# The Role of Nurses in VA Care Coordination

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The World Health Organization (WHO) states that “Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity”. Nurses often serve as experts in care coordination to address the Veteran’s holistic needs including biopsychosocial, spiritual, and environmental domains of health. Nurses serve in multiple care coordination roles throughout the VA, such as care coordinators, care managers, case managers, and nurse navigators in the inpatient, outpatient, residential, and community settings. In the outpatient setting, the Patient Aligned Care Team (PACT) RN Care Managers partner with Veterans suffering from chronic disease(s) such as diabetes mellitus or heart failure, to strengthen self-management knowledge and strategies. In the inpatient setting, RN Care Coordinators lead interprofessional efforts to optimize inpatient care coordination and prepare the Veteran for discharge, ensuring a seamless transition from the inpatient to home and outpatient settings. In Mental Health Residential programs, RN Coordinators bridge the gap between mental health and physical health, ensuring the Veteran’s body and mind are cared for as one. Home Telehealth RN Coordinators provide disease management and care coordination support to improve Veteran outcomes related to chronic disease management in the home setting. Nurses are positioned along the continuum to facilitate communication, collaboration, and coordination of the Veteran’s care.

Nurses are integral to the Care Coordination & Integrated Case Management (CC&ICM) Initiative, in partnership with Social Work partners to lead nationwide transformation efforts in realigning resources and integrating organizational and clinical processes. The goal is to more effectively and efficiently coordinate care along a seamless continuum that enhances the Veteran experience through the assignment of a Lead Coordinator. Often, Veterans may feel lost when multiple health care teams are involved in care planning and treatment delivery, especially if collaboration and communication among the varied disciplines is not well harmonized. Veterans with the highest risks often use the most resources, resulting in being assigned to more than one care coordinator, care manager, and/or case manager along the continuum. These multiple assignments result in duplicative and fragmented care coordination services, which inevitably lead to Veteran and clinical dissatisfaction with the care process. The Office of Nursing Service is leading the CC&ICM Initiative with a team of subject matter experts and field advisers, including frontline care managers, case managers, and Nurse Managers to transform how care services are integrated throughout the VHA. The CC&ICM initiative addresses many enterprise risks identified in the VHA Modernization Plan, including strengthening vertical and horizontal integration of care delivery along the entire organization, clearly defining roles and responsibilities related to care coordination, and utilizing predictive data analytics at the point of care to capture the right Veteran at the right time within the right level of care coordination for the right cost. Additionally, the CC&ICM initiative is aligned with the VHA Operational Plan by striving to improve the Veteran and Employee experience, integrating VA and Community Care with the MISSION Act, enhancing documentation tools within both CPRS and Cerner to capture seamless care coordination services, and transforming business systems by taking a systems and clinical integration approach to transform care coordination delivery through a Lead Coordinator assignment.

The CC&ICM initiative is one of many ways VA Nurses throughout the nation are leading healthcare transformation. To hear more about Veterans’ experiences with the CC&ICM Initiative, please watch: <https://www.youtube.com/watch?v=qJLU_25ZeQs&list=PL3AQ_JVoBEyyzD7KKLkjdffNE717HAwFc&index=4>