Case Study Part A: 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 outside resources, and the clinical-community linkages that may exist or new ones that may be beneficial. Discuss each question below. After your group completes this case study activity, we will have report out. Within your group please identify a scribe and a person who will report out.*

You find Mr. Lawson's record while reviewing the morning's Admission Discharge and Transfer (ADT) list. Mr. Lawson is a 68-year-old male who was just discharged from the hospital for an exacerbation of COPD and extreme fatigue. You have access to his PCP medical record as well as the inpatient chart. Per office protocol you schedule a transition of care phone call to Mr. Lawson.

Background obtained from medical records.

Mr. Lawson has a history of COPD, smoking and uncontrolled HTN. During his hospital visit a routine X-ray revealed a large mass in his left lower lung. He was discharged with home O2, new prescriptions and an oncology consult. His PCP medical record also reveals that he is retired and lives at home with his wife, who does not work and suffers from her own health needs. He stated at his last office visit that he receives monthly social security but that his pension was cut off a few months ago. His immediate relatives live out of state.

You perform your transition of care phone call.

During the post-discharge phone call to Mr. Lawson admits he really has not been taking care of himself which led to the hospitalization secondary to not taking his medications and his continued smoking. He states that the diagnosis of the lung mass scares him and doesn't know what he is going to do. He goes on to tell the care manager that he is the caregiver of his grandchildren ages 5 and 9, ever since his daughter passed away three months ago. His daughter was living with them at the time and provided financial assistance. He struggles to make ends meet since his pension from the steel worker union stopped and all he receives is $800 per month in social security. This has led him to make choices between filling his prescriptions, paying the heating bill, or buying groceries. His wife also receives $700 in social security per month, however they still have trouble making ends meet. He is fearful of losing his home and concerned about who will take care of the grandchildren when he and his wife are no longer here. He currently has Medicare however he did not sign up for part B or prescription coverage and does not know how he is going to pay for the new

prescriptions. Mr. Lawson did state that the social worker in the hospital had started the application for Medicaid. Mr. Lawson agrees to come in for a visit.

During the initial visit you complete a comprehensive assessment

You meet with Mr. Lawson in the clinic. He was late for the appointment stating he has unreliable personal transportation and at times has to rely on neighbors to get around. During the visit he opens up more about his health and what is going on in his life. He begins to talk about the lung mass that was found and that he has yet to tell his wife for fear of causing her more distress and anxiety. The hospital did not give him much information except to follow up with an oncologist. Mr. Lawson admits he hasn't seen his physician in over a year. He admits he doesn't read very well and was very confused about the discharge instructions he was sent home with. Furthermore, there has been the threat of child protective services getting involved and he is fearful he might lose his grandchildren. He is trying to do his best, to keep things together for his family.

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.

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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?

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Part B Case Study – SDOH (Day 4)

After reading the case study use your Post It Notes by answering each of the five questions below. Place your answers with the appropriate categories listed on the wall.

1. What system issues are noted?
2. What are the SDOH present?
3. What behavioral concerns are present?
4. What clinical/medical issues are present?
5. What relationship issues exist?

Additional Discussion Questions:

1. What is Mr. Lawson's top priority?
2. How would you approach Mr. Lawson's situation?
3. What community resources would be of value?
4. If Mr. Lawson presented to your practice, would you be able to meet the needs presented in this case study?

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