CARE CONNECT

Issue 13

PATIENT SUCCESS STORY

Kevin and ALS nurse case manager, Zach Tonkin

How Care Coordination Helped One Patient on the Road Back Home

Two years ago, Kevin was diagnosed with ALS, a devastating neurological disorder for which there is no cure and little treatment. He turned to St. Peter's ALS Regional Center in January 2017.

Zach Tonkin, nurse/case manager, guided Kevin and his family through the complex changes and losses that ALS brings. Dr. Roberta Miller, medical director, helped manage care, even seeing Kevin in his home when he could no longer attend appointments at the center.

Kevin developed arm, leg and extremity weakness early on, and later lost the ability to walk. By last fall, his diaphragm weakened, leading to respiratory decline. Clearly, Kevin needed more support managing his home care.

Dr. Miller referred to: Eddy Visiting Nurse & Rehab Association – Home Based Palliative Care Services, where Elizabeth Hanlon, palliative nurse, provided home visits, and

St Peter's Health Partners

Northeast Home Medical Equipment where Bob Amiot, respiratory therapist, guided Kevin in using a cough assist machine and non-invasive ventilation.

During a follow-up visit, Bob found Kevin in acute respiratory failure. He waited for EMTs to arrive advising them to take Kevin's trilogy (a non-invasive ventilator) with them on route to the hospital, which kept him alive.

Bob followed to provide ER staff important information and alerted Kevin's ALS and palliative care teams. Dr. Miller contacted St. Peter's ER with more pertinent information.

On December 11, Kevin was discharged home, returning to the ER a day later with respiratory distress and severe anxiety. Kevin began to realize how serious it was.

Elizabeth contacted Julie Huss, nurse practitioner, Palliative Care Partners at St. Peter's Hospital. Everyone agreed to hold off on discharge until a safe, comfortable care plan was in place to ensure a successful transition home… to stay. Care teams met with Kevin and his family, along with Angela Katrichis, social worker, to discuss Hospice care and his wish to be home.

Through his hospitalizations and time home, Kevin's care teams worked through the challenges and maintained ongoing communication.

Furthering continuity of care, Elizabeth transitioned to Kevin's hospice nurse. With support from The Community Hospice and his entire care coordination team, Kevin returned home on December 21, in time for Christmas.

"Without teamwork and ongoing communication, Kevin's life and path could have well taken a very different road, not one of comfort and choice," says Karen Spinelli, operations manager, St. Peter's ALS Regional Center.

Congratulations to all the Rock Stars who contributed to Kevin's success story: Zach Tonkin, nurse case manager, St. Peter's ALS Regional Center; Elizabeth Hanlon, Eddy Visiting Nurse and Rehab Association, Home Based Palliative Care Service, The Community Hospice; Bob Amiot, respiratory therapist, Northeast Home Medical Equipment; Dr. Roberta Miller, medical director, St. Peter's ALS Regional Center; Julie Huss, nurse practitioner, Palliative Care Partners at St. Peter's Hospital; Angela Katrichis, social worker, Palliative Care Partners at St. Peter's Hospital; Jamie Borge, RN team leader, The Community Hospice; and Robyn Bortle, nurse, The Community Hospice.

DID YOU KNOW?

The staff at the Healthy Families of Rensselaer County program.

Healthy Families of Rensselaer County Provides Support Services to Parents

It's arguably the toughest job in the world but it's also the most rewarding… parenting. While few parents ever receive training going into their new roles and caring for a newborn, there is help.

Healthy Families of Rensselaer County collaborates with area hospitals, doctors, schools and community agencies to help parents learn and feel confident in their roles. The program assesses and identifies the successes and challenges unique to each family, and offers personalized support to parents as they work on goals that are important to their family. Expectant parents or parents of a baby younger than three months who live in Rensselaer County are eligible.

Staff can help families in: planning for the arrival of their baby, providing regular home visits with a trained family support worker, and educating parents in infant and child development.

Funded by the New York State Office of Children & Family Services, Healthy Families of Rensselaer County is a program of Healthy Families New York. The program has been serving families since 1994 with assessment and referral, and home visiting services. For more information, please contact Laurie McBain at **(518) 274-1279.**

ICCS UPDATE

Rescue Plans Effective in Reducing Need for Emergent Care for High-Risk Diagnoses

Eddy Visiting Nurse and Rehab Association (EVNRA), in partnership with St. Peter's Health Partners Medical Associates (SPHPMA), has been trialing a new care model dedicating specialty case managers to work with patients with high-risk diagnoses likely to lead to multiple ED visits and or hospitalizations.

Sharon Timpano, RN, embedded specialty case manager, Albany Associates in Cardiology, and ReGina Donofrio, RRT, embedded specialty case manager, Pulmonary and Critical Care, are forging solid working relationships with providers and patients to improve patient experience and outcomes, while lowering costs by avoiding unnecessary ED trips and hospitalizations.

Embedded managers work with providers and home care staff to identify patients in need of intensive case management and arrange for them to receive telehome monitoring through EVNRA. The patient's weight, blood pressure, pulse, and pulse oximetry are read daily, with results outside the normal range reported back to the embedded managers to follow up with the provider and implement changes to the medical regime directly with the patient or caregiver. They also act as the primary contact for patients and home care staff to report any issues that need resolution.

Embedded rescue plans have greatly reduced ED trips for heart failure patients. For ex: if the patient has symptoms relating to a heart failure exacerbation, the embedded manager works with the patient and provider to increase diuretics, returning the patient to baseline and avoiding the ED.

Since inception, rescue plans have followed 124 patients through telehealth, with more than 60 percent still being monitored; while implementing 33 rescue plans 64 times, with only three readmissions.

"Having a nurse case manager dedicated to our heart failure patients has made a real difference," says Dr. John Filippone, cardiologist, Albany Associates in Cardiology, part of SPHPMA, who is a strong proponent of the new model and involved in creating the rescue plans. "Patients feel more connected to our practice and to the health care system in general. Implementing the heart failure rescue plan has undoubtedly avoided multiple hospital admissions and improved the quality of life for this challenging population."

"We sincerely appreciate the role of the RT (respiratory therapist) specialty care manager," says Dr. Harold Sokol, pulmonologist, Pulmonary and Critical Care, part of SPHPMA. "This program has decreased hospital admissions and increased our COPD patient's quality of life."

QUESTIONS?

If you have questions about care coordination, how it works or what we hope to accomplish, we're here to help. Please contact:

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Please consider submitting patient stories that cross care transitions and/or service lines to be highlighted in the "Did You Know?" section of the newsletter. Your input is welcomed.