Petaluma HealthCenter

The Nursing and Case Management Department

Team Nursing	RN Case Management
• A team of nurses provides population health support for a group of patients • The objective of team nursing is to give the best possible quality of patient care by utilizing the abilities of every member of the staff to the fullest extent and by providing close supervision both of patient care and of the individual who give it.	• Case Managers provide ongoing support for high risk clients with the goal of improving patient health outcomes and reducing re-hospitalization within 30 days of discharge. • Case Managers collaborate with providers and other partners to manage multiple aspects of a patient's care, including planning and assessment, coordination of services, patient education, and clinical monitoring.
Patient: • Has an appointment at health center • Walks in for triage • Calls in with a question, concern or request • Medical Complex • Mentally ill with medical complexity	**Patient is:** • Medically complex • Mentally ill with medical complexity • In Crisis **Patient has:** • Multiple ER visits or hospital admissions • Multiple Specialists • Multiple issues requiring extensive care plan and follow up
Patient needs: • INR • Medication reconciliation • Triage appointments if a provider is not available/ walk ins • UNNA boots • Wound care • Asthma management • UTI symptoms • Sore throat complaints • Diabetic appointments, A1C, BG testing • Contraceptive counseling • Emergency contraception • Multi-dose vial Testosterone injections • Ceftriaxone injections • Synagis injections	**Patient needs:** • Assistance transitioning from hospital care, i.e. medical follow-up and psychosocial needs. • Help identifying and prioritizing list of health issues, and creating a plan for immediate and long-term health goals. • Long term care, largely related to chronic illness(s). • Ongoing follow-up help with medication, including supplements/vitamins and clarifying dose, frequency, and perceived benefit. • Education and counseling about disease management. • Help identifying problems with healthy food choices, exercise, and stress reduction/management. • Direction towards accessing social and community resources by deferring to Patient Navigators.
Benefits for the Health Center: • Central part of the comprehensive, patient-centered health care team. • Each member of the team participates in decision making and problem solving. • Provides continuity of care and facilitates meaningful care giving. • Improves patient health outcomes and quality of care, and boosts patient retention.	**Benefits for the Health Center:** • Improve patient health outcomes and quality of care. • Reduce re-hospitalization of patients. • Improves medical adherence and self-management skills. • Frees up provider schedules by reducing unnecessary clinic or hospital visits. • Maintains good working relationship with community health partners by working as a liaison with other agencies and the community.

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Patient Navigator

- Coordinates care and provides ongoing support for high risk clients by identifying and addressing the social barriers to health, including assistance with navigating the complex web of social and community resources.
- Provides one-time assistance with identifying and accessing social and community resources, and maintains list of available community resources for patients and clinic staff.

Patient is:

- Medically stable
- Mentally stable

Not in crisis

Patient needs:

- Help identifying and prioritizing list of social needs affecting health (needs assessment), such as Housing, Employment, Food, Medical Insurance, Transportation, Legal or Financial Issues, or other issues as needed.
- Information about various community resources available to them to address their needs.
- Ongoing support to access necessary community resources, including an advocate acting on the patient's behalf, and follow up to ensure next steps have been completed appropriately.
- Ongoing/repeated help looking for employment or filling out forms online.
- Help with multiple forms and following up with their progress.
- Referral to CEC for obtaining medical insurance and food stamps if needed.
- Direction towards additional clinic resources such as group classes, acupuncture, etc., and help enrolling and scheduling.
- One time consult related to Housing, Employment, Food, Medical insurance, Transportation, Legal or Financial issues, or other issues as needed.
- Application assistance, including filling out forms and providing translation for those available only in English (e.g., Burbank housing).

Benefits for the Health Center:

- Improve patient health outcomes and quality of care.
- Extend clinic's time with patients but frees up Provider schedules
- Free up CAAs and Case Managers from less-complicated problems with easy solutions.
- Maintains good working relationship with community health partners by working as a liaison with other agencies and the community.