CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

Welcome NCM Core Curriculum Learners!

NURSE CARE MANAGER/COORDINATOR BEST PRACTICE SHARING MEETING

FEBRUARY 15, 2022

Agenda

Topics	Duration
Welcome & Review of Agenda *Susanne Campbell, CTC-RI*	5 minutes
NCM Core Curriculum Learner Presentations Bettina Cullinane and Lerin Peckham Katherine Patterson, Dorothy Hanson, Andrea Ripa Nancy Andreozzi, Jordan Aptt, Courtney Sullivan Samantha Fuimarello, Judith Tally, Nina Laing Aimee Roy MaryAnne Fritz Lindsey Oldham Pamela Greenhalgh	85 minutes (9 minutes each)

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

UnitedHealthcare®

RHODE ISLAND DEPARTMENT OF HEALTH

Please register for the March Geriatric Education Series as our March Best Practice Meeting

Register here: https://bit.ly/BRH5reg

Contact:
Email: rigec@etal.uri.edu
Phone: 401.874.5311

RIGEC
Rhode Island Geriatric Education Center

Geriatric Education Series

A Strengths-Based Approach to Dementia Care

Live Webinar

Tues., March 15, 2022 | 8:05–9:05 AM EST

People with dementia retain many valuable life-long abilities despite the amount of care they may need. Without addressing ways to support and develop a patient's strengths, the loss of ability to function due to factors other than dementia itself. may occur.

Speaker:
Colin Burns, DNP, APRN-AGNP
Gerontology Nurse Practitioner
Westerly Hospital, Westerly RI

Learning Objectives:

After completing this webinar, participants will be able to:

- Define strength-based model of care.
- Describe how to conduct a strengths-based interview.
- Identify strategies to maintain strength and resilience in persons with dementia.

Register here:
https://bit.ly/BRH5reg

This activity has been submitted for 1.0 contact hours of continuing nursing and social work education.

Next Week: Geriatric Education Series from the RI Geriatric Education Center

Exercise for Cognitive and Physical Function in Older Adults with Cognitive Impairment

Wednesday, February 23, 2022 | 12:00–1:00 PM EST

Register here:
https://bit.ly/brh4reg

Learning Objectives:

After completing this webinar, participants will be able to:

1. Describe the benefits of exercise on brain health and physical function.
2. Discuss mechanisms of neuroplasticity in relation to exercise.
3. Identify practical methods to adapt exercise interventions for people with cognitive impairment.

Speaker
Ellen McGough, PT, PhD
Professor and Department Chair of Physical Therapy, University of RI

Register here: https://bit.ly/brh4reg

Contact:
Email: rigec@etal.uri.edu
Phone: 401.874.5311

Presentations from Reena Jariwala's Group

Capstone: Bettina Cullinane and Lerin Peckham

Capstone available here: Lerin & Bettina Capstone Presentation.pdf (ctc-ri.org)

XG HEALTHCARE MANAGEMENT EDUCATION PARTICIPANT CAPSTONE

Dorothy Hanson RN, CDOE

Katherine Patterson, RN, BSN, CDOE

Andrea Ripa, RN, MS, CCM

BACKGROUND

- Patient is a 72-year-old male who resides in RI & lives in subsidized elderly housing
- Patient has support in the way of a son who lives about 30 minutes away from him
- Patient lives an overall sedentary lifestyle & leaves his residence for grocery shopping and medical appts
- Patient has low health literacy and relies on his medical team to assist him with all aspects of his care
- Patient has intermittent compliance to the treatment regimen. He misses appts often and/or doesn't make appts with his providers. He has poor compliance with medications. He has depression and limited family support which exacerbates his compliance issues.

H&P

- Patient's past medical history includes:
  - Type 2 DM, Stage 3b CKD, COPD, hypothyroidism, HTN, CHF, A Fib, Prostate Cancer with SP tube, HLD, Major Depressive Disorder, Vit B12 and Vit D deficiencies

- Current Medications:
  - Albuterol, Eliquis, Atorvastatin, Symbicort, Vit B12, Cymbalta, Vit D2, Amaryl, Lantus, Levothyroxine, Mag oxide, Metoprolol, Torsemide

MATTERS FOR CONSIDERATION

- Gaps in care:
  - Patient due for a colonoscopy
- Barriers to care:
  - Low health literacy, low socio-economic status, limited family support, major depression, chronic illnesses
- Driver of the case:
  - Patient with several admissions/ED visits
- Relationship with PCP office:
  - Patient is a long-term patient of his PCP, he became known to NCM in 2019 but began more regular contact with NCM in 2021 due to his increase in ED visits and admissions.

COLLABORATION/INTERVENTIONS

- NCM has collaborated with:
  - **Pharmacy:** In-office Pharmacist in PCP office (assistance with patient assistance program forms) and via Lifespan Pharmacy (pill packing services.)
    - NCM, in collaboration with Pharmacist and Clinical Nurse in PCP office, were able to successful apply for zero-cost insulin Lantus and Entresto via the respective drug manufacturers.

COLLABORATION/INTERVENTIONS (CONT.)

- NCM has collaborated with:
  - **Landmark Health:** NCM facilitated set up with Landmark Health services, which provides him with a visiting MD as well as a NCM and SW who regularly visit him and collaborate closely with NCM in the PCP office.
  - **Visiting nursing agencies (VNAs):** NCM is in touch with VNA often regarding teaching and monitoring they are doing in the home. This was a close contact when patient began treatment with insulin.

COLLABORATION/INTERVENTIONS (CONT.)

- NCM has collaborated with:
  - **BCBS of RI:** Care Management initially set up BC rides and BC grocery program for patient, which he now manages and independently contacts for services.
  - **Other MD offices:** NCM has collaborated with cardiologist and GI office to facilitate appts/med changes/clarifications.
  - **Meals on Wheels:** NCM referred patient to their meal delivery program, and he is now a long-term recipient of this service.
  - **RI Dept of Elderly Affairs:** NCM referred patient to the Dept of Healthy Aging.

PLAN OF CARE

- Interventions:
  - Patient:
    - will continue services with Lifespan Pharmacy pill packing, patient assistance programs for zero-cost medications, involvement from Landmark Health, visiting nursing services, Meals on Wheels, transport and free groceries programs via BCBS of RI
    - will reach out to his PCP office with any needs
  - NCM will continue attending all PCP office visits for continuity of care

PLAN OF CARE (CONT.)

- Goals:
  - Patient:
    - will strive for improved quality of life
    - have access to resources
    - will be an active participant in his health
    - will avoid/reduce ED visits/admissions

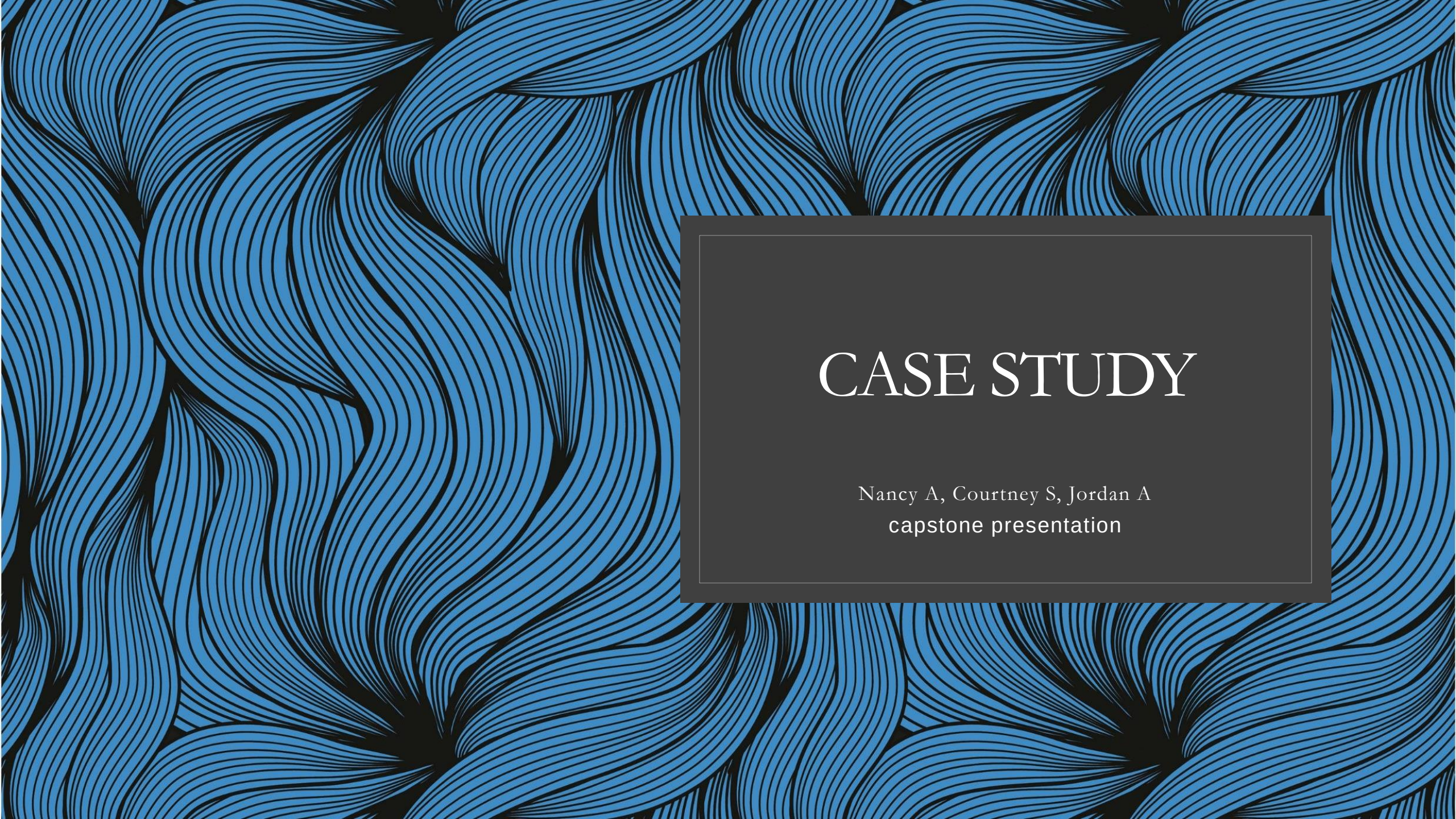
PLAN OF CARE (CONT.)

- Barriers:
  - Patient:
    - continues to have issues with compliance to treatment plan by way of making appts, and keeping them, with his PCP and specialists
    - has familial support
    - has limited financial resources

CONCLUSION

- From Jan 2021 to Sept 2021, patient had 4 ED visits and 5 admissions.
- Since starting pill packing, obtaining zero-cost medications, and with regular f/u with NCM, patient has had zero ED visits or admissions since Sept 2021.

QUESTIONS?



CASE STUDY

Nancy A, Courtney S, Jordan A

capstone presentation

History of Patient

Age: 62

Gender: female

Support System: Patient is followed and supported by her Coastal NCM and MSW, is linked with BH team, had participated in CHT in the past, has a sister involved in her care

Socioeconomic Status: Female, lives in her own home alone, with her dog; recently reached out for food insecurities, participated in day programs Butler for ETOH

Life Style: Smoker, ETOH. Patient is not currently working and has applied for SSDI

Past Medical History: Depression with anxiety, nicotine dependence, insomnia, carpal tunnel syndrome, ETOH, intrinsic eczema, macrocytosis, seasonal allergies, pilonidal cyst, swallowing dysfunction, COPD with asthma, Dupuytren's contractor of left hand

Chronic Conditions: Depression with anxiety, COPD with asthma, ETOH, nicotine dependency

MEDICATIONS

- Citalopram 40 mg tablet
- **SYMBICORT 160 mcg-4.5 mcg/inh aerosol**
- **Ventolin HFA CFC free 90 mcg/inh aerosol with adapter**
- **VITAMIN D 125 mcg capsule**
- **TraZODone 50 mg tablet**
- **Vitamin B1 100 mg tablet**
- **Folic acid 1 mg tablet**
- **Ibuprofen 600 mg tablet**
- **Eucrisa 2% ointment**
- **Fexofenadine 180 mg tablet**
- **Famotidine 20 mg tablet**
- **Magnesium oxide 400 mg tablet**
- **Gabapentin 300 mg capsule**
- **Montelukast 10 mg tablet**
- **Incruse Ellipta 62.5 mcg (0.0625 mg)/inh powder**
- **Magnesium oxide 400 mg tablet**

Patient Understanding of Disease Process

Patient Understanding of Disease Process: The patient is knowledgeable and understanding of her ETOH abuse. She understands the short and long-term potential side effects and consequences. As well as the way her disease affects her relationships with her family and friends. She knows when she is not doing well and is able to effectively communicate when she relapses.

Compliance to Treatment Regime: She is compliant and open to her treatment options, she does want to receive help, reason being why she continues her attempts at rehab and stays connected to her therapist. The problem is when she returns home, is isolated, and solely depends on her own judgement and self-control, which causes a continuous loop of setbacks.

Recent Acute Episodes: She continues to drink. She had an annual on 1/18/22 in which the provider noted that she is still drinking 2-3 bottles of wine per day. Her last rehab stay was in November. She continues to follow with her BH team.

Matters For Consideration Identify the Following:

- Barriers to Care: She has been in and out of Butler partial program with relapse. Once patient is home post Butler stay, she immediately drinks. Patient would benefit from following through with long-term care. Previously spoke with BH team and NCM regarding an inpatient rehab in PA, patient has not yet confirmed that she will be going. Patient also has COPD which worsens from drinking. Finance is a secondary barrier; PA facility would cost patient $500 and recent butler stay cost $1000 OOP.

- Gaps in Care: Patient is working with the BH team, a therapist, and NCM. Unfortunately, patient is not currently utilizing the support that is being offered to her for longer term rehab. Patient was working with her therapist regarding cost of the facility in PA for long-term care. Has siblings and children for support.

- Medical Neighborhood Needs (who would you collaborate with regarding patient care needs): Behavioral health team. Patient would benefit from an in-patient rehab stay. Plans to go to a facility in PA for a longer therapy session. Patient has not yet followed through. PA is $500 copay for a 28 day stay through insurance. Patient would also have to set up a ride/flight to PA which is adding to the expense.

Plan to address Identified Concerns

- What is your immediate plan for this patient? Further research facility in PA including pricing, time frame, and transportation for patient. Also, to research closer facilities that offer the same assistance.
- What Patient Education will you provide? Additional resources for facility in PA, follow up regarding state insurance and financial support.
- What are three signs/symptoms patient should report to PCP/CM as soon as possible?
  - 1. Depression, Hopelessness
  - 2. Family stressors
  - 3. Social stressors
- What are your long-term plans for this patient? Continue to follow up with NCM, PCP and BH teams. Follow closely with Pulmonologist. NCM to continue monthly outreaches and as needed. Identify closer long-term facility for additional counseling and support.

Conclusion

- This is a 62-year-old female that has followed with case management for over a year. When enrolled in case management patient had financial insecurity, food insecurity and needs for social support. Patient is currently in the process of applying for SSDI. Patient has stable housing and weekly counseling. Patient is very educated and understands her current state of health. She knows how to identify her barriers to care. Patient is very engaged with PCP, Pulmonologist, NCM and BH team. Patient has a good understanding of when to contact her health team.

xG HealthCare Management Education Participant Capstone

Presented By: Samantha, Judy, Nina

Date: 01/22/22

Capstone Case Study Presentation

1. **Pt is** 81-year-old male patient of Dr. Pickett's
2. **Matters for Consideration-Identified Concerns**
3. **Immediate Patient Plan of Care**
4. **Long Term Patient Plan of Care**

Patient Presentation

Age: 81

Gender: male

Support System: wife and daughter, extended family

Socioeconomic status: retired fire fighter, middle class

Lifestyle: owns home, lives with wife, noncompliant with diabetic and cardiac diets, sedentary lifestyle

Past Medical History

Chronic Conditions: Patient has multiple comorbities

Current Medications: Multiple medications needs assist with has prepackaged by Kent hospital

Patient Understanding of Disease Process: Patient has fair understanding of how disease processes.

Past Medical History Continued

Compliance to Treatment Regime: Patient is now compliant with medication since prefilling packaging has been instituted. Patient is noncompliant with diet

Recent Acute Episodes: patient had amputation on 3rd finger R hand from infection.

Matters For Consideration

Have You Identified Any of The Following

Barriers to Care: Dietary noncompliance, home bound, weakness and unsteady gait, immobility, wife who is CG is in frail health as well daughter is local but not very involved in daily care of pt.

Gaps in Care: Patient is generally compliant with scheduled OV with PCP and specialists

Driver of The Case: PCP in conjunction with ID and other specialists.

Medical Neighborhood Needs (who would you collaborate with regarding patient care needs): cardiologist, pulmonologist, endocrine, palliative care, Kent pharmacy home meds, VNS services

Plan to Address Identified Concerns:

How Would You Address Concerns Identified:
Patient has had multiple In office, home and telephone NCM visits for diabetic diet review and wound assessment as well as medication management. Diet reviewed with pt wife and daughter as well. Pt has been referred to VNS for PT/OT (currently doing hand therapy), SN, dietitian, MSW for long term planning and patient remains on Palliative care services with Kent VNS. Pt has CNA provide by VNS 1-2 times a week for assist with ADL's. Pt will benefit form ongoing NCM and palliative care support. Pt was referred for med prefill and packaging. Patient has good family support.

Plan of Care Patient Education

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

Patient assess for bilat. LEE	Sign/symptom:
• Any new wounds or scabs on bilateral hands and feet	• Increased SOB or difficulty breathing • Weight Gain

Immediate Plan of Care

What is your immediate plan for this patient?

Patient plan is to continue to monitor pt for exacerbations of symptoms by SN VNS, wife and daughter and patient and to report immediately to NCM. Pt has telemonitor system in place in home.

Long Term Plan of Care

NCM will continue to follow up with patient. Patient wife/ SN VNS to call NCM/PCP office with any new symptoms or concerns to report. Palliative services to remain in place for pt. Kent pharmacy to continue to prefill medications.

Conclusion:

Patient continues to need support from family, VNS services, medications packing, palliative care. Pt continues to need close follow up and support for PCP and NCM. Pt continues to go to specialist appt. follow up visits as scheduled. Pt and CG is in agreement with POC. Continued COC with support services to ensure pt safety and symptom management.

Presentations from Carol Falcone's Group

Capstone Case Study

Aimee Roy, RN
Case Manager
Blue Cross and Blue Shield of RI

Case Study

- 85-year-old female with PMH: HTN, hyperlipidemia, Alzheimer's disease, GERD, recurrent falls, DM2 and COPD with new coughing episodes.
- Daughter/caretaker frequented the Blue Stores with multiple questions regarding members health, medication changes, and coughing spells. Member referred to case management for outreach.
- Patient lives with daughter and has adequate family support from multiple children.

Medications

- alendronate 70mg weekly
- amlodipine 5mg daily
- atorvastatin 10mg daily
- donepezil 5mg daily
- lisinopril 20mg daily
- memantine 10mg twice daily
- metoprolol 25mg daily
- multivitamin daily
- pantoprazole 40mg daily
- miralax as needed
- quetiapine 25mg daily
- sertraline 25mg 2 tabs daily.
- glipizide 5mg daily

Labs

Chol: 121

HDL: 60

LDL: 46

Triglycerides: 76

HgbA1C: 5.7

PLAN:

- Outreached to daughter/POA regarding patients needs and concerns.
  Biggest concerns are new coughing episodes, member being up most of the night, and PCP is retiring and felt patient was “too complex "for continued follow up
- New PCP appt set up for patient with request for lab work prior to appointment
- Skilled homecare referral set up for Nursing, PT, OT, MSW and CNA for oversight in the home.
- Non skilled benefit set up and utilized for private CNAs
- AMC monitoring set up for daily BP, HR, SpO2 oversight

Plan Continued:

- Order DME equipment to best meet patients needs
- Call pulmonologist to discuss inhaler options for COPD and new coughing episodes
- Order glucometer and provide teaching on use, signs and symptoms of hyper/hypoglycemia
- Complete medication reconciliation with new PCP office
- Outreach to neurologist for medication reconciliation and concerns over patients sleep cycle and mental state
- Discussed palliative care with daughter who was thankful for information but doesn’t feel she is ready for this level of care at this time. Patient remains a full code.

Follow up

- ✓Hospital bed ordered for patient who is now able to elevate her head at night to help with coughing spells.
- ✓Outreach to pulmonologist who had patient covid tested (-) as well as chest xray completed (-)
- ✓Pulmonologist ordered a nebulizer machine as needed along with ProAir with aero chamber, education provided to daughter on use of both. COPD zone tool sent to daughter.
- ✓New PCP completed full work up on member including lab work and EKG. Glucometer ordered. Education provided to daughter on glucometer use daily along with keeping log of blood sugars. Education provided on signs and symptoms of hyper/hypoglycemia. Zone tool sent to daughter as well. Blood sugars have been consistently in the low 100 range.

Follow up continued:

- ✓Neurologist made medication changes based off patient symptoms.
- ✓Seroquel was replaced by Trazodone with good effect
- ✓PCP discontinued Lisinopril and added Losartan Potassium
- ✓OT and PT working with patient on energy conservation techniques along with relaxation techniques
- ✓Coughing spells have decreased with change in medications
- ✓With medication changes, DME equipment coughing spells have decreased and patient is sleeping better at night.
- ✓Dietician at Blue Cross outreached to daughter to provide dietary education
- ✓Daughter is feeling more supported with increase in supports in home as well as AMC monitoring and new PCP. Patient has shown improvement in symptoms.
- ✓Case Management to continue with every two-week outreaches and as needed based on members ongoing needs.

xGLearn®

xG Learn Care Management Education:

Care Manager

Capstone Presentation

Presented By: MaryAnne Fritz

January 27, 2022

xG HEALTH SOLUTIONS® powered by Geisinger

Capstone Study Presentation Outline

1. Brief Patient History
2. Pertinent Medical History
3. Identified Gaps in Care
4. Identified Escalation Points-Needs Assessment
5. Resources Put in Place

Patient Presentation

Age: 60

Gender: Male

Support System: Nurse Care Manager, PCP, Daughter

Socioeconomic status: On SSDI, disabled. Long history of smoking. Has regular contact with his daughter but lives alone.

Life Style: Sedentary, diet limited, difficulty getting out. He does not drive.

Past Medical History

Chronic Conditions: Severe COPD, HTN, peripheral vascular disease, diabetes, depression, hx of lung neoplasm.

Current Medications: Venlafaxine, Cilostazol, Atenolol, Lisinopril, Atorvastatin, Glipizide, Gabapentin, Percocet, ProAir HFA, Combivent Respimat.

Patient Understanding of Disease Process: Patient has a fairly good understanding of his issues. He worked hard at giving up smoking and at our last conversation, had gone 10 days without a cigarette.

Past Medical History (Continued)

Compliance to Treatment Regime: Compliance is fair at best. Patient does not check his glucose levels. Was recently checked while here in the office and his A1c was 6.9. As noted, he has stopped smoking which is a victory for him.. He does not follow up with referrals.

Recent Acute Episodes: Had an episode of numbness on one side of body but refused to go to ER or urgent care for evaluation. By the time we could get him in here, it had mostly resolved. CT scans of his brain did not show any acute problems.

Matters For Consideration → Identify the Following:

Barriers to Care: Lack of transportation, difficulty with mobility. Patient's O2 level desatted to low 80's at his last office visit. At rest, his level is well into the 90's. We have ordered an oxygen concentrator for him to use when he is out and about.

Gaps in Care: Needs dental care, follow up with oncologist.

Driver of The Case: COPD, low O2 levels.

Medical Neighborhood Needs (who would you collaborate with regarding patient care needs): Durable medical equipment supply, dentist, oncology, pulmonologist.

Plan to Address Identified Concerns:

How Would You Address Concerns Identified: Frequent contact with patient and reminders to make needed appointments. An O2 concentrator has been ordered and received. The patient seems to be willing to use this when he goes out. When he is home and more sedentary, his O2 levels are fine.

Plan of Care: Patient Education

What are **3** signs/symptoms patient should report to PCP/CM as soon as possible:

Sign/symptom:	Sign/symptom:	Sign/symptom:
• **Increased difficulty breathing**	• **Edema in any part of the body**	• **Transportation issues**

Immediate Plan of Care:

What is your immediate plan for this patient? Getting the O2 concentrator for patient is primary concern, and this has been done. He is up-to-date on his vaccines, including the flu shot, pneumonia vaccine and Covid booster. Need to find out when his last visit with oncology was, and when he is due again. He states he has a dentist, want to make sure he connects.

Long Term Plan of Care:

What is your long term plan for this patient? Would love to get patient interested in some form of exercise, as most days he does not leave his home and rarely gets out. I do not want him to become socially isolated on top of his other issues. His daughter is involved in his life.

Conclusion:

This patient has a great awareness of his own pitfalls. He knows he should be exercising more, but lacks motivation. He has done a good job cutting back on smoking, but feels it is enough to cut back and isn't really interested in stopping altogether. His personal care is not the best; he often comes in in clothing that has obviously not been cleaned in some time, although he seems to be clean personally.I have not been able to interest him in using his glucometer, although he takes his Glipizide regularly.

Case Study

LINDSEY OLDHAM

- My patient is a 67 year old male who lives in subsidized housing on SSDI.
- Patient has one daughter that he is estranged from.
- He lives with his wife who is disable and blind.
- Patient drives and is able to leave his home. He does the shopping for him and his wife.

Past Medical History

- Diabetes mellitus type 2
- Anxiety
- Depression
- HTN

Current Medications

- Aspirin
- Famotidine
- Fenofibrate
- Glipizide
- Lopressor
- Metformin
- Tramadol
- Simvastatin
- Omeprazole

PATIENT'S UNDERSTANDING OF DISEASE PROCESS

- Patient is a newly diagnosed diabetic. His understanding of disease process is extremely poor, patient is illiterate. Patient reports that he takes his medications as ordered but does not let NCM complete medication reconciliation as he does not allow anyone in his home. Patient reports blood sugars within normal range, but this does not coincide with his A1C.

Interventions

- NCM speaks to patient often. Patient is illiterate and refuses to have his medications packaged from the pharmacy. Patient always reports blood sugars “below 200”, but NCM is unsure if patient is compliant with monitoring his blood sugar. Patient has agreed to participate in glucometer/diabetic program and will be mailed a glucometer.

Barriers to Care

- Patient does not allow anyone in him home. NCM has been to home a handful of times, but he does not allow anyone else. Patient does not allow homecare staff that he and his wife could greatly benefit from.

Medical Neighborhood

- PCP
- NCM

IMMEDIATE PLAN

- Enroll patient in diabetes/glucometer program.
- Encourage patient to have medications pre-packaged and delivered.
- Encourage patient to complete medication reconciliation with NCM.

Patient Education Needs

- Diabetes education with graphs/pictures
- Glucometer teaching with demonstration and teach back

Long Term Plan

- Patient will accept pre-packaged medications to avoid medication errors.
- Patient will participate in glucometer/diabetes program to have blood sugars sent directly to NCM to monitor and adjust medications as needed.

Conclusion

- Patient is difficult to manage has he has a hard time trusting caregivers. Patient is insecure about his living situation and does not like people to come into his home. Patient and his wife could greatly benefit from home care nurse/CNA, but patient declines. Patient is not able to read and write. Patient is his wives primary care giver which causes him much stress and anxiety. NCM has built a bond/trust with patient and will continue to work on assisting he and his wife more as they allow.

Capstone Case Study

Pam Greenhalgh NCM

EBCAP

CASE STUDY

My patient is a 59 yo female who lives at home with her husband on a horse farm. She and her husband are independent with their ADLs, medication management and both care for their multiple horses on their property.

PAST MEDICAL HISTORY

Patient has a pertinent PMH of hypertension, hyperlipidemia, sigmoid diverticulitis, colostomy placement, moderate tobacco use, and mild anxiety

CURRENT MEDICATIONS

- HCTZ, Atorvastatin, and recently added: Wellbutrin and Amlodipine

PATIENT'S UNDERSTANDING OF DISEASE PROCESS

- Patient contacted to see if she would like to participate in the Hypertension Remote Patient Monitoring Program earlier this year based on her HTN dx in our system. She was happy to participate but considered it to be unnecessary. She volunteered to be the "control" participant with steady, controlled, unproblematic blood pressure. I proceeded to enroll her despite her insistence that she was not in need of intervention. Patient very pleasant and agreeable to all suggestions. Within a week in the HTN program, patient flagged as having consistent out of range BP readings and some critically high readings with an average of 152/100. Patient shocked and concerned that her BP was not as stable as she thought. She was pleased she was in the RPM program and agreed to continue. Patient has a colostomy that was placed in 5/2019 r/t sigmoid diverticulitis. Patient hoping for a reversal.

INTERVENTIONS

- NCM initiated HTN RPM program. After elevated BP readings identified, PCP notified and appointments made for BP evaluation/medication review. Patient's tobacco use addressed. Patient reports smoking 10 cigarettes/daily. Smoking cessation discussed and patient reluctant at this time. We discussed the reversal surgery and possible criteria for candidacy. Surgeon confirmed the patient needs to reduce her weight by 20 lbs and quit smoking before colostomy reversal surgery. NCM encouraged patient to seriously consider smoking cessation and diet/exercise adjustments to reach her BP and surgical goals. Patient agreed to cut down on smoking and start Wellbutrin to assist with successful smoking cessation. She also agreed to a weight loss plan of cutting down on saturated fats, reducing red meat consumption and restricting sodium. These efforts will assist patient reach her BP goals as well as her surgical goal of colostomy reversal. Patient encouraged to remain in HTN RPM program and she agreed.

BARRIERS TO CARE

- When I first met this patient, the only barrier was a **lack of knowledge and understanding** about her own HTN dx and how her risk factors of a high fat/sodium diet and tobacco use can affect her health and HTN disease process over time. Her **anxiety** presents as a barrier as it interferes with her ability to effectively interact with her health care team and occasionally cancel appointments. The anxiety also contributes to her previous inability and unwillingness to proceed with smoking cessation plans. Patient has good social/emotional support at home, good stress relieving hobbies, independence with transport, and is financially stable.

GAPS IN CARE

- Gaps include the time patient was not keeping her PCP appointments while under the impression that she had no health concerns that needed intervention. Now that patient is in the HTN RPM program, this gap has been identified and filled with PCP follow up, NCM support, medication adjustments, and home monitoring.

MEDICAL NEIGHBORHOOD

- PCP, NCM, Gastroenterologist, Pharmacy

IMMEDIATE PLAN

- Patient started on smoking cessation plan including Wellbutrin rx, frequent calls from NCM for support and accountability. Patient to continue in HTN RPM program to monitor BP as medication adjustments have been made and to monitor for any potential changes during planned weight loss. Stress management methods and strategies will continue to be discussed and encouraged such as caring for her animals and plenty of exercise.

PATIENT EDUCATION NEEDS

- Smoking cessation support and health benefits, weight loss strategies, heart disease process, and diverticulitis diet education, surgical risks and criteria for colostomy reversal.

LONG TERM PLAN

- Successful smoking cessation efforts, successful weight loss, colostomy reversal surgery completed. HTN well controlled and consistently within target range with (or without!) appropriate med regime and target weight/healthy cardiac diet.

CONCLUSION

- This is a patient that might have gone under the radar if not identified by a useful RPM program. She is a great example of how a RPM program is not just useful for the already identified patient with an uncontrolled diagnosis, but for any patient that has been recently diagnosed or that has risk factors. My patient benefited from a thorough PCP with full NCM services within the office that includes RPM technology in their care for their patients. This patient now has her uncontrolled HTN identified and treatment is under way with monitoring in place to determine if it continues to be sufficient and appropriate. She is on her way to reaching her goals of continuing to live at home with her husband and be able to care for her horses. With NCM's help, she is able to successfully work towards achieving her goals of smoking cessation, weight loss and completion of the colostomy reversal surgery.

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Thank you
Stay Healthy and Safe

NEXT MEETING:

MARCH 15, 2022– GERIATRIC EDUCATION SERIES FROM URI

(REGISTRATION REQUIRED: HTTPS://BIT.LY/BRH5REG)