Patient Activation Using Technology-Supported Navigators

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Sands Expo: Lando 4205

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Conflict of Interest

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Consulting Fees
Agenda/Introduction

1. Review of STEPS Value
2. Role of Technology and Navigators in Improving Health Outcomes
   A. Supporting Research
   B. Technology
   C. Role of Navigator
3. Navigator in Health Care Settings
   A. Home Health Care
   B. Physician Office (CCM)
   C. Hospital Case Management
   D. Call Centers
4. STEPS Outcomes
Learning Objectives

1. Identify components of a technology-enabled program for community residing older adults
2. Identify advantages of synthesis of “High-tech, High touch” approach to technology use in health care
3. State impact of technology supported navigators on outcomes of: rehospitalization, ER usage, patient satisfaction and patient activation
An Introduction of How Benefits Were Realized for the Value of Health IT

Health IT creates five kinds of value of benefit to patients, healthcare providers and communities.

- S: Patient Satisfaction
- T: Treatment/Clinical
- E: Electronic Secure Data
- P: Patient Engagement and Population Management
- S: Savings

- HIPAA Compliant
- Targeted Health Education Interventions
- Patient Activation
- Cost
- Rehospitalizations
- ER Usage
- Ease of CCM Compliance

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Reimbursement model is changing

OLD WAY
Fee for Service Model

- Episodic interaction
- Stand alone plans of care
- No requirement for psycho-social assessment
- Little accountability for quality or cost
- Patient initiated interactions
- Duplicate tests, activities, tasks

NEW WAY
Value-Based Model

- Chronic disease driven interactions
- Recognition of **Social Determinants of Health**
- Inter-visit coaching/contact
- Post-visit follow up
- **Comprehensive** Plan of Care development & management
- Technology adoption
- Data collection & assessment
- Outcome-based reimbursement
Social Determinants of Health

Those non-medical issues that make a diagnosis or treatment difficult for patients. Healthcare barriers can be due to:

- Socioeconomic conditions
- Health Literacy
- Logistical issues (access to care)
- Language or culture
- The healthcare system itself!
Why?????
Combining High-tech + High-touch

HIPAA-compliant extension to existing EHR

Trained patient advisors address non-clinical issues
Components of a “High-Tech” System

• Ease of Use-Patient Centric
• Compatibility with existing Health IT programs
• Accessible across the health care continuum:
  Acute & Post Health Facility-Navigator-Patient-Family
• “One True Source”
• Meets Requirements of Chronic Care Management
• Cost Effective
“High Touch”- Role of Navigator

Gunn et al (2014) identified a nine principle framework for the role of the navigator:

**Individual Level Principles**
- Eliminating Barriers to Timely Care
- Providing patient-centric care
- Integrate fragmented system
- Navigate across disconnected system

**Program Level Principles**
- Program cost effectiveness
- Level of skill is defined
- Clear scope of role
- System is coordinated

Willis et al (2013) identified additional skills:
- Community Resource identification
- Patient Empowerment
- Ethics and Professional Conduct
- Cultural Competency
Navigator Curriculum

- **Module 1**  Introduction/Job Description
  - HIPAA
- **Module 2**  Orientation to MyKinergy
- **Module 3**  Chronic Illness: A Lifestyle Disease/Adult Education
- **Module 4**  Communication
- **Module 5**  Medications
- **Module 6**  Mental Health/
  - Neurologic Diseases
- **Module 7**  Red Flags
  - Escalation Policies
- **Module 8**  Working with Families
- **Module 9**  Professional Relationships
- **Module 10**  Customer Service
- **Module 11**  Review of Specific Chronic Diseases
- **Module 12**  Use of PAM
- **Module 13**  Role of Navigator in Various Settings
- **Module 14**  How Do We Measure Success?

Additional Requirements: Final Exam, 12 Hours on-the-job supervision, including monitored phone calls
Current Supporting Research
Certified Navigator role in Readmissions Reduction

Recent study highlights ROI opportunity:

- 1,531 patients worked with a care navigator
- 3.16% were readmitted
- 4% decrease in Medicare readmissions totaling $29,702 in savings over 6 months
- 5% decrease in private pay readmissions totaling $127,102 in savings over 6 months


“Lay Navigator delivers positive ROI in 3 months with Medicare and private pay patients who have known challenges with care plan compliance.”
Use of “Care Guides” in achieving patient identified health goals

230 patients receiving telephone follow up with a “care guide” along with usual care in a weight management program. (Adams et al, 2013)

Estimated cost was $286 per patient per year.

Patient’s with “care guides”

- achieved more goals than usual care patients (82.6% vs. 79.1%)
- reduced unmet goals by 30.1% compared with 12.6% for usual care patients;
- improved meeting several individual goals, including not using tobacco.

Significant improvements in

- patient satisfaction scores
- healthier eating habits
- improved quality of life
- more success with goal attainment
Additional Research Supporting Effectiveness of Navigator

Use of navigators has been demonstrated to:

• Decrease rehospitalizations (Fay & McLaughlin, 2014; NOHA 2012; Balderson & Safavi, 2013),

• Decrease cancelled and missed appointments (Fay & McLaughlin, 2014; NE Ohio Center for Health Affairs, 2012; Balderson & Safavi, 2013; CHA, 2012).

Disease specific interventions with significant findings with Navigators include:

• Improve control of heart failure management (Smith et al, 2008)

• Improved control of diabetes through measurement of A1C levels when a navigator is added to usual care (Wilson et al, 2013)

• Decrease in delay of treatment of breast cancer (Hoffman, et al, 2013)
Areas Utilizing Lay Health Navigators

- Certified Home Health Agencies
- Physician Office with CCM (Chronic Care Management)
- Call Centers
- Hospital Case Management
Demonstrated Uses in Certified Home Health

• Support case managers in meeting non-medical issues that impact health status (Social Determinants of Health)
• Communicate patient outcomes quickly to referral sources
• Focused programs on areas of patient satisfaction needing improvement via targeted intervention programs by navigators
• Immediate feedback of patient concerns so they are immediately resolved, increasing overall patient satisfaction
PAM 13 Question

Level 1
- When all is said and done, I am the person who is responsible for taking care of my health

Level 2
- Taking an active role in my own health care is the most important thing that affects my health
- I am confident I can help prevent or reduce problems associated with my health
- I know what each of my prescribed medications do
- I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.
- I am confident that I can tell a doctor concerns I have even when he or she does not ask.
- I am confident that I can follow through on medical treatments I may need to do at home
- I understand my health problems and what causes them.

Level 3
- I know what treatments are available for my health problems
- I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising
- I know how to prevent problems with my health
- I am confident I can figure out solutions when new problems arise with my health.

Level 4
- I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.

Also available PAM 6
Patient Activation Measure Personas

<table>
<thead>
<tr>
<th>Activation Objective</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consumer Profile</strong></td>
<td>Promote belief that an active member role is important, starting with self-awareness</td>
<td>Support the building of confidence and knowledge necessary to take action</td>
<td>Initiate new behaviors and improve health</td>
<td>Resilience even under stress &amp; able to plan for difficult situations</td>
</tr>
<tr>
<td>Does not understand the role they should play in managing their health</td>
<td>Lack knowledge about their condition, treatment options, and/or self-care options</td>
<td>Has minimal confidence in handling certain aspects of their health</td>
<td>Has made most of the necessary behavior changes, but may have difficulty maintaining behaviors over time or during stress</td>
<td></td>
</tr>
<tr>
<td>Does not believe or understand that they hold the key to their health and functioning</td>
<td>Has little experience or success with behavior change</td>
<td>Has the basic facts of their conditions and treatments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Areas of Focus

- Condition and Symptom Management (Red Flags)
- Medication Adherence
- Diet and Nutrition
- Physical Activity
- Stress and Coping
- Smoking Cessation
Home Health Care/Hospice Added Advantages

- Ability to maintain patient contact with health care provider to assure possible reimbursement for the next 10 years expectation of hospital admissions, readmissions.
- Differentiate organization from competitors due to enhanced services.
- Positive impact on HHCAHPS scores for Patient Satisfaction.
- Identify patient usage of other providers-hospitals, home care, physician through data collection.
- Decreased off-hour and ER visits for hospice patient
Certified Navigator Role in Medicare Chronic Care

New CMS Chronic Care Management Rules

- Physician reimbursement ~ $42.60 per patient per month
- CMS estimates $130,000 - $190,000 annually per physician in new revenue generation
- 2+ chronic conditions
- CPT code 99490

Acknowledges Effectiveness of non Face-to-Face Care

- 20 minutes non face to face time/patient/month
- Delivered by care team with oversight by physician
- Care plan coordination among health care team, patient and family
- Specific patient identified goals and addressing of psycho-social issues (SDH)
- Requires the use of technology
- Provides “concierge-type” service
Role of a Navigator in Chronic Care Management (CCM)

- Identify qualified patients
- Written consent during face to face meeting
- Create comprehensive care plan

Scope of Service

- Physical, mental, cognitive, functional, psychosocial, environmental
- Structured data from certified EHR
- 24 x 7 accessibility by entire patient care team

- Monitor and update comprehensive plan of care
- Medication reconciliation
- Communication with patient and family caregivers (24 x 7 secure accessibility)
- Oversee patient self-management

- Care team communication & coordination (specialist, home health, community)
- Arrange for community services
- Manage care transitions and provide follow-up care
- Ensure preventative care services

- Document CCM activities by team member

= Navigator’s can provide
Medication Interview

- Guides patient through creation of a comprehensive medication list
- Meds listed by condition
- Patient is prompted as to how to think about what they use.
Goals of Medication Interview

1. Assure client has all medications prescribed, understands when and how to take them.

2. Assists client in obtaining clarification of medication discrepancies by reporting to health care provider.

2. Reviews medication list with client to see if client has all of the medications listed and know which to take that day.

3. Problem solves with client to resolve common barriers to medication adherence:
   a) Obtaining Rx from MD
   b) Obtaining medication from pharmacy
   c) Knows when to take it.
   d) Is physically able to get medication out of container and take?
   e) Remembers when to take medication

4. Keeps medication list as “One True Source” by updating as appropriate.
View Medication

Medication/Dosage: Atorvastatin 80 mg
How many to take: 1 tablet
Condition being treated: Coronary Artery Disease
How is it taken: Mouth
How often do you take it: 1x Day @ 10:00 PM

Reminders:
Special Instructions:
Side effects or other problems to report:
Start Date:
Duration:
Prescribing Physician:
Keywords:
Status: Active
- Earn revenue of $139K+ annually **per physician** in your practice
- Strong ROI
- Minimal up-front fees
- Turnkey solutions available

**Reimbursement Opportunity for One Physician**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of physicians</td>
<td>1</td>
</tr>
<tr>
<td>Patient panel size (per physician)</td>
<td>2,000</td>
</tr>
<tr>
<td>Medicare patients</td>
<td>22% (440)</td>
</tr>
<tr>
<td>Eligible for 99490</td>
<td>62% (272)</td>
</tr>
<tr>
<td>Per Patient Reimbursement/Mo</td>
<td>$42.60</td>
</tr>
<tr>
<td>Monthly gross revenue</td>
<td>$11,587</td>
</tr>
<tr>
<td>Annual gross revenue</td>
<td>$139,046</td>
</tr>
</tbody>
</table>

Efficient way to grow practice and increase revenue
# Improved Appointment Metrics in MD offices Pre/Post Use of Navigators

<table>
<thead>
<tr>
<th>Data Point</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of kept appointments</td>
<td>87.55%</td>
<td>90.32%</td>
</tr>
<tr>
<td>Percentage of cancelled appointments</td>
<td>7.92%</td>
<td>5.43%</td>
</tr>
<tr>
<td>Percentage of no-show appointments</td>
<td>4.54%</td>
<td>4.26%</td>
</tr>
<tr>
<td>Percentage of no-show for head/neck radiation appointments</td>
<td>12.45%</td>
<td>9.68%</td>
</tr>
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*Source: The Center for Health Affairs & Accenture, Northeast Ohio Patient Navigation Pilot Results.*
Call Centers

- Identify and resolve non-medical issues with lower cost staff.
  - Large % of calls are non-medical in nature (Social Determinants of Health)
- Use of escalation policies to direct calls to appropriate level of staff
- Patients are better able to self-manage with improved activation, comfort in asking questions
- More frequent contacts cost effective in preventing escalations/Increase patient loyalty.
- Allow current staff to manage a greater volume of high-risk patients.
- Facilitate communication among patient, providers, caregivers and family.
- Used in support and education of family caregivers
Hospital Case Management
Statistics

• 88.3% of emergency hospital admissions of older adults caused by adverse drug events (NEHI, 2012)
• Nearly two-thirds of the hospitalizations were due to unintentional drug overdoses from
  • insulins
  • oral antiplatelet agents,
  • oral hypoglycemic
• A review of 55 observational studies found:
  Up to 40% of the time, medication information was missing from discharge
• Patients with medication discrepancies had a 30-day hospital readmission rate of 143% compared with 6.1% for patients without a medication discrepancy.
Navigators Post-Discharge

• Clarify discharge instructions and ensure care plan understanding.
• Ensure follow-up activities are scheduled.
• Provide coaching and modeling of positive health behaviors.
• Assure med schedule is understood and prescriptions are filled.
• Identify barriers or condition change and escalate.
High Tech/High Touch Approach

• Patients are better able to self-manage.
• Allow current staff to manage a greater volume of high-risk patients. (RPI)
• Measure impact on avoidable readmissions.
• Improve HCAPHS care transitions scores.
• Increase patient loyalty.
• Facilitate communication among patient, providers, caregivers and family.
Discharge Checklist for Family

Discharge Plan of Care Checklist

The Discharge Plan of Care Checklist is a guide to collect the information you need to transition from one care environment to another - for example, from the hospital back home, or to an assisted living facility.

Click on the arrows to open any topic below. Information you have already entered into MyKinsrg will appear automatically. You can add any additional information here and it will update in your profile. This is a collaborative health record, so some information will need to come from your healthcare providers. If your provider is on your MyKinsrg care team, that provider can log in and enter the information directly. These sections can be completed in any order.

Hip Surgery
Elizabeth Cheekhurst
11/28/2012

Mom had hip replacement surgery and will be coming home to stay with me while she recovers. She will need some assistance during the day while I am at work so I will need to set up some home care.

Attachment:

Attach File

- Review Care Team Members
- Create Plan of Care
- Update Emergency Contact Information
- Add New Prescriptions
- Make a Follow-Up Appointment
- Identify Special Needs
- Identify Local Services
Patient Testimony to Support Navigator Intervention
An Introduction of How Benefits Were Realized for the Value of Health IT

- Patient
- Employee
- Payer
- Self Care Goals
- Medications
- HIPAA Compliant
- Targeted Health Education Interventions
- Patient Activation
- Cost
- Rehospitalizations
- ER Usage
- Ease of CCM Compliance

http://www.himss.org/ValueSuite
Employee Satisfaction
Positive comments from Case Managers

STEPS: Satisfaction Graphics

Patient
Payer
Employee
Satisfaction
STEPS: Treatment/Clinical

Self-Care Goals
Achieved
Medication
Adherence
STEPS: Patient Engagement & Population Management

Patient Activation Scores
References


Center for Health Affairs.(CHA), (2012). Emerging field of patient navigation: A Golden opportunity to improve health care. Accessed on line at: http://www.chanet.org/CHA/TheCenterForHealthAffairs/MediaCenter/NewsReleases/~/media/A92355F0A6E140F1A13493BC3C349CAB.ashx


References cont’


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