VIRGINIACARE PARTNERS | An HCA affiliate

PROGRESS NOTES

from the CMO, Dr. Georgean deBlois

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Enhanced Care Coordination for Patients Seen at HCA Facility

Providers Notified of Hospital Visit

VCP's **Transitions of Care** Nurse Care Managers visit network attributed patients after admission and before discharge from HCA facilities to provide support as they transition home. They call patients seen in the ED and admitted patients after discharge. Transitions of Care, with support from HCA, is a benefit of your participation in the network. Your VCP patients receive additional care coordination at no additional cost to them.

TRANSITIONS OF CARE*

VCP Attributed Patient Presents in:

HCA Va Inpatient or ED	Non HCA Inpatient or ED
CARE COORDINATION	**CARE COORDINATION**
VCP Nurse Care Manager:	
Visits patient in hospital or follows up by phone if seen in ED to ensure that	?
• patient understands diagnosis • PCP is notified of admission • patients receive After Hospital Care Plan (if admitted) which includes discharge instructions, immunizations received, med list, etc.	?
PATIENT DISCHARGED	**PATIENT DISCHARGED**
Calls patient to provide support and	?
• review discharge meds and orders • schedule and coordinate follow up appointments, labs and other tests • assess patient status to identify potential complications or problems and alert providers if necessary • integrate behavioral health services when needed under direction of PCP	?
CLOSED LOOP CARE COORDINATION	**CLOSED LOOP CARE COORDINATION**
• faxes discharge summary, medication list and orders or ED report to PCP and/or specialist(s) • collaborates with HCA hospital team to coordinate post-discharge services • follows up with providers on outstanding test results	None

* Excludes maternity delivery, oncology, psych admits and rehab

This dedicated approach to improved care coordination enabled by the VCP/HCA affiliation delivers value to you and your patients by:

- ensuring continuity of care
- sharing of medical documentation and patient status
- increasing patient satisfaction
- reducing readmissions and repeat emergency department visits

The Transitions of Care team includes Nurse Care Managers, a clinical pharmacist, a licensed clinical social worker and a registered dietician.

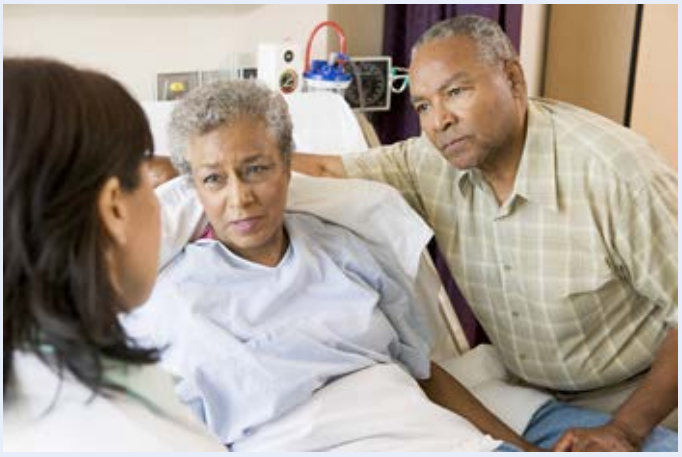
The program is offered at the following HCA facilities: Chippenham, Johnston Willis, Parham Doctors', Henrico Doctors', Retreat, John Randolph Medical Center and West Creek, Hanover and Swift Creek Emergency Centers.

Transitions of Care in HCA Facilities Demonstrates Success

Enhances Patient and Provider Satisfaction

A patient newly diagnosed with congestive heart failure (CHF) was visited by Ari Sprenkle, one of VCP's Transitions of Care nurse care managers, during his stay at Johnston Willis. The patient wanted to be proactive about his health but didn't understand many of the instructions (i.e. the reason for daily weights, fluid restriction and low sodium diet). Ari educated him about why he needed to do these things and coordinated follow-up appointments with his PCP and cardiologist.

VCP's nurse care manager Karen McFarland, while visiting a patient in Henrico Doctors' ICU after being admitted for a heart attack, asked about other specialists or providers that he sees. Karen subsequently notified his endocrinologist. The patient told Karen he was delighted when the endocrinologist contacted him at home. The physician was concerned for the patient she had managed for many years and would not have known he'd been hospitalized without Karen's notification. The patient and the doctor were appreciative of Karen's work in making sure his care providers were aware of his condition.



After a patient was seen in one of HCA's Emergency Centers for depression and was discharged with a recommendation to see a behavioral health provider, Jeff Beck, VCP's new LCSW, worked with network behavioral health providers to find a follow-up appointment within the week. The patient's family was relieved as they were having difficulty finding a provider who was available soon after discharge. Jeff will be following up with the patient and his family to insure that he is receiving the care he needs.

For VCP attributed patients seen in an HCA facility, their providers are notified and receive medical documentation including discharge summary and orders, medications, immunizations received and any lab tests done during hospitalization. In addition, this serves to notify the practice that their patient is eligible for office-based transitions of care visits. The nurse care managers and team follow up with patients 1 and 9 days, and more frequently if needed, after hospitalization to coordinate care, monitor status and alert providers of complications or concerns if necessary.

LCSW Joins Clinical Team

Jeff Beck, LCSW

Essential to improving the health status of patients is the integration of behavioral health into the delivery of care provided by the network. As part of our clinical team that provides Transitions of Care and Chronic Disease Care Management for diabetes and hypertension, VCP welcomes Jeff Beck, a licensed clinical social worker.

For patients discharged from an HCA facility with a behavioral health diagnosis or for chronic disease care management patients who score high on depression screening, Jeff will connect patients to their EAP benefits and coordinate care with behavioral health network providers in collaboration with the patient's PCP. He will also support patients in management and adherence to treatment plans.

Before coming to VCP, Jeff was Director of Community Based Services at St. Joseph's Villa. He worked as a clinical supervisor and family therapist at Family Insight and received his Masters of Social Work from VCU.

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