Case Management Monthly

Complex case: Using readmission as a strategy

Pat, a nurse case manager, had noticed an increase in the number of uninsured patients at the hospital where she worked. She didn't know why the past few months had seen so many uninsured come through the doors, but she wondered whether it had to do with her state's healthcare reform. Patients who legally immigrated to the state but did not have five years of residence in the U.S. could only receive insurance coverage for acute hospital stays. They had no coverage for postacute care services. This was the case for Pat's current extended stay patient, Mrs. M, whose hospital stay had lasted more than 30 days. Mrs. M's admission diagnosis was severe stroke associated with symptoms affecting the use of her hands and impacting her ambulation. For the first 25 days, she'd had to be fed through a feeding tube. While waiting for Mrs. M to recover from the acute stages of her stroke, Pat became familiar with the patient's sister, who had sponsored her entry and stay in the U.S.

The sister was a single mother of a 17-year-old, working as a housekeeper with minimal income. When Mrs. M first arrived in the U.S., she and her sister shared an apartment and jointly contributed to expenses; however, since Mrs. M's stroke, the sister had been struggling to make ends meet. When presented with the idea of being Mrs. M's primary caregiver, her sister pushed back. However, Pat knew there were few options for Mrs. M. She could ask the hospital administration about purchasing a plane ticket for Mrs. M to access healthcare in her country of origin, but Pat was not ready to do that. Based on her experience, she felt transitioning Mrs. M to her sister's home was possible.

Pat had been closely assessing Mrs. M's progress over the past two weeks in anticipation of that transition. To help get herself ready, Mrs. M had been participating in an enhanced physical and occupational therapy daily regimen. This intensity of rehabilitation was not usual for patients at Pat's hospital, but special arrangements had been made in order to ensure the patient's progress toward discharge was the primary goal. After those two weeks, Mrs. M had made good progress—using her hands plus developing the ability to ambulate. She also transitioned from the feeding tube to increasing oral food intake.

With this much progress achieved, Pat called a healthcare team meeting to get all the providers on the same page and develop the discharge plan. The providers agreed on planning for Mrs. M to be discharged in 1.5 weeks. A family meeting was arranged, and physical therapy recommended the purchase of home equipment to support the patient's ambulation. Pat began preparations by trying to call Mrs. M's sister, but the calls weren't answered; she asked the social worker to help with this issue. Next, Pat formally requested that hospital administration cover the costs of all the ambulation equipment and approximately two weeks (six visits) of homecare. These visits would allow for patient assessment and would help Mrs. M adapt to the home. Pat also requested timely intervention by the homecare nurse if any unexpected issues arose, plus the implementation of new interventions as the patient continued to progress.

Hospital administration agreed to cover the costs, but asked if Pat could continue to assess the patient to identify any opportunities to reduce expenses. Pat agreed. Still unable to contact Mrs. M's sister, she reached out to the social worker to reconfirm the patient's legal status and ensure the sister had in fact sponsored Mrs. M's green card. She wanted to do this in case deportation would ultimately be necessary. The social worker was worried about contacting legal services, but Pat assured her it was just to verify the patient's status and validate the sister's responsibilities; Pat knew that whoever had sponsored Mrs. M's green card status in the U.S. would be responsible for her care.

Pat left another message for the sister, including an explanation of her role as sponsor. The sister finally returned Pat's call and agreed to attend only one family meeting, as she did not have reliable transportation. Pat offered a round-trip cab voucher for this family meeting, as well as others if needed, but the sister did not agree to any more than a single meeting. Realizing she had limited access to the sister and her son, Pat reconvened the healthcare team to make sure that one meeting would be as effective as possible. Once the team had agreed to the plan, purchased all the necessary equipment, and secured the services of the homecare agency, the family meeting was held. After hearing about the details of Mrs. M's care, her sister agreed to the plan. The target discharge date was set for one week from the meeting, and Pat continued to work to pull the plan together.

Pat aimed to anticipate every potential care issue that could arise at home, and she believed she was on goal when one of her case management colleagues asked how she knew the patient would transition successfully. Because Pat had experience discharging similar patients home, she answered that she was doing the best she could with what she currently knew about Mrs. M's clinical and social condition. Pat added that sometimes, one or two short readmissions might be necessary to deal with unexpected care situations, and that the healthcare team was okay with this reality. She also knew that if necessary, a short readmission or two would secure the patient's stay at home.

With the plan in place, Mrs. M transitioned successfully to home, and Pat and the healthcare team awaited updates from the homecare agency—prepared for a readmission if one occurred.