

Care Navigator Interview Transcript

Interviewee(s): Julia Cowan

Organization: SCL Health/Good Samaritan Medical Center

Date: 8/31/17

Could you tell us a little bit about yourself, including what your official title is?

I am a physical therapist. My title is Orthopedic Navigator. I have a pretty diverse and eclectic background. Most of my career has been spent in various post-acute rehabilitation settings including, acute rehab, skilled nursing, home health, and outpatient. Within those settings my responsibilities ranged from management and administration to program development and marketing. These work experiences have enhanced my success as an Orthopedic Navigator – it's all about Team Work. I understand the need to have everybody on the same page to assist in moving the patient through the continuum successfully. I think my background has brought a unique perspective to my position.

Yes, I will say that we have done many interviews and you are our first person with a therapist background.

Yes, I believe as a physical therapist and having prior experience in the post-acute space has been really helpful. The Ortho Navigators within our system have different backgrounds, there has been a social workers an ortho nurse and a nurse case manager. It's been a great advantage for us as we pool our past experiences and ideas. The collaboration amongst the various navigators has helped us create a well-rounded program.

Those folks that you were just naming – are they current navigators, or are those folks who in the past have served in your role?

We have four hospitals participating in CJR in our market. These folks are all current ortho navigators from the different hospitals within our system. We meet as a Team monthly, it's great to bounce ideas off each other, pull from our individual experiences and learn from each other.

How long have you been with the hospital? Is this a new position for you?

This is a new position for my hospital. I've been here just about a year – a year this month.

And they hired you specifically for this navigator role?

Yes that is correct.

So why don't you share a little bit about what you do? What are your core responsibilities?

Depending on surgery schedules, each day can look very different. Patient identification is a big part of my role, to make sure we identify and capture all patients who might fall into the CJR bundle. Daily review of our EPIC Navigator Dashboard, reviewing surgical schedules, and reviewing the in-house census to verify admissions is a daily occurrence.

Establishing a good rapport whether by phone or in-person with our patients is key. Patient outreach has been critical to the success of our program. I'd say patient outreach is the biggest part of my core

responsibilities and accounts for the majority of my time. Whether making initial intake calls, pre-operatively, to establish rapport and gather initial information about our patients or making the post-discharge calls, patient compliance is always better if I can connect with them early. I also visit our patients while they are in a skilled nursing facility. This helps to ensure both the patient and the post-acute provider are working towards the right discharge plan.

Another of my core responsibility is care coordination. Routine communications either in person, by email or phone, with post-acute care providers, surgeons, PAs, etc. making sure that we're all on the same page. This 'care coordination' includes the inpatient care teams as well, making sure that the rest of the team in the hospital is on the same page, so communicating with the PMNR team; the admissions team so they know who is coming in and when; making sure that the anticipated discharge plan is in line with the surgeon's, so lots of coordination in that realm.

Data review and patient tracking is also an important part of my day to day routine. I also teach the hospital joint class on a weekly basis, specifically the physical therapy and occupational therapy portion. With monthly and quarterly meetings with our post-acute care providers, physicians, and hospital staff there is plenty to do!

That's great. You sound quite busy in your role. How many patients are you typically responsible for in a given time?

I'd say on any given month, between 35 and 45 depending on where patients fall on their 90 day journey. Due to the positive outcomes we've seen with the CJR population, related to improved outcomes and decreased readmissions, I follow all of our elective total hips and total knees, regardless of the payer. I don't follow all of them for the full 90 days, but do follow them prior to surgery with the intake call, making sure they get into joint class, and then for up to 30 days post-operatively. Depending on how they are doing or my concerns, I may follow them longer, but in general about 30 days after. Does that make sense?

It does. In terms of the fracture patients, do they have any support that they receive from others? Or is that too difficult of a population to kind of integrate into care navigation and care coordination?

At the moment, non-CJR hip fractures are not being followed. We've discussed the need to bridge that gap but have not solidified a plan. Does that answer your question?

It does, I misunderstood. I thought you were saying you just focus on the elective patients.

Right, anybody that falls into CJR I follow which can include both electives and trauma (for those total hip replacement). For the non-CJR, non-Kaiser I am following just the elective hips and knees.

Got it, okay. So you mentioned a couple of different touch points that I wanted to hear a little bit more about. It sounds like your first interaction is at intake, and that is a phone call?

Yes.

What kinds of things do you go over with them at that time?

My first question is always whether they have attended or are scheduled for the hospital joint class. There is a lot of critical information disseminated there. I also try to meet them during the joint class so I

can introduce myself and establish a relationship. It gives me the opportunity to see how they're moving and at what functional level. During the intake call, I go over the basics – living situation, supports systems, current community resources they may have in place, who will care for their pets while they are in hospital, etc. Past medical history, comorbidities and how those comorbidities may impact their recovery as well as recent emergency room visits or hospitalizations. I do complete the RAPT Tool the Risk Assessment and Prediction Tool. We review falls in the last six months and any fear of falling. I talk a lot about their home and what kind of setup they have, what barriers they have and what and what equipment they are currently using. We talk about their current functional status? Are they independent with their ADLs? Are they independent with their IADLs? What assistance are they needing with housekeeping, meal prep, etc.? What activities have decreased due to their current pain levels? What narcotics are they taking? I also ask them if this is their first total joint replacement, or their third or fourth, it makes a difference. Getting a solid idea of what their current functional status, overall health and current activity level is critical in preparing for their surgery. I leave a lot of time to answer any questions or concerns they may have. I try to make it personal, so that it is helpful and beneficial and they feel supported and cared for through the process.

It sounds like you have sort of checklists or there's sort of a list of questions that you have? Sort of structured or standardized, that you go through?

Yes, I use an intake form that covers all the pertinent information I need to know at the onset. All the Navigators within our hospital system utilize the same intake format and questions. We've come to realize that this consistency ensures positive outcomes.

Once they come into the hospital and have their surgery, I think you mentioned that you do round on them in the hospital to kind of check in on them.

Yes, when they're in the hospital I meet with them and their family and/or support person. I'm in constant contact with the case manager, the surgeon, the PA, and the rehabilitation team to stay in the loop on how they're doing. Are we on target for our anticipated discharge and post-acute plan? Are there any complication or changes to the discharge disposition?

Great. And once they are discharged, you do some follow-up, it sounds like phone calls, even if they're going to skilled nursing facilities?

Yes, however the follow-up is different if they're going to a skilled nursing facility versus if they're going home with support at home. If they're going home, I usually call them between 48 and 72 hours after discharge from the hospital. And then, about a week out; about two weeks out; at 30 days; and then, depending on how they're doing, I decide on how many calls I need to do from there. If they're doing really well, I may not call them until 60 days. If I feel like they may need more support, I may call them more often. I set a basic call schedule and adjust it based on the individual and how they're doing. If they go to the skilled nursing facility, my initial contact is within 48-72 hours of that admission. After that I usually visit weekly and meet with the skilled nursing care teams and the patient.

Interesting. And how has the staff and the care teams at the skilled nursing facilities received that?

They have been very open. A big piece of our success in the post-acute area has been education and team work! I have a very strong preferred partner network, and we all have worked hard to establish

those relationships and set expectations. Our preferred partners have been really great about working with us and being true partners. Transparency has been key – being open to the hard conversations and being good about receiving feedback – good and bad. If a patient chooses to go outside the preferred partner network, I will contact that partner directly to educate them about the program and expectations for communication and discharge planning. The overall goal is that we are all working together for the benefit of the patient.

That's great. It sounds like having those preferred providers has really facilitated your ability to be successful in following up with patients if they have to go to skilled nursing.

Absolutely. I think a solid relationship with your post-acute partners is key to the success of the navigation process. When I think about successes, I do believe that part of our success is our preferred partner network because we've developed good lines of communication and together we've had to do some creative thinking on different challenges with certain patients. How can we best serve them and help them? Sometimes it takes more than one person to figure that out. Having a rehab manager at a home health who's willing to call me up and say, "Hey, this is going on." Together, we problem solve issues and have had some really good outcomes. As you can imagine, being at a Level 2 Trauma, we have some really unique and challenging cases. Mine are not all simple, active total hips or total knees. Sometimes their situations are quite unique and take more coordination and creativity to manage.

I noticed that you're kind of using the language of "we're all kind of here for the patient" and "trying to do what's best for them." I wonder if framing it that way has also helped to get folks on board and get people more willing to share information, and even maybe – I don't know if you've experienced this, but have they made any changes in terms of care protocols that they may be using that you all have recommended?

Yes. I feel like in this market, we have pretty progressive healthcare partners. They have all been very open to and on board with adjusting and changing, which I think is also the key to success in any payment reform model. Our partners know this is an ever-evolving process based on data and quality outcomes as well as improved care initiative in the acute setting. We all have to be willing to adapt and be fluid. Our skilled nursing partners have been very willing to re-examine how they provide care; adjusting therapy schedules to ensure patients are evaluated and treated within 24 hours of admission, providing therapy services 7 days a week and establishing the discharge plan within 48 hours of admission. We've been transparent with our partners that a lot of our patients are going straight home with home health or going to outpatient because we've made a lot of changes in our operating room and with our anesthesia teams to improve recovery time. Communication is key.

And not just 'telling' partners what the program parameters need to be, but demonstrating that we want to have a true partnership so that they feel comfortable calling and saying, "Hey, we have an issue. We have a challenge and a concern and we need help to work through this" I think is really important. Ultimately at the end of the day, our goal is to have the best outcomes that we can for our patients. It is a best practice to decrease readmissions, to decrease any potential problems related to surgery. If we're all working towards those same goals, we are improving patient care. That, I believe, is the intent. I hope that answered your question.

It did, that was really helpful. I know in particular that's a place that's been challenging for folks to figure out how to develop those relationships and work collaboratively with the post-acute care

providers. So I was definitely interested to hear a little bit more about how you all were able to do that.

As a system, SCL Health, sent out a Request for Information (RFI), on behalf of the hospitals participating in CJR, to the post-acute care providers. The RFI included requests for clinical outcomes, staffing metrics, quality data points, etc. With that information as well as CMS's publically available data and physician input, we were able to narrow our network. We did establish criteria both for our partners and ourselves, including open lines of communication, data sharing as well as commitment to quarterly meetings. Post-acute partners had to agree on these criteria points before becoming part of our preferred partner network. This process enabled our partners to come to the table willing, and understanding that this is a new horizon, a new opportunity to work together on behalf of our patients. I think, coming from post-acute care, I have always understood it would be best to have open lines of communication. What I do in the acute care space impacts how the post-acute care manages the patient and certainly some of the knowledge I have benefits them, and vice versa. Together we can create better outcomes.

So in many ways, you already had the folks who were already most engaged and open and willing.

Yes, absolutely. It's more challenging, certainly, if a patient chooses to go outside of the preferred partner network. Those transitions require diligent communication on my part to assist those post-acute partners in understanding the common goals for the patients.

What are some of the successes that you've achieved in your role as a care navigator?

I certainly feel that we've had some successes with our patient outcomes, definitely. I will tell you that we've had some very challenging, complex cases, I should say, so we are not always under target. But in the end, many of them ended up in much better scenarios and had better outcomes than we could have hoped for. And that wouldn't have happened had there not been the navigator position. So I feel really grateful that that has been an opportunity for us to help some of these patients.

Developing relationships with the ortho surgeons and the Pas, helping get them to understand the commitment of the hospital, how they can work with us and we can work with them. My surgeons are community surgeons, they are not employed by SCL Health, so getting them on board, developing that relationship, helping them see the value of this position and the role, and how it can improve the outcomes for their patients has been a success.

I've already mentioned the preferred partner relationships. I do believe that coming from the post-acute area has been a great asset for me. I understand a lot of what their unique challenges are and am able to talk their language and understand their regulations. It gives us the opportunity to work well together. Those would be a couple of them. We do have a couple of cases that have been pretty unique that, through working with our partners, we've really been able to be very successful in helping them get to a good outcome, and some of them even a better quality of life.

Could you share with us one of those stories, one of those patients that you've really helped?

Sure. I had a patient who was a 50-year-old female with developmental delay and some motor functional delays. When I first started to interact with her on my intake call, she was in between foster family homes, so she wasn't sure if she should stay in the current home she was at or move to her new home before the surgery. She attended the joint class by herself. Her care coordination was extensive

since I was working with her care team through the developmental disability group here locally, in addition to both her care manager and new foster family. There was a lot of coordination to consider. Where would she be going home to? Will her new family be able to manage her care?

She had a lot of questions and answers to process, so consistent messaging was really important. It took a little time for her to understand how the surgery was going to impact her and what the recovery would look like. She worked in a supported work environment and navigating the time off as well as restrictions post-surgery were things she needed help with. For most people, having surgery is overwhelming and scary enough, but when you have a developmental delay it takes longer to process all the different information and it can be very overwhelming. She also doesn't read, which made the educational information and instructions a challenge to convey. We did quite a bit of pre-planning with her and lots of extra care coordination. I saw her multiple times while she was here in the hospital. I made her a daily call afterwards, for about two weeks, which included calls directly to her as well as speaking with her foster care family and the home health agency. I talked to her weekly after home health services were complete, and now she just calls me for social calls because she likes to keep me updated on what's going on in her life. She's doing great!

Oh, that's nice. That must be rewarding.

It is. She's so sweet. She's walking without an assistive device and is doing very well in her new foster home. She's back at work. She's definitely been a success story.

That's a great story. Wonderful. If you had to give a couple pieces of advice or tips to someone who is just starting out in a similar role, what would you tell them? What are the key things they should focus on?

I think truly learning and understanding what the CJR bundled program means and how it impacts both your hospital and your patients is really important, educating yourself is paramount. Talking to others is very important. Making sure that all the key players are educated and understand what the program entails. It's one of those programs that despite best efforts to educate throughout the hospital it's not always well-understood since it may not directly impact any one person's jobs. Making sure that the admissions and scheduling teams understand and flag those patients, that the care management team and PMNR are on the same page, the preadmission testing staff, the pre-op, the OR, the post-op are aware, you cannot assume that they understand what the CJR program is. Make sure that you take the time to meet and educate them. That was a lot of what I did in the beginning, developing relationships and communications with the surgeon and the PAs is very important.

Developing a comprehensive hospital joint class with clear messages, stated goals, and easy to understand educational materials is vital to being successful. Making sure that the messages are consistent throughout those 90-days, from the surgeon, to the joint class, through the hospital stay and well into the post-hospital discharge are key.

Developing your resources. In addition to a narrow network of post-acute providers, what are additional community resource in your area? How can patients get connected with senior resources, non-medical home care, meal services and transportation to name just a few. We have a mobile 'ER' service called Dispatch Health. What are some of the resources that your patients might need and making sure that you know how to connect patients to those resources.

Those are great tips. I think that will be really helpful for others.

Wonderful. I hope it is helpful.

Yeah, I think it will be. Is there anything else that you'd like to share before we get wrapped up?

I think that's it.

Great. This has been really helpful. We really appreciate it.