



## Patient Navigator Toolkit

### Program Development

- Identify goals – determine specific need for your community. Grand County’s 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
- Advisory committees
  - One advisory committee for program development to ensure no duplication of services and program aligns with goals and community needs. This committee helps review the job descriptions, policies and procedures, and set up. Engage people/organizations that make sense in our community. Grand County’s advisory committee was:
    - Social services
    - Hospital – primary care provider, social worker, CNO
    - Private primary care clinic – primary care provider or nurse
    - Family resource center
    - Board of Directors – primary care provider and small business owner
  - One professional advisory committee to provide ongoing professional support to navigator team, discuss specific client issues, assure program efficiency, and identify program improvement opportunities. Engage people with the expertise and onus to support the program in your community. Grand County’s professional advisory team consists of representatives from:
    - Social Services
    - Home Health
    - Public Health
    - Hospital – CNO, primary care provider
    - Private primary care clinic - nurse
    - Mental health – county director
    - Family resource center
    - All navigators & support team
- Patient Navigator Job Description
  - Utilize existing navigator job descriptions and mold to fit the need in your community. Highlights in Grand County’s job description are:
    - 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

- Policies and Procedures
  - Policies and procedures are necessary tools to provide guidelines for navigators. Navigators can become emotionally attached to the client and their success, and therefore want to go above and beyond job expectations, licenses allowance, etc. Grand County’s P&P topics are:
    - 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
- Intake
  - The intake is a long, but important process for the navigators to understand client needs and the program to collect necessary data. We have identified two intake forms: simple cases and complicated cases. The simple intake for simple cases collects necessary demographics, up to three barriers to care, and allows for room for case notes and follow-up. The complicated case intake consists of the following elements:
    - Primary needs
    - Barriers
    - Primary care provider
    - Action plan
    - Disclosures and Release of info liability
- Release of Information
  - This document is vital at the intake, as well as throughout the client’s case. Updated release of information forms must be signed when each new barrier is identified so the navigator can advocate for the client, receive necessary medical records (example: from out-of-county specialists), and provide interdisciplinary team case management. Grand County’s release includes:
    - Social services partners (e.g. social services, public health, home health, early intervention services, family resource center, domestic violence team, etc.)
    - Receiving medical records/communication with medical, dental, mental health and pharmaceutical providers
    - Hospice
    - Local funding partners
- Action plan
  - Initial action plan (during intake) consists of up to three action items for the client to take and up to three for the patient navigator.
  - Ongoing action plan consists of a half-page card with three action items for each the client and the navigator.
- Training
  - Colorado Patient Navigator Training Program – [www.patientnavigatortraining.org](http://www.patientnavigatortraining.org) – online modules, patient navigator I & II training, ongoing
  - Mental Health First Aid by Mind Springs Health (transforming from Colorado West Regional Mental Health)

- Community study – in-depth research and info sharing with partners, providers, etc.
- Outreach Plan
  - Marketing
  - Community presentations
  - Regular presence at events (e.g. Senior lunches)
- Memorandums of Understanding, if applicable

### Program Evaluation

- Evaluation plan
  - Use a consultant from the beginning to create an evaluation plan. Important investment in the program.
    - Kaia Gallagher PhD, President, Center for Research Strategies, 303-860-1705, [kaia.gallagher@crsllc.org](mailto:kaia.gallagher@crsllc.org); [www.crsllc.org](http://www.crsllc.org) Self-empowerment
    - Patient Activation Measure – Insignia Health, <http://www.insigniahealth.com/solutions/patient-activation-measure>
  - Follow-up survey
    - Patient Outcomes – examples include: did you have a primary care provider prior to the program? Do you now? Did the navigator help you get the resources you need?
    - Patient Navigator examples include: (rating) my calls were returned in a timely manner; I felt my navigator knew about my case.
    - Program – examples include: Please rate satisfaction of overall program
  - Data tracking: In-depth data system with specific data points that help illustrate your goals and outcomes
    - ClientTrack Software - [www.clienttrack.com/](http://www.clienttrack.com/)
  - Patient Navigator caseload
    - Identify data indicators on typical clients profile:
      - Medical versus mental health
      - Duration
      - Advocacy
    - Time study on how navigators spend their time
  - Articulating to Partners and providers on re-hospitalization
    - Create a per patient cost
    - Tools to educate providers on patient profiles, benefits to patient and system, and what an appropriate referral looks like
    - Relationship between higher PAM scores and other benefits (e.g. lower re-hospitalizations, less likelihood of needing long-term care, etc.)

### Program Communication Tools

- Health and Human Services Organization Chart
- Patient Navigator Work Flow
- Illness progression illustration

### For more information

- Please visit our website, [www.gcruralhealth.com/HealthResources/ForProviders](http://www.gcruralhealth.com/HealthResources/ForProviders) for downloads including: the full presentation, toolkit, Organization Chart, Work Flow, and Illness progression
- We will be happy to work with you on an individual basis. Please contact Jen Fanning at 970-725-3477 or [jfanning@co.grand.co.us](mailto:jfanning@co.grand.co.us).