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The Role of Nurse Case Managers in Preventing Readmissions for High-Risk Patients: Review

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Abstract

Background: The rising prevalence of chronic illnesses and multimorbidity among patients necessitates innovative healthcare strategies to improve care coordination and prevent hospital readmissions. Nurse Case Managers (NCMs) play a pivotal role in addressing these challenges through comprehensive care management.

Methods: This review utilized electronic databases including PUBMED, SCIELO, SCOPUS, and DIALNET to analyze the literature on the effectiveness of NCM interventions in managing high-risk patients. Search terms included "nurse," "case management," and "chronic illness." A manual examination of references was conducted to identify additional relevant studies.

Results: The findings indicate that NCMs significantly enhance patient outcomes by providing holistic, patient-centered care. Interventions led by NCMs resulted in reduced readmissions, decreased emergency department visits, and improved self-management of chronic conditions. The NCM's approach fosters better communication among healthcare providers and encourages patient empowerment, leading to greater satisfaction and adherence to treatment plans.

Conclusion: The role of Nurse Case Managers is critical in the healthcare system, especially for patients with chronic illnesses. By improving care continuity and coordination, NCMs effectively reduce hospital

readmissions and enhance the overall quality of care. Future research should focus on standardizing NCM practices and evaluating their long-term impact on healthcare systems and patient outcomes.

Keywords: Nurse Case Manager, chronic illness, healthcare coordination, readmission prevention, patient outcomes.

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1. Introduction

In all healthcare services, prioritizing the patient within the care system is correlated with the quality of the health system. Consequently, the user transitions from a passive recipient of information to an active participant, possessing more knowledge about their health and rights, and adopting a more proactive stance. Nurses are essential workers in healthcare since empirical data demonstrates that a shortage of nurses poses a substantial danger to patient health [1, 2].

The population's health situation has largely improved in recent years; nonetheless, "long-term disability and chronic diseases are rising due to a rapidly aging population" [3]. Addressing chronicity is a problem for all health systems, including Spain, owing to the implications of an aging population, the need to accommodate the rising number of individuals with chronic illnesses, and the prevalent comorbidity. Addressing these health issues incurs significant expenses in services and benefits that must be managed. This circumstance necessitates the establishment of new professional nursing profiles, characterized by enhanced and advanced competencies tailored to meet emerging needs across many settings and domains of care. The Nurse Case Manager (NCM) exemplifies a rising professional role globally [4].

Case management originated in the United States during the 1950s and 1960s, first used in mental health situations; it subsequently expanded to address individuals with high-risk health issues and significant expenses, "intending to enhance efficiency and reduce variability" [5]. Case management is the collaborative process of assessing, planning, implementing, coordinating, monitoring, and evaluating the options and services required to address an individual's health needs, facilitating communication, and utilizing available resources to enhance quality and cost-effective outcomes. The NCM has emerged as a prevalent entity in Spain, providing care in a dynamic society and addressing individuals with complicated issues stemming from chronic conditions, multimorbidity, frailty, and aging [4]. In Spain, the NCM organizes and oversees the management of patients with chronic illnesses, mostly within Primary Health Care (PHC), particularly for more complex situations necessitating enhanced health system coordination [4].

Although case management has not been primarily conducted by nursing professionals, nurses have often been the preferred practitioners in various hospital environments, although physicians and social workers have also performed this role. Nurses often lead case management due to their holistic understanding of addressing human needs, fostering self-care, and evaluating and planning care [6]. The NCM employs the nursing process as a dynamic approach grounded in theory, facilitating humanistic care aimed at effectively attaining goals. This nurse has a comprehensive understanding of the bio-psycho-social context of the

patient, including their community, networks, and settings, which enhances collaborative decision-making with other professionals in care planning, while accepting responsibility for case management [7].

The case management framework used was the Chronic Care Model (CCM), created by E. Wagner, in 1998 (USA) [8]. The CCM identifies the following components as essential for the management of chronic diseases: the health system, clinical information systems, patient decision support, patient self-management, delivery system design, and the community, encompassing patient organizations and resources, that interact with clinical practice [8]. The primary aim of this approach is to ensure that patients remain engaged and educated throughout the therapeutic relationship, facilitated by proactive professionals equipped to provide quality treatment and achieve optimal health outcomes, with a high level of patient satisfaction. The fundamental concept of this paradigm is that patients will ultimately manage their condition, facilitated by the aforementioned factors [9].

Additionally, the Kaiser Permanente risk stratification model, which categorizes patients based on their required degree of care, has been regarded as a supplementary model [7,10]. At the apex of the pyramid are the highly complex chronic patients, necessitating specialized care from professionals with advanced competencies, such as the NCM, who possess comprehensive knowledge of the patient and their environment, and can facilitate multidisciplinary collaboration and continuity of care [4,6-8].

The case management paradigm enhances Integrated, Coordinated, and Continuous Care by establishing a connection between Hospital Care (HC) and Primary Health Care (PHC). This enhances the coordination of care areas, preventing care loss that jeopardizes the integrity and continuity of the health system [6,9-11]. The NCM's efforts address the complexities faced by patients requiring healthcare across various settings, hence substantiating the need for case management.

Case management is identified as a paradigm of advanced nursing practice that is holistic, and patient-centered, encourages personal autonomy and social engagement, and enables access to resources [12-15]. Furthermore, the responsibilities of the NCM include recruiting dependent patients necessitating a comprehensive multi-professional approach; identifying individuals with significant pathological burdens and elevated risks of hospital admission; striving to deliver the least invasive care; fostering collaboration between primary healthcare (PHC) and hospital care (HC) professionals; ensuring coordination and continuity of care for patients requiring complex treatment across various care levels; developing personalized care plans that incorporate PHC providers; and promoting self-care for individuals and families [16-19].

Given that the patients with whom the NCM engages are those with chronic illnesses and multimorbidity, particularly those with complicated conditions, it is essential to evaluate the outcomes associated with the advanced practice role of the NCM. This is significant due to the rise in long-term disabilities and chronic illnesses, coupled with a profound socio-demographic shift stemming from an aging population, necessitating the reconfiguration of health services and the competencies of its personnel [20-24].

This research aims to elucidate the function of the NCM in care management, assessing its efficacy in managing chronic diseases (health outcomes) and its efficiency within the healthcare system.

2. Methods

The present review used the following electronic databases: PUBMED, SCIELO, SCOPUS, and DIALNET. Terms from the "Medical Subject Headings" [12] (nurse, case management, chronic illness) were used. Furthermore, the phrase "care management" was also used. A manual examination of the bibliographic references of the chosen papers was conducted to include other possibly relevant research into the review using the reverse or secondary search approach.

3. Health Impacts: Efficacy Outcomes in Patients with Chronic Illnesses

The treatments implemented by the NCM were superior in effectiveness and efficiency in managing individuals with chronic conditions compared to those conducted under the old paradigm [25-28]. This nurse can provide equivalent quality of care to doctors across a diverse range of services, including regular monitoring of chronic patients and first assessments of individuals with minor health issues. Enhancements in illness self-management, disease awareness, and quality of life were seen in the investigated patients [25,27].

Case management has shown efficacy in the treatment of several chronic illnesses, including diabetes, hypertension, obstructive pulmonary disease, and cancer care [18,26,27]. The nurse's interventions encompassed the consistent involvement of the NCM with the patient and family during consultations, home visits, telephone communications (enhanced care), assistance in daily decision-making for disease management (personalized patient planning), and the establishment of a follow-up protocol for complications [29,30].

The aforementioned treatments align with those examined by Joo and Huber [22] and Davisson and Swanson [31], whereby the NCM aimed to provide continuous care for the patient with appropriate monitoring to enhance their health status. Caregivers received support via active listening and both emotional and instrumental assistance, enabling them to continue delivering optimal patient care.

Participants enjoyed the case management program's accessibility, both by telephone and in person; the consistency of treatment provided by the same personnel; and the interpersonal interaction developed between the nurse and the patient [31]. The professional-patient relationship enabled the nurse to counsel the patient against immediate self-medication, facilitating a new approach to care that enhanced patients' understanding of their conditions and the identification of warning signs, thereby restoring the efficacy of the aforementioned self-management.

The enhancement of psychological outcomes was examined in studies exhibiting several commonalities, including a gradual shift of care from hospitals to communities, facilitated by ongoing follow-up through home visits or telephone calls (coordinated and continuous care from the hospital setting to the communities). These interventions included holistic care, referral services, patient assistance, and the formulation of shared and consensus-driven objectives [10,21,22,30].

A meta-analysis revealed that there are no significant changes in patient mortality, despite the adverse outcomes associated with case management methods [22]. Nonetheless, no significant impacts were seen

that favored case management for self-reported health status in the short term, patient satisfaction (both short and long term), and functional health, as previously documented [10,18,19,21,24,29-31].

4. Profitability Outcomes: Efficiency

The NCM decreased the use of the emergency department, hospital admissions, readmissions, and the length of these among the examined patients [10,17,21,22,25,29]. This resulted in a decrease in both direct and indirect costs for the healthcare system, as reduced utilization of the hospital emergency department led to fewer diagnostic tests and, due to the accessibility of the case management program, a diminished need for hospitalizations [17,20,21].

Moreover, there was enhanced mobilization of social resources when patients with chronic illnesses received treatment from the NCM [24,25,29,30]. Moreover, it was noted that patients with low income and lower educational attainment experienced equivalent benefits to those with higher income and educational levels regarding diabetes treatment, thereby creating a cost-efficient and effective approach to mitigate diabetes complications, ultimately reducing social inequalities.

5. Discussion

Our research sought to identify the most effective interventions of the NCM to enhance population health and the consequent advantages for the health system. The majority of the previously reviewed research concurred that interventions associated with a case management program, often implemented by nurses, positively influenced individuals' health and resulted in cost savings for healthcare institutions [10,17-19,21,22,24-31].

The ability to analyze articles from various countries reveals that health data concerning individuals with chronic conditions and comorbidities is prevalent globally, particularly among elderly chronic patients who incur substantial healthcare costs [10,17,19,20,23,24,28]. Consequently, efforts have been instituted to achieve savings by enhancing the competencies of professionals, particularly nurses. The treatments used by the NCM have shown a holistic approach, evaluating the individual's requirements and circumstances to provide care that addresses their health issues [10,17-19,21,26,27]. These initiatives seek to diminish the fragmentation of health services to provide integrated and continuous treatment [10,19,23,31].

The interventions conducted by the NCM were thorough, evaluating the individual's requirements and circumstances to provide treatment that addresses their health issues [10,19,21,26,27]. These initiatives seek to diminish the fragmentation of health services to provide integrated and continuous treatment [10,19,23,31]. Furthermore, we observed a significant level of patient satisfaction with the services provided by the NCM, since this nurse dedicates more time to patients, offering them enhanced information and guidance, particularly in chronic follow-up procedures [18,19,26,31]. Except for the last cited paper [31], it is crucial to acknowledge that patient satisfaction with the function of NCM is substantiated by a sufficient degree of evidence.

The reviewed literature indicates that nurse case managers enhanced specific health outcomes: they facilitated medication adherence, resulting in reduced hypertension; they lowered glycated hemoglobin

levels in type II diabetes mellitus patients through direct patient engagement; and they decreased substance abuse by providing users with access to health system services through regular follow-up [19,22,24,26,27]. The substantial data from these investigations instills confidence that enhancing clinical outcomes in patients substantiates the need for NCM. All these studies emphasized the empowerment attained by both patients and their caregivers, facilitated by the training provided by the NCM, which enhanced their ability to manage chronic diseases (hypertension, diabetes, chronic obstructive pulmonary disease, or substance use) [18,26,27,31]. The NCM engaged in several activities, including consistent interaction with the patient and their family at consultations, assistance in daily decision-making, development of a follow-up procedure for problems, support for caregivers, and telephone follow-up [22,25-27,31].

Numerous studies confirmed that the NCM may provide superior outcomes in patients with mental diseases [20,22,30], attributed to motivational interviews and the enhanced interaction of this Advanced Practice Nurse, possessing advanced abilities, with the patients. Despite the existence of research that critiques case management, the same authors demonstrate enhancements in patient satisfaction and functional health [23].

The case management approach has led to a reduction in the use of health services associated with complications of patients' conditions, as well as a diminished risk of complications such as hospitalizations, crises, or readmissions. This resulted in significant savings in healthcare expenses, demonstrating the profitability of the services provided by the NCM [19,21,22]. Despite the variability in case management program characteristics among the assessed studies, all indicate a continuity of follow-up treatment facilitated by home visits or telephone calls conducted by the NCM. The authors indicated that consistent interaction with the case manager may have impacted hospital use outcomes [10,17-19,21,22,24-31]. While the efficacy of NCM seems established, the data may be contentious due to the nature of the research conducted.

Patients highly praised many characteristics, including accessibility (both telephonic and in-person), continuity of treatment (same nurse), and the interpersonal interaction developed between nurse and patient, with the feeling of enhanced support from healthcare professionals. Numerous investigations [21,25-27,31] have determined that the NCM facilitates clients' understanding of their sickness and reduces the need to visit emergency services for inquiries or problems. The findings suggest that the accessibility and nature of the patient connection with NCM constitute a positive for the health system.

The only research that contradicts the case management model is that of Stokes et al. [23], who contended that this treatment approach is ineffective for patients categorized as "at risk" (co-morbid) in primary healthcare. This research just delineates some enhancements in patient satisfaction. These results may be contentious, since Davisson and Swanson [31] assert that the patients identified the nurse as the most crucial component of the program, being the professional most connected to their care and attention. Nonetheless, the predominance of research indicating the improvement of patient health after the

introduction of a case management program underscores the significance of NCM as a pivotal role within health systems.

Numerous research [18,20-23,28], all possessing robust or satisfactory evidence, indicate that nurses refrained from implementing evidence-based practice owing to the absence of a model that integrates NCM treatments. This issue has resulted in a significant diversity of interventions noted in several reviews [20,21,24], which, while producing effective and efficient outcomes, precludes generalization and in-depth analysis due to the absence of a cohesive theoretical model that uniformly integrates all nursing practices.

6. Constraints

This literature review has limitations, as the NCM activities in different countries have been considered; thus, although the activities are similar, the socio-cultural context and the academic development and competence of nurses in each country may affect them. Moreover, the examination of several chronic conditions has precluded a more thorough comparison of case management intervention strategies focused on a singular disease.

Conversely, several studies did not specifically address the NCM but rather presented a broad case management model; while mostly composed of nurses, some of these models also included other professions, including social workers. Consequently, it is essential to conduct additional studies centered on the model developed by nurses to elucidate the results achieved while minimizing potential biases.

The current study should assess the duration required for the NCM to have beneficial health impacts on patients, a facet that has not been examined. Furthermore, they must integrate standardized procedures and established clinical practice standards together with a unique care model to mitigate the diversity of treatments identified in the literature research.

7. Conclusions

The treatments implemented by the NCM are comprehensive, addressing the aims and requirements of each individual while ensuring coordinated and ongoing care. The initiatives undertaken by the NCM enhance the health of individuals with chronic illnesses and comorbidities, facilitating improved outcomes in health metrics. Case management is mostly successful and efficient, as shown by the majority of the research reviewed, leading to a reduction in healthcare expenses and an enhancement in the quality of treatment.

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دور ممرضي إدارة الحالات في منع إعادة دخول المرضى ذوي المخاطر العالية: مراجعة

الملخص

الخلفية :أدى الارتفاع المتزايد في انتشار الأمراض المزمنة وتعدد الأمراض لدى المرضى إلى ضرورة تطوير استراتيجيات رعاية صحية مبتكرة لتحسين تنسيق الرعاية ومنع إعادة دخول المستشفيات. يلعب ممرضي إدارة الحالات (NCMs) دورًا محوريًا في مواجهة هذه التحديات من خلال إدارة شاملة للحالات.

الطرق :استخدمت هذه المراجعة قواعد بيانات إلكترونية مثل PUBMED و SCIELOو SCOPUSو DIALNETلتحليل الأدبيات المتعلقة بفعالية تدخلات ممرضي إدارة الحالات في إدارة المرضى ذوي المخاطر العالية. شملت مصطلحات البحث "ممرض"، "إدارة الحالات"، و"الأمراض المزمنة". كما تم إجراء فحص يدوي للمراجع لتحديد الدراسات ذات الصلة الإضافية.

النتائج :تشير النتائج إلى أن ممرضي إدارة الحالات يعززون بشكل كبير نتائج المرضى من خلال توفير رعاية شاملة تتمحور حول المريض. أدت التدخلات التي يقودها ممرضي إدارة الحالات إلى تقليل معدلات إعادة الدخول للمستشفيات، وتقليل زيارات أقسام الطوارئ، وتحسين إدارة المرضى للأمراض المزمنة. يعزز نهج ممرضي إدارة الحالات التواصل بين مقدمي الرعاية الصحية ويشجع تمكين المرضى، مما يؤدي إلى زيادة رضا المرضى والالتزام بخطط العلاج.

الاستنتاج :يلعب ممرضي إدارة الحالات دورًا حاسمًا في نظام الرعاية الصحية، خاصةً للمرضى الذين يعانون من أمراض مزمنة. من خلال تحسين استمرارية وتنسيق الرعاية، يساهم ممرضي إدارة الحالات بفعالية في تقليل إعادة الدخول للمستشفيات وتحسين جودة الرعاية بشكل عام. ينبغي أن تركز الأبحاث المستقبلية على توحيد ممارسات ممرضي إدارة الحالات وتقييم تأثيرها طويل الأمد على أنظمة الرعاية الصحية ونتائج المرضى.

الكلمات المفتاحية :ممرض إدارة الحالات، الأمراض المزمنة، تنسيق الرعاية الصحية، منع إعادة الدخول، نتائج المرضى.