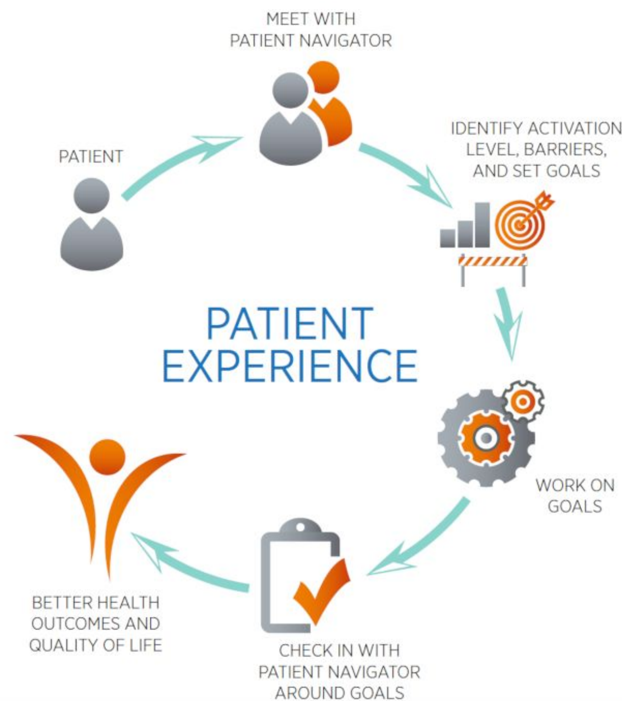
# Level 2: Advanced Care Coordination for Patient Navigators

Patient Navigator Training Collaborative

## Course Description

This course focuses on the role of the patient navigator in team-based care coordination. A Level 2 patient navigator may be a nurse or social worker with a bachelor's or master's degree. Some Level 2 navigators have less education but a lot of experience as patient navigators. These navigators work with patients in healthcare or community settings after patients receive a diagnosis, through treatment or disease management, into health maintenance, and sometimes at the end of life. Level 2 navigators may focus on behavior change, adjustment to life with a chronic illness, or help clients maintain a healthy lifestyle. They address barriers to healthcare, coordinate care, tailor health information to patient needs, and motivate clients to make healthy choices.




© 2013-2022 Patient Navigator Training Collaborative. Reproduce only with permission.

# Table of Contents

**Module 1: Care Coordination and Team-Based Care** **p.3-4**

- ➔ Care Coordination Introduction & Overview ……………………………………….3
- ➔ Active Listening…………………………………………………………………...4

**Module 2: Panel Management** **p.5**

- ➔ Introduction/Overview & Risk Stratification……………………………………………5

**Module 3: Patient-Centered Care Coordination** **p. 6-7**

- ➔ Introduction & Self Care Management Support……………………………………6
- ➔ Patient Centered Goal Setting & Planned Care Visits………………………………..…7

**Module 4: Evaluating Care Coordination** **p. 8**

- ➔ Introduction & Overview…………………………………………………………………8

**Program Information** **pg. 9**

© 2013-2022 Patient Navigator Training Collaborative. Reproduce only with permission.

# CARE COORDINATION AND TEAM-BASED CARE
# MODULE 1

**Learning Objectives**

- Compare and contrast common terms related to care coordination.
- Identify groups of patients that benefit most from care coordination.
- Recognize conditions and situations that pose risks to certain patient populations.
- Discuss system factors that affect patient safety in the collaborative care setting.
- Build a toolkit for effective communication with patients and their family caregivers as well as the members of healthcare teams.

## Introduction

- What is care coordination?
  - Organization of patient care activities
- Who is involved?
  - Between two or more participants (including the patient) involved in a patient's care
- Why?
  - To facilitate the appropriate delivery of health care (McDonald et al., 2007).

Purpose of care coordination: to improve outcomes of healthcare by providing safe care, quality care, and affordable care through:

- Teamwork
- Care management
- Medication management
- Health information technology
- Patient-centered medical home

## Roles of Healthcare team through care coordination

### Healthcare Team

**Clinical Staff**

- Physicians (MD, DO)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Registered Nurse (RN)
- Registered Dietician (RD)
- Social Worker (LCSW)

**Non Clinical Staff**

- Patient Navigator
- Promotor/promotora
- Community Health workers (CHW)

### 9 Foundational Care Coordination Activities

1. Establish accountability or negotiate responsibility
   - Role: Team Leader
2. Communicate
   - Role: Everyone
3. Assess needs and goals
   - Role:RN, LCSW, Patient Navigator
4. Create a proactive plan of care
   - Role:RN, LCSW, Patient Navigator
5. Facilitate transitions
   - Role:RN, LCSW, Patient Navigator
6. Monitor, follow up, and respond to change
   - Role:RN, LCSW, Patient Navigator
7. Link to community resources
   - Role: Patient Navigator
8. Align resources with patient & population needs
   - Role:Patient Navigator
9. Support self-management goals
   - Role: RN, LCSW, Patient Navigator

## Patients benefiting from Care Coordination

- Vulnerable populations
  - Have certain chronic conditions
  - Multiple comorbidities
  - See many providers
  - Take many medications
  - Have depression symptoms
  - Have poor health literacy
  - Lack a home caregiver
  - Have been hospitalized in the last 6 months
  - Are physically frail
  - Could die within 1 year
- 8Ps Risk Factor Assessment tool is to assess your patient for their risk of vulnerability

## System Factors Affecting Patient Safety

- Teamwork: everyone involved in patient's care
  - Assess your team: Team Attitude Questionnaire
- Team communication
  - Make time for good communication
- Team Accountability
  - Follow up with other care providers & the patient after a referral or transfer of care
- Standardized Processes to facilitate transitions in care
  - Build good routines for patient safety by standardizing referral processes
  - SBAR Tool

© 2013-2022 Patient Navigator Training Collaborative. Reproduce only with permission.

## Effective Communication within Teams and with Patients

- Active Listening: deeply engaged in and attentive to what the speaker is saying

### Types of Active Listening

- **Paraphrasing:** Restate the same information using different words to more concisely reflect what the speaker said
  - Why do it?
    - Tests your understanding of what is heard by communicating your understanding of what the speaker said.
    - Allows the speaker to 'hear' and focus on his or her own thoughts.
    - Allows the speaker to see that you are trying to understand their message and perceptions. Encourages the speaker to continue speaking.
  - Examples
    - "What I'm hearing is..."
    - "Sounds like you are saying..."
    - "I'm not sure I'm with you but..."
    - "If I'm hearing you correctly..."
    - "So, as you see it..."
    - "it sounds like what's most important to you is..."

- **Clarifying:** Invite the speaker to explain some aspect of what she or he said.
  - Why do it?
    - Gives the speaker the opportunity to elaborate and clarify what was said.
    - Gives you the opportunity to identify anything that is unclear and to check the accuracy of your understanding.
  - Examples
    - "I'm not sure I quite understand; or do you mean that..."
    - "Can you say more about..."
    - "You have given me a lot of information, let me see if I've got it all..."

- **Reflecting:** Relaying what was said back to the speaker to show that you understand how he/she feels about something.
  - Why do it?
    - Deepens understanding of feelings and content.
    - Allows the speaker to see that you are trying to understand their message and perceptions.
  - Examples
    - "I get the sense that you might be feeling afraid about what might happen if..."
    - "To me, it sounds like you are frustrated about what was said, but I am wondering if you are also feeling a little hurt by it."
    - "It seems like you felt confused and worried when that happened."
    - "So, you're saying that you were feeling more frightened than angry."

- **Summarizing:** Identify, connect, and integrate key ideas and feelings in what the speaker said.
  - Why do it?
    - Helps both listener and speaker identify what is most important to the speaker.
  - Examples
    - "Let me summarize what I heard so far..."
    - "So, on the one hand...but on the other hand..."
    - "I think I've heard several things that seem to be important to you, first _____, second_____, third____."
    - "It sounds like there are two things that really matter most to you..."

- Other Communication Techniques
  - Closed Loop Communication
  - Motivational Interviewing for Patient Behavior Change
  - O.A.R.S.

© 2013-2022 Patient Navigator Training Collaborative. Reproduce only with permission.

# PANEL MANAGEMENT
## MODULE 2

### Learning Objectives

- Define panel management and related concepts.
- Risk stratify a fictional patient panel.
- Differentiate between clinical and nonclinical registries.
- Prioritize patients accordingly to their needs and barriers to care.

## Introduction

Patient Panel: list of patients assigned to each care team in the practice.

- The care team is responsible for preventative care, disease management, and acute care for all the patients on its panel

Panel Management: working together as a primary care team and using computer tools to ensure all the patients receive timely, safe, effective, patient-centered, efficient, and equitable care.

- Requires a proactive approach to ensure that every patient assigned to a clinic is up to date on basic preventative care

In-Reach: an invitation to a patient who is already an active participant in care to use another service, ie., and additional screening tests, diabetes education, a cooking class.

Outreach: inviting a patient to come to the office because of lapses in care.

- Pertains to patients who are due or overdue on services

Care Quality: the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

- 6 domains: safe, effective, patient-centered, timely, efficient, equitable

Patient-Centered Medical Home: model of organization of primary care that delivers the core functions of primary health care.

- 5 functions & attributes: comprehensive care, patient centered care, coordinated care, accessible services, quality & safety

## Primary Care Panels and Panel Management

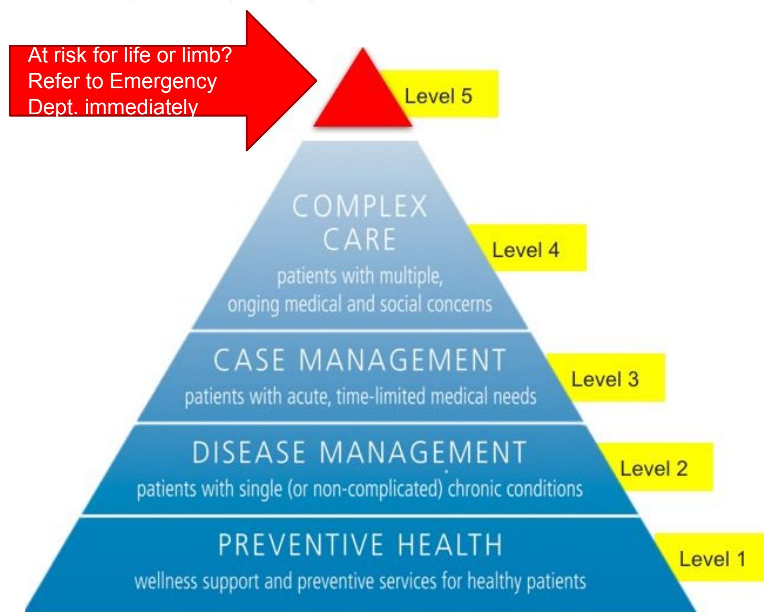
- Panel management depends on identifying certain patient needs,
- Risk stratification: grouping patients based on shared characteristics that impede their health

## Purpose of Risk Stratification

- To determine complexity and risk of patient to then be able to plan on addressing the patient's needs
- Helps determine which patients need immediate or extra care

## Risk Stratification Tools

- Several tools exist and vary between clinics and hospitals, and team leader as well as prioritization of needs
- Types: Computerized Stratification, manual scoring tools (by hand), and risk stratification pyramid (below)




[Source: Kaiser Permanente (n.d.). Risk Stratification Model.]

## Registry Tools

- A registry is a large spreadsheet that keeps all pertinent information about a patient regarding prominent disease
- Groups patients together for effective and efficient management
- Helpful to highlight or flag any patient info to follow up with treatment or care
- Registry info can include clinical or non-clinical info
- Resources: Registries Made Simple -- FPM (aafp.org)
  - Registry Tools

© 2013-2022 Patient Navigator Training Collaborative. Reproduce only with permission.

### Learning Objectives

- Recall the 9 foundational care coordination activities.
- Select the appropriate care management tasks and responsibilities for various care coordination roles.
- Distinguish between self-care and self-care management support.
- Identify patient strengths and barriers to care.
- Engage patients in goal setting to develop a patient-centered action plan within planned care visits.

## Care Coordinator Job Description

- Job Description Example
- Take note of all activities performed and discuss responsibilities and roles within care team
  - Planning tool for Care Team

## Introduction to Care Management

Care management: concrete activities that we do to temporarily assistant patients with their health care needs

- Transitioning patients towards independence

Care management activities

Unlicensed & Licensed Care Coordinator shared roles

- ➔ Leading patients & families towards self-care management
- ➔ Coaching patients & families
- ➔ Engaging patients & families
- ➔ Empowering patients & families
- ➔ Educating patients & families
- ➔ Managing appointments
- ➔ Managing referrals
- ➔ Medication reconciliation

Additional Licensed Care Coordinator Roles

- ➔ Managing medications (RN)
- ➔ Counseling patients & families (SW)
- ➔ Managing transitions in care (hospital discharge planner)

Self-Care Management: Patient is truly independent despite having chronic conditions

- Strategies
  - Show patients concrete skills to act on their problems
  - Let patients define "their" problems and on what they are willing to work first
  - Provide real-life problem solving skills that focus on consequences
    - Example: "When you do this, this can happen ____. But if you do that, you could have___ (e.g. more pain free days).
  - Help patients become more confident. Break large goals into smaller steps to improve confidence to succeed
  - Let patient do what they can do for themselves

## Self-Care Management Support

Self-care management support: effort of healthcare staff to train the patient to become confident in engaging in self-care management

Purpose:

- Prompts change towards health behaviors
- Teaches patients strategies for self-reliance
- Empowers patient to become partners to health care team
- Helps patients understand treatment and stick with it

Activities:

- Engaging and activating patients
- Beginning the conversation
- Healthy activities and prevention
- Helping patients understand their chronic disease
- Sticking with it when it's tough

Steps

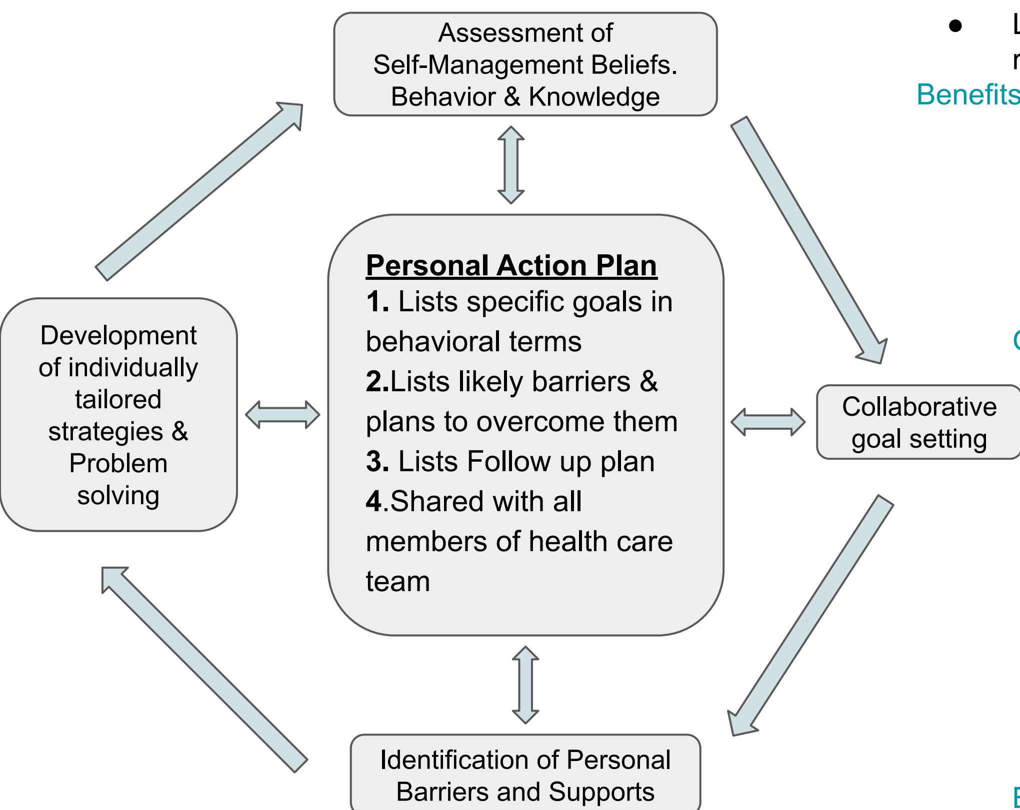
1. Put the patient in charge (what to discuss)
   - Communication Strategy for Patient-Centered Education and Self-Care Management
2. Assess the patient's readiness
   - Readiness Ruler
3. Educate and Coach
   - Assessment of Patient Self-management Ability
   - Teach back approach
   - Patient worksheets: My action plan

© 2013-2022 Patient Navigator Training Collaborative. Reproduce only with permission.

# PATIENT-CENTERED CARE COORDINATION
## MODULE 3

### Patient-Centered Goal Setting

- Inadequate support for self-management of patient's illness can lead to patient thinking clinicians do not explain well
- Focus efforts on getting to know the patient and understanding their goals




**SMART**: mnemonic for goal setting

### Planned Care Visits

Purpose: set special time for a care coordinator and patient to go over what the patient understands or needs clarified before leaving the clinic

- May require more than 1 visit

Can assess:

- What the patient struggles with
- Develop self-care goals
- Further teach about patient's home regimen
- Less one discusses the more the patient retains info

Benefits:

- Better clinical control of illness
- Reduce symptoms
- Improve overall health & quality of life
- Fewer acute care visits
- Reduced costs
- Greater patient satisfaction

General Setup of Planned Care Visit

- Choose patient population to focus on
- Generate List of patients at particular risk within group
  - At risk:
    - Not adhering to their medication
    - Clinical evidence of poor disease control
    - Haven't received important medications or services for their condition

Before Visit

- Call patients and explain need for visit
- Schedule visit and instruct patient to bring all medications
- Prepare for visit: Doctor-Patient Talk
- Review medications prior to visit

At Visit

- Review patient's concerns & questions, clinical status & treatment, medications (eliminate or adjust)
- Discuss & resolve adherence issues
- Collaboratively develop a action plan that the patient can & will follow

Tools

- Self-management Support Workflow

© 2013-2022 Patient Navigator Training Collaborative. Reproduce only with permission.

# EVALUATING CARE COORDINATION MODULE 4

## Learning Objectives

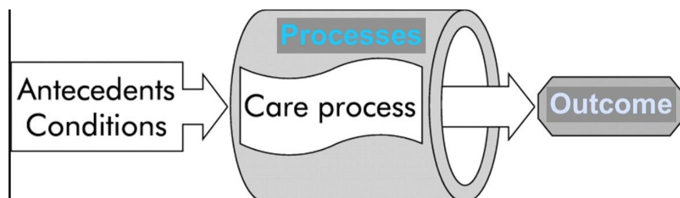
- Define how to measure successful care coordination.
- Distinguish between process and outcome measures.
- Choose appropriate individual and population health indicators to measure the effectiveness of team-based care coordination.
- Use the PDSA cycle as a tool for team performance improvement.

## Introduction

Care coordination success can be viewed as:

- Our patients improved their health?
- We reduced barriers for our patients?
- Our patients became better at self-management?
- Our team worked together more effectively and efficiently?
- Our clinic got better at providing preventative care?
- Our entire patient panel reported to be satisfied with our care management?

## How do we Know Care Coordination is Successful?




- ➔ Each patient has a unique set of conditions, symptoms, and social issues (antecedents conditions)
- ➔ Process Measure: capture whether the actions a health professional or the team (including the patient) take to improve care or self-management have been successful.
- ➔ Outcome Measure: measures of end-result of care
    - ◆ E.g: percentage of diabetes patients that achieved HbA1c levels below 7

## Scientifically Validated Quality Measures for Care Coordination

Predominant reports of scientifically validated care coordination quality measures:

- Care Coordination Quality Measure for Primary Care (CCQM-PC)
- AHRQ Care Coordination Measures Atlas
- NQF Care Coordination Measures
- Boston Children's Hospital CYSHCN Care Coordination Measurement Tool

## Individual Patient-Level Measures

- Encompasses both process and outcome measures

Most common patient-level outpatient care coordination measures:

- Measuring Social Determinants of Health (SDoH)
- Measuring Disease Prevention
- Measuring Self-Management, Life Style, and Behavioral Change
- Measuring Patient Perception of Care Coordination
    - Patient Satisfaction Tool
    - Health-Related Quality of Life (HRQOL) Instrument
    - General Patient Self-Efficacy Assessment

## Population Health Measures

Population Health Management: seeks to improve health and lower costs for a defined population through preventative, coordinated, evidence-based care.

Tools::

- Measurement Plan for Population-Level Outcomes
- MACRA Measurement Plan and examples

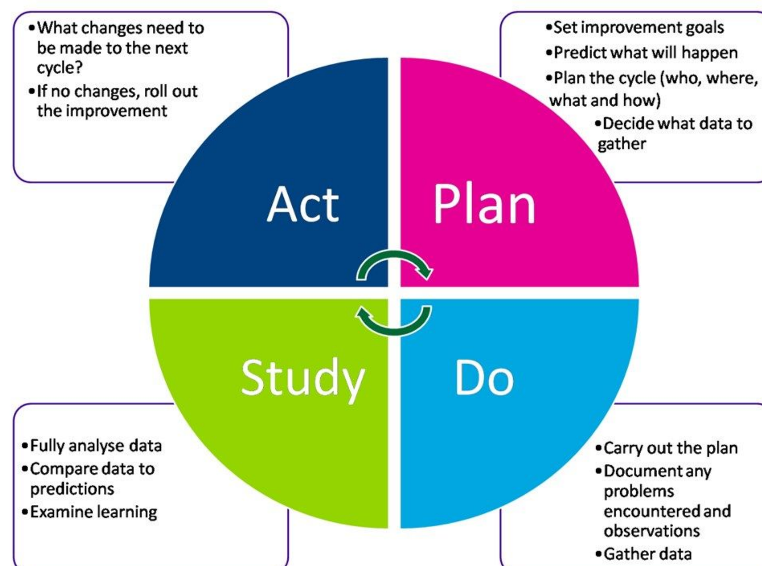
Prevention Screening Services

U.S. Preventive Services | Prevention TaskForce (uspreventiveservicestaskforce.org)

## Improving One Small Step at a TIme

Taking steps toward the right direction (forward)

**PDSA CYCLE:**



# Program Information

## About Us

The Patient Navigator Training Collaborative (PNTC) is designed to help you prepare for the growing profession of patient navigation. The program offers a full curriculum with face-to-face courses, online courses, self-paced eLearning courses, and webinars. Our program team includes patient navigators and navigator supervisors, educators, medical experts, social workers, psychologists and evaluators. We work continuously to improve courses so they are of high quality and relevant to situations that navigators face every day.

Program partners include Denver Health and Hospital Authority; the Center for Public Health Practice and the Rocky Mountain Public Health Training Center; University of Colorado School of Public Health; the Denver Prevention Training Center, Trailhead Institute and Red Rocks Community College.

This curriculum was developed by Nora Flucke, PhD, RN, with contributions from Patricia Valverde, PhD, MPH, Beverly Wasserman, RN, and other curriculum development experts on the PNTC team.

## Program Funding

This program is funded by a combination of registration fees, grants and fee-for-service projects. We would like to acknowledge previous funding streams through Amendment 35 funds at the Colorado Department of Public Health and Environment (CDPHE) and Colorado Health Foundation.

## Contact Us

View upcoming courses, sign up for our listserv, and more at patientnavigatortraining.org.
Questions? Email admin@patientnavigatortraining.org.

## Use of Training Materials

The blend of our instructor experience and active learning approach is unique. We ask that you do not distribute or share these materials without our permission. Much of the learning takes place during the exercises led by instructors.

**Materials are not intended for use by those not participating in the course. In addition, you do not have permission to use these materials to train on the curriculum within this manual.**

© 2013-2022 Patient Navigator Training Collaborative. Reproduce only with permission.