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): Elaine D'Aprile, RN, CCM, CNLC, CNOR/Nurse Case Manager
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: edaprile@medicalandlifecare.com

1. Please indicate the number of years of experience in care coordination/case management.

I have worked as a registered nurse for 40 years, with varied opportunities to care for and coordinate care for patients requiring inpatient, outpatient and primary care. I obtained certification as an operating room nurse (CNOR) in 1990 and as a certified legal nurse consultant (CLNC) in 1992. After serving for 28 years as a flight nurse in the US Air Force, I was hired as the initial care coordinator / case manager for military members at the US Pentagon, Washington, DC.

I became certified as a case manager (CCM) in 2013 and presently work as a nurse case manager with Medical and Life Care Consulting (MLCC) in Massachusetts.

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 case management experience has included patients in the outpatient setting with physical illnesses such as diabetes and cancer, one patient with ALS and others with traumatic injuries such as TBIs, amputations and back injuries. Presently, I perform both telephonic and on-site case management for work related injuries. I have 30-40 patients with injuries that require pain management. These are acute injuries that at times require surgery, and along with post-op pain management there are often requests that develop into chronic management. With my present case list of 32 patients, there are 29 who have eliminated taking any narcotic, and are using an NSAID or non-narcotic pain reliever such as Tylenol. This is 90.625% of present patients. Pharmacotherapy Reviews with physicians to address patient use of narcotics are included in my practice. These cases are all reviews of patients that are using over 100 MME, often for many years. I have visited with physicians of seven patients over the past year, four of whom were

being prescribed dosages greater than 400-500 MME. At these meetings, the physician is offered a pharmaceutical review of the patient and prescription time period and dosage.

3. Please indicate the best geographic area where you have greatest experience.

I travel all areas of Massachusetts and New Hampshire and can travel to all of New England during the day. I also have experience in the cities of Washington DC, Maryland and Virginia, as I have lived there and served the military population and their family members in those locations.

4. Please explain your background/experience with addiction or pain management.

As previously stated, I have worked as a Registered Nurse for 40 years. During the initial phase of my career, patients were prescribed narcotic medications without consternation, as often they wanted them. I recall patients as well as friends with back pain who had a never-ending supply. While working in the OR at a Trauma 1 medical center in the middle of Boston, surgery was performed on hundreds of people per day. During their pre-op intake, patients had on hand their Dilaudid, Codeine, Vicodin, et al, but did not report meds taken for other medical needs such as hypertension and migraine headaches, in addition to supplements. Their meds were placed in their bags and delivered to their inpatient rooms where a family member can retrieve. Also, this hospital served the homeless and vagrant population who had their own source of medication supply. While in the US Air Force, I transported patients with illnesses and injuries. They had meds in their pocket from possibly playing a poker game the night before. Percocet was used in betting, as well as being shared or sold.

While working at the Pentagon, patients were seen in the primary care clinic with their primary care physician. The physicians understood their patients' needs and monitored their prescriptions. However, many patients had poly-pharmacy abuse, where they would go out to a civilian physician and obtain another prescription. I had one female patient who travelled the country on weekends, saying that she sold Mary Kay products. She had narcotic prescriptions from Florida, North Carolina, Texas, and other states. Her commander was notified, but she continued with her military career. It was unknown if she sold the medications; it is known that this occurs in their community.

I see that Holistic medicine has become a large alternative to promoting pain relief. Many of our injured patients also have negative feelings about their overall health and gaining wellness. Physical, emotional and spiritual imbalances can occur. Holistic treatments such as acupuncture, exercise, psychotherapy and massage therapy can provide relief of pain, and affect a quicker recovery. Patients with back pain can find relief with physical therapy, yoga and proper exercise as offered by an exercise consultant or therapist. Some older patients who are injured at their job have a fear of never returning due to their age. Communication with a support group and social worker can have a big effect on becoming energized, without all the painful stimulus.

There is very much more to learn about pain relief and the case manager can have a lot to offer with communication and education to the patient, family and care givers.

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: This patient's injury was described as falling from scaffolding while hanging drywall. He was diagnosed with a left comminuted calcaneal fracture. The patient had a history of IV drug abuse and attended a methadone clinic every morning prior to injury. At the time we met, 5 months after surgery he described his pain as 3/10. He had not begun physical therapy and had not returned to work. He reported taking Ibuprofen 600 mg every 4 hours prn for pain. His prescriptions for pain management at that time had included orders for Hydrocodone 5 mg, 1-2 tabs every 4-6 hours prn, Percocet 5-325 mg every 4-6 hours every 4 hours prn and Methadone HCl was listed.

During our time, we met at doctor's appointments every 4-6 weeks. He was scheduled and with assistance began to attend physical therapy appointments regularly. He continued to complain of pain in his foot and had difficulty walking throughout the course of the day. He asked to have the surgical plate and screws removed to assist in pain relief. Post op he continued to use medications heavily but alternate medications were suggested and facilitated so his narcotic medication was decreased and then eventually discontinued

I do believe communication here was imperative in order for him to begin healing. With his history of drug abuse and daily appointments at the Methodone clinic, he was in a precarious position to resume using again. With proper education and support, he understood how the wrong choice again could impact him and how it has affected his life and his child's life.

Case # 2: Ms. H. sustained a rotator cuff tear, leg pain, cervical neck pain and a concussion from a work related accident. Over the course of many months, she was treated with pain relief for her neck and leg, diagnostics were done for her concussion, a rotator cuff repair was completed and a second rotator cuff repair was done. Ms. H. eventually reported a history of drug abuse prior to this injury.

Ms. H. reported that she had taken Buprenorphine and Naloxone in the past. At her physician appointments, she would randomly blurt out that she never took heroin. Obviously, this behavior made them very suspicious of her prior medication usage. She claimed repeated difficulties when calling this surgeon's office for medication, stating that she did not receive a return call, and stating that one time, she was refused when she requested a refill after her second rotator cuff surgery. Throughout her courses of treatment, she was often late for appointments, did not show for physical therapy appointments, and began to state that she was being followed at all times when driving and at her home. Continuously, she repeated that she was never a heroin abuser and did not understand why she was under such intense surveillance.

This case was difficult because the suggested drug abuse was not experienced during her post-op courses or during her injury evaluations. However, it affected her interactions with those caring for her and she was very paranoid about their responses to her. Many of the office staff were exposed to her outbursts while she was in the physician's exam room, or in the checkout area. She was hard to manage and her providers recommended that she seek medical assistance with

her psychological problems. Her treatment plan ended with a functional evaluation. She reported that she did not want to return to her job and did not complete the testing.

I continued to work with Ms. H. for an extended period of time post-op. I have a belief that during our time together, she did not over medicate. In fact, there were times that she did not medicate at all. She stayed focused on her goals so she could return to work and begin to live a normal life. At the time we concluded her case management, she was committed to continuing her progress to 100% recovery and was using massage and music therapy for pain management.

Case #3: Mr. M. was injured on 3/5/15 at a job where he worked as an aerator. He stated that his pain was a "persistent, stabbing shoulder pain" that would not go away. After extensive follow-up and evaluation, surgery was recommended. Prior to surgery and Mr. M underwent many evaluations for an accurate diagnosis. During this time he experienced no pain relief and was heavily and consistently medicated, with over 100 MME. Surgery was then completed and his medications were closely monitored. He was heavily medicated for a short period of time and then over the course of his post op treatment he was transitioned to: Lidoderm 5% patch, 1 QD, with instructions to apply 2 hours prior to therapy; Neurontin 300 mg, TID; Ultram, 50 mg, Q6H, prn, with instructions to take before therapy and then only when needed; Gabapentin three times per day. Upon completion of therapy and his recovery, Mr. M was released to return to work without restrictions. He was not in pain and was not taking any medications.

I believe the care and treatment of this patient was successful due to the continued monitoring of his symptoms and medications, and with communication with the patient and all his caregivers, friends and family.

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 every day in all locations of my travels. We discuss the restrictions, and now State laws, regarding opioid use and the need to limit or eliminate the use of prescribed opioids for ongoing pain management.

7. Do you have a vehicle and are willing to travel to meetings and medical appointments?

Yes. I have a vehicle and am available to travel.

8. Please indicate, if applicable, any language skills other than English.
N/A

All referrals should be sent through Medical and Life Care Consulting Services, Inc.:
cbourbeau@medicalandlifecare.com