Case Study – Day 4
Care Management Process

Directions: Read the case study below. Together, you and your clinical team will apply the Care Management Process: referral, screening, enrollment, management, case closure. Keep in mind the community resources: a) the clinical-community linkages that may exist and b) new ones that may be beneficial. Discuss each question below. After your group completes this case study activity we will have a report out. Within your group, please identify a scribe and a person who will report out.

Background

Mary is an 80-year-old female patient with exacerbation of heart failure. Over the last 6 months she has been hospitalized three times for fluid gain and shortness of breath. Her medical history includes COPD and Type II Diabetes. She is scheduled to see the doctor today. Her primary care physician feels that Mary could benefit from care management services and wants you to meet with her later today.

History Obtained from Medical Records

Prior to meeting with Mary you access her medical record to get a better understanding of what has been going on. You noticed that with this last hospitalization she was admitted for increased shortness of breath and a weight gain of 15 pounds. Upon discharge she was sent home with a new diuretic and oxygen. Mary currently lives alone. She lost her spouse 3 years ago. She receives assistance from her daughter a few days a week. Her current medications include Lasix, Lopressor, and Metformin.

Initial Visit

You meet with Mary after being introduced by her physician. During your conversation Mary admits that she has been having increased difficulty with her vision which has made it harder for her to drive and to manage her medications. She states she has not filled her new prescription yet. She admits that at times she has taken the wrong medication or not at all, even though her daughter sets up her pill box weekly. She complains of SOB when ambulating to the bathroom. She has been afraid to tell her daughter about her vision problems for fear she may have to give up some of her independence. She is on a fixed income which consists of monthly social security. She admits she has been eating mostly canned vegetables and microwave dinners because they are cheaper and easier for her to prepare. You explain to Mary what your role is and how her physician feels she could use a little extra support to help manage her heart failure a little better. She also states that she has been depressed ever since her husband passed away, but has kept this hidden. She is afraid to ask her daughter for more help since she does not want to burden her with any additional concerns. After talking with Mary, you note that she is appropriate for care management. Mary agrees to care

management services to help give her the extra support she needs. In addition, Mary gives you permission to speak with her daughter regarding her care. You touch base with the physician to let her know that care management services will take place. The physician addresses her treatment plan with you focusing on her fluid management and nutrition.

You touch base with her daughter by phone to explain care management services. During the conversation the daughter sheds some light on other issues affecting her mom. She noticed that her mom has had difficulty remembering simple things and when she addressed this with her mom she becomes very defensive. She does not want to put her mother in a nursing facility, but doesn't know what options are available. Due to her other commitments, the daughter is not able to give any more time in assisting her mother.

Referral:

Where did the referral originate?

What other ways might the referral originate?

Screening:

Where would you obtain information to help screen for Mary's appropriateness for care management?

What information would be helpful in screening for Mary's appropriateness for care management?

Enrollment/Engagement:

How would you make the case for care management to Mary? Where would you document her consent to have care management?

What information would you gather during the comprehensive assessment? What would be a top priority/concern?

What screening tools might you use? Remember to only screen for those needs that can be addressed through additional resources.

What SDOH are present?

Management:

Based on the comprehensive assessment, what would be the first step in helping Mary to establish her plan of care?

What might be a short-term goal to help get her started? Long-term goal?

What team members might be involved with Mary's care? What areas might they help address? Include outside resources as well.

How would you communicate Mary's plan with the rest of the team?

Management Follow-Up:

What would you and your team follow-up on with Mary?

How would you and your team follow-up with Mary after helping to establish her plan? How often would you follow-up with Mary?

Closure:

When would it be appropriate to consider discharging from care management?