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

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1. Please indicate the number of years of experience in care coordination/case management.
I have been a Board Certified Case Manager since 2001. I earned this credential by examination through the Commission for Case Manager Certification, and I maintain this credential through ongoing education. The Commission for Case Manager Certification requires 80 approved continuing education credits every five years for renewal of certification.

2. Please provide the approximate number cases with morphine milligram equivalent above 100 (MME > 100) that you have assisted with in past three years.
I do not have an exact count, but I would estimate that I have been involved in dozens of cases in the past three years in which high doses of narcotic medications have been prescribed. In the worker's compensation arena, I see a range of cases, including patients requiring short-term pain management, such as with acute injuries or post-operatively; catastrophic injuries that require chronic pain management; and individuals with pre-existing addictions or developing addictions. In my practice, I am involved with Pharmacotherapy Reviews, which involves meeting with physicians/prescribers to discuss the medication treatment plan of patients. These reviews are usually prompted by the chronic prescribing of high doses of narcotic pain medication. The goal is to address alternative treatment options, including a plan for weaning, trials of non-narcotic medications, interventional pain management, or, in some cases, detoxification and addiction rehabilitation programs.

3. Please indicate the best geographic area where you have greatest experience.
I am licensed as a Registered Nurse in Massachusetts and Connecticut. Because New England includes several states in close proximity, my practice does involve travel to Rhode Island, New Hampshire, Vermont, Maine, and New York. I reside in Western Massachusetts, but I have equal experience throughout the State.

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

Pain management has been part of my practice throughout my nursing career. Upon graduating from nursing school in 1986, my first position was on a neurosurgical/trauma unit. The majority of my patients had experienced traumatic injuries and multiple traumas, including head injuries and spinal cord injuries, fractures, amputations, burns, wounds, and surgeries. In my position at an acute rehabilitation hospital, managing pain was essential for these patients to participate in their rehabilitation programs in order to improve functional independence. Although the mindset regarding pain management techniques has changed dramatically over the years, and we are facing an epidemic opioid crisis, we maintain the goal of balancing pain management with function and quality of life. This holds especially true for individuals with work-related injuries, as most employers will not allow employees at the workplace while taking narcotics, and our goal is to keep employees working and/or to facilitate early return-to-work and progression back to full-duty/regular activities.

I have personal experience with family members and friends who are challenged with addictions. I have had an opportunity to observe many facets of addiction and the struggles faced by these individuals and their families. I have supported people throughout various phases of their struggles, including intervention, rehabilitation, relapse, and ongoing commitment to sobriety. I have also experienced loss due to overdose and substance abuse. I have assisted individuals with locating appropriate treatment programs throughout the region.

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: Ms. P. was employed as a motel housekeeper when she was injured in 2005 at the age of 50. She reports that she was arriving at one of the motel units and was getting out of her car when another car came around the corner and hit her, running over her left foot and throwing her onto her car. She sustained a trimalleolar ankle fracture in addition to other injuries. She underwent an ORIF with fixation of the posterior malleolus initially. She developed left subtalar joint arthritis, and underwent left ankle arthroplasty in 2013. During this time, Ms. P. was taking high doses of narcotics and benzodiazepines. She became reclusive and depressed, and it was reported that she was sleeping most of the time, crying, and chain-smoking cigarettes. She was confused due to being heavily medicated. She was treating with a pain management center for chronic left ankle pain with neuralgia and neuritis of her left foot. Multiple procedures, including injections and nerve blocks, were ineffective.

In mid-2016, Ms. P. was referred to another pain management physician. Over several months, Ms. P. was completely weaned off Oxycodone. In order to succeed with this, she was placed on a regimen of Venlafaxine, Methylphenidate, and Clonazepam. Her pain was fairly well-managed, and she reported that she was sleeping better at night and was able to stay awake and function better at home during the day. She reported increased energy and focus, as well as improved mood. This regimen initially involved multiple dosing of medications throughout the day; however, after a few months, the physician was able to simplify the dosing without changing the total amount of medication. In addition, Ms. P. was started on a topical compound cream for her left foot and ankle, which has provided additional relief of pain, allowing her to start getting out of her house to go to a warm water pool for exercise and social interaction. She is still not working or driving, but she is slowly improving function and quality of life.

Case #2: Mr. K. is a 24-year-old male who was employed at an oil refinery as a switchman/operator. He was injured in December 2015 while disconnecting hoses from two train cars. There was miscommunication with directions, and he became caught between the two train cars, crushing his left foot and his lower leg. Over the course of three weeks, he underwent 11 surgeries, including amputation of his left great toe and part of his foot and multiple skin grafts with donor tissue from his left arm. He was on bedrest for two months and non-weight-bearing for another two months. Between April and October of 2016, Mr. K. started gradual weight bearing and was finally able to get a shoe on; however, he was experiencing substantial pain, impaired sleep, flashbacks, anger issues, and depression. He attempted suicide in October 2016. In addition to his injury/trauma and pain, Mr. K. moved across the country, became a father, and his home burned completely in a fire. Upon relocating to MA in November 2016, Mr. K. was set up with a treatment team including an occupational medicine physician, a podiatrist, a psychiatrist, and a psychologist. He had been working with a telephonic nurse case manager, but he was referred to me for on-sight case management in February 2017. At that time, Mr. K. was reporting 9/10 pain with various types of nerve pain/hypersensitivity, including burning, stabbing, and tingling. He was taking various medications to manage his pain, neuropathy, anxiety, and depression, but with only fair effect, and he was stating that he did not want to take medications unless absolutely necessary.

The most improvement was obtained when he was started on Cymbalta. That, along with psychotherapy, improved his mood and sleep patterns. He obtained relief with a plantar fascia steroid injection in March 2017, along with orthotics, and minimal relief with NSAIDs, gabapentin, alpha-lipoic acid, and muscle relaxers. He did not like taking oxycodone, Vicodin, or tramadol, and would avoid unless necessary. Mr. K. was also reporting back and neck pain and spasm, most likely due to impaired gait. He was started on an aggressive physical therapy program, which has been very effective. Also, he underwent surgery in July 2017 to release contractures of the left 2nd and 3rd toes and arthrodesis of the 2nd toe. He did require a short course of narcotics post-operatively, but was able to wean off them completely. He has resumed PT and is in the process of obtaining a custom orthotic. He is weaning the gabapentin and is only taking a dose at bedtime, along with Amitriptyline. He continues to take Cymbalta and finds it to be extremely effective. He has also been trying various topical creams for his foot, including Biofreeze and capsaicin, which are helpful. He is working with a vocational rehabilitation specialist to find alternate employment. This was initiated early on in attempt to provide some focus and encouragement, and it is anticipated that Mr. K. will be at MMI within the next couple of months.

Case #3: Ms. B. is a 57-year-old certified nursing assistant who was injured while working in 2012. She twisted her right knee and developed chronic myofascial pain, swelling, and neuropathy. She remained in work, as she had worked for this employer for nearly 30 years; however, she reported that she was unable to function aside from going to work. She stated that she would go home, apply ice to her knee, and elevate her leg. She was not able to engage in social activities, manage her home, or travel. She was offered various medications and procedures, but they were either ineffective, or they made her feel terrible. She explained that she is very sensitive to medications, so she does not like to take anything other than an occasional OTC medication, such as Advil.

In 2015, she was referred by the NCM to a pain management physician whom she described as her “life saver.” He has been prescribing Lidocaine patches and a topical compound cream, and she states that she is able to work full-time as a CNA, and she has resumed her regular activities,

including travel, maintaining her home, and socializing with friends and family. She states that she has been given her life back.

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 several providers who are committed to reducing or eliminating opioids from their patients' treatment regimens. Some have demonstrated a great deal of compassion and patience during the process, making sure that the patient is on board and more likely to succeed. I have seen others abruptly stop prescribing opioids to their patients without any preparation or discussion of the plan to do so. On the other extreme, I have seen prescribers on many occasions enter the exam room with prescriptions in hand without assessing pain levels or efficacy of the medications, let alone having a discussion about the medications or treatment alternatives.

7. Do you have a vehicle and are willing to travel to meetings and medical appointments?
Yes, as mentioned, I regularly travel throughout Massachusetts, Connecticut, Rhode Island, and sometimes into New Hampshire, Vermont, parts of Maine, and parts of New York.

8. Please indicate, if applicable, any language skills other than English.
I am not fluent in any other language, but I do have minimal understanding of Spanish. In my practice, I generally prefer to utilize a translator to ensure that communication is accurate and effective.

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