Implementation of an RN Case Management Program in Student Health

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Introduction

Nursing Case Management is a dynamic and systematic collaborative approach to providing and coordinating healthcare services to a defined population. It is a participative process to identify and facilitate options and services for meeting individuals' health needs, while decreasing fragmentation and duplication of care and enhancing quality, cost-effective clinical outcomes. The framework for nursing case management includes five components: assessment, planning, implementation, evaluation and interaction. (Llewelyn & Leonard, 2009, p.12).

Importance of Case Management in the College Health Setting

1. Promote wellness, healthy choices and a culture of safety
2. Establish an ongoing relationship with students to provide health education and management to ensure optimal health and well-being
3. Coordinate care for chronic or acute medical conditions and assist in managing on and off campus referrals and payor sources

Objectives

- **A nursing case management program is necessary to improve health and wellness in the college clinic setting**
  - Improves the coordination of medical care between disciplines across campus and with off campus medical providers and offices
  - Provides one-on-one education and management of chronic or acute disease processes and new diagnoses

References:

Case Management Referral Process

1. Referral & Warm Handoff: During a healthcare visit, the provider places a Referral to RN Case Management in the EHR and attempts a warm handoff to the RN case manager.
2. Referral Review & Intake: The RN case manager reviews and acknowledges the referral and schedules an initial meeting.
   a. One-time support: Assistance with accessing outside care, often same-day
   b. Ongoing support: Care coordination with outside agencies; intake questionnaire completed
3. Care Coordination: The RN case manager partners with the student to establish goals, schedule appointments, and collaborate with internal and external providers.
4. Provider Communication: Progress and outcomes are shared with the referring provider to support continuity of care.
5. Discharge & Documentation: Once goals are met, the student is discharged and the referral is completed in the EHR.

Intake Form

Purpose: Gather comprehensive, student-centered information to guide care coordination.

- **Presenting Problem** – Reason for referral or primary concern
- **Treatment Goals** – Student's short- and long-term goals
- **Medical History** – Relevant conditions, symptoms, past treatment
- **Family History** – Pertinent medical or mental health history
- **Support Network** – Family, friends, and other supports
- **Cultural Factors** – Considerations influencing care or preferences
- **Employment** – Work status and related concerns
- **Academics** – Year, major, and academic impact
- **Activities & Interests** – Clubs, hobbies, engagement
- **Strengths** – Coping skills and personal assets
- **Trauma History** – Relevant disclosures, if shared
- **Needs & Preferences** – Care, communication, or support needs

Case Example

A 20-year-old female with a history of depression, anxiety, adjustment disorder, OCD and restrictive eating disorder presented with chest pain, dizziness, and exercise intolerance affecting her academic performance

She required pulmonary and cardiac evaluations, complicated by lack of insurance and financial resources.

Case management assisted with applications for hospital financial aid and Medicaid. The student received concurrent virtual psychiatric and psychosocial support through the university. Although she ultimately changed majors due to ongoing symptoms, she obtained necessary medical and mental health care and remained enrolled fulltime. Coordinated care supported her physical, emotional and academic well-being and helped maintain stability in her educational environment.