Over more than 15 years as administrator of the Teamsters Local 830 Health and Welfare Fund in Philadelphia, Pennsylvania, Samuel J. Kenish, CEBS, had experienced only limited success in engaging members to better manage their health and make informed health care decisions.

According to Kenish, conventional case management and disease management initiatives had failed in the past for several reasons, including:

- Those doing the outreach hadn’t first had an opportunity to develop a relationship or to demonstrate credibility or value.
- The resource had not established a community presence.
- When the vendor worked for an insurance company, members believed the resource did not have the ability to deliver unbiased support.
- The resource was not positioned to influence timely decision making around choice of professional providers and facilities to address acute and chronic issues.

That changed when Kenish partnered with Betty Long and her team of registered nurses (R.N.s) in mid-2013 to create a resource known as the Teamsters Local 830 Mobile Care Coordinator™ (MCC). The MCC program was built on seven premises:

1. Members lack the ability to make informed health care decisions on their own.
2. Assistance in making such decisions will be accepted only from a trusted resource.
3. The resource cannot be provided by an insurance company.
4. In order to establish trust, initial interactions with the resource must happen at a time when members are most in need of help, e.g., when they must deal with a significant health issue, are hospitalized or need some type of medical intervention.
5. Data must be furnished to the resource in a timely manner so that those most in need of help can be identified and reached out to immediately.
6. The resource must be recognized in the member community so that credibility can be established/enhanced.
7. The resource must be mobile to facilitate in-person interaction when necessary.

The one-year pilot program developed by Kenish and Long, who is president, CEO and founder of Guardian Nurses Healthcare Advocates, called for Heidi Petersohn, R.N., to telephone or visit Local 830 members who were experiencing a health care issue. Petersohn offered support and guided them through the health care system. She made her visits—to acute care facilities, patient homes and physician offices—in a cobranded Ford SUV. Petersohn was responsible for coordinating care, guiding members and supporting them as they made more informed decisions.

The fund’s insurance vendor would provide the MCC R.N. data to help her identify those who needed assistance. Each day, she received two reports—one showing who had been hospitalized and the other showing who had been issued precertification for complex diagnostic, surgical or other procedures.

Following her review and investigation into the individual patient’s case, Petersohn...
telephoned the patient or his or her loved one.

The insurance vendor also shared other broader and less timely reports, like quantification of members with high claims or identification of high-risk patients. These reports typically supplemented the nurse’s work with engaged members or highlighted a member needing outreach.

The fund covers 4,400 lives located throughout Pennsylvania, New Jersey and Delaware, and the MCC R.N. also had the in-person and telephonic support of Guardian Nurses’ team of nurse advocates. For instance, one nurse might accompany a member to a physician visit in New Jersey while a different nurse accompanied another member to his second opinion consultation with an oncologist in Philadelphia.

When a patient’s case would benefit from additional clinical expertise, such as pediatric oncology or adolescent mental health, the case was referred to the appropriate member of the Guardian Nurses’ team.

The case of Bill, a 56-year-old truck driver and Local 830 member, shows how the program worked. Bill was diagnosed with prostate cancer. He also was the primary caregiver for his paraplegic, wheelchair-bound wife. Upon learning of Bill’s diagnosis, his wife called the fund office in tears, afraid that her husband and caregiver was facing a terminal diagnosis. This was two days into the launch of the MCC program.

A nurse called Bill’s home and spoke with him, explained her role and the new program (which had not yet been marketed at his jobsite) and offered her support. He did not express the same fears as his wife but he readily agreed. He also asked that the nurse speak with his wife to “calm her down.” The conversation between the two women went well, and the wife expressed relief and gratitude that the MCC R.N. would be meeting them the following week at the urologic oncologist’s office at the local hospital.

After that visit, at which treatment options were discussed, the nurse asked Bill if he wanted a second opinion. She explained the clinical value of consulting another specialist and offered to arrange for and coordinate that appointment. Bill agreed, and one week later all three of them were again sitting in the office of one of the region’s top doctors for prostate cancer.

This visit went much differently, with more positive discussion, more details shared about each treatment and more questions asked by both the physician and his nurse practitioner. Bill and his wife felt much more confident that the treatment plan and the care he would receive would be high-level and successful. They opted to work with the consulting surgeon.

Following surgery, the nurse visited Bill in the hospital and made sure that both he and his wife understood his discharge plan for home. She made several calls to Bill following the sur-
what’s working

Gery, and Bill made one or two calls one weekend to the nurse for reassurance about some postoperative symptoms.

A week before Bill returned to his job, the insurance company’s case manager telephoned him. She explained that she had seen that he was diagnosed with prostate cancer and offered to help. Bill responded: “What are you going to do now for me? I’ve been working with our MCC R.N. for three months.”

After Bill returned home from work one day, his wife was taken to the emergency room for heart issues. Bill called the nurse to let her know and to ask for her help.

Long said that as these relationships were established, Petersohn also began reaching out to high-risk members with various chronic diseases. A protocol was established that when a nurse had had a previous interaction with a member, that nurse was the person who called the member about a chronic health issue even if another staff member would be providing ongoing support. In cases where there had been no prior interaction with the MCC, fund office staff made the initial contact to help establish trust. Kenish said that this approach worked far better than anything the fund had tried previously.

By the end of the yearlong pilot program, a total of 1,077 patients had engaged with the nurses, Long said. There were 1,161 total cases, including 84 “repeat customers.” Of that total caseload, there were 672 acute cases and 489 chronic cases. And of the acute cases, there were 142 accompaniments and 72 hospital and home visits.

Kenish said that because of the continued marketing of the MCC R.N. resource and the success of the work done with members with acute issues in the first year—the pilot ran from September 2013 through August 2014—the number of direct calls made to the MCC R.N. had increased in the first quarter of the second year of the program. Another part-time nurse has been added to the Local 830 team.

“Members are beginning to rely on the MCC R.N. to help them manage their health and make informed health care decisions,” Kenish said. “This is the kind of engagement needed to impact future health care spending.”

This article is based on a presentation by Samuel J. Kenish, CEBS, and Betty Long, R.N., M.H.A., at the 60th Annual Employee Benefits Conference last fall in Boston, Massachusetts.