CivicHealth

Using High Tech to Improve High Touch

Patient Navigator Initiatives

Bridging Healthcare Providers and Social Services with CivicHealth Software Platform

OVERVIEW

There has been an upsurge of interest in implementing post-discharge programs that extend far beyond traditional medical care.

This new attention is largely based on two factors:

1) new studies are documenting a strong link between social factors and healthcare outcomes; and

2) federal and state mandates are pushing providers toward bundled and value-based reimbursement. Newly completed studies offer compelling evidence that supports the benefit – both financially and in terms of patient outcomes – that comes from post-discharge follow-up.

As healthcare systems add personnel to tackle care coordination, they quickly discover that their EHR systems are ill-suited to address social services. CivicHealth's technology solution integrates EHR information, regardless of the systems used, to help social and clinical care workers align the coordination and communication of patient needs. With more than a decade of use in communities across the country, CivicHealth's technology platform is uniquely qualified to assist with this evolution in healthcare delivery.

The Emergence of Patient Navigators

They are called by different names – patient navigators, case managers, community health workers, liaisons or social workers – but their mission is the same: improve outcomes by helping patients throughout the continuum of care.

Patient navigators (the term used in this document) represent an important step in the transition to value-based reimbursement. They serve as a link between the episodic intervention provided by hospitals and physicians, while helping ensure patients have the social support they need to achieve compliance and avoid costly rehospitalizations.

Less than a decade ago, addressing issues far outside the hospital walls seemed counterintuitive when seeking means of reducing the cost of care and improving outcomes. However, studies show that behavior and environment account for about 70 percent of health outcomes, and medical care only about 10 percent. [1]

According to a report from the Robert Wood Johnson Foundations' Commission to Build a Healthier America, the single largest social factor driving health is income. Education level is another indicator of health. According to the report, a 25-year-old college graduate can expect to live up to nine years longer than a 25-year-old who has not completed high school.[2]

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> — Commission to Build a Healthier America
> Robert Wood Johnson Foundation

In January 2014, the Commission issued three recommendations, one of which urged, "Broaden the mission of the U.S. health care system to address nonmedical factors that affect health, and connect patients to resources and services in the community that can improve their ability to pursue better health." [3]

The Case for Patient Navigators

Post-discharge care planning has been gradually assuming a place in the spotlight, due in part to the advent of Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs). The recent completion of several well-documented studies is adding credibility to those pushing for better post-discharge care coordination.

University of Pennsylvania Health Center Health – A paper from the Penn Center for Community Health Workers was published in the February 2014 issue of the *Journal of the American Medical Association*, bringing statistical validity to a field of study that is often criticized for lack of objectivity.[4] The purpose of the study was to determine whether intervention by community health workers would improve post-hospital outcomes among a patient population with low socioeconomic status. The paper notes, "Traditional hospital personnel often lack the time, skills and community linkages required to address these factors."

For the study, 446 adult inpatients from five high-poverty zip codes were randomly assigned to two groups. Patients in one group were visited in the hospital by a community health worker, who assisted with anything they needed for at least two weeks after discharge. Members of the assisted group were 50 percent more likely to follow up with a primary care provider, and were less likely to be readmitted multiple times – all after two weeks of intervention. The health system is tripling the size of the program.

In a commendatory accompanying the *JAMA* article, Harrison J. Alter, an assistant clinical professor at the University of California, San Francisco, who oversees a community health program in his hospital's emergency department, wrote, "This report is among the best evidence so far in support of what some are now calling upstream medicine, a term based on a common parable about

children rushing down a river toward a waterfall. Rather than exhaust all resources to snag children as they pass, it seems only reasonable to send a party upstream to see who is throwing them in the river in the first place."[5]

Sinai Health System is another organization that has begun tackling the social, economic and environmental conditions in the communities it serves as part of their program to reduce hospital readmissions and improve outcomes. Sinai saw hospital readmissions among heart failure patients fall by 45% between 2010 and 2012, according to the system's 2012 annual report.[6]

A pilot study conducted by Accenture and the **Cleveland Clinic** targeted 108 high-risk patients with poorly controlled diabetes. Over the course of a year, patient navigators worked with the patients, their families and care providers. The result: patients improved their blood glucose control by 32 percent and cut their no-show appointment rate in half. Accenture also conducted a study with Cleveland's safety net hospital, MetroHealth. The study showed that no-show and cancellation rates were reduced by three percent with the use of navigators, and the revenue they generated paid for the salaries of two full-time navigators in less than four months.[7]

Barriers to Coordinated Community Care

There are considerable barriers to implementing a community care program, with the primary roadblock being financial. The move to replace service-based reimbursement with a system that is value-based has been in discussion for some time, and is bolstered by the Accountable Care Act (ACA). However, the mechanics of actually implementing such a system are still in development except within some ACOs and PCMHs.

One incentive within the ACA is Section 9007, which strengthens the requirements that nonprofit hospitals provide community benefit programs in order to justify their tax-exempt status. Not only do nonprofit hospitals have to closely track the charity care and community services they provide, but every three years they must work with stakeholders to conduct a community needs assessment.[8]

While hospitals and health systems are being financially punished if they don't reduce Emergency Department visits and readmissions, there is still considerable discussion about how to accomplish these goals, and who will pay for the required infrastructure.

Further complicating the issue is the need for new resources during a time period when most hospitals are struggling with shrinking reimbursement. From a personnel standpoint, patient navigators and their ilk may already be employed by the health system, but new demands on their time are growing exponentially. There is also a need for locally based navigators, who know their community and can help a patient who is geographically removed from hospital services for follow-up care.

Those administrators seeking technology support within their current EHR system are bound to be disappointed. Even as EHRs expand to include more hospital and provider functions, the need to coordinate resources outside the traditional healthcare system is beyond the limitations of current systems.

How Technology Supports Success

Many patient navigators are low-cost, trained community members who serve as liaisons between patients, care teams and social services, assisting high-risk patients with medically complex diseases such as diabetes, heart disease and cancer. Ideally they are local and are familiar with the neighborhoods of the patients they serve. Often they have experience providing a similar service through a healthcare system or community social service organization.

As hospital employees, they can access the EHR; however, that does not support post-discharge care plans except when referring patients to other care providers. The EHR does not address sourcing the basic needs of these low-income patients such as food, shelter, clothing, prescription assistance, transportation and education on their condition.

One frustration for hospital-based patient navigators is the need to coordinate with community organizations and overcome the gap between EHR information and any systems used by social services. The CivicHealth software platform fills that gap, facilitating care coordination and resource management, with the ability to pull information from multiple EHRs and other software systems.

With CivicHealth, patient navigators can more easily manage an extended network of community resources. The software allows for management of all referrals from hospital discharge, to patient centered medical home referrals, to any social service, care support and wellness, to disease pathway initiatives in a community.

Hospitals, ACOs and PCMHs use CivicHealth's proven technology to:

- Determine eligibility and access to clinical and nonclinical programs
- Link social and clinical care workers to align the coordination and communication of patient needs
- Manage multiple disease pathways and programs in one platform across multiple caregivers, facilities and providers
- Capture integrated data to create steps and decision support for patient compliance
- Generate reports on targeted population health by program
- Track and document community benefit programs for non-profit hospitals

CivicHealth puts community resources at patient navigators' fingertips. The unique cornerstone of CivicHealth's platform is the integrated community network that serves as the local referral source and network extension. This removes the burden of locating support and social services and makes it easy to coordinate community resources and connect partner organizations that provide patients in need with food, clothing, shelter and insurance, as well as assistance with prescriptions, rent and utilities.

By combining all treatment records, assessments and other discharge plans, CivicHealth's platform creates a comprehensive community health record for each patient. This integrates case managers and workers into the entire spectrum of care, promoting better patient compliance and outcomes. The automated process creates a patient relationship management process, which triggers goals and interventions supported by enhanced care team communications while reducing workloads and streamlining workflow.

Conclusions

The healthcare industry is undergoing significant changes that affect not only the delivery and reimbursement of care, but even the definition of what healthcare means. As more hospitals and healthcare systems address the issue of improving the overall health of people in their communities, there is a need for patient navigators to broaden the reach and follow-up of providers. Equipping these frontline personnel with task-specific software will improve their productivity and effectiveness.

The CivicHealth platform, which is HIPAA compliant as well as ICD-10 and Meaningful Use Stage 3 ready, is unique in its focus and ability to integrate data across multiple EHR and information systems. Initially created to support community and healthcare workers seeking to improve individual and population health, CivicHealth offers a proven, affordable solution for any healthcare systems as they seek to improve the health and well-being of patients within both their walls and their communities.

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[1] http://health.usnews.com/health-news/hospital-of-tomorrow/articles/2014/02/13/treating-hunger-as-a-health-issue

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[3] http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2014/01/commission-to-build-a-healthier-america-recommends-seismic-shift.html (accessed 3/3/14)

[4] Shreya Kangovi, MD, MS; Nandita Mitra, PhD; David Grande, MD, MPA; Mary L. White; Sharon McCollum; Jeffrey Sellman, BA; Richard P. Shannon, MD; Judith A. Long, MD. Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial. *JAMA Intern Med.* Published online February 10, 2014. doi:10.1001/jamainternmed.2013.14327

[5] http://medcitynews.com/2014/03/community-health-workers-boost-primary-care-follow-repeat-readmissions-new-upenn-study/#ixzz2v1pXyPQM

[6] http://www.sinai.org/sites/default/files/2012%20Sinai%20Annual%20Report.pdf

[7] http://medcitynews.com/2014/02/patient-navigators-helped-diabetics-improve-blood-glucose-control-32-cleveland-clinic-pilot/

[8] http://health.usnews.com/health-news/hospital-of-tomorrow/articles/2014/02/13/treating-hunger-as-a-health-issue