Grand County "Generalist" Patient Navigator as a Model for Rural Colorado

Assuring clients get the care they need when they need it

Public Health in the Rockies
September 19, 2013

Grand County Partnership

Today's Goals

1. Explain how the Grand County community determined the need for a generalist patient navigator and how it fits with the local healthcare providers' 10-year plan;
2. Discuss patient navigator 'toolkits' to implement a well thought-out program from the beginning that illustrates outcomes to partners and funders;
3. Describe a patient navigator model in rural communities and how it may differ from urban expectations.

N
To Steamboat Springs
Rabbit Ears Pass
Lake Agnes
Continental Divide
To Walden
Never Summer Wilderness Area
Rocky Mountain National Park
To Estes Park
Arapaho National Forest
Turquoise Creek
Willow Creek
Cabin Creek
Tonahutu Creek
GRAND LAKE
Grand Lake
East Inlet
Shadow Mountain Reservoir
Willow Creek Reservoir
Granby Reservoir
Indian Peaks Wilderness Area
Red Dirt Reservoir
Gore Creek
To Toponas
KREMMLING
HOT SULPHUR SPRINGS
Colorado River
GRANBY
SILVERCREEK
Meadow Creek Reservoir
Caribou Lake
Columbine Lake
PARSHALL
Williams Fork Reservoir
Routt National Forest
Colorado River
Beaver Creek
Fraser River
TABERNASH
RADIUM
Williams Fork
FRASER
Corona Lake
Pumphouse Lake
WINTER PARK
To State Bridge
To Silverthorne
Kayser Creek
Kinney Creek
St. Louis Lake
St. Louis Creek
Vasquez Creek
Jim Creek
Darling Creek
To I-70 and Denver
Arapaho National Forest
South Fork Williams Fork

Case Study #1 – Joe Smith

- Initial presentation & referral
- Initial hospitalization(s)
- Initial diagnosis
- Initial barriers

Determining Community Need

Community Need

<u>Needed "No Wrong Door" Approach</u>

- Variety of health and human services
- Variety of resources in- and out-of-county
- No one entity with most up-to-date information
- Several systems not working efficiently together

2010 Qualitative Evaluation

Four pillars of healthcare in Grand County. Combined, these pillars will create a ***medical neighborhood***!

1. ***Health Literacy***
2. ***System Navigation***
3. ***Accessibility***
4. Technology

2010 Qualitative Evaluation

- Develop an advocate program to inform patients about health resources
  - Organize information and provide referrals
- Hire a patient navigator to assist in accessing healthcare and insurance options

- Community directed Registered Nurses
  - Expertise in healthcare and medical language
- “Generalist” rather than disease or population specific

Community Need

Healthy Grand County 2020 plan

- Created by local healthcare providers in 2010 to improve healthcare by the year 2020
  - 18 topic areas – all with the ultimate goal of ensuring everyone has a medical home and improved health literacy
- Care coordination and patient navigation is the cornerstone to the plan

Healthy Grand County 2020 Plan

Commitments to Grand County

- Removing all perceived barriers to care
- Assisting patients in finding a personal medical home
- Educating the public to educate the community as a whole and begin a culture (healthcare) paradigm shift.

- 1st Step in accomplishing these commitments was to hire a county patient navigator

Case Study #1 – Joe Smith

- Providing base of health literacy
- Increasing self-management
- Community Connections

Program Development Toolkit

Program Development Toolkit

- Identify goals
- Advisory committees
- Patient Navigator Job Description
- Policies and Procedures
- Intake
- Release of Information
- Action plan
- Evaluation tools
- Training
- Data tracking
- Outreach
- Memorandums of Understanding, if applicable

Program Development

Goals:

- Coordinates medical care by linking patient, healthcare providers and human services
- Reduces barriers to care
- Improves patient and/or care-givers' health literacy and self-managed care through empowerment and coaching
- Reduces unnecessary Emergency Department visits, especially for the chronically ill
- Reduces hospital re-admissions within one month of initial hospital visit

Patient Navigator Program

<u>Advisory Committee</u>

- Social services
- Hospital
- Private primary care clinic
- Family resource center
- Board of Directors

<u>Professional Advisory Committee</u>

- Social Services
- Home Health
- Hospital
- Private primary care clinic
- Mental health
- Family resource center
- All navigators

Patient Navigator Duties

Job Description

- Acts as the extension of the PCP by reinforcing treatment plans, education, etc.
- Advocates for the patient
- Coordinates care
- Follows patients for 1 month after hospital stays to prevent re-admission / coordinate care transition

Patient Navigator Program

Policies and Procedures

- Point-of-Entry
- Patient responsibility
- Patient navigator responsibility
- Healthcare provider responsibility
- Routine practice & exemptions
- Wait list
- Customer complaint & appeals
- Scope of Work
- Evaluation implementation
- Assisting clients with finances
- Home visits
- Transporting clients
- Volunteering for clients

Assessing Clients' Needs

Intake

- Primary needs
- Barriers
- Primary care provider
- Action plan
- Disclosures and Release of liability

- Simple intake for simple cases

Release of Information

- Social services partners
- Receiving medical records/communication with providers
- As PN deems necessary

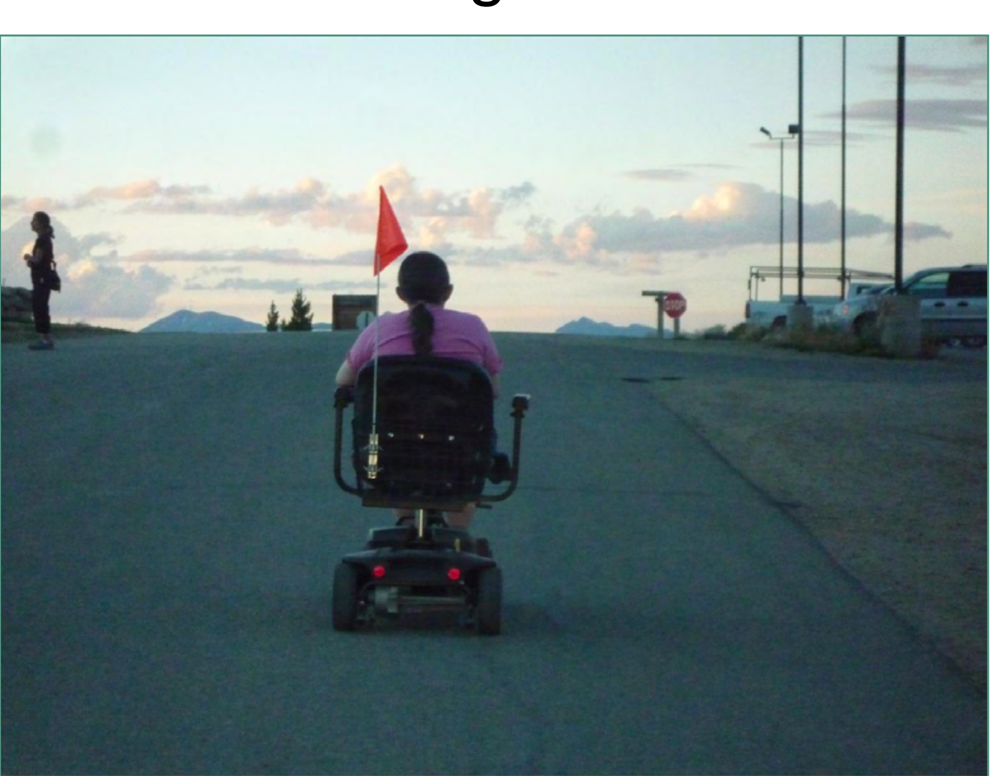
Action Plan

- Initial & ongoing

Assessing Program Efficacy

Evaluation Tools

- Self-empowerment
  - Patient Activation Measure – Insignia Health
- Patient Outcomes
- Patient Navigator
- Program



Patient Navigator Development

<u>Training</u>

- Colorado Patient Navigator Training Program
  - Online modules
  - Patient Navigator I & II training
  - Bridges Out of Poverty – book by Ruby Payne
  - Ongoing
- Mental Health First Aid
- Community Study
  - In-depth research and info sharing with partners, providers, etc.

Program Development

Data Tracking

- In-depth data system
  - ClientTrack

Community Outreach

- Marketing
- Community Presentations
- Regular presence

Memorandum of Understanding

- With direct partners, if applicable

Program Launch

Phases of Program Launch

1. Pilot
2. Ongoing
3. Expansion
   - Services
   - Navigators
   - Support team
   - Lay navigators

Collaboration

GCRHN

- The expert in Patient Navigation, both in-county and for rural areas
  - 2.5 years of program implementation
  - Established an accepted caseload for generalist navigators in rural area
    - 50 active clients
    - Different from urban counterparts at 100
- 1 FTE generalist navigator for all extreme cases
- Navigator for all ‘other’ clinics

Collaboration

MPMC:

- The CAH and treats the majority of clients with public insurance (Medicaid, Medicare, CHP+, and CICP).
- 2 PTE navigators embedded in Primary Care Clinics with access to EMR
  - Generalist navigators for all patients with PCP at MPMC clinics
  - Generalist navigators for ER patients
  - More difficult mental health cases

Evaluation plan

Program Evaluation

Toolkit

Evaluation plan is imperative at the beginning of program implementation.

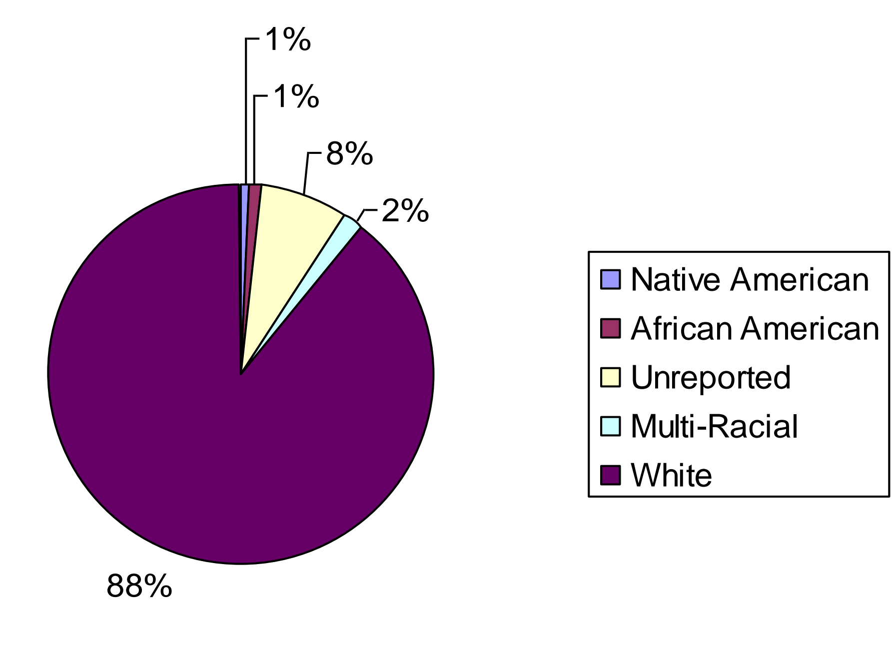
- Data results
- PAM survey
- Patient Navigator caseload
- Program value relative to re-hospitalization

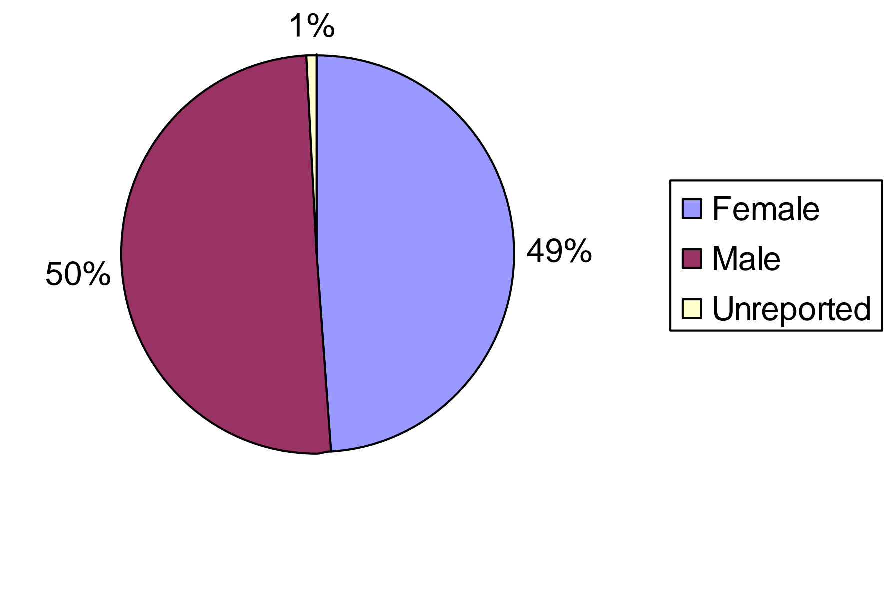
Developed by Kaia Gallagher at Center for Research Strategies

Data Results 2013 YTD

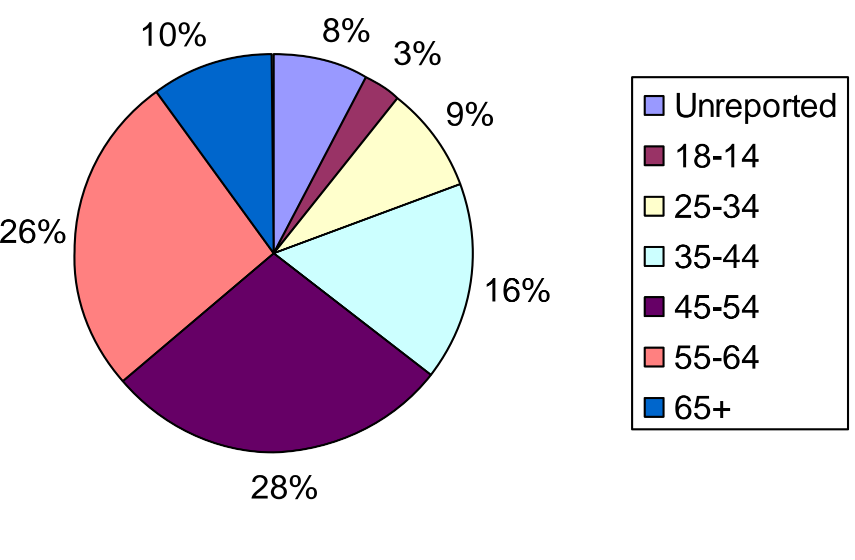
- 114 Total clients – unduplicated
  - 67 at GCRHN
    - 53 complicated
    - 14 simple
  - 47 at MPMC
    - 45 complicated
    - 1 simple
- Funds:
  - $14,926.57 direct funds obtained
  - $ 1,416.00 indirect funds
  - Durable medical equipment

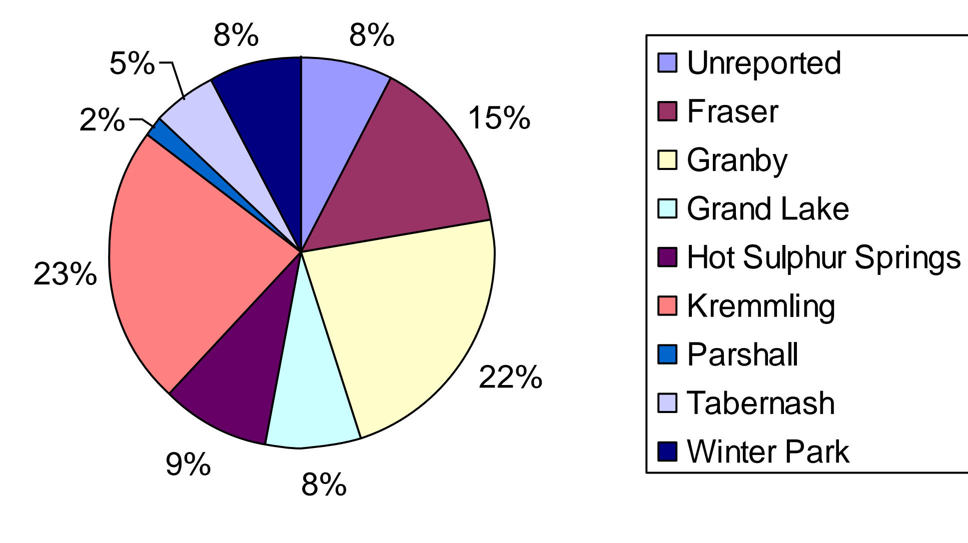
Statistics



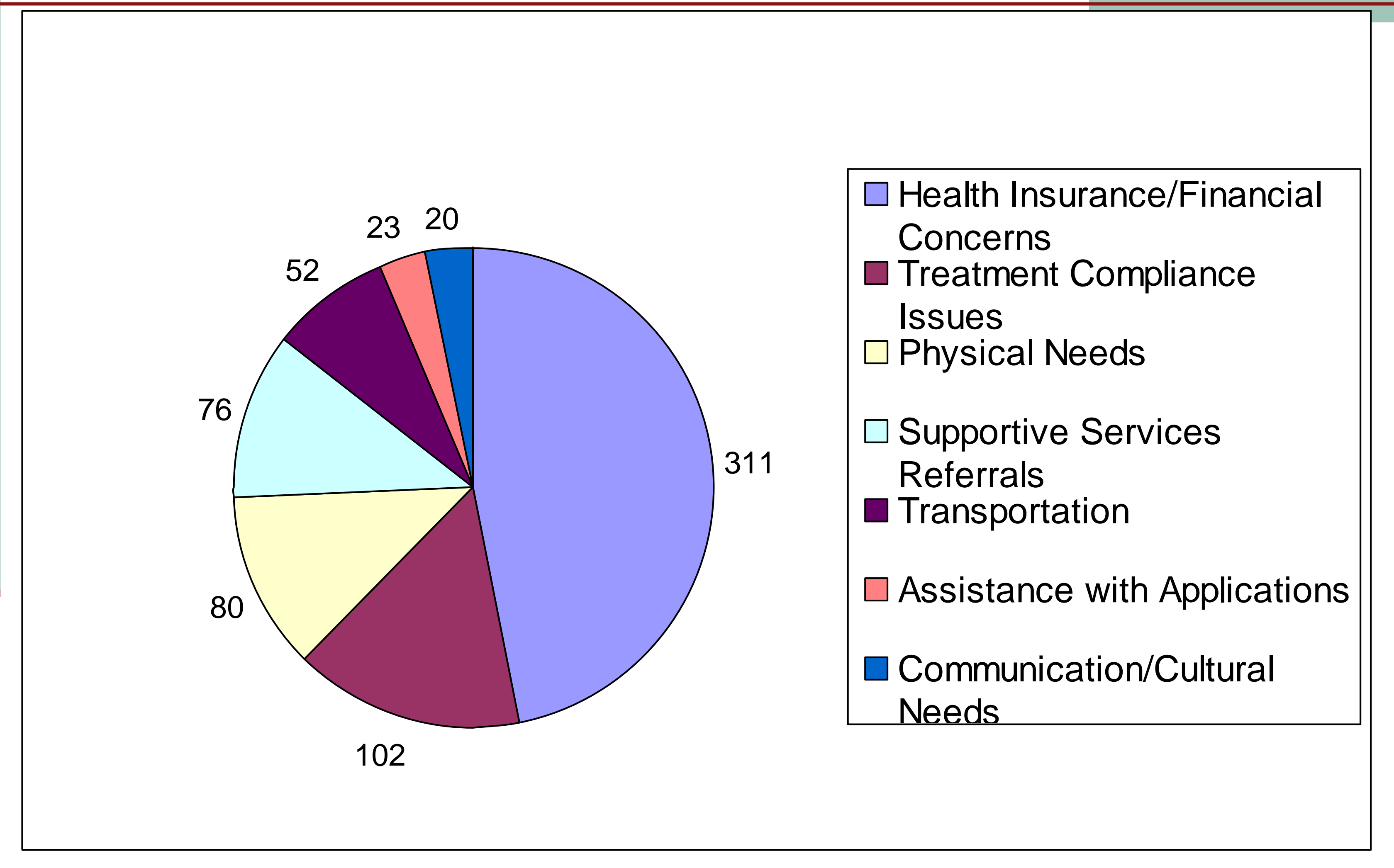


Statistics





Barriers to Care

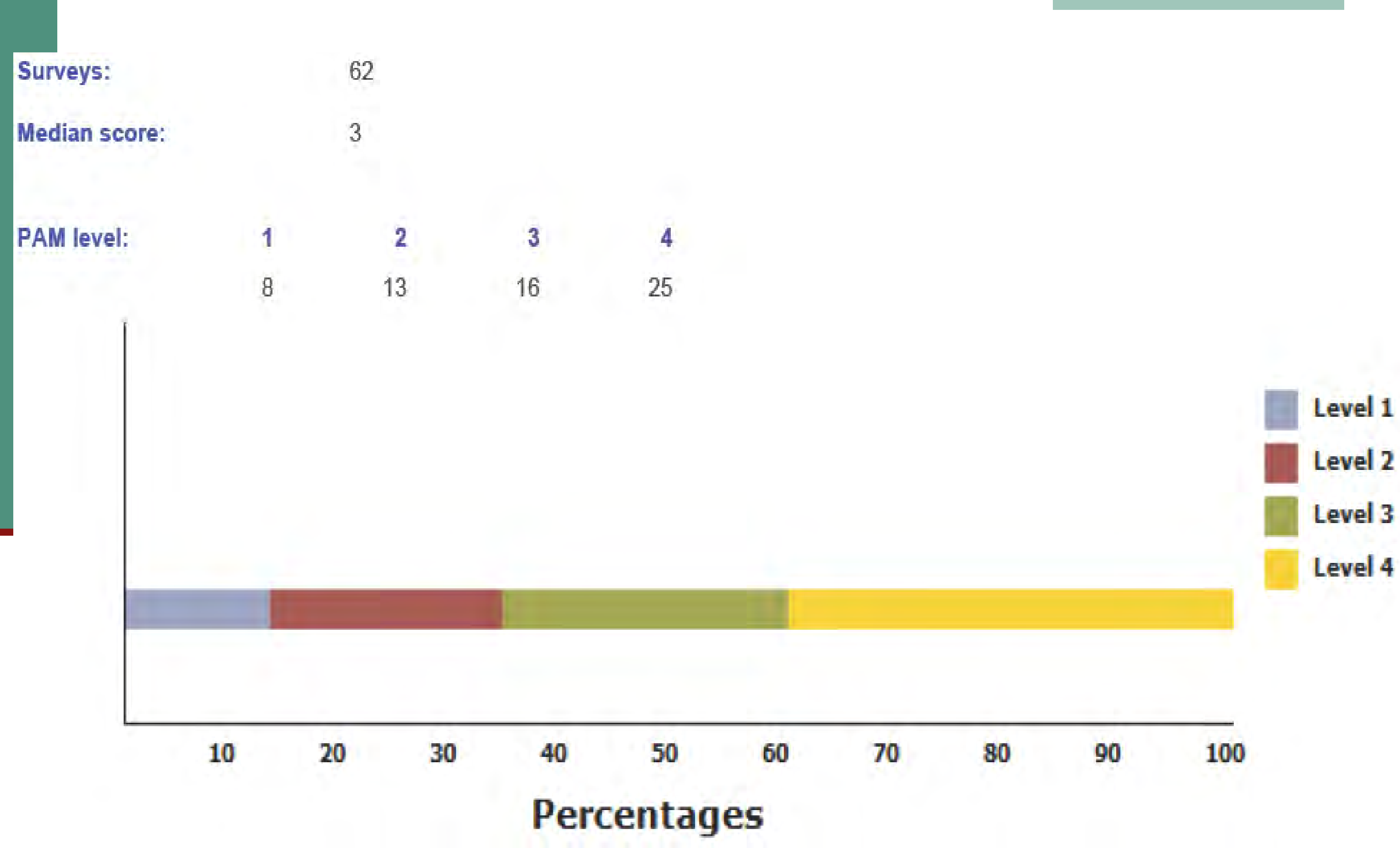


Quantifying Self Empowerment

Patient Activation Measure

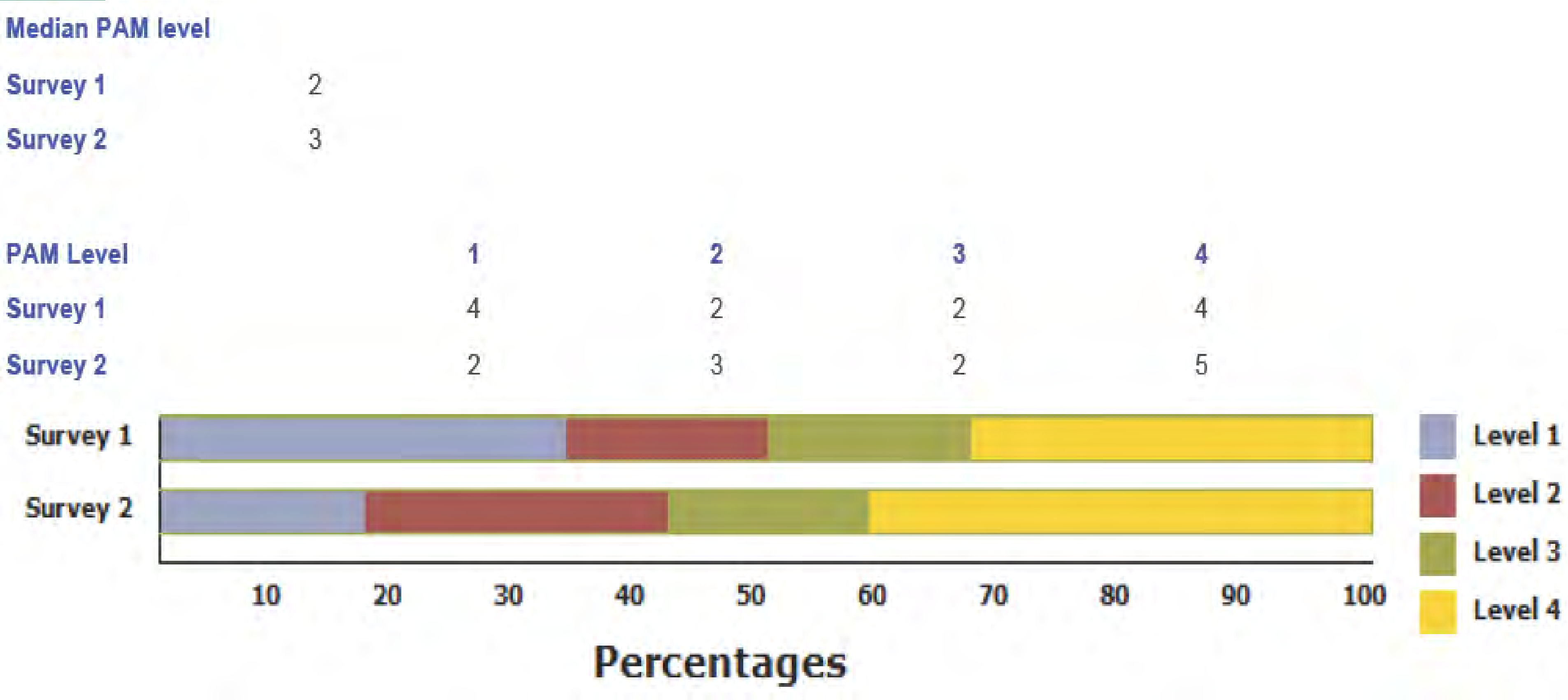
- Evidence-based tool
- Policy on when to use
  - At intake
  - Every 3-6 months depending on activity level
  - At major ‘A-ha’ moments or life ‘dips’
- Coaching for Activation
  - Supports intuition with tools to correspond with PAM score

Patient Empowerment



Patient Empowerment

Two Surveys



Median PAM level	
Survey 1	2
Survey 2	3

PAM Level	1	2	3	4
Survey 1	4	2	2	4
Survey 2	2	3	2	5

Patient Empowerment

Median PAM level	
Survey 1	3
Survey 2	3
Survey 3	3

PAM Level	1	2	3	4
Survey 1	3	0	3	2
Survey 2	1	1	3	3
Survey 3	1	0	3	4

Survey 1
Survey 2
Survey 3
Level 1
Level 2
Level 3
Level 4
10 20 30 40 50 60 70 80 90 100
Percentages

Case Study #1 – Joe Smith

Patient Empowerment

1/21/2013 – 53.00

6/21/2013 – 49.90 – concurrent with huge medical and mental issue

Patient Navigator Caseload

- Typical client profile
  - Medical vs. mental health
  - Duration
  - Advocacy
- Typical Patient Navigator caseload
  - Time Study
- Integrated care looks different:
  - In rural settings
  - County vs. clinic setting

Time Study

Determine difference in caseload by setting

- Initially tracked daily
- Snapshot in time

- Volume of complicated cases
- Clinic setting differences
- EMR / data tracking
- Timeline to complete study

Time Study

Breakdown of top 10 categories by time

	Category	Time
1.	Administration	23.08 hours
2.	Transportation/Coordination	3.34 hours
3.	Case Management with partners	3.33 hours
4.	Other (mostly Patient Navigator training)	3.25 hours
5.	Resource Research	3.17 hours
6.	Patient Advocate	3.08 hours
7.	Patient Education / Empowerment	2.67 hours
8.	Case Management with client	2.50 hours
9.	Disability Application Assistance	2.50 hours
10.	In-County Referrals	2.50 hours

Time Study

GCRHN

1. Administration – 17 hrs
2. Case Management with Partners – 5 hrs
3. Other (PN training) – 4.75 hrs
4. Resource Research – 4.5 hrs
5. Patient Advocate – 4.25 hrs
6. Patient Education/ Empowerment – 3 hrs
7. Case Management w/ Client – 2.5 hrs
8. Disability App. Assist – 2.5 hrs
9. In-County Referrals – 2.5 hrs
10. Medicare Insurance – 2.5 hrs

MPMC

1. Administration – 26.13 hrs
2. Case Management with Client – 13.25 hrs
3. Other (PN training)– 9.38 hrs
4. Case Management with Partners – 6.13 hrs
5. Intake – 3.75 hrs
6. Navigation – 3 hrs
7. Resource Research – 2.63 hrs
8. General assessment – 2.5 hrs
9. Travel to client – 2 hrs
10. PAM survey – 1.875 hrs

Program Value

Articulating to Partners and Providers

- Create a per patient cost
  - # of hours and cost for varying patient profiles
- Create tools to educate providers on patient profiles and benefits to patient and system for appropriate referrals

Relative to Re-Hospitalization

- Compare client data to county level disease patterns
- Relationship between higher PAM scores and other benefits (e.g. lower re-hospitalizations, less likelihood of needing long-term care, etc.)

Lessons Learned

Program Successes

Tools

- Resource book
- Experienced colleague(s)
- Integrated care team meetings
- Work flow and progression chart

Navigators / Team

- Celebrate the small successes
  - Moving the PAM score by 1 point is important
- Community Support

System

- $ amount saved – Case Study #1

Program Successes

Value

- More patients to clinics.
- Less money spent on hospital re-admissions, ER.
  - 22 patients avoided re-admits, ER visits
  - 3 other clients returned to ER for noncompliance
    - 1 patient “fired”; 1 patient had ER visit one week after becoming a client; 1 multiple visits
- Helping patients apply to CICP, Medicaid and Medicare Supplement
  - Actual payment source for 39 previously uninsured patients.
- Extending nursing staff for patient support

Case Study #1 – Joe Smith

Goal Achievement

- Linked to new resources
- Barriers reduced and eliminated
  - Insurance, income, self
- Improved self-management – improved PAM scores?
- No ER visits after the initial sequence
- No re-hospitalization after initial sequence

Program Definition

What Patient Navigator Program is NOT

- Case management
  - Fine line between case manager and patient navigation
  - Case management is a part of navigation, but should not be the focus
- Catch-all for patients no one else wants
  - Substance abusers not ready to take control of disease
  - Mental health illnesses not ready to face disease

Best Practices for Rural Setting

Rural Navigator

- 50 active cases
- Generalist
- 1-3 touches per week during first month most common, 8 month average total
- Removal of barriers: simple, complicated, ongoing, co-morbid, rural-specific
- Research all needs to remove complicated barriers
- Transportation / coordination a main focus
- Role: RN as patient navigator, social worker, discharge planning, counseling, resource research, education
- Home visits, community visits, and provider/clinic visits as advocate
- Working in partnership with ‘outside’ community providers and out-of-county
- Varied access to patient’s medical records

Urban Navigator

- 100 active cases
- Disease specific, clinic specific, or task specific
- 1-3 total touches most common
- Removal of barriers that don’t require a lot of research
- Role: Discharge planning visit and immediate follow-up
- Clinic or office setting primarily
- Working in partnership with providers in established setting
- Immediate electronic access to patient’s medical records

Program Improvement

System

- Articulating a good referral
- Created evaluation on the go

Client Factors

- Rugged Individualism
- Fear
- Uninformed

Mental Health

- Traumatic Brain Injury
- Substance Abuse
- Depression

Outside Factors

- Seasonal

Case Study #2 – Susie Bean

- Initial referral 2011 – case history
- Bounce back in 2013 – case update.

Program Sustainability

Financial

- ACO
- Other providers
- Re-admission
- Grants

Partner Accountability

- GCRHN / MPMC
- SS / PH / HH
- Ancillary

Patient Navigator

- Mental health up-training
- Community advocacy
  - PCP survey
- Lay navigators

Patient

- System drain
- Education
- PAM

Health Equity

<u>Economic and insurance</u>

- More equal playing field
- Dealing with basic human needs
- Educating that insurance is not full barrier

<u>Open to everyone</u>

- Served infant to 88 year old
- All diseases
  - Medical, oral, and mental
- All barriers

Health Equity

<u>Systems</u>

- PN is extension of PCP and other providers
- Educating individuals about resources
- Creative solutions for complex problems
- Problem solving in system

<u>Collaborations</u>

- Mutually enhance and support agencies
- Multi-disciplinary team

Client Testimony

“When it comes to navigating programs linked to healthcare — ‘it takes a village.’ I’m thankful ours is Grand☺”

- Sent to navigator via e-mail

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Resources

Evaluation

- Kaia Gallagher, PhD, President, Center for Research Strategies, 303-860-1705, kaia.gallagher@crsllc.org; www.crsllc.org
- Patient Activation Measure: http://www.insigniahealth.com/solutions/patient-activation-measure
- ClientTrack Software – www.clienttrack.com/