Community Health Navigation

Hardwiring interventions to address social, economic, and behavior needs of KP members and communities we serve to achieve better health at lower cost.

Work in Progress. Updated: 7-21-17

Why we need Community Health Navigation

- **Business Necessity:** CMS requirement by 2019 Medicare will require hospital and health systems to address social needs
- **Addressing social needs is a national priority, an navigators can accelerate this work**
- **Increasing demand to better coordinate with community mental health and addiction medicine services**. Upcoming potential legislation to penalize hospitals who fail to connect members with mental health services post ED.
- **Lack of transportation is the #1 unmet social need** leading to a significant number of missed appointments (25% nationally) and contributed to 1,800 canceled surgeries.
- **Assessment of high utilizers revealed that these patients had at least four unmet socials** needs which is double that of non high utilizers.
- **Employers want patient navigator at their worksite** to assist their workforce with community resources – reduces absenteeism, barriers to care and improves health outcomes.
- **Accelerates partnerships with community based organizations**

Teams we work with

- Emergency room
- Primary Care
- Team Based Care
- Specialty Care- OB
- Pediatrics

Best Practice Workflows

- Navigators put their contact info on the LPOC
- IN ED, they add themselves as care team in TAS
- To identify target population, they use Pre-Manage and EDIE
- Every primary care navigator has pool to route to
- Regionally, Navigators receive referrals through “community resource order”
- Navigator have work cell phones for communication
- Navigators use Voicera in the ED

Goals and Metrics

Care Utilization:

- Reduce ED bounce backs for target population
- Reduce no show rate in primary care

Benefit Literacy/Financial Health

- Medicare FFS converted to SA
- Medicaid Applications Completed

Quality

- Care gaps closed
- Social Needs Assessments
- Community Connections

Service

- KP.org Enrollment and Activity

Core Interventions

- Screen for social needs (housing, food, transportation, financial concerns and social support) using validated tool. Refer to appropriate community resource
- Coordinate with community resources on behalf of the member
- Address member financial health concerns
- Coordination and application assistance (Navigators are State certified OHP Assisters)
- Identify and close care gaps
- Provide ongoing follow-up until resource needs are unmet
- Coordinate with peer departments in KP and at other healthcare organizations (e.g. KP ENCC, Providence ED Guides and FamilyCare)
- Assist in coordination between primary care, specialty care, Emergency and post-acute care
- **Provide culturally competent care**

Not Core Interventions

- Arranging for placement in SNF, ALF, RCF, ICF
- Providing support in acute mental health crises
- Proving support for addiction or substance abuse-related issuesPlacing referral to ethics board
- Writing ED Plan of Care
- Implementing clinical guidelines or goals (i.e. monitoring A1C)
- Conducting medication reviews or reconciliations, advising regarding medication purposes or side effects
- Communicating tests or diagnostic results
- Discharge Planning

MEET OUR TEAM

Bureaucratic Ninja's – Nurses, Navigators and Social Workers removing obstacles that keep people from taking care of themselves and their family