Selected MiPCT Care Manager Stories

March 2016

Stories of Your Care Management Success, featuring Jennifer Train, St. John Providence Partners in Care

Northpointe Pediatrics was looking to ensure adequate and appropriate follow-up for newly diagnosed ADD/ADHD patients. This was due in part to HEDIS measures requiring that patients be seen within 30 days after “index prescription start date,” and then again two more times in the following 270 day period. Initially, there was difficulty establishing a way to identify those who were newly diagnosed. One idea that the office tried was to make a master list of patients with the diagnosis of ADD or ADHD then compare a new registry search on a monthly basis for new names. This proved time consuming and inaccurate. The office tried a few different ways to keep an accurate account of newly diagnosed patients but nothing proved very helpful or time effective. Initial trials were not successful. Subsequently, our physician had an idea, which we implemented:

To help ensure that we were tracking and following-up with our newly diagnosed ADD/ADHD patients, physician champion, Dr. Engel, created an internal ICD 10 code. Providers in the office would use this code along with the pertinent ICD 10 code for ADD/ADHD on the “index prescription start date”. This new code allowed the gaps in care coordinator along with the care manager to utilize the electronic registry to track patients who were newly diagnosed with ADD or ADHD. Once the list was generated it was easy to ensure adequate follow-up was taking place. In addition, the care manager and gaps in care coordinator now had the ability to check on those patients monthly who had been started on medication in the past nine months and ensure that they were being followed closely and met the HEDIS measure. *NPO NOTE: There are likely easier solutions to identify patients but this story was included as an example of CM for ADD/ADHD*

The change the practice made has led to an increase in medication compliance as well as follow up needed for those patients with ADD/ADHD. In addition, we have been able to identify those patients who have been non-adherent due to side effects of medication, difficulty obtaining those medications and those not progressing well on their new medication regimen. As a result of this, our gaps in care coordinator created a spreadsheet of newly diagnosed patients designated by month. Those patients are then checked to ensure they have follow up appointments scheduled. If patients do not have a current appointment scheduled or have expressed concerns regarding medication, side effects, or other areas of concern she then forwards that information to the care management team or the provider for further follow up as needed.

Jan 2016

Stories of Your Team -Based Success: *Improving Care for Patients with Asthma Integrated Health Partners, Cereal City Pediatrics/Moazami Pediatrics, Dee Dailey, Practice Coach*

Cereal City Pediatrics and Moazami Pediatrics wished to increase staff awareness of asthma as a means of improving patient care for patients who have asthma. The practice identified the need for precise, accurate, and informative

training for existing and new staff. They sought to have training that would address the topics of allergy injections, respiratory distress symptoms, telephone triage, and spirometry use.

The practices made the decision to implement changes to their training program. The PO Leader, PCP, MiPCT Care Manager, and Office Support Staff worked together to ensure the success of their new program. An asthma educator conducted an in-service training with the entire office, including front office staff. An asthma allergy center provided training on injections. Additionally, physicians conducted an in-service with the nursing staff on the topic of identifying respiratory distress.

Many improvements were recognized as a result of this change in training. Content from the training topics was included in new employee orientation. Staff now receives annual training, which was developed during the new training program. Patient asthma education folders were created and are given to newly diagnosed asthma patients.

Individual care management education sessions are conducted to teach patients how to use a spacer, inhaler, or nebulizer. Refill requests are monitored to assess for medication adherence. Annual well visits with an asthma action plan are required for all medication refills and school notes for medication usage for patients with asthma. Priority calls are placed to patients with asthma when flu vaccines arrive, along with other high-risk patients, before reminder calls are made for healthy patients.

Standard tools and processes were also developed. A cough protocol and algorithm for the front desk and triage staff were created to screen phone calls and prioritize appointments. The office purchased a spirometer and had the vendor develop tools and conduct training. Asthma patients are tracked and flagged in our EMR and gaps in care reports to ensure that services are provided.

Implementing a designated Asthma Champion had a significant impact. Metrics were collected that demonstrated the success of this team-based improvement program.

Sept 2015

Stories of Your Team-Based Success: Mercy Physician Community PHO LLC

Mercy Physician Community PHO LLC has taken a step forward in not only recognizing diabetic gaps in care for their patient population, but identifying unique patient barriers contributing to these gaps. Mercy Physician Community was then able to create a workflow for their team, closing gaps and improving patient care.

Mercy Physician Community is located in a rural area, over thirty miles from the nearest Endocrinologist office or Diabetic Educational Center. This rural location contributed to patient non-adherence to treatment plans, often due to transportation difficulties or life schedules not conducive to multiple face to face visits. A unique workflow was created.

Uncontrolled diabetic patients were identified and referred to Care Management services by the PCP for a 4-12 week program to improve blood sugars and A1C levels. Patients were advised up front by office staff that frequent visits or phone calls would be short term to jump start diabetic control. Visits were then set up on a weekly or bi-weekly basis dependent on the patients' circumstances; telephonic visits were made in between the face to face visits that were scheduled further apart. The team felt that this schedule increased patient compliance and attendance to visits.

The Care Team then assessed and identified the patients' barriers to blood glucose control and their current methods of self-management. Beginning needs were addressed to ensure that the patients had the right tools to manage their condition. This included a working glucometer, testing supplies, and a log book. Depending on patient needs coordination of a new testing kit and/or supplies through either mail-order their local pharmacy was completed. Also evaluated, was the patients knowledge of their condition, including how often and best times of day to check blood sugar, target ranges and action plans.

An individualized care plan was created for each patient to include SMART goals, follow up time frames and method of future visits. Follow up visits included reviewing blood sugar logs, food logs, use of medication/insulin, any patterns in blood sugar levels, and all pertinent changes since last visit. The care team, including the patients' PCP and office staff, met to determine any needed changes. New medications or changes in medication was completed by the PCP. The office staff scanned any logs into EMR as well as making any needed changes to the patients' medical record.

During the program, the care team and PCP continuously explained any changes to the patients' plan of care, along with continued brief education in areas that were contributing to their blood sugar patterns. Education included stress management activities, exercise, changes in medications, illness, and diet. SMART goals and the plan of care were updated at each patient visit as well as each team meeting.

Throughout the program, patients started to feel better and see improvement in their blood sugar. They became more open to additional care of their diabetes that had been challenging to address in the past. The practice as a whole saw increased patient compliance, routine follow up visits, and eventual openness to attending a Diabetic education program in the future. Gaps in measures such as eye exams, A1C testing, podiatry visits, even wearing diabetic shoes were readdressed and referrals were completed successfully. Patients became increasingly compliant with their medications/insulin and were less likely to let them run out. As the patients' confidence grew with managing their diabetes, they became more comfortable with keeping regular PCP visits due to the pride in their achievements. The benefit of patients with diabetes having regularly scheduled visits with their PCP includes proactively addressing risk factors. This has the potential to improve patients' overall health status.

July 2015

Stories of Your Care Management Success, featuring Carrie Jacobson, RN, HCM: OPNS – Waterford Family Physicians

"James" is a patient with a history of chronic obstructive pulmonary disease, congestive heart failure, and diabetes. James had numerous hospitalizations and emergency room visits for exacerbations of his uncontrolled chronic conditions. In 2013 James was one of the top three Medicare utilizers at the practice, with 9 inpatient hospitalizations and frequent ED visits. James was referred to the care management team by Dr. Woelke for assistance with addressing his chronic conditions and reducing unnecessary hospitalizations and ED visits.

After reviewing James' chart as well as hospitalization records, the care manager found that James had a history of drug and alcohol abuse, was overweight, non-compliant with taking his medications, and was not monitoring his diet or weight. James was enrolled in care management services in March, 2013.

The initial care management assessment presented a look into James' difficulties and thought process surrounding his health. James felt that going to the hospital was cheaper and easier for him because he did not have a co-pay, and was able to be taken care of quickly. James was not taking his medications as prescribed. Upon assessment of his readiness, he was not inclined to address these issues. The initial visit with James was spent addressing major stressors in his life and how to monitor for CHF exacerbations.

James' longterm goal was to stay out of the hospital for 2 months. Throughout James' visits, education was provided about congestive heart failure. Initially goals were designed for James to monitor daily weights by keeping a log. Although James was not ready to change eating habits or medication adherence, a small goal was set to start watching his sodium intake.

Over the first year, many resources were used with the assistance of a home health agency. The in-home services provided to James included additional teaching and monitoring by registered nurses, home visits by a dietitian, as well as a social worker to help with James' financial difficulties, including appropriate housing as he was also going through a divorce.

James was not receptive to a complete lifestyle change; however, working with the care manager as well as the home health care staff assisted James in improving his understanding about congestive heart failure. One year after starting care management services, James became increasingly receptive to changing some of his habits. In June 2014, the patient agreed to weekly phone calls to check status of weight, blood pressure and blood sugar to monitor for fluctuations more closely and catch exacerbations early.

Since June of 2014, James has not had any hospital admissions or emergency room visits. His weight is well maintained and he quickly contacts his care manager with any changes in his weight or breathing. During this time his care manager helped make adjustments in collaboration with his PCP. James is very pleased and excited about the fact that he has been

out of the hospital for this length of time, never thinking this would have been possible. As a result of care management services, James' overall health has improved.

Feb 2015

Stories of Your Care Management Success, Featuring Lisa Foley, MSN, MHA, RN, Internal Medicine Columbus Center, Henry Ford Health System

The patient, "Sarah," was identified by the daily MiPCT appointment list. She was a 43 year school teacher with the diagnosis of diabetes, hypertension, and obesity. Upon review of her medical record it was noted that her last primary care appointment was 2 years ago, her last appointment with endocrinology was 3 years prior to her PCP visit, and her last appointment with gynecology was 5 years prior to this PCP appointment. At her PCP appointment 2 years ago, her A1C result was 13.5. At the appointment, Sarah stated she was not taking her medications as prescribed, nor was she checking her blood sugars. In addition, she admitted that she did not eat healthy or exercise.

The care manager discussed the case with the PCP, who agreed that care management may benefit the patient, but thought the patient may not be receptive to care management since the patient was in denial about her disease process. The care manager did meet with the patient, and during the meeting the care manager identified some of the patient's barriers. The greatest barrier was the patient's bad experience and fear of reoccurrence of Hodgkin's lymphoma which she had as a teenager. Other barriers included lack of time and energy.

The patient was a busy school teacher and took everyone else's needs first before her own. She had a sick, elderly mother. The patient had no idea what her blood sugar levels were since she had not been testing her blood sugar.

After meeting with the patient, the care manager offered to assist Sarah in learning how to self-manage her condition. The patient agreed to care management and established goals to be healthier, make time for herself, check her blood sugars daily, and take her medications as prescribed. In addition, the patient agreed to an appointment with the Diabetes Care Center and endocrinologist.

The labs drawn at the visit with the PCP showed a HgA1C of 11.5 and Hgb of 7.5. Sarah was referred to the Emergency Department for a blood transfusion for the low hemoglobin. Sarah was reluctant to go for the transfusion and ultimately refused to have the transfusion.

A work-up was planned to determine the source of the low hemoglobin. There were referrals to hematology, gastroenterology and gynecology. Hematology placed her on an iron supplement and found no cause for the low hemoglobin. The gynecologist could not find a cause for the low hemoglobin either. The gastroenterologist did find a cancerous polyp and after two surgeries, the patient was cleared of cancer.

Over the course of seven months, the care manager had several face-to-face and telephone encounters with Sarah. The outreach consisted of motivational interviewing, empathic listening, support and education on self-management of her diabetes and hypertension. Sarah did require encouragement to keep her appointments and continue with the plan of care.

Seven months after Sarah became engaged with care management, Sarah met her goals. She is checking her blood sugars daily, taking her medications as ordered, eating healthier and attending the Diabetes Care Center for further understanding of her diabetes. In addition, she was cancer free. Her lab values at the seven month interval were HgA1C of 7.5 and Hgb of 12.0.

Through care management the patient was encouraged to follow through on the work-up for her low hemoglobin which uncovered a potentially life-threatening new diagnosis. In addition, the care management assisted the patient with taking control of her diabetes.

The PCP, commented, "Care management was able to get this patient to do things that I have been not been able to do in years. The patient had a long standing history of diabetes and was in denial of her disease for years. It was very difficult for this patient to follow-up and see the specialist. Through care management we were able to uncover a potentially life-threatening new diagnosis, and the patient is managing her diabetes for the first time in years. I would recommend care management to all my patients."

The patient stated, "Lisa was able to explain things to me in a way that I could understand, and she allowed me to do things at my own pace."

Jan 2015

Stories of Your Care Management Success, Featuring Anitra Pressley, RN, BSN, Detroit Internal Medicine, K-15, Henry Ford Health System, Medicaid Success Story

"Pearl" is a 51 year old female with Medicaid insurance who was discharged from the hospital in May 2014, for acute congestive heart failure. She was identified on the daily MiPCT hospital discharge list and referred by her PCP to the MiPCT Care Manager. Her history included sleep apnea, diabetes type II, morbid obesity, chronic kidney disease and anemia. She has had multiple admissions for fluid overload. Pearl's weight when the case was opened was 313 lbs. She had a distended abdomen and pitting edema in her lower extremities. She complained of shortness of breath during the day even during rest. Pearl voiced discontentment with her condition and lack of faith in her medical team.

Pearl appeared to looking for someone to listen to her. She was very receptive to learning how she could make changes in her lifestyle. She shared with the care manager her sister recently died from cardiomegaly and felt it was possible she could die from heart disease as well.

The MiPCT care manager collaborated with the PCP and worked very hard to develop a trusting relationship with Pearl and calm her fears. Pearl's plan of care included a referral to the Advanced Heart Failure Clinic, telehealth electronic in-home monitoring, home care and diagnostic cardiac catheterization. Until the patient had trust in the care manager, Pearl was reluctant to allow these services. Once the trust was established she agreed to the work up.

After the initial home care and telehealth visits, Pearl saw the benefits and was pleased with the services. Even though she agreed to the cardiac catheterization, she was very nervous. The care manager, along with the cardiology nurse, worked together to describe the procedure in detail and answer any questions Pearl had regarding the procedure. Following the cardiac catheterization Pearl was so pleased the study did not reveal an aortic valve stenosis.

Since May 2014, Pearl has lost 33 lbs. and has not been seen in the Emergency Department for her congestive heart failure. She adheres to a cardiac diet with fluid restriction. At her PCP visit in July 2014 her blood pressure was 124/72 controlled on medications. It was also noted she did not have a distended abdomen or peripheral edema. Pearl stated she felt so much better with the care manager calling her to work with her on her health issues, and as a result she now communicates more effectively with her providers on any concerns. Pearl's shared transportation had been a barrier to her maintaining appointments. However, her sister gave her a van and the transportation is no longer an issue.

Pearl's long term self-management goals include; maintaining a healthy lifestyle, exercising 30 minutes per day, and adhering to a cardiac/fluid restriction diet. She also plans on keeping her scheduled specialty appointments and maintaining communication with providers when she has concerns. Pearl's statement to her MiPCT care manager was, "I could not have done it without you."

The PCP stated, "Thanks for your diligence, Anitra. This patient illustrates the invaluable role care managers play in the patient-centered team care model. Just as it takes a 'whole village' to raise a child, a patient's health and overall well-being is dependent of the entire healthcare team coordinating their efforts to bring about a good outcome."

Dec 2014

Stories of Your Care Management Success, Featuring Anita Tuneff, Moderate Care Manager, IHA, IHA-Milan Family Medicine

A Medicare patient LS was originally enrolled in MiPCT Complex Care Management 4/1/13 following a hospital admission for Metabolic Encephalopathy. Although LS developed a good relationship with a Complex Care Manager she did not seem to understand the importance of better blood sugar control. Her A1c was 13.2 and she was not ready to make any life style changes.

LS was transferred from the MiPCT Complex Care Manager to Anita, a moderate care manager for Diabetes self-management. LS was always friendly, but very indifferent when discussing changes to improve her health. She was

repeatedly “too busy” and was not eating meals or taking her medications regularly. The patient eventually stopped responding to Anita’s calls and the case was closed to care management on 12/12/13.

On 5/20/14 LS was re-enrolled in care management by Anita with an A1c of 16.0 after a referral from her PCP. The patient was very friendly and willing to engage with Anita, but did not seem motivated to make healthy changes. LS did not understand the implications of elevated blood sugars, and shared she was “very busy”. She expressed she did not always like to come to the PCP office, because she felt her PCP “yelled at her”, even though her PCP was always very gentle in her discussions regarding the importance of better blood sugar control.

The patient’s medical record indicated that LS should be checking her blood sugar four times a day, taking insulin with meals and additional oral diabetic medications. LS freely admitted she was not following any of her PCP’s orders.

On 5/23/14 LS was admitted to the hospital for confusion, CVA, and uncontrolled DM. This hospitalization was the turning point for the patient. She finally realized her uncontrolled blood sugars had major implications on her health.

Once LS was discharged from the hospital her family became involved in her care. With coaching from Anita the patient’s daughter began helping her with meal planning and regularly scheduled meals. Her husband began to support LS also.

The care manager continued to provide diabetic education and LS soon realized she could control her blood sugars if she followed a diabetic diet and took her medications regularly. LS followed up with her Endocrinologist and medication adjustments were made.

Anita continued to provide LS with regular visits to answer questions, help coordinate care, and continue to provide education on Diabetes and A1c results. Anita provided educational materials which included, medication information, patient resources, information about hyper and hypoglycemia, meal planning, and managing sick days. Anita provided ongoing support and congratulated her on the improvements she was making.

Today the patient’s A1C is 6.1. She is administering her insulin as ordered. Due to her controlled blood sugar LS has decreased the amount of blood sugar checks from four times a day to twice a day.

LS continues to actively manage her health as evidenced by her Ophthalmologist visit, controlled BP, and maintenance of a log where she records her blood sugars and blood pressures which she brings to every PCP appointment. Since LS has been successful in controlling her blood sugar, she now feels empowered and motivated to reach another health goal of losing five pounds in the next month.

As the patient’s health status stabilized Anita provided a contact person in the office other than herself who could answer patient questions knowing the care manager was always available as a resource if needed. Anita focused on the things LS was doing and not on the things she was not doing. The care manager’s consistent interventions and supportive

relationship made LS more willing to contact the office and accept PCP and practice team care management. As a result, the patient's overall health has improved and she is now able to manage her health.

Nov 2014

Stories of Your Care Management Success

- **Becki Strawderman,** RN, HCM, Otsego Memorial Group, CIPA, and
- **Lori Lynn,** RN, HCM, Cherry Street, CIPA

Becki, a MiPCT HCM, was contacted to assist in care coordination of a Medicare patient who lived in Lewiston and had been treated at Otsego Memorial Hospital (OMH) after sustaining several fractured ribs, pneumothorax, and leg injury from a fall off a ladder. The 65 y/o patient had spent 9 days in OMH when he was discharged and released to the care of his family (brother and sister-in-law) in Grand Rapids, four hours from his home in Lewiston. During his convalescence with his family in Grand Rapids, MI he developed complications, which included bilateral pulmonary embolisms, a pleural effusion, bilateral deep vein thrombus and urinary retention. After an eight day inpatient stay in a Grand Rapids hospital the patient was released again to his family living in Grand Rapids to convalesce. He suffered further complications, and again had to be readmitted for sepsis and bilateral pleural effusion. The patient had spent 29 days out of 37 days in the hospital.

It was evident that the patient's health was too fragile for him to return to his home in Lewiston, MI. Therefore, a discharge plan inclusive of follow-up care in Grand Rapids would require additional care coordination as the patient's primary care provider was located four hours away. The patient was discharged from the hospital and follow up care arranged at a MiPCT practice, Cherry Street, in Grand Rapids. Becki contacted Lori, the HCM at the Cherry Street practice and provided a care update to help facilitate a comprehensive post-hospital transition.

Lori and the practice team from Cherry Street collaborated with Becki from the Otsego Memorial Group while providing transition of care follow-up, and at the Cherry Street Practice in Grand Rapids, while the patient convalesced with his family.

Two months after his last discharge from the Grand Rapids hospital the patient was well enough to return to his home in Lewiston. The Cherry Street team provided the patient copies of his medical record in lieu of mailing it to his primary care physician. This was done in case the patient had to stop on his return to Lewiston for any needed care.

Becki was grateful for the coordination of care provided by the Cherry Street practice team. In turn, Lori and the practice team were proud of the patient's favorable outcome and thankful for the patient's uneventful trip home to Lewiston, MI.

Oct 2014

Stories of Your Care Management Success

Karen McWilliams, RN, HCM, Lakeshore Medical Center-Shelby, Lakeshore Health Network

Karen McWilliams, RN, is a Hybrid Care Manager at Lakeshore Medical Center-Shelby within Lakeshore Health Network. Karen was working with a patient covered by BCBSM insurance. He is a 67 year old male with Benign Prostatic Hypertrophy (BPH), Hypertension (HTN), Gout, and Hypercholesterolemia. The patient's Prostate-Specific Antigen (PSA) was being monitored and took a sudden jump in July of 2013. He consulted with an Urologist in Muskegon and had surgery for Prostate cancer in July of 2013. Following his discharge he received a call from Karen.

He accepted care manager services the first month after his surgery. Within a couple of weeks of surgery he developed some complications. These included elevated blood pressure, anxiety, depression, development of a fistula, and urinary catheter. The fistula resulted in further surgeries including a colostomy and subsequent reverse colostomy. He continued with care management during this time. He and his wife describe care management as their "lifeline".

Karen was able to help coordinate services with the urologist in Muskegon, Gastroenterologist in Grand Rapids, Cardiologist in Lansing, home care nurses and ostomy nurse. She coordinated lab work and preoperative procedures, performed medication reconciliation after each procedure, confirmed discharge orders after each procedure, and encouraged healthy behaviors to promote optimal healing. Karen even assisted the patient in preparing to go hunting safely with his urinary catheter and colostomy. He was able to take numerous trips to the other side of the state to his cottage because as he stated, "I have my connection with my care manager [Karen] if I need anything".

His surgical incisions healed without complications and his chronic conditions remained stable throughout his recovery. Blood Pressure stabilization and a healthy diet promoted optimal healing. His depression and anxiety improved with treatment. Ultimately, his colostomy was reversed and is now well healed. On February 13, 2014 Karen and the patient met face to face for the first time when his PCP gave him the good news that his labs showed his PSA was <0.01.

Sept 2014

Stories of Your Care Management Success: Pam Szymanski, RN, CM, Domino Farms Family Medicine, Dexter Family Medicine, UMHS

Pam Szymanski, RN is a MiPCT Complex Care Navigator at Domino Farms Family Medicine and Dexter Family Medicine within the University of Michigan Health System. Pam was working with a patient covered by Medicare insurance. Mr. L was referred to Pam by the patient's PCP for frequent hospitalizations. His diagnosis included CHF, COPD, OSA (on BiPAP-

bi-level pressure airway device), CRI Obesity, and Pulmonary HTN. Mr. L. receives specialty services from Pulmonary and the Neurology sleep clinic. In a three month period Mr. L was hospitalized three times for CHF and/or COPD exacerbations.

Mr. L was obese and not using his BiPAP at bedtime. Pam discussed with him the importance of using the BiPAP at bedtime and assessed his understanding of this intervention and any barriers that may be preventing him from complying. His complaint was that he would fall asleep with the BiPAP on, but the forced air through the BiPAP woke him up at night. He also was waiting from the Medical Supply Company to deliver the ASV (automatic Servo ventilation) attachment for the BiPAP.

Pam contacted Mr. L's pulmonologist and neurologist (who ordered the ASV) with a patient update. Both physicians were aware that Mr. L was not using the BiPAP as he should and he really needed the ASV attachment. Mr. L insisted that the 2-4 liters of oxygen via nasal cannula at bedtime was keeping his oxygen saturations in the 90's while he slept. To confirm the patient's sleeping oxygen saturation level Pam requested an order for an overnight saturation study to be done. The study revealed that Mr. L's oxygen saturations dropped in the low 80's several times during the night.

Mr. L and Pam began discussions related to the correlation of weight loss related to less strain on his heart and improved respiratory status. He agreed with a plan to lose weight and brought his wife with him to an appointment so she could support a change in diet and physical activity.

Pam educated Mr. L regarding the importance of calling her or the office with any change in symptoms so treatment could be initiated early and hospitalization avoided. Mr. L. voiced agreement as he too wanted to avoid further hospitalizations.

Mr. L lost weight and experienced less respiratory difficulty. His blood gases improved, walking distance improved and he is able to work at his hobby of woodworking in his garage. In following up with Mr. L. she learned he had not received the ASV attachment from the Medical Supply Company. Pam contacted the company again and learned Mr. L needed further testing to get the ASV attachment approved for the BiPAP machine. A blood gas with 2 liters of oxygen was ordered and the results of this test were within the range needed for the ASV approval.

Mr. L received the ASV attachment; however, he was not using the BiPAP machine consistently as ordered. Pam continued to educate and encourage Mr. L. to use the BiPAP machine every night. She made several contacts to the pulmonologist and neurologist who both discussed the importance of using the BiPAP with Mr. L at each of his scheduled appointments. Pam arranged two mask fitting appointments with the Medical Supply Company to address any issues Mr. L experienced with mask fit to improve his use of the BiPAP machine. Mr. L shared with Pam that he was able to do more and feeling much better. He continued to question if BiPAP was necessary for him.

During a subsequent follow up appointment with his PCP, pulmonologist, and neurologist, all three physicians agreed to have the BiPAP machine removed from the home. Although it was anticipated that Mr. L would be relieved, instead he said he would like to keep the BiPAP machine and try to get used to using it every night.

Since receiving MiPCT care management services Mr. L has lost weight, become more active and he has not been hospitalized. During phone visits with Pam he shares how frequently he is using the BiPAP machine and his blood gas results have improved.

Pam continues to support Mr. L as he continues to work on his goal of losing more weight by making healthy food choices and increasing his physical activity. She provides praise and encouragement for his healthy choices.

June 2014

Stories of Your Care Management Success:

Lynn Czech RN, BSN, MiPCT Hybrid Care Manager, Henry Ford – Sterling Heights Pediatrics

Lynn Czech, RN, BSN is a MiPCT Hybrid Care Manager at Henry Ford Sterling Heights Pediatrics within Henry Ford Health System. “Juan”, age 12, was a Medicaid insured patient identified on the daily emergency department discharge list by Lynn as someone who might benefit from MiPCT care management services. Lynn conducted a transition of care call. During their first conversation, Juan’s mother reported that Juan was playing in his first basketball game of the season when he jumped to take a shot. As he came down he twisted and “fell into a heap” on the court. Juan was unable to sit up and was in extreme pain. He was taken to the emergency department by his mother. X-rays confirmed bilateral fractures to the growth plates of both tibias, and Juan was transferred to Children’s Hospital of Michigan for further management. Fortunately, he did not require surgery. He was placed in bilateral knee braces, given crutches and discharged home with no weight bearing for 6 weeks. Juan’s mother stated to Lynn, “I can’t believe this is happening”. She seemed overwhelmed by the situation and unsure of what to do.

Arrangements were made for DME equipment including a shower chair, elevated toilet seat, wheelchair, walker, and a temporary ramp for home entry. Juan’s mother declined additional adaptive devices, stating “this is temporary.” Juan was unable to flex his knees with the immobilizers on; making it difficult for him to get in and out of a vehicle. As a result, additional arrangements were made for in-home physical and occupational therapy, as well as temporary home-schooling.

Lynn reviewed and discussed Juan’s neurologic / vascular assessment with his mother so she would be able to identify and report any problems if they occurred. Lynn also advised Juan’s mother on appropriate nutritional intake to promote tissue healing and prevent constipation due to Juan’s decreased mobility and use of pain medication.

Juan's teacher visited his home two to three times a week to review course materials and provide lessons and tests so he would not fall behind in school. However, his mother expressed that Juan was sad and feeling down because his friends would call or text occasionally, but only one or two friends visited him during his first two weeks at home. She said he missed playing basketball and seeing his friends. Since she did not know all his friends on the basketball team and at school, Lynn suggested she talk to his teacher. For the remainder of his recovery at home, they arranged for his friends to visit opposite the days his teacher came (so it would not interfere with his school lessons). Juan looked forward to these visits. His mother reported his spirits were lifted and he completed his homework quicker and worked harder in therapy.

Juan returned to the orthopedist six weeks after his injury. His leg braces were removed at that time. He was advised to continue with PT and OT twice a week for four to six weeks and to follow up with his orthopedist in three months. Gym restrictions are in place and Juan cannot participate in vigorous activity until cleared by PT.

Juan's pain had been managed by a non-steroidal anti-inflammatory drug (NSAID) for the majority of his recovery, but his mother recently reported that he had some abdominal discomfort. A change to an over the counter analgesic and antipyretic was recommended, which has been successful in eliminating his abdominal pain. Juan has returned to school without the use of assistive devices and is allowed extra time between classes due to his fatigue. His mother expressed he continues to progress toward a full recovery and stated to Lynn, "Thank you so much for helping us during this time. We would've done what we needed to do, but it was a relief knowing I had someone to call whenever we needed anything. Having his friends schedule their visits was a great suggestion. It was a big lift to his spirits and I believe helped him recover faster. You are wonderful."

Jan 2014

Elizabeth Eaton, RN, MPH
MiPCT Clinical Lead, and Care Manager,
Sparrow Medical Group-North

Elizabeth Eaton, RN, MPH is a care manager at Sparrow Medical Group-North and a MiPCT Clinical Lead. Elizabeth received a referral from Dr. Cynthia Buchweitz, MD to work with a patient, 'Wanda'. 'Wanda' is a 68 year old, married female with multiple chronic conditions. These include DM, HTN, CKD, CAD, Hyperlipdemia, Glaucoma and hypothyroidism. At the time of the referral 'Wanda's' diabetes was uncontrolled (HgA1c of 13.5 and blood sugar readings in the 300-400's). She did not have insulin because she could not afford her copays. She was not taking many of her medications because of high copays.

Elizabeth met with 'Wanda' and identified potential barriers to effective management of her chronic conditions. These included financial issues, problems navigating the medical insurance and prescription coverage environment, skipping medications and not refilling prescriptions due to copays costs, very low vision, no longer driving and relying on her

husband (who is in poor health and was recently hospitalized) to draw up and administer her insulin, not following up with the Diabetes Center and Endocrinologist as requested by her PCP and it had been seven months since her last office visit.

Elizabeth helped 'Wanda' reconnect with the Diabetes Center and Endocrinologist. She obtained sample insulin through the drug reps at the Diabetes Center. Elizabeth provided education and assisted 'Wanda' and her husband with pharmacy benefits and use of the pharmacy mail order program. Based on Elizabeth's patient assessment, referrals were requested and made to home care nurse and physical therapy as well as meals on wheels.

Elizabeth included 'Wanda's' daughter in her care as well. Initially, Elizabeth made calls to 'Wanda' daily for the first three weeks of intervention. As 'Wanda' demonstrated better self-management and control of her diabetes, Elizabeth was able to decrease the frequency of calls to weekly and then monthly.

Over the course of five months, 'Wanda's' overall condition has improved. Her HgA1c initially decreased to 8.8 in three months and is currently 8.3. She has gained physical strength and no longer requires the use of a walker or cane for ambulation. 'Wanda' is very engaged in her care. She is keeping her appointments with both her PCP and Endocrinologist, testing her blood sugars regularly and reordering her medications before they run out.

Elizabeth continues to assist 'Wanda' with medication adherence due to financial limitations, specifically the cost of insulin. 'Wanda' remains dependent on her husband to draw up and administer her insulin as well as provide transportation to her appointments because of her poor vision. Continued care management support will be needed because of these persistent potential barriers as well as the fact that 'Wanda's' daughter moving out of the area, creating a decrease in social support and available resources. Despite significant barriers to care, 'Wanda' has been able to impact the management of her diabetes because of care management interventions.