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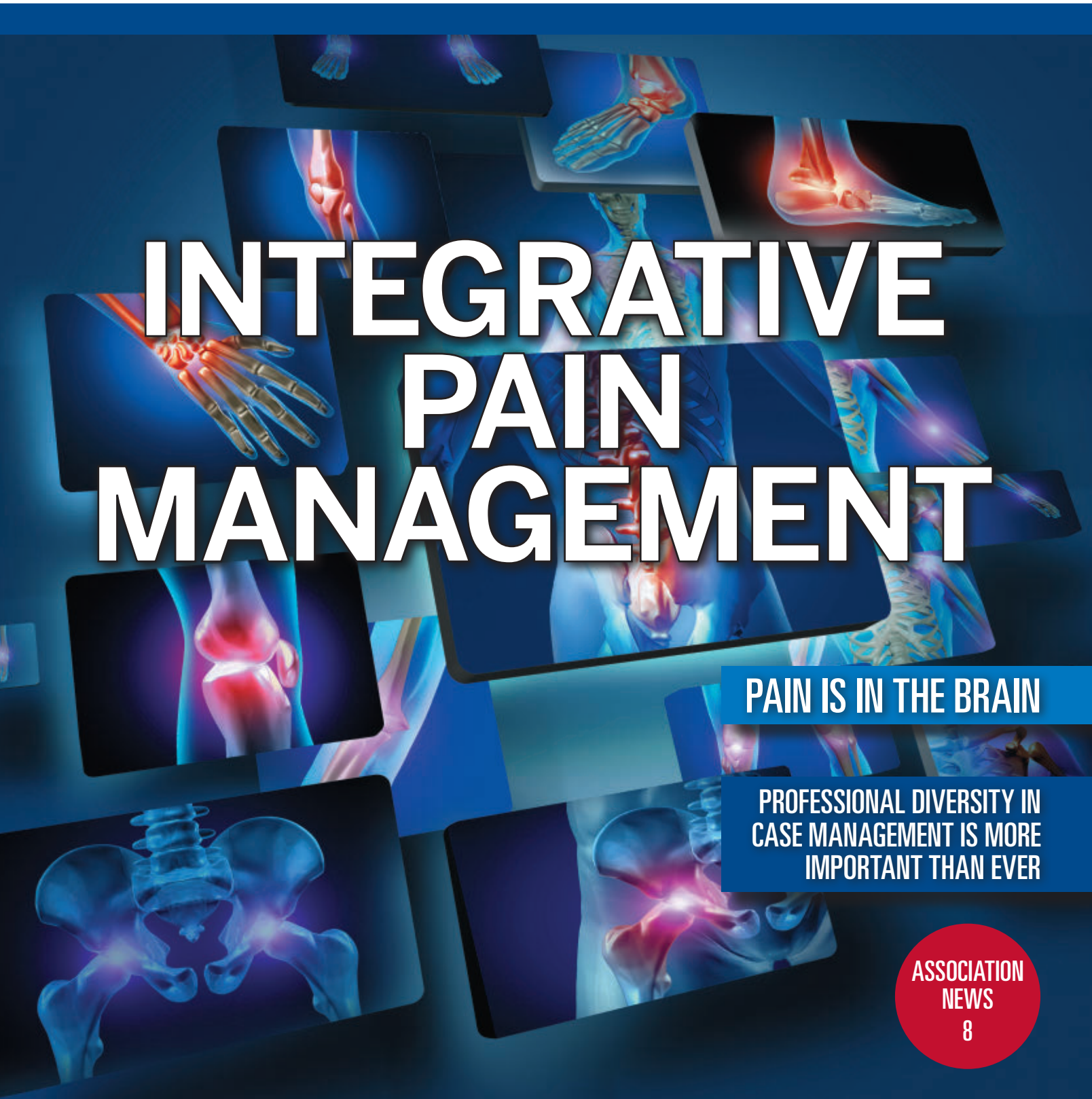

INTEGRATIVE PAIN MANAGEMENT

PAIN IS IN THE BRAIN

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ASSOCIATION NEWS 8

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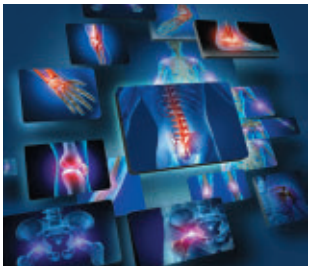

IN THIS ISSUE

ISSUE THEME
INTEGRATIVE PAIN MANAGEMENT

Musculoskeletal disorders – injury or pain in joints, ligaments, muscles, nerves and tendons – are the second largest contributor to disability worldwide, with lower back pain being the leading cause of disability globally. Some disorders arise suddenly and are short-lived, such as fractures, sprains and strains; however, others lead to lifelong conditions associated with chronic pain and disability.

FEATURES

COLUMNS

DEPARTMENTS

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Embrace, Anticipate, Innovate, Celebrate

BY MELANIE A. PRINCE, MSN, BSN, NE-BC, CCM

I suspect there are many of you experiencing a roller coaster ride of professional and emotional reactions to our world, your family and careers. Consider the COVID-19 pandemic: There have been extraordinary changes to our life patterns as we prevent, mitigate and navigate the healthcare environment with additional layers of complexity due to all of the above. What is not receiving enough public attention is the fact that other illnesses and diseases are still present. Injuries continue to occur as a function of living, playing and working. Many people need surgeries, and others desire elective procedures to improve their quality of life. This gumbo of scenarios leaves our patients confused about choices, and providers are challenged with what to tackle first. How can case managers bring calm to chaos?

EMBRACE. The roller coaster analogy is a good illustration of how case managers may tackle complex challenges head on. The minute we make the decision to take the ride, strap in, check our surroundings for any loose ends, make eye contact with our riding partner to inspire confidence, then settle in, we have embraced the knowledge that we will be turning, twisting, circling, ascending and descending in our journey.

ANTICIPATE. The first ascension gives us time to prepare mentally and just maybe plan with our partner how we will react during certain parts of the ride. As case managers, we reflect on prior cases that were similar, consult with colleagues and interdisciplinary professionals, host care meetings to collect information, then develop a plan and set that plan in motion as we address each barrier, standard, resource or situation along the way. As we reach the top of that first coaster climb, we have our plan, we have engaged the system and we are ready to see where that takes us. This is where different roller coaster designs come into play.

INNOVATE. One roller coaster design may have a short initial drop, then a few feet of smooth riding, then a jerk into multiple twists, turns, flips and spins. Another design may drop into a smooth and exhilarating downhill ride for several seconds before the chaotic turning, circling, twisting, upside-down spinning kicks in. Either design is filled with unknowns, unexpected movement, and a false sense of security that leaves us feeling fear, satisfaction, excitement and anxiety all at the same time or within a few seconds. Managing the care of patients in the COVID-19 environment at a time of resource constraints, reduced opportunities for transitions, in a fatigued healthcare system that is stressed financially and systemically – and where patient safety is at its highest risk – makes case management even more dynamic and complicated. Case managers are fulfilling new roles and upskilling their practice to accommodate unique twists and turns present in today's hospital, ambulatory and community care environments.

CELEBRATE. Continuing with the roller coaster analogy, the ride typically begins its conclusion with one final climb to a high point, and then a death-defying drop that evokes a sense of accomplishment that you have made it to the end as the remainder of the ride will be smooth sailing into a steady state of contentment at the terminal. That last ascension to the top represents a culmination of lessons learned, patient responses to treatment and care planning, resources that required tremendous effort to secure are now in place and the interventions are now reset to achieve the ultimate outcome. The case manager is now paused at the top, having mastered the previous chaos and ready to descend toward achieved outcomes and finally, case closure. That last drop is gratifying, affirming and celebratory for the case manager, patient and family.

With this analogy, every patient or client presents a different care journey, and most are represented by twisting, upside-downs, starts and stops scenarios that require a skilled, professional case manager to turn chaos into smooth, coordinated care that results in a steady state of self-management. Case managers create solutions by embracing the situation, anticipating the complexities and innovating results.

I intend to use those same attributes for CMSA as our association embraces the complexities of the healthcare environment during this pandemic, anticipates what and how we provide support for our members and drives innovative solutions for the profession. My ask of you is to be open to serving on a committee or as an advisor or lending your talents to lift CMSA to new peaks on our roller coaster of member association engagement and leadership. Embrace, Anticipate, Innovate…We can do this! ■

Melanie A. Prince, MSN, BSN, NE-BC, CCM, *is president of Case Management Society of America 2020. Recently retired as an Air Force colonel, she is chief executive officer, Care Associates Consulting and frequently requested to deliver presentations, editorials and training on various case management and leadership topics. Melanie is a certified professional case manager and nurse executive, and possesses master's degrees in nursing case management and military strategic studies.*

safe at home

HELPING SENIORS AGE AT HOME

According to the American Association of Retired Persons (AARP), nearly 90% of seniors want to stay in their own homes as they age, even as their health needs change. After all, that is the place they've grown accustomed to, where their memories are and where they're most comfortable. But as the years pass, how do families ensure their loved ones stay safe living at home? A few home modifications can help seniors avoid falls and remain independent as they age.

Bring in experts

Anyone can clean up clutter or check a smoke alarm battery. Many home modifications are best left to the experts. Check with an occupational therapist or with your local Right at Home office to ask for recommendations. And, always check references to ensure you are using a reputable contractor.

1 in 4

Americans over the age of 65 falls each year*

every 11 seconds

an older adult is treated in the emergency room for a fall*

Home modifications that can help:

major

- Roll-in shower
- Lowered kitchen cabinets
- Widened doorways
- Stair lift or elevator
- Wheelchair ramp or ramped entryway
- Nonslip, nonglare flooring

modest

- Grab bars in the bathtub or shower and next to the toilet
- Raised toilet seats
- Rocker-type light switches
- Improved lighting indoors and out
- Handrails on both sides of stairs

quick

- Rearrange furniture to remove any trip hazards
- Remove throw rugs and tack down carpets
- Clean up clutter and break the habit of placing items on stairs
- Keep extension cords out of the pathway

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For seniors with arthritis, visual impairment, the effects of a stroke, or other physical and cognitive challenges, some home tasks just aren't safe, even with home modifications. Professional in-home care can make all the difference. Trained Right at Home caregivers can help with:

fall prevention

- Removing hazards and safety supervision
- Laundry and housekeeping to prevent falling on stairs

independence

- Transportation when it's no longer safe for a client to drive
- Grocery shopping and meal preparation

healthy & happy

- Lower infection risk with home hygiene assistance
- Medication reminders to prevent overdose or forgetting a dose

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* National Council for Aging Care

For practical information and resources to help seniors and their family, **visit us at www.rightathome.net/cmsa**.

CMSA WELCOMES A NEW EXECUTIVE DIRECTOR

CMSA President Melanie A. Prince, MSN, BSN, NE-BC, CCM

CMSA has embarked upon a longevity-defining journey with Parthenon Management Group (PMG) as a premier Association Management Company (AMC) responsible for executing the strategic vision of the Board of Directors and providing the operational expertise to ensure we are successful in our mission. The PMG staff of experts is a cadre of professionals that will deliver association management in critical areas for CMSA and position us to secure state of the art technology, achieve fiscal success with precise and strategy-based financial management, build and revitalize chapters, support the national governance structure, and develop innovative strategies for membership support and content creation.

As with any team, a strong, influential and impactful leader is the driver for successful mission accomplishments. With the participation of CMSA, Parthenon Management Group hired Ms. Amy Black to serve as the Executive Director. Amy was the stand-out candidate after successfully navigating PMG's rigorous hiring process including, response to a national job announcement, scrutiny of application and career references, a matching of personal and professional attributes to CMSA's short- and long-term priorities, and thorough interviews with PMG President and a chapter/national leader panel representing a cross-section of the CMSA membership. Amy sailed through the process and CMSA is excited to welcome her as Executive Director.

CMSA Executive Director Amy Black

Amy hails from Chicago, Illinois but will relocate to Nashville, Tennessee, headquarters of PMG. She brings a wealth of experience to association management and has first-hand experience working in all levels of an AMC company with successful and regular advancements to the position of Executive Director. Amy has demonstrated outstanding achievements in Strategy Operations Oversight, Execution Budget Development and Member Relations and Retention. Amy is a forward-thinking visionary and will set CMSA on a path that will not only sustain us as the premier case management member association, but will also establish new value propositions for members, corporate partners and professional alliances. Most of all, she is experienced, prepared and ready to do this!

"I am deeply honored to have been chosen as the next Executive Director of CMSA and am delighted to have the opportunity to lead such a great organization" said Black. "CMSA plays a vital role in the success of the case/care management profession and I'm excited to collaborate with the board, staff, members, and partners to forge new paths, drive innovation, and increase value. With a strong commitment to ensuring quality professional development, I look forward to building upon the great foundation that has already been established while bringing the work of this essential organization to even more members of our community. CMSA will continue to evolve to elevate the case management profession and be the support and resource you will need to tackle the challenges ahead." ■

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URAC

CERTIFICATION IN CASE MANAGEMENT

BY JOAN SEVY MAJERS, DNP, RN, FACHE, CENP, CCM

There has never been a greater need for skilled, knowledgeable healthcare providers. At the time of this article, globally, there are over one million confirmed cases of COVID-19 (cdc.gov). Case managers have significant leadership roles in facilitating the transition of patients in an overburdened healthcare system to the most appropriate levels of care, in coordinating the resources needed for those now home-bound with chronic diseases and at great risk and for families whose social and healthcare needs will exceed their available resources in this difficult time.

Despite the resources that may be brought from local, state or federal governments, patients and clients may lack the knowledge or ability to access them. Many may not have had the need for such services for themselves or their families in the past and will need skilled case managers to guide them through the processes. Community-based case managers must be there for this critical need. Patients requiring acute care will require careful assessment and planning. Appropriate transitioning to facilitate expeditious system throughput and referral will be vital in the case management process at this time.

In the previous role and function study completed by the Commission for Case Manager Certification (CCMC®), the results indicated that "despite the increase in demand for case managers who are prepared at the bachelor's degree or higher, training of those who assume the role remains a challenge" (Tahan, Watson & Sminkey, 2016, p.19). Further, 89% of the respondents to the survey at the time indicated that on-the-job training was the means for their training to the practice. At the time, only 117 of the 7,668 participants indicated use of an academic program as preparation for their case management practice, leading to an observation that "despite the recent increase in popularity and acceptance of the value of case management by employers, academicians have yet to fully realize the value of offering formal academic programs in case management" (Tahan et al, 2016, p. 19). The study at the time indicated that this presented an opportunity for the practice of case management.

With that information, an approach to a certificate program in case management has been developed at a midwestern university college of nursing. Four graduate-level courses have been developed, with syllabi, and approved by the college of nursing curriculum committee, university graduate school, and placed into the electronic curriculum. Individuals with a baccalaureate degree from a health-related field from a regionally accredited institution field have been eligible for the certificate program. If licensed or certified in their profession, then a current, active unrestricted license or certification in the individual's profession has been required. One or more years' experience within the last 5 years has also been required in the individual's profession. All courses have been structured online, without a preceptorship, into 7-week schedules and allowing for two courses per semester. Only one course has been required prior to any of the other courses. The courses have been based on the CCMC 2015 role and function study and the CMSA *Standards of Practice*:

- Introduction to Case Management
- The Healthcare System and Case Management Services

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- Reimbursement and Regulatory Issues in Case Management
- Case Management Principles of Quality and Standards of Practice

Discussion has ensued with surrounding employers regarding interest in the program. Potential options suggested included, as the market suggested, since there are selected certificate programs already included in some employer programs eligible for tuition reimbursement, that this program might be placed into consideration with the new budget year. Candidates for positions might be hired and required to take the program and complete it within a designated period of time. Outcomes would be agreed upon regarding return on investment.

Although the most recent role and function study has been repeated by the Commission, and full results have not yet been published, results indicate that case managers continue to practice in diverse fields and indicate the most important aspects of their jobs remain:

- Ensuring appropriate care
- Educating and empowering clients
- Coordinating care
- Helping clients identify issues and set goals
- Helping clients move from one care setting to the next

The Commission remains committed to workforce development and indicates also an interest in "seeking Partners in Excellence to drive and encourage certification as a career pathway" (CCMC.org). 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" (CMSA.org). In this time, case managers will build upon their knowledge and experience gained and provide the highest level of care and service to the populations they serve. Looking to the future, let us explore collaboratively effective means of preparing gifted professionals for the practice, who subsequently seek certification as case managers. ■

Joan Sevy Majers, DNP, RN, FACHE, CENP, CCM, *recently recertified as a CCM and is also certified in executive nursing practice. She is a fellow in the American College of Healthcare Executives. Joan has served as director of case management and chief nursing officer in a variety of settings. She earned her diploma from Bellevue School of Nursing; BSN from Hunter College; MSN from THE Ohio State University and DNP from Wright State University. She is currently assistant professor at the University of Cincinnati College of Nursing, teaching leadership and management at the graduate level and preparing a case management certificate program.*

"Despite the resources that may be brought from local, state or federal governments, patients and clients may lack the knowledge or ability to access them. Many may not have had the need for such services for themselves or their families in the past and will need skilled case managers to guide them through the processes. Community-based case managers must be there for this critical need."

PAIN IS IN THE BRAIN

BY MARK PEW


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For the approximately 20% of American adults who have chronic pain[1] – pain you wake up with, go to sleep with, and that won't go away until you die – appropriate treatment is of paramount interest. The easiest way to confirm that is by fast-forwarding through commercials on television. But finding treatment whose benefits exceed the risks while enabling a quality of life for an individual in pain can prove challenging because the U.S. healthcare model has often ignored the most important tool for managing chronic pain – the brain.

A Bio-Psycho-Social treatment approach, similar to what Harvard MedTech uses in conjunction with virtual reality to deliver relief to people with either acute or chronic pain, leverages the full humanness of the patient. While there are three components in this approach – bio, psych, social – the brain plays a central role in each. As the article title suggests, pain is in the brain. Not that it's made up by the patient – although pain is highly subjective and therefore can vary dramatically between patients – but the patient's brain has an inordinate amount of influence on the response to pain and therefore the outcomes. Addressing psychosocial issues is a major key to positive clinical outcomes.

Three areas of the brain are of utmost importance in determining how pain is perceived:

- The thalamus is responsible for directing nerve messages to the appropriate part of the brain for processing while also being responsible for pain perception
- The ventromedial prefrontal cortex processes risk and fear, emotional responses, decision-making and self-control
- The cerebral cortex is where all inputs go to be converted into perceptions (thoughts) but, more importantly, into responding actions

A growing understanding of the brain explains how it is key to managing pain. In fact, pain is not pain until it reaches the brain. The mere presence of noxious stimuli does not define pain – the brain does.

For physical pain, the "bio" (biological) model can be incredibly important for recovery ("to bring back to normal position or condition"[2]). If the noxious stimuli represent something that cannot heal on its own – for example, a compound fracture – a biological intervention like surgery is required. Other actual or potential damage can be healed by the body with some help from the patient; for example, a sprained ankle that requires RICE (rest, ice, compression, elevation). If the pain involves a disease, like Parkinson's, then medications are usually a necessary component of the treatment. In the case of fibromyalgia, a condition that leads to widespread pain but often without a specific source, there are likely many interventional procedures used for both treatment and ongoing diagnosis.

In many cases, a Bio-Medical model[3] can properly resolve the pain and help the patient return to normalcy of life. But in other cases – often frustrating to both the clinician and the patient – that primary focus on the body is insufficient.

For example, an over-reliance on prescription painkiller pills (especially opioids) in the U.S. has led to disastrous results, not just in tolerance, addiction and overdose death but in fostering a passive approach to one's own well-being. Relinquishing locus of control by assuming somebody or something else is going to take care of the problem is one of the most dangerous side effects from a Bio-Medical model. This passivity can enable poor behavior, like solely relying on prescription medications to treat diabetes without losing weight and adopting a more nutritious diet.

In 1977, George Engel proposed a Bio-Psycho-Social treatment approach that takes into account the whole person. "Engel's model prescribes a fundamentally different path from the still-guiding biomedical model: To be scientific, a model for medicine must include the psychosocial dimensions (personal, emotional, family, community) in addition to the biological aspects (diseases) of all patients."[4] This became "patient-centered" medicine that "puts the patient's needs foremost (e.g., interests, concerns, questions, ideas, requests) but continues to include disease issues." This major paradigm shift needed some time to gain a foothold in healthcare, but now most enlightened providers, patients and payers fully understand the value of this approach to pain management and can cite anecdote, statistics and science to confirm its efficacy.

Part of the confirmatory science of a Bio-Psycho-Social model is the natural biological occurrence of neuroplasticity, first mentioned in 1948 by Jerzy Konorski but more widely acknowledged in the 1960s. Simply, neuroplasticity is the constant changing of an individual's brain to adapt to interactions, stimuli and experiences by creating new neural pathways. Six practices offer the "potential to rewire and retrain your brain to react differently to pain:

1. Regular exercise;
2. Healthy eating;
3. Quitting smoking;
4. Keeping your mind active, engaged and challenged;
5. Relaxation techniques to keep stress at bay;
6. Mindfulness meditation (Irving, 2016)."[5]

The new neural pathways created constantly by neuroplasticity can either be a positive or negative addition to how someone thinks about – perceives – their pain. If it is negative, then a Bio-Psycho-Social model is the only treatment approach that will help the patient.

These two profound advancements – Bio-Psycho-Social and neuroplasticity – are relatively recent in the history of mankind. But better understanding of how the brain works and how inputs change how the brain works has created a massive evolution in the treatment of pain. This new knowledge opens up acceptance for treatment options beyond pills and procedures to address co-morbidities that increase the intensity and duration of pain.

Every patient brings unique experiences to their pain. These include physical healthiness, adverse childhood experiences, genetic makeup, past and current socioeconomic circumstances, family history of physical and mental health, personal and family history of substance abuse, social determinants of health and many other internal / external influences that make each individual an individual. Every human being encounters trauma at some point, but not everyone is equipped, because of their background, to overcome it. All of this "baggage" can have an indirect impact on the pain based on their level of resilience. The American Psychological Association offers some excellent advice on four core components for establishing resilience – connection, wellness, healthy thinking and meaning – because "as much as resilience involves 'bouncing back' from these difficult experiences, it can also involve profound personal growth."[6]

Stress, anxiety and depression can often be a by-product of lingering chronic pain and in some cases can actually accentuate the pain. Stress is a natural hyperarousal survival mechanism – in other words, it's a good thing for an immediate threat – but when it is extended for hours, days, months or years it becomes destructive as it impairs cognition, sleep and social skills. Anxiety can be a companion to stress and creates both physical and psychological symptoms when it becomes unmanaged or long-term and merges into a "self-sustaining feedforward loop."[7] A never-ending cycle of not feeling well can devolve into episodic or clinical depression. But since both pain and depression are influenced by the neurotransmitters serotonin and norepinephrine, a physical injury can actually cause depression based on chemicals and not just emotions. All three of these are emotions ("psych") that can negatively affect the ability to cope with pain that will possibly never go away and probably get progressively worse. Unfortunately, they all can lead to "social" isolation, which makes matters worse.

When all of these psychosocial considerations are taken into account, it is obvious that actively training (or re-training) the brain toward self-efficacy ("confidence in the ability to exert control over one's own motivation, behavior, and social environment"[8]) must be the goal for the effective management of pain. Waiting for somebody or something else to fix it will only exacerbate the psychosocial co-morbidities, leading to a downward spiral in capability and motivation.

Clinicians wanting to go beyond the superficial to address these psychosocial issues in order to achieve optimal clinical outcomes must change how they interact with the patient. Some methods to consider are:

- Focus on active listening in a non-judgmental manner.
- Respect the patient's expertise in their pain experience.
- Build value and worth by identifying and clearly articulating the patient's strengths.
- Empower the patient to (re)discover their locus of control.
- Rewrite the dominant narrative by changing negative thought patterns ("I deserve this") to positive thought patterns ("I am an overcomer").
- Honestly prepare them for the path ahead so they are not surprised by the inevitable setbacks.
- Utilize tools like Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, Motivational Interviewing, pain coaching, support groups and virtual reality to help rewire their brain and reframe their pain.
- Encourage mindfulness and deep diaphragmatic breathing for self-control.
- Incorporate outcome measures like PROMIS, PHQ and PCS at baseline and over time to not only measure improvements but provide positive affirmation that what's being done is working (and to make adjustments if it's not).
- Engage a multidisciplinary approach for complex circumstances – the best programs include a physician, behavioral psychologist and physical therapist but can also include an occupational therapist, nutritionist, yoga instructor, massage therapist, acupuncturist, vocational rehabilitation counselor and other clinical perspectives to help address every aspect of that individual as they build appropriate coping mechanisms.

For many clinicians, a Bio-Psycho-Social approach – such as the one provided by Harvard MedTech's Vx® Pain Relief Program – requires a much deeper relationship with the patient than their current practice. That might also mean the payer needs to reimburse for a higher level of care. But when provided the opportunity to help someone live a meaningful life in spite of their pain, then the extra effort is worth every penny of that investment. That investment looks even better when compared to the exorbitant costs of treating a patient for opioid addiction or, worse yet, overdose.

In order to fully treat pain, there must be a partnership between the clinician and patient to create a customized management plan. The only way that happens is by having access to every potential evidence-based tool available and then deploy/evolve whatever tactics work for this individual in an empathetic, whole-person (Bio-Psycho-Social) method. But it all starts with understanding and leveraging the most magnificent pain management tool of all – the brain. ■

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Mark Pew, *advisory board member, Harvard MedTech, is a passionate educating and agitating thought leader in workers' compensation and award-winning speaker, blogger, author and jurisdictional advisor. Known as The RxProfessor, he has been focused on the intersection of chronic pain and appropriate treatment since 2003 as it relates to the clinical and financial implications of prescription painkillers, non-pharma treatment modalities and the evolution of medical marijuana. Mark received the WorkCompCentral Magna Comp Laude award in 2016 and the IAIABC's Samuel Gompers Award in 2017. He has served on the advisory board for Harvard MedTech since October 2019.*

PAIN MANAGEMENT: SEEK OUT ALTERNATIVES

BY MICHELLE DESPRES, PT, CEAS II, CETS, AND KEVIN GLENNON, RN, BSN, CDMS, CWCP, QRP

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SITUATION

Musculoskeletal disorders – injury or pain in joints, ligaments, muscles, nerves and tendons – are the second largest contributor to disability worldwide, with lower back pain being the leading cause of disability globally. Some disorders arise suddenly and are short-lived, such as fractures, sprains and strains; however, others lead to lifelong conditions associated with chronic pain and disability.[1]

These conditions, and the chronic pain that is so often associated with them, can cause a host of problems for employers – absenteeism, lost productivity, increased healthcare and workers' compensation costs. For the individual, chronic pain can lead to poor physical function, cognitive impairment and overall reduced quality of life. The Bureau of Labor Statistics reports that musculoskeletal disorders account for an average of 11 days away from work and 31% of workers' compensation costs.[2] More specifically, back injuries are the most common type of workplace injury among employees, according to the Occupational Health and Safety Administration.[3]

To manage chronic pain, many have turned to opioids. In fact, the dramatic increase in opioid prescriptions to manage pain has contributed to a now recognized epidemic. Nearly two million Americans have developed a prescription opioid use disorder (OUD), and more than 600,000 have developed OUD from using heroin and fentanyl.[4]

Overprescribing of opioids has resulted in misuse and abuse – 128 people die every day from an opioid overdose.[5]

The burden of managing pain and the subsequent opioid crisis have come to a tipping point – there is an immediate need for more safe, long-term solutions. Underdiagnosis and undertreatment of chronic pain remain valid concerns, but greater utilization of opioids is not seen as a viable treatment option.

As case managers, it is important to educate, support, provide resources and alternatives and develop an individualized plan for patients living with chronic pain. We spoke with experts Michelle Despres and Kevin Glennon from One Call, a leader in specialty network management services for the workers' compensation industry, during this year's virtual CMSA conference. Following is a recap of their thoughts on this very complex topic.

DETERMINING AN INDIVIDUALIZED PLAN OF ACTION

The pain experience is complex and has a biopsychosocial component that requires a multifaceted approach. For starters, pain scales are subjective but can provide a reference point for a patient. We know one person's 2 out of 10 pain level might be similar to another's response of 7 out of 10 in terms of how they function. But, when a person can indicate improvement or worsening based on a number, there is value. More importantly, it provides an objective baseline that is actionable based on ability and function, and pulls the focus away from pain alone.

ALTERNATIVE: PHYSICAL THERAPY

When musculoskeletal disorders cause chronic pain and disability, it is important to uncover the root cause of pain to prevent delayed return-to-work and mounting claim costs. Physical therapy acts like a detective by working to identify the root cause. Once that happens, a treatment regimen can be established to break the pain cycle.

For example, a patient may be experiencing lower back pain resulting from tightness in the hips. The problem stems from the hips, not the back; however, the pain source, not the root cause, is often addressed. Patients are prescribed medications to help ease the pain, but there is no long-term solution. Instead, a physical therapist should provide the patient with a regimen of hip stretching to address the root cause of the back pain.

A 2016 report from The Centers for Disease Control and Prevention stated that non-pharmaceutical pain treatment, such as physical therapy, might do a better job at controlling pain conditions over other, more popular treatments options.[6] When a severe injury or pain occurs, physical therapy should be one of the first treatments of choice.

The quicker a patient connects with a physical therapist after injury, the quicker trust is established. A physical therapist can then encourage a patient to become actively engaged in their recovery versus just being a passive recipient of it.

Research findings suggest that patients achieve better outcomes and help drive lower costs when they have the skills and confidence to manage their own health.[7] Similar to engaged employees leading to increased productivity, engaged patients lead to quicker recovery timelines.

ALTERNATIVE: MEDICAL MARIJUANA

Many individuals with chronic pain have also turned to medical marijuana as an alternative form of pain management. According to the National Center for Complementary and Integrative Health, medical marijuana, also known as medical cannabis, has been used for more than 3,000 years as a medical treatment for a plethora of conditions. It is estimated that 2.1 million Americans use medical cannabis, and a recent study revealed that more than 62% of individuals who use it do so to treat chronic pain.[8]

The evidence for cannabis' treatment efficacy across different conditions fluctuates extensively. A survey conducted from 2013-2015 of 244 participants with chronic pain aimed to discover whether using medical cannabis for chronic pain would change individual patterns of opioid use. Among the participants, medical cannabis use was associated with a 64% decrease in opioid use, decreased number and side effects of medications, and 45% reported an improved quality of life.[9]

CONCLUSION

One Call's team and high-quality provider partners can set patients up for success. For example, more than 90% of our clients' injured workers who have undergone physical therapy through One Call have functional strength and minimal to no pain at time of discharge. Eighty-five percent have functional range of motion at time of discharge. We stay involved every step of the way to ensure the underlying injury and accompanying pain are treated.

For more information about pain management alternatives, contact Michelle Despres at **Michelle_Despres@onecallcm.com** or Kevin Glennon at **Kevin_Glennon@onecallcm.com**. ■

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TREATING PAIN FROM THE POLYVAGAL PERSPECTIVE

BY DAVID HANSCOM, MD

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A few years ago, I saw four surgical patients within two weeks who caused a profound change in my thinking about patients' perception of pain.

Historically, I would focus on pain patterns and correlate them with imaging studies. If the symptoms seemed to be caused by the anatomical abnormality, I would consider surgery. If there was not a match, surgery wasn't an option. I have long considered anxiety as a factor that affected the level of pain, but not as a primary complaint. I have since learned that anxiety is what signals "danger" and is the pain.

FOUR PATIENTS

The conversation with these four men was around the decision to undergo spine surgery. All were successful professionals between the ages of 45 and 65. They had leg pain originating from an identifiable problem in their spine, and it was severe enough that each wanted to have surgery. I noticed on the intake questionnaire that they were all at least an 8 out of 10 on the anxiety scale and weren't sleeping well. Their stresses included seriously ill children, loss of jobs, marital problems, other medical problems, and none of them were coping that well.

Each of them was familiar with the self-directed care program for solving chronic pain, Direct your Own Care (DOC). The principles and tools are presented on the website **www.backincontrol.com**. They were skeptical and had not engaged with the concepts at a meaningful level and were coming back for their second and third visits.

Finally, I asked each of them the same question: "What would it be like if I could surgically solve the pain in your leg, but the anxiety you are experiencing would continue to progress?" Their eyes widened with a panicked look and they replied, "That would not be OK. I couldn't live like this." Each of them also grabbed his leg and asked, "Won't getting rid of this pain alleviate my anxiety?" My answer was "no."

Anxiety is a reaction to any threat. Although surgically removing the spur and decreasing the pain would relieve some anxiety, it wouldn't come close to solving it. Your brain will land on something else to worry about. Solving anxiety is a different problem requiring a specific skill set.

THE QUEST

I told them that although I would love to get rid of their leg pain with surgery, my bigger concern was their severe anxiety and possibly chronic pain. I recalled my 15-year battle with pain and anxiety. I was on an endless quest to find the one answer that would give me relief; especially for the anxiety. I also remembered the intensity of that need. At that moment I realized that each of these patients felt that by getting rid of the pain they could lessen or solve their anxiety.

It is actually the opposite scenario. As your anxiety resolves, it is common for pain to abate. As stress chemicals decrease, nerve conduction slows and there is less pain.[1] The techniques for addressing anxiety don't include surgery. Also, after a failed surgery, another level of hope has been taken away.

CAN YOU LIVE WITH YOUR LEG PAIN?

Then I asked each of them, if I could help them resolve their anxiety but they would have to live with their leg pain, what would that be like? Although not completely happy about the scenario, they thought they could deal with it. It was more palatable than experiencing no improvement in their fear.

"NO" TO SURGERY

These patients didn't want to jump to surgery, and they wanted to give the DOC program a try. Within six to twelve weeks, as they calmed their nervous system, their pain disappeared or subsided to the level where they weren't even considering surgery. Although I know pain and anxiety are linked circuits, I had never realized that for many patients the pain relief they were asking for was really peace of mind.

Conversely, I've had many patients over the years undergo a successful surgery for a severe structural problem with no improvement or worsening of their pain. Now I understand. "Neurons that fire together wire together." Pain, anxiety and anger are tightly intertwined. As long as the anxiety/anger pathways are fired up, they will keep the pain circuits firing.

DECIDING ON SURGERY

My surgical decision-making dramatically changed over the last five years of my practice. In spite of watching so many successes of people healing from chronic pain without

surgery, I still had a surgical mindset and was always looking for a surgical lesion that I could "fix."

In the first edition of my book, *Back in Control: A Surgeon's Roadmap Out of Chronic Pain*,[2] my advice was that if you had a surgical problem, get the surgery done first and engage in the rehab process later. But I wasn't aware of the research that shows there is a 40% chance of inducing chronic pain as a complication of any surgery if you operate in the presence of untreated chronic pain in any part of the body. It can become a permanent problem 5-10% of the time.[3]

Chronic pain as a complication of surgery is not a well-known concept. If I had a neurological complication rate of 5%, I would not have remained in practice for long. This occurs even if the procedure goes well.

ANXIETY IS AN INFLAMMATORY PROCESS

The most important point of this article is to understand that anxiety is not primarily a psychological issue. It is your whole body's response to a threat. Part of this reaction is mediated through the immune system and cytokines.

Cytokines are small proteins that serve as messengers, transmitting higher-level signals and coordinating activities at the cellular level. They are central to modulating the immune system and inflammatory response. There are two kinds of cytokines: pro-inflammatory (Pro-I) and anti-inflammatory (Anti-I). While Pro-I cytokines protect us by warding off acute perils, Anti-I cytokines keep us safe by allowing us to regenerate, thrive and prepare us for battle with environmental enemies.

Both Pro-I and Anti-I cytokines are necessary for survival – one to defend against threat, the other for growth and regeneration. However, sustained elevations of Pro-I's can destroy parts of the body and give rise to chronic mental and physical disease. They are elevated in almost every chronic disease state. One paper showed that some types of depression are inflammatory responses of the central nervous system.[4]

THREAT

Any mental or physical threat, perceived or real, is going to be met with a defensive response from your body. Much of this is mediated through the vagus nerve, at the core of the autonomic nervous system. The response is the well-known flight, fight or freeze reaction.[5] We are all familiar with the physical manifestations of increased heart rate, sweating, muscle tension, elevated blood pressure, etc. But what you may not know is that the immune system also gets fired up and mobilizes many types of cells that fend off predators such as bacteria, viruses and cancer cells. The result is inflammation where the "warrior cells" exit the blood stream through widened openings in the vessels to destroy the invaders (antigens). Cytokines are small proteins that are the "switches" that activate and deactivate this response.

"The most important point of this article is to understand that anxiety is not primarily a psychological issue. It is your whole body's response to a threat. Part of this reaction is mediated through the immune system and cytokines."

Although threats come in many forms, they always activate pro-inflammatory (Pro-I) cytokines. Physical threats include allergens, parasites, bacteria, viruses, lions, tigers, bears and people we perceive as dangerous. Less obvious but even more inflammatory are mental threats, because we can't physically escape them. They create a sustained inflammatory response that forms the basis for chronic mental and physical disease. Examples of mental threats are memories, negative thoughts, suppressions, repressions, insecurities (social, financial, health, etc.), cognitive distortions and loss of life perspective and purpose.

Discovery and acknowledgement of **all our threats** – whether real, imagined, anticipated, or repressed – is the first step toward addressing them. The second is choosing an adaptive rather than a maladaptive escape to safety, whether the threat be physical or spiritual. We are better at physical escapes to safety than we are at spiritual ones.[6] If you don't feel safe and peaceful, you are carrying elevated levels of cytokines.

There are several distinct ways to reduce your inflammatory cytokines. When suffering from chronic pain, this is more challenging. The pain is a threat, which increases inflammation, which increases the speed of nerve conduction, and increases the pain.[1]

LOWERING YOUR CYTOKINES (ANXIETY AND PAIN)

Below I have outlined **some ways** to reduce your inflammatory cytokines. This is just a small sampling of possibilities.

1. **Understand and treat anxiety.** Anxiety is simply your body signaling danger. It is the sensation generated by elevations of your stress hormones, activation of the sympathetic nervous system, elevated Pro-I's and the inflammatory reaction. It is *not* a "psychological issue," although mental threats are more likely to over-stimulate the nervous system than physical ones. The unconscious survival response is much more powerful than your conscious brain, and this is not a "mental health" diagnosis. The treatment is centered around calming down the nervous system. In workers' comp situations, this translates into being as supportive as possible of the worker's plight. The overall approach is presented on the website **www.backincontrol.com**.
2. **Get adequate sleep.** At least seven hours a night of restful sleep lowers your stress response and inflammation levels. Lack of sleep actually induces chronic low back pain.[7]
3. **Employ expressive writing.** You can't control your thoughts and emotions, but writing them down and then tearing up and discarding the paper separates you from them. The practice has a remarkable impact on both mental and physical symptoms.[8]
4. **Practice forgiveness.** Anger creates a powerful neurochemical reaction with marked elevations of Pro-I's and inflammation. Interestingly, anger experienced while feeling trapped is deadly; but if

the anger results in gaining control and power, it raises Anti-I's – the safe cytokines.[9,10] There is no shortcut to overcoming anger, but it needs to be dealt with quickly. You also must address your deepest wounds. Do you want the person or situation you hate to be what ultimately kills you? Who would win? It has also been shown that most people in chronic pain remain angry at the person or employer who caused the injury.[11]

5. **Follow an anti-inflammatory diet.** This can make a big difference in lowering Pro-I cytokines.
6. **Decrease stimulation of your nervous system.**
   a. Limit watching the news.
   b. Avoid watching violent and overstimulating shows, especially at night. Just witnessing violence will increase Pro-I's.[12]
   c. Stop negative talk, such as complaining, gossiping, discussing your medical problems or care, giving unasked-for advice and criticism.
7. **Maintain an exercise regimen.**
   d. At least 30 minutes a day
   e. Moderate and enjoyable
8. **Directly address family issues.** All families trigger each other, but there are many effective ways to create a structure that will minimize conflict.
   f. Living in chaos is not only unpleasant; it also has a negative impact on your health.
   g. Your family is usually the source of your biggest triggers.
   h. Be nice! Any member of your family who feels trapped is at higher risk for an illness or chronic disease.
9. **Play.** Having fun is one of the most powerful ways to stimulate the production of Anti-I's and relaxation hormones.

From the claim's position, I would summarize the approach as "being nice" regardless of how difficult the client may be. They are suffering, trapped and angry. It has been documented that the impact of chronic pain on a person's life is similar to that of having terminal cancer.[13] Anger is not that rational. It is remarkable how quickly this change in perspective can create a shift in the whole situation for both the examiner and client. Remember the whole comp system was set up to help, not harass an injured worker. Firing up the nervous system is not helpful.

> "Discovery and acknowledgement of all our threats – whether real, imagined, anticipated, or repressed – is the first step towards addressing them. The second is choosing an adaptive rather than a maladaptive escape to safety, whether the threat be physical or spiritual. "

I can't put into words the depth of the paradigm shift that occurred with these four patients. As much as I knew about anxiety, I did not remotely place pain complaints and anxiety in the same bucket. My surgical decision-making changed dramatically and we instituted a program of rehab before elective surgery in every patient for at least 8-12 weeks.

Many patients with surgical problems canceled surgery because the pain (anxiety) resolved, including these four men. Surgery may or may not help your arm or leg pain. It rarely solves neck or back pain. It really doesn't work for anxiety. What relief are your clients asking for? ■

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UTILIZATION OF ACUPUNCTURE AS A SOLUTION FOR PAIN MANAGEMENT

BY SANDRA KAHN, MSOM, BSN, RN, AP, Dipl. AP

The proven, time-tested benefits of acupuncture are why it has grown exponentially in its use throughout the medical spectrum. The practice of acupuncture is fairly new in the U.S., dating back only to the 1970s. Since then it has made significant strides from being known only as a form of alternative care unrecognized and discounted as real medicine by the medical community to currently being allocated as part of the medical research consortium, credentialed in state licensure and national certification, inclusion in private and workers' compensation (WC) insurance coverages, and as a respectable part of the integrative medical team in hospitals and universities around the country.

In 1996, the FDA declared the acupuncture needle to be a medical device, therefore crediting the acupuncture needle as an "accepted medical instrument," indicating that acupuncture is a safe and effective medical treatment. Acupuncture is the insertion of micro-fine, single-use, sterile needles into points along pathways on the surface of the body called meridians. The meridians are pathways in which blood, oxygen and nutrients of the human body are circulated. Acupuncture points have a higher electrical conductance and a larger concentration of neural and fine vascular components, along with a greater distribution of mast cells. These mast cells, when punctured by an acupuncture needle, release leukotrienes and prostaglandin to promote vasodilation and an anti-inflammatory process, as well as triggering the local proprioceptive nerves and sensory pain nerves to fire.

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Nociceptors are the nerves which sense and respond to parts of the body which suffer from damage. The pain is typically well localized, constant and often with an aching or throbbing quality. When activated, they transmit pain signals (via the peripheral nerves as well as the spinal cord) to the brain. Proprioceptive neurons are known to modulate pain, especially that of deep muscle tissue and from visceral sources. They tell the brain the location of the pain. Patients with chronic pain have a proprioceptive neural threshold too low, not allowing a patient to pinpoint the exact location of pain; therefore, the midbrain release of endorphins is not promoted.

Acupuncture creates a strong stimulation which jumps the neural signal threshold to activate the brain to release endorphins. This needs to be done often since the signal gets weak again and until the body remembers and re-establishes the normal threshold to signal the brain. This reduces myofascial pain and trigger point activity and provides the patient with improved range of motion and increased flexibility while maximizing the strength and mobilization.

The major benefit of acupuncture is that it is an effective, safe and cost-effective treatment for numerous types of acute and chronic pain. Although pain is the most common reason for acupuncture, other benefits include the strengthening of the immune system, blocking pain impulses by closing certain nerve gates from the site of pain to the brain, enhancing overall blood and oxygen flow throughout the body and improving mood and releasing stress.

Some of the most common issues seen among patients, both private and WC, treated by acupuncture are low back pain, neck pain, headaches, joint pain, muscle

pain, nerve pain, sciatica, opioid dependency, anxiety, depression and emotional distress. Chronically painful conditions of the musculoskeletal system accompanied by restricted movements of the joints are often treated with acupuncture if surgical intervention is not necessary. For traumas, acupuncture is not only useful for relieving pain without the risk of drug dependence, but may also expedite recovery by improving local circulation.

For instance, in WC, chronic pain cases result in a significant utilization of resources. It is important for claims and nurse case managers to identify these cases early to ensure that proper, safe and effective care is provided. Evidence-based integrative medicine and acupuncture are receiving increasing attention as potentially safer, cost-effective treatment options. Early access to physical medicine interventions, such as acupuncture, is associated with improved patient outcomes at lower cost to the employer. Musculoskeletal complaints are among the most common reasons for WC medical visits. Offering acupuncture can improve clinical outcomes, such as improvements in physical functioning and fear of pain and reduction of opioid prescriptions, usage and dependency, while lowering the costs of care for patients with common musculoskeletal conditions.

Because of the side effects of long-term drug therapy for pain and the risks of dependence, acupuncture analgesia can be regarded as the method of choice for treating many chronically painful conditions. Acupuncture's analgesic effective rate in the treatment of chronic pain is comparable with that of morphine.

Review of clinical trial reports as documented by the NIH and WHO have shown that chronically painful conditions of the musculoskeletal system accompanied by restricted movements of the joints are often treated with acupuncture if surgical intervention is not necessary. Acupuncture not only alleviates pain, it also reduces muscle spasm, thereby increasing mobility with changes demonstrable by X-ray. Acupuncture analgesia has been well recognized and has been confirmed in controlled studies to relieve postoperative pain.

I would like to share 3 WC patient cases who benefitted from acupuncture in addition to manual therapies (including cupping), heat therapy and electrostimulation/electroacupuncture:

Case #1: 56-year-old female presented with history of numbness and pain to bilateral wrists and hands for 8 years. Patient diagnosed with bilateral carpal tunnel syndrome as per orthopaedic surgeon. After completing eight acupuncture treatments, patient reported significant pain relief, increased strength and improved function.

Case #2: 50-year-old female presented with history of right shoulder and thumb pain for 3 years.

Patient diagnosed with strain of right shoulder as per neurologist. After completing seven acupuncture treatments, patient reported no pain with full range of motion of right shoulder. Patient released to full-time work status.

Case #3: 53-year-old male presented with history of neck pain for 3 years. Patient diagnosed with cervical spine herniated disc as per neurosurgeon. Patient referred for smoking cessation in preparation for surgery. After 11 acupuncture treatments, patient completed protocol releasing tobacco dependence. Patient released to full-time work status and no longer required surgery due to overall healing process.

The outcome measures which supported continued treatment included reduction in pain score, objective improvement of functionality and reduction in analgesics and pain medication usage.

In response to the opioid epidemic, acupuncture was recommended to be used as a first-line non-pharmacologic therapy by the FDA and the National Academies of Sciences, Engineering, and Medicine in coping with the opioid crisis. The Joint Commission has also mandated that hospitals provide non-pharmacologic pain treatment modalities. When searching for a licensed acupuncturist, assure they have completed an accredited master's-level graduate program and are licensed through their state board of acupuncture. In addition, a diplomate status is achieved by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) – the ONLY national organization that validates entry-level competency in the practice of acupuncture and oriental medicine through professional certification. All licensed acupuncturists are required to carry professional liability insurance.

In conclusion, acupuncture is a safe, cost-effective, medication-free modality as a front-line approach to achieve improved outcomes and reduced costs. It is a form of integrative medicine which is a quality-driven, patient-centered, relationship-oriented practice offering significant potential for patients, payers and employers. ■

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"REVIEW OF CLINICAL TRIAL REPORTS AS DOCUMENTED BY THE NIH AND WHO HAVE SHOWN THAT CHRONICALLY PAINFUL CONDITIONS OF THE MUSCULOSKELETAL SYSTEM ACCOMPANIED BY RESTRICTED MOVEMENTS OF THE JOINTS ARE OFTEN TREATED WITH ACUPUNCTURE IF SURGICAL INTERVENTION IS NOT NECESSARY. ACUPUNCTURE NOT ONLY ALLEVIATES PAIN, IT ALSO REDUCES MUSCLE SPASM, THEREBY INCREASING MOBILITY WITH CHANGES DEMONSTRABLE BY X-RAY."

EVIDENCE-BASED CASE MANAGEMENT PRACTICE = IMPROVED OUTCOMES

THE CMSA FOUNDATION

Poster Presented at the 2020 National CMSA Virtual Conference

BY SUSIE RATTERREE, BSN, RN, CCM, AND SHEILAH McGLONE, RN, CCM

Case management practice is not a new concept and has been around in some form since the early 1900s. It has changed dramatically over the years without much research to prove the value and return on investment. The Case Management Society of America (CMSA) has developed a comprehensive definition of case management and *Standards of Practice*, (SoP16); however, these guidelines have not been globally adopted by the healthcare industry. There are many models of case management practice, but unfortunately there is no theoretical framework to demonstrate the effectiveness of the models or their interventions. Developing evidence-based practice (EVBP) interventions within models of care management is essential to improved quality of care and patient outcomes by decreasing fragmented care, implementing successful transition of care and focusing on patient values and preferences.

Healthcare reimbursement is ever-changing, and the system continues to demand quality care, cost containment and positive outcomes. These objectives often fall under the responsibility of the case manager who "assesses, plans, facilitates, coordinates care transition and patient advocacy" in a collaborative effort with the patient, their support systems, and the healthcare team (SoP, 2016).

More research is needed that demonstrates the value and effectiveness of case management. For this reason, it is important for case managers to gain knowledge of how using EVBP empowers them to use effective tools and interventions to validate return on investment. Case managers need to understand how to access resources to develop process improvement and research programs. Process improvement projects and research promote improved quality of care within our own practice and the healthcare system.

We all know of Florence Nightingale, but did you know that she was an English social reformer and statistician? She revolutionized nursing through her evidence-based research. The title of her landmark observational study is "Notes on Matters Affecting the Health, Efficiency and Hospital Administration of the British Army" during the Crimean War. She documented the importance of sanitary living conditions and improved hygiene for the English soldiers during the war (1850s), resulting in a significant decrease in mortality for the soldiers in a short period of time. She made rounds every night to offer comfort and peace to her soldiers. Her fundamental nursing theory of person, environment and health are still relevant today throughout nursing education.

How do you define EVBP? Evidence-based practice is composed of information from several different sources. It may start with the case manager's cumulative experience and education since case managers have excellent skill sets. Clinically relevant research is accessed that was conducted with sound methodology. The information should be derived from a well-done systematic review taken from multiple studies identified through a literature search. It is also important to include the patient's values, preferences, and unique concerns. Treatment expectations and goals should always be discussed with the patient.

As case managers, we are always exploring and analyzing areas where there may be process improvement opportunities. A process improvement plan formally documents a strategy for improving or making things better. To create a basic process improvement plan, identify an area that can benefit from a change in strategy or process. The purpose of the study should be clearly defined. The plan should be presented to the leadership team and institutional rules, including the roles of participating staff, must be agreed upon and adhered to. An action plan is developed and implemented. The outcome of the review will then be measured and evaluated and re-evaluated, leading to a new and improved process.

There are many areas of health that have shown improved patient outcomes through process improvement studies. Some examples include transition of care planning, prevention of overutilization of resources, case management productivity and compliance with state and federal quality measures. The CMSA Integrated Case Management Model (CMSA ICM) uses a numeric scoring methodology to stratify patients according to complexity across all domains of health. This model simplified the ability to create an award-winning research project

continued on page 30

Evidence-Based Case Management Practice = Improved Outcomes

Presented by: *Susie Ratterree, BSN, RN, CCM, Foundation Secretary*
Sheilah McGlone, RN, CCM, Foundation Director

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OBJECTIVES

Recognize	Demonstrate	Understand
Recognize the importance of developing case management improvement processes to decrease fragmented care, ensure successful transition of care and improve outcomes.	Demonstrate increased knowledge of how using evidence-based research empowers the case manager to utilize effective tools and interventions to validate return on investment.	Understand how to access resources to develop process improvement and research programs.

PURPOSE

- There are many models of case management practice, but no theoretical framework to demonstrate effectiveness of the models or interventions. Developing evidence- based practice interventions or models of care management are essential to decreasing fragmented care, successful transition of care and improved outcomes.
- Healthcare reimbursement is ever changing and continues to demand quality care, cost containment and positive outcomes. These objectives often fail to the case manager who "assesses, plans, facilitates, coordinates care transition and client advocacy" in a collaborative effort with the patient, their support system and healthcare team. (Jun, 2016)
- More research is needed that demonstrates the value and effectiveness of case management.

2019-2020 CMSA Foundation Board

The CMSA Foundation is a charitable, not for profit organization created to support education, research, and professional development for case management professionals.

OUR VISION

The Case Management Society of America Foundation (CMSA Foundation) envisions a better future for the case management industry through a collaborative, inclusive community of healthcare professionals working together to build industry-wide solutions to case management issues.

OUR MISSION

Our mission is to become the leading philanthropic organization for case managers, supporting education, research and professional development.

Florence Nightingale

Revolutionizing Nursing through Evidence-Based Research

English social reformer and statistician.

Landmark observational study "Notes on Matters Affecting the Health, Efficiency and Hospital Administration of the British Army" during the Crimean War (1860s).

Evidence-based research and documented observation on the importance of sanitary living conditions and improved personal hygiene for English soldiers.

Outcomes demonstrated a significant decrease in mortality for English soldiers in a short period of time.

Evidence-Based Case Management Practice

Integrating the case managers clinical expertise with the best available external clinical evidence from systemic research.

Information should be obtained from the following resources:

1. Expert opinions
2. Practice analyses
3. Roles and functions research
4. Patient's values and preferences

What is Evidence-Based Practice?

Clinical Expertise	Best Research Evidence	Patient Values and Preferences
Clinician's Cumulated: • Experience • Education • Clinical Skills	• Clinically relevant research • Conducted using sound methodology	• Personal • Preferences • Unique Concerns • Expectations • Values

Steps for Case Management Process Improvement

- Purpose
- Methods
- Results
- Conclusions
- Action
- Re-evaluate

Common Areas of Health demonstrating Improved Patient Outcomes through Process Improvement Studies

- Transition of Care Planning
- Integrated Case Management Models
- Quality Care
- Quality of Life
- Patient Satisfaction
- Prevention of Over Utilization of Resources
- Case Management Productivity
- Compliance with State and Federal Quality Measures

Case Management Foundation Awards

CMSA Foundation's **Case Management Practice Improvement Award** and **Case Management Research Award** recognize individuals, groups, or organizations that uses finding from a research or quality/ performance improvement (QI/PI) initiative for innovation in the advancement of case management practice and/or improved client outcomes.

Case Management Practice Improvement 2019 Award Recipient

Pathway Home™
Coordinated Behavioral Care, Inc

Purpose

Improve process of transitioning clients from an extended hospital stay through community integration in adults with serious mental health.

Results

- Improved readmission rates (10.8% to 1.7%)
- Improved client behavioral change in attending medical appointments and improved medication adherence
- Improved quality of services, client quality of life and well being of client
- Improved efficiency

Award received by:
Mary Granek, LSWC
Program Director, CBC Pathway Home

Case Management Research 2019 Award Recipient

Case Study: Triad Case Management Model Applying Human Performance Technology

By Kelson Zehr

Purpose

Investigate performance across units in one hospital in the southeastern United States that implemented a new model of case management.

Results

- Involve case managers in change of processes
- Cost Reduction of Care
- Improved Quality of Care
- Improved Patient Satisfaction

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PROFESSIONAL DIVERSITY IN CASE MANAGEMENT IS MORE IMPORTANT THAN EVER

BY MARYBETH KURLAND, CAE, HUSSEIN M. TAHAN, PhD, RN, FAAN, AND VIVIAN CAMPAGNA, MSN, RN-BC, CCM

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The demands placed on healthcare professionals, providers and payers have been well-documented, with the continued rise of value-based care and accountable care models that emphasize cost-efficiency and outcomes (Tahan, Kurland, and Baker, 2020a). Within this dynamic, the role of the professional case manager is crucial, particularly in care coordination, transitions of care and management of care delivery and resources for clients and their support systems across the continuum of health and human services.

Professional case management is vital, especially for clients with complex conditions, such as those involving multiple co-morbidities and/or requiring care transitions intra-facility (e.g., to and from intensive care), inter-facility (e.g., from acute care to sub-acute or home), or inter-provider (e.g., from a general medical provider to specialty care practitioner). As advocates for patients (or "clients"), professional case managers support the achievement of the individual's health and care goals while also helping to reduce financial risk in the provision of care. In other words, case management has been well recognized as integral to the pursuit of the triple aim to reduce the cost of care delivery and to improve both patient outcomes and population health.

Most recently and on a global level, healthcare systems have been in the eye of an unprecedent storm: the coronavirus disease 2019 (COVID-19) pandemic. Hospitals and healthcare systems across the continuum have become overwhelmed with a sudden influx of patients that could exceed their capacity for months (*The Lancet*, 2020). To respond to such pressures and the need to serve patients in a variety of settings, healthcare systems have rapidly expanded their modes of care delivery, including digital health, telehealth, virtual care and remote work contexts. The result is an accelerated "disruption in how healthcare is delivered, paid for and perceived," stated Dr. Stephen Klasko, president and CEO of Jefferson Health, as quoted in *Becker's Hospital Review* (Dyrda, 2020). If such changes (or even if only

some) in healthcare become permanent, the impact will no doubt also affect professional case managers across a variety of care settings and professional disciplines.

As this article will discuss, expanding the diversity of professional backgrounds (e.g., health disciplines) among case managers continues to be necessary, not only to meet the rising demand for these professionals, but also to adapt to emerging trends in healthcare across the continuum. It is also evident that the essential expansion includes acute and subacute care, home health, telephonic case management, community-based, mental health counseling, accountable care organizations, virtual and retail-based care sites and other care settings. Without question, these diverse and expanding care sites demand a diverse case management workforce.

PROFESSIONAL DIVERSITY TO MEET THE CASE MANAGEMENT CHALLENGE

Well before the global pandemic, the evolving role of professional case managers was already documented. Now, innovative approaches to case management and care delivery to meet the demands imposed by the COVID-19 crisis will no doubt be forthcoming (WHO, 2020). As one of the authors of this article wrote previously, "The context of the case management practice has been shifting from a single care setting or an episode of care to one that does not recognize boundaries" (Tahan, 2019, p. 15). Tahan also identified three key shifts that define the transformation of the professional case management role. First and most important is the provision of person-centered care interventions and services. The second is the focus on multiple care settings (traditional and non-traditional) to facilitate the provision of both health and human services; and the third is the recognition of health promotion, wellness and prevention, instead of the more traditional "reactive approach" of diagnosis and treatment (Tahan, 2019, p. 16).

The challenge, however, is that increased demands have been placed on the case management community for years, concurrent with a need for succession planning in the field. To illustrate, the most recent role and function study conducted in 2019 by the Commission for Case Manager Certification (CCMC) found that more than half of survey respondents (54.31%) were between 51 and 65 years of age, with the largest group within that demographic being 56 to 60 years of age (21.04%) (Tahan, Kurland, and Baker, 2020a). Given a projected nursing shortage (AACN, April 2019), it's clear that future demand for professional case managers cannot be met solely by nurse case managers, who continue to account for the largest professional discipline among Certified Case Managers® (CCMs) (Baker & Kurland, 2020).

The way forward then is with increased professional diversity among case managers in all practice settings. From the standpoints of workforce management, practice environment and employer, the case management community must engage in and support greater workforce diversity. For example, CCMC has several outreach initiatives underway, including a special focus on increasing the involvement of social workers as case managers (NASW, n.d.), in addition to encouraging more participation in professional case management by mental health counselors, pharmacists and other healthcare professionals.

As another author of this article has written, "The future of healthcare is greater collaboration. What we see in patient-centered practice, in which interdisciplinary teams can improve outcomes for patients, is also true among professional organizations. Greater collaboration among certifying bodies and professional organizations will foster mutual respect, understanding and collaboration" (Kurland, 2019, p.24). The fruits of these efforts are already evident.

CCMC has observed a steady increase in the number of non-nursing case management professionals pursuing certification, in particular social workers. That increase was reflected in the results of the 2019 role and function study, in which 11.2% of those who responded identified themselves as social workers, about double the percentage of respondents (5.8%) in the 2014 practice analysis survey (Tahan, Kurland, and Baker, 2020a). Among other 2019 role and function respondents, occupational therapists and vocational rehabilitation counselors accounted for 1.45%, and counselors and psychologists were another 1.26%. Although small, these percentages apply to a growing population of CCMs overall, numbering more than 48,000 currently in practice, an increase from 37,000 five years ago.

In addition, professional case management is practiced in a variety of healthcare settings, the most common being health plan/insurance company and hospital/acute care. Other settings include workers' compensation, independent case management, ambulatory/outpatient care/primary care/urgent care clinic, and government agency (2.67%) (Tahan, Kurland, and Baker, 2020a). The presence of professional case managers in diverse care settings is essential to meeting the demands of the healthcare industry amid ongoing changes, especially regulatory standards and reimbursement methods.

What's important to understand is that greater professional diversity, in terms of the background discipline and practice setting, is not meant to elevate or diminish any one discipline. Nursing case management, as the dominant discipline, has brought many skilled clinicians from the bedside into a specialty practice of providing care and treatment for the whole patient. However, it is important to emphasize that professional case management is, by its nature, interdisciplinary/interprofessional; it spans both health and human services, across diverse health and support service care settings. This reflects best practices in care delivery, as research demonstrates the benefits of interdisciplinary care for patients, as well as for members of the care team of interdisciplinary professionals (Lippincott, 2018). Thus, one can argue that as the case management field becomes increasingly interdisciplinary, it further enriches the profession and its advocacy for individuals and their support systems across health and human services.

Additionally, the current state of case management practice calls for continued workforce planning and management, not only to counter the effect of those exiting the workforce due to retirement, but also to increase the diversity of the workforce (by ethnicity, age group, gender, and professional discipline representation). In addition, expanding the case management population and the professional disciplines among them will support and mentor the next generation of professional case managers, as well.

CERTIFICATION AS THE COMMON GROUND

As the complex and varied dynamics of the healthcare environment continue to influence the role of the professional case manager, it is vitally important to engage

in regular field surveys (known as practice analyses). To that end, CCMC conducts its role and function studies every five years, the most recent being in 2019 with results published in 2020 (Tahan, Kurland and Baker, 2020a; 2020b). The purpose of the role and function study is usually twofold: first, to identify and confirm the essential activities (what professional case managers must do) and the knowledge domains (what professional case managers must know to effectively perform their role responsibilities); and second, to inform the relevance and currency of the CCM certification examination blueprint. Clear descriptions of the roles and functions of professional case managers are identified, along with the knowledge required for competent performance (Tahan, Kurland, and Baker, 2020b). Such clearly defined roles and functions capture the essence of professional case management and its evolution over time – regardless of the practitioner's title, practice setting, background discipline or specialization.

The rigor of this field research and its application to board-certification also establish the common ground among all professional case managers. No matter their professional background or where they practice, case managers who meet the eligibility criteria for and pass the certification examination join the growing ranks of CCMs in practice. Certification in the specialty of case management differentiates those with advanced knowledge and competence in the practice. It also differentiates them as qualified experts who can effectively mentor others, especially those new to or contemplating entry into the practice. These are invaluable considerations in workforce planning and management: how to nurture the next generation of professional case managers.

LOOKING AHEAD

Over the years, changes in professional case management practice have reflected overall trends in healthcare. To give one example, the emergence of ambulatory care has been accompanied by a rise in the number of respondents to role and function surveys who identify themselves as practicing in that care setting (Tahan, Kurland, and Baker, 2020b). Another example is the need for healthcare organizations to manage their financial reimbursement risks, such as avoiding unnecessary hospital readmissions. To that end, professional case managers can identify and measure outcomes not only from case management services, but also from the interdisciplinary care team and even across the organization.

The changing nature of healthcare – now, more than ever, during COVID-19 – puts the professional case manager in the spotlight. While the ranks of CCMs continue to grow, currently numbering over 48,000 actively in practice, more will be needed. Meeting this demand will require greater professional diversity, and for far more than sheer numbers. As professional case managers enter the field from a variety of backgrounds and disciplines, they will contribute to an approach centered on patients and their support systems/families. Certification will ensure their foundation in case management, while their own specialized knowledge and experience in health and human services will make them even more impactful. ■

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MaryBeth Kurland, CAE, *is CEO of the Commission for Case Manager Certification, the first and largest nationally accredited organization that certifies over 48,000 professional case managers and nearly 2,300 disability management specialists. The Commission is a nonprofit, volunteer organization that oversees the process of case manager certification with its CCM credential and the process of disability management specialist certification with its CDMS credential.*

Hussein M. Tahan, PhD, RN, FAAN, *is a case management consultant, expert, author and researcher. Dr. Tahan has nearly 30 years of experience in hospital management and operations and professional case management practice; is a member of the editorial advisory board of* Professional Case Management*; author of multiple textbooks, including the CMSA's* Core Curriculum for Case Management and Case Management: A Practical Guide for Education and Practice*; chief knowledge editor of the Case Management Body of Knowledge online portal sponsored by the Commission for Case Manager Certification; and the recipient of CMSA's 2016 Lifetime Achievement Award for his contributions to the field of case management.*

Vivian Campagna, MSN, RN-BC, CCM, *is the chief industry relations officer (CIRO) for CCMC. Vivian has been involved in case management for more than twenty-five years and has been a volunteer for the Commission in various capacities, including as chair, prior to joining in a staff role.*

POEM

THE CASE MANAGER

BY CAROLYN G DUNBAR, MSN, RN, CASE MANAGER

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The Job of a case manager
To others is sometimes hard to describe
Because we can take care of our Clients
With dignity, without actually standing by their side

Because in the healthcare field
If you're not specifically hands on
Others may try to judge you
Because you're not physically tired and worn

But case managers do get tired
And there's proof that it's true
Although sometimes it's very extensive
To explain what case managers do

For some think case management is the perfect job
They think we only talk to clients on the phone
They don't understand we also go through trial
and tribulations
Trying to keep our Clients healthy in their home

You see case management is not new
It's been around for over 90 years
We've been tolling and managing for our Client
Sometimes through blood, sweat and tears

Case management was started for Clients who had
chronic illnesses
Whose care was looked over in a rush
Not realizing that this Client need much more guidance
And not just a special touch

So a case manager goes the extra mile
To make sure that the supervision is there
To ensure that Clients get the best treatment they deserve
And seamless transition to excellent healthcare

Now there are many different types of case managers
But they all fill the same role
To Advocate for the Client
Because we all have the same goal

Sometimes case managers are not liked
And some think we are healthcare bullies
But we know the purpose of our jobs
And we put our heart into it fully

Case managers have a code of Ethics
And this is for a reason
Because the case manager's scope of practice
Include Autonomy, Justice, Veracity, Beneficence and
Nonmalefience

So case manager's just want you to understand
That we are the Client's voice
And they put their trust in us
To make the right choice

It's not just the Client we take care of
It's also the family that we serve
So case managers provide precise and effective communication
So the Client and family can understand the treatment that
they truly deserve

Everyone cannot be a case manager
For they do not have the assets by which case managers
are described
Motivator, Coach, Educator, Therapist,
With a huge dose of Compassion and Patience on their side

So when you come in contact with a case manager
Just know they are trying to provide the best care
To provide quality healthcare treatment for the Client
Is a responsibility we all must share ■

The Benefits of Belonging to a Professional Organization When Disaster Strikes

PRESENTED BY CMSA PAST PRESIDENT ANNE LLEWELLYN, MS, BHSA, RN - BC, CCM, CRRN, ON BEHALF OF WENDY JAFFE, RN, MSN, ACM

This article shows the value of belonging to professional organizations and the connections made through networking. The members and the past presidents of CMSA are resources you can tap into for advice, mentoring and referrals and are key people when you, a member of your family or a friend are suddenly thrust into the complex healthcare system.

IT BEGINS WITH 'THE CALL'

This is the call you dread to get in the middle of your day…a frantic, desperate call pleading for your help. My closest friend was struck by an SUV while walking her dogs in southern Florida, sustaining a massive brain bleed. We had just been on the phone planning our next hiking trip to Portugal, and now with a heavy heart I realized I would start to work on a new plan for my dear friend. As a certified case manager in Illinois, I knew she would benefit from having a case manager to help streamline communication as the team coordinated her care to ensure the best outcome. I reached out to the case management department of the community hospital where she was admitted but was dismayed and, frankly, upset at the response I got from the professionals I talked to.

I quickly realized exactly what I needed to do to get help. I put in a call to the president of my local Case Management Society of American Chapter, CMSA Chicago. Colleen Morley immediately contacted Anne Llewelyn, nurse advocate, who is a past president of CMSA and the current president of the South Florida Case Management Network, to see if she could help me. Anne responded right away, and Colleen connected us both to see what we could do to address my friend's needs.

Anne was a wealth of knowledge, experienced and informative. Together, we talked about how we would move forward to learn how my friend was doing, what the plan of care was and try to find the resources that would help the patient find the right level of care to meet her needs. Anne sent me her consent form and asked to have the patient's family review and sign the form if they wanted us to help. We actually had a call with the patient's daughter to explain what we wanted to do and how it could help her and the patient navigate the system. The daughter has her own healthcare challenges, and the stress of this ordeal was taking a toll on her condition.

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Anne helped me research facilities I had never heard of since I am a hospital-based case manager in Illinois, not familiar with Floridian facilities. Together we developed with the healthcare team at the hospital to design a discharge plan utilizing our case management skills to ensure the patient could transfer when ready and get the best care to address her traumatic brain injury. We worked hard to communicate with the hospital case manager but ran into resistance. We both could not understand why we met resistance; were we not colleagues? It was disappointing. We spoke to the various physicians and the nurses on the unit to gain information on the plan.

CHALLENGES

I had to intervene at one point, as my friend's "case manager" decided to transfer her to a lower level of care, a skilled nursing facility, based solely on her age! When I asked about the COVID situation in these facilities, she stated she had no idea and would get back to me, and I never heard back from her. Without hesitation, I asked for a multidisciplinary team meeting with medical representation to discuss the treatment plan and discharge needs. I spoke up during the meeting to advocate sending her to an LTAC as the most appropriate level of care, not a skilled nursing facility as the case manager was representing. Prior to the accident, my friend was active, alert and very independent. She needed acute rehabilitation, not a skilled care facility.

During her hospitalization, we thought we might have to transfer my friend to northern Florida; Anne put me in touch with a case manager from the area who knew the area and the resources. This person helped me identify facilities that would meet my friend's complex needs. We felt the next step should be an acute brain rehabilitation program, and again with Anne's assistance, I researched the various facilities to see if they were in the patient's insurance network. The patient was transferred from the hospital to an acute brain injury program for intense cognitive therapy.

THE OUTCOME

The facility where the patient was transferred did a good job. The case management team was excellent, and the patient is making progress. The family and I were kept up to date, and all were satisfied with the patient's progress.

We have a good plan going forward as we plan next steps to meet my friend's long-term needs. Her family is engaged and grateful for the help.

This situation made me realize the value of my professional organization, the Case Management Society of America. With one call to a colleague in my area, I was able to meet a case manager in South Florida who knew the resources and the people to connect me to who could help all involved.

I understand what was happening and feel comfortable as we navigate the complex and fragmented healthcare system in an organized and professional manner.

My next step is to write a letter to the director of case management at the hospital where my friend originally taken. I want to talk to the leadership to share my concerns and help them realized how we could have collaborated for the good of the patient when family members of complex patients are out of town. I want to use the experience as a learning experience and one that could help their team improve.

The patient is doing well, and the family is optimistic. It was a challenging case, personally and professionally, and with the collaboration of many people, we had a good outcome! ■

Wendy Jaffe, RN, MSN, ACM, *is a patient care coordinator at the University of Illinois Hospital & Health Sciences System in Chicago. She received her BSN from Lewis University and her MSN at Elmhurst University. She has worked a variety of settings and has been an active member of the Case Management Society of America Chicago chapter for 23 years. You can reach Wendy by email at WendyJ@uic.edu.*

"My closest friend was struck by an SUV while walking her dogs in southern Florida, sustaining a massive brain bleed. We had just been on the phone planning our next hiking trip to Portugal, and now with a heavy heart I realized I would start to work on a new plan for my dear friend."

demonstrating a decrease in emergency department visits and hospitalizations for a group of Medicaid recipients. Patient satisfaction and quality of care surveys are commonly used within hospitals, managed care organizations, state and federal agencies and provider practices. Improving patients' healthcare experiences helps organizations work toward Quadruple Aim goals and financial return.

The CMSA Foundation is a charitable, not for profit organization created to support education, research and professional development for case management professionals. It was founded "by case managers for case managers." The Foundation envisions a better future for the case management industry through a collaborative, inclusive community of healthcare professions working together to build industry-wide solutions to case management issues. Through our donors, we were able to offer a scholarship for the CMSA ICM training and a Margaret Leonard Public Policy Grant. The Public Policy Grant was created with the intent to raise visibility and public awareness of the professional case management practice. This year we were able to provide scholarships for conference registration that included a one-year CMSA membership due to the generosity of our donors.

The CMSA Foundation's Case Management Practice Improvement Award/ Case Management Research Award recognizes individuals, groups or organizations that use findings from a research or quality/ performance improvement (QI/PI) initiative for innovation in the advancement of case management practice and/or improved client outcomes. We encourage you to submit your application for our 2021 awards. For more information and to meet the winners of this year's awards, please review our website at **www.cmsafoundation.org** for additional information and read the articles from the 2019 award winners.

As case managers and healthcare providers, we are dedicated to helping patients from all walks of life "one person at a time." Let us not forget how the review of aggregated data is critical to move forward with process improvement and research leading to improved patient outcomes. Case managers are essential front- line workers counseling and coordinating care during these unsettling times. We are all heroes. ■

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Susie Ratterree, BSN, RN, CCM, *recently retired from Lincoln Financial Group, where she was a clinical research specialist and nurse case manager in the commercial disability arena. She has practiced in a variety of settings in her 30+ years as a nurse, with 25 of those years in case management. She is active in her local chapter, served on numerous committees at the national level and is the current secretary of the CMSA Foundation.*

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