Medical and Life Care Consulting, Inc.
Case Management - Life Care Planning

Cynthia M. Bourbeau
RN, CRRN, CCM, CNLCP®
Founder & President

PO Box 1041, Belchertown, MA, 01007 Phone: 413.323.9705 Fax: 413.930.4138

Name/Professional Title(s): Cynthia Bourbeau, RN, CRRN, CCM, CNLCP®
Rehabilitation Nurse Case Manager
President, Medical and Life Care Consulting Services, Inc.
Business address: Medical and Life Care Consulting Services, Inc.
P.O. Box 1041/23 Main Street,
Belchertown, Mass. 01007
Telephone number: 413-323-9705 (Office)
Email address: cbourbeau@medicalandlifecare.com

1. Please indicate the number of years of experience in care coordination/case management.
I became certified 27 years ago while working at Rehab West Acute Rehabilitation Hospital. At that time I was the Program Coordinator of the Pain Management Program, working with Dr. A. McKee, Program Director for the Oncology Rehabilitation Program. I designed and implemented both Inpatient and Community Case Management for the program.

2. Please provide the approximate number cases with morphine milligram equivalent above 100 (MME > 100) that you have assisted with in past three years.
My work experience includes on-site case management for catastrophic injuries that are work related and major medical cases non-work related. These are acute injuries with pain management that most often becomes chronic management. As I manage primarily catastrophic injuries now, most patients are in the above range at the onset of their treatment but the goal is to wean them down and off narcotics. With 95% of patients I was able to do this. I manage catastrophic injuries long term and 95% of them are off of narcotics. I keep 30-40 patients at one time and 75% of them were on high dose narcotics at onset. Approximately 25 patients over 3 years.

Included in my practice, my nurses and I do Pharmacotherapy Reviews with physicians to address patient use of narcotics. These cases are all reviews of patients that are using over 100 MME. Often use was > than 400-500 MME. The focus of the meetings is to address either weaning off of the medication with physician assistance, or inpatient stays to come off of the medication and transitioning the patients to non-narcotic treatment modalities.

3. Please indicate the best geographic area where you have greatest experience.
I travel all areas of Massachusetts. My business is located in Western Mass but I travel to see patients every week in Boston, North Shore, South Shore, Cape and Islands, and Central Mass. We also manage cases which will include travel to New Hampshire, Rhode Island, Connecticut, and Vermont, and occasionally New York and Maine for catastrophic cases.

4. Please explain your background/experience with addiction or pain management.
As a nurse I have worked as a Rehabilitation Nurse for 37 years. I am certified in rehabilitation and case management and am a Certified Nurse Life Care Planner. Pain management has been part of my nursing process since I became a nurse. My first working experience started on an orthopedic and neuro surgical floor with patients with chronic pain syndromes, failed back syndromes, etc. After 10 years of Acute Care Nursing, I became certified in rehabilitation and I was the Case Manager and Program Coordinator for the Oncology Rehabilitation Program at Rehab West in Ludlow, Massachusetts.

In my role at Rehab West, I defined the pain management program. My department was working with patients with spinal cord injuries, cancer treatment and pain management for all diagnoses such as RSD (CRPS), failed back syndromes, phantom pain, burns and general pain management. I became certified in case management and set up outpatient programs to do follow-up post discharge. In addition, I did an outcomes program for further evaluation of successes and failures of the program. In that time period, multiple modalities were utilized to treat pain but use of opioids was liberal. Large dosages of narcotics were ordered by physicians. These resulted in multiple complications and side effects which we, as case managers, had to monitor and assist in resolving.

I have worked as a Certified Nurse Case Manager for 27 years, initially working for other companies. However, I started my own business in 2001 and have continued to do case management for multiple diagnoses, both in worker's comp, major medical illnesses and assistance with short and long-term disability. In addition, as a Certified Nurse Life Care Planner, I also do medical cost projections, life care plans and Medicare set asides for patients.

Facilitating pain management occurs with each case I manage. Treatment modalities include medication management with oral medications, topical anesthetics, injections (steroid, botox, etc.) and intrathecal pumps to facilitate aggressive rehabilitation and functional restoration. In addition I believe that there are many things that contribute to the pain experience such as anxiety, depression, fears, etc. I feel that understanding this and treating the whole patient, holistically with a goal towards total good health, needs to be part of the process. Each treatment plan and options are unique to each patient.
Holistic measures such as acupuncture, meditation, and counseling are all important parts of the process. My role is education. Educating the patient and outlining the goals are also key for success. The goal is maximum quality of life for each individual patient.

5. Please provide a very brief outline of three cases you have assisted with within last three years (i.e., starting MME, what treatment plan seemed to help and how case ended). Please explain the results of the three cases.

Case #1: Mr. A. was injured when a bucket loader came down on his foot. The crushing injury resulted in multiple fractures and soft tissue injuries to the foot. He underwent several surgeries and eventually had a below-the-knee amputation of the foot with resulting phantom pain. Initially he received IV narcotic management in the hospital. He was in the hospital for months and the dosage was adjusted regularly. He then received high doses of narcotics with long acting Oxycontin every 12 hours with breakthrough medication of Oxycodone with doses up to 200 MME. Oftentimes, patients are given medication and they just take it routinely because they feel that that is what the physician told them they could and should do. From day one, I began educating him on how to properly take his medication and to wean down. Alternatives were explored with the physician and blocks were done. He was started on non-narcotic medications such as Gabapentin, topical medication, anti-depressants, etc. He began aggressive physical therapy and was functionally independent. Over the next 6 months to a year he was able to wean off of the narcotics and although he still has some phantom pain, he is able to be fully active and manage it with Gabapentin. He is down to a minimal dosage at night and is living a full life which included finding a new job. Through diligent monitoring and assessing what was actually decreasing or affecting his pain, he was able to be totally narcotic free and fully active physically.

Case #2: Mr. D experienced a car accident and developed pain in his shoulder. He underwent physical therapy, oral medication management, injections and work modification with no improvement of his symptoms and was eventually operated, undergoing a decompression of his shoulder. He tolerated this well with a decrease in his pain but soon after surgery he started therapy and experienced severe pain in his shoulder which radiated into his neck and down his arm. His shoulder was fully evaluated by several physicians and there was no intra joint impingement noted. However, his arm became hyper sensitive and painful. He could not stand anyone touching it. Swelling to the entire arm occurred, as well as discoloration at times. His cervical spine was evaluated and it was determined that there was no pathology noted in that area. The diagnosis of CRPS versus thoracic outlet syndrome was noted. For further definition he was evaluated by a thoracic surgeon who ordered Botox injections to the Pec, with no results. The patient underwent a brachial plexus decompression and pec minor release. Throughout this entire process he was evaluated by 3 different pain centers for diagnosis and treatment. High dose narcotics were offered and ordered at these pain clinics. Alternative medications were requested and ordered and he was taken off of narcotic medication, except for the post-op period. Close monitoring occurred. The surgery completed was determined a failure by the patient as he felt that his pain was unchanged. However, through education and close monitoring, it was apparent that the surgery did help with his symptoms. The swelling decreased, and his range of motion and function improved. He still had pain but he was now dealing and living with it. He has no clear diagnosis of CRPS by any of these symptoms. He is now working in a functional restoration program for re-entry into the work force. He is narcotic free and pain is managed with topical medications, lyrica and anti-depressant medication.

Case #3: Mr. L is a C5-6 incomplete quadriplegic who was electrocuted, fell 20 feet, and fractured his neck and was burned. I was not involved in his initial injury and treatment but was contacted later, after he had failed to effectively work with other case managers. He had been in the acute hospital for months and in acute rehab for 6 months until he was discharged to home. He was wheelchair bound when I met him, with the ability to transfer from chair to bed only. He

was on 330-400 MME on a daily basis. He was self-injecting morphine for pain management. Fentanyl patches did not work due to his burned skin. Normal case management was started to assist with all care needed in the home, equipment, physicians appointments, etc. Injuries from his burns and from his spinal cord injury affected all systems and resulted in pain in his hands, neck, chest and legs. Intense evaluations were facilitated with appropriate pain management physicians and alternatives to narcotics were added to his treatment plan. He was treated with Neurontin, topical creams and anti-depressants, water therapy and counseling. Through this process he achieved better pain control and we were able to transition him to Methadone. His Methadone was then decreased so that he was able to function very well on 20-30 mg bid. With the management of his pain, he was able to tolerate therapy and was able to walk with a cane short distances. From the spinal injury and burns he had malformation of his hands and feet but was able to live independently without direct care and just needed assistance with household tasks. He was able to drive and travel. He was last taking 10 mg of Methadone, 2-3 tablets, one time per day.

These were short summaries of very complicated cases. If you would like a more detailed summary that can be provided. I see failed back syndrome as being one of the diagnoses that result in long-term narcotic use. I have had multiple patients with this problem but who are narcotic free upon completion of treatment.

6. Do you work with, or are you familiar with, any health care practitioners who specialize or have had success with assisting patients to reduce daily opioid intake? Yes, I have worked with physicians all over New England who are working towards this. I can compile a list of them. I am happy to say I have noticed a marked change in the environment over the last few years in how physicians approach opioid ordering and am pleased to see the tighter controls.

7. Do you have a vehicle and are willing to travel to meetings and medical appointments? Yes. I am an On-site Nurse Case Manager. I travel all over New England seeing patients.

8. Please indicate, if applicable, any language skills other than English. Unfortunately I only speak English but use interpreter services or apps to assist with communication for those that do not speak English.

I feel that this is a very important project and I would like to be involved in the resolution of this problem. At MLCC we have the ability and are collecting data on comorbidities, treatments, use of medications, return to work status and pain status throughout rehabilitation process, with outcomes on treatments of multiple diagnoses. In addition we have developed care pathways, a program with physicians throughout Massachusetts, to facilitate greater outcomes and evaluate what about the physician's treatment plans needs to be changed for greater outcomes. We developed a computer program to monitor these findings and will be doing a retrospective study to assess ways to improve patient outcomes. I hope to hear that we can be included in your program. Thank you.

Any referrals for myself and any other nurses with Medical and Life Care Consulting should be referred to cbourbeau@medicalandlifecare.com.