HIP IHI Triple Aim Site Team
Health Navigator Project Update

To ensure that uninsured adults in our community successfully navigate through our complicated health system for full recovery and linkage to a primary health care home and needed services following their stay in the hospital

What do we want to call our *Navigator* –
What is our **term/concept**?

- Patient *Advocate*
- Health Advocate
- Community Health Advocate
- Health Care Access *Advocate*
- Community Health *Advisor*
- Discharge *Navigator*
- Community Health *Navigator*
- Health Recovery *Coach*
- Health Access *Coach*
- Health Access *Coordinator*
- Health *Ally*; *Ally* for Health;
- Community Health Ally

Other ideas?

We need to consider translation to Spanish:

- Advocate: Literal translations are all about legal representation, other ideas:
- Aliado de Salud (Health Ally)
- Companero de Salud (Partner for Health)
- Representate de Salud (Health Agent, Health Representative)

We could still use the word *Advocate* in English and use *Aliado* or *Representante* in Spanish, or:

- Navigator: Translates well – Navegante
- Navegante de Salud (Health Navigator)
- Asistente (Assistant)
- Ayudante (Helper)
- Asesor (Advisor)
- Diligencia (supposedly means Coach, have never heard this usage)
- Coordinador (Coordinator)
- Guia (Guide)

Project Connect staff to tested names with their clients (frequent users of the ED) and recommended the title **Health Navigator.**

Role Definition:

- Our health navigator is a person with direct knowledge of the local community who functions as a "guide" and offers assistance to community members in "navigating" the health care system and accessing related social and financial services to facilitate access to: recommended primary care, specialists, medications and other care/services.
- Our navigator is someone who understands the patient's fears and hopes, and who removes barriers to effective care by coordinating services thus increasing the patient's chances for a full recovery and reduced risk for future hospitalizations or complications following discharge.
- A primary function our navigator is to establish and help maintain communication between the patient, their families, physicians, and the health care system while offering additional assistance.
- The navigator will assist individuals and families to negotiate access to complex service systems and will serve as an advocate to bolster clients' confidence and effectiveness when dealing with multiple providers and service systems.

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- The navigator will educate consumers as to the importance of timely use of primary care, especially their post-acute follow-up, and help to ensure a solid connection to a primary care home.
- The Navigator will provide an enhanced assessment of post-discharge needs, will help the patient to assess what they do and don't understand about their discharge plan and medications and help them to communicate their needs for clarification or more support at discharge.

Typical Health Navigator Duties:

- Anticipate, identify, and provide practical help to patients to overcome barriers within the health care system and ensure timely access to primary care follow-up as identified in hospital discharge plan
- Coordinate access to and assist with linkage to programs that assist in establishing eligibility for relevant health coverage programs and patient assistance programs for discounted medications
- Identify and schedule appointments with, culturally competent caregivers;
- Arrange for needed language translation or interpretation services;
- Assist with coordination of transportation to scheduled diagnosis and treatment appointments;
- Helping patients and their families access support systems;
- Helping patients understand treatment options, diagnoses, medications and recommended follow-up care including self-care management and prevention/behavior change
- Assess need for and provide support related to client motivational factors involved in implementation of discharge plan
- Providing emotional support and related information
- Serve as a reliable ally for the patient to lean on for advice, support, and direction.

What kind of person makes a good navigator? Advice from other Navigator Programs: Health navigators need to have direct knowledge of the communities they serve. Individuals should demonstrate basic talents and a strong interest in the community and its people. Navigators should also be committed to ongoing learning, able to model the behavior and activities that will support both individual development and community capacity-building, and possess communication and other interpersonal skills that can ensure an ability to work with a diversity of people and organizations.

Navigators should be able to demonstrate effective communication with community members that recognizes the cultural sensitivities and health literacy levels within the population.

Duration of Health Navigator Intervention

Our navigation services will span the period from hospital discharge through completion of post-acute follow-up appointment with primary care provider and at least first appointment with at agencies/specialist care providing other needed services and medications are accessed. Patients will be tiered according to level of support likely needed, with most assigned to Tier 1 and completing in 30 days and those in Tiers 2 and 3 needing up to a max of 90 days.

Comprehensiveness of navigator services:

HRSA: Once a relationship has formed between an individual and a health navigator, the program extends to helping the individual and family through the health care system. Applicants are encouraged to take a holistic, patient-centered approach and define the role of the navigator broadly to include all chronic diseases **(for us all related health issues?)** and relevant health care treatment, detection, and prevention services.

Data Collection – For testing and redesign of model:

a. Number of patients navigated, number of health navigators, and coverage area;
b. Number of patients referred (to treatment, pharmaceutical assistance programs, ombudsman programs/other health insurance programs, community organization) and follow-up outcomes (number of insured who get health coverage;
c. Patient demographics (i.e., insurance status, income, education level, gender, age, race and ethnicity, primary language, number of family dependents);
d. Type of navigation services (number of calls, meetings, where meetings occur, accompany to appointments, other practical support)
e. Type and stage of diagnosis when entering into the system;
f. Screening location and date;
g. Distance of patient's home from health care facilities utilized, also: type of transportation assistance needed and provided
h. Housing issues and homelessness;
i. Patient access barriers encountered, how they were resolved, time needed to resolve;
j. Average length of hospital stay reduction;
k. Percentage of follow-up visits scheduled before the patient leaves the hospital;
l. Compliance rate for initial and follow-up appointments and reasons for noncompliance;
m. Education/information materials provided to patient/family by navigator;
n. Other navigation services requested or provided (e.g., insurance, counseling, transportation referrals; language translation);

Maybe create a checklist tool (excel spreadsheet) with most common anticipated ► barriers? With a place for a brief note on each another checklist for linkages to services?

o. Number of hospital or ER visits for each client/patient the 12 months before and after discharge
p. Other specific measures as appropriate

Recommended oversight or supervision for the navigator by a licensed health professional (s) – Directly supervised by Project Connect (PC) PHN with consultation from LCSW PC Team Supervisor

Clinical or Physician Champion Role: Developing local physician and/or clinical buy-in of the program goals will be important. A key element in winning that buy-in will be a local "clinical or physician champion." The clinical champion will serve as the liaison between the program and the local clinical community and will serve as a resource to the local physicians about the program.

Still to do:

- Look at IHI readmission interview for any other key services that navigator should provide or system level changes we should be addressing.
- Describe how the Navigator will inter-relate (roles, expectations for MOU) with:
  - Project Connect
  - Hospitals – Multiple departments (including data)
  - Medi-Cruz
  - Safety Net Clinics

- We also have a developing list of types of care and services the Navigator will most often link patients to.