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Clinical Navigators: Facilitating Transitions of Care

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Hae Mi Choe, PharmD, Associate Chief Clinical Officer for Quality and Care Innovations

Michelle Neeley, Project Manager

Vikas Parekh, MD, Associate Chief Medical Officer and Professor of Internal Medicine
Michigan Medicine, Ann Arbor, MI

Learning Objectives

- Describe a team-based approach to reduce admissions through a centralized, bundled, transitions-of-care program.
- Discuss how to identify and address team-based gaps in transitions of care from inpatient to post-acute and outpatient settings.
- Identify how to incorporate clinical navigator roles to smooth transitions of care between teams.

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Bridging The Gap - An Integrated Approach to Transitions in Care

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". . . those days when I was newly diagnosed
and clueless as to what I was facing ahead . . .

. . . to have a liaison, dedicated to helping your patients,
is so kind and generous . . .

. . . would make the patient,
who honestly is scared to death,

. . . feel safe and not alone,
that they have an expert taking the journey with [them]."

-Patient & AML Survivor

Intervention

Multimodal Intervention

- Alignment with best practice
- Advanced care planning
- Patient education, medication management, and preparation for self-management
- Discharge coordination, planning, and education
- Clear, visible, and direct handoff process to outpatient providers

Multidisciplinary Team

- Medical team (inpatient and outpatient providers)
- Social Worker
- Clinical Resource Coordinator
- Nurses
- Dietician
- Physical and Occupational Therapists

Coordinated Across Settings

- Inpatient care coordination across teams (teaching service, nonteaching service, ICU)
- Primary Oncology Team
- Local Specialists/Primary Care Providers
- Home Care

Outcomes & Lessons Learned

This role brought clarity to me when everything felt murky.

Primary Outcome Metrics	Pre (n = 68)	Post (n = 91)
30-day unplanned readmissions	23.5%	15.0%
Serious Illness Conversations	11%	95%

Process Metrics (Staff are confident that patients . . .)	Pre (n = 75)	Post (n = 65)
. . . understand discharge instructions	23.5%	32.3%
. . . understand their follow up care	2.7%	29.2%
. . . felt supported by the care team	12.0%	41.5%

We learned that:

- Bridging the gap is possible
- One size won't fit all for the patient
- Role clarity is key
- We needed to be flexible and creative
- The role empowers others

Key Takeaways

In Quality Improvement

- Make sure the voice of the patient is represented
- Create opportunities for feedback throughout, and be receptive
- Develop standardized documentation
- Allow & foster autonomy

To Improve Transitional Care

- Keep bringing the “big picture” to primary care teams
- Include the Serious Illness Conversation framework (or similar)
- Do a discharge phone call
- Be present at the post-acute appointment
- Embed clinical expertise in the process

Questions?

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Associate Chief Medical Officer

Michelle Neeley
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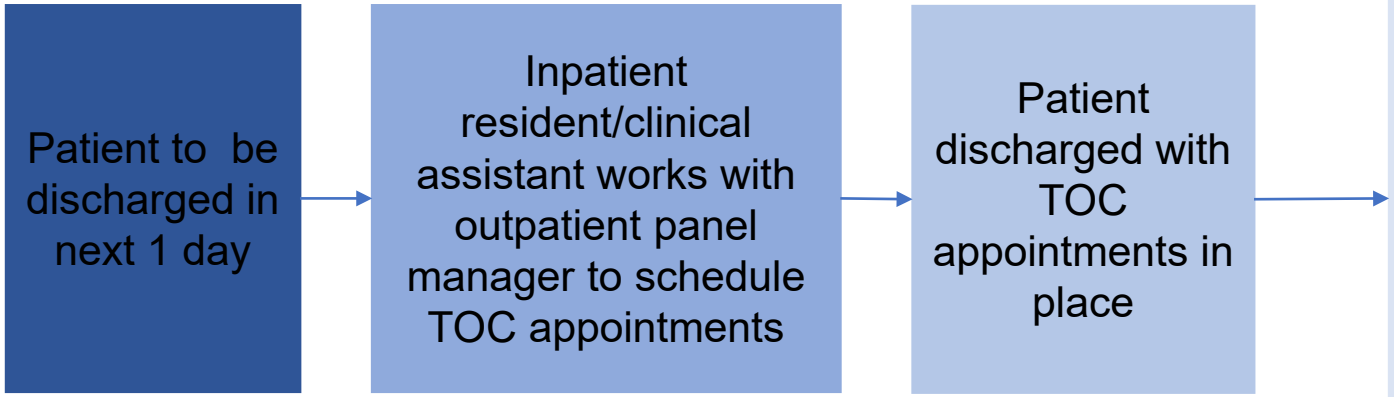
Opportunity

- A bundled approach to post-discharge transitions of care (TOC) with a centralized nurse care navigator and clinical pharmacist combined with prompt primary care follow up was previously shown to reduce readmissions in our institution
- Our previously established system was not able to effectively reach our targeted patients with this TOC bundle
- The COVID-19 pandemic highlighted the inefficiencies and inequities in our prior process for arranging transitions of care
  - We were able to pivot workflows to mitigate capacity constraints
  - Created a strong partnership between the inpatient and outpatient care teams
  - Leveraged rapid expansion of tele-medicine to increase primary care access and completion rates
  - Created a centralized scheduling system with standard scheduling guidelines
  - Leveraged EMR in-basket messaging to communicate and arrange post discharge appointments prior to discharge

Our Transition of Care Program

Target Population: Established primary care patients discharged home from General Medicine, Family Medicine or Medicine Observation Services



- **2 days post-discharge:** Nurse Care Navigator contacts patient to assess patient and proactively identify and triage any issues that may lead to readmission
- **3-5 days post-discharge:** Clinical Pharmacist completes phone visit with patient for medication reconciliation and answers any medication related questions or concerns
- **5-7 days post-discharge:** Patient sees primary care provider for hospital follow-up visit

Outcomes (~6,200 patients/year)

PCP f/u in 14 days post-discharge	⬆ 57% to 79%	30d Readmissions PCP f/u vs. none	⬇13.7% vs. 26.2%
Pharm D f/u prior to PCP appt	⬆ 9% to 55%	30d Readmissions PharmD f/u vs. none	⬇18.2% vs. 24.9%

Lessons Learned

- Siloed process between inpatient and outpatient care teams can be inefficient and lead to inequitable results
- EMR in-basket messaging is a great tool for staff to communicate between settings
- Centralized and standardized scheduling is key

Key Takeaways

- Establish a clear TOC process with clear responsibilities among team members
- A multi-disciplinary TOC operations team is critical to establish shared goals and collaboration between inpatient and outpatient care teams
- Centralized TOC resources (RN Care Navigator and PharmD) are more efficient and can reach more patients
- Tele (Video) Visits may greatly increase PCP f/u rates post-discharge

Questions?

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Panel Discussion

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