Care Manager Value Stories *Names and identifying details were changed to protect patient privacy.

NO TIME OFF FROM CHF

Scott,* a patient with congestive heart failure (CHF), returned from a vacation and was experiencing shortness of breath. He had not reported this to his doctor, but revealed it during a routine phone call with his care coordinator, who helped Scott avoid a visit to the emergency room by getting him in to see his doctor right away.

The doctor instructed Scott to take extra Lasix, a diuretic pill, in an effort to get rid of extra fluid in his body and bring his weight back down to his baseline.

The treatment worked. Scott's weight dropped, his shortness of breath went away, and he felt much better, with a lot more energy. The cause of the problem was traced to how he ate while on vacation. Like many people do when they travel, Scott embraced his time off as a chance to let go. He did not pay attention to his normal diet and not only consumed too much salt while he was away, he ate too much in general, leading to health problems upon his return.

Patient education is an important part of chronic disease management. When it comes to congestive heart failure, lifestyle changes such as losing weight, reducing sodium in your diet, managing stress and exercising can make a difference and improve your quality of life.

The care coordinator recognized this temporary setback as an opportunity for Scott to review his approach to self-care. They worked together to evaluate how Scott was managing his heart condition, discussed his diet and medications, and formed a plan for avoiding similar complications moving forward.

A CRITICAL CONFESSION

Having a trusted care coordinator in your corner can have a significant impact on a patient's health. Beth* was living with two chronic health conditions. Though she was under a doctor's care, her health was suffering, and her providers did not understand why.

After reaching out to Beth by phone and taking the time to get to know her, the care coordinator earned her patient's trust. Beth told the care coordinator that she felt like she cared about her situation. She then confided in her what she had been unable to admit to her own doctor: that she had not taken her prescribed medications, for either condition, in at least two years.

Upon hearing this confession, the care coordinator offered to partner with Beth to help her straighten out her medical situation and take back control of her health. First, she encouraged Beth to tell her doctor her current circumstances. The doctor got Beth into the office right away and immediately adjusted her medications to get her back on an appropriate drug regimen.

When a patient is unable or unwilling to comply with medication orders, there may be life-or-death consequences. In Beth's case, one of her prescriptions was blood pressure medication. Because the drug had seemed ineffective as originally prescribed, Beth's doctor had increased the dose, not realizing that the patient was ignoring instructions to take the drug. Had she started taking her blood pressure medicine at the higher strength, Beth may have put herself at risk for a stroke. Thanks to intervention by her care coordinator and help from her physician, the patient was able to get her treatment back on track.

GOING THAT EXTRA MILE

Care coordination can help a patient avoid a relapse or hospital readmission. This may be achieved by scheduling follow-up appointments, reviewing discharge instructions from a hospital or skilled nursing facility, or educating a patient about medications and self-care.

Other times, a care coordinator is most effective when advocating for a patient—helping an individual or family navigate a complex health care system, addressing barriers to care, or connecting them to community-based agencies that provide vital services.

Sam* had suffered a concussion caused by a fall. He needed to go to a specialized rehabilitation facility for outpatient concussion therapy, but was too dizzy to drive himself and did not have someone who could take him. He contacted a transportation service in his community, but because he lived outside of the designated zone, the company would not pick him up.

Sam had other health issues, and his inability to receive treatment for his dizziness was making matters worse. A social work care coordinator contacted Sam and learned the patient had fallen several more times at home. It was time to get him into therapy.

“I heard about a gentleman with his own licensed transportation service, and I contacted him on Sam’s behalf,” said the care coordinator. “He was very kind and compassionate when he learned of the situation, and his cost was less than Uber or a cab.”

The care coordinator put Sam in touch with the driver and the two worked out a schedule and rate. Sam began his concussion therapy and was delighted with his new arrangement.

REMOVING BARRIERS TO CARE

Care coordinators manage a variety of situations on behalf of their patients, including identifying and removing barriers to care. Among the more common challenges that can interfere with patient care are lack of transportation or financial concerns. Occasionally, they discover something completely unexpected.

Such was the case with Patricia,* a patient who was battling cancer but had been missing her chemotherapy sessions of late. Patti’s care coordinator was unable to determine why she was not showing up for treatments, even after speaking with her on the phone. Then the care coordinator had an idea.

“If I could magically do one thing for you, what would it be?” she asked.

“I have bed bugs,” Patti confessed.

“A lot of people do,” the care coordinator said. “How bad are they?”

“Pretty bad,” Patti answered.

It turned out that Patti was hesitant to go to chemotherapy because she was too embarrassed to risk transmitting bed bugs from her home to the facility, and she couldn’t afford to hire an exterminator.

The care coordinator made a call to a home advisor to ask if he knew of any exterminators who had done work for charity. He gave her three numbers to try. Upon hearing Patti's story, the first exterminator on the list generously agreed to donate two professional treatments to rid her house of the pests. With this obstacle removed, Patti was able to resume chemotherapy and focus once more on her health.

EMPOWERING SELF-CARE

William,* a 58-year-old male with a diagnosis of heart failure, hypertension and sleep apnea, was referred for care coordination following a two-day hospital admission. After contacting the hospital case manager, the nurse care coordinator learned that home care nurse visits and telemonitoring had not yet been set up for the patient because he planned to return to work. It was determined that William would benefit from outreach and patient education.

After multiple attempts, the care coordinator was able to reach William by phone. He was very receptive to the idea of care coordination. They began with a comprehensive assessment of his medical, work and living situations. The care coordinator learned that William had returned to his job, only to work half a day and realize he was exhausted. His goals were not only to eventually return to work, but also to get strong enough to travel the four-hour journey to visit his son and grandchildren.

His care coordinator took the time to review William's understanding of heart failure management and taught him how to monitor himself daily, how to report his findings and to whom, and what to do if he became symptomatic. Together they went over his list of medications, and the care coordinator encouraged William to move up his next doctor's appointment so he could discuss with his physician his concerns about possible overexertion.

William spoke with his employer and applied for short-term disability, while the care coordinator worked with William's cardiology team to set up home care nurse visits and telemonitoring. She even arranged to provide him with a scale so the patient could monitor his own weight at home. Finally, the coordinator suggested that William set up his home voicemail in order to make it easier for his care team to reach him moving forward—which he did.

Through periodic follow-up calls, the care coordinator learned that William successfully completed his home care and telemonitoring program, continues to monitor his own weight, and follows up regularly with his heart failure nurse practitioner and cardiologist. William has returned to work part time and has had no recent hospital admissions or emergency room visits.

His nurse care coordinator will continue to provide patient outreach and collaborate with his other health care providers to help William manage his heart failure and to support and improve his quality of life.

BREATHING EASIER

Jessica* was referred to a nurse care coordinator to assist with her transition home following a two-day hospital admission for an asthma exacerbation.

Jessica's initial concern was that she would run out of the asthma medication she started using in the hospital, before her follow-up appointment with her pulmonologist. The care coordinator instructed Jessica to call the doctor, who refilled it for her immediately.

The patient also expressed concerns about feeling jittery and experiencing insomnia and heart palpitations. The care coordinator talked to her about the side effects of the medication she was taking and explained what to expect during the tapering process. Once she finished her course of the drug, her symptoms resolved.

The care coordinator continued reaching out to Jessica to check on her recovery. Together they reviewed all of her medications and discussed the purpose of each one. The patient had edema (water retention) of the hands and feet and was taking a diuretic she had left over from the year before. The nurse explained the importance of checking in with her primary care physician (PCP) before taking any medications not currently ordered for her.

They discussed Jessica's long-term battle with depression and options for managing the condition, which had gone unreported to her current doctor and untreated for years. She was also referred by her care coordinator for a recommended cancer screening.

Finally, they talked about the patient's ongoing sleep apnea and her inability to use a CPAP (continuous positive airway pressure) device after an unsuccessful attempt three years prior. The care coordinator encouraged Jessica to discuss it with her pulmonologist, who recommended she see a sleep specialist. The sleep specialist ordered Jessica a newer device to try instead. Her care coordinator partnered with the patient's insurance company to make sure Jessica understood her benefits and received the equipment she needed to treat her condition.

Jessica's case is a reminder of the value of care coordination. Though she is independent and capable of managing her own care, the patient benefited from having a nurse to answer her questions, educate her about her prescriptions, and help her navigate next steps in her care.

As a result, Jessica is now better informed about her medications, has been successfully treating her sleep apnea, is back in therapy to address her depression, is scheduled for a colonoscopy, and has had no readmissions for her asthma.

MAKING CONNECTIONS

Mike* was initially contacted by a nurse care coordinator to help him manage diabetes. Her intervention opened the door for him to seek support for other medical concerns as well.

Mike reported that he had been experiencing hypoglycemic (low blood sugar) episodes almost daily and was having problems with his insulin. He had reached out to his endocrinologist's office but had not yet heard back. With Mike's permission, his care coordinator called the specialist, who followed up with Mike immediately. His next appointment was also moved to that same day, after the doctor reviewed data that Mike downloaded from his pump.

Mike told his care coordinator that he wanted to quit smoking. She connected him to a smoking cessation program offered through his employer, and he registered for a class. The care coordinator also spoke with a pharmacist to discuss cost saving options and the insurance requirements to get Mike approved for a prescription drug to help with smoking cessation.

Mike visited his primary care physician and reviewed all of the concerns he had been discussing with his care coordinator, so everyone would be on the same page.

He expressed additional health concerns with his care coordinator, including his desire to see a counselor because of stress. The coordinator connected Mike to an employee assistance program and he began counseling.