Clinical Services Collaborates to Change Lives

The Health Plan's (THP) disease management program strives to ensure that our members receive the right care, at the right time, for the right cost. Through telephonic outreach and coordination of care, our nurse case managers in Clinical Services are improving the lives of members every day. In the case of Rita*, a 65-year old Medicaid member, she experienced notable improvements to her health through the 16 months she was in our program.

After THP learned Rita was diagnosed with COPD, diabetes, and heart disease through data collected by a health risk assessment, she was contacted by two nurse case managers from THP's disease management program. Due to the multiple ailments Rita was living with, she experienced a variety of complications that were impacting her quality of life. At the time, she was enrolled with THP, and was being evaluated for an electric wheelchair because she was having trouble getting around due to her weight and degenerative joint disease. Because of her poor health condition, she was unable to get medical clearance for joint surgery. Our nurses made it their mission to help Rita regain control over her life and her health.

Every three to six weeks, Rita was contacted by two nurses from THP to receive education on how she could self-manage her chronic diseases. Rita learned about topics such as dietary changes, appropriate use of medications, and chair exercises to help increase her physical activity despite her inability to walk more than a few steps. Our nurses also worked with Rita's in-home caregiver and primary care physician to get her referrals for an endocrinologist for more specialized diabetes care. They also helped Rita receive a referral for in-home physical therapy to increase her strength and mobility.

The relationships our nurses build with members can end up revealing insightful information into factors impacting their health and wellbeing. After talking to Rita and assessing her situation, our nurses determined that she was not taking her insulin as prescribed because she didn't understand her doctor's orders. It was also revealed that Rita wasn't taking her home breathing treatments as ordered because she didn't like the way it made her feel. Taking this information into consideration, our nurses were able to educate Rita, her husband, and in-home caregiver on the correct way to use an insulin scale so she was taking a proper amount each day. Our nurses also were able to work with her doctor to recommend other breathing medications with less side effects, allowing Rita to adhere to the medication she needed to control her COPD.

The services provided by The Health Plan's disease management program left a lasting impact on Rita's life. In the 16 months she was in the program, she lost 68 pounds by following a low-salt, low-fat, and portion and carbohydrate controlled diet. Due to weight loss and gradual increase of physical activity, she noticed significant increases to her strength and mobility, and was able to get around by using a walker. Rita was also armed with the tools she needed to take control of her diabetes—She was able to reduce her A1c from 10.6% to 6.2%. In addition to reducing her A1c, she was also able to reduce the number of insulin doses and total number of medications she took each day.

Rita was thankful for the help she received from our nurses throughout the program. She believed that the educational materials and phone calls they provided really helped her to make lasting changes to her health. She also appreciated the ongoing phone calls, which she said, "kept her in line." Above all else, it's the teamwork and dedicated support that allows our nurses to create lasting change with our members living with chronic conditions.

**This story is based on an actual member. Names and other identifying details have been changed to protect the privacy of individuals.*