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Care Navigators Offer Cost-Effective Solution for Improving Value-Based Care

By Dawn Hawkins Johnson and Darcie Goodman

In the first year of a care navigator program, one health system saved $19 million as emergency department visits, hospitalizations, and intensive care unit readmissions declined.

Although patient populations, services, settings, and geographies differ, U.S. health systems face similar sets of challenges in delivering the quality and health outcomes that will effectively control the total cost of care under population health models. The growing numbers of seniors and other fragile, at-risk populations, many with behavioral health issues, require high-touch, collaborative, patient-centered care. But all of this patient support does not have to be high cost.

Effective care coordination across the health system and beyond is a proven way to decrease costs while improving patient satisfaction and outcomes. At the University of Alabama Health System (UAB), Adventist Health System, and other healthcare providers, a key to better-yet-affordable care management is the new role of nonlicensed

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individuals within the traditional care team, sometimes known as care navigators.

Unlike nurse navigators, who are involved in managing both clinical and non-clinical aspects of patients' care, care navigator roles can be filled by nonlicensed, nonclinical staff. These care navigators focus on coordinating care at critical transition points across the continuum, including providing follow-ups that identify and help overcome barriers to patient recovery and health.

The return on investment is swift: During the first year UAB assigned care navigators to support patients with active cancer diagnoses, the health system saved $19 million as emergency department visits, hospitalizations, and intensive care unit readmissions declined, according to a *JAMA Oncology* article. At another three-hospital system, readmission rates for the top eight diagnoses fell 50 percent within six months among patients having post-discharge interventions by care navigators. The addition of care navigators also enabled clinical staff on care teams to practice at the top of their licenses and align more closely to manage complex patient needs.

6 Steps for Leveraging Care Navigators at the Point of Need

Care navigators can play vital roles in achieving success under risk contracts and capitation. The care navigator defined care management model should include the following factors:

> Demonstrate improved clinical performance and outcomes
> Maintain healthy status in those patients identified as low-risk
> Improve management of increasingly at-risk patients to avoid future, potentially costly, episodic care
> Improve utilization of the ambulatory care network outside of the hospital
> Improve coordination and efficiency of services delivered

As members of patient-centered care teams, care navigators can take the lead in areas that are important when managing population health but do not require highly trained clinicians, such as checking with discharged patients that prescribed medications are obtained and services are in place, ensuring that patients and family members understand discharge instructions, tracking whether post-discharge appointment or referrals have been made, and identifying any potential barriers or worries patients may be experiencing with regard to their care.

Care navigators are highly suited to support patient-centered care teams in three general areas: patient engagement, education, and support within care transitions. They can increase engagement by enrolling patients in providers' online portals and making reminder calls for preventive screenings. As patient educators, they can share and reinforce materials about specific diseases, provide information about community resources, and direct patients to appropriate access points of care within health systems. Care navigators also can ease the transition between care settings by ensuring the coordination of services.

The most cost-efficient and effective solutions require determining when, where, how, and for whom care navigators can deliver the most benefit. A six-step process can help organizations arrive at the best program for them.

Assess existing infrastructure and processes impacting patient care, and identify potential gaps. Evaluate patient populations served, care team structures, referral processes, and other infrastructures—including IT—to outline current challenges and opportunities for improvement. Data analytics can be used to target potential at-risk populations and interview care team members for additional insight.

Document current care coordination processes. Are nurses trying to make follow-up calls between patient appointments? Are there formal policies and procedures for tracking and helping specific patient populations? Is staff time used efficiently? Are your team members serving in various capacities without proper workflows and best use of their licensures?

Develop a program to reach the desired future state, focusing on patient friction points and outreach methods, such as telephone versus in-person interactions. Establish clear roles for care navigators and other care team members, mapping out escalation procedures for involving social workers, nurses, pharmacists, and others. Seek input and refine program design with help from care team members who will interact with care navigators. Consider the benefits of cross-training clinical staff to practice at the top of their licensure.

Identify and recruit care navigator candidates. Develop a list of criteria, such as good communication and people skills, an interest in healthcare, and an understanding of

Rising At-Risk Populations

At-risk populations covered by government insurance with declining payment rates are on the rise. One in five Americans, or 80 million people, is now on Medicaid, while seniors 65 and older are expected to account for more than 20 percent of all Americans by 2050, numbering nearly 84 million out of a total population of 400 million, according to government reports.

Care Navigators: A Mini Case Study

One health system has trained cohorts of bilingual care navigators to successfully engage patients in the emergency department and other hospital units. Working seven days a week, care navigators facilitate hospital discharge and follow-ups for 80 or more patients with congestive heart failure and pneumonia each month. They also initiated a program to call discharged patients needing rehabilitation, routinely reaching three out of four patients. Care navigators also took over maternity follow-up calls from nurses, increasing call-completion rates by as much as 62 percent a month.

the community/population's challenges. Organizations may find strong prospects within their existing workforce, especially among employees looking for new career opportunities, or in their communities, including those considering or studying for health careers.

Create and launch a training program for care navigators. Elements could include defining organizational mission, values, goals, and scope; overview of community needs; explanation of coordinated care across the continuum, including clinical workflows and staff roles and responsibilities; motivational interviewing; and IT training.

Acculturate the program throughout the health system, reassuring clinicians who may be initially uncomfortable with nonclinicians taking on care navigator responsibilities.

Getting Started: 3 Target Areas for Care Navigators

Often, common hand-off points are where patients fall through the cracks. This offers prime opportunities for care navigators to improve care coordination that will meaningfully enhance population health and manage costs. Three of the most vital areas are the periods following hospital and emergency department discharge, care transitions between primary care and specialists, and the process of delivering preventive care.

Focusing care navigators on these areas can increase patient engagement and adherence to the medical plan, which drives toward improved outcomes.

Advances in Value-Based Care

Targeted interventions by care navigators can make a big difference in population health and patient satisfaction without a big cost. Faced with unrelenting financial pressures and the strategic imperative to move ahead with value-based care, care navigators can help providers make advances on both fronts. It's a cost-effective solution that improves quality and increases both provider and patient satisfaction. +

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