

# **Keys For Success:**

## **Continuity of Care**

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**Marianne Canady, RN, MA, CPHQ, CCM**  
**Program Director, Home Health Quality Improvement,**  
**Health Services Advisory Group (HSAG)**

# Continuity of Care Coalition (C3) Goal

- To achieve the safe transition of care

# C3 Objective

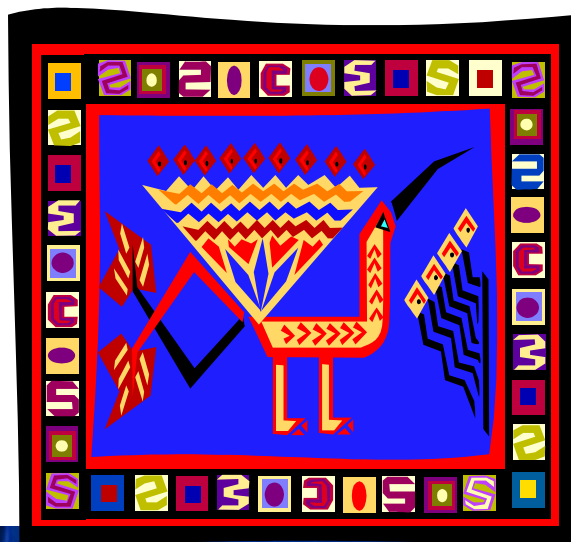
- To achieve timely transfer of complete and accurate patient information in every transition of care

# C3 Stakeholders

- AAHC
- AHCA
- AHCCS
- AzAHA
- Health Plans
- HSAG
- MICA
- SHM

# Community Collaboration to Improve Patient Care for Pressure Ulcers

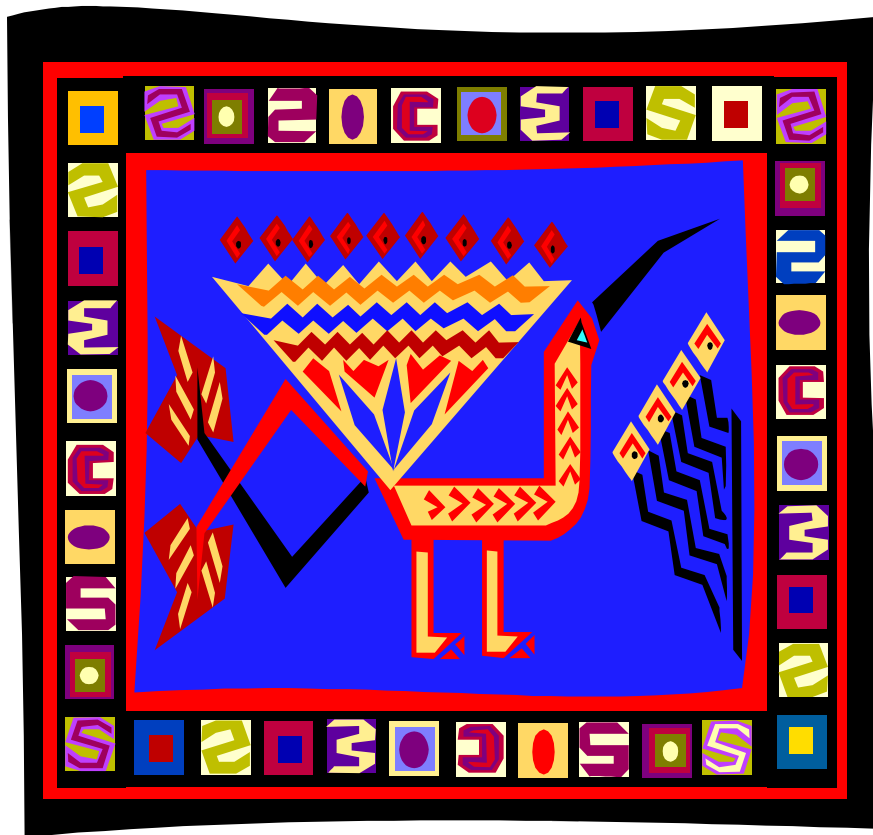
## Provider's Coordination Of Care (PCOC) Prescott Work Group



# PCOC

Rural workgroup in  
Prescott, Arizona

- Nursing home
- Hospital
- Home health agencies



# PCOC Mission

- To improve the health outcomes of Arizona's Medicare beneficiaries in nursing homes, hospitals, and home health programs through effective cross-setting coordination of care.

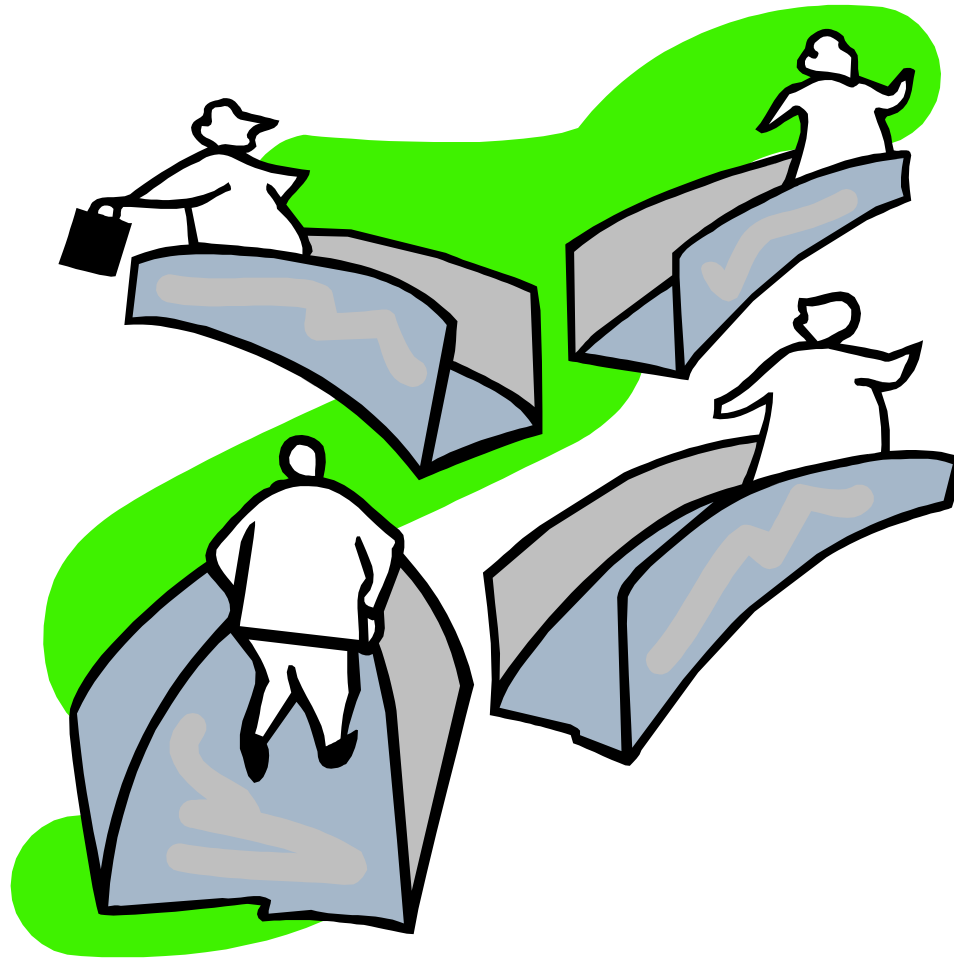
# Successes

- Sharing information
- Breaking down barriers
- Appreciating what other settings do
- Recognizing strengths and opportunities for growth
- Greater appreciation for the importance of coordination and consistency of care

# Successes (continued)

- Importance of continuity of care in regards to:
  - Patient satisfaction
  - Appropriate use of resources
  - Cost-effective care
- Potential cost savings
- Improved compliance with regulatory requirements
- Develop a sense of community

# The Bridge Between



# Case Management

The Bridge Between:

- Settings
- Disciplines

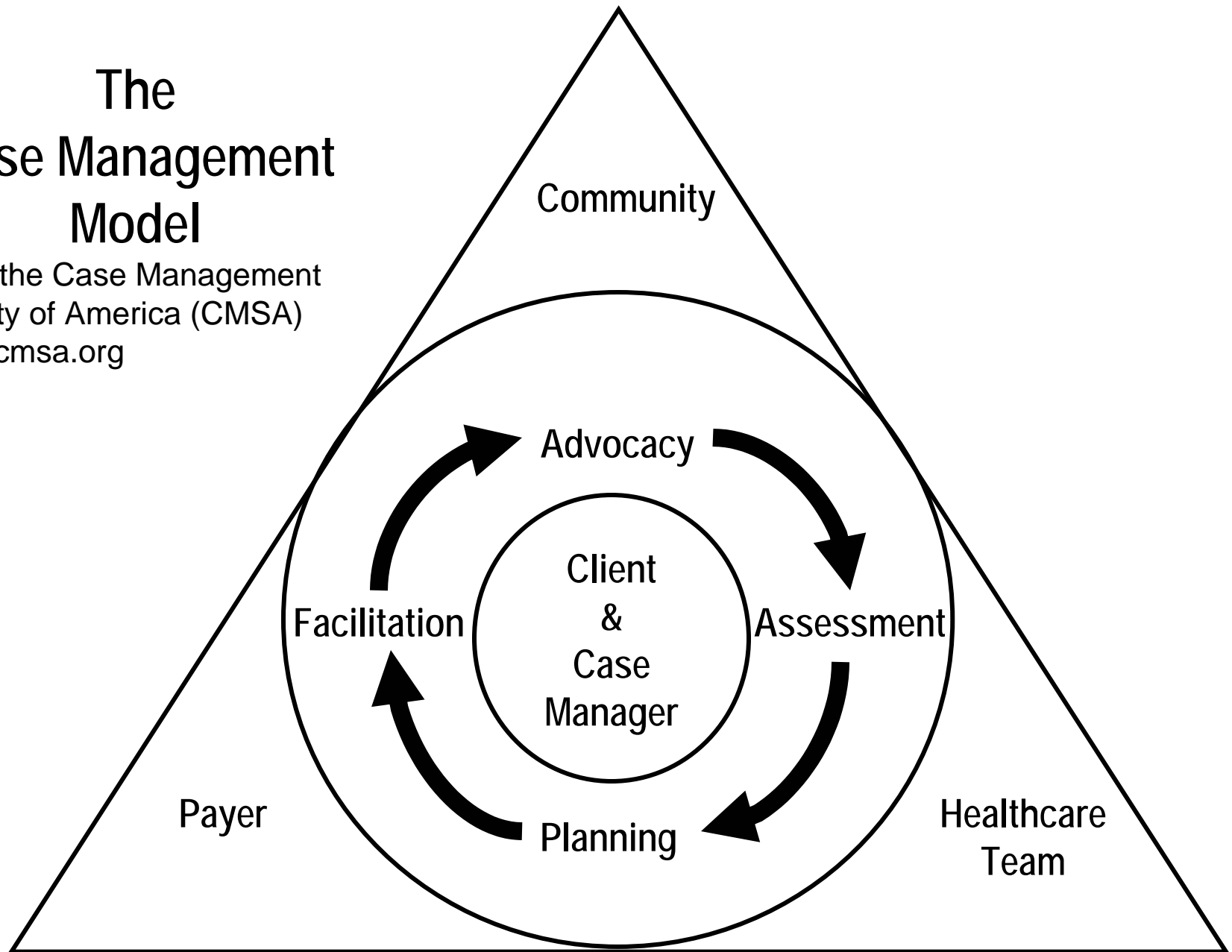
# WHY Should Case Managers Care?



- Because they constitute the cornerstone of good medical care by:
  - Optimizing clinical and economic outcomes.
  - Facilitating proper diagnosis.
  - Maximizing clinical effectiveness.
  - Eliminating unnecessary care.
- Because case managers (and CMS) are committed to “*the right care for every person, every time.*”

# The Case Management Model

From the Case Management Society of America (CMSA)  
[www.cmsa.org](http://www.cmsa.org)



# The Case Manager as a “Planner and Monitor” of Care

Three key elements from CMSA include:

1. Engaging the client/family in the planning process.
2. Ensuring the development of appropriate contingency plans for EACH step.
3. Recognizing the the plan of care is DYNAMIC and may require ongoing assessment and re-evaluation of health and progress.

# Role of Case Management

- Planning
- Facilitation
- Education

# Role of Case Management

- Problem solving
- Client empowerment
- Advocate

# Questions?

**Tell me and I'll forget.  
Show me, and I may not remember.  
Involve me, and I'll understand.**

**-Native American Proverb**

# Contact Information

Mary Fermazin, MD, MPA

VP, Health Policy & Quality Measurement

602.745.6207

[mfermazin@hsag.com](mailto:mfermazin@hsag.com)

Marianne Canady, RN, BSN, MA, CPHQ, CCM

Director, Home Health Quality Improvement

602.665.6113

[mcanady@azqio.sdps.org](mailto:mcanady@azqio.sdps.org)

Colleen Angotti

Administrative Assistant II

602.745.6295

[cangotti@azqio.sdps.org](mailto:cangotti@azqio.sdps.org)