CareManagement

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FROM THE EDITOR-IN-CHIEF

Gary S. Wolfe

The Code of Professional Conduct

Every day the case manager is faced with decisions about "doing the right thing." Sometimes it's a simple decision, but frequently it is complex and involves ethics. With an increasing amount of knowledge available to everyone, people have more choices. What does the case manager do? Some of the issues, as I suggested, are simple, but many address some of the most complex issues in health care: access to care, treatment options, continuing treatment, care at end of life, withholding feeding, and the list goes on and on. What does the case manager do? The decisions and behavior of the case manager are guided by the Code of Professional Conduct (Code) promulgated by the Commission for Case Manager Certification (CCMC)/ Certified Disability Management Specialist (CDMS). Such codes may go by different names: ethical codes, professional codes, code of ethics, codes of professional conduct, and codes of ethical conduct.

Codes are not new. The Hippocratic Oath taken by physicians is the oldest and most widely known treatise of medical ethics dictating duties and responsibilities of the physician when caring for patients. The Hippocratic Oath has been around since the fifth century. All health professionals and workers have a Code. A Code is not optional in health care. It is an essential and integral part of health care and everyone involved. The primary purpose of the Code is to protect the public, but other purposes include declarations of the values to which case managers commit themselves, as codifications of the expectations about how case managers will conduct themselves, and a mechanism for holding individuals and their organizations accountable to stakeholders.

Professional Codes are intended to guide decision-making and direct behavior. Codes are intended as a guide and framework for the case manager to consider in ethical dilemmas and when making decisions.

The Code of CCMC/CDMS consists of Principles, Rules of Conduct, and Standards of professional Conduct. According to the CCMC Code of Professional Conduct, "The Principles provide normative guidelines and are advisory in nature. The rules of Conduct and the Standards of Professional Conduct prescribe the level of conduct required of every board-certified case manager.

Principles

- Principle 1: Board-certified case managers (CCMs) will place the public interest above their own at all times.
- Principle 2: Board-certified case managers will respect the rights and inherent dignity of all of their clients.
- Principle 3: Board-certified case managers will always maintain objectivity in their relationships with clients.

Principle 4: Board-certified case

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Catherine M. Mullahy

Addressing Complex Ethical Issues … a Moral Imperative for Case Managers

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

One only has to look at the headlines and listen to commentary across the media to realize that the conflicts being faced by those in our country, and across the world, are increasingly problematic. These conflicts span a very broad spectrum of issues, including racial discrimination and its impact on mental health, and implicit biases involving race, ethnicity, religion, sexual orientation, socioeconomic background, and education. These are especially challenging to health care professionals who are trying to strike the appropriate balance between providing care within the context of health equity and the standards of their profession. As with so many other issues, case managers, once again, are on the front lines. For many years, case managers have been considered the "conscience of an organization" with our mandate to balance quality of care with the available financial resources. It's important for us to understand the implications these troublesome issues present to ensure our patients are not impacted in a negative manner.

These are especially challenging to health care professionals who are trying to strike the appropriate balance between providing care within the context of health equity and the standards of their profession.

Thankfully, we have several resources to provide guidance including the CMSA Standards of Practice and CCMC Code of Professional Conduct.

Two Ethics CE articles in this last edition for 2023 and the first for 2024 address both of these issues: "The Ethical Imperative in Addressing Racial Discrimination's Impact on Mental Health" (Chikita Mann, MSN, RN, CCM, and a member of our Editorial Advisory Board), and "Implicit Bias: Ethical Implications for the Case Manager"(Gary Wolfe, RN, CCM, FCM, our Editor-in Chief) are particularly noteworth, and I encourage you to read each of them.

Since the October 7 Hamas attack on Israel and the ensuing war, we have witnessed a disturbing trend of increasing antisemitism, particularly played out on US college/university campuses. Reuters recently reported on the results of an Anti-Defamation League survey, which found that nearly three in four Jewish college students in the US said they had experienced or witnessed antisemitism during the 2023-2024 school year. The same survey showing that 38.6% of Jewish students said they "felt comfortable on campus knowing they are Jewish" compared to 63.7% before October 7th. Of course, we have also witnessed a rise in anti-Islamic discrimination and discrimination against African Americans and Asian Americans over the past several years. Examples of the antisemitic protests occurred at Ivy League institutions such Columbia, Cornell, and the University of Pennsylvania, as well as Wellesley College, Lafayette College, and Cooper Union for the Advance of Science. In response, the federal government has opened civil rights investigations into these schools and one K-12 school system, the Maize Unified School District in Kansas, over allegations of , or ethnicity should not be faced with brazen discrimination or hate.

As case managers, it is within our role to serve and support our patients, which also includes addressing their concerns over social issues that may affect their health. The CMSA Standards of Practice and CCMC Code of Professional Conduct address these matters and call for us to help our patients and their families, regardless of their race, religion, or ethnicity to cope with stresses that may occur as a result of world events that may also lead to incidents such as those we have been witnessing. While ours is not a political role, we must always consider our patients and how external events may be affecting their emotional well-being, which we all know is intrinsically linked to their physical well-being.

Interestingly, the third article, from Hannah Schroeder, LISW-S, and

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Justice—for All: A Case Management Value

By R. Keith Franklin, PhD, LPC-S, LCDC, ACS, CEAP, CCM

JUSTICE IS AN ETHICAL PRINCIPLE of case management, grounded in the concepts of fairness and equality. It is a high standard—and ideal—that calls us to do our best to provide equal access to resources and treatment to all. But in the complexity of health and human services today, and given all the challenges and barriers that exist, providing for a just outcome can be difficult.

In my role as a mental health counselor and based on my professional experience working mostly with active military service members, I have identified 5 concepts that, in my view, speak to some ways in which case managers can strive to uphold the value of justice.

1. **Fairness and Equal Treatment.** We start with a commitment to treat individuals fairly and equally, irrespective of things like background, ethnicity, or race. Our goal is to find a level playing field in providing care and support, rather than treating people based on their ability to pay or other external factors. Sometimes, however, we encounter incidents in which there is a lack of fairness. An individual who has insurance can be treated at a certain private hospital, while someone who is uninsured goes to a different hospital. As case managers, however, we cannot perpetuate this sense of injustice by making the assumption that a particular hospital is where some should or must go. Rather, as advocates, case managers should discuss the risks and benefits with the individual and their support system. For example, the benefits of going to a private hospital might include access to certain specialists; however, receiving care at that hospital would result in risk of a financial burden to the individual. Ultimately, it is up to the individual to make that decision—not to have it happen to them by default.

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Practicing justice within case management is not an easy task. When we face challenges, we can find support and guidance from colleagues, both within our organization and across our profession.

2. **Identifying and Eliminating Disparities**. Case managers play an important role in addressing disparities in access, outcomes, and social determinants of health (SDOH). We are bound by our ethics and standards of our profession to advocate for resources where they are most needed. This is where we encounter the differences between equality and equity. Equality can be thought of as beginning at the hospital entrance. Equity takes into account whether someone can even get to the hospital door. For example, if the nearest bus route is 1 mile away from a particular hospital, people who have transportation limitations will have difficulty receiving treatment there. There is no equity compared to those with cars. When we encounter such unfairness, we need to lend our voices within our organizations and hospitals, the community, or even on the community and state level to articulate what disparities exist and how they need to be changed. In this example, it may be advocating for a new or extended bus route so that more people can equitably access a hospital.
3. **Cultural Competence and Sensitivity.** The more culturally competent and sensitive we are to others, the better we can understand and respect people from diverse backgrounds and their values. With that understanding, we can create care plans that are tailored to their needs to promote equitable health outcomes. For example, some individuals may not believe in vaccines because of religious or cultural reasons. Regardless of the case managers' own personal opinions, they need to inform these individuals of the risks and benefits of vaccination. Sensitivity requires us to be mindful of our communication, both verbal and nonverbal. Word choice,

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Two Perspectives, One Goal: Case Management and Population Health Working Together

By Colleen Morley, DNP, RN, CCM, CMAC, CMCN, ACM, RN, FCM

Recently, I was invited to moderate a panel at the RISE Population Health Summit. As I have long held the position that case management and population health are inextricably intertwined (despite what my Population Health professor thought), I was eager to participate and honored to moderate a panel titled "Destigmatizing Hospice" as well as expand my perspective from a population health lens.

Population health represents a holistic approach to understanding and improving the health outcomes of a specific group. It transcends individual patient care by focusing on the broad spectrum of factors affecting the health of entire populations, including social, economic, and environmental elements. The RISE 2023 Population Health Conference in Tampa, Florida, gathered health care professionals, policy makers, and thought leaders to share insights, strategies, and innovations in population health management. The conference served as a melting pot for ideas, fostering collaboration and learning, and highlighting the crucial role of integrated health care practices in enhancing population well-being. This annual event is a venue for professionals, especially case managers, to explore and deepen their understanding of how best to implement and evolve population health strategies.

Population health represents a holistic approach to understanding and improving the health outcomes of a specific group. It transcends individual patient care by focusing on the broad spectrum of factors affecting the health of entire populations, including social, economic, and environmental elements.

Colleen Morley, DNP, RN, CCM, CMAC, CMCN, ACM-RN, FCM, *is current president of the Case Management Society of America National Board of Directors and principal of Altra Healthcare Consulting in Chicago, IL. She has held positions in acute care as director of case management at several acute care facilities and managed care entities in Illinois for over 14 years, piloting quality improvement initiatives focused on readmission reduction and care coordination through better communication and population health management. Her current passion is in the area of improving health literacy. She is the recipient of the CMSA Foundation Practice Improvement Award (2020) and ANA Illinois Practice Improvement Award (2020) for her work in this area.*

Understanding Population Health

Population health is an interdisciplinary field that focuses on the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is a concept that extends beyond the treatment of individual patients, aiming to improve the health of an entire population. This approach is increasingly vital in health care as it allows for a more effective allocation of resources and tailored interventions that address widespread health concerns.

The primary goal of population health management is to enhance health care quality and patient outcomes while reducing health care costs. It involves identifying health risks within a population and implementing proactive strategies to mitigate these risks. This approach fosters a comprehensive understanding of health determinants, including genetic, behavioral, environmental, and social factors, and how they interact to affect health.

Determinants of population health are multifaceted. Social determinants, such as education, income, and social support networks, significantly influence health outcomes. Economic factors, including access to health care services and employment opportunities, also play a crucial role. Environmental elements, like housing, pollution, and urban design, impact the health of populations as well. Understanding these determinants is crucial for developing effective population health strategies.

Role of Case Management in Population Health

Case management in health care is a collaborative process of assessment,

planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs. In the context of population health, case managers play a pivotal role in bridging the gap between individual patient care and wider community health initiatives.

Case managers contribute to population health by ensuring that patients receive coordinated, efficient, and effective care tailored to their specific needs. They work with patients to navigate the complex health care system, facilitating access to necessary medical services, support systems, and community resources. This individualized care approach helps in managing chronic diseases, preventing hospital readmissions, and improving overall health outcomes, which collectively benefit the larger population.

An illustrative example of this is in the management of chronic conditions like diabetes. Case managers work with diabetic patients to develop personalized care plans, incorporating medical treatments, dietary recommendations, and lifestyle changes. They also coordinate with various health care providers and community resources to ensure consistent and comprehensive care. This not only improves the health of individual patients but also contributes to better health outcomes for the population with diabetes as a whole, exemplifying the integration of case management in population health.

Insights From RISE 2023 Population Health Conference

The RISE 2023 Population Health Conference in Tampa, Florida, was a convergence of health care professionals, sharing innovative strategies and insights into the evolving field of population health. A key theme that emerged was the integration of technology in health care, particularly in enhancing patient engagement and data management. Speakers emphasized leveraging digital tools to personalize patient care and streamline health data analysis.

Notable presentations included discussions about artificial intelligence (AI) and machine learning applications in predictive health analytics. Experts showcased how these technologies can identify at-risk populations and tailor interventions accordingly and highlighted the need for educating both health care providers and patients in utilizing technology effectively (in alignment with CMSA's Technology Standard of Practice).

A key theme that emerged was the integration of technology in health care, particularly in enhancing patient engagement and data management.

Another significant theme was addressing social determinants of health. Several speakers presented case studies illustrating successful community-based programs that improved health outcomes by focusing on social, economic, and environmental factors. This holistic approach underlined the conference's emphasis on comprehensive health strategies.

The panel I moderated spoke to the need to break the stigma of hospice from both provider and patient perspective, turning away from the "failure" perspective to recognizing the use of hospice and palliative care as an integral part of the health care continuum and patient life journey. Case managers have long been advocates of the use of hospice and palliative care services, earlier rather than when death is imminent, and the panel addressed the use of palliative care in readmission reduction and hospice's role in not only end-of-life care but support of the patient's family.

Challenges and Opportunities

Integrating case management with population health can present several challenges. One primary challenge is the fragmentation of health care systems, making it difficult to coordinate care effectively across different service providers. I often wonder why there is a lack of collaboration between population health, quality management, case management, and other areas. As evidenced by my own experience in my class that I referenced earlier, why the territoriality? Working together, we could help to eliminate the challenge of ensuring equitable access to health care services, particularly for underserved populations who may face barriers due to social determinants of health.

These challenges also present opportunities for innovation. There is a growing need for integrated health care models that bring together various health care practitioners and services. Standardized protocols and communication channels are often lacking between case managers and other health care professionals, leading to inconsistencies in patient care. Developing standardized protocols and improving interprofessional communication can enhance care coordination. Moreover, there is an opportunity to leverage technology to provide more personalized and efficient care, particularly in remote or underserved areas.

Looking Ahead: The Future of Population Health and Case Management

Sharing data between population health management and case management can lead to better outcomes. By analyzing data trends, health care providers can identify at-risk populations and intervene early, potentially preventing more severe health issues.

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Upholding Justice: Extending Advocacy in Service to Others

By Patricia Nunez, MA, CRC, CDMS, CCM

Certified Disability Management Specialists (CDMS) are expected to uphold ethical principles that provide guidance on how to advocate for others. Among these principles is justice, which the CDMS Code of Professional Conduct describes as "to act or treat justly or fairly."

CDMS credential holders, like their Board-certified case manager (CCM) counterparts, are likely to view this principle as providing access to resources justly or fairly. Based on my professional experience in disability case management, however, I can attest to there being instances when health care resources cannot be distributed to every individual in the same way because of rules and regulations. For example, an employee who was injured in the workplace may want to be treated at a certain facility or by a particular specialist. But when medical expenses are being covered by workers' compensation, statutory limitations may prevent access to certain resources. For example, some medical providers may not accept workers' compensation referrals.

CDMS credential holders, like their Board-certified case manager (CCM) counterparts, are likely to view this principle as providing access to resources justly or fairly. Based on my professional experience in disability case management, however, I can attest to there being instances when health care resources cannot be distributed to every individual in the same way because of rules and regulations.

A similar situation can arise with cases involving nonoccupational illnesses and injuries. While the person could choose to receive care from any doctor or hospital, the cost of selecting out-of-network providers would result in a significant financial burden. The practical effect is to make their choices far more limited.

Even when confronted by such realities, CDMS certificants can pursue justice on behalf of the people they are serving. One important way is educating clients on how to advocate for themselves. Self-advocacy promotes justice by empowering individuals to speak up and ask questions such as about exploring all available treatment options and understanding the benefits and/or risks of certain treatments. Advocating for oneself also means collaborating with the employer to explore work accommodations since employees, themselves, know their jobs better than anyone. The goal is to approach any relationship (whether with a provider or the employer) in a way that seeks the best possible outcomes for all involved.

Moreover, self-advocacy also encourages people to know their rights and to pursue them. Consider an individual in a physically intensive occupation who is afraid to report a workplace injury because of concerns over losing their job; or an employee who was up for a promotion before they became injured at work may be fearful of losing that opportunity when they return to the workplace with temporary, modified duties. As advocates, we can help clients work through their fears while also learning how to ask for what is fair and just. This might also mean engaging with the supervisor on the return-to-work plan, including when the employee will likely be back to their regular duties.

As advocates, we can do more to promote justice, particularly in the context of recent laws and interpretations of those laws. The Americans with Disabilities Act Amendments Act (ADAAA) offers a great example of

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Discharge Planners/Case Managers: What Would Patients and Their Families Think?

Elizabeth E. Hogue, Esq.

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

Many postacute providers have heard about Louis Vuitton handbags, cars, trips to Napa Valley or other luxury destinations, etc., given to discharge planners/case managers. They've seen case managers/discharge planners with thick stacks of gift cards received from postacute providers.

Here is what a representative of the Justice Department said about kickbacks in a recent press release:

"Whether you pay them or receive them, kickbacks undermine the integrity of our health care system. Patients need to know that health care referrals they receive are in their best interest, not in the best interest of someone else's bottom line. Our office will always be on guard to prevent unscrupulous operators from trying to take financial advantage of our health care systems."

"Whether you pay them or receive them, kickbacks undermine the integrity of our health care system. Patients need to know that health care referrals they receive are in their best interest, not in the best interest of someone else's bottom line."—US Department of Justice.

Key questions for discharge planners/case managers must be:

- What would patients and their families think if they knew about the gifts we receive from postacute providers?
- What would patients and their families think if they knew that the expensive handbag I'm carrying today came from the postacute provider to which I referred the patient?

Case managers/discharge planners have gotten a "pass" from fraud enforcers for many years. Time is up!

Recently, for example, a US District Judge in California sentenced an owner of a postacute provider to 18 months in prison for 1 count of conspiracy to commit health care fraud, and 1 count of conspiracy to pay and receive health care kickbacks. From July 2015 through April 2019, the provider paid and directed others to pay kickbacks to multiple case managers/discharge planners for referrals of Medicare patients, including employees of health care facilities and employees' spouses. Recipients of the kickbacks included a discharge planner/case manager at a hospital and discharge planners at skilled nursing and assisted living facilities.

Payments of kickbacks resulted in over 8,000 claims to Medicare for patients referred to the provider. Medicare paid the provider at least $2 million dollars for services provided to patients referred in exchange for kickbacks. Because the provider obtained patient referrals by paying kickbacks, the provider should not have received any Medicare reimbursement. The discharge planners/case managers who received kickbacks from the provider also pled guilty and will be sentenced soon.

The Office of Inspector General (OIG) of the US Department of Health and Human Services (HHS), the primary enforcer of fraud and abuse prohibitions, says that discharge planners/case managers and social workers cannot accept the following from providers who want referrals:

- Cash
- Cash equivalents, such as gift cards or gift certificates
- Noncash items of more than nominal value
- Free discharge planning services that case managers/discharge planners and social workers are obligated to provide

Discharge planners/case managers and social workers provide extremely

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CE1 ETHICS CEU Approved for 1 hour of CCM, CDMS, and nursing education ethics credit
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Implicit Bias: Ethical Implications for the Case Manager

By Gary Wolfe, RN, CCM, FCM

Do you have biases? A typical answer is no, but in reality, everyone has biases. Bias is a human trait resulting from people's tendency and need to classify individuals into categories as we strive to quickly process information and make sense of the world. (Allport 1979). Biases are much more widespread than is generally assumed. To be completely unbiased is almost impossible. It is a natural human instinct to make judgments based on first impressions and preconceived ideas or knowledge. Bias consists of attitudes, behaviors, and actions that are prejudiced in favor of or against one person or group compared with another; or one idea compared with another idea. Bias is a subjective way of thinking that originates from an individual's own perceptions or point of view. Bias is a uniquely human attribute; in some cases, it may be subconscious, and the individual may not be aware that they are experiencing bias towards others. Some biases are based on physical characteristics such as race or gender. Although biases can sometimes be positive, in most cases, biases are negative. There are different types of bias people experience that influence and affect the way they think, behave, and perceive others. Bias affects everything an individual does. Bias is shown in education, health care, policing, criminal justice, government, business, and more. Here are some examples (Burch et al 2022):

- Women presenting with pain are often perceived as having less severe pain, or their pain is downplayed, suggesting a biased belief that women exaggerate pain.
- Black women with fibroids are more likely than white women to have invasive treatments like a hysterectomy, suggesting a bias against working with the patient for less invasive treatment.
- Asian Americans are the least likely racial and ethnic group to receive recommended diabetes screening. (Tune et al 2017)
- About 30% of CEOs are taller than 6¢2² compared with 4% of American males, suggesting an implicit bias associating height with success.
- A survey of CEOs revealed that the deeper their voice, the more likely they were to earn higher salaries, suggesting a preference for deep voices in male CEOs.
- Black students are more likely than White students to be suspended for the same offence, suggesting a bias against Black students.
- Individuals may judge overweight people more harshly than thin people, suggesting a bias to overweight.

Types of Biases

Hundreds of biases have been identified, but there are two main types: conscious bias and unconscious bias. Conscious bias is also known as explicit bias. This is a type of bias that the individual is aware of. The bias is happening consciously, in that the individual knows they are being biased and are acting with intent. Unconscious bias is also known as implicit bias. Implicit bias is very different from explicit bias. Implicit biases are beliefs and attitudes that operate outside a person's awareness and control. Implicit biases are involuntary reactions. Implicit bias can be in direct contrast with the beliefs and values an individual may hold. Individuals may not even be aware of implicit biases. Implicit bias is a normal behavioral phenomenon. It happens to everyone all the time.

There are many types of implicit bias. Here are the most common types:

- **Affinity bias.** This refers to the unconscious preference for people who share qualities similar to your own.
- **Attribution bias:** This relates to how an individual perceives their own actions compared with the actions of others.
- **Beauty bias:** This is the belief that attractive people are more successful, competent, and qualified than unattractive people.
- **Confirmation bias:** Conformity bias is when an individual's views are influenced or changed by the views of others.
- **Contrast bias:** This is when two or more things are compared with each other rather than assessing them based on their individual merit.

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Patients can pick up on a clinician's implicit bias, and patients have reported a poor experience for that reason. A patient who senses a clinician's implicit bias may feel less inclined to engage fully in their care.

The most common biases are based on characteristics such as:

- Race
- Ethnicity
- Gender
- Religion
- Sexual orientation
- Socioeconomic background
- Educational background
- Causes of Implicit Bias

Implicit bias occurs due to unconscious mental processes. Here are some of the factors at play in the development of implicit biases (Pellegrine et al 1988):

Our brain creates categories. We have the natural tendency to assign everything we see into a category. Even though this happens unconsciously after categorizing things or people, we also assign a positive or negative association to them. Categories allow our brain to know what to do or how to behave. The downside of this is that classification often causes individuals to overgeneralize.

We seek out patterns. The brain has a natural tendency to look for patterns and associations to make sense of a very complicated world.

We rely on mental shortcuts. Most of the time, we rely on "automatic" information processing that involves little conscious thought. This allows individuals to exert little mental effort in their everyday lives and make swift judgments. Mental shortcuts can relate to flawed memory, issues of paying attention, emotional input, social pressures, ageing, and the attempt to simplify information.

Society and cultural influences. Upbringing, social environment, and direct and indirect experiences with members of various social groups imprint on individuals. These shape the perception at a deeper level, even if the person is not conscious of it.

Consequences of Implicit Bias in Health Care

Implicit bias is among many factors that contribute to disparities and other negative effects in health care. (Sabin et al 2022) Implicit bias affects access to health care, treatment options, treatment adherence, participation in patient education programs, attention and respect to a patient, overlooked or dismissed symptoms, selection of subjects for clinical trials, how quickly patients are processed and seen, communication, availability of diagnostic procedures, diversity of the health care workforce, which procedures will be recommended, allocation of research funding, health care quality, outcomes, and health inequity. (Sabin et al 2022) In its 2003 report, Unequal Treatment, the Institute of Medicine concluded that unrecognized bias against members of a social group such as racial or ethnic minorities affects communication or the care offered to those individuals. All aspects of health care are impacted by implicit bias even when the actions may not be directly ill-intentioned. Consequences can still be serious.

Patients can pick up on a clinician's implicit bias, and patients have reported a poor experience for that reason. A patient who senses a clinician's implicit bias may feel less inclined to engage fully in their care. A patient recognizing an implicit bias may be discouraged from or less inclined to visit that clinician again if they feel the clinician treated them differently. Because of implicit bias particularly, Black and Brown patients lack trust in and are reticent to engage with medical institutions. (Blair et al 2011) Implicit bias can be a stumbling block when a clinician limits the depth of shared decision-making or explanation of medical concepts when their implicit bias tells them a patient does not have the health literacy to fully understand. Likewise, a clinician because of their implicit bias may not suggest appropriate medical equipment—such as an insulin pump—if they implicitly believe the patient doesn't have the skill to operate the equipment. Clinicians may not make referrals to specialty programs because the clinician feels the patient can't afford or won't go—all because of implicit bias. Although it is rare for a clinician to act out of malice, it is happening regularly and frequently and negatively impacting health care for patients.

Ethical Considerations

Ethics refers to well-founded standards of right and wrong that prescribe what individuals are to do, usually in terms of rights, obligations, benefits to society, fairness, and specific virtues. Ethics is a system of moral principles. The term ethics is derived from the Greek work ethos, which can mean custom, habit, character, or disposition. Ethics can cover the following dilemmas:

Bias is a human trait resulting from people's tendency and need to classify individuals into categories as we strive to quickly process information and make sense of the world.

- How to live a good life
- Rights and responsibilities
- The language of right and wrong
- Moral decisions—what is good or bad

Ethics came about because of abuses of human subjects in research, medical interventions without informed consent, experimentation in concentration camps in World War II, advances in medicine, medical technology, and societal changes. These events led to the evolution of bioethics from one concerned about professional conduct to the present status with an extensive scope that includes clinical ethics, research ethics, public health ethics, and organizational ethics.

In health care, ethics affects how individuals make decisions and receive care. Case managers and disability management specialists must adhere to two Codes of Professional Conduct, one for certified case managers and for certified disability management specialists, (Commission for Case Manager Certification 2023; Certified Disability Management Specialists 2023) and the code of ethics governing the profession on which the individual's eligibility for the CCM/CDMS designation is based. The underlying values (Commission for Case Manager Certification 2023; Certified Disability Management Specialists 2023) applicable to case managers include:

- Case management is a means for improving client health, wellness, and autonomy through advocacy, communication, education, identification of service resources, and service facilitation.
- Dignity, worth, and rights of all people.
- Understand and commit to quality outcomes for clients.
- When the individual reaches the optimum level of wellness and functional capability, everyone benefits.
- Guided by autonomy, beneficence, nonmaleficence, justice, and fidelity.

The role of the case manager is to ensure that all values of ethics are maintained for each client. If the case manager has an implicit bias in any area, ethics are at risk. The following ethical principles are in jeopardy if the case manager has an implicit bias:

- Autonomy—honoring the right for patients to make individual decisions—the basis for informed consent, truth-telling, and confidentiality
- Beneficence—doing good to others
- Nonmalificence—doing no harm to others
- Justice—acting fairly
- Fidelity—adhering to facts.

Communication is paramount in all areas. The case manager must communicate with the patient in clear and straightforward language, without the use of medical terminology or bias. The case manager should beware of all patient factors that may compromise decisional capacity, such as anxiety, fear, pain, lack of trust, and different beliefs and values that impair effective communication. (Dubler et al 2004) The case manager's implicit biases may violate the Code of Professional Conduct.

It is always the responsibility of the case manager to place the client's values, wishes, and desires above their own. Sometimes the case manager may have a different opinion than the client, but the decision-maker is the client, regardless. Failure to comply with the Code of Professional Conduct may result in disciplinary action by the certifying body.

Strategies to Reduce the Impact of Implicit Bias

The first step in overcoming implicit bias is to acknowledge that you have a bias. Implicit biases affect behavior, but there are things that you can do to reduce your own bias(es). It is important to become aware of your implicit bias and work towards change. To become aware of your bias, start by educating yourself. Paying attention to your thoughts and examining your beliefs can help identify the assumptions you currently hold. The key is to slow down and investigate your beliefs and assumptions so that you can see the patient for who they truly are. Taking a few minutes to reflect on your beliefs/assumptions can make a significant difference. Focus on seeing people as individuals. Rather than focusing on stereotypes to define people, spend time considering them on a personal, individual level. You can work on consciously changing your stereotypes. If you recognize your response to a person might be rooted in biases or stereotypes, make an effort to consciously adjust your response. Here are some questions you can reflect on:

- What core beliefs do I hold? How might these beliefs limit or enable me to work with patients?
- How do I react to people from different backgrounds? Do I hold stereotypes or assumptions about a particular social group?
- Do I acknowledge and leverage differences?

Clinicians may not make referrals to specialty programs because the clinician feels the patient can't afford or won't go—all because of implicit bias.

- Do my words and actions actually reflect my intentions?
- Do I put myself in the shoes of the other person and empathize with their situation, even if I don't relate?

When you pay attention to your answers, you will find patterns of thinking and behavior that will help you become aware of your bias.

Meditation can be a helpful technique in addressing implicit bias. Practicing mindfulness is one potential way because it reduces the stress and cognitive load that otherwise leads to relying on implicit bias. A brief study found that brief meditation decreased implicit bias against Black people and elderly people, providing insight into the usefulness of this approach and paving the way for this intervention.

Education is critical. Understanding what implicit biases are, how they can arise, and how to recognize them in yourself and others are incredibly important in working towards overcoming implicit bias. Learning about other cultures or groups different than yourself and what language and behaviors may seem to be offensive is critical as well. Increasing time with different groups can help you overcome your implicit biases.

In 2019, the American Academy of Family Physicians published eight tactics that can be used to reduce implicit bias using the acronym IMPLICIT (Edgoose et al 2019):

- **Introspection:** Take time to understand your biases by taking an inventory of them.
- **Mindfulness:** Once you recognize your biases, be mindful that you are more likely to give in to your bias when you are under pressure or need to make a quick decision. When stressed, pause for a minute, collect yourself, and take a few deep breaths.
- **Perspective-taking:** If you think you are stereotyping someone or a group, imagine what it would feel like for others to stereotype you.
- **Learn to slow down:** Don't jump to conclusions. Take time to think about a situation. Think about positive situations.
- **Individualization:** Remind yourself everyone has individual characteristics. Focus on things you have in common.
- **Check your messaging:** Use statements that embrace inclusivity.
- **Institutionalize fairness:** Work in a setting that embraces and supports diversity and that fosters equitable policies.
- **Take two:** Overcoming implicit bias takes time. It is a lifelong process and deprogramming our biases requires constant mindfulness and work.

Organizational change has a role to play in addressing implicit biases. Organizations can provide leadership in establishing education and training programs to recognize and counteract implicit biases and address the impact implicit bias has in the health care setting. Organizations can foster a culture of openness and acceptance. Holding focus groups of patients to better understand the population you serve may be an effective tool for identifying and addressing implicit biases. Safe employee groups promoting honest and open communication about employees' biases is a good tool. Make sure policies and procedures do not reflect any implicit biases when they were written/developed. Create awareness campaigns for all staff around implicit biases.

Implicit-association Test

People don't always recognize or aren't always aware of their implicit bias. One way is becoming more aware or identifying your implicit bias is through testing. Based on research in 1988 on bias by social psychology researchers Anthony Greenwald, PhD, Mahzarin Banaji, PhD, and Brian Nosek, PhD, the implicit-association test (IAT) was developed as an assessment intended to detect subconscious associations between mental representations of objects (concepts) in memory. (Greenwald et al 1988) The test aims to measure hidden or implicit attitudes, so it is done indirectly. Otherwise, respondents will not answer truthfully. There are different versions of the IAT; it typically consists of five rounds using a computer. In each round, respondents need to quickly sort words into categories that are on the left-hand and right-hand side of the computer screen. The key assumption underlying any IAT is that the stronger the association a respondent has between two concepts, the faster they are to make implicit connections. The test has been applied to a variety of belief associations, such as those involving racial groups, gender, sexuality, age, and religion, as well as the self-esteem, political views, and predictions of the test taker. The IAT is available at www.implicit.harvard.edu.

Like any habit, it is difficult to change biased behavior with just one strategy. A multifaceted approach will work best. It takes work and consciousness awareness. Education, exposure, and a systematic approach incorporating a continuous process of improvement, practice, and reflection will allow you to

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The Ethical Imperative in Addressing Racial Discrimination's Impact on Mental Health

By Chikita Mann, MSN, RN, CCM

Counseling session between an injured worker who sustained a traumatic amputation of his right forearm and his counselor:

Counselor: It seems like you have a lot that you want to say, but you are hesitant to say it. Why?

Injured worker: I don't want to appear as an angry Black man.

The counselor is taken aback as this is the first time that they have had this response from a client. Then they are saddened for the injured worker as they realize that the injured worker is speaking his truth *and* his reality.

Racial discrimination directly and indirectly influences a person's life, permeating through the fabric of societies and leaving an indelible mark on individuals' well-being. Its insidious impact extends beyond immediate experiences, infiltrating the very core of mental health. As we navigate the complex interplay between racism and psychological well-being, it becomes increasingly evident that addressing the profound consequences of racial discrimination is not only a matter of social justice but a fundamental ethical imperative. For those providing care coordination, it is crucial to grasp how racial discrimination can hinder an individual's capacity to engage in their health care.

The hesitancy among Black, Indigenous, and People of Color (BIPOC) communities to seek and receive mental health care is deeply rooted in historical injustices that have shaped their experiences within health care systems. The historical legacy of systemic discrimination, including the unethical exploitation of BIPOC individuals in medical research and the perpetuation of stigmatizing stereotypes, has engendered a pervasive mistrust. Instances such as the Tuskegee Syphilis Study and the forced sterilization of Indigenous women have left lasting scars, fostering a skepticism towards the intentions of health care providers. Additionally, the lack of cultural competence within mental health services often exacerbates feelings of alienation and misrepresentation, further deterring individuals from seeking the support they need. There is a crucial link between racial discrimination and mental health. The constant exposure to discriminatory practices, whether subtle or overt, contributes significantly to mental health disparities. The chronic stress, anxiety, and emotional toll inflicted by systemic racism can lead to adverse psychological outcomes.

As our population becomes increasingly diverse and income inequality grows, we must address health disparities, especially in mental health. According to the US Department of Health and Human Services' Office of Minority Health, racial and ethnic minorities are less likely to have access to health care. (Ndugga & Artigga 2023) The National Alliance on Mental Illness (NAMI) indicates that experiences of discrimination can exacerbate mental health conditions, making it more challenging for individuals to engage in their health care. (NAMI 2023) This article delves into the ethical dimensions associated with racial discrimination's sway on mental health, exploring the urgent need for a conscientious and inclusive approach to rectify disparities, foster resilience, and build a more equitable future.

What is Racism?

Race, a social construct, involves the classification and grouping of individuals according to their skin color and assumed ancestry. Racism denotes the belief in the superiority of one racial group and encompasses the deliberate actions through which other groups of individuals are systematically and individually oppressed by societal and political structures. Table 1 provides an explanation of different types of racism. But before addressing the types of racism, we must

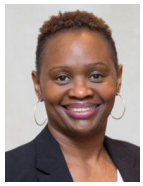

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TABLE 1

TYPE	DEFINITION
Direct (or overt) racism	Openly prejudiced and adverse treatment of an individual based on their ethnic heritage, skin color, or perceived racial background
Everyday racism	The systematic process through which individuals encounter racism in their day-to-day lives
Institutional racism	Socioeconomic disparities and limited access to opportunities based on racial identity
Microaggressions	Verbal, nonverbal, or environmental expressions of bias, discrimination, or insensitivity that communicate derogatory or negative messages to individuals based on their race, ethnicity, gender, sexual orientation, or other marginalized characteristics
Structural racism	The systematic and institutionalized practices, policies, and structures within a society that perpetuate racial inequalities
Subtle racism	Less overt, often unintentional, forms of discriminatory behavior or attitudes based on an individual's race or ethnicity
Systemic racism	The complex and deeply embedded structures, policies, and practices within a society that perpetuate racial inequalities, often across various institutions such as education, employment, health care, and criminal justice

MacIntyreet al 2023.

understand the interplay between racism and the stigma BIPOCs encounter when seeking mental health treatment. Racism can intersect with cultural norms, creating a stigma around mental health within racial and ethnic communities. Historical traumas, cultural expectations, and societal perceptions may shape a reluctance to acknowledge mental health issues, leading to internalized stigma. Racial and ethnic minorities may experience racialized stigma, in which mental health struggles are viewed through a racial lens. Stereotypes and biases associated with their racial or ethnic background can compound the stigma, making individuals hesitant to seek treatment due to fears of discrimination or misunderstanding. Experiences of racism, whether historical or contemporary, contribute to a general mistrust of institutions, including health care systems. This institutional mistrust can amplify mental health stigma, as individuals may hesitate to disclose personal struggles, fearing potential biases or mistreatment.

Let's now briefly explore how different types of racism affect one's desire to engage in seeking and participating in mental health care treatment. For the sake of this article, we will address institutional racism, microaggressions, and structural racism.

Types of Racism Explained

Institutional Racism

Within the realm of health care, various forms of racism manifest, casting shadows on the very foundations meant to provide equitable and compassionate support. Institutional racism, a systemic issue deeply ingrained in policies and practices, perpetuates disparities in health care access and outcomes based on race. Institutional racism often leads to unequal distribution of mental health resources, with marginalized communities having limited access to facilities, professionals, and support services. Mental health institutions may lack cultural competence, perpetuating an environment in which professionals may not fully understand or cater to the diverse cultural backgrounds of their patients. This deficiency can create a disconnect, hindering effective communication and therapeutic relationships. Racial biases may influence how mental health conditions are identified and addressed, leading to disparities in the types and quality of care provided to individuals from different racial backgrounds. The underrepresentation of professionals from marginalized communities within mental health institutions contributes to a lack of diverse perspectives and cultural understanding. (Elias & Paradies 2021)

Microaggressions

Microaggressions, subtle yet impactful, contribute to a hostile environment for patients of diverse backgrounds. They contribute to the stigma surrounding mental health within marginalized communities. Individuals who experience microaggressions may internalize negative stereotypes, feeling shame or reluctance to acknowledge their mental health needs due to fears of judgment or further discrimination. Persistent exposure to microaggressions can contribute to chronic stress and negatively impact mental health. The accumulation of these subtle, often daily, incidents can lead to anxiety, depression, and other mental health challenges, potentially exacerbating the need for professional support. Individuals who have experienced microaggressions may be hesitant to seek mental health care due to concerns about encountering similar biases within therapeutic settings. Fear of being misunderstood or invalidated may deter individuals from reaching out for the support they need. For those who do initiate mental health care, ongoing exposure to microaggressions within therapeutic relationships can lead to disengagement from treatment. Individuals who feel invalidated or misunderstood may struggle to fully engage in therapeutic

The constant exposure to discriminatory practices, whether subtle or overt, contributes significantly to mental health disparities. The chronic stress, anxiety, and emotional toll inflicted by systemic racism can lead to adverse psychological outcomes.

processes, affecting the overall quality of care and potentially diminishing positive treatment outcomes. (Montoya 2021)

Structural Racism

Structural racism contributes to the unequal distribution of mental health resources, with marginalized communities often having limited access to mental health facilities, professionals, and support services. Economic disparities resulting from structural racism can affect access to mental health care. Individuals from marginalized communities may face financial barriers, including a lack of health insurance or the inability to afford out-of-pocket costs, limiting their choices and opportunities to address mental health needs. Structural racism can lead to disparities in education, impacting mental health literacy and awareness within marginalized communities. Structural racism within mental health institutions can result in cultural competence gaps, where professionals may lack an understanding of the unique cultural backgrounds and experiences of individuals from marginalized communities. (Braveman et al 2022)

Intersectionality, Racism and Mental Health

Intersectionality, a concept coined by Kimberlé Crenshaw, is crucial in understanding the nuanced interplay between racism and mental health. It acknowledges that individuals experience multiple intersecting forms of oppression or privilege, and these intersecting identities shape their unique lived experiences. (Shim 2021). In the context of racism and mental health, intersectionality recognizes that racial identity does not exist in isolation; it intersects with other factors such as gender, sexuality, socioeconomic status, and more. Discrimination and prejudice based on these intersecting identities can compound challenges, influencing mental health outcomes. For instance, individuals at the intersection of racial and gender-based discrimination may face distinct stressors that impact their mental well-being. Intersectionality prompts a more comprehensive understanding of how racism operates within a matrix of interconnected social categories, highlighting the need for tailored, inclusive approaches in mental health care that address the complex interplay of diverse identities and their impact on mental health outcomes.

The Psychological Toll of Racism on Mental Health

The psychological toll of racism on individuals is profound and enduring. Racial trauma is a form of psychological distress resulting from exposure to racial discrimination, oppression, and prejudice. It encompasses the emotional and mental toll individuals and communities experience due to direct or vicarious encounters with racism. (Cénat 2022) This trauma can manifest through a range of responses including anxiety, depression, hypervigilance, and a heightened state of emotional distress. Additionally, studies show a link between racial discrimination and posttraumatic stress disorder. Racial trauma can negatively affect one's capacity to cope. Whether stemming from explicit acts of discrimination or insidious microaggressions, racial trauma reflects the cumulative impact of systemic racism and individual encounters with racial injustice. It is not confined to isolated incidents but extends to the historical, intergenerational, and pervasive nature of racialized harm. (MacIntyre et al 2023; Veterans affairs; Boynton 2020)

Persistent exposure to prejudice and bias can lead to chronic stress, anxiety, and depression. Individuals may grapple with feelings of powerlessness, frustration, and anger as they navigate a world that marginalizes them based on their racial identity. Internalizing the negative messages of racism can erode self-esteem, contributing to a sense of inferiority and self-doubt. (Boynton, 2020; Stopforth et al 2022) Additionally, the psychological toll extends beyond individual experiences to include the collective trauma of communities that have historically faced systemic racism.

Equitable Mental Health Care

Mental health treatment is indeed a fundamental right that should be accessible to all individuals. Just as physical health is recognized as a basic human right, mental health should be afforded the same level of importance and attention. Access to quality mental health care is crucial for individuals to lead fulfilling and productive lives. Mental health affects our overall well-being, ability to function, and our relationships with others. It impacts our capacity to work, learn, and contribute to society. Therefore, ensuring that everyone has access to appropriate mental health treatment is essential for promoting overall societal well-being.

Recognizing mental health treatment as a fundamental

right means acknowledging that it should be available, accessible, affordable, and high quality. It involves removing barriers that prevent individuals from seeking help, such as stigma, discrimination, and lack of resources. It also requires integrating mental health services into primary health care and promoting early intervention and prevention strategies.

Ethical Considerations

The board-certified case manager has the standards (Figure 1) of the Code of Professional Conduct for Case Managers and Certified Disability Management Specialists (CDMS) as a guide for ethical care coordination. (CCMC® 2015) Empathy and cultural competence play a crucial role when supporting a diverse clientele in coordinating mental health care. (Stubbe 2020) Before delving into the ethical principles of justice, beneficence, advocacy, nonmaleficence and veracity, we should look at the interrelationship between empathy, implicit bias, cultural competence, and mental health care coordination.

Cultural Competence

The board-certified case manager should be committed to increasing their cultural competence. Culturally competent care recognizes and respects the diverse backgrounds, beliefs, and experiences of individuals, acknowledging that cultural factors play a significant role in shaping mental health outcomes. Cultural competence enhances the understanding of diverse cultural perspectives on mental health. This understanding is critical in recognizing that different racial and ethnic groups may have unique experiences, beliefs, and coping mechanisms related to mental health challenges. Culturally competent mental health care allows for the tailoring of treatment approaches to better align with the cultural values and preferences of the individual. This personalized approach enhances the effectiveness of interventions and promotes better outcomes. Culturally competent professionals are better equipped to identify and mitigate microaggressions, which are subtle, often unintentional, discriminatory behaviors.

The Role of Empathy

Cultural competence and empathy are fundamental in promoting equitable and compassionate care for individuals from diverse cultural backgrounds. Ethical mental health care involves respecting individuals' autonomy, including their cultural autonomy. Cultural competence ensures that health care practitioners understand and honor the diverse cultural beliefs, values, and practices of their patients. Empathy is ethically grounded in recognizing and valuing these cultural perspectives, fostering an environment where individuals are empowered to express their mental health needs within the context of their cultural identity.

FIGURE 1

PRINCIPLES OF THE CODE OF PROFESSIONAL CONDUCT FOR CASE MANAGERS

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

Empathy fuels ethical advocacy efforts, promoting policies and practices that strive for equitable access to mental health resources and services, especially for marginalized and underserved communities.

Cultural competence ensures that providers understand the cultural nuances related to privacy and confidentiality in different cultural contexts. Empathy contributes to building trust by creating a safe and non-judgmental space where individuals feel comfortable sharing their mental health concerns. Ethical mental health care is person-centered and holistic. (Boardman & Dave 2020) Cultural competence supports this ethical approach by recognizing individuals as unique beings with diverse cultural backgrounds. Empathy enhances this by considering the person's emotions, experiences, and cultural context, promoting a more comprehensive understanding of their mental health needs.

Implicit Bias

Implicit bias and cultural competence are interconnected concepts that influence how individuals perceive, interact with, and provide care for people from diverse backgrounds. Implicit bias refers to unconscious attitudes or stereotypes that affect our understanding, actions, and decisions. Cultural competence, on the other hand, is the ability to interact effectively with people from various cultural backgrounds, considering and respecting their unique perspectives, values, and needs. (Merino et al 2018).

Implicit bias, often unintentional and subconscious,

The underrepresentation of professionals from marginalized communities within mental health institutions contributes to a lack of diverse perspectives and cultural understanding.

influences health care practitioners' decisions, potentially resulting in differential treatment. When health care practitioners hold implicit biases or harbor racist attitudes, it can lead to disparities in access to care and unequal treatment experiences for individuals from marginalized communities. Implicit biases can influence the initial assessment and diagnosis of mental health conditions. Practitioners may inadvertently overlook or misinterpret symptoms, leading to inaccurate diagnoses or delayed treatment. This can result in inadequate or ineffective care for individuals who already face numerous barriers to accessing mental health services. Moreover, implicit biases can affect the quality of communication and therapeutic relationships between providers and patients. Stereotypes and prejudiced attitudes may lead to misunderstandings, reduced trust, and decreased patient engagement. This can hinder the effectiveness of therapy and hinder the healing process for marginalized individuals. (Merino et al 2018)

Addressing implicit bias requires self-reflection, awareness, cultural humility, and ongoing education. Board-certified case managers need to examine their own biases and actively work to confront them. This can involve cultural competency training and engaging in open dialogue with colleagues and clients. This can help to create an environment where individuals feel understood and supported.

Cultural Competence and Justice

The relationship between cultural competency and the ethical principle of justice is symbiotic, as both concepts are integral to fostering fair, equitable, and respectful treatment for individuals from diverse cultural backgrounds. The ethical principle of justice, in the context of cultural competency, recognizes and values the diversity of individuals and communities. Justice demands the fair allocation of resources. Cultural competency contributes to this by ensuring that resources are distributed in a manner that considers the unique needs of different cultural groups. It prevents discrimination based on cultural factors, promoting justice in resource allocation. Justice is served through the application of culturally competent practices. This involves adapting approaches to align with the cultural beliefs and preferences of individuals, ensuring that justice is realized through respectful, inclusive, and responsive care. (Daneshpour 2023)

Cultural Competence and Beneficence

The relationship between the ethical principle of beneficence and cultural competence is rooted in the shared goal of promoting the well-being and positive outcomes for individuals in diverse and culturally rich contexts. Beneficence, as an ethical principle, underscores the obligation of health care practitioners to contribute to the welfare of their patients and to act in ways that promote their overall well-being. Beneficence requires health care professionals to provide care that is sensitive to the needs and preferences of individuals. (Manderius et al 2023) Cultural competence ensures that this sensitivity extends to diverse cultural backgrounds, acknowledging and respecting the cultural values, beliefs, and practices that contribute to the well-being of patients.

Both beneficence and cultural competence advocate for tailored and individualized care. Beneficence emphasizes providing care that is in the best interest of the patient, while cultural competence ensures that this care is adapted to align with the unique cultural context and identity of everyone. The ethical principle of beneficence is balanced with respect for autonomy. Cultural competence aligns with this balance by recognizing and respecting the autonomy of individuals within their cultural context, allowing patients to actively participate in decisions about their care while considering their cultural values. Beneficence calls for practices that are inclusive and equitable. (Manderius et al 2023) Cultural competence actively works toward these goals by promoting practices that acknowledge and respond to the diverse needs of individuals, contributing to improved well-being for all patients.

Cultural Competence, Advocacy, and Mental Health Literacy

The relationship between advocacy and mental health literacy is intertwined and complementary, as both play crucial roles in promoting understanding, support, and equitable access to mental health resources. Advocacy efforts contribute to raising awareness about mental health issues, reducing stigma, and fostering a more informed society. (Saha 2021) Mental health literacy is a powerful tool in combating racism within mental health care, as it empowers individuals, communities, and professionals to navigate and address the complexities of racial disparities in mental health.

Mental health literacy helps dispel myths and misconceptions surrounding mental health, fostering a more informed and empathetic understanding. By educating individuals

Individuals who feel invalidated or misunderstood may struggle to fully engage in therapeutic processes, affecting the overall quality of care and potentially diminishing positive treatment outcomes.

about the commonality of mental health challenges, it contributes to reducing the stigma associated with seeking help, particularly within racial and ethnic communities. It equips individuals and professionals with the knowledge to provide culturally competent care, recognizing and respecting the unique needs and experiences of individuals from different racial backgrounds. An informed understanding of mental health challenges, especially within the context of racism, fosters empathy.

Mental health literacy helps individuals comprehend the impact of systemic racism on mental health outcomes, promoting a more compassionate and supportive approach to those facing racialized mental health disparities. Mental health literacy encourages critical examination of biases within mental health professions. Individuals, including mental health professionals, who are literate in racial disparities can actively work to address biases, challenge stereotypes, and contribute to creating an anti-racist mental health care system.

Cultural Competency and Nonmaleficence

The relationship between cultural competence and the ethical principle of nonmaleficence is rooted in the shared commitment to avoiding harm and ensuring the well-being of individuals, particularly within the context of diverse cultural backgrounds. Nonmaleficence, as an ethical principle, obliges health care professionals to do no harm and to minimize the potential risks of harm to patients. (Manderius et al 2023) Cultural competence aligns with nonmaleficence by emphasizing the importance of avoiding harm related to cultural insensitivity or ignorance. This involves recognizing that cultural beliefs, practices, and preferences can significantly impact the well-being of individuals, and health care professionals must be attuned to these factors to prevent inadvertent harm. Cultural competence contributes to cultural safety, ensuring that health care environments are free from practices that may harm individuals based on their cultural background. Nonmaleficence is upheld by fostering cultural safety, acknowledging, and mitigating potential harms related to cultural insensitivity or bias.

Cultural competence emphasizes the need for culturally sensitive communication to prevent misunderstandings or harm caused by miscommunication. Nonmaleficence is upheld by ensuring that communication respects cultural norms and avoids harm that may arise from misinterpretation. Nonmaleficence is supported by cultural competence in the customization of care to align with cultural preferences and practices. Recognizing and respecting cultural diversity ensures that care is beneficial and avoids harm by considering the individual needs and expectations shaped by cultural factors.

Cultural Competence and Veracity

The relationship between cultural competence and the ethical principle of veracity lies in their shared commitment to truthful and honest communication, particularly within the context of diverse cultural backgrounds. Veracity, as an ethical principle, emphasizes the obligation of health care professionals to be truthful and transparent in their communication with patients. Cultural competence emphasizes the need for health care professionals to be sensitive to the cultural context when conveying information. Veracity is maintained by ensuring that truthful communication is conducted in a manner that respects cultural norms and does not cause unnecessary distress or misunderstanding (Amer, 2019).

Veracity is closely linked to informed consent, and cultural competence plays a crucial role in ensuring that the information provided for informed consent is culturally sensitive and comprehensible. This includes respecting diverse perspectives on medical decision-making, thereby upholding the ethical principle of veracity. Cultural competence helps prevent miscommunication that may arise from cultural differences in language use, non-verbal cues, or expressions. Veracity is upheld when health care professionals ensure that their truthful communication is accurately understood, considering potential cultural variations in interpretation. Cultural competence involves respecting cultural norms related to privacy and confidentiality. Veracity is supported when health care professionals ensure that truthful information is disclosed in a manner that aligns with cultural expectations and safeguards the privacy and confidentiality of patients. Cultural competence involves respecting cultural norms related to privacy and confidentiality. Veracity is supported when health care professionals ensure that truthful information is disclosed in a manner that aligns with cultural expectations and safeguards the privacy and confidentiality of patients. (Amer 2019)

The board-certified case manager can utilize the following measures for culturally appropriate mental health care coordination:

Combating racism in mental health care coordination is not just a professional responsibility but a moral imperative.

1. Familiarize themselves with the client's cultural background.
2. Reassure with words and actions that their preferences are being utilized to create a treatment plan.
3. Allow the client to discuss their experiences and values openly.
4. Explore the use of interpreters to ensure effective communication.
5. Collaborate with the client to develop a culturally sensitive treatment plan.
6. When speaking with the client, recognize and emphasize the client's cultural strengths and resilience.
7. Research mental health providers and provide options to the client to promote a collaborative relationship.

Conclusion

Combating racism in mental health care coordination is not just a professional responsibility but a moral imperative. By acknowledging the pervasive impact of racial discrimination on mental health outcomes and understanding the ethical dimensions associated with racism in health care, we pave the way for transformative change. Embracing cultural competence, empathy, and an unwavering commitment to dismantling systemic injustices, health care professionals can foster an environment where all individuals receive dignified, equitable, and effective mental health care. The journey toward combating racism in mental health care coordination is an ongoing, collaborative effort, one that requires continuous education, introspection, and advocacy to ensure that the mental health system reflects the values of fairness, inclusivity, and genuine concern for the well-being of every individual, regardless of their racial or ethnic background. CE II

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CE3 Approved for 1 hour of CCM, CDMS, and nursing education credit
Exam expires on June 17, 2024

Expanding the Partners for Kids Vision:

An Exploration of Initial Efforts to Meet the Care Coordination Needs of Justice-Involved Youth in Franklin County, Ohio

By Hannah Schroeder, MSW, LISW-S; and Stephanie Kruszynski, MSW, LISW-S

Since 1994, Partners for Kids (PFK), one of the nation's oldest and largest pediatric accountable care organizations and a nonprofit organization operating in partnership with Nationwide Children's Hospital (NCH) and Dayton Children's Hospital in Ohio, has aimed to improve pediatric health outcomes through innovative care and community partnerships. PFK's vision is to create a system of care that promotes best outcomes in pediatric health. One of the ways PFK accomplishes this vision is by providing care coordination services to children and their caregivers who need help navigating the health care system. Since the inception of the program, over 41,000 children (about the seating capacity of Wrigley Field, home of the Chicago Cubs) have received care coordination from PFK. Due to the unique relationship with NCH, many of PFK care coordination's multidisciplinary teams of registered nurses, social workers, and paraprofessional support staff are integrated into both primary and specialty care clinics. These teams build expertise in the particulars of a community or diagnosis (eg, cerebral palsy, diabetes, epilepsy) and can provide specific and tailored care coordination to patients and their caregivers based on their most complex or predominant needs while engaging in constant and ongoing collaboration with the practitioners in those clinics.

Care coordination is a voluntary service and is patient- and family-driven. Upon referral and confirmation of eligibility for PFK care coordination, patients are assigned to a care coordination team based on an assessment and review of their needs, diagnoses, and most frequented clinics. The team is then tasked with contacting the family to gauge their interest in enrollment. If in agreement with enrollment, the care coordination staff works with the patient and/or their caregiver to complete a comprehensive biopsychosocial health risk assessment (HRA) and design a specialty plan of care (SPOC) based on the unmet needs surfaced by the HRA. The SPOC comprises a series of targeted care plan goals that are used to map out and track progress toward meeting the patient's health and social needs. No care plan goal is added to the patient's SPOC without the express consent of the patient or their caregiver. If a family would prefer not to address a certain gap or need in care coordination, their wishes are honored.

PFK utilizes a standardized library of 22 care plan goals to build the SPOC in concert with the patient and/or their caregiver. Each care plan goal includes more specific subgoals to choose from and is written in standardized language with associated standardized interventions that can be modified to suit the individual patient. As an example, if preventive care is an agreed upon goal for the patient, the care coordination staff will be prompted by the electronic health record in which the SPOC is populated and updated to choose one or more of the following:

- Needs preventive care
- Needs dental care
- Establish practitioner/referral.

If the team member were to select

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"Needs preventive care," a care plan with the goal of "Keep well-child visits/immunizations up to date" would populate to the SPOC along with the following suggested tasks or interventions:

- Educate on routine well-child visits and immunizations
- Ensure appointment is scheduled and attended
- Provide caregiver reminders when child's well visits/vaccinations are coming due
- Provide vaccine information statements (VIS)/vaccine schedules from the Centers for Disease Control and Prevention (CDC)
- Use Ohio Impact Statewide Immunization Information System (ImpactSIIS) web portal, primary care practitioner, and schools to ensure immunizations are up to date in patient's chart
- Remove barriers to attending child checks and/or immunization appointments

Care coordination team members may remove any tasks that are not applicable and will mark "complete" the remaining tasks as those milestones are met.

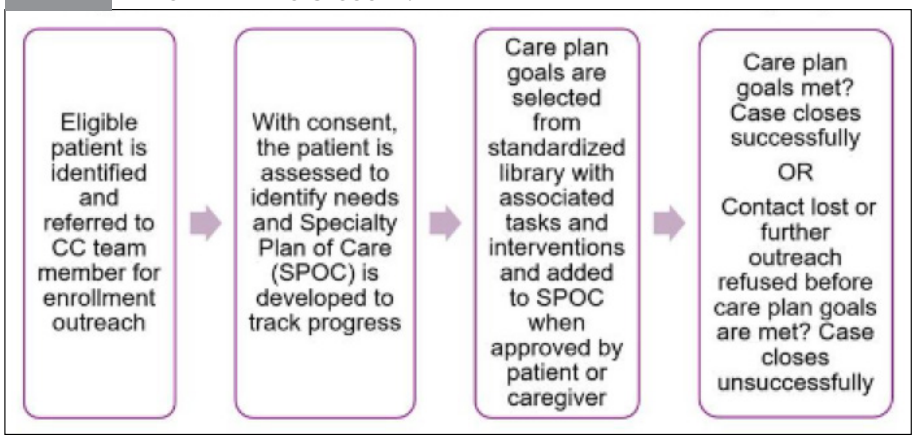
Upon completing the HRA and SPOC, the care coordination team is tasked with deciding the patient's level of acuity, which dictates contact and reassessment schedules. Patients can be stratified to either a high- or medium-risk stratification, with concerns such as risk for utilization or unstable social situation often requiring that the patient be designated as "high." At regular intervals as determined both by the patient and/or caregiver and risk stratification, the care coordination team contacts the patient and/or caregiver to review current progress toward meeting care plan goals and identify next steps necessary. Once a care plan goal has been met to the patient and/or caregiver's satisfaction, the goal is considered "complete." If the patient and/or caregiver is no longer interested in working toward a particular care plan goal, it is deleted. Once all care plan goals have been completed or removed based on family's stated preferences, the patient's care coordination case can be closed successfully under the heading "Goals Met," a positive outcome for the patient and the care coordination team. If a patient and/or caregiver either ceases responding to outreach for more than 60 consecutive days or elects to end care coordination before all care plan goals have been addressed, the care coordination is closed "Unable to Contact" or "Refused," respectively, which are negative outcomes in care coordination. See Figure 1 for a simplified model of this process.

Care Coordination for Justice-Involved Youth

In August 2021, PFK leveraged this existing care coordination infrastructure and expertise to expand its mission and vision by launching a team specifically focused on serving the needs of justice-involved youth (JIY) in Franklin County, Ohio. Justice-involved youth are more likely than their non–justice-involved peers to be diagnosed with dental problems and sexually transmitted infections; 65% to 70% of JIY have mental health disorders, 20% for whom the condition is impairing. (MACPAC 2018; Teplin et al 2013; Skowyra & Cocozza 2007) Improved access to primary care is an intervention thought to be meaningful in addressing these increased risks. (Aalsma et al 2017) But while held in detention, JIY are ineligible for enrollment in Medicaid in most cases and are also ineligible for the Children's Health Insurance Program (CHIP). Further, less than half of juvenile correctional facilities nationwide offer mental health evaluations to all detained youth. (MACPAC 2018) Lapses in health insurance coverage for all children are associated with unmet needs, resulting in worse health outcomes, and among uninsured JIY, these unmet needs lead to lower rates of preventive care visits, increased use of emergency services, and increased risk of reincarceration by age 23. (Olson et al 2005; Aalsma et al 2017; Baggio et al 2018)

PFK's specialized team is one prong in NCH's multifaceted set of collaborative initiatives named Stand Against Racism, Stand For Health Equity. The social justice pillar (within the larger initiative) specifically targets children involved in the juvenile justice system. Providing care coordination to JIY is aimed at improving care and access to resources for incarcerated youth, youth at risk of incarceration, and children

FIGURE 1 THE BASIC CARE COORDINATION MILESTONES IN THE PROCESS FROM ENROLLMENT TO CLOSURE.



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with incarcerated parents. The NCH social justice committee guides the work and decision-making for all social justice initiatives, including the decision to dedicate resources and staff to this specialized team to address known population-specific challenges related to the transition from incarceration to the community including restoring health insurance access, needed linkage to physical health, behavioral health, and other treatment services, and needed referrals and successful linkage to community-based services and resources. Resulting from its integration into the Franklin County Juvenile Intervention Center's (JIC) health clinic, which is operated by NCH, the JIY care coordination team has on-demand access to both JIC clinic and corrections staff to provide collaborative and customized services for patients and their caregivers toward meeting these needs.

In its first 2 years, a hallmark of the success of this specialized care coordination team has been this integration and collaboration. The JIC clinic team, after completing the initial comprehensive physical exam of each patient who is admitted to the JIC, screens for care coordination needs and then refers appropriate patients directly to the JIY care coordination team for enrollment outreach. The team then forms their outreach attempt around the needs identified by the JIC clinic to engage the guardian or caregiver in a conversation about enrolling in care coordination. Across the PFK care coordination programs, we have seen a notable increase in family enrollment in care coordination when initial contact is focused on the needs of most significance to the patient and family, or as we call it, "Leading with the need." Doing so puts the needs of the patient and family at the forefront of the discussion and inspires hope that these needs can be resolved through their work together while making it less likely that families will decline or ignore enrollment outreach attempts. The JIY team has taken the notion of leading with the need a step further with a strategy that has proven meaningful to caregivers and patients alike. With permission from the caregiver, care coordination staff will meet with each youth in person in the setting of the JIC clinic following their initial health care assessment to start the relationship-building process and earn their buy-in to engaging in the care coordination process. Families have reported feeling encouraged by the knowledge that a care coordinator is communicating and visiting with their child and helping them to identify their goals and develop a care plan reflective of their needs.

The JIY care coordination team can provide ongoing care coordination to every enrolled patient until the patient's 22nd birthday as long as the patient and/or caregiver consents. Because Medicaid enrollment can be variable and inconsistent among this population due to coverage restrictions, patients in the JIY need not have a specific type of insurance coverage, or any insurance coverage, to be eligible for care coordination. While a youth remains in the JIC, the JIY care coordination team's efforts are focused on planning for their release while ensuring that any specialized needs that may arise during their detention are given proper attention. Once released, the JIY care coordination team shifts its focus to ensuring the patient's needs are being met in the community setting. Preventive care and chronic condition follow-up and linkage with behavioral health treatment can become more challenging to readily accomplish in the community setting. Common barriers to achieving these goals include waitlists, lack of or changing insurance coverage, transportation access concerns, and shifting patient and family priorities. Examples of care coordination enrollment and goal completion successes demonstrate both the key interventions and challenges faced by this special population.

Case 1

A 17-year-old male was referred for care coordination due to the need for an annual well exam, dental follow-up for cavities, and outpatient therapy to address behavioral health needs.

The care coordination team member met with the patient while he was detained in the JIC while also continuously collaborating with the clinic staff, patient's mother, and patient's juvenile probation officer. The patient and mother expressed interest in pursuing additional community-based programming. Due to this collaboration, the care coordination team member was able to support the patient's quick linkage to a mentorship program upon release from the JIC. Having already built a relationship with the probation officer, the care coordination team member had a reliable communication

Patients can be stratified to either a high- or medium-risk stratification, with concerns such as risk for utilization or unstable social situation often requiring that the patient be designated as "high."

pathway available through which the team could provide notification of upcoming visits and appointments in the community to support the patient's compliance with probation restrictions.

Case 2

A 20-year-old male released from an out-of-state facility and transferred to the JIC for a parole violation was referred to a care coordination for concerns related to controlled psychotropic medication and pending release to a halfway house. The care coordination team member initiated care coordination activities with the patient in person at an appointment in the JIC clinic. The patient reported a strained relationship with the family and no existing support system; he also expressed anxiety about being able to obtain necessary medical care and manage his needs independently upon his release. The patient shared concerns about dental-related pain and a desire to be weaned permanently from the psychotropic medication. The patient was not insured at the time of enrollment, so while he was still in the JIC, the care coordination team member assisted the patient in completing his successful application for Medicaid during a visit. Once the patient transferred to the halfway house, care coordination team members assisted him with identifying and attending an appointment with a dental practitioner. The patient is now released from the halfway house, is no longer taking any psychotropic medication, and is staying with family. The care coordination team member remains involved to support the patient in obtaining needed dental surgery.

Case 3

A 16-year-old male was enrolled in care coordination and released from the JIC with an upcoming significant court date and no means of transportation. The care coordination team member requested that court-provided transportation be arranged for the patient and was informed that only court personnel can make such a request. The care coordination team member contacted and collaborated with the patient's juvenile probation officer to complete the necessary request forms. The patient was able to successfully travel to and from court for his hearing and was able to remain in the community, as a result.

Analysis of Data

It is of ongoing interest to NCH, PFK, and the social justice initiative committee to maintain an understanding of the areas of greatest need most relevant to and prevalent among the Franklin County JIC population and to track the care coordination team's progress in achieving milestones through collaboration and engagement with patients and caregivers. With the program's recent 2-year anniversary, it seemed pertinent to conduct an analysis of available data in support of answering these questions.

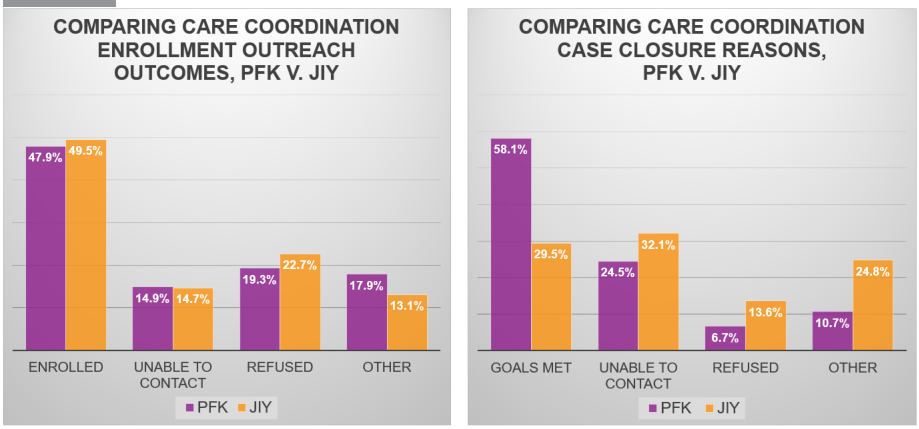
PFK care coordination teams utilize an electronic health record (EHR) to discreetly capture key milestones in the care coordination process. For the JIY care coordination team specifically, a paginated report using Structured Query Language (SQL) was developed to display all JIY care coordination team patient data from the time of referral until case closure. An additional report summarizing the volume and distribution of case closures was developed to compare enrollment outreach and case closure reasons. The frequency with which care plan goals appeared in the EHR and care plan goal status by reason for case closure, were calculated using the results of these reports. Given the literature's emphasis on JIY's restricted ability to access care, JIY cases were analyzed to determine the frequency of occurrence for each care plan goal and identify the most common goals and their outcomes. Only closed care coordination episodes were considered in this analysis and data were collected from the period of February 14, 2022 through July 31, 2023. During this period, the JIY CC team closed 72 JIY cases for one of the following reasons: Goals Met, Unable to Contact, or Refusal.

In alignment with the literature, the most common patient- and caregiver-selected care plan goals among the cases under study reflected an acute need for linkage to preventive, dental, and behavioral health care and access to community resources. Data analysis related to enrollment outreach outcomes, case closure outcomes, and care plan goal outcomes based on case closure reason provided additional insights into the JIY care coordination team's strengths and opportunities for improvement.

Figure 2 compares the JIY care coordination team's outcomes at enrollment outreach and at case closure to all PFK outreaches and closures during the period under study.

The data indicate that the JIY care coordination team experiences nearly identical responses at enrollment

FIGURE 2



Bar graphs comparing the JIY care coordination team's outcomes at initial outreach (left) and case closure (right) with PFK departmental outcomes during the period of February 14, 2022, to July 31, 2023.

outreach from patients and/or their caregivers as do all PFK care coordination staff. In fact, despite concerns that this population may be more difficult to engage with or more hesitant to invite additional case management involvement into their lives, the JIY care coordination team converted a greater proportion of referrals into enrollments during the study period. However, these patterns do not persist throughout case engagement to case closure. Although PFK care coordination staff accomplished a successful case closure rate of 58.1% during the study period, the JIY care coordination team experienced higher proportions of unsuccessful case closures and a significantly lower proportion of successfully closed cases. According to the data, the consequences of unsuccessfully closed cases are significant for JIY patients and their families. Families have multiple goals on their care plans and when they achieve only 1 or 2 of these goals and then do not stay enrolled in care coordination to complete all of the goals on their care plans, the risk is that those that may be harder to achieve in a short period of time but may be equally or more important, go unmet.

Figure 3 illustrates the satisfactory completion (based on patient and/or caregiver agreement) of the 4 care plan goals most frequently added to a JIY patient's care plan by case closure reason.

As might be expected, when a case is closed successfully, a significant majority of the most common care plan goals, if included in the SPOC, have already been or are closed in tandem with case closure for satisfactory conclusion per patient and/or caregivers' report. The reverse is true for unsuccessful cases by significant margins, though there is some evidence to suggest that it is possible to meet some patient needs regardless of the case's final negative outcome.

During data analysis, it was hypothesized that those cases closing successfully may be open for shorter durations of time suggesting that achieving success more quickly is the key to satisfactory completion of care coordination. However, an analysis of the same 72 JIY cases found that the average length of enrollment (in days) in care coordination by closure reason was:

- Goals Met: 240.6
- Unable to Contact: 196
- Refusal: 190.5

Though not conclusive, these data suggest that extended involvement in care coordination may lead to positive outcomes for the patient and their caregivers.

Our data analysis was limited in several ways. Though the JIY care coordination team launched in August 2021, case level data were not made available until February 2022 following a significant upgrade to the EHR. The inability to access these outcome data limited the size of the sample for analysis. It is also important to note that the sample of JIY care coordination cases included in the study comprise only a small proportion of all PFK enrolled care coordination cases during the same time frame. Additionally, care

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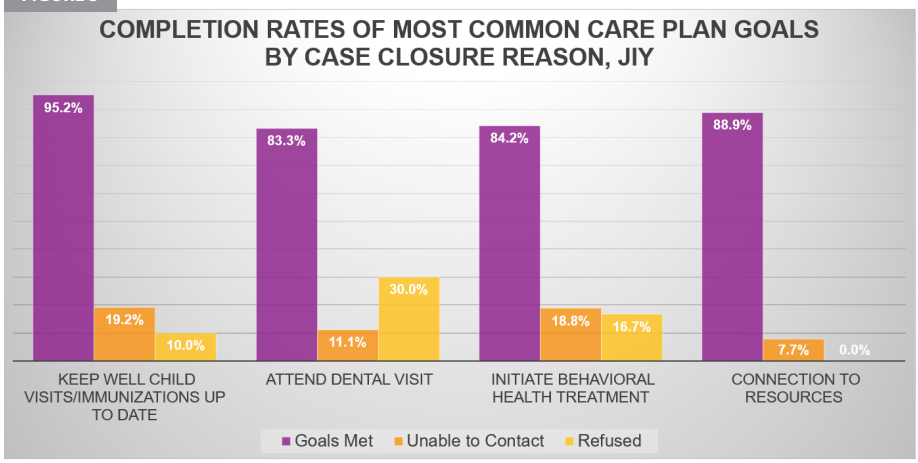
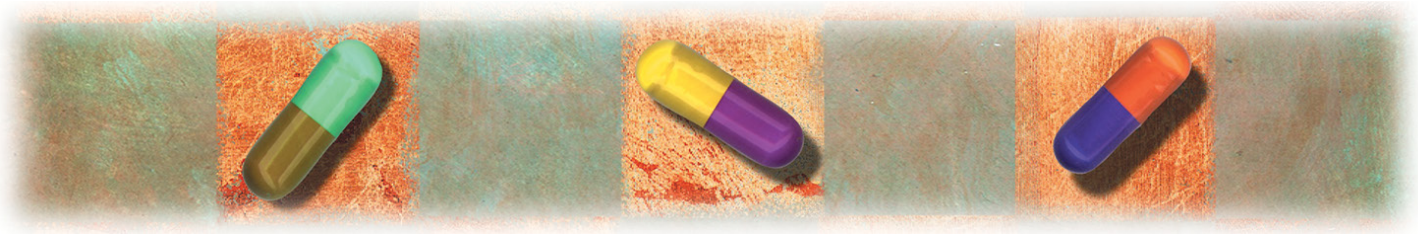
FIGURE 3



A bar graph of the successful completion of the four most requested care plan goals categorized by reason for case closure.

PharmaFacts for Case Managers



ZEPBOUND™ (tirzepatide) Injection, for subcutaneous use

INDICATIONS AND USAGE

ZEPBOUND™ is indicated as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults with an initial body mass index (BMI) of:

- 30 kg/m2 or greater (obesity) or
- 27 kg/m2 or greater (overweight) in the presence of at least one weight-related comorbid condition (eg, hypertension, dyslipidemia, type 2 diabetes mellitus, obstructive sleep apnea, or cardiovascular disease).

LIMITATIONS OF USE

- ZEPBOUND contains tirzepatide. Coadministration with other tirzepatide-containing products or with any glucagon-like peptide-1 (GLP-1)-receptor agonist is not recommended.
- The safety and efficacy of ZEPBOUND in combination with other products intended for weight management, including prescription drugs, over-the-counter drugs, and herbal preparations, have not been established.

ZEPBOUND has not been studied in patients with a history of pancreatitis.

DOSAGE AND ADMINISTRATION

Patient Selection

Select adult patients for ZEPBOUND treatment as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management based on their BMI. BMI is calculated by dividing weight (in kilograms) by height (in meters) squared.

Recommended Dosage

- The recommended starting dosage of ZEPBOUND is 2.5 mg injected subcutaneously once weekly. The 2.5 mg dosage is for treatment initiation and is not intended for chronic weight management.
- After 4 weeks, increase the dosage to 5 mg injected subcutaneously once weekly.
- The dosage may be increased in 2.5 mg increments, after at least 4 weeks on the current dose.
- The recommended maintenance dosages of ZEPBOUND in adults are 5 mg, 10 mg, or 15 mg injected subcutaneously once weekly.
- Consider treatment response and tolerability when selecting the maintenance dosage. If patients do not tolerate a maintenance dosage, consider a lower maintenance dosage.
- The maximum dosage of ZEPBOUND is 15 mg injected subcutaneously once weekly.

DOSAGE FORMS AND STRENGTHS

Injection: Clear, colorless to slightly yellow solution available in pre-filled single-dose pens of the following strengths:

- 2.5 mg/0.5 mL
- 5 mg/0.5 mL
- 7.5 mg/0.5 mL
- 10 mg/0.5 mL
- 12.5 mg/0.5 mL
- 15 mg/0.5 mL

CONTRAINDICATIONS

ZEPBOUND is contraindicated in patients with:

- A personal or family history of medullary thyroid carcinoma (MTC) or in patients with multiple endocrine neoplasia syndrome type 2 (MEN 2).

Known serious hypersensitivity to tirzepatide or any of the excipients in ZEPBOUND. Serious hypersensitivity reactions, including anaphylaxis and angioedema, have been reported with tirzepatide.

WARNINGS AND PRECAUTIONS

Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with ZEPBOUND. Such monitoring may increase the risk of unnecessary procedures, due to the low test specificity for serum calcitonin and a high background incidence of thyroid disease. Significantly elevated serum calcitonin values may indicate MTC and patients with MTC usually have calcitonin values > 50 ng/L. If serum calcitonin is measured and found to be elevated, the patient should be further evaluated. Patients with thyroid nodules noted on physical examination or neck imaging should also be further evaluated.

WARNING: RISK OF THYROID C-CELL TUMORS

- In rats, tirzepatide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures. It is unknown whether ZEPBOUND causes thyroid C-cell tumors, including MTC, in humans as human relevance of tirzepatide-induced rodent thyroid C-cell tumors has not been determined.
- ZEPBOUND is contraindicated in patients with a personal or family history of MTC or in patients with MEN 2. Counsel patients regarding the potential risk for MTC with the use of ZEPBOUND and inform them of symptoms of thyroid tumors (eg, a mass in the neck, dysphagia, dyspnea, persistent hoarseness). Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with ZEPBOUND.

Severe Gastrointestinal Disease

Use of ZEPBOUND has been associated with gastrointestinal adverse reactions, sometimes severe [see Adverse Reactions 6.1]. In clinical trials, severe gastrointestinal adverse reactions were reported more frequently among patients receiving ZEPBOUND (5 mg 1.7%, 10 mg 2.5%, 15 mg 3.1%) than placebo (1%). ZEPBOUND has not been studied in patients with severe gastrointestinal disease, including severe gastroparesis, and is therefore not recommended in these patients.

Acute Kidney Injury

Use of ZEPBOUND has been associated with acute kidney injury, which can result from dehydration due to gastrointestinal adverse reactions to ZEPBOUND; including nausea, vomiting, and diarrhea.

In patients treated with GLP-1-receptor agonists, there have been postmarketing reports of acute kidney injury and worsening of chronic renal failure, which may sometimes require hemodialysis. Some of these events have been reported in patients without known underlying renal disease. A majority of the reported events occurred in patients who had experienced nausea, vomiting, diarrhea, or dehydration. Monitor renal function in patients reporting adverse reactions to ZEPBOUND that could lead to volume depletion.

Acute Gallbladder Disease

Treatment with ZEPBOUND and GLP-1-receptor agonists is associated with an increased occurrence of acute gallbladder disease.

In clinical trials of ZEPBOUND, cholelithiasis was reported in 1.1% of ZEPBOUND-treated patients and 1% of placebo- treated patients, cholecystitis was reported in 0.7% of ZEPBOUND-treated patients and 0.2% of placebo-treated patients, and cholecystectomy was reported in 0.2% of ZEPBOUND-treated patients and no placebo-treated patients. Acute gallbladder events were associated with weight reduction. If cholecystitis is suspected, gallbladder diagnostic studies and appropriate clinical follow-up are indicated.

Acute Pancreatitis

Acute pancreatitis, including fatal and nonfatal hemorrhagic or necrotizing pancreatitis, has been observed in patients treated with GLP-1-receptor agonists or tirzepatide.

In clinical trials of tirzepatide for a different indication, 14 events of acute pancreatitis were confirmed by adjudication in 13 tirzepatide-treated patients (0.23 patients per 100 years of exposure) versus 3 events in 3 comparator-treated patients (0.11 patients per 100 years of exposure). In ZEPBOUND clinical trials, 0.2% of ZEPBOUND-treated patients had acute pancreatitis confirmed by adjudication (0.14 patients per 100 years of exposure) versus 0.2% of placebo-treated patients (0.15 patients per 100 years of exposure). ZEPBOUND has not been studied in patients with a prior history of pancreatitis. It is unknown if patients with a history of pancreatitis are at higher risk for development of pancreatitis on ZEPBOUND.

After initiation of ZEPBOUND, observe patients carefully for signs and symptoms of pancreatitis (including persistent severe abdominal pain, sometimes radiating to the back, which may or may not be accompanied by vomiting). If pancreatitis is suspected, discontinue ZEPBOUND and initiate appropriate management. If the diagnosis of pancreatitis is confirmed, ZEPBOUND should not be restarted.

Hypersensitivity Reactions

There have been postmarketing reports of serious hypersensitivity reactions (eg, anaphylaxis, angioedema) in patients treated with tirzepatide. In ZEPBOUND clinical trials, 0.1% of ZEPBOUND-treated patients had severe hypersensitivity reactions compared to no placebo-treated patients. If hypersensitivity reactions occur, advise patients to promptly seek medical attention and discontinue use of ZEPBOUND. Do not use in patients with a previous serious hypersensitivity reaction to tirzepatide or any of the excipients in ZEPBOUND.

Serious hypersensitivity reactions, including anaphylaxis and angioedema, have been reported with GLP-1-receptor agonists. Use caution in patients with a history of angioedema or anaphylaxis with a GLP-1-receptor agonist because it is unknown whether such patients will be predisposed to these reactions with ZEPBOUND.

Hypoglycemia

ZEPBOUND lowers blood glucose and can cause hypoglycemia.

In a trial of patients with type 2 diabetes mellitus and BMI ≥ 27 kg/m2, hypoglycemia (plasma glucose < 54 mg/dL) was reported in 4.2% of ZEPBOUND-treated patients versus 1.3% of placebo-treated patients. In this trial, patients taking ZEPBOUND in combination with an insulin secretagogue (eg, sulfonylurea) had increased risk of hypoglycemia (10.3%) com-

pared to ZEPBOUND-treated patients not taking a sulfonylurea (2.1%). There is also increased risk of hypoglycemia in patients treated with tirzepatide in combination with insulin.

Hypoglycemia has also been associated with ZEPBOUND and GLP-1-receptor agonists in adults without type 2 diabetes mellitus.

Inform patients of the risk of hypoglycemia and educate them on the signs and symptoms of hypoglycemia. In patients with diabetes mellitus, monitor blood glucose prior to starting ZEPBOUND and during ZEPBOUND treatment. The risk of hypoglycemia may be lowered by a reduction in the dose of sulfonylurea (or other concomitantly administered insulin secretagogue) or insulin.

Diabetic Retinopathy Complications in Patients with Type 2 Diabetes Mellitus

Rapid improvement in glucose control has been associated with a temporary worsening of diabetic retinopathy. Tirzepatide has not been studied in patients with nonproliferative diabetic retinopathy requiring acute therapy, proliferative diabetic retinopathy, or diabetic macular edema. Patients with a history of diabetic retinopathy should be monitored for progression of diabetic retinopathy.

Suicidal Behavior and Ideation

Suicidal behavior and ideation have been reported in clinical trials with other chronic weight management products. Monitor patients treated with ZEPBOUND for the emergence or worsening of depression, suicidal thoughts or behaviors, and/or any unusual changes in mood or behavior. Discontinue ZEPBOUND in patients who experience suicidal thoughts or behaviors. Avoid ZEPBOUND in patients with a history of suicidal attempts or active suicidal ideation.

DRUG INTERACTIONS

Concomitant Use with an Insulin Secretagogue (eg, Sulfonylurea) or with Insulin

ZEPBOUND lowers blood glucose. When initiating ZEPBOUND, consider reducing the dose of concomitantly administered insulin secretagogues (eg, sulfonylureas) or insulin to reduce the risk of hypoglycemia.

Oral Medications

ZEPBOUND delays gastric emptying and thereby has the potential to impact the absorption of concomitantly administered oral medications. Caution should be exercised when oral medications are concomitantly administered with ZEPBOUND.

Monitor patients on oral medications dependent on threshold concentrations for efficacy and those with a narrow therapeutic index (eg, warfarin) when concomitantly administered with ZEPBOUND.

Advise patients using oral hormonal contraceptives to switch to a non-oral contraceptive method, or add a barrier method of contraception, for 4 weeks after initiation with ZEPBOUND and for 4 weeks after each dose escalation. Hormonal contraceptives that are not administered orally should not be affected].

USE IN SPECIFIC POPULATIONS

Pregnancy

Pregnancy Exposure Registry

There will be a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to ZEPBOUND (tirzepatide) during pregnancy. Pregnant patients exposed to ZEPBOUND and health care providers are encouraged to contact Eli Lilly and Company at 1-800-LillyRx (1-800-545-5979).

Risk Summary

Weight loss offers no benefit to a pregnant patient and may cause fetal harm. Advise pregnant patients that weight loss is not recommended during pregnancy and to discontinue ZEPBOUND when a pregnancy is recognized (see Clinical Considerations). Available data with tirzepatide in pregnant patients are insufficient to evaluate for a drug-related risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes. Based on animal reproduction studies, there may be risks to the fetus from exposure to tirzepatide during pregnancy.

In pregnant rats administered tirzepatide during organogenesis, fetal growth reductions and fetal abnormalities occurred at clinical exposure in maternal rats based on AUC. In rabbits administered tirzepatide during organogenesis, fetal growth reductions were observed at clinically relevant exposures based on AUC. These adverse embryo/fetal effects in animals coincided with pharmacological effects on maternal weight and food consumption (see Data).

The estimated background risk of major birth defects and miscarriage for the indicated population is increased when compared to the general population. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.

Clinical Considerations

Disease-Associated Maternal and/or Embryo/Fetal Risk

Appropriate weight gain based on pre-pregnancy weight is currently recommended for all pregnant patients, including those with obesity or overweight, due to the obligatory weight gain that occurs in maternal tissues during pregnancy.

Females and Males of Reproductive Potential

Contraception

Use of ZEPBOUND may reduce the efficacy of oral hormonal contraceptives due to delayed gastric emptying. This delay is largest after the first dose and diminishes over time. Advise patients using oral hormonal contraceptives to switch to a non-oral contraceptive method, or add a barrier method of contraception, for 4 weeks after initiation with ZEPBOUND and for 4 weeks after each dose escalation.

Pediatric Use
The safety and effectiveness of ZEPBOUND have not been established in pediatric patients less than 18 years of age.

Geriatric Use
In ZEPBOUND clinical trials, 226 (9%) ZEPBOUND-treated patients were 65 years of age or older, and 13 (0.5%) ZEPBOUND-treated patients were 75 years of age or older at baseline.

No overall differences in safety or effectiveness of ZEPBOUND have been observed between patients 65 years of age and older and younger adult patients.

Renal Impairment
No dosage adjustment of ZEPBOUND is recommended for patients with renal impairment. In subjects with renal impairment including end-stage renal disease (ESRD), no change in tirzepatide pharmacokinetics (PK) was observed. Monitor renal function in patients reporting adverse reactions to ZEPBOUND that could lead to volume depletion.

Hepatic Impairment
No dosage adjustment of ZEPBOUND is recommended for patients with hepatic impairment. In a clinical pharmacology study in subjects with varying degrees of hepatic impairment, no change in tirzepatide PK was observed.

CLINICAL STUDIES
Weight Management Studies in Adults with Overweight or Obesity
Overview of Clinical Studies
The efficacy of ZEPBOUND for chronic weight management (weight reduction and maintenance) in conjunction with a reduced-calorie diet and increased physical activity was studied in two randomized, double-blind, placebo-controlled trials (Study 1 and Study 2), in which weight reduction was assessed after 72 weeks of treatment (at least 52 weeks at maintenance dose). In Study 1, the dose of ZEPBOUND or matching placebo was escalated to 5 mg, 10 mg, or 15 mg subcutaneously once weekly during a 20-week titration period followed by the maintenance period. In Study 2, the dose of ZEPBOUND or matching placebo was escalated to 10 mg or 15 mg subcutaneously once weekly during a 20-week titration period followed by the maintenance period.

In Studies 1 and 2, all patients received instruction on a reduced-calorie diet (approximately 500 kcal/day deficit) and increased physical activity counseling (recommended to a minimum of 150 min/week) that began with the first dose of study medication or placebo and continued throughout the trial.

Study 1 (NCT04184622) was a 72-week trial that enrolled 2539 adult patients with obesity (BMI ≥30 kg/m2), or with overweight (BMI 27 to <30 kg/m2) and at least one weight-related comorbid condition, such as dyslipidemia, hypertension, obstructive sleep apnea, or cardiovascular disease; patients with type 2 diabetes mellitus were excluded. Patients were randomized in a 1:1:1:1 ratio to ZEPBOUND 5 mg, ZEPBOUND 10 mg, ZEPBOUND 15 mg, or placebo once weekly. At baseline, mean age was 45 years (range 18-84 years), 68% were women, 71% were White, 11% were Asian, 9% were American Indian/Alaska Native, and 8% were Black or African American. A total of 48% were Hispanic or Latino. Mean baseline body weight was 104.8 kg and mean BMI was 38 kg/m2. Baseline characteristics included 32% with hypertension, 30% with dyslipidemia, 8% with obstructive sleep apnea, and 3% with cardiovascular disease.

Study 2 (NCT04657003) was a 72-week trial that enrolled 938 adult patients with BMI ≥ 27 kg/m2 and type 2 diabetes mellitus. Patients included in the trial had HbA1c 7-10% and were treated with either diet and exercise alone, or any oral anti-hyperglycemic agent except dipeptidyl peptidase-4 (DPP-4) inhibitors or GLP-1-receptor agonists. Patients who were taking insulin or injectable GLP-1-receptor agonists for type 2 diabetes mellitus were excluded. Patients were randomized in a 1:1:1 ratio to ZEPBOUND 10 mg, ZEPBOUND 15 mg, or placebo once weekly. At baseline, mean age was 54 years (range 18-85 years), 51% were women, 76% were White, 13% were Asian, and 8% were Black or African American. A total of 60% were Hispanic or Latino. Mean baseline body weight was 100.7 kg and mean BMI was 36.1 kg/m2. Baseline characteristics included 66% with hypertension, 61% with dyslipidemia, 8% with obstructive sleep apnea, and 10% with cardiovascular disease.

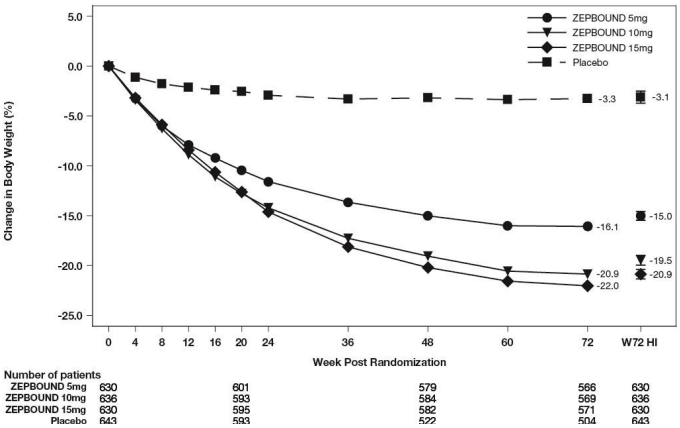
Results
The proportions of patients who discontinued study drug in Study 1 were 14.3%, 16.4%, and 15.1% for the 5 mg, 10 mg, and 15 mg ZEPBOUND-treated groups, respectively, and 26.4% for the placebo-treated group. The proportions of patients who discontinued study drug in Study 2 were 9.3% and 13.8% for the 10 mg and 15 mg ZEPBOUND-treated groups, respectively, and 14.9% for the placebo-treated group.

For Studies 1 and 2, the primary efficacy parameters were mean percent change in body weight and the percentage of patients achieving ≥ 5% weight reduction from baseline to Week 72.

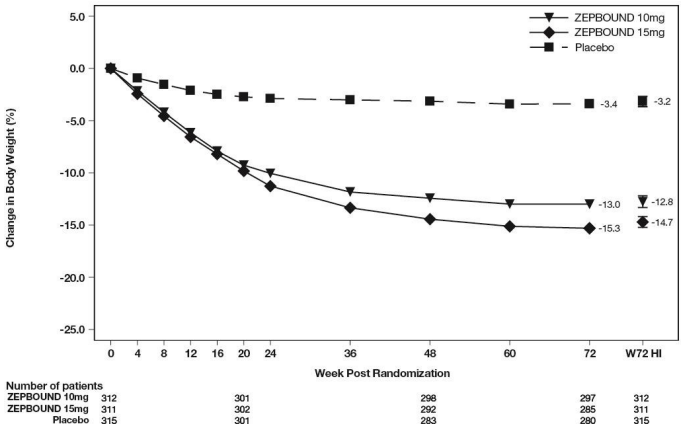
After 72 weeks of treatment, ZEPBOUND resulted in a statistically significant reduction in body weight compared with placebo, and greater proportions of patients treated with ZEPBOUND 5 mg, 10 mg, and 15 mg achieved at least 5% weight reduction compared to placebo. Among patients treated with ZEPBOUND 10 mg and 15 mg, greater proportions of patients achieved at least 10%, 15%, and 20% weight reduction compared to placebo. A reduction in body weight was observed with ZEPBOUND irrespective of age, sex, race, ethnicity, baseline BMI, and glycemic status.

The time courses of weight reduction with ZEPBOUND and placebo from baseline through Week 72 are depicted below for Study 1 and Study 2.

Change from Baseline (%) in Body Weight in Study 1



Change from Baseline (%) in Body Weight in Study 2



HOW SUPPLIED/STORAGE AND HANDLING

How Supplied

ZEPBOUND is a clear, colorless to slightly yellow solution available in pre-filled single-dose pens as follows:

Total Strength per Total Volume	Carton Contents	NDC
2.5 mg/0.5 mL	4 single-dose pens	0002-2506-80
5 mg/0.5 mL	4 single-dose pens	0002-2495-80
7.5 mg/0.5 mL	4 single-dose pens	0002-2484-80
10 mg/0.5 mL	4 single-dose pens	0002-2471-80
12.5 mg/0.5 mL	4 single-dose pens	0002-2460-80
15 mg/0.5 mL	4 single-dose pens	0002-2457-80

Storage and Handling

- Store ZEPBOUND in a refrigerator at 2°C to 8°C (36°F to 46°F).
- If needed, each single-dose pen can be stored unrefrigerated at temperatures not to exceed 30°C (86°F) for up to 21 days. If ZEPBOUND is stored at room temperature, it should not be returned to the refrigerator.
- Discard if not used within 21 days after removing from the refrigerator.
- Do not freeze ZEPBOUND. Do not use ZEPBOUND if frozen.
- Store ZEPBOUND in the original carton to protect from light.

For full prescribing information, see Product Insert.
ZEPBOUND is marketed by Lilly USA, LLC

Addressing Complex Ethical Issues … a Moral Imperative for Case Managers *continued from page 3*

Stephanie Kruszynski, LISW-S, titled, "Expanding the Partners for Kids Vision to Meet the Care Coordination Needs of Justice Involved Youth in Franklin County, OH," likely has some involvement with youngsters who have incurred bias and discrimination. I would recommend this for your reading consideration as well.

Without a direct request to our organizational partners, both CCMC and CDMS elected to feature an ethical value in their respective Codes of Professional Conduct. CCMC's column Justice for All is titled "A Case Management Value" (R. Keith Franklin, PhD, LPC-S, LCDC, ACS, CEAP, CCM), and the column from CDMS is titled "Upholding Justice: Extending Advocacy in Service to Others" (Patricia Nunez, MA, CRC, CDMS, CCM) .

While these are serious and compelling issues to address, we also need to celebrate the work that we do, the successes that we've achieved, and the growing determination to communicate the value that case management provides. CareManagement will continue, with the help of our case management authors and organizational partners, to "tell the story" of case management. We do make a difference…one patient at a time and our role can extend beyond health care and into the realm of social injustice.

On behalf of all of us, we thank you, our readers, for your loyalty, and you, our contributors, for your thoughtful and insightful articles. We would like to wish you a joyful holiday season and a Happy New Year!

Warm regards,

Catherine M. Mullahy

Catherine M. Mullahy, RN, BS, CRRN, CCM, FCM, *Executive Editor*
cmullahy@academyccm.org

LitScan for Case Managers

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

Clin Infect Dis. 2023 Nov 1:ciad608.

False-reactive fourth-generation human immunodeficiency virus testing in cancer patients

Chiu CY, Mustafayev K, Bhatti MM, et al.

BACKGROUND: The fourth-generation (4th-gen) human immunodeficiency virus (HIV)-1/2 antibody/antigen (Ab/Ag) combination immunoassay currently used for HIV screening offers greater sensitivity than previous assays, but false-reactive results occur in up to 20% of patients. Large-scale observations in cancer patients are lacking.

METHODS: We conducted a retrospective study of cancer patients seen at the University of Texas MD Anderson Cancer Center (March 2016-January 2023) who had reactive 4th-gen ARCHITECT HIV-1/2 Ab/Ag combination immunoassay results. We analyzed characteristics of patients with true-reactive and false-reactive results, defined based on Centers for Disease Control and Prevention criteria.

RESULTS: A total of 43 637 patients underwent 4th-gen HIV screening, and 293 had reactive 4th-gen HIV test results. Twenty-one patients were excluded because they did not have cancer. Among the remaining 272 patients, 78 (29%) had false-reactive results. None of these patients experienced delays in their cancer treatment, but 26% experienced mental distress. Multivariate logistic regression analysis identified 5 predictors of having false-reactive RESULTS: age >60 years (adjusted odds ratio [aOR], 6.983; P < .0001), female sex (aOR, 6.060; P < .0001), race/ethnicity (Black: aOR, 0.274; Hispanic: aOR, 0.236; P = .002), syphilis coinfection (aOR, 0.046; P = .038), and plant alkaloids therapy (aOR, 2.870; P = .013).

CONCLUSIONS: False-reactive 4th-gen HIV test results occur in almost one-third of cancer patients. Physicians should be aware of the high rates of false-reactive HIV screening results in this patient population. These findings may have implications for counseling regarding testing, especially among those at low risk for HIV infection.

PLoS One. 2023 Nov 9;18(11):e0288588.

Potential contribution of PrEP uptake by adolescents 15-17 years old to achieving the "Ending the HIV Epidemic" incidence reduction goals in the US South

Hamilton DT, Wang LY, Hoover KW, et al.

BACKGROUND: The "Ending the HIV Epidemic" (EHE) initiative seeks to reduce new HIV infections in the US by prioritizing federal resources towards highly impacted populations. Antiretroviral therapy (ART) and pre-exposure prophylaxis (PrEP) are essential for reaching EHE goals. Adolescents are often at increased risk for HIV because they may lack agency in negotiating their sexual partnerships and may not have the same access to treatment and prevention as adults. This study estimates the potential contribution of expanded PrEP coverage among adolescents ages 15-17 to achieving the EHE goals in the South.

METHODS: An HIV-transmission model was built to simulate the HIV epidemic in the South. Increased ART and PrEP uptake were systematically varied with and without PrEP eligibility including individuals age < 18.

RESULTS: Prioritizing PrEP for adolescents had a negligible impact on incidence. At 50% uptake among eligible adolescents and 90% ART coverage, including adolescents only improved the percentage of infections averted from 80.1% to 80.3%. In 10 of 15 scenarios explored, there was no reduction in new infections when PrEP eligibility was expanded to include adolescents age < 18. At 95% ART coverage at the population-level incidence among adolescents declined by over 80%, but PrEP uptake among adolescents did not contribute to additional declines in incidence among adolescents.

CONCLUSIONS: Prioritizing PrEP for adolescents did not significantly contribute to reaching EHE incidence reductions goal. Focusing resources to specific adolescent populations at risk, such sexual minority males in high incidence settings, will remain an important public health goal outside the context of EHE.

AIDS. 2023 Nov 2.

Characterizing residential mobility among people living with HIV in Tennessee and its impact on HIV care outcomes

Ahonkhai AA, Bian A, Robbins NN, et al.

OBJECTIVE: Our objective was to assess the prevalence and patterns of mobility among people living with HIV (PWH) in Tennessee, and its impact on HIV care outcomes.

DESIGN: Retrospective cohort study.

METHODS: We combined residential address and HIV surveillance data from PWH in Tennessee from 2016 to 2018. Using Poisson regression, we estimated associations between in-state mobility (change in address or total miles moved) in one year and outcomes in the subsequent year; retention: having two CD4/HIV RNA values (labs) in a calendar year at least three months apart, loss to follow-up (LTFU): having labs at baseline but not the subsequent year, and viral suppression: HIV RNA < 200 copies/mL. We applied a kernel density estimator to origin-destination address lines to visualize mobility patterns across demographic subgroups.

RESULTS: Among 17,428 PWH (median age 45 years [IQR 34, 53]), 6,564 (38%) had ≥ 1 move. Median miles moved was 8.9 (IQR 2.6, 143.4)). We observed in-state movement between major cities (Chattanooga, Knoxville, Memphis and Nashville) and out-of-state movement to and from Georgia and Florida. Having ≥ 1 in-state moves was associated with a decreased likelihood of retention (adjusted relative risk [aRR] = 0.91; 95% CI 0.88-0.95), and an increased risk of LTFU (aRR = 1·17; 95% CI 1·04-1·31 2-3 moves vs none). Greater distance moved in-state was associated with decreased retention and increased LTFU (aRR = 0.53; 95% CI 0.49-0.58, aRR = 2.52; 95% CI 2.25-2.83 respectively for 1000 vs 0 miles). There was no association between mobility and viral suppression.

CONCLUSIONS: Mobility is common among PWH in Tennessee and is associated with initial poor engagement in HIV care.

AIDS. 2023 Oct 30.

Auditory neural processing in children living with HIV uncovers underlying central nervous system dysfunction

Ealer C, Niemczak CE, Nicol T, et al.

OBJECTIVE: Central nervous system (CNS) damage from HIV infection or treatment can lead to developmental delays and poor educational outcomes in children living with HIV (CLWH). Early markers of central nervous system dysfunction are needed to target interventions and prevent life-long disability. The Frequency Following Response (FFR) is an auditory electrophysiology test that can reflect the health of the central nervous system. In this study, we explore whether the FFR reveals auditory central nervous system dysfunction in CLWH.

STUDY DESIGN: Cross-sectional analysis of an ongoing cohort study. Data were from the child's first visit in the study.

SETTING: The infectious disease center in Dar es Salaam, Tanzania.

METHODS: We collected the FFR from 151 CLWH and 151 HIV-negative children. To evoke the FFR, three speech syllabi (/da/, /ba/, /ga/) were played monaurally to the child's right ear. Response measures included neural timing (peak latencies), strength of frequency encoding (fundamental frequency and first formant amplitude), encoding consistency (inter-response consistency), and encoding precision (stimulus-to-response correlation).

RESULTS: CLWH showed smaller first formant amplitudes ($p < .0001$), weaker inter-response consistencies ($p < .0001$) and smaller stimulus to response correlations ($p < .0001$) than FFRs from HIV-negative children. These findings generalized across the three speech stimuli with moderately strong effect sizes (partial $\eta 2$ ranged from 0·061 to 0·094).

CONCLUSION: The FFR shows auditory central nervous system dysfunction in CLWH. Neural encoding of auditory stimuli was less robust, more variable, and less accurate. Since the FFR is a passive and objective test, it may offer an effective way to assess and detect central nervous system function in CLWH.

Clin Infect Dis. 2023 Nov 2;77(Suppl 5):S416-S422.

Phage therapy in lung transplantation: current status and future possibilities

Aslam S.

Patients with chronic lung disease and lung transplantation have high rates of colonization and infection from multidrug-resistant (MDR) organisms. This article summarizes the current state of knowledge regarding phage therapy in the setting of lung transplantation. Phage therapy has been used in several lung transplant candidates and recipients on a compassionate use basis targeting mostly MDR gram-negative infections and atypical mycobacterial infections with demonstrated clinical safety. Phage biodistribution given intravenously or via nebulization has not been extensively studied, though preliminary data are presented. Phage interacts with both the innate and adaptive immune system; current literature demonstrates the development of serum neutralization in some cases of phage therapy, although the clinical impact seems variable. A summary of current clinical trials involving patients with chronic lung disease is presented, though none are specifically targeting lung transplant candidates or recipients. In addition to treatment of active infections, a variety of clinical scenarios

may benefit from phage therapy, and well-designed clinical trials involving this vulnerable patient population are needed: pre- or peritransplantation use of phage in the setting of MDR organism colonization may lead to waitlisting of candidates currently declined by many centers, along with potential reduction of waitlist mortality rates and posttransplant infections; phage may be used for biofilm-related bronchial stent infections; and, finally, there is a possibility that phage use can affect allograft function and chronic rejection.

Am J Cardiol. 2023;207:69-74.

Impact of frailty on left ventricular assist device clinical outcomes

Imburgio S, Udongwo N, Mararenko A, et al.

Frailty is a clinical syndrome prevalent in older adults and carries poor outcomes in patients with heart failure. We investigated the impact of frailty on left ventricular assist device (LVAD) clinical outcomes. The Nationwide Readmission Database was used to retrospectively identify patients with a primary diagnosis of heart failure who underwent LVAD implantation during their hospitalization from 2014 to 2020. Patients were categorized into frail and nonfrail groups using the Hospital Frailty Risk Score. Cox and logistic regression were used to predict the impact of frailty on inpatient mortality, 30-day readmissions, length of stay, and discharge to a skilled nursing facility. LVADs were implanted in 11,465 patients who met the inclusion criteria. There was more LVAD use in patients who were identified as frail (81.6% vs 18.4%, p <0.001). The Cox regression analyses revealed that LVAD insertion was not associated with increased inpatient mortality in frail patients (hazard ratio 1.15, 95% CI 0.81 to 1.65, P = 0.427). Frail patients also did not experience a higher likelihood of readmissions within 30 days (hazard ratio 1.15, 95% CI 0.91 to 1.44, P = 0.239). LVAD implantation, n did not result in a significant increase in inpatient mortality or readmission rates in frail patients compared with nonfrail patients. These data support continued LVAD use in this high-risk patient population.

Circ Heart Fail. 2023 Nov 6.

An economic modeling analysis of an intensive GDMT optimization program in hospitalized heart failure patients

Dixit NM, Parikh NU, Ziaeian B, Fonarow GC.

BACKGROUND: The STRONG-HF trial demonstrated substantial reductions in the composite of mortality and morbidity over 6 months among hospitalized heart failure patients who were randomized to intensive guideline-directed medical therapy (GDMT) optimization compared to usual care. Whether an intensive GDMT optimization program would be cost-effective for patients with heart failure with reduced ejection fraction (HFrEF) is unknown.

METHODS: Using a 2-state Markov model we evaluated the effect of an intensive GDMT optimization program on hospitalized patients with HFrEF. Two population models were created to simulate this intervention, a "Clinical Trial" model, based off the participants in the STRONG-HF trial and a "Real-World" model, based off the Get With The Guidelines-HF Registry of patients admitted with worsening HF. We then modeled the effect of a 6-month intensive triple therapy GDMT optimization program comprised of cardiologists, clinical pharmacists, and registered nurses. Hazard ratios from the intervention arm of the STRONG-HF trial were applied to both populations models to simulate clinical and financial outcomes of an intensive GDMT optimization program from a United States healthcare sector perspective with a lifetime time horizon. Optimal quadruple GDMT use was also modeled.

RESULTS: An intensive GDMT optimization program was extremely cost-effective with incremental cost-effectiveness ratios < $10,000 per quality-adjusted life year in both models. Optimal quadruple GDMT implementation resulted in the most gains in life years with incremental cost-effectiveness ratios of $60,000 and $54,000 in the Clinical Trial and Real-World models, respectively.

CONCLUSIONS: An intensive GDMT optimization program for patients hospitalized with HFrEF would be cost-effective and result in substantial gains in clinical outcomes especially with use of optimal quadruple GDMT. Clinicians, payers, and policy makers should prioritize creation of such programs.

ASAIO J. 2023 Nov 1;69(11):993-1000.

A paradigm shift in heart preservation: improved post-transplant outcomes in recipients of donor hearts preserved with the SherpaPak system

Shudo Y, Leacche M, Copeland H, et al.

Traditional ice storage has been the historic standard for preserving donor's hearts. However, this approach provides variability in cooling, increasing risks of freezing injury. To date, no preservation technology has been reported to improve survival after transplantation. The Paragonix SherpaPak Cardiac Transport System (SCTS) is a controlled hypothermic technology clinically used since 2018. Real-world evidence on clinical benefits of SCTS compared to conventional ice cold storage (ICS) was evaluated. Between October 2015 and January 2022, 569 US adults receiving donor hearts preserved and transported either in SCTS (n = 255)

or ICS (n = 314) were analyzed from the Global Utilization And Registry Database for Improved heArt preservatioN (GUARDIAN-Heart) registry. Propensity matching and a subgroup analysis of >240 minutes ischemic time were performed to evaluate comparative outcomes. Overall, the SCTS cohort had significantly lower rates of severe primary graft dysfunction (PGD) (P = 0.03). When propensity matched, SCTS had improving 1-year survival (P = 0.10), significantly lower rates of severe PGD (P = 0.011), and lower overall post-transplant MCS utilization (P = 0.098). For patients with ischemic times > 4 hours, the SCTS cohort had reduced post-transplant MCS utilization (P = 0.01), reduced incidence of severe PGD (P = 0.005), and improved 30-day survival (P = 0.02). A multivariate analysis of independent risk factors revealed that compared to SCTS, use of ice results in a 3.4-fold greater chance of severe PGD (P = 0.014). Utilization of SCTS is associated with a trend toward increased post-transplant survival and significantly lower severe PGD and MCS utilization. These findings fundamentally challenge the decades-long status quo of transporting donor hearts using ice.

Ann Vasc Surg. 2023 Nov 7:S0890-5096(23)00757-4.

Diabetes, hypertension, and smoking do not affect outcomes of iliofemoral vein stenting for chronic proximal venous outflow obstruction

Kang Y, Bai H, Storch JB, et al.

OBJECTIVE: Diabetes, hypertension, and smoking are well-recognized risk factors for Peripheral Artery Disease (PAD), but little is known of their impact on chronic venous insufficiency (CVI). This study evaluates these factors in patients undergoing iliac vein stenting (IVS) for CVI.

METHODS: A registry of 708 patients who underwent IVS from August 2011 to June 2021 was retrospectively analyzed. Symptoms were quantified using venous clinical severity score (VCSS) and CEAP classification. Both major and minor reinterventions were recorded. Logistic regression models were used to determine the unadjusted and adjusted odds ratio (OR) of any reintervention. Log-rank test was used to assess differences in reintervention-free survival.

RESULTS: The prevalence of hypertension was 51.1% (N = 362), diabetes was 23.0% (N = 163), and smoking was 22.2% (N = 157). Patients with diabetes (3.6 vs 3.4; P = 0.062), hypertension (3.6 vs 3.3; P < 0.001), and smoking (3.7 vs 3.4; P = 0.003) had higher CEAP scores than those without these comorbidities. Improvement in VCSS composite scores showed no differences postoperatively (diabetes: P = 0.513; hypertension: P = 0.053; smoking: P = 0.608), at 1-year follow-up (diabetes: P = 0.666; hypertension: P = 0.681; smoking: P = 0.745), or at 5-year follow-up (diabetes: P = 0.525; hypertension: P = 0.953; smoking: P = 0.146). Diabetes (P = 0.454), smoking (P = 0.355), and hypertension (P = 0.727) were not associated with increased odds of major reintervention. Log-rank test similarly showed no differences in reintervention-free survival for major or minor reoperations between those with and without diabetes (P = 0.79), hypertension (P = 0.14), and smoking (P = 0.80).

CONCLUSIONS: Diabetes, hypertension, and smoking were prevalent among CVI patients, but unlike in PAD patients, they had little to no impact on long-term outcomes or reinterventions after IVS.

J Hum Hypertens. 2023 Nov;37(11):1015-1020.

More moderate-intensity physical activity and less prolonged sedentary time are associated with better very short-term systolic blood pressure variability in healthy adults

Schwartz BD, Shivgulam ME, Petterson JL, et al.

Whole-day movement guidelines for improving health recommend that adults engage in at least 150 min per week of moderate-to-vigorous aerobic physical activity and limit their sedentary time. In young adults, higher systolic blood pressure variability (BPV) is a precursor for the development of hypertension. The impact of habitual activity that comprises (inter)national guidelines on BPV is unclear. We tested the hypothesis that less habitual physical activity and greater sedentary time would be associated with larger BPV. Ninety-two normotensive participants [age: 19-38 years, body mass index (BMI): 23.6 ± 3.3 kg/m2, 44♀] wore an activPAL monitor on their thigh for 7.0 ± 0.3 days. Ten minutes of supine systolic arterial pressure was measured via finger photoplethysmography (115 ± 11 mm Hg). Beat-by-beat systolic BPV was measured using the average real variability index (1.1 ± 0.6 mm Hg). Relationships between habitual activity outcomes and BPV were assessed via multiple regressions adjusted for age, sex, and BMI. Moderate-intensity physical activity (average: 36 ± 19 min/day-1; β = -0.010, P = 0.02) and time spent in sedentary bouts > 1 h (245 ± 134 min/day; β = 0.002, P < 0.001), but not light-intensity activity, vigorous-intensity activity, standing time, sedentary breaks, or time spent in sedentary bouts < 1h (all, P > 0.10) were predictors of systolic BPV. Higher moderate physical activity and lower prolonged sedentary time were associated with attenuated systolic BPV responses in young adults. These findings highlight the cardiovascular benefits of habitual activity among younger adults and suggest that simple strategies such as reducing long periods of uninterrupted sitting and increasing moderate-intensity physical activity may be efficacious for reducing the risk of developing or delaying the onset of hypertension.

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Ann Surg. 2023 Dec 1;278(6):e1259-e1266.

Operative time is associated with postoperative complications after pulmonary lobectomy

de Angelis P, Tan KS, Chudgar NP, et al.
Paolo de Angelis [1], Kay See Tan [2], Neel P Chudgar [1], Joseph Dycoco [1],

OBJECTIVE: To investigate the association between operative time and postoperative outcomes.

BACKGROUND: The association between operative time and morbidity after pulmonary lobectomy has not been characterized fully.

METHODS: Patients who underwent pulmonary lobectomy for primary lung cancer at our institution from 2010 to 2018 were reviewed. Exclusion criteria included clinical stage ≥IIb disease, conversion to thoracotomy, and previous ipsilateral lung treatment. Operative time was measured from incision to closure. Relationships between operative time and outcomes were quantified using multivariable mixed-effects models with surgeon-level random effects.

RESULTS: In total, 1651 patients were included. The median age was 68 years (interquartile range, 61-74), and 63% of patients were women. Median operative time was 3.2 hours (interquartile range, 2.7-3.8) for all cases, 3.0 hours for open procedures, 3.3 hours for video-assisted thoracoscopies, and 3.3 hours for robotic procedures (P =0.0002). Overall, 488 patients (30%) experienced a complication; 77 patients (5%) had a major complication (grade ≥ 3), and 5 patients (0.3%) died within 30 days of discharge. On multivariable analysis, operative time was associated with higher odds of any complication [odds ratio per hour, 1.37; 95% CI, 1.20-1.57; P < 0.0001] and major complication (odds ratio per hour, 1.41; 95% CI, 1.21-1.64; P < 0.0001). Operative time was also associated with longer hospital length of stay (β, 1.09; 95% CI, 1.04-1.14; P =0.001).

CONCLUSIONS: Longer operative time was associated with worse outcomes in patients who underwent lobectomy. Operative time is a potential risk factor to consider in the perioperative phase.

BMC Neurol. 2023 Nov 9;23(1):400.

Patterns of use of symptomatic treatments for Alzheimer's disease dementia (AD)

DiBello JR, Lu Y, Swartz J, et al.

BACKGROUND: Symptomatic treatment for Alzheimer's disease (AD) dementia could temporarily slow symptom worsening and improve the quality of life for both AD dementia patients and their caregivers. A comprehensive evaluation of symptomatic treatment patterns using recent data for newly diagnosed AD dementia has not been performed and compared across different countries.

METHODS: The drug name, time to the first therapy, duration, discontinuation or switches were described in newly diagnosed AD dementia patients in two databases (a major US health plan [US] and UK-Clinical Practice Research Datalink [CPRD GOLD]). This analysis included patients with newly diagnosed AD dementia in 2018-2019, who initiated symptomatic AD drug therapy, with ≥ 1 year baseline period and ≥ 1 year of follow-up.

RESULTS: Over median follow-ups of 698 and 645 days, 63% and 65% of AD dementia patients used symptomatic treatments, with 34% and 77% newly initiating therapy, constituting analytic samples of 7637 patients in the US database and 4470 patients in the CPRD, respectively. The median time to the first therapy was 14 days for US and 49 days for CPRD; donepezil ranked as the most frequently used (69% vs 61%), followed by memantine (19% vs 28%) in the US database and CPRD, respectively. Median time on first therapy was 213 and 334 days, and 30% and 12% of patients proceeded to a second treatment in the US and CPRD databases, respectively.

CONCLUSION: Approximately two-thirds of newly diagnosed AD dementia patients utilized approved symptomatic treatment. Time on first therapy was relatively short (< 1 year) and the majority did not move to a second therapy, highlighting the need for better adherence and persistence to existing AD symptomatic therapies and the need for additional therapies to alleviate the significant burden of AD dementia.

The Code of Professional Conduct
continued from page 2

managers will act with integrity and fidelity with clients and others.

- Principle 5: Board-certified case managers will maintain their competency at a level that ensures their clients will receive the highest quality of service.
- Principle 6: Board-certified case managers will honor the integrity of the CCM/CDMS designation and adhere to the requirements for it use.
- Principle 7: Board-certified case managers will obey all laws and regulations.
- Principle 8: Board-certified case managers will help maintain the integrity of the Code by responding to requests for public comments to review and revise the Code, thus helping ensure its consistency with current practice.

Rules of Conduct

- Rule 1: A board-certified case manager will not intentionally falsify an application or other document.
- Rule 2: A board-certified case manager will not be convicted of a felony.
- Rule 3: A board-certified case manager will not violate the code of ethics governing the professional upon which the individual's eligibility for the CCM/CDMS designation is based.
- Rule 4: A board-certified case manager will not lose the primary professional credential upon which eligibility for the CCM/CDMS designation is based.
- Rule 5: A board-certified case manager will not violate or breach the Standards of Professional Conduct.
- Rule 6: A board-certified case manager will not violate the rules and regulations governing the taking of the certification examinations and maintenance of CCM/CDMS Certification.

Violation of any of these rules may result in disciplinary action up to and including revoking of the individual's certification.

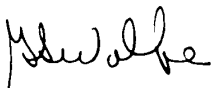
The Code is based on several underlying values including:

- Believing that case management is a means for improving client health, wellness, and autonomy through advocacy, communication, education, identification of service resources, and service facilitation.
- Recognizing the dignity, worth, and rights of all people.
- Understanding and committing to quality outcomes, appropriate use of resources, and the empowerment of clients that is supportive and objective.
- Embracing the underlying premise that when the client reaches the optimum level of wellness and functional capability, everyone benefits.
- Understanding that case management is guided by the ethical principles of autonomy, beneficence, nonmaleficence, justice, and fidelity.

The Code really is about doing what is right for the client under all circumstances. Rather than dictating actions, the Code describes the ethical environment for the delivery of case management services and reflects the character and general approach. Good ethical practice has been linked to improved clinical care, making knowledge and understanding of the Code an important part of a case manager's skill set. Although the CCM/CDMS Code of Professional Conduct is mandatory for those certified, the Code has become the standard of practice for all case managers.

More education for case managers about the Code is needed. Studies have shown that most health care professionals are aware of their respective code, but the studies showed poor levels of self-evaluated awareness of their contents. Barriers to upholding or using the Codes in practice were mentioned in the studies. Barriers mentioned include institutional barriers such as understaffing or conflicting work practices and policies; lack of knowledge; and conflicts with others including doctors, nurses, patients, and others. More education and awareness of the Code is necessary. The need for more education falls to employers as well as individual case managers, which is why the CCMC/CDMS requires continuing educations in ethics for the maintenance of CCM/CDMS certification.

Professional Codes are intended to guide decision-making and direct behavior. Codes are intended as a guide and framework for the case manager to consider in ethical dilemmas and when making decisions. The Code is a framework for trust between the client and the case manager and between the case manager and the whole of society. It offers practical guidance for case managers as they confront the challenges of day-to-day case management practice.



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ACCM: Improving Case Management Practice through Education

Expanding the Partners for Kids Vision: An Exploration of Initial Efforts to Meet the Care Coordination Needs of Justice-Involved Youth in Franklin County, Ohio *continued from page 24*

plan goal data related to rate of inclusion on SPOCs and to completion in relation to case closure reason are not currently collected for any other populations served by PFK. As a result, we were unable to conduct a comparative analysis in relation to all PFK care coordination cases, which limits our understanding of how frequently other PFK care coordination teams are satisfactorily completing at least some care plan goals before unsuccessful closure or establishing a benchmark.

Enrollment outcomes suggest that JIY and their caregivers recognize the value of care coordination, but enrollment is not a predictor of continued engagement until successful closure. There may be a meaningful correlation between the duration of a patient's involvement in care coordination, the reason for case closure, and successful resolution of needs.

As the JIY care coordination team begins its third year of operation, our data analysis offers some direction toward identifying interventions that would address patient and/or caregiver disengagement and support the expansion of PFK's efforts to meet the needs of a traditionally vulnerable and under-resourced pediatric population. Given patient and/or caregiver needs are more likely to be met when their care coordination case is closed successfully and that these cases also tend to remain open for longer durations than JIY cases closed for other reasons, future research should explore engagement strategies that support and encourage extended patient and/or caregiver participation in the care coordination process. Additionally, barriers to faster care plan goal completion and methods to decrease the length of time required to meet patient and/or caregiver needs should also be explored and trialed. CM

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Upholding Justice: Extending Advocacy in Service to Others *continued from page 7*

how court cases determine how laws should be applied. We need to be aware of the latest regulatory information, such as by reading articles in professional journals, attending seminars, and taking classes. Otherwise, a lack of understanding or, even worse, misinformation could lead to disservice to our clients.

Additionally, in disability management and case management, alike, we do not need to face challenges and ethical dilemmas alone. The first place to turn is to supervisors and other more experienced colleagues. Consulting with peers, both within the organization for which we work and within our professional networks, can help us access guidance and a fresh point of view. Chances are, while the details will differ, someone has faced similar challenges and found an ethical solution.

To uphold justice is to pursue an ideal. But even when reality is far less than the perfect state, we need to know the principle so we can put it into practice. That's what we strive toward in every case and circumstance. CM

Implicit Bias: Ethical Implications for the Case Manager

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address your implicit biases. As a case manager, you must identify your implicit biases and work to overcome them because they have a significant impact on the care management services you provide and allow you to fulfill the requirements of the Code on Professional Conduct. It is important to recognize your implicit biases and work toward change. CE1

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Justice—for All: A Case Management Value
continued from page 4

intonation, and inflection all portray judgment. We have to present information that is fair, unbiased, and factual, even when we disagree with the individual's opinions on certain matters. An easier way to say this is to refer to an old-school terminology: it's bedside manner. Then, with a fuller understanding, we can devise a care plan that is tailored to their beliefs, values, and goals.

4. **Advocating for Vulnerable Populations.** Justice requires case managers to do all they can to advocate for those who are marginalized and face significant barriers to accessing the care and resources they need. Case managers need to be aware of social determinants of health (SDOH)—the economic, social, and environmental factors and influences that affect health and outcomes. Delivering care to vulnerable populations, such as people who are undomiciled or the elderly who may have economic, mobility, and transportation barriers, may require collaborating with community organizations to provide that care.
5. **Ethical Decision-making.** Justice is tied closely to ethical decision-making, especially in the field of case management. As case managers, we must prioritize the best interests of the individual and, in a broader sense, the community. This means balancing individual rights with the greater good and ensuring that these decisions do not inadvertently perpetuate systemic injustice. The COVID-19 outbreak presented a number of significant changes to equality, equity, and justice. It is well known that underserved and underrepresented communities were often the hardest hit by COVID-19. By providing access to more resources such as mobile test clinics, temporary housing for the undomiciled to isolate when they were infected by COVID-19, and community care for follow-up became a matter of individual and community health.

Practicing justice within case management is not an easy task. When we face challenges, we can find support and guidance from colleagues, both within our organization and across our profession. Otherwise, we can get siloed in our own views of what is and is not possible, and that's where systemic injustice breeds. By reaching out, talking to others, remaining informed and relevant, we can best serve our clients with justice, equality, and equity. CM

Two Perspectives, One Goal: Case Management and Population Health Working Together *continued from page 6*

Both fields can collaborate to ensure integrated care coordination. Case managers can help in navigating complex health care systems, ensuring that patients receive comprehensive care that addresses not just immediate health concerns but also long-term wellness.

Engaging with communities to understand their specific health needs and barriers can lead to more effective health interventions. Case managers can play a crucial role in this outreach, helping to bridge the gap between population health initiatives and individual patient needs. Working together, population health and case management can develop and implement educational and preventive health programs. These programs can focus on lifestyle changes, chronic disease management, and health literacy, targeting both individuals and broader communities.

Collaborating on health care policy development and advocacy can lead to systemic changes that benefit population health. Case managers can provide valuable insights into the needs and challenges faced by patients, informing policies that promote equitable access to health care. By combining their strengths, population health and case management can provide more cohesive and effective health care services, ultimately leading to improved health outcomes for individuals and communities. CM

The Case Management Society of America *(CMSA) facilitates the growth and development of professional case managers across the full health care continuum, promoting high quality, ethical practice benefitting patients and their families. We strive for improved health outcomes by providing evidence-based resources, impacting health care policy and sustaining the CMSA-developed Standards of Practice for Case Management.* *www.cmsa.org*

Discharge Planners/Case Managers: What Would Patients and Their Families Think? *continued from page 8*

important services that are valued by many patients and their families, but their credibility and trustworthiness is destroyed when they make referrals based on kickbacks received. CM

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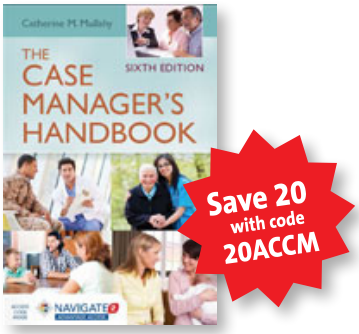

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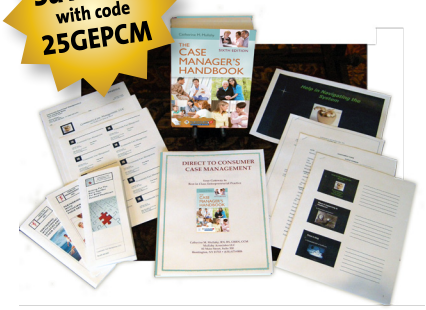

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