

# CARE COORDINATION

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# CARE COORDINATION

SUPPORTS THE DOMAINS OF VALUE:

--Access

--Satisfaction

--Cost-effectiveness

# CARE COORDINATION

## SUPPORTS VHA STRATEGIES

- Continuously improve the quality and safety of health care for veterans, particularly in those health issues associated with military service
- Provide timely and appropriate access to health care by implementing best practices
- Continuously improve veteran and family satisfaction with VA care by promoting patient-centered care and excellent customer service.
- Promote excellence in business practices through administrative, financial, and clinical efficiencies.

# WHAT IS CARE COORDINATION?

From the VHA Office of Care Coordination:

“Care coordination in VHA is the wider application of care and case management principles to the delivery of health care services using health informatics, disease management and telehealth technologies to facilitate access to care and improve the health of designated individuals and populations with the intent of providing the right care in the right place at the right time.”

# OFFICE OF CARE COORDINATION

- Care Coordination Home Telehealth—involves home telehealth technologies and supporting the care of veterans in the home
- Care Coordination General Telehealth—involves videoconferencing between hospitals and clinics
- Care Coordination involving Store-and-Forwards Telehealth—involves use of teleretinal imaging for diabetic patients.

# DISEASE ENTITIES CONSIDERED APPROPRIATE FOR CARE COORDINATION

- CHF/Acute heart failure
- HPN
- HEP C/HIV
- Palliative Care
- COPD
- Diabetes
- Chronic Pain
- Anticoagulation
- Low ADL
- Depression
- Dementia
- PTSD
- Bipolar
- Schizophrenia

# VA SUNSHINE NETWORK (VISN 8)

- **Mission:** coordinating the right care, in the right place at the right time
- **Vision:** the place of residence is the site of care
- **Values:**
  - Teamwork
  - Caring
  - Visionary
  - Expertise
  - Advocacy
  - Commitment

# WHAT IS CARE COORDINATION?

From DOD Medical Management Guide:

“...the process of assisting individuals with complex personal circumstances (that place them at risk from diminished independence) to gain access to needed medical, social, educational and other services across different organizations and providers.”

# COMMUNICATION

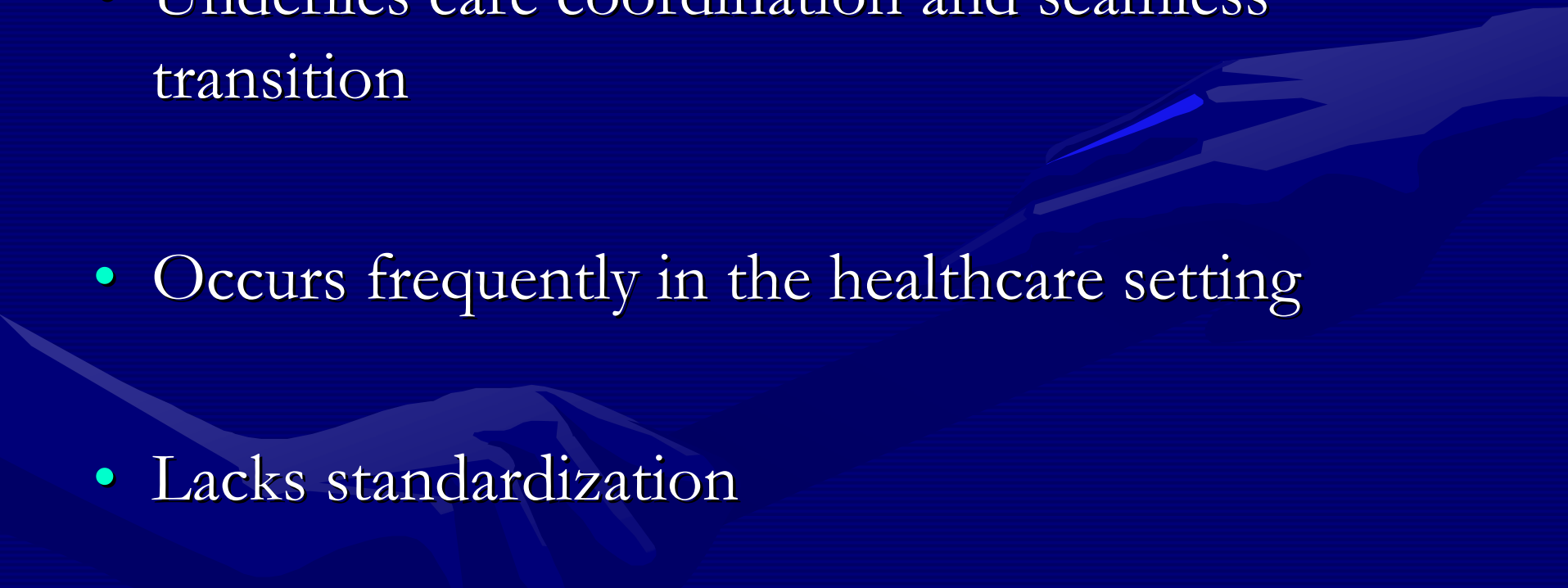
UNDERLIES CARE  
COORDINATION

# CARE COORDINATION

UNDERLIES SEAMLESS  
TRANSITION



# HAND OFF COMMUNICATION

- Underlies care coordination and seamless transition
  - Occurs frequently in the healthcare setting
  - Lacks standardization
- 
- A faint, stylized illustration of two hands shaking is visible in the background, positioned behind the list of bullet points. The hands are rendered in a light blue color, matching the overall theme of the slide.

# COMMON HAND OFFS

- SHIFT TO SHIFT
- EMERGENCY DEPARTMENT TO PATIENT CARE AREA
- ONE PATIENT CARE AREA TO ANOTHER
- PATIENT CARE AREA TO PROCEDURAL/DIAGNOSTIC AREA
- INPATIENT TO OUTPATIENT

# CARE COORDINATION APPLIED TO NURSING

SHIFT TO SHIFT COMMUNICATION  
(AKA REPORT)

- STANDARDIZE USING INFORMATICS
- INVOLVE THE PATIENT

# OUTPATIENT TO INPATIENT

Includes ER To Inpatient Area, Clinic To Inpatient Area, Diagnostic/Procedural Area To Inpatient Area

What information is needed to care for the patient?

Is there standardization?

Who needs to know what?

(Right care in the right place at the right time)

# INTRAHOSPITAL HAND OFFS

Commonly between critical care and other inpatient units often with a stop at a procedural/diagnostic area as a bridge

Utilize informatics and standardize

Do the nurses speak the same language?

(Assist individuals with complex needs to gain access...)

# PATIENT CARE AREA TO PROCEDURAL/DIAGNOSTIC AREA

- Does the staff in the procedural/diagnostic area know the patient?
- What information is essential to provide good care?
- Is it standardized?
- Is the patient involved?

# INPATIENT TO OUTPATIENT

This hand-off is particularly high risk for mistakes, miscommunication and loss of continuity of care.

Discharge instructions—where do they end up?

Informatics is a real solution here.

Need standardization but individualization at the same time.

# The Tallahassee Memorial Healthcare experience

Partnership between the healthcare system and an  
HMO

Looked at their sickest (most complex) patients

Primary care clinic based (center for chronic care)

Patient self management as a cornerstone

# TMH RESULTS

- PCP visits increased 250%
- Pharmacy costs increased 22%
- Inpatient days decreased 40%
- Claims cost for the HMO decreased 18%

<http://www.ihl.org/IHI/Topics>

# CARE COORDINATION OUTCOMES

- PATIENT SAFETY
- PATIENT SATISFACTION