AHRQ HEALTH CARE INNOVATIONS EXCHANGE

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Innovation Profile:

Health Navigators Support Self-Management With Primary Care Patients, Leading to Improved Behaviors and Lower Utilization

Snapshot

Summary

Using a combination of health coaching, case manager, and care coordinator skills, health navigators help insured and uninsured patients cared for by patient-centered primary care medical homes adopt healthier behaviors and better manage chronic diseases. As members of the care team, health navigators establish close, supportive relationships with patients through in-person visits and phone calls, helping them set health-related goals and access medical and community-based services and resources to help achieve these goals. Health navigators may operate out of a practice site or community setting. The program improved lifestyle-related and self-management behaviors, leading to better health outcomes and significant reductions in emergency department and inpatient utilization.

Evidence Rating (What is this?)

Moderate: The evidence consists primarily of pre- and post-implementation comparisons of self-reported data from patients receiving health navigator support for at least a 6-month period between 2003 and 2009. Data come from telephone surveys conducted at enrollment and after 6 months of participation in the program.

Developing Organizations

Genesys HealthWorks

Date First Implemented

1997

The Genesys HealthWorks health navigator model has been developed and tested in several pilot and research projects in various populations of patients over 13 years, demonstrating its effectiveness. The development of the HealthWorks health navigator model began in 1997 and has evolved through a variety of pilot projects.

Patient Population

The Genesys HealthWorks model is currently implemented with three patient populations: patients receiving care at the Genesys East Flint Campus Family Medicine Residency Clinic, members of the Genesee Health Plan (GHP), and patients of the Genesys Physician Hospital Organization. Currently, the HealthWorks model is being applied in more than 33 Genesys PHO practices, serving more than 59,000 patients.

Vulnerable Populations > Impoverished; Medically uninsured

What They Did

Problem Addressed

Poor diet, smoking, and physical inactivity remain common, and these behaviors increase the risk of disease, hospitalization, and death, especially among the uninsured and other low-income populations. Interventions that support healthier lifestyles can be effective, but, in the current acute model of care, busy primary care practices rarely have time to offer such support.

- **High prevalence of unhealthy behaviors:** More than 21 percent of Americans smoke, and many are physically inactive and have poor diets—all of these unhealthy behaviors contribute to approximately 70 percent of preventable deaths annually in the United States.[1]
- **Especially in low-income populations:** Low-income populations have higher rates of poor health outcomes and unhealthy behaviors than the typical American. For example, these behaviors are more common in Genesee County, MI, where the demise of the automobile industry has led to high unemployment (exceeding 15 percent in 2009) and to many individuals lacking health insurance (with 18.7 percent of nonelderly adults in the county being uninsured).[2]

Description of the Innovative Activity

Using a combination of health coaching, case manager, and care coordinator skills, health navigators help insured and uninsured patients being seen in a patient-centered primary care medical home adopt healthier behaviors and better manage chronic diseases. As members of the care team, health navigators establish close, supportive relationships with patients through in-person visits and phone calls, helping them set health-related goals and access medical and community-based services and resources to help in achieving these goals. Health navigators may operate out of a practice site or a community setting. Key elements of the program include the following:

- **Open to all patients:** Health navigators can serve any patient, regardless of insurance status or current health status. The program serves seemingly "healthy" patients who want to lose weight as well as those facing medical conditions (e.g., asthma) or environmental challenges (e.g., homelessness) that often affect health status. This approach addresses both prevention and chronic disease management.
- **Multiple entry points:** Patients can be engaged by a health navigator over the phone or through the practice's electronic medical record system. Referrals can come in a variety of ways, as outlined below:
    - **At enrollment in a plan or practice:** Patients enrolling in a practice or health plan can be identified by a primary care provider or health plan staff, who will then initiate the patient's engagement with a health navigator. Common "triggers" include having chronic care needs, such as unmanaged diabetes, asthma, pain, or depression, or engaging in unhealthy behaviors, such as smoking.
    - **During visits:** Patients may be identified by providers during office visits, after the physician engages the patient in setting a behavior-related health goal, such as quitting smoking.
    - **After acute episodes:** Patients can be engaged in the program after they experience an acute episode in the emergency department (ED) visit or hospital stay.
- **Initial meeting between health navigator and patient:** The health navigator, in the office or over the phone, spends 30 to 60 minutes establishing a rapport, assessing needs, and discussing the patient's readiness to change. During the meeting, the health navigator focuses on key areas, as outlined below:
    - **Making a plan:** Based on the patient's readiness to make changes and adopt a healthier lifestyle, the health navigator works with the individual to set health goals and initial realistic steps toward reaching those goals, such as eating more fruits and vegetables, going for a walk 2 or 3 days a week, or monitoring blood-sugar levels daily. As needed, the health navigator also provides relevant educational materials.
    - **Connecting to community and medical resources:** Based on the individual's needs and established goals, the health navigator recommends and facilitates access to appropriate medical and community-based resources. To assist in this process, the health navigator uses an up-to-date guide that lists available community-based programs, such as recreation facilities, bus passes (for travel to and from medical appointments), prescription assistance programs, nutrition programs, smoking cessation programs, housing assistance programs, legal services, and mental health services. As needed, the health navigator also assists patients in accessing these resources, such as helping them to apply for a discount or free drug program. The health navigator maintains close working relationships with community service providers, thus facilitating the ability to connect patients to these programs. In 2009, health navigators made 4,534 links to community services and other resources; the most common referrals were back to primary care providers (representing 27 percent of all referrals), exercise and nutrition programs (19 percent), and smoking cessation programs (13

percent).
    - **Ongoing collaboration and networking with providers:** Health navigators work closely with health care providers to facilitate a team approach to care and a coordinated care plan.
- **Follow up support:** The health navigator calls the patient periodically to check on his or her progress, with the frequency of such calls being based on individual needs. During this follow up period, health navigators work to maintain and strengthen their relationship with the patient, which is critical to facilitating ongoing self-management and lifestyle changes. The health navigators typically perform a formal reassessment every 3 to 6 months, with a focus on monitoring and documenting progress toward established goals as well as supporting health behavior change.

References/Related Articles

Genesys HealthWorks: Pursuing the Triple Aim Through a Primary Care-Based Delivery System, Integrated Self-Management Support and Community Partnerships. Available at: http://www.commonwealthfund.org/Content/Publications/Case-Studies/2010/Jul/Genesys-HealthWorks.aspx

Genesys HealthWorks Integrates Primary Care with Health Navigator to Improve Health, Reduce Costs. The Triple Aim Summaries of Success. Institute for Healthcare Improvement. Available at: http://www.ihi.org/offerings/Initiatives/TripleAim/Documents/IHITripleAimGenesysHealthSystemSummaryofSuccessJul09v2.pdf

Genesys HealthWorks Web site. Available at: http://www.genesys.org/GRMCWeb.nsf/0/668F2B7E8639D626852576CF00625E85

Holtrop J, Summers, Dosh SA, et al. The community health educator referral liaison (CHERL): a primary care practice role for promoting healthy behaviors. Am J Prev Med. 2008;35(5):S365-72. [PubMed]

Holtrop J, Baumann J, Arnold A, et al. Nurses as practice change facilitators for healthy behaviors. J Nurs Care Qual. 2008;23(2):123-31. [PubMed]

Contact the Innovator

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Did It Work?

Results

The program improved lifestyle-related and self-management behaviors, leading to better health outcomes and significant reductions in ED and inpatient utilization.

- **Better lifestyle-related behaviors:** Among those patients who worked with a health navigator for 6

consecutive months (representing 1,763 of 5,911 Genesee Health Plan patients receiving health navigator services between 2003 and 2009), 53 percent increased levels of physical activity, 53 percent increased their fruit and vegetable intake, and 17 percent of smokers quit.

- **Better self-management behaviors:** The program improved patients' self-management behaviors related to diabetes. Among 797 diabetic patients who had not previously performed self-care, 82 percent began checking their blood sugar levels regularly, 90 percent began checking their feet regularly, 52 percent who had not previously had an eye examination got one, and 45 percent who had never received formal diabetes education attended a self-management session.
- **Better health outcomes:** Several cohorts of patients receiving health navigator services experienced better outcomes. For example, 42 percent of depressed patients reported improvements in symptoms after working with health navigators. Thirty-seven percent of chronic pain patients reported improvement in their pain management.
- **Lower ED and inpatient utilization:** In the 6 months after beginning to work with health navigators, patients experienced a 50 percent decline in both ED visits and inpatient admissions.

Evidence Rating (What is this?)

Moderate: The evidence consists primarily of pre- and post-implementation comparisons of self-reported data from patients receiving health navigator support for at least a 6-month period between 2003 and 2009. Data come from telephone surveys conducted at enrollment and after 6 months of participation in the program.

How They Did It

Context of the Innovation

Genesys Health System, a member of Ascension Health, developed a model of care known as Genesys HealthWorks to improve the health of the population in Flint, MI, and surrounding Genesee County, while also improving patients' experience of care and lowering or reducing the rate of increase in the per capita cost of care. HealthWorks has become one of the four pillars of Genesys' 25-year vision, which is referred to as VisionScape. The Health Navigator Self Management Support System integrated with strong primary care serves a pivotal function in transforming care delivery to a model of care that is focused on health rather than just disease. The program evolved from Genesys' health advocate model, which featured a telephone-based counseling service that focused on promoting disease management and lifestyle changes (see the Community Health Educator Referral Liaison profile at http://www.innovations.ahrq.gov/content.aspx?id=2244). Based on successful findings from pilot and research projects conducted at various practice sites, Genesys began redesigning the health advocate model, with the end result being the health navigator program.

Planning and Development Process

Key steps in the planning and development process included the following:

- **Selection, training, and ongoing learning for health navigators:** Health navigators can be health educators, social workers, nurses, dieticians, or other health care professionals. The key characteristics are that they are good listeners, empathetic, and put the patient's agenda first. They also need skills in engaging physicians and other providers and familiarity with community resources. Health navigators receive 3 days of initial training, with a major focus on motivational interviewing. During training, health navigators also learn about available medical and community resources and learn to develop relationships with providers and organizational leaders to facilitate effective and efficient referrals for medical and community-based services. Ongoing learning and improvement take the form of regular case sharing and topic-based care conferences within the team of health navigators.
- **Establishing partnerships with practices:** Health navigators function as part of the primary care practice team. Their effectiveness is dependent on both patients and providers perceiving them as a key member of their health care team. Patients need to believe that the support provided by the health navigator is an extension of the physician's office ("My doctor cared enough to have you call and follow up with me."), and the focus on healthy behavior is a direct result of their physician's advice ("My doctor thinks my quitting smoking is one of the best things I can do for my health."). Physicians need to trust that the information and

support provided by the health navigator is consistent with their care plan for the patient, and any medical questions that arise will be referred back to them as the lead decisionmaker.
- **Identifying funding sources:** Multiple payment mechanism can be secured to support this new model of care.
- **Focus on healthy lifestyles:** Although patients often have multiple complex medical and social problems, keeping a focus on healthy lifestyles is important. Physical inactivity, poor diet, and tobacco use are the leading causes of morbidity and mortality in our county, state, and nation. Improving these lifestyle factors are key for both the prevention and management of leading diseases (cardiovascular disease, diabetes, hypertension, hyperlipedimia, stroke, cancer). Complex medical and social issues are barriers to healthy lifestyles, and the health navigator supports patients in overcoming these barriers.

Resources Used and Skills Needed

- **Staff:** The program includes five full-time equivalent health navigators employed by the Genesys Physicians Health Organization, seven health navigators (three full-time equivalents) employed by the Genesee Health Plan, and one part-time health navigator employed at the Genesys East Flint Campus Family Medicine Residency Clinic. Health navigators can be nurses, social workers, or health educators. The typical health navigator works with a target population of 6,000 to 6,500 patients, engaging about 600 patients per year.
- **Cost:** The primary cost for implementing the health navigator program consists of the salaries and benefits paid to the health navigators, which averaged $72,000 in 2009. The average cost of providing navigator services is about $1 per patient per month.

Funding Sources

Blue Cross Blue Shield of Michigan; Genesys Health System/Genesys HealthWorks; Blue Cross Blue Shield of Michigan Foundation; Genesee Health Plan

- Provider Delegated Care Management Agreement between Blue Cross Blue Shield of Michigan (BCBSM) and the Genesys Physician Hospital Organization.
- BCBSM Physician Groups Incentive Plan Patient Centered Medical Home incentive dollars.
- Genesee Health Plan administrative dollars.
- Genesys Health System direct investment.
- BCBSM Foundation Grant.

Tools and Other Resources

A more detailed description of the program can be found at http://www.genesys.org/GRMCWeb.nsf/0/1FA06E5540B456BE852576CF00631DF7.

Adoption Considerations

Getting Started with This Innovation

- **Develop a detailed project plan:** This is essential to effectively implement this innovation. When developing the plan, the following questions must be answered, based on each organizations individual needs:
  - Who makes up the planning team for the innovation?
  - Who are key decisionmakers for the innovation?
  - How will stakeholders be engaged?
  - Who is the target population?
  - How will the population be segmented?
  - How will patients be identified and engaged?
  - Who will serve in the health navigator role?
  - What is the patient engagement target for first year?
  - How will the health navigator be integrated into the practice team?
  - How will the health navigator's workflow be managed?

- How will the intervention be structured?
- How will implementation of the intervention be documented?
- How will physician providers be engaged?
- What outcome measures will be tracked and how will they be reported?
- Where will initial funding come from?
- How will we secure reimbursement or long-term funding?

Sustaining This Innovation

- **Monitor and report:** To be sustainable and garner support for ongoing reimbursement, these programs must demonstrate value. It is crucial to build in monitoring and reporting capabilities from the beginning. Data to be gathered should include data on healthy behaviors (e.g., frequency of physical activity), health outcomes (e.g., control of chronic diseases), cost (e.g., hospital and ED utilization), and patient experience (including patient satisfaction). This data will most likely need to be gathered from a variety of sources, including patient self-report, the medical record, and billing information. This data should be tracked and reported over time both to support ongoing program improvement efforts and to share with stakeholders.
- **Assure funding sources:** Reimbursement for Health Navigator Self Management Support services can come from a variety of avenues. New approaches to funding the Patient Centered Medical Home or Accountable Care Organizations may include direct or indirect funding for care management and self-management support services. These may take the form of the following:
  - Direct payment for services using new billing codes for nonoffice-based nonphysician-based services (e.g., T-codes).
  - Enhanced reimbursement or performance based incentives to physician practices, who in turn can invest in the health navigator self-management support system to help them achieve the best outcomes.
  - Insurance companies that previously implemented their own case management or disease management services may choose to delegate those responsibilities and payment to provider groups through a delegation agreement, to be satisfied through their implementation of the Health Navigator Self Management Support System.
  - Demonstration and research grants can be helpful during initial startup and expansion phases and to support ongoing program improvement.

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[1] Mokdad A, Marks J, Stroup D, et al. Actual causes of death in the United States, 2000. JAMA. 2004 Mar 10;291(10):1238-45. [PubMed]

[2] Hall M. The costs and adequacy of safety net access for the uninsured, Genesee County (Flint), Michigan. Robert Wood Johnson Foundation. June 2010. Available at: http://www.rwjf.org/files/research/safetynetmichigan201006.pdf

Comment on this Innovation

Innovation Profile Classification

Patient Population:

Coordination of care

Medically underserved

Improving patient self-management
Primary care
Provider-patient communication
Provider-provider communication

IOM Domains of Quality:
Effectiveness
Patient-centeredness

State:
Michigan

Quality Improvement Goals and Mechanisms:
Avoidable hospitalizations
Medical home

Organizational Processes:
Referrals
Staffing
Training, knowledge management

Developer:
Genesys HealthWorks

Funding Sources:
Blue Cross Blue Shield of Michigan
Genesys Health System/Genesys HealthWorks
Blue Cross Blue Shield of Michigan Foundation; Genesee Health Plan

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