Eriksson Health[1]

Business Case for Dedicated Patient Navigator

2013 Action Plan for Care Program Clinical Goal: Inpatient Navigation

2013 Action Plan for Cancer Program Clinical Goal: Inpatient Navigation

Commission on Cancer Standard 4.8

Standard 4.8: Annually the quality improvement coordinator under the direction of the cancer committee implements 2 patient care improvements. One improvement is based on the results of a completed study that measures cancer patient quality of care and outcomes. One improvement can be identified from another source or from a completed study. Improvements are documented in the cancer committee minutes and shared with medical staff and administration.

Summary: Patient navigation proactively assesses the needs of the patients, provides clinical and psychosocial support, identifies barriers to care, and assists patients with resources. The Cancer Care Committee has indentified an opportunity to improve interdisciplinary collaboration and communication between outpatient navigation and inpatient support to provide seamless, coordinated care to our cancer patients both inpatient and outpatient.

Measure: The success of this goal will be measured by tracking the number and percent of inpatients who are referred for outpatient navigation as well as monitoring the effectiveness of handoff communication and collaboration between disciplines.

Issues Identified:

Several opportunities for improvement were identified with the previous process. Prior to implementing an inpatient navigator, Case Management (CM) and Medical Social Services (MSS) assisted patients in the hospital with supportive needs. The hand-off communication was inconsistent as social workers rotated throughout the hospital, and there was not one consistent person assigned to the oncology service line. This created a high risk for poor communication, poor collaboration, duplication of services, and patient dissatisfaction.

1) Pseudonym.

Source: Oncology Roundtable interviews and analysis.

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Action Plan

Action Plan:

- Hire an inpatient navigator assigned to the cancer service line to assist patient with psychosocial needs.
- The inpatient navigator is to be a Licensed Clinical Social Worker to work in collaboration with Case Management and the outpatient navigators to streamline supportive care and enhance communication. This position was filled 6/23/13 and the roles and responsibilities were developed in collaboration with CM, MSS, the inpatient navigator, and the outpatient navigators.
- A process to improve handoff communication is to be developed and implemented. Starting 7/1/13, daily census are printed and reviewed by outpatient navigators every morning to see if any of their patients have been admitted. If so, hand-off communication is given by outpatient navigator to inpatient navigator. The inpatient navigator's office is physically located with the outpatient navigators and reports to the same manager to improve opportunities for communication and collaboration. The inpatient navigator tracks new inpatient referrals, discharge dates, and if a referral was made to outpatient navigation for follow-up after discharge. If able, the outpatient navigators will see the patient while still inpatient to introduce themselves and inform the patient that they will follow-up in a couple of days. Patients are to be given outpatient navigation's contact information to call if needs arise before being contacted.
- Implement MagView as the electronic medical records for outpatient navigation. Currently we do not have an electronic outpatient documentation system for navigation. The outpatient navigators document narrative notes in Outlook as encounters or meetings on the calendar. These are shared with other disciplines as needed to facilitate care and provide detailed notes. MagView will allow us to share our notes with appropriate disciplines more effectively and efficiently. We anticipate this going live in the first quarter of 2014.

1) Pseudonym.

Source: Oncology Roundtable interviews and analysis.

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Dates, Goals, and Survey

Dates Reported to Cancer Committee:

- Goal # 1: >50% of patients receiving supportive social services in the hospital are referred for continued outpatient support as measured by inpatient navigation tracking tool.
- Goal # 2: An average satisfaction rating of 4 on a 5 point scale will be achieved when surveying CM, Inpatient navigator, and Outpatient navigators on questions regarding effective handoff communication, collaboration, and streamlined care as measured by Survey Monkey. Surveys will be conducted every six (6) months to assess satisfaction.

HAND-OFF COMMUNICATION SURVEY	Model A Prior to 7/1/13	Model B 7/1/13 - 1/5/14	Model C 1/5/14 - Current — 4/30/14
The culture of the organization (teamwork, respect) promoted successful hand-off between outpatient and inpatient navigation services.	3.11	4.22	2.8
The communication method/process was effective to promote successful hand-off communication between outpatient and inpatient navigation services.	3.11	4.44	2.67
Key information and critical elements about patients were communicated effectively when handing off patients.	3	4.5	2.56
There was adequate opportunity to ask questions or clarification when receiving a patient.	2.88	4.63	2.88
The psychosocial needs of patients were adequately met with this model.	3.33	4.33	2.44
The hand-off communication process met the needs to continue caring for patients effectively and efficiently.	3.22	4.56	2.67

Model A: Case Management and Medical Social Services had separate roles and rotated throughout the hospital.
Model B: CM & MSS had separate roles, but inpatient SW navigator assigned to oncology service line throughout the hospital.
Model C: CM & MSS cross trained to become transitional navigators and cover assigned units.

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Source: Oncology Roundtable interviews and analysis.

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Situation, Background, Assessment, Recommendation

SBAR for Hand-Off Communication

Situation:

Patient navigation proactively assesses the needs of the patients, provides clinical and psychosocial support, identifies barriers to care, and assists with resources. In 2013, identified an opportunity to improve interdisciplinary collaboration and communication between outpatient navigation and inpatient support to provide seamless, coordinated care to our patients both inpatient and outpatient.

Background:

Prior to July, 2013, Case Management (CM) and Medical Social Services (MSS) assisted patient in the hospital with discharge planning and psychosocial needs. The hand-off communication was inconsistent as social workers rotated throughout the hospital, and there was not one consistent person assigned to the oncology service line. This created a high risk for poor communication, poor collaboration, duplication of services, and dissatisfaction.

In July, 2013, the Patient Navigation team hired a 1.0FTE patient navigator (social worker) to address these concerns and improve our process. The Patient Navigator covered the inpatient oncology service line, so no matter where the patient was physically located in the hospital, that patient had a consistent person assisting with his/her psychosocial needs throughout the hospital stay. A hand-off process was defined, and hand-off communication significantly improved. In the first 6 months of 2013 (prior to this position being implemented), we received 39 referrals for continued navigation for oncology patients who were discharged. In the 6 months after implementing this position, we received 157 referrals for continued navigation post discharge (402% increase).

In January 2014, implemented a new model and cross-trained CM and MSS to perform both discharge planning and social work functions. They were assigned teams, and units for coverage. This directly impacted our inpatient patient navigator, and his FTE was included in this new model. He is now assigned to the 6th floor with a team rather than the oncology service line. Rather than providing psychosocial support to all our oncology patients throughout the hospital, he now provides CM and MSS functions to a portion of the patients on the 6th floor as the assignments are divided out amongst the team members. This has created disconnect in hand-off communication and collaboration, as there is no longer one consistent person caring for our oncology patients.

Assessment:

With the model change in January, a new hand-off communication process flow was created, and staff education was done. With this in place, we have still seen a significant decrease in referrals for outpatient follow-up. In January 2014, we received 5 referrals for continued navigation post-discharge, and in February, we received 17. The increase in February was a result of the outpatient navigators reacting to the decrease seen in January and proactively reviewing charts to see which patients might benefit from continued support. This can only be a temporary fix as their current workload does not permit doing this on a daily basis.

Recommendation:

Understanding the psychosocial needs of our oncology patients, and the need to provide consistent support, we recommend that the 1.0FTE Patient Navigator position be removed from the model change that occurred in January so that position can be dedicated to providing consistent psychosocial support to our oncology patients who are in the hospital.

1) Pseudonym.

Source: Oncology Roundtable interviews and analysis.