Training for the Race:

{ Effective Approaches to Preparing Care Navigators for the Road Ahead

Ice Breaker

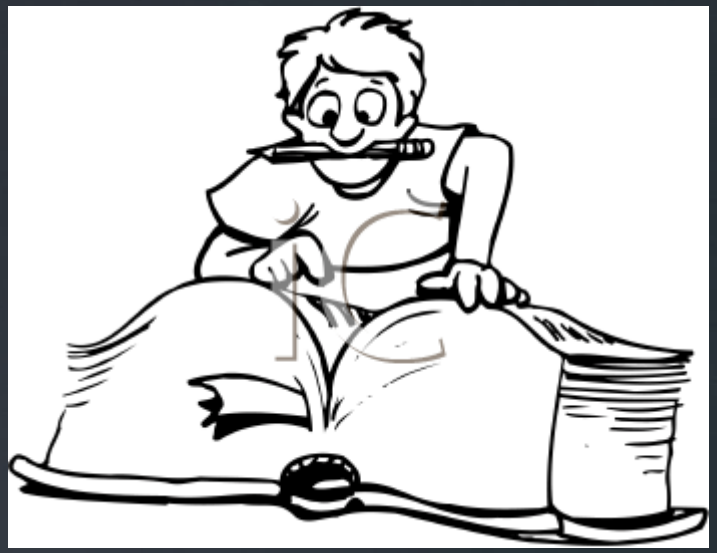
Agenda

1. Ice Breaker
2. Introductions
3. Educational Objectives
4. Presentation
    a) Definition of Care Navigator, and New Hire Agenda
    b) Daily Tasks, Workflows, and our ACTR
    c) Shadowing/Reverse Shadowing
    d) Supervision and Beyond
5. Questions/Comments

Introductions.

Educational Objectives

- Thorough training/team building through coworker shadowing, external trainings, and its effect on staff productivity.
- Implementation of care team reports and workflows as effective patient progress tracking for care navigators.
- Effective model for supervision of staff, and its increase in person-centered care.



So you're a new care navigator…

What is a Care Navigator?

- Care Management is a team-based, person-centered approach to helping patients and their supports manage their chronic medical and behavioral health conditions, navigate social determinants and become their healthiest self
- Our care navigators define themselves as advocates, and assist with coordinating the Patient's needs and goals while addressing and overcoming barriers around their healthcare.

Our New Hire Agenda

- Each new hire receives a training packet that includes documents, checklists, activities, and calendars that will help them navigate training/supervision over the first three months

- New care navigators meet with our Care Management Coordinator a total of five full days to review documents, complete activities and exercises, and familiarize themselves with day to day expectations

Department of Social Support Services
Care Management Program
Care Navigator Welcome Packet

Welcome to the Institute for Family Health's Care Management Program under the Department of Social Support Services! We are happy to have you on the team! For your first 3 months, you will undergo extensive training and gradually build your Care Team of patients. This Welcome Packet includes everything you will need to get started and settled in your new role.

Included are the following:

- ☐ Training Schedule
- ☐ Business Cards (blank)
- ☐ Notebook
- ☐ Site Orientation Checklist
- ☐ Department Orientation Checklist
- ☐ IFH Social Support Services Department Organizational Chart
- ☐ Required Competencies for Care Navigator
- ☐ What is Care Management?
- ☐ Common Terminology
- ☐ SMART Goals
- ☐ Health Home Case Scenarios
- ☐ Case Studies
- ☐ Individual Supervision Templates
- ☐ Group Supervision Structure
- ☐ Care Plan Template
- ☐ Care Plan Example
- ☐ Care Plan Tip Sheet
- ☐ Comprehensive Assessment Template

Training Documents to be reviewed not included in this packet (on Share Point):

- ☐ Daily Tasks/Expectations
- ☐ Monthly and Annual Tasks/Expectations
- ☐ Outreach and Engagement Work Flow
- ☐ Transitional Care Work Flow
- ☐ Cancer Screenings Training

NOTE: You will also receive an ID badge, work cell phone, and employee ID number (utilized to clock in).

Daily tasks and workflows

- Daily Tasks
  - New hires are given a “day to day tasks” packet.

- Workflows
  - Care navigators work together to create workflows for certain tasks that take more time (i.e. DME requests, Home Care orders, Housing, etc.).

- **Active Care Team Report** and the TCM (transitional care management) report are run daily by care navigators.

Workflows

- Clinical team along with Care Navigators work together to create time efficient workflows.
- Workflows change often, CN's work together inform team of new processes.
- Workflows for Documentation, DME, Home Health care, Housing, and In-House programs.

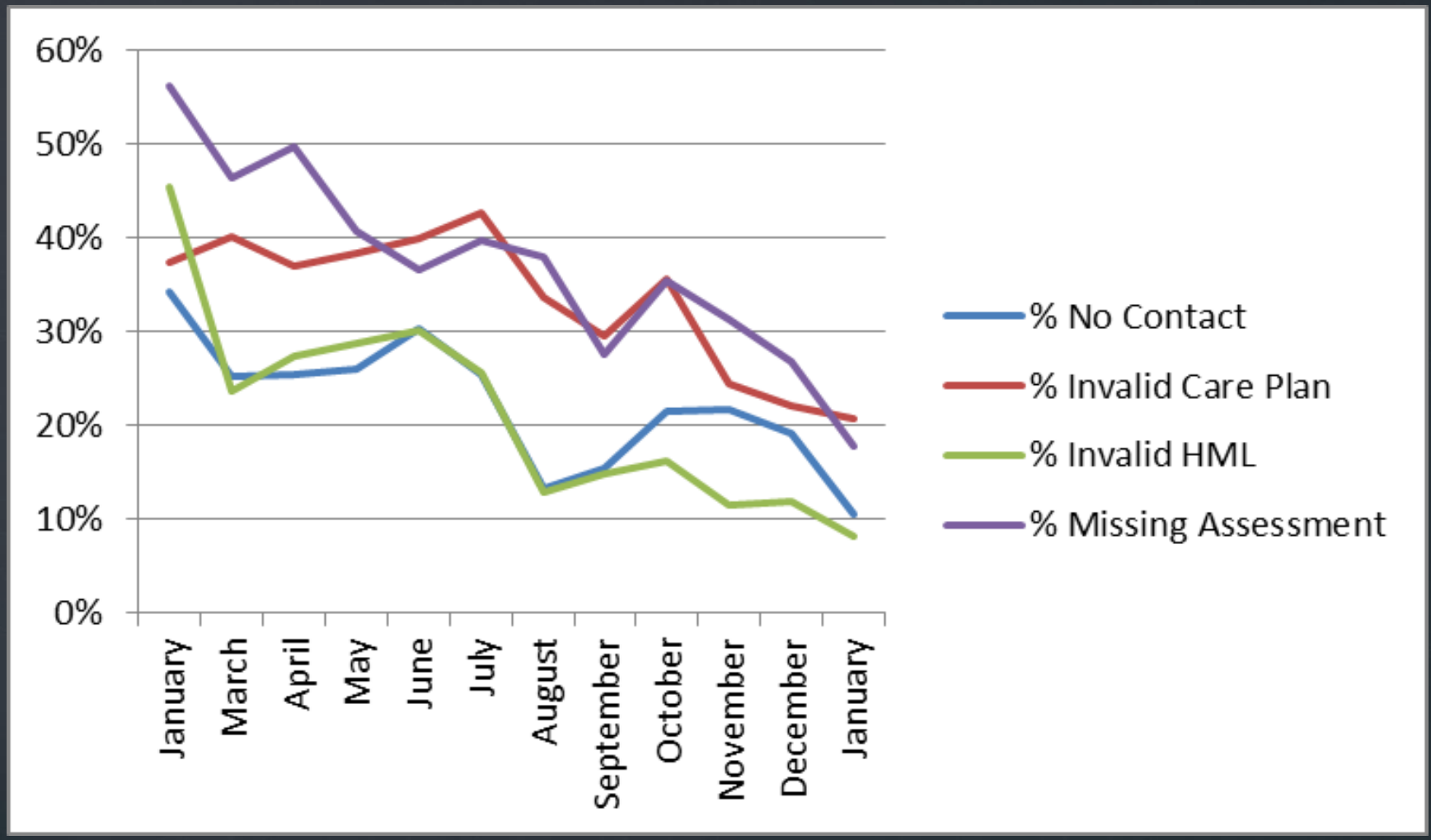
Active Care Team Report

Suicidality	Frequent ED User	MRN	Patient Name	Primary Insurance	Medicaid ID	Active Care Management	Episode Care Management Type	Name of Health Home	Adult/Children's HH	Health Home Status	Health Home Enrollment Date
!		12345	Doe, Jane	HealthFirst Medicaid	AB1234 5Z	Yes	Health Home	CCMP	Adult	Enrolled	10/1/2017

CM Non Face-to-Face Contact	CM Face-to-Face Contact	Last HML Date	Comp Assessment	Care Plan Date	Next Department	Next Appointment	PCP	Care Navigator	Pt Portal Status (MyChart)	My Sticky Note Text
Yes	No	4/3/2018	11/1/2018	12/1/2017	Family Med	5/2/2018	Neil Calman, MD	John Doe	Active	Refer pt to wheelchair clinic

- Created in 2017 as a way to improve patient contact, increasing quality of care by providing visuals of upcoming required documentation.

- Purpose
  - For Care Navigators to increase Patient encounters and decrease invalid necessary documentation.
  - For supervisors to increase oversight and utilize during individual supervision with the CN.
- Outcome
  - 12/2016 – 01/2018
    - Patient encounters increased from 65% to 92%
    - Invalid Comprehensive Assessments decreased from 41% to 22%
    - Invalid Care Plans decreased from 75% to 24% (over 50%!)


60%
50%
40%
30%
20%
10%
0%
January
March
April
May
June
July
August
September
October
November
December
January
% No Contact
% Invalid Care Plan
% Invalid HML
% Missing Assessment

Questions?

Shadowing Case/Care Managers

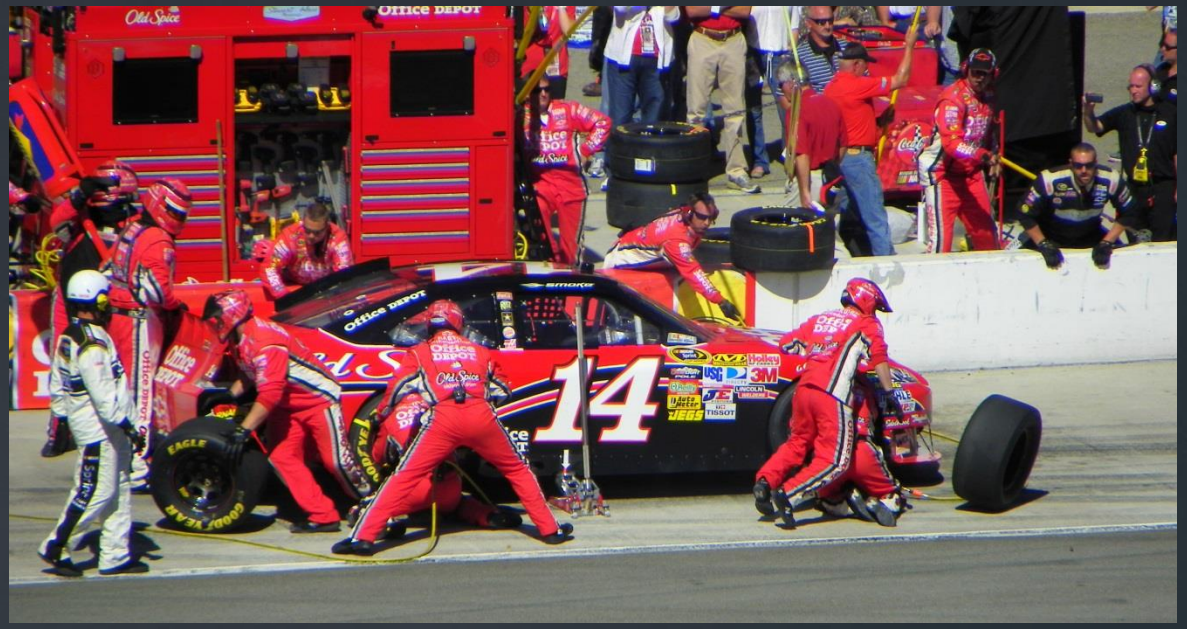
- Prepares and exposes new hires to daily duties
- Gives new hires a chance to interact with patients and to see how workflows are implemented
- Most importantly it shows new hires how to effectively exercise person-centered care

Getting behind the wheel

Start with a small caseload

- Hands on experience
- Reverse shadowing - having a case/care manager follow the new staff
- Reverse shadowing allows new hires to feel supported and comfortable asking questions if necessary

For example…



Pit Stop:
Bi-Weekly Supervision

- Care Navigators, depending on which site, meet with their director weekly, bi-weekly, or monthly for clinical/administrative supervision.

- Supervision is emphasized as “your time” - express concerns, bring up ideas, create personal care plan

- Each care navigator along with the director creates a supervision document in excel to track progress, show results, and create personal goals

Administrative Supervision			
Patients			**Trainings Requested**
Total # of patients			1)
# of enrolled pts			2)
# of outreach pts			3)
# of No Contact			
Care plans (for enrolled pts)			**Documentation Questions**
# of care plans completed in past 6 months			1)
# of care plan reviews that require completion			2)
# of initial care plans that require completion			3)
Assessments (for enrolled pts)			**Administrative Tasks**
# of assessments completed in past year			1)
# of assessments that require completion			2)
Episodes			
# of pts missing episodes			
HMLs (for HH enrolld pts)			
# of HMLs completed this month			
# of HMLs that require completion this month			
No Contact for Enrolled Patients			
MRN	Reason for No Contact	Plan for Contact in next 30 days	
Outreach over 30 days			
MRN	Reason for Cont. Outreach	Plan for Outreach in next 30 days	

- Care Navigators are encouraged to seek outside trainings and to attend conferences to increase knowledge of field, network, and further professional growth

- NYSOH Marketplace Assistor, 2010e Application Certification, AMSR (Assessing and Managing Suicide Risk), Cultural Competency, Motivational Interviewing, and more!

- This conference, and others like it!