral replication. Incivek is approved for people who are new to treatment and for people who were treated previously but who did not achieve a viral cure (relapsers, partial responders, and null responders).

Prior relapsers: People whose hepatitis C virus was undetectable after a full course of previous treatment, but whose virus became detectable during the follow-up period

Prior partial responders: People who achieved at least a 2 log(10) reduction in hepatitis C virus at week 12, but whose hepatitis C virus never became undetectable by week 24 of a prior course of therapy

Prior null responders: People who achieved a less than 2 log(10) reduction in hepatitis C virus at week 12 of a prior course of therapy

Trial Data

The approval of Incivek was based on data from three Phase III studies that showed that people who received Incivek combination treatment achieved significantly higher rates of sustained



viral response (SVR, or viral cure) compared with those who received pegylated-interferon and ribavirin alone, regardless of their prior treatment experience:

- People new to treatment: 79% vs 46%
- People who were treated previously but did not achieve a viral cure:
- Relapsers: 86% vs 22%
- Partial responders: 59% vs 15%
- Null responders: 32% vs 5%

In clinical trials Incivek was given for 12 weeks in combination with pegylated-interferon and ribavirin, two other medicines approved to treat hepatitis C. After the first 12 weeks, all patients stop receiving Incivek and continue treatment with pegylated-interferon and ribavirin alone for an additional 12 weeks or 36 weeks of treatment. With Incivek combination treatment, more than 60% of people treated for the first time, as well as those who relapsed after previous therapy, are expected to complete all treatment in 24 weeks—half the time needed if they were to take pegylated-interferon and ribavirin alone. All other patients will receive a total of 48 weeks of treatment.

Dosing

Incivek (750 mg) is given as two 375-mg tablets three times daily. It is packaged in weekly boxes that include daily blister strips to help patients keep track of their doses.

Side Effects

Rash and anemia are the most serious side effects associated with Incivek. The most common side effects reported with Incivek combination treatment include fatigue, itching, nausea, diarrhea, vomiting, anal or rectal problems, and taste changes.

Incivek can cause other serious side effects, including:

- Birth defects or death of an unborn baby
- Incivek combined with peginterferon alfa and ribavirin may cause birth defects or death of an unborn baby.

Patient should not take Incivek alone to treat chronic hepatitis C infection. It must be used with peginterferon alfa and ribavirin to treat chronic hepatitis C infection.

Contraindications

Incivek is contraindicated in pregnant women or those who may become pregnant, or in men with a sexual partner who is pregnant.

Incivek is contraindicated in patients who are taking alfuzosin hydrochloride (Uroxatral), atorvastatin (Lipitor, Caduet), ergot-containing medicines such as methylergonovine (Methergine), lovastatin (Advicor, Altoprev, Mevacor), pimo-

(Orap), rifampin (Rifadin, Rifamate, Rifater), sildenafil citrate (Revatio) or tadalafil (Adcirca) for pulmonary artery hypertension (PAH), simvastatin (Zocor, Vytorin, Simcor), St. John's wort (*Hypericum perforatum*), or triazolam (Halcion).

Talk to your healthcare provider before taking Incivek if any of the above applies to you. Your healthcare provider may need to change the amount of medicines you take.

Patient Assistance Program

The manufacturer (Vertex) is offering a comprehensive financial assistance and patient support program to help patients who might not otherwise be able to afford the drug. For eligible patients, the program includes the following:

Insurance Benefits Research and Support: Case managers will research patients' insurance benefits for Incivek combination treatment, assist people with insurance appeals, and help guide them to other forms of financial support, including Vertex's free medicine and co-pay programs

Free Medicine Program: Vertex will give Incivek for free to people who do not have insurance and have an annual household income of \$100,000 or less

Co-Pay Support: Vertex will cover copay or coinsurance costs up to 20% of the total cost of Incivek for people who have private insurance plans that cover Incivek, regardless of their household income. For people covered by government insurance, Vertex will also donate to the independent, non-profit Patient Access Network Foundation, which has a fund to provide copay support to people taking hepatitis C medicines.

More information about this program is available by calling 1-855-837-8394 or visiting www.Incivek.com.

Edurant (rilpivirine)

The FDA has approved the new antiretroviral Edurant, a non-nucleoside reverse transcriptase inhibitor, for use in people with HIV who have not previously been treated.

Edurant (rilpivirine) will be marketed by Tibotec Therapeutics, a subsidiary of Johnson & Johnson. Tibotec also markets the anti-HIV drugs Intelence (etravirine) and Prezista (darunavir).

The approval adds a new non-nucleoside reverse transcriptase inhibitor (NNRTI) to the list of approved anti-HIV drugs. It also increases the chances that a new combination pill, containing Edurant plus Truvada (emtricitabine/tenofovir), will be approved by the FDA.

The combination pill, which is intended as an alternative to Atripla (efavirenz/emtricitabine/tenofovir), will be marketed by Gilead Sciences. Gilead applied for approval of the combination pill in November 2010, and a decision is expected in August. ►



The approval of Edurant is based on clinical trial results showing that the drug is as effective as Sustiva (efavirenz) in treatment-naïve people with HIV. Sustiva is the most commonly prescribed NNRTI in the US and, according to current treatment guidelines, is the preferred NNRTI for people who have not previously been treated for HIV. Sustiva is also a component in Atripla, the most commonly prescribed antiretroviral regimen.

After 48 weeks of treatment, 83% of study participants taking Edurant achieved viral suppression (undetectable amount of HIV in the blood), compared to 80% of participants taking Sustiva.

Resistance

The FDA noted in its press release that Edurant does have some disadvantages relative to Sustiva. Clinical trial participants who failed treatment with Edurant were more likely to show drug resistance than those who failed treatment with Sustiva. They were also more likely to become resistant to the other antiretrovirals they were taking and to other NNRTIs.

In addition, clinical trial participants who started with higher viral loads of greater than 100,000 copies/ml were less likely to achieve viral suppression than participants who started with lower viral loads. Overall, 13% of trial participants taking Edurant experienced virologic failure, compared to 9% taking Sustiva.

Dosing and Side Effects

Edurant is taken as a once-daily 25-mg pill and must be taken with food. Its approval by the FDA is for use in combination with other antiretrovirals.

Side effects for Edurant were similar in nature and frequency to those for Sustiva. The most common side effects were depression, difficulty sleeping (insomnia), headache, and rash. However, fewer patients stopped taking Edurant because of side effects (2% percent vs 7% taking Sustiva).

Costs and Patient Assistance

The drug will cost \$21 per pill, or about \$7,700 per year. Sustiva currently costs around \$7,200 per year, assuming a normal adult dose of 600 mg daily.

Tibotec also plans to add Edurant to its patient assistance program, which provides Tibotec's anti-HIV drugs free to low-income patients, as well as to its other patient support programs.

Victrelis (boceprevir)

The FDA has approved Victrelis (boceprevir), for the treatment of genotype 1 chronic hepatitis C in combination with peginterferon alfa and ribavirin, in adult patients (18 years of age and older) with compensated liver disease, including cirrhosis, who are

previously untreated or who have failed previous interferon and ribavirin therapy. Victrelis is a direct-acting antiviral (DAA) agent that interferes with the ability of the hepatitis C virus to replicate by inhibiting a key viral enzyme (NS3/4A serine protease).

The FDA approval of Victrelis is based on the efficacy and safety results from two large Phase III clinical studies that evaluated approximately 1,500 adult patients with chronic HCV genotype 1 infection. Both studies included two treatment arms with Victrelis: a response-guided therapy (RGT) arm, in which patients with undetectable virus (HCV-RNA) at treatment week 8 were eligible for a shorter duration of therapy, as well as a 48-week treatment arm. All patients receiving Victrelis in these studies were first treated with peginterferon alfa-2b and ribavirin (P/R) in a 4-week lead-in phase, followed by the addition of Victrelis after week 4. The studies also included a control arm in which patients received 48 weeks of treatment with P/R alone. Historical null responders were not enrolled.

Primary results from the two pivotal studies:

- Treatment-naïve patients: 63% (8-week treatment) and 66% (48-week treatment) vs 38% (control)
- Treatment-failure patients: 59% (8-week treatment) and 66% (48-week treatment) vs 23% (control)

In a separate, prespecified cohort of 159 Black treatment-naïve patients, the addition of Victrelis to P/R resulted in a significant increase in SVR to 42% (8 weeks) and 53% (48-week) vs 23% for control. Relapse rates were 12% (8 weeks) and 17% (48 weeks) vs 14% for control.

The following points should be considered when initiating Victrelis for treatment of chronic hepatitis C infection:

- Victrelis must not be used as monotherapy and should only be used in combination with peginterferon alfa and ribavirin.
- Victrelis efficacy has not been studied in patients who have previously failed therapy with a treatment regimen that includes Victrelis or other HCV NS3/4A protease inhibitors.
- Victrelis in combination with peginterferon alfa and ribavirin has not been studied in patients documented to be historical null responders (less than a 2 log HCV-RNA decline by treatment week 12) during prior therapy with peginterferon alfa and ribavirin.

Safety and Tolerability

Serious adverse events were reported in 11% of patients receiving Victrelis in combination with P/R, compared to 8% of patients receiving P/R alone. Adverse reactions that led to dose modifications of any drug (primarily P/R) occurred in 39% of patients receiving the combination of Victrelis with P/R compared to 24% of patients receiving P/R alone. The most common reason for



dose reduction was anemia, which occurred more frequently in patients receiving the combination of Victrelis with P/R than in patients receiving P/R alone.

Anemia has been reported with peginterferon alfa and ribavirin therapy. The addition of Victrelis to peginterferon alfa and ribavirin is associated with an additional decrease in hemoglobin concentrations. The addition of Victrelis may result in a worsening of neutropenia associated with peginterferon alfa and ribavirin alone. Complete blood counts should be obtained pretreatment, and at treatment weeks 4, 8, and 12, and should be monitored closely at other time points, as clinically appropriate. If a patient has a serious adverse reaction potentially related to peginterferon alfa and ribavirin therapy, the peginterferon alfa and/or ribavirin dose should be reduced or discontinued. Victrelis must not be administered in the absence of peginterferon alfa and ribavirin.

The most commonly reported adverse reactions (greater than 35%) in clinical trials in adult patients receiving the combination of Victrelis with peginterferon alfa-2b and ribavirin were fatigue, anemia, nausea, headache and dysgeusia. Of these commonly reported adverse reactions, fatigue, anemia, nausea, and dysgeusia occurred at rates greater than or equal to 5% above the rates for peginterferon alfa and ribavirin alone in either clinical study. The incidence of these adverse reactions in previously untreated patients that were treated with Victrelis combination therapy compared with peginterferon and ribavirin alone were fatigue (58% vs 59%), anemia (50% vs 30%), nausea (46% vs 42%), dysgeusia (35% vs 16%), respectively. The incidence of these adverse reactions in previously treated patients that were treated with Victrelis combination therapy compared with peginterferon and ribavirin alone were: fatigue (55% vs 50%), anemia (45% vs 20%), nausea (43% vs 38%), dysgeusia (44% vs 11%), respectively.

Important Safety Information

Victrelis in combination with peginterferon alfa and ribavirin is contraindicated in pregnant women and in men whose female partners are pregnant. Victrelis is contraindicated in coadministration with drugs that are highly dependent on CYP3A4/5 for clearance, and for which elevated plasma concentrations are associated with serious and/or life-threatening events.

Victrelis also is contraindicated in coadministration with potent CYP3A4/5 inducers where significantly reduced boceprevir plasma concentrations may be associated with reduced efficacy. Drugs that are contraindicated with Victrelis include: alfuzosin, carbamazepine, phenobarbital, phenytoin, rifampin, dihydroergotamine, ergonovine, ergotamine, methylergonovine, cisapride, St. John's Wort (*hypericum perforatum*), lovastatin, simvastatin, drosperinone, Revatio® (sildenafil) or Adcirca® (tadalafil) (when

used for the treatment of pulmonary arterial hypertension), pimozide, triazolam, and midazolam (orally administered).

Patient Assistance

The manufacturer (Merck) is expanding its support of public awareness and education programs for CHC. Resources include coupons to help eligible patients with their medication cost, reimbursement support to help patients understand their insurance coverage for Victrelis, and 24/7 nurse phone support.

Separately, Merck will also add Victrelis to its patient assistance program through which eligible patients may be able to receive product free of charge.


Dosing and Administration

Victrelis must be administered in combination with peginterferon alfa and ribavirin. Therapy is initiated with peginterferon alfa and ribavirin for 4 weeks. Beginning in treatment week 5, Victrelis is added at a dose of 800 mg (four 200 mg capsules) orally three times daily (every 7-9 hours) with food (a meal or light snack). Based on the patient's virus (HCV-RNA) levels at treatment weeks 8, 12, and 24, dosing is adjusted using the following response-guided therapy guidelines.

Treatment-naïve patients: Patients who are undetectable at treatment weeks 8 and 24 complete all therapy at treatment week 28. Patients who are detectable at treatment week 8, but undetectable at treatment week 24, complete Victrelis at treatment week 36 and continue on peginterferon alfa and ribavirin alone until treatment week 48.

Treatment-failure patients: Patients (previous partial responders or relapsers) who are undetectable at treatment weeks 8 and 24 complete all therapy at treatment week 36. Patients who are detectable at treatment week 8, but undetectable at treatment week 24, complete Victrelis at treatment week 36 and continue on peginterferon alfa and ribavirin alone until treatment week 48. Response-guided therapy was not studied in treatment-failure patients who had less than a 2 log decrease in virus (HCV-RNA) at treatment week 12 of prior treatment (null responders). If treated, these patients should receive 4 weeks of peginterferon alfa and ribavirin followed by 44 weeks of Victrelis in combination with peginterferon alfa and ribavirin.

Patients with compensated cirrhosis should receive 4 weeks peginterferon alfa and ribavirin followed by 44 weeks of Victrelis in combination with peginterferon alfa and ribavirin.

Patients who have HCV-RNA results greater than or equal to 100 IU/mL at treatment week 12 discontinue the three-medicine regimen. Patients who have confirmed detectable HCV-RNA at treatment week 24 discontinue the three-medicine regimen. 



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.

Dig Dis Sci. 2011 May 17. [Epub ahead of print]

Novel biomarker candidates to predict hepatic fibrosis in hepatitis C identified by serum proteomics.

Yang L, Rudser KD, Higgins L, et al.

BACKGROUND: Liver biopsy remains the gold standard to assess hepatic fibrosis. It is desirable to predict hepatic fibrosis without the need for invasive liver biopsy. Proteomic techniques allow unbiased assessment of proteins and might be useful to identify proteins related to hepatic fibrosis. **AIMS:** We utilized two different proteomic methods to identify serum proteins as candidate biomarkers to predict hepatic fibrosis stage in patients with chronic hepatitis C virus (HCV) infection. **METHODS:** Serum was obtained from 24 people with chronic HCV at time of liver biopsy and from 6 normals. Liver biopsy fibrosis was staged 1-4 (Batts-Ludwig). Pooled serum samples (six in each of four fibrosis groups and controls) were analyzed with 4- and 8-plex isobaric tags for relative and absolute quantitation (iTRAQ), determining protein identification (ID) and ratios of relative protein abundance. Nonpooled samples were analyzed with two-dimensional (2-D) gels and difference in gel electrophoresis (DIGE) comparing different samples on the same gel and across gels. Spots varying among groups were measured with densitometry, excised, digested, and submitted for tandem mass spectrometry (MS/MS) protein ID. **RESULTS:** iTRAQ identified 305 proteins (minimum 99% ID confidence); 66 were increased or decreased compared with controls. Some proteins were increased or decreased for specific fibrosis scores. From 704 DIGE protein spots, 66 were chosen, 41 excised, and 135 proteins identified, since one gel spot often identified more than one protein. **CONCLUSIONS:** Both proteomic methods identified two proteins as biomarker candidates for predicting hepatic fibrosis: complement C4-A and inter-alpha-trypsin inhibitor heavy chain H4.

Department of Pediatrics, University of Minnesota, Minneapolis, MN, USA.

J Heart Lung Transplant. 2011 Feb;30(2):144-50. Epub 2010 Sep 19.

Antibody testing for cardiac antibody-mediated rejection: which panel correlates best with cardiovascular death?

Revelo MP, Stehlik J, Miller D, et al.

BACKGROUND: Recent efforts are being undertaken to update and refine current diagnostic criteria for antibody-mediated rejection (AMR) in heart transplantation. We believe that the appropriate reactants are those that best predict the adverse consequences of AMR and therefore tested various models using different reactants to find the best predictors of cardiovascular mortality in pathologically defined AMR. **METHODS:** The study group included only patients in whom all immunofluorescence antibodies of interest had been tested on biopsy specimens obtained after 2002 when C4d was routinely added. We analyzed our data using 3 Cox proportional hazard models with time-varying covariates using an end point of cardiovascular mortality, as previously defined. **RESULTS:** In 3,712 biopsy specimens from 422 patients, the 2-antibody model achieved a value of $R(2)=0.930$ using C3d and C4d antibodies alone. A model that used 4 antibodies—C3d, C4d, human leukocyte antigen-D related (HLA-DR) and fibrin—was superior ($R(2)=0.988$). The model that best predicted cardiovascular mortality included all 6 antibodies: HLA-DR, immunoglobulin (Ig) G, IgM, C3d, C4d, and fibrin ($R(2)=0.989$). The models using 4 or 6 antibodies were significantly superior to the model using only C3d and C4d (for each interaction, $P<0.0001$). **CONCLUSIONS:** The combination of complement components, HLA-DR and fibrin, is valuable in defining AMR in patients at risk for allograft loss from cardiovascular causes. Fibrin is particularly important for detecting the presence of severe AMR, with a high likelihood of poor long-term patient outcome.

George E Wahlen Veterans Affairs Medical Center, Utah Transplantation Affiliated Hospitals, Salt Lake City, UT, USA.

Eur J Cardiothorac Surg. 2010 Sep;38(3):277-84. Epub 2010 Apr 3.

Long-term outcome of double-lung and heart-lung transplantation for pulmonary hypertension: a comparative retrospective study of 219 patients.

Fadel E, Mercier O, Mussot S, et al.

OBJECTIVE: Whether double-lung transplantation (DLT) or heart-lung transplantation (HLT) is the best option in patients with pulmonary hypertension (PH) remains unclear. At our institution, patients with severe right ventricular dysfunction or congenital systemic-to-pulmonary shunt (CSPS) are preferentially treated with HLT. We sought to determine whether the outcomes warrant continuing this policy. **METHODS:** We retrospectively reviewed cases of DLT (n=67) or HLT (n=152) performed for end-stage PH between 1986 and 2008 at our institution. According to the new clinical classification of PH, 147 patients were group I (pulmonary arterial hypertension group, of which 30 had CSPS), 24 were group III (PH associated with lung disease and/or hypoxemia), 20 were group IV (chronic thromboembolic PH) and 20 were group V (sarcoidosis or histiocytosis X). **RESULTS:** Compared with the HLT group, the DLT group had less severe disease as reflected by a higher preoperative cardiac index (2.5 + or - 0.8 vs 2.0 + or - 0.4; P=0.0006), lower New York Heart Association (NYHA) functional class (3.4 + or - 0.4 vs 3.8 + or - 0.5; P<0.0001), lower rates of kidney failure (31% vs 66%; P<0.0001) and liver failure (13% vs 38%; P=0.0003) and less need for preoperative inotropic support (10% vs 25%; P=0.014). Nevertheless, survival after 1, 5, 10 and 15 years was not significantly different between the two groups (HLT group: 70%, 50%, 39% and 26%; and DLT group: 79%, 52%, 43% and 30%; respectively; P=0.932). Freedom from obliterative bronchiolitis-related death was significantly greater in the HLT group (100% at 1 year, 84% at 5 years and 74% at 10 years; compared with 98%, 70%, and 59%, respectively, in the DLT group; P=0.035). **CONCLUSIONS:** In patients with end-stage PH, good long-term survival rates were obtained using either DLT or HLT. However, these results were achieved with preferential use of HLT in patients with right heart failure or CSPS. Obliterative bronchiolitis-related death was less common with HLT than with DLT.

Department of Thoracic and Vascular Surgery and Heart-Lung Transplantation, Hôpital Marie-Lannelongue, Le Plessis Robinson, Paris-Sud University, Paris, France.

Am J Med. 2011 Jun;124(6):498-500.

Office management of hypertension in older persons.

Aronow WS.

ABSTRACT: Antihypertensive drug therapy reduces cardiovascular events in older persons. In the Hypertension in the Very Elderly Trial, at 1.8-year follow-up, patients aged 80 years and older treated with antihypertensive drug therapy had a 30% reduction in fatal or nonfatal stroke (P=.06), a 39% reduction in fatal stroke (P=.05), a 21% reduction in all-cause mortality (P=.02), a 23% reduction in death from cardiovascular causes (P=.06), and a 64% reduction in heart failure (P<.001). The goal of treatment of hypertension is to lower the blood pressure to less than 140/90 mm Hg in older persons and to less than 130/80 mm Hg in older persons with diabetes or chronic kidney disease if tolerated. The selection of antihypertensive drug therapy in persons with associated medical conditions depends on their medical conditions. Large meta-analyses of published trials show that thiazide diuretics, angiotensin-converting enzyme inhibitors, calcium channel blockers, angiotensin-receptor antagonists, and beta-blockers do not significantly differ in their ability to lower blood pressure and to exert cardiovascular protection in older and younger persons. If the blood pressure is more than 20/10 mm Hg above the goal blood pressure, drug therapy should be initiated with 2 antihypertensive drugs. Other coronary risk factors must be treated.

Department of Medicine, Divisions of Cardiology, Geriatrics, and Pulmonary/Critical Care, New York Medical College, Valhalla, NY, USA.

HIV Med. 2011 May 22. doi: 10.1111/j.1468-1293.2011.00933.x. [Epub ahead of print]

Safety and efficacy of raltegravir in patients with HIV-1 and hepatitis B and/or C virus coinfection.

Rockstroh J, Tepler H, Zhao J, et al.

OBJECTIVE: The aim was to examine the long-term safety and efficacy of raltegravir in patients with HIV-1 and hepatitis B virus (HBV) and/or hepatitis C virus (HCV) coinfection in three double-blind, randomized, controlled Phase III studies. **METHODS:** In STARTMRK, treatment-naïve patients ►

received raltegravir 400 mg twice a day (bid) or efavirenz 600 mg at bedtime, both with tenofovir/emtricitabine. In BENCHMRK-1 and -2, highly treatment-experienced patients with multi-drug resistant virus and prior treatment failure received raltegravir 400 mg bid or placebo, both with optimized background therapy. Patients with chronic HBV and/or HCV coinfection were enrolled if baseline liver function tests were ≤ 5 times the upper limit of normal. HBV infection was defined as HBV surface antigen positivity for all studies; HCV infection was defined as HCV RNA positivity for STARTMRK and HCV antibody positivity for BENCHMRK. **RESULTS:** Hepatitis coinfection was present in 6% (34 of 563) of treatment-naïve patients (4% HBV only, 2% HCV only and 0.2% HBV+HCV) and 16% (114 of 699) of treatment-experienced patients (6% HBV only, 9% HCV only and 1% HBV+HCV). The incidence of drug-related adverse events was similar in raltegravir recipients with and without hepatitis coinfection in both STARTMRK (50 vs 47%) and BENCHMRK (34 vs 38.5%). Grade 2-4 liver enzyme elevations were more frequent in coinfecting vs monoinfected patients, but were not different between the raltegravir and control groups. At week 96, the proportion of raltegravir recipients with HIV RNA < 50 HIV-1 RNA copies/mL was similar between coinfecting and monoinfected patients (93 vs 90% in STARTMRK; 63 vs 61% in BENCHMRK). **CONCLUSION:** Raltegravir was generally well tolerated and efficacious up to 96 weeks in HIV-infected patients with HBV/HCV coinfection.

Department of Medicine I, University of Bonn, Bonn-Venusberg, Germany; Merck Research Laboratories, North Wales, PA, USA.

AIDS. 2011 May 17. [Epub ahead of print]

A randomized cross-over study to compare raltegravir and efavirenz (SWITCH-ER study).

Nguyen A, Calmy A, Delhumeau C, et al.

BACKGROUND: Efavirenz (EFV) causes neuropsychiatric side effects and an unfavorable blood lipid profile. We investigated the effect of replacing EFV with raltegravir (RAL) on patient preference, daytime sleepiness, sleep quality, anxiety, and lipid levels. **METHOD:** Switch-ER was a randomized, double-blind, cross-over study. Patients who tolerated EFV, with < 50 copies/ml HIV-RNA, were randomized in 2 groups: the RAL-first group started with RAL (400 mg twice daily) plus EFV-placebo, and the EFV-first group with EFV (600 mg once-daily) plus

RAL-placebo. After 2 weeks, both groups switched to the alternate regimen. The primary endpoint was patient preference for the first or the second regimen, assessed after 4 weeks. **RESULTS:** 57 subjects were enrolled with a median CD4 cell count 600/ μ L, and duration of previous EFV therapy 3.4 years. 53 subjects completed the study. When asked about treatment preference after 4 weeks, 22 preferred RAL, and 12 preferred EFV, while 19 did not express a preference. A significant difference in anxiety and stress scores favoring RAL ($P=0.04$ and 0.03 respectively) was observed. Median plasma cholesterol levels decreased by 0.4 mmol/L (16 mg/dL, $P<0.001$), triglycerides by 0.2 mmol/L (18 mg/dL, $P=0.036$), and LDL by 0.2 mmol/L (8 mg/dL, $P=0.004$) after replacing EFV with RAL. After study completion, 51% of patients switched to RAL. **CONCLUSION:** Half of patients previously on a stable EFV preferred to switch to RAL, after double-blind exposure to RAL for two weeks. Substitution of EFV by RAL significantly impacted on lipid levels, stress and anxiety scores.

University Clinic of Infectious Diseases, University Hospital of Geneva; University Clinic of Infectious Diseases and Div. of Clinical Pharmacology and Toxicology, University Hospital of Lausanne; University Clinic of Infectious Diseases, University Hospital of Basel; University Clinic of Infectious Diseases, University Hospital of Bern; Infectious Diseases Unit, Hospital of Lugano Infectious Diseases Unit, Hospital of St-Gallen, Switzerland.

Diabetes Care. 2011 May 18. [Epub ahead of print]

Increased risk of hypertension after gestational diabetes: findings from a large prospective cohort study.

Tobias DK, Hu FB, Forman JP, Chavarro J, Zhang C.

OBJECTIVE: Whether a history of gestational diabetes mellitus (GDM) is associated with an increased risk of hypertension after the index pregnancy is not well established. **RESEARCH DESIGN AND METHODS:** We investigated the association between GDM and subsequent risk of hypertension after the index pregnancy among 25,305 women who reported at least one singleton pregnancy between 1991 and 2007 in the Nurses' Health Study II. **RESULTS:** During 16 years of follow-up, GDM developed in 1,414 women (5.6%) and hypertension developed in 3,138. A multivariable Cox proportional hazards model showed women with a history of GDM had a 26% increased risk of developing hypertension compared with those without a his-

tory of GDM (hazard ratio 1.26 [95% CI 1.11-1.43]; P=0.0004). These results were independent of pregnancy hypertension or subsequent type 2 diabetes. **CONCLUSIONS:** These results indicate that women with GDM are at a significant increased risk of developing hypertension after the index pregnancy.

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BMC Cancer. 2011 May 23;11(1):193. [Epub ahead of print]

The association of quality of life with potentially remediable disruptions of circadian sleep/activity rhythms in patients with advanced lung cancer.

Grutsch JF, Ferrans C, Wood PA, et al.

BACKGROUND: Cancer patients routinely develop symptoms consistent with profound circadian disruption, which causes circadian disruption diminished quality of life. This study was initiated to determine the relationship between the severity of potentially remediable cancer-associated circadian disruption and quality of life among patients with advanced lung cancer. **METHODS:** We concurrently investigated the relationship between the circadian rhythms of 84 advanced lung cancer patients and their quality of life outcomes as measured by the EORTC QLQ C30 and Ferrans and Powers QLI. The robustness and stability of activity/sleep circadian daily rhythms were measured by actigraphy. Fifty-three of the patients in the study were starting their definitive therapy following diagnosis and 31 patients were beginning second-line therapy. Among the patients who failed prior therapy, the median time between completing definitive therapy and baseline actigraphy was 4.3 months, (interquartile range 2.1 to 9.8 months). **RESULTS:** We found that circadian disruption is universal and severe among these patients compared to non-cancer-bearing individuals. We found that each of these patient's EORTC QLQ C30 domain scores revealed a compromised capacity to perform the routine activities of daily life. The severity of several, but not all, EORTC QLQ C30 symptom items correlate strongly with the degree of individual circadian disruption. In addition, the scores of all four Ferrans/Powers QLI domains correlate strongly with the degree of circadian disruption. Although Ferrans/Powers QLI domain scores show that cancer and its treatment spared these patients' emotional and psychological health, the QLI Health/Function domain score revealed high levels of patients' dissatisfaction with their health, which is much worse when circadian

disruption is severe. Circadian disruption selectively affects specific Quality of Life domains, such as the Ferrans/Powers Health/Function domain, and not others, such as EORTC QLQ C30 Physical Domain. **CONCLUSIONS:** These data suggest the testable possibility that behavioral, hormonal and/or light-based strategies to improve circadian organization may help patients suffering from advanced lung cancer to feel and function better.

Cancer. 2011 May 11. doi: 10.1002/cncr.26206. [Epub ahead of print]

Thoracic radiation therapy improves the overall survival of patients with extensive-stage small cell lung cancer with distant metastasis.

Zhu H, Zhou Z, Wang Y, et al.

BACKGROUND: The authors conducted a retrospective study to evaluate the effects of thoracic radiation therapy (TRT) for patients with extensive-stage small cell lung cancer (ED-SCLC). **METHODS:** Between January 2003 and December 2006, the records of 119 patients who were diagnosed with ED-SCLC (all with distant metastasis [M1]) were included in the study. Sixty patients received chemotherapy (ChT) and TRT (ChT/TRT), and 59 patients received ChT alone. The ChT regimens consisted of either carboplatin and etoposide (CE) or cisplatin and etoposide (PE). The total dose of TRT ranged from 40 to 60 grays (Gy) at 1.8 to 2.0 Gy per fraction. **RESULTS:** For the entire group, the median survival was 13 months, and the 2-year and 5-year overall survival (OS) rates were 26.1% and 6.5%, respectively. The median survival and the 2-year and 5-year OS rates were 17 months, 35%, and 7.1%, respectively, in the ChT/TRT group and 9.3 months, 17%, and 5.1%, respectively, in the ChT group (P=.014). However, this improvement was achieved at the expense of low toxicity. Multivariate analysis revealed that receiving ≥ 4 cycles of ChT (P=.032) and TRT (P=.005) were favorable prognostic factors for OS. Of all toxicities, only high-grade leucopenia (grade >3) was more frequent in the ChT/TRT group. **CONCLUSIONS:** The addition of TRT to ChT improved the OS of patients with ED-SCLC. Furthermore, receiving ≥ 4 cycles of ChT and TRT were independent, favorable prognostic factors for OS.

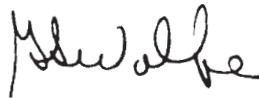
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Patient Adherence: A Challenge for the Case Manager *continued from page 2*

underestimate nonadherence in their patients. If you are unable to detect nonadherence, it is impossible to correct the problem. It is imperative to measure and evaluate patient adherence reliably. This can be done by self-reports, pill counting, and in some cases measuring serum or urine drug levels. Of these, self-report is the most practical and widely used tool. In general, patients can be very accurate in reporting whether they are adhering to their treatment regimens if they are asked simply and directly. Moreover, regular assessment of patient adherence by itself can lead to increased patient adherence.

Patient adherence is complex and

a challenge for the case manager. Any approach to patient adherence requires an understanding that all patients are different. The patients' needs, journey, reactions, decision-making processes, and behaviors are unique. The case manager plays a pivotal role in patient adherence. Improving patient adherence may be the best cost containment strategy of a case manager.



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ACCM: Improving Case Management Practice through Education

Encouraging Face-to-Face Encounters With Home Health Patients

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substandard care by case managers/discharge planners.

Finally, a key goal of all hospitals is to avoid readmissions. The initiation and continuation of home health services certainly plays a key role in achieving this goal.

Understandably, home health agencies, physicians, and case managers/

discharge planners are not eager to take on additional burdensome activities and paperwork. It is unlikely that the requirements described above will change, since they are mandated by a federal statute. Consequently, practitioners must focus on their first priority, which is, of course, to provide the best care possible to patients and to work cooperatively to do so. **CM**

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Commission for Case Manager Certification Unveils Knowledge Framework *continued from page 5*

through the CMBOOK and automatically update their personal education records through the Commission's online CM Dashboard.

"The CMBOOK has been in development for 2 years, and simply put, it is the go-to resource for those interested in the process and practice of professional case management," said Patrice Sminkey, RN, the Commission's chief staff executive. "It is the Commission's

hope that the Knowledge Framework and the CMBOOK product will inform community health programs, medical practices, hospital programs, and health plans as they develop new products and services designed to effectively coordinate care in a meaningful way."

The CMBOOK was written by leading case management experts and its contents underwent peer review; it embodies both the science and art of case management. Its years in development represent the Commission's commitment to excellence and realize the Commission's vision for advancement

Managing the Care Complexity of Spinal Cord Injury

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the patient and family, the case manager is the one person who can be relied on to ensure that the discharge is both safe and proficient. **CEU**

Colleen Fulton, MSPT, graduated from Indiana University in 1995 with a Bachelors of Science in Biology. She graduated from Washington University Program in Physical Therapy with a Master's degree in Physical Therapy in 1998. She has worked for Children's Healthcare of Atlanta since April 1999. She served in direct patient care from 1999 to 2007 and in case management on the comprehensive inpatient rehabilitation unit from 2007 to present.

Exam starts on page 18

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and evolution of case management.

"The greatest challenge has been and will continue to be condensing the available knowledge to meet the practical needs of the various case management professionals, health disciplines and audiences," said Hussein Tahan, DNSc, RN, past chair of the Commission, Role and Function Study chief researcher and now knowledge editor of CMBOOK.

The Commission has engaged an advisory board of case management professionals as well as employers, policy makers, academics, researchers, ►

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Commission for Case Manager Certification Unveils Knowledge Framework *continued from page 28*

health plans and other providers who, working with the CMBOK's knowledge editor, will identify areas in the CMBOK for addition or updates. **CM**

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