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

JANUARY 18, 2022

Agenda

Topics	Duration
Welcome & Review of Agenda *Susanne Campbell, CTC-RI*	5 minutes
NCM Core Curriculum Learner Presentations • Kristen Lherisson (presented by faculty Jayne Daylor) • Jenn Rossi (presented by faculty Jayne Daylor) • Allison Abdo • Samantha Machado • Allison Stapleton, Anna Marie Folan & Jessica Micek • Isabel Raposa, Christina Ring & Courtney Bricault • Karina Arias & Kim Owens • Joyce Macintyre, Tammy Juriansz & Brenda McGee • Donna Needham • Gabrielle Koussa	85 minutes (8 minutes each)

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

UnitedHealthcare®

RHODE ISLAND DEPARTMENT OF HEALTH

Announcement: 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

Capstone: Kristen Lherrison
Up next: Jenn Rossi

xG Health Solutions Geisinger

Capstone Project

Patient Introduction

*44 year old male w/uncontrolled Type II DM and high cholesterol

*Family history of both conditions in mother's and father's side of the family

*Patient added to writer's caseload as a warm hand-off

PMH: DM II and High Cholesterol

DM II

Prescribed a 3 medication regimen to better control however, patient is non-compliant with regimen

Patient reports trying to maintain lifestyle changes but is having difficulty with them

Patient had discontinued his own medications and ended up in the emergency room w/an A1C >15 and a bg reading >599

High Cholesterol

- Patient does not require medications at this time
- Patient reports trying to maintain lifestyle changes but is having difficulty with them

Social Needs

- Patient does not have a history of tobacco or illicit drug use
- Patient reports using ETOH “socially, not even once per week”
- Patient works 1.5 jobs and lives in an apartment with his wife and two children-patient denies food and/or financial insecurity
- Patient has family and friends in the area and they do travel to Cape Verde every few years to visit with their family there

Medications

- Did not have insurance and even through the 340B program at our pharmacy, they were still costly
- Patient denies understanding the need for “all these medications” and doesn’t know how to use the insulin

- Metformin 1000mg twice daily
- Glipizide 5mg twice daily before meals
- Basaglar 10 units at hour of sleep
- Glucometer Kit-check bgs fasting, 2 hours after biggest meal of the day and anytime you feel unwell

After meeting with this patient in-person and talking to him on the phone:

- Patient provided with education about DM II and High Cholesterol (diet, exercise, progression of diseases, common comorbidities, importance of foot care, DEEs, dental care, timely vaccinations etc)-patient was provided with ACP education in Portuguese
- Patient was provided with glucometer and insulin education-patient was able to check his blood glucose and administer insulin at the time of the meeting-patient was provided education for his glucometer and insulin in larger print in Portuguese
- Pharmacy redid patient's medication labels in Spanish as patient is able to read Portuguese and Spanish
- OEC met with patient and was able to get him insurance
- All appointments conducted with the use of a Portuguese Creole interpreter

Resources

- Additional educational material in addition to what was noted above: educational posters with clear pictures and written descriptions of Hyper/Hypoglycemia in Portuguese and corrective actions
- Patient has seen OEC and received insurance; no other unmet needs at this time (depending on the progress we can make with medications etc, he may need an endocrinology referral which will require assistance from a Portuguese Creole speaking CHT staff)
- I will conduct weekly f/u's to check on patients blood glucoses, titrate insulin based upon the provider's orders and will update the provider weekly; A1C check in 6 weeks as he just restarted medications (patient also has my backline to f/u as necessary)

Up next: Allison Abdo

Capstone: Jenn Rossi

Capstone available here: Jenn Rossi Capstone.pdf

Capstone: Allison Abdo

Up next: Samantha Machado

History of Present Illness;
This is 51-year-old female with alcoholic cirrhosis and recurrent large right pleural effusion consistent with hepatic hydrothorax. This patient has several year history of alcohol abuse and cirrhosis of the liver. She stopped drinking about 6 months ago. She initially had ascites however during the past few months had complications of Pleural effusions. Pt has had 8 IP stays since February. While at home she has had increase SOB which pt was found to have a near collapse of right lung with large pleural effusion. Pt did have multiple chest tubes placed though out her hospital stays.
{Patient has had thoracentesis in Sept which removed 1200 cc another one in July that removed 1000cc and paracentesis in March, April, and May. Pt requiring Oxygen.
Pertinent Medical History:
Hysterectomy, small varices, banding of varices, ETOH abuse, Crohn's, C-Diff associated to Colitis, hepatic encephalopathy, back and abdominal pain.
Patient understands her chronic condition which the need is to go to Beth Israel to start the Liver transplant process. For the most part the pt is adherent to treatment but the pt needs reminders at times to take medications as prescribed for example" Taking her lactulose to help with prevention of encephalopathy. Pt currently c/o back and abdominal pain. Pt's gabapentin was increased 300 mg 1 cap at QHS, plus 100 mg in the morning and afternoon. Patient is currently IP at Beth Israel for evaluation.
Social needs:
Pt is nonsmoker, quit drinking about 6 months ago. Was working as real-estate agent. Patient currently stays home due to current health issue including back and abdominal pain, and the use of oxygen for increase SOB. Pain management remains a concern for the pt. Pain is so severe it limits her normal functional ability. Noted on a Sick Visit with Coastal provider a discussion on the risk verus the benefit of several medication options including muscle relaxant and narcotics and how they may affect her chronic liver disease.

Medications:
- Zinc daily
- Vit B1 100 mg 1 tab daily
- Trazodone 50 mg 1-tab QHS, gabapentin 300 mg 1 cap QHS and 100 mg 1 cap in morning and afternoon
- Ensure enlive BID
- Albuterol 2 puffs every 6 hrs. as needed
- Copper gluconate 2 mg 1 tab daily,
- pantoprazole 40 mg 1 tab twice a day,
- MVI daily
- Melatonin gummies at QHS
- Ferrous sulfate 325 mg 1 tab daily
- Folic acid 1 mg 1 tab daily
- Align 4 mg 1 cap daily,
- oxycodone 0.5-1 tab twice a day as needed,
- lactulose 10g/15 ml syrup take 30 ml twice a day
- Levofloxacin 75 mcg 1 tab daily,
- Xifaxan 550 mg twice a day, Cost for the pt was issue so Pharmacy team was involved and obtain coupon at Walgreens to help with the expense but the pt was not sure if GI doctor was going to keep her on this medications. Coupon was mailed to the pt anyways.

Up next: Allison Stapleton, Anna Marie Folan & Jessica Micek

Case Study

Samantha Machado capstone presentation

History of Patient

- R.L is a 69-year-old male who is retired LPN who lives with his wife and disabled son (who has support services in the home)
- He has had 5 hospitalization in the last 6 months for multiple issues from HF exacerbations ,COPD exacerbation, urinary tract infections requiring IV antibiotic use, change In mental status and right hip pain
- Medical history:
- Heart failure, COPD, Type 2 DM, CKD, gout, A-fib and pulmonary HTN

Observations

The patient is very well versed on his medical conditions, and he can teach back many of the education points that I am able to review with him

I feel like it is difficult sometimes to teach him new ideas or ways to help with his medical conditions since he is a retired medical professional

Ways I have assisted with the patients transitions of care

Enrollment in our TOC RPM platform and hear failure and COPD platform

Coordination with PCP and specialty providers allows for a seamless transition home and management of other chronic conditions

We outreach to our program patients upon discharge to the community, so I can review his medication with the HF team which includes a pharmacist

Community Care Coordination

Prior to R.L last hospitalizations I was able to help coordinated not only with the patient and his wife but also his pulmonologist to make sure that we were encouraging him to go to a rehab in order to prevent further hospital stays.

Allison Stapleton, Anna Marie Folan & Jessica Micek

Up Next: Isabel Raposa, Christina Ring & Courtney Bricault

[Capstone 2022 Allison Stapleton, Anna Marie Folan and Jessica Micek.pdf (ctc-ri.org)]

Isabel Raposa, Christina Ring & Courtney Bricault

Up Next: Karina Arias & Kim Owens

[Capstone Presentation Christina Ring and Isabel Raposo.pdf (ctc-ri.org)]

Karina Arias & Kim Owens

Up Next: Joyce Macintyre, Tammy Juriansz & Brenda McGee

[Capstone Kim O and Karina A.pdf (ctc-ri.org)]

Up next: Donna Needham

xGLearn®

xG Learn Care Management Education:

Care Manager

Capstone Presentation

Presented By: Tammy Juriansz , Joyce Macintyre, and Brenda McGee

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Capstone Study Presentation Outline

1. 62-year-old female with many ED visits and Inpatient Hospitalizations. Pt expressing, she is stressed with Independent living situation.
2. ESRD-dialysis M-W-F, CHF, HTN, T2 DM, Hypothyroidism, Obesity, Mitral Value Prolapse, CVA left temporal lobe, and Anemia
3. GYN f/u recommended otherwise UTD
4. Social worker at Lifespan reached out to CM to escalate assist with housing needs FS of RI referral completed.-SW assigned. CM needed to assist w/ workaround w/ NHP - reminders
5. Family Service of RI –Insurance issue medication co-pays –she must call NHP 48 hour prior to a fill or risk paying hefty co-pay . Pharmacy frustration-educated to stop always changing her pharmacy. and Lower Level Of Care. Independent versus Assisted Living

Patient Presentation

Age: 63

Gender: Female

Support System: Sister

Socioeconomic status: At Risk-ESRD-Placed on Transplant List- Ex husband is a match. Per 12-10-21 Transplant Consult note- Good Candidate for Transplant- Transplant Multidisc meeting sch'd. soon..

Lifestyle: Independent to Assisted

Past Medical History

Chronic Conditions: ESRD, CHF, HTN, IDDM, Hypothyroidism, Anemia, CVA left temporal lobe, obesity, and Mitral value prolapse

Basaglar 20 units Sc daily

Humulin 70/30 12 units Sc before breakfast and dinner –Correction Factor 2 units for q 50 over 150 max 36 units

Valproic Acid 250mg 1 capsule po twice a day

Vimpat 50mg po bid except on the mornings of dialysis

Amlodipine Besylate 2.5mg po daily

Aspirin 81m g po daily

Ezetimibe 10 mg daily

Sertraline HCL 50mg daily

Levothyroxine 50 mcq po daily

Atorvastatin 80mg po daily

Calcium Acetate (phosphate binder) 667mg po 2 caps with meals

Pantoprazole 40mg Delayed Release po

Past Medical History (Continued)

Compliance to Treatment Regime:

High level stress due to dialysis three times a week,
Difficult to adhere to insulin regime runs out of Dexcom supplies/Insulin due to forgetting to call insurer 48 hours b/f fill. A1c as of 10/21 is 7.9 down from 9.1

Difficulty adhering to seizure medications regime since workaround for pharmacy required

Requires LLOC-Independent to Assisted Daily Living

Recent Acute Episodes: 12-24-21 Pulmonary Edema-missed dialysis d/t schedule change by dialysis. 2/16/21 stroke, 3/1/21 aphasia, 6/30/21 vomited at dialysis, 7/4/21 overdose of insulin, hyperglycemia/fatigue and 9/17/21 aphasia vs stroke

Matters For Consideration → Identify the Following:

Pt current living situation causing stress

Gaps in Care: Once settled in Anchor ay Assisted Living will address

Medical Neighborhood Needs:

Brown Pharmacist Review of insulin fills

Neighborhood Health Plan Member services

Family Service of RI Provided resources for Real Estate agents

Dialysis SW Investigated current housing plan and advocated for ALF

Lifespan SW at Lifespan contacted NHP, and workaround put in place –Pt must call 48 hours b/f a medication refill with mail away Pharmacy.

Capitol Home Care VN weekly

How Would You Address Concerns Identified: Collaborated with the team

- Ms. Scott SW at Lifespan catalyst for ALF-secure message received requesting support in changing independent living to Assisted Living level of care.
- SW at Dialysis investigated subsidized housing –pt was at top of 2 lists of senior housing in E. Providence but refused accommodations since did not feel secure in this situation. Advocated for Assisted Living.
- CM involved Family Service of RI –their SW assisted with locating a real estate agent options so patient could place her home on the market-closed 12-17-21. Real estate agent provided helper so patient could get organized.
- SW also investigated insurance options via Health Source RI. Pt decided to switched back to her regular pharmacy versus mail away
- Brown pharmacist reviewed insulin fills to see if correction factor was being adhered to-weekly checks ins to insure she follows max 36 units a day. Pt wasn't adhering to max dose but now only uses the correction factor 3 times a week.

Plan of Care: Patient Education

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

- Stress

Stress

- Anxiety

Anxiety

Funds are almost below $4000

Immediate Plan of Care:

What is your immediate plan for this patient?

- Lower level of care need addressed as a priority
- Adherence to insulin dosing including correction factor

Long Term Plan of Care:

What is your long-term plan for this patient?

- Once patient does the spend down, she will need assistance with transitioning to Medicaid waiver for her Assisted Living accommodation ongoing support will be provided. Anchor Bay has already communicated to patient Medicaid Waiver is accepted.
- If stress becomes an ongoing issue telephonic counseling will be offered and provided.

Conclusion:

- Pt had fire inspection the week of 12-27-21 and passed, she has moved belongings into Anchor Bay Assisted Living and is just waiting on a closing date for her home. She is staying with sister marcia until then.
- Pt closed on sale 12-29-21 of her house and moved into Anchor Bay Assisted Living on 1-3-22. CM assisted with ensuring immunizations up to date prior to move in time.
- Last known ED visit was 12-24-21-follow-up w/ PCP provided by CM . This ED visit was due to dialysis changing days from T-TH-Sa to T-TH-Su that week. Pt experienced Pulmonary Edema.
- During organizing and packing patient needed a same day sick visit to discuss her anxiousness about her upcoming lifestyle change/living arrangement. Same day appointment provided via CM. Sertraline was prescribed and if phycological counseling is needed it will be offered prn.
- Currently, patient loves Anchor Bay Assisted Living accommodation and is acclimating well. Lastly, as of 12-10-21 it was noted she is being presented at her Transplant Doctor's Osband's multidisciplinary rounds soon. She is very excited!

Up next: Gabrielle Koussa

xGLearn®

•xG Learn Care Management Education:

•Care Manager

•Capstone Presentation

Donna Needham, RN

December 15, 2021

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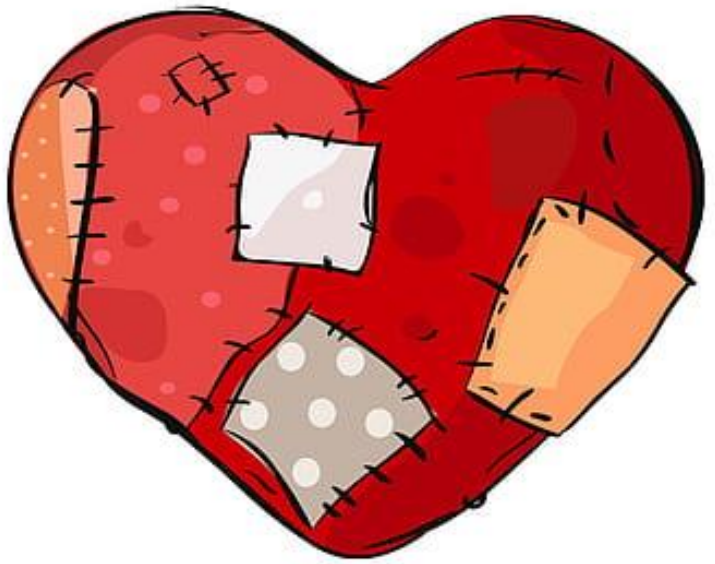
The patient is a beautiful little 2 ½ year old boy born at Women and Infant's Hospital at 38 weeks as a first child to his 24-year-old mother. Mom received routine prenatal care. He went home with mom and dad with a diagnosis of jaundice and the need for repeat bilirubin test.

HISTORY OF PRESENT ILLNESS

- In September 2021, child developed a left neck mass that mom stated was present for 2 weeks. He was initially brought to a local hospital near his home and diagnosed with acute parotitis, prescribed Augmentin and sent home.
- When neck mass was not decreasing and child developed dysphagia and fevers, mom brought him back to hospital.
- Mother admitted that child would not take the antibiotic and then mom dropped the almost full bottle. Mom did not report this to PCP.
- Pt was transferred to Hasbro Children's Hospital and evaluation showed that patient was lethargic and had a large left neck mass that was firm and erythematous with deep red/purple discoloration. After I+D, he was diagnosed with superinfected venolymphatic infection. Wound culture grew MSSA. He was hospitalized and treated with IV antibiotics.

PRESENT ILLNESS CONTINUED

- Mom did spend time in hospital with the patient. Of significance, RN caring for child in hospital noted that child was always in soiled diapers when she checked on family. All care provided by RN who was unable to successfully have mom engage in any care to the patient and mom was not receptive to nurse's requests to change pt, perform hygiene or remove him from crib while eating.
- Patient was discharged home after mom performed one dressing change.
- Hospital report was called in to NCM who requested that VNA services be brought into home.



PRESENT ILLNESS CONTINUED

- NCM called mother the day after discharge and reviewed medications and dressing changes. Mom had not picked up antibiotic. Needed to wait to borrow car first. Medication picked up next day.
- NCM reviewed follow up visits with ID and ENT. Appointments were made on day that grandmother could transport the patient and his mom.
- Mother No Showed 1st ENT visit. Stated she couldn't find the building. ENT put in call to DCYF.

PAST MEDICAL HISTORY

- Plagiocephaly
- Failed newborn hearing test

COMPLIANT TO TREATMENT REGIMENS

- Child failed newborn hearing screen done at Women and Infants Hospital.
- Rescheduled 4 times.
- Presently scheduled for 12/23/2021
- DCYF involved due to numerous No-Show appointments and continued failure to obtain repeat hearing test. When Dad was involved in care, he worked during day and could not accept calls at work. Even with DCYF involvement, visits were scattered. Transportation often the problem.
- Education was given to both parents regarding the reasons for continued preventative visits and immunizations.

FAMILY HISTORY

- Mother diagnosed with asthma, depression, tobacco dependence, being overweight and GERD
- Father diagnosed with cardiac disorder (abnormal EKG with no follow-up)
- Mother with history of domestic and mental abuse by patient's father

LIFE AT HOME (SOCIAL HISTORY)

After his birth, patient went home to live in a multigeneration home. His Dad was initially involved in his care but has now been out of his life for over a year.

Presently, he lives with his mother, 2-month-old brother, maternal grandmother, 25-year-old maternal aunt, the aunt's 4-yr-old daughter, and 17-year-old maternal aunt.

Mom is single, unemployed and is a tobacco smoker and sometimes recreational marijuana user.

Grandmother tries to help daughter with transportation since she has a car but is only available for short periods on Thursdays.

Good nutrition is a problem since the patient is often seen eating candy at breakfast by VNA nurse. Receives SNAP/WIC.

Cat in home often urinates on the patient's clothes so he is often only in a diaper.

Mom has legal issues

MEDICATIONS

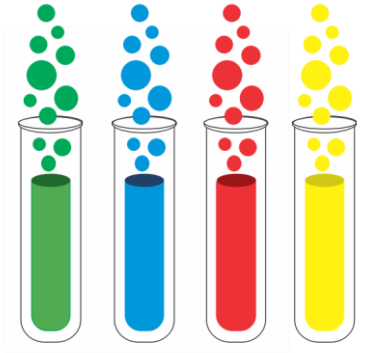
- Keflex Liquid 250 mg liquid suspension was prescribed post discharge three times a day.
- VNA nurse reported to NCM that there were 3 unopened bottles of Keflex in the refrigerator. This NCM and VNA nurse educated mom on why this medication is so important for patient's healing process.
- Miconazole topical 2% cream diaper rash
- Mom has no copays for his medications.
- Again, transportation can be an issue and reviewed with mom that all medications can be delivered to her home from her pharmacy.

OBJECTIVE OBSERVATIONS

- NCM has only spoken on the phone with the patient's mother.
- When speaking with her, she usually sounds very tired. She is always holding newborn who can be heard crying during the call. Closed ended questions do not support the best way to obtain information. Mom tends to say yes to all questions, so will use open-ended as much as possible.
- There have not been any family meetings yet.

LAB DATA AND IMAGING

1. **C-reactive protein** is now decreasing since post hospital discharge
   - Initial was 58.32 and current is 10
2. **Wound culture** of neck abscess
   - Staphylococcus aureus (MSSA)
3. **WBC**
   - Only obtained once at beginning of hospitalization and was 19.1



CT : Neck and soft tissue

- Complex mixed cystic and solid lesion noted in the left neck. Diminutive IJ seen on that side with small collateral vessels including a vessel coursing centrally through the fluid portion of the lesion. The diagnosis is a superinfected venolymphatic malformation.

Lead level at 11 months=2

Non-compliant with 2nd lead test

ASSESSMENT (MATTERS FOR CONSIDERATION)

- NCM was notified that the patient and his family when the new sibling (3-month-old brother) had No Showed his appointments. Prior to June 2021, our Pediatric department did not have a Pediatric NCM.
- NCM did case review of the patient and red flag first noted when child did not show up for 1st Newborn visit and did not go for repeat bilirubin test. Family did not call to let PCP know that there was an issue. Ultimately, the patient had blood work done once THC sent an Uber.
- Repeat hearing test never completed. Of note, newborn also failed hearing test and initially noncompliant with f/u.
- Many No Shows—DCYF contacted at 6 months of age related to No Shows and noncompliance with scheduling hearing test. Test still not rescheduled even with DCYF involvement. Continued issues with transportation despite offering visits in evening to accommodate father when he was still involved.

BARRIERS AND GAPS IN CARE

- No NCM in place until June 2021
- Missing recommended preventive care services and post hospital visits
- No coordination of care between outside services (in this case, DCYF) and the PCP
- Transportation barrier
- Lack of basic parenting knowledge
- Question if mother has bonding issues with the patient
- Question cognitive issues with mother

COLLABORATION WITH MEDICAL NEIGHBORHOOD

- NCM spoke with **HCH discharge planner** before the patient was sent home. Reviewed the addition of VNA services for wound care, medication compliance and future appointments.
- Communication with **VNA nurse**. Based on her recommendations, home visits increased to daily visits. She was able to have a visual of home life that is missing in a clinical setting.
- Home delivery for **medications for the future.**
- Due to conditions in home, NCM collaborated with **DCYF** to have **FCCP involvement**.
- FCCP worker is in tune to home life and is scheduling transportation for visits.
- Phone calls from mother through **Call Center** are now handled as a warm transfer to NCM. Mom has also been given NCM's phone extension.

PLAN OF CARE AND PATIENT EDUCATION (SHORT TERM)

During the **immediate** hospital discharge setting, the goals were to monitor the following regarding his impaired skin integrity related to neck wound:

- Worse redness, swelling, warmth, bleeding, or drainage at the wound area. Worse or uncontrolled pain. Acting more and more upset or agitated. A new fever higher than a 101. Increased diarrhea or bloody stools. Not drinking. Decrease in wet diapers.
- Any difficulty with wound care process
- Sent home with detailed instructions regarding dressing changes, follow-up and red flags.
- NCM made daily calls to mom and check-ins with VNA nurse regarding wound care and medication.

PLAN OF CARE AND PATIENT EDUCATION (LONG RANGE)

While the immediate danger precipitated by the patient's neck mass has resolved, there are multiple concerns that remain in the family.

- **Lack of knowledge about child's health maintenance**
  - Reminder calls for health maintenance and immunization visits and specialist visits
  - Need to continue to appraise mom's resources and availability of social support systems and financial support.
  - Set up transportation until mom has reliable vehicle
- **Impaired parenting as evidenced by hospital documentation and VNA witness.**
  - Need to foster acquisition of positive parenting skills.
  - Need to encourage mom to seek information and resources that increase her knowledge of emotional and physical development of the child.
  - Assess maternal depression, perceptions of difficult temperament in toddler, and low maternal self-efficacy.

FCCP is in the home and NCM to stay connected with worker and family on a weekly basis.

THANK YOU!

Questions?

Capstone: Gabrielle Koussa

Amplified Musculoskeletal Pain Syndrome(AMPS)

Patient History

- The patient is a 12 year old female with a medical history of AMPS, POTS, anxiety, depression, celiac disease, eczema and multiple allergies.
- Her current medications include: Escitalopram, Gabapentin, Melatonin, Meloxicam, EpiPen, Cetirizine, Flonase, Azelastine nasal spray, Triamcinolone, Famotidine, Vitamin D, and a Multivitamin with iron

Patient Presentation

- Support system: family and friends
- Socioeconomic status: lives with two siblings and both parents. Both parents have a college or graduate degree, no house or food insecurity, parents' employment status is satisfactory
- Life style: Likes to read, into fashion and design. Isolates when feeling sad/in pain-will read or play games on iPad/Computer. In some after school programs

Pertinent History

- Compliance to Treatment Regime: Good
- Recent Acute Episodes: Recently feeling more sad-
  - will be moving to New Hampshire
  - unable to find a good fit for Psychiatrist
  - death of grandmother

Barriers to Care

- Insurance Company- In the past, the patient had a good rapport with a Psychiatrist through the Hasbro Pain Clinic, Dr. Sandhu. Dr. Sandhu then moved to CT Children's Hospital and Hasbro's Pain Clinic shut down. Insurance initially would not approve Dr. Sandhu due to being in Connecticut.
- Gaps in Care: Unable to find a Psychiatrist that insurance will cover who is skilled in dealing with anxiety and depression related to AMPS and who the patient can connect with
  - Pain clinic no longer in RI, BCH was not a good fit for her

Barriers to Care cont.

- Driver of the case: Insurance company
- Medical Neighborhood Needs: Primary Care Provider, Nurse Care Manager, CT Children's Hospital, Insurance company, and mom

Plan to Address Concerns:

- Follow up calls
- Open communication with mom and CT Children’s
- Communicating needs
- Asking for an appeal to the insurance denial

Plan of Care: Patient Education
3 signs/symptoms patient should report to PCP/CM ASAP:

- 1. Worsening depression
- 2. Worsening pain
- 3. Signs/symptoms of POTS not improving with techniques

Immediate Plan of Care

- Appeal insurance denial
- Work on getting in with Fit Teen- CBT, PT and OT each for 16 weeks for 14 months. Geared towards kids with AMPs. all virtual, run through Cincinnati hospital

Long Term Plan of Care

- Pain management
- Decreasing anxiety and depression

Conclusion

- Letter to insurance company to appeal their denial was sent, overturned and approved for 4 visits with Dr. Sandhu!
- Hopefully after those 4 visits are complete, she will be able to join FIT TEEN in February which will offer CBT. After FIT TEEN no CBT allowed for 3 months after completion of program so have time to work with insurance for more visit approvals.

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Thank you
Stay Healthy and Safe

NEXT MEETING: FEBRUARY 15, 2022