New Hampshire Nurses Association
Innovation and Quality Improvement Conference

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True Story

DID YOU WANT TO TALK TO
THE
DOCTOR
IN CHARGE, OR
THE
CASE MANAGER
WHO KNOWS
WHAT’S GOING ON?
Congress established the U.S. Department of Veterans Affairs (VA) Office of Rural Health (ORH) to address rural health care challenges through research, innovation and dissemination of new models of care.

The mandate states that ORH will:

- Conduct, coordinate, promote and disseminate research into issues affecting Veterans who reside in rural communities
- Develop, refine and promulgate policies, best practices, lessons learned, and innovative and successful programs to increase access to care for rural Veterans
Veterans Rural Health Resource Centers (VRHRCs) are ORH’s field-based satellite offices located at VA medical centers in Iowa City, Iowa; Salt Lake City, Utah; and White River Junction, Vermont. As hubs for rural health care research, innovation and dissemination, VRHRCs:

- Collaborate with VA Health Services Research & Development to conduct research on health care disparities affecting rural Veterans
- Innovate new approaches to care coordination for dual use Veterans, including those who use Community Care programs
- Identify primary care provider recruitment and retention techniques to address rural provider shortages
- Develop innovative interdisciplinary treatment models to improve the quality and efficiency of care
- Use VA Telemedicine and Informatics tools to improve access to care
- Analyze data to identify patterns and characteristics of rural populations associated with suicide, suicide-related behavior and substance use disorder
- Use geospatial solutions to drive rural geographic database design, rural policy analysis, and strategic planning in support of rural Veteran health care
Background

- There is a movement within Veteran's Health Administration and the healthcare industry to provide Veteran wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation with the use of Case Management.

- Case Management is a collaborative process of assessment, planning, facilitation, and advocacy to meet a Veteran’s individualized health care needs through communication and available resources to promote quality cost-effective outcomes. Within our current structure, there was a lack of case management practice and care coordination which leads to Rural Veterans receiving fragmented care and suboptimal outcomes.
Overall Goal

- To implement a Case Management program at Manchester VA Medical Center to have care coordination, continuity of care, and enhance community partnerships for the rural Veterans of New Hampshire.
Specific Aims

- **Excellence in Clinical Care**: Clinical outcomes will be enhanced by developing and implementing standard processes.

- **Maximizing Financial Resources**: The process of review of patients in outside facilities under Fee Services authorization by case managers will be enhanced by ensuring this is a responsibility of case management in all clinical settings.

- **Community Stewardship**: Established staff responsibilities, cross coverage and standardized processes will result in improved relationships with community hospitals and healthcare agencies.

- **Preserving and Promoting a Healthy Workforce**: Ongoing educational programs and initiation of basic Case Management competency criteria will result from this consolidated work group.

- **Performance Standards**: Manchester will help lead Case Management programs within the VISN to have a standardized and comprehensive Case Management system that combines utilization management, clinical resource coordinators and outpatient case management into one department to serve our vulnerable Veteran population.
Methods

- Initiation of Outpatient Nurse and Social Work Case Managers in the Northern New Hampshire CBOCs with a comprehensive and methodical approach.

- Planning and design of a tried and sustained model of Case Management from White River Junction VAMC.

- Control and integration of informatics, communication tools, and training to implement the program.

- Evaluation will be ongoing with assessments, interventions, and monitoring of workloads, flows and Veteran outcomes.
Products/Deliverables

- Use multiple metrics to identify patients with modifiable risks and implement risk-based approaches to identify patients most in need of care management services and implemented resources for successful Veteran-centric management.

- A Case Management program which provides leadership and strategic direction for Care Coordination/Case Management programs across the organization, in a variety of settings, including primary care, mental health, and clinical resource coordinators to improve care and outcomes to Veterans.
Rural Health Grant

- Rural Health Grant submitted May 2018 for $888,617.00
- Awarded $888,617.00 in June 2018

And here is where the fun began.................
Collaboration starts – “We are all in this together”

- Weekly meetings between Office of Community Care Medical Director, Case Management Nurse Manager and Chief of Social Work.

- Observations of need and dialogue with clinic staff and leaders.

- Interviews
  - Each RN and Social Work position interview panel included both Nursing and Social Work staff.

- Site visits to each clinic – paint the picture for the future, review space and continue conversation on goals.
May 2018 application submitted to Rural health grant

June 4th
2 RNCM, 2 SW and 1 Advanced MSA posted

Advanced MSA: Started 9/6/18
RN Case Manager (RNCM) Tilton: Started 9/20/18
RN Case Manager (RNCM) Conway: To Start 10/1/18
SW Conway: Started 8/19/18
SW Tilton: Start Date 9/30/18

August 13th
2 RNCM 1 SW and Advanced MSA Posted

September 10th Interviews started
Advanced MSA:
RN Case Manager Portsmouth: RN Case Manager Somersworth: SW Portsmouth:

October 1st inpatient case managers will begin tracking 30 day readmissions for Conway and Tilton CBCOC’s

Mental Health RN Case Manager started 10/14/18

Tentative offers accepted by Somersworth and Portsmouth RNCM selections.

Grant application approved. May 2018 $880,000. First Installment deposited to Manchester VA Medical Center

July 2-6 all interviews conducted

VETERANS HEALTH ADMINISTRATION
What is Case Management

- Case management is a specialized and highly-skilled component of patient care management. Case management has an accepted and recognized role in the coordination of care required by patients with chronic, catastrophic, or complex high-risk or high-cost health care issues.

- Case management also has a recognized role in the coordination of care required by patients with mental health, psychosocial, or environmental issues.
Who do we care for?

- Individuals who require case management often require intensive support and monitoring due to complex medical, mental health, or psychosocial factors beyond the services offered by the care management team.
Nurse Case Managers

- Nursing case management addresses the medical, nursing, and/or personal care needs of Veterans to enable their return to an optimal level of functioning.

- They identify cost-effective resources while providing quality care to reach the desired outcome and is an essential component of case management services.

- RNs conduct a comprehensive assessment of the Veteran and the Veteran’s family/caregiver.

- RNs also support systems that identify actual or potential problems, set health care goals, reassess the Veteran's progress towards those goals, and adjust the Veteran’s health care plan as needed in collaboration with the Veteran’s multidisciplinary health care team.
Social Work Case Managers

- Social Work Case Managers (SWCM) address the individual’s bio-psychosocial status, social system, and resources available. The SWCM accomplishes this by linking Veterans with services, resources, and opportunities to optimize their quality of life.

- SWCM demonstrate their expertise by navigating complex health and social service systems, combined with their unique psychosocial perspective, in helping Veterans and their families/caregivers access resources, to maximize the Veteran’s independence, health, and well-being.
Levels of Case Management

- **Intensive-Acute Case Management** requires daily or weekly patient and family/caregiver contact.

- **Progressive-Chronic Case Management** requires at least monthly patient and family/caregiver contact to ensure a support system is in place.

- **Supportive-Chronic Case Management** requires, at a minimum, quarterly patient and family/caregiver contact to allow for the monitoring of the care plan.

- **Lifetime-Chronic Case Management** ensures consistent access to, and collaboration for, care delivery at the medical facility, with other providers, or community resources.
1) Assign appropriate level of CM
2) Enter in tracking tool
3) Monitor for CM

Assign RN or SW Case Manager

Provide comprehensive assessment

Monitor progress towards goals

Intervention

Create a measurable goals or treatment plan

Terminate/Warm Handoff

Case Management or Social Work Consult is received

Provide comprehensive assessment

Intervention
Care Coordination: Case Example

A real example of 90 minutes spent with Veteran and Spouse with a RNCM in Tilton

Case Management Assessment and Actions

1. Schedule PACT appointment. Veteran hasn’t met his new PCP, and was last seen in Primary Care in April 2018 (prior to his amyloidosis diagnosis). Medication list is also not up to date.

2. Schedule Social Work appointment. Veteran doesn’t have advance directives.

3. Enter Home Health Aide/Homemaker consult. Veteran needs full care for multiple ADLs.

4. Entered Caregiver Support consult. His wife got emotional multiple times on the phone. She’s dealing with a lot, plus one of their adult children passed away 2 years ago.

5. Enter GEC Skilled Home Health consult for PT/OT. They recently had Merrimack VNA providing PT/OT services, but she was not happy with their care. She has put these services on-hold right now. Will request the home health services not to be outsourced to Merrimack VNA. He has declined since starting chemo in August; however, he’s now on a new treatment. He is unable to walk and can only pivot for transfers. He was walking and driving only 2 months ago.

6. Enter HBPC consult. He’s homebound and I think he would be a very appropriate HBPC referral. His CAN is 90.

7. Enter order for incontinence supplies that they’re currently paying out of pocket for – incontinence briefs, disposable chux, condom catheters, and drainage bags.

8. Review community hem/onc records because there was apparently a medication that was denied by the VA because it’s non-formulary, but there was never a non-formulary request entered. Working on obtaining.

9. Change Midodrine medication from community pharmacy to VA pharmacy. They have a ~$40/month copay.

10. Enter HISA grant consult. They’re interested in getting a walk/roll-in shower because it’s a lot of work to get him in/out of the tub right now. They do have a ramp into their home that the American Legion built for them.

11. Wife wants to hold off on a respite consult for right now until she talks about it more with Veteran.

12. Email to his PACT team to continue care coordination.

Veteran Outcome Care Coordination
Ambulatory Care Sensitive Condition
COPD

Case Management Nurses Started


COPD COPD COPD

COPD

Linear (COPD) Linear (COPD)
Ambulatory Care Sensitive Condition
Heart Failure

Case Management Nurses
Started

Prorated Admissions
Prorated Readmissions
Uniques
Linear (Prorated Admissions)
Resources


Questions