Care Navigator Interview Transcript

Interviewee(s): Lisa Clark
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Why don't you tell me a little bit about yourself? What is your title? We've noticed that they vary quite a bit across hospitals.

My title is Orthopedic/Surgical Navigator. I have been a nurse for 40 years. My background is varied and includes ICU (critical care) where I was an educator as well as the Charge Nurse. I then became a certified Cardiac Rehab Clinical Specialist and eventually the Manager of the Cardiac Wellness Department where I was fortunate enough to build the employee wellness program as well as build a very successful Cardiac Rehabilitation program as well as an Exercise Physiologist intern program. After 20 years at St Anthony Hospital in Denver I changed completely and spent 7 years in the Home Care arena when my children were little. I developed a clinical pathway for all open heart patients and we excelled at getting our patients educated and back into rehab. My next endeavor was a Discharge Planner/Care Coordinator for 2 years before being wooed back into a management role as the Director of the ICU at Longmont United Hospital. I helped to build the dialysis suite and start the Vascular Access Team. I spent 6 years in this role and then had the opportunity to start the In-patient Transitions of Care program with a grant from the Colorado Hospital Association to monitor Medicare re-admissions. With this transitions position I was also involved with Surgery Utilization and physician education related to CPT codes and the necessary documentation in the patient history and physical to meet criteria. This evolved into looking at orthopedic patients closely and I was invited to be part of the Co-Management Committee. From the work done with the orthopedic patients this became a full time navigator role due with the emphasis on seeing and meeting the patients far enough in advance to allow for the discharge plan to be set prior to admission.

As a navigator I have helped to build a very successful program from joint class through discharge and follow up. It has been rewarding to build the relationships with all disciplines involved with our total joint patients. My strength has always been process improvement.

And it sounds like that happened before CJR?

The Navigator Role did happen before CJR. I was fortunate to be able to addend the CJR training in the fall of 2015. As a Centura Hospital we are part of Catholic Health Initiatives System. The education we received was focused on the evolution of the Navigator role. I have been very fortunate to be able to build the role and expand what we do. We also received our certification from The Joint Commission for our total joint program.

I was going to ask – are you the only one?

Currently within Centura I believe I am the only Orthopedic Navigator. I have been included in several of the meetings that are looking at changes throughout the Centura System and have helped to formulate a rough draft for the position.

It's been really rewarding. It's been really challenging. Collaboration with the physicians is key.

I have a few follow-up questions. You mentioned the risk assessment that you developed. It sounds like it's focusing both on clinical risk and social risk.

The risk assessment has proved to be invaluable. It has questions that address the patient's physical limitations as well as medical conditions. It helps patients to understand that their health and activity level is all considered when having surgery.

Our program is unique in Longmont. We have a very committed Pre-Admission Testing (PAT) nursing staff that actually presented their research at their national convention. This research was tied to the dollars saved to the Medicare beneficiaries. We don't make the patient go see their primary care physician prior to surgery if they have seen them recently and have no co-morbidities that are not controlled. When they come for their 3-week PAT visit we do an extensive history that is documented and reviewed by anesthesia. If they've had bloodwork done at their primary care physician, we obtain this and do not duplicate. If they've had an EKG and/or seen their cardiologist we connect and get these results as well. If there are issues that are identified extra testing may have to be done but many of our total joint patients are otherwise healthy and don't need these extra MD visits. Anesthesia will clear the patient or direct them for further testing if needed. Many hospitals use Hospitalists either before surgery for the assessment or to manage them on the floor. We do not routinely do this as it's an added cost that is most times not necessary. Our orthopedic surgeons are the primary physician on most of our cases.

Are there other things that you can see that are really valuable from having you? Are there readmissions that you prevented?

We have decreased our readmissions and we have postponed several patients with the results of their Pre-Screening Risk Assessment. We want the best outcomes. This is elective surgery so we want our patients to do as well as they possibly can. Being prepared in advance has helped to decrease length of stay and increased patient satisfaction.

That's interesting. You're having a big impact on patient satisfaction then.

We do, patients feel cared for and knowing they have a familiar person to reach out to has helped.

What are some of the challenges that you've faced in your role?

My biggest challenge is that I need more of me. I am being included in more program standardization and meetings. The hardest part is to keep up with the follow up phone calls. Most patients are not home after 30 days so making phone calls in the middle of the day is not beneficial.

One of the biggest challenges early on was building the relationship with the physicians and the multidisciplinary teams. We all have to be speaking the same language to the patient in terms of expectations and outcomes. I am not duplicating what is being taught by the PAT nurses or the floor nurses but having done home care it's extremely important to really get to the bottom of what a person's home is like and who their caregiver will be. I'm conditioned to ask those questions and will get very helpful information from the patient because they have met me and seen me and talked to me multiple times.

The hardest challenge was helping our surgeons understand that starting the process 4-6 weeks before surgery benefits all.

In terms of patient satisfaction I always end my phone conversations with…"If there was one thing that we could have done to improve your stay, what would it have been?" It's amazing, most patients are so pleased they have nothing to add. For those that share what they would have liked to see, this is our opportunity to continue improving our program. I do get comments about how well everyone knew exactly what the plan was and how we are all saying the same thing.

And.. I don't get phone calls. They don't call me. They don't need to. They have my phone number and once in a while I'll get a call, but for the most part, they don't call me. They do great. They go home, they do their home care, if they don't have home care they to outpatient rehab. They do really well.

That's great. How many patients are you typically following at a time?

It depends on the scheduling of the week.

We do 2 joint classes a month and there are upwards of 25 patients in each class plus their caregiver/spouse etc. Surgeries vary depending on the week we can do up to 18 in one week and have only 5 the next. This is up to the surgeons as they are not exclusive to LUH. We have weeks where I will be scheduled 15 PAT visits as well. It's always different and there are always multiple phone calls weekly.

When we developed our joint program we did not make it exclusive to CJR population. We treat all total joint patients the same.

If you had to give one or two tips or key pieces of advice to someone who is new to their role as a navigator, what would you tell them?

Start the process as far out as possible. The more prepared the patients are the better they seem to do. The outcomes are better. Their stress level is better.

Collaborate with all team members. Build the relationship with the physicians, all the disciplines the patient comes in contact with and most importantly the post discharge providers. It's key to have a great relationship with the Home Care Agencies and the SNF/Rehab facilities that you refer to. I actually developed criteria for our Home Care Providers and SNF/Rehab facilities so they understand our expectations of visits, disciplines and length of stays.

Help convince the surgeons that it takes time to prepare. All education needs to be repeated at least 3 times so make it a team goal that they are hearing the same instructions from different people.

What kinds of support would be helpful for you, in terms of information, resources, or tools? Is there anything that you can think of that would help you in your role?

Thinking outside the box. Utilize the resources you have to help with some of the tasks. I am a process person and as a Director I had sticky notes that said "Hey I have a great idea, how about you do this instead of me". I have a volunteer who makes the packets. Look at what resources we have to help with some of the "tasks" that accompany this type of program. Are there down time folks that could help with phone calls. Is there someone that can help keep the stats? We are starting a spine program that mirrors our joint program so there is never a lack of something to do. Our electronic call back system will be changing and I am excited to present this to patients in a very positive light so they know we will be keeping connected.