Case Management Monthly

Complex case: A case manager coordinates care for a loved one

Ever since Pat became a nurse case manager three years ago, both family and friends have reached out to her for healthcare advice. She really doesn't mind and almost expects it, especially since healthcare can be complex and challenging.

By sharing her knowledge as a case manager, Pat can often help people navigate healthcare complexities.

While Pat is great at helping patients at her hospital, she will often go to extremes to help friends and family. For example, Pat's 92-year-old father-in-law, Ray, was hospitalized with heart failure (HF) while Pat was vacationing in Quebec, Canada. Ray is brought to Hospital X, which is in Pat's community but is not where she is employed. However, Pat knows several of the case managers at Hospital X and reaches out to them.

Ray has not been hospitalized for his HF in two years. He has been successfully living at home with minimal medical intervention and a good quality of life.

Pat is worried about Ray but is vacationing too far away to visit Hospital X. The best she can do is to speak with Ray and other family members to piece the case together so she can try to help plan his hospital stay and discharge. After assessing Ray over the phone, Pat decides that it was a pretty straight forward case. She believes this acute exacerbation of her Ray's HF is brought on by normal aging.

The cardiologist orders a Lasix IV drip with cardiac monitoring, at which point it appears he will discharge Ray with three new medications. However, the cardiologist wants further diagnostic testing to confirm his medical course, so the length of stay is targeted at four days.

But over the course of the stay, Ray becomes slightly physically deconditioned and his need for home physical therapy and possible occupational therapy becomes evident. It is then determined that home care intervention is needed to evaluate Ray's response to the new medications and reinforce the education the hospital provides Ray about his medication. Pat realizes that her father-in-law has many immediate needs, but her primary concern is that he returns to the same level of health he was at prior to admission.

Pat believes Ray should be referred to a HF telemonitoring program that incorporates the national HF best practice standards. Since Ray will be discharged home on three new medications, it is particularly important that he see a cardiologist and/or primary care provider within three to five days of discharge, which is a best practice standard. Pat recommends homecare cardiac telemonitoring for daily assessment of Ray's weights while on his new diuretic regime and to prevent future admissions. Daily blood pressure checks are also part of the plan.

Lastly, Pat requests that the cardiologist order a sliding Lasix administration scale to be provided by the home care nurse to intervene at the beginning of any episode of weight gain, ultimately avoiding any future hospitalizations.

Pat cares about Ray and knows repeat hospitalizations would put him at great risk for unforeseen complications and could affect his quality of life.

Pat begins regular discussions with Ray's case managers, who state that they agree with the discharge plan. However, to Pat's surprise and disbelief, not one of her requests is met post-discharge. Ray has home care in place to help with his new medications and physical and occupational therapy, but there is no telemonitoring component or element of a HF transitions in care component. In addition, Ray's visit with his cardiologist is scheduled for three weeks post-discharge. Pat considers this lack of follow-through from personal and clinical case manager perspective and realizes that Ray's case is a clear example of why there are such high readmission rates for patients with HF conditions.

Pat steps in to reinforce her discharge plan, believing that Ray would surely be readmitted to the hospital if her plan were not followed. Pat confirms that Ray is still in agreement with the original discharge plan.

Pat becomes Ray's healthcare proxy, which allows her to contact the cardiologist and home care staff to implement her transition plan. Pat is satisfied that she has taken the right steps to ensure Ray's maximal recovery and health.

Pat isn't sure why the case management team failed to incorporate her wishes into Ray's transition plan, but this case taught her that HF standards that were once new innovations are now a critical component of routine HF care for all patients.