ADVANCING INTEGRATED HEALTHCARE

Welcome NCM Core Curriculum Learners!

NURSE CARE MANAGER/COORDINATOR BEST PRACTICE SHARING MEETING

JANUARY 17, 2023

Agenda

Topics	Duration
Welcome & Review of Agenda *Susanne Campbell, CTC-RI*	10 minutes
NCM Core Curriculum Learner Presentations Ian H. Sandham Cheryl Davis Tatiana Simas Deana Davis, Sandy Irizarry & Carol O'Mara Chelsea Sylvaria & Meghan Beauregard Ann-Marie Murphy, Ozevette DeLorenzo, Joyce Masse Rosemarie Sepe	80 minutes (8 minutes each)

Thank you to the funders of the NCM Core Curriculum Program:

Ian Sandham–
Capstone Document

Faculty Introduction: Jayne Daylor
Up Next: Cheryl Davis

Faculty Introduction: Jayne Daylor
Up Next: Tatiana Simas

xG HealthCare Management Education Participant Capstone

Presented By: Cheryl Davis R.N.

1. Patient Presentation
2. Past Medical History
3. Matters for Consideration-Identified Concerns
4. Immediate Patient Plan of Care
5. Long Term Patient Plan of Care

Age: Patients age is 85.

Gender: Patients gender is female

Support System: Patients support system is primarily her husband who also has health issues

Socioeconomic status: Patient was a former smoker and rarely uses alcohol. Her mother had Alzheimers Disease and her father had pancreatic cancer. She has adult children that live out of state and one son who passed away due to cirrhosis.

Life Style:

Patient is retired and lives with her spouse in a cape style home and uses a walker or cane to ambulate. Patients husband drives her to appointments. Patient tries to stay active with daily exercise and eating healthy

Chronic Conditions: **Chronic Systolic and Diastolic Heart Failure, Coronary Artery Disease Hypertension, Atrial Fibrillation, Asthma, Anxiety and Depression . Also noted to have Chronic back pain associated with Spinal Stenosis and Osteoarthritis**

Current Medications: Atenolol 50mg in the morning and 75mg in the evening,Famotidine40mg twice a day, Furosemide 80mg twice a day, Ferrous Gluconate 324mg, Lorazepam 1 mg daily, Omeprazole 40mg a day, Rosuvastatin 5mg daily, Eliquis 5mg twice a day, Sertraline 50mg daily, Lamotrigine100mg a day, Doxazosin 1mg at night, Levothyroxine 50mcg daily, Fluticasone , Saline nasal spray, Folic Acid 1 mg and Vitamin D 2000 Units and Albuterol

Patient Understanding of Disease Process:

Patient does currently have a good understanding of her heart disease condition. The respiratory symptoms with her asthma and her anxiety level are heightened when she is having fluid overload.Patient frequently calls me when she has gained too much weight . On one encounter she was upset and crying as she told me how frustrating it is with her decrease in exertion level and being so short of breath.

Past Medical History Continued

Compliance to Treatment : Patient is compliant with her medications and faithfully weighs her self daily. Patient has had an increase in her number of hospitalizations this year particularly during cold and flu seasons. Patient has abided by her treatments and fluctuations in medications and recovered well each time.

Recent Acute Episodes: Patient was noted to be coming down with an infection in May of this year and had chest pain so she was hospitalized with Acute Respiratory Failure with Influenza A . She also had two other occasions when she was in heart failure and was hospitalized in August and again in November of this year

Have You Identified Any of The Following

Barriers to Care: Patients husbands hospitalization and rehab over the summer caused increased stress for the patient due to being without her primary support person. Patient was also hospitalized in the end with CHF and went home with acute homecare and had more assistance temporarily from a relative that came in from out of state temporarily . Patient has resisted the need for more assistance at home and continues to be as active as she can but it had been a barrier over the summer.

Gaps in Care: Rehospitalizations and changes in patients medication regimen has left patient unsure of dosing changes . Some things were not clarified during transitions of care . Patient had also missed a Cardiologist appointment due to being in the hospital .

Driver of The Case: Support and guidance in patients self care at home and redirection when changes need to be made .Continuation of management of fluid retention, assistance with anxiety control and prevention of infection or triggers cardiorespiratory exacerbations

Medical Neighborhood Needs (who would you collaborate with regarding patient care needs): Collaborations with skilled homecare or any outside assistance as needed for medication reconciliation and plan of care. MTM has been set up for ride service if patient needs it. Patient has had physical therapy and sees her cardiologist so if updates or reports are needed they are contacted as needed.

How Would You Address Concerns Identified:

I feel I will need to address the need for more assistance at home as patients chronic condition progresses. I will discuss introducing Meals on Wheels or other meal assistance programs. Patient may need to utilize the ride service available to her. Long term aide assistance may need to be addressed and I will ask the POINT , RI elderly assistance about having a social worker helping patient and her husband

Plan of Care
Patient Education

What are three signs/symptoms patient should report to PCP/CM as soon as possible:

- Weight gain of 2 lbs. or more per day or 5 lbs. in a week

- Changes in cough like dryness, hacking quality and becoming more frequent

- Shortness of breath at rest

What is your immediate plan for this patient?

My plan is to increase the frequency of outreach calls to the patient .Patient does call the office to speak to me often but I will plan to be in contact with her every 2 to 3 weeks to check in. Patient had recent abnormal labs with abnormal alkaline Phosphate levels during her last hospitalization and will be referred to a gastroenterologist to assess her liver and gall bladder status further.

Long Term Plan of Care

What is your long term plan for this patient?

Continued support and assist to manage her care .Review her medications, routine health maintenance measures and assess mobility and endurance. Long term care plan will include home health aide assistance with medication reminders, assistance with ADLs and assess safety. White cross medication could be applicable . Palliative care if chronic changes in heart failure or other conditions occur

Conclusion:

This patient has been on care management for a long period of time and has adapted to the change with a new care manger nurse . This patients history was noted to have less hospitalizations in the past few years that I researched. I feel that I have established a good connection with her as she has had and increase in her episodes of fluid retention and respiratory symptoms this year. This case has helped me realize that a lot of emotional support is involved in this position .Through all aspects of care , it makes a world of difference to go through changes in medical conditions having someone available to discuss issues with .I feel that I will be able to assist this patient with making decisions with her care choices as her conditions change or progress in the future .

xG

Tatiana Simas– Capstone Document

Faculty Introduction: Jayne Daylor
Up Next: Deana Davis, Sandy Irizarry & Carol O'Mara

Faculty Introduction: Jayne Daylor
Up Next: Meghan Beauregard & Chelsea Sylvaria

xG HealthCare Management Education Participant Capstone

Presented By: Deana Davis RN NCM
Sandra Irizarry RN NCM
Carol O'Mara RN

Capstone Case Study Presentation

1

PATIENT PRESENTATION

Patient invited to Complex Care Clinic due to increased ED utilization for pain management related to recurring kidney stones

2

PAST MEDICAL HISTORY

Hyperparathyroidism, MDD/PTSD, subclinical hypothyroidism, asthma, essential hypertension, vitamin D deficiency, obesity BMI 30, carpal tunnel syndrome on right, bursitis of elbow, kidney calculi, nephrocalcinosis, tobacco abuse, and an unstable housing situation.

3

MATTERS for CONSIDERATION-IDENTIFIED CONCERNS

Patient identified by NCM to formulate alternative plan for pain management, and to utilize multi disciplinary approach offered at these appointments. Discovering patient had not been able to obtain antihypertensive, homeless since 2020 and unemployed. History of depression and PTSD with current symptoms of tearfulness and reported flashbacks.

4

IMMEDIATE PATIENT PLAN OF CARE

Planned established for pain control was to call NCM/Clinic for same day appointment at onset of pain. (Nurse Manager initiated IM Toradol to be administered in clinic) Reestablished hypertensive agent. Social work present to arrange counseling. Psychiatry present to adjust medications. NCM to follow up weekly. Dietary restrictions reviewed.

5

LONG TERM PLAN OF CARE

Sustain established pain control plan, bilateral lithotripsy with stent placement. Patient will actively participate in plan of care and continue taking medications as prescribed. Continue to use Psychiatry and social work support as needed. Empower patient by providing a knowledge base through education of both disease process and community resources. Secured housing in a family shelter with children was established. Patient is currently looking for low-income housing. She is looking forward to returning to work after her second procedure later this month.

AGE

42 years old

GENDER

Female

SUPPORT SYSTEM

Patient, brother and mother assist in housing 2 children

SOCIOECONOMIC STATUS

Temporarily disabled related to acute and frequent kidney stones, unemployed related to this health issue, and living in her car

LIFESTYLE

Patient is homeless and living in her car. She is a single mother with 3 children. The oldest is incarcerated, her middle child is in high school and lives with mom's brother. Youngest child is 14 years old and lives with his grandmother.

Past Medical History

CHRONIC CONDITIONS

Hypertension, obesity, MDD, bilateral nephrolithiasis, PTSD, asthma, tobacco abuse, hypothyroidism, hyperparathyroidism

CURRENT MEDICATIONS

Pyridium, Ditropan, Flomax, Tylenol, Zoloft, Proventil HFA,, MiraLAX, Tramadol, Seroquel, Norvasc, Motrin, Colace, NicoDerm CQ, Nicorette.

PATIENT UNDERSTANDING OF DISEASE PROCESS

Our patient has a decent understanding of the disease process. However, her limited knowledge of resources, treatment options and her current mental health struggles were detriments to optimizing healthy outcomes.

COMPLIANCE TO TREATMENT REGIMEN

When patient presented to complex care clinic, she was noncompliant with her HBP medication. She would skip refills at times. However, once a plan was created by the team and the patient, compliance improved, and ED visits were avoided. Our patient had needed guidance and information.

RECENT ACUTE EPISODES

Patient was flagged by her PCP as a high utilizer of ED services. On average she had an ED visit at least 1-2 times a month for acute flank pain. Most recent visit was 10/12/2022. Diagnosed with bilateral kidney stones. She has an extensive history of this with lithotripsy in past. Found to be hypertensive in emergency room and pain at that time reported 10/10 with nausea. Treated with Flomax, Zofran and Toradol with good effect for these episodes. No hydronephrosis noted discharged home with follow up in clinic.

Have You Identified Any of The Following

BARRIERS TO CARE

Housing insecurity, poverty, inadequate support system, mental heath issues and knowledge deficit of resources available.

GAPS IN CARE

Missed appointments, PAP smear overdue, antihypertensive noncompliance and lack of care plan for acute episodes were identified.

DRIVER OF THE CASE

Frequent utilization of ED for Acute flank pain.

MEDICAL NEIGHOOD NEEDS

Social work partners for guidance with psychosocial insecurities, for example, counseling as needed, Unite Us for housing and food insecurities. Other specialty providers as needed –urology in conjunction with the PCP.

Plan to Address Identified Concerns:

OUR PLAN

Patient was scheduled for a complex care appointment. This is our multi disciplinary team approach which includes partners from social work, psychiatry, pharmacy, nurse care manager and primary care provider. Prior to the appointment, all participants will review the patients chart together and discuss health problems, gaps, needs, medications, and a potential treatment plan. When the patient arrives, she will meet with each team member and a plan will be formulated that reflects patient's participation in her health and welfare goals. The plan is developed with shared decision-making between patient and provider.

Social work will follow up regarding housing and food insecurity. Nurse care manager will follow up with medication accessibility and compliance. Follow up with urologist was arranged and procedure scheduled. Pain management plan: comprised of patient calling clinic/ NCM on direct line for same day appointment. Toradol to be administered IM in clinic (recently made available by Clinical Manager). If she is not able to drive Clinic can arrange a Lyft or uber to transport patient to and from Clinic.

IN CONCLUSION

Happy to report patient is residing in a family shelter that has been secured for one year with 2 children. She is actively trying to find low-income housing and is looking forward to returning to work after her second procedure later this month. Patient is adhering to medication regimen and follow up appointments. First lithotripsy with stent placement and subsequent removal was completed without complications.

THE PATIENT HAS HAD NO ED VISITS FOR ACUTE KIDNEY STONE PPAIN SINCE HER COMPLEX CARE CLINIC VISIT!

Faculty Introduction: Karolyn McKay
Up Next: Ann-Marie Murphy, Ozevette DeLorenzo & Joyce Masse

xG HealthCare Management Education Participant Capstone

Presented By: Meghan Beauregard & Chelsea Sylvaria

1. Patient Presentation
2. Past Medical History
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Age: 63

Gender: Female

Support System: Widowed, lives alone, supportive sister who is EC, has HHA 50h 6 days/week, children not involved, has a dog

Socioeconomic status: disabled since 2000, lives in housing with elevator access

Life Style: generally sedentary, leaves home for medical appointments

Chronic Conditions: CAD, HL, HTN, hypothyroidism, depression, obesity, bipolar d/o, falls, fibromyalgia, COPD, CKD st 3a, DMII not on insulin, remote hx alcohol use s/o, tobacco, cocaine, and methamphetamine abuse in remission, ascites, encephalopathy due to ammonia, end-stage liver disease, NASH cirrhosis requiring 2x/weekly paracentesis

Current Medications: Acetaminophen-hydrocodone, Sucralfate, Lactulose, Narcan, Ursodiol, Seroquel, Hydroxyzine, Propranolol, Combivent, Lasix, Spironolactone, Cipro, Milk Thistle, MVI, Potassium, Xifaxan, Gabapentin, Albuterol, Levothyroxine

Patient Understanding of Disease Process: Knowledge of disease process developing gradually

Compliance to Treatment Regime: Improved compliance over time with her plan of care and medications due to realization of the severity of her illness

Recent Acute Episodes: Abdominal pain, ascites, peritonitis, all presentations requiring paracentesis

Have You Identified Any of The Following

Barriers to Care: lack of family/social support, transportation, cost of co-payments, adjustment to illness/disease process, physical limitations

Gaps in Care: Obtaining supplies- not enough Pleur-X kits in the home, communication between outside care teams, waiting for testing and approval to get on transplant list

Driver of The Case: Inability to meet disease process needs in the community due to insurance coverage limitations

Medical Neighborhood Needs (who would you collaborate with regarding patient care needs): TOC, NCM, PCP, Pharmacy, VNA, Paramedicine, Specialists, CNCM, MSW, insurance company

What are three signs/symptoms patient should report to PCP/CM as soon as possible:

Sign/symptom:	Sign/symptom:	Sign/symptom:
• Weight gain; shortness of breath	• Abdominal pain	• Change in mental status

What is your immediate plan for this patient? As a Transition of Care Nurse, my role is important in the acute phase of a hospitalization and prevention of 30-day readmission. Obtain discharge paperwork and any pertinent imaging/labs. Outreach within 48h of discharge notification. Complete a focused assessment, review discharge plan, ensure appropriate follow up with PCP and/or specialists. Identify any new/ongoing barriers. Education surrounding disease process and expectations. Complete a comprehensive med rec. Refer to pharmacy for cost barrier on new medication or to update med pack with changes. Collaborate with VNA/specialists regarding supplies. Warm hand-off to the NCM as she has already been identified for the High-Risk panel. Enroll on remote patient monitoring for bi-weekly check-ins (follow-up call with the patient if not engaged in RPM). Deploy paramedicine if needed. Present patient at care conference with IDT.

What is your long-term plan for this patient? As a Nurse Care Manager, the patient and I continue to meet goals and work towards others together as new barriers arise. Regarding her recent hospitalizations, I arranged for Denver PleurX's directly from the hospital when VNA had none. I also worked with pts GI to have her scheduled in VIR clinic 2x/week for outpatient paracentesis and arranging for transportation. Additionally, I helped her in completing necessary steps needed by the transplant center to get on the liver transplant list. Over the years I have assisted her in addressing many needs and barriers. Examples include: PM1 form for long-term CNAs, MTM setup, MOW, CHT referral and follow up, East Bay Community Action Plan referral, help transferring pharmacy, Paramedicine Program referral, assistance with refills, handicap placard. Pt has direct line, GV text, portal, enrollment in wellness RPM. I check in monthly or more if needed. Every change in status or hospitalization the patient and I will update her care plan together. She will receive a copy in the mail and through the portal for her to refer to.

Conclusion:

The patient has met many short-term goals since being identified for the high-risk nurse care manager program. Her utilization and 30-day readmissions have significantly decreased in 2022 compared to previous year (about 50% decrease). She was recently identified by VNA for having no skilled need and well managed independently at home. A liver transplant remains the main goal, but symptom management, treatment compliance and prevention of unnecessary utilization remain key until then.

Ann-Marie Murphy, Ozevette DeLorenzo, Joyce Masse

[Capstone Document]

Faculty Introduction: Karolyn McKay
Up Next: Rosemarie Sepe

Faculty Introduction: Karolyn McKay

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xG Learn Care Management Education:

Care Manager

Capstone Presentation

Rosemarie Sepe

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Patient Presentation

Age: 54 years old

Gender: Male

Support System: Patient lives with 2 roommates in a 3-bedroom apartment.

Socioeconomic status: Patient is an every day smoker of cigarettes and marijuana. He is on Medicaid disability. The roommates split the rent and the utilities. Member is unemployed.

Life Style: Patient is minimally active as in no exercising. He ambulates independently. He finds temporary jobs to make a little extra money.

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Past Medical History

Chronic Conditions:

Type 1 DM, A-fib, HTN, Peripheral neuropathy, HLD, past MI

Current Medications:

Atorvastatin 20MG, Eliquis 5MG BID, gabapentin 600MG TID, Metoprolol succinate ER 25MG, Omeprazole 20 MG, Basaglar 10units daily, [illegible] scale TID

Patient Understanding of Disease Process:

Patient is actively obtaining a better understanding of his disease process. Patient needs continual reminders and teaching of med compliance. Slow progression d/t resistance.

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Past Medical History (Continued)

Compliance to Treatment Regime:

Patient needs continued encouragement to adhere to plan of care. He is resistant to the new regiment d/t his "doing it his way for a long time". Member continues to smoke marijuana that interrupts his dietary recommendations. Re-enforcement is needed to keep member from changing his insulin administration to "how he feels" and adhering to his ordered sliding scale.

Recent Acute Episodes:

2 episodes of re-hospitalization for DKA. Member was changing his insulin intake and not adhering to his diet.

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Barriers to Care:

Knowledge deficit of his disease process

Resistance to change.

Running out of medications.

Changing insulin doses on his own according to “how he feels”.

Need continued re-enforcement of plan of care and encouragement.

Doesn’t like to prick finger 4 times a day.

Gaps in Care: In the past patient has not refilled his insulins on time d/t; transportation issues, losing med and too early for refills, discarding med stating that “it was old and didn’t work as well” (member felt that the insulin lost its potency after 15 days).

Driver of The Case: Primary Care Provider and NCM

Medical Neighborhood Needs: MTM for appointments, Re-enforced education, Nephrologist and Nutritionist referrals.

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Immediate actions

What is your immediate plan for this patient?

- Getting member to go to an Endocrinologist and Nutritionist
- Provide MTM transportation information for rides to appts and pharmacy.
- Get script for a Freestyle Libre to avoid finger pricks.
- Continued education, encouragement, reminders, and support.
- Show milestones and goals met.

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Addressing Identified Concerns

How Would You Address Concerns Identified?

- Provide continued support and education.
- Re-enforce medication compliance and address any barriers.
- Encourage continued engagement and compliance with Nutritionist and Endocrinologist and address concerns with any new orders.

Plan of Care: Patient Education

What are the signs or symptoms patient should report to PCP or CM as soon as possible?

A-fib:

- Irregular Heartbeat
- Heart palpitations
- Lightheadedness
- SOB
- Chest pain
- Extreme fatigue

Diabetes:

- Hyper or Hypo glycemia
- Abnormal high or low blood sugars
- Blurred vision
- Becoming easily irritated, anxious, or moody
- Increased thirst
- Frequent urination

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Ongoing Care

What is your long term plan for this patient?

- Continue monthly outreaches for support, education and encouragement with member knowing when to outreach to the NCM or PCP.
- Continue insulin administration as ordered and not self adjusting without consulting with his providers.
- Review provider notes after each appointment for recommendations to reinforce their messages with the patient

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Thank you
Stay Healthy and Safe

NEXT MEETING: FEBRUARY 21, 2023