

Case STUDY

 **Learning Systems**
for Accountable Care Organizations

Atlantic Dialysis Management Services' Patient Navigator Program

This case study describes how Atlantic Dialysis Management Services (Atlantic) developed and operates a patient navigator program that provides nonclinical support for patients with end-stage renal disease (ESRD). Through this program, Atlantic intends to strengthen its patients' adherence to dialysis treatment, enhance their care experience, and reduce costs associated with preventable care. Navigators support patients in addressing the psychosocial challenges associated with dialysis care, assist with care coordination, and refer patients to relevant community resources. Thus far, patients and clinical staff have offered positive feedback about the program. Atlantic's experience can help to inform other organizations that are interested in launching a navigator program for patients with ESRD.

BACKGROUND

Organization

Atlantic Dialysis Management Services (Atlantic) is the management company for the Gotham City End Stage Renal Disease Seamless Care Organization (ESCO), a collaboration of dialysis units, nephrologists, and other health care providers working to improve health care delivery and outcomes for patients with ESRD while reducing the cost of care. The ESCO joined the Comprehensive ESRD Care Model in 2017 and currently serves approximately 1,200 patients across New York City's Brooklyn, Queens, and Manhattan boroughs.

Launching the patient navigator program

Atlantic launched the patient navigator pilot program in 2016 at the ESCO's Ridgewood Dialysis Center (RDC) in response to feedback from RDC's patient advisory committee. During committee meetings, patients expressed a need for more transparency regarding Atlantic's clinical and administrative processes,

sought information to clarify what they can expect from their dialysis care, and advocated for better support and communication from RDC's clinical and nonclinical staff. This feedback aligns with Atlantic's ongoing efforts to increase patients' engagement in care, prevent emergency department (ED) visits, hospitalizations, and readmissions, and address mental health issues through referrals to social workers.

Atlantic's director of quality and education, Steve Weiss, led the development of the program. He first considered whether patient navigators or clinical case managers would be best suited to addressing the committee's feedback. Atlantic then selected the patient navigator model in order to specifically address patients' nonclinical concerns. The navigators' strong interpersonal skills enabled them to provide effective emotional support for patients and to facilitate communication between clinical staff and patients, thus paving the way to better clinical outcomes. Atlantic also considered the cost implications; navigators' salaries are less costly than case managers' salaries for the dialysis center.

Once Atlantic's directors selected the patient navigator model, they collaborated with key RDC stakeholders to define the program goals, design the model, and implement the program. The program's goals include (1) increasing communication between patients and in-center clinical staff, (2) increasing patients' engagement in their own care and adherence to their treatment regimens, (3) reducing high-cost service utilization, and (4) improving patients' satisfaction. The program offers a variety of nonclinical services, including patient and family support, care coordination, and referrals to community resources. The RDC navigators work with approximately 40 patients each, representing just under 30 percent of RDC's 280-patient panel.

PROGRAM STAFFING AND OVERSIGHT

Atlantic and RDC currently collaborate to hire, onboard, and supervise the patient navigators. RDC's administrator manages the daily operations of the program, whereas Atlantic's director of quality education advises and monitors the program.

Recruiting. Atlantic worked with RDC to identify a set of key skills required to meet the needs of the patients at the dialysis center. They noted the need for staff who could cultivate interpersonal relationships and foster trust with patients. Therefore, the interview team, comprised of Atlantic and RDC staff, prioritized an applicant's ability to connect with people and focused the screening process on assessing communication, listening skills, and authenticity in personal interactions. The position also required a high school education (college preferred) and two years of experience in customer service. Fluency in English and Spanish was preferred to communicate appropriately with their patient population. Based on these criteria, RDC currently employs two navigators, Dawn Lowery and Shanida Howard, each of whom has been with the program since its inception.

Training. Atlantic encourages navigators to hone their skills through on-the-job experience and provides training to support professional development. When navigators join the organization, they participate in an initial training that includes an overview of the scope of work and boundaries of duties, basic education about kidney disease and dialysis, and standards for identifying urgent issues that require immediate attention or consultation with a provider. Navigators also receive training on record keeping and on legal requirements relevant to the position.

Beyond these formal components, Atlantic empowers navigators to take ownership of the program and to tailor their roles to their patients' needs. For example, the navigators identified the need for a catalogue of community resources that supported the frequent needs of patients. As a result, they developed an inventory of relevant services and a system to update it regularly.

"All too often, we design a program and tell people we want them to own it, and then we tell them how they should own it. And we didn't do that with this program. We let them build their program."

—Steve Weiss, Atlantic's Director of Quality and Education, and Program Advisor

Supervising. The RDC administrator directly supervises navigators, reviews their performance, troubleshoots challenges, and supports their growth and professional development. Atlantic's director of quality and education also supports the program as a program advisor. In this role, he provides general implementation support and ensures that the navigators are effectively integrated into the existing team. The program advisor also helps to develop solutions if a staff conflict arises. For example, to alleviate the social workers' concerns about the potential for their role to overlap the navigators' role, the program advisor supports RDC's efforts to clearly define and differentiate between the two roles to prevent discord between staff and the duplication of work.

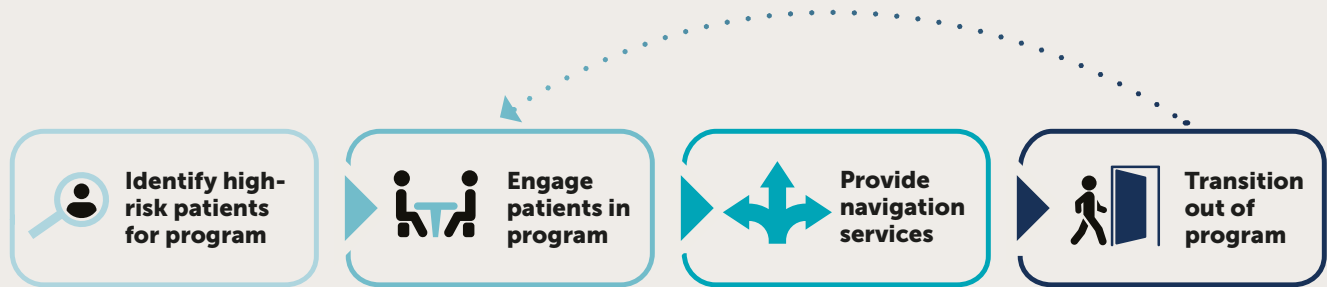
To support continuous quality improvement, the program advisor initially monitored the navigators' case notes and their performance daily to provide feedback. The frequency of reviews gradually decreased as navigators became more experienced. Three years into program implementation, the program advisor now reviews charts and holds quarterly meetings with the navigators to discuss progress and identify areas for improvement.

Based on what the program advisor has observed through monitoring, Atlantic and RDC identify refinements to increase the efficiency and effectiveness of the program. For example, navigators recorded their interactions with patients on paper when the program initially launched. As the navigators' documentation skills strengthened over time, Atlantic revised the process so that navigators can enter their notes directly in the electronic health record (EHR). This approach allows the full care team to access information about the patients' challenges and the navigators' strategies for addressing them.

OPERATIONALIZING THE PATIENT NAVIGATOR PROGRAM

The pathway through the patient navigator program includes four steps (Figure 1). First, RDC staff use established criteria to identify and refer patients who would benefit the most from navigator support. Second, navigators contact referred patients, to engage them in the program by offering services and collaborating with them to build relationships based on trust. Third, navigators provide emotional support, education, care coordination, and community referrals to support patients in addressing challenges until they feel self-sufficient and engaged in their own dialysis care. Finally, patients transition out of the program, though they may return if their needs change.

Figure 1
Pathway through the patient navigator program



Identifying patients for the program

Atlantic recognizes that many factors can influence a patient’s ability to cope with, manage, and comply with their dialysis regimen. Although all RDC dialysis patients are eligible for the program, Atlantic focuses on providing navigation services to high-risk patients who may benefit from additional support, including:

- Patients who are new to dialysis
- Patients who require(d) ED or hospital-level care
- Patients who do not routinely comply with their dialysis treatment protocol

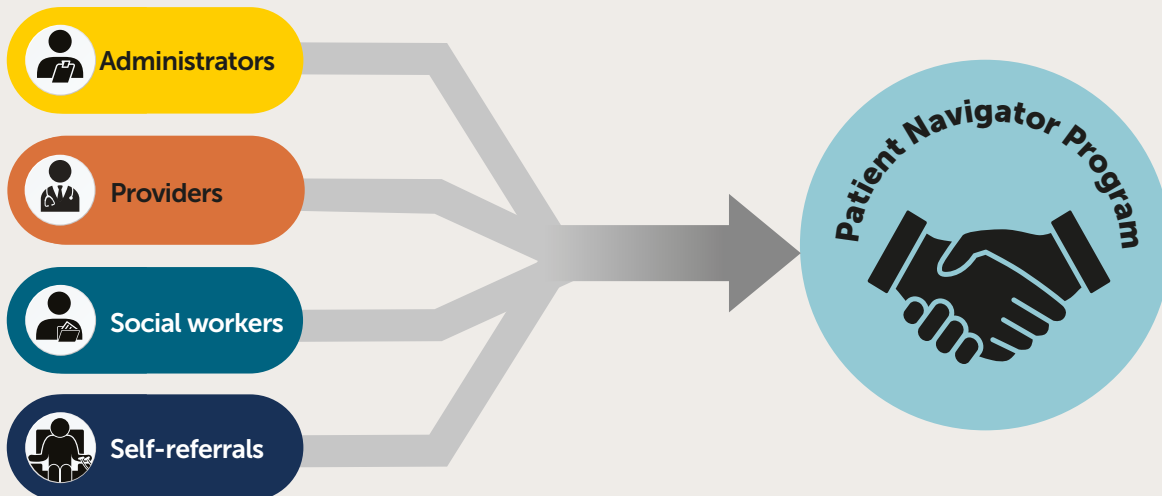
Multiple RDC staff use these criteria to identify patients who would benefit from the program and refer them to a navigator (Figure 2). The RDC unit administrator is responsible for identifying and referring patients who are new to dialysis and who are currently or were recently hospitalized. Providers are typically

the first to identify patients who have trouble complying with their dialysis protocols on a regular basis. Social workers are most likely to identify and refer patients whose health-related social needs—such as unstable housing and food insecurity—affect their ability to participate in treatment. Finally, patients may self-refer to the program. The RDC unit administrator filters all referrals from the unit staff to the navigators to ensure quality control.

Engaging patients in the program

To foster the patients’ engagement in the program, navigators make themselves easily accessible and ensure that the program is responsive to each patient’s unique needs. After a referral, navigators meet with patients to explain the benefits of the program and formally invite them to participate. Navigators have the flexibility to meet at locations and times that are most convenient for patients, including at the chairside during dialysis treatment, or in the navigator’s office within the dialysis unit. To make the program as accessible as possible, appointments are

Figure 2
Sources of program referrals



not required to meet with a navigator. The navigators' goal is to meet with their patients each time they come in for treatment; navigators also offer open office hours when any patient can speak with them about questions or challenges. Navigators also create a welcoming atmosphere and make themselves approachable. They do not wear white coats, and they speak to patients in lay language, both of which make patients feel that they can speak freely.

Providing navigation services

Navigators offer services that boost a patient's ability to cope with, commit to, and guide his or her own health care. As shown in Figure 3, navigators offer emotional support and educate patients, families, and caregivers about ESRD and dialysis treatment. Navigators also monitor their patients' compliance with dialysis and facilitate the coordination of clinical care. Finally, navigators can engage family members and caregivers in managing a patient's care, and they refer patients to community services to address their health-related social needs.

Patient support and education. Navigators provide emotional support for patients who struggle with managing their dialysis treatment, making the lifestyle changes required to manage ESRD, and coping with their prognosis. Navigators do this by developing authentic, personal connections with patients that foster trust, listening to their patients' concerns, and understanding their needs, abilities, and preferences. Once this

relationship is in place, navigators can suggest coping strategies and refer patients to various disease-specific peer support groups. Navigators do not provide clinical counseling or psychotherapy, but they do notify RDC's social workers of patients who exhibit signs of mental health issues.

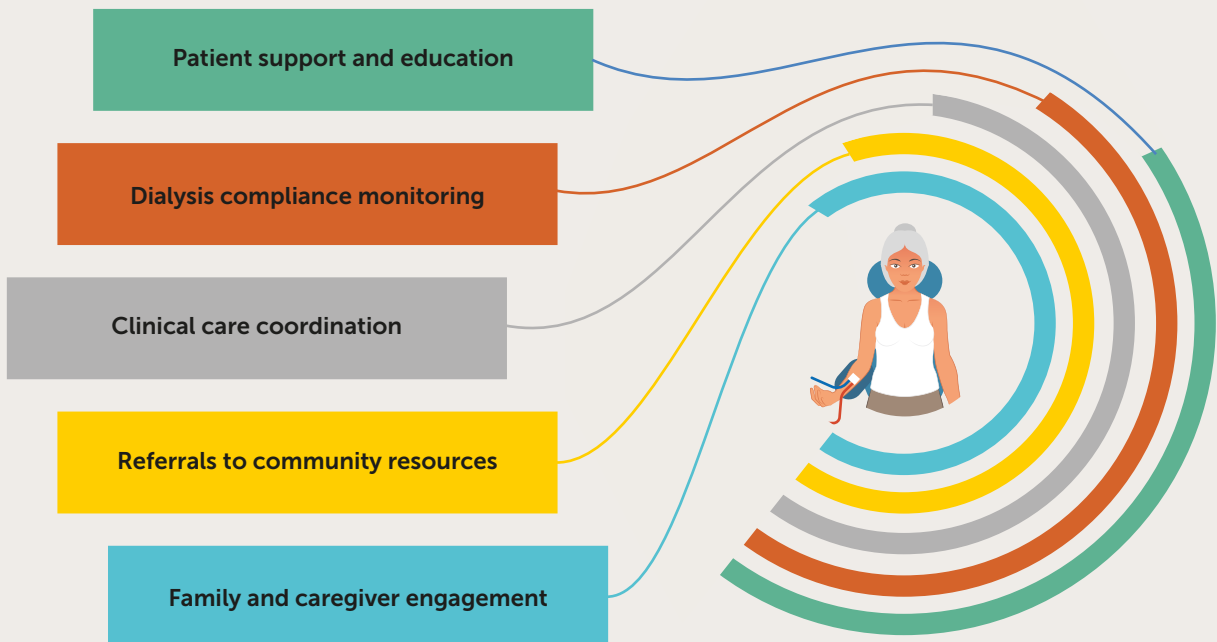
"A lot of patients when they come, they're scared, they're afraid, they're really not sure what dialysis is. And we're here to make them feel comfortable, we're here to be the listening ear."

—Dawn Lowery, Patient Navigator

Navigators also educate patients about ESRD and dialysis treatment to increase their understanding of, and empower them to manage, their disease. For example, one patient in the program expressed an interest in learning about kidney transplant options, so the navigator explained the application process and gave the patient a list of the hospitals at which this surgery is performed. This supportive information enabled the patient to engage in and make a decision about her care. After the patient chose a hospital and scheduled an appointment, the navigator helped her to collect and submit the required documentation.

Monitoring compliance with dialysis. Navigators closely monitor compliance with dialysis to identify potential barriers to treatment. If a patient misses a dialysis session, the navigator

Figure 3
Navigation services



calls the patient to encourage him or her to reschedule as soon as possible. Navigators explain the importance of attending scheduled dialysis treatments and work with their patients to identify, address, and prevent future barriers.

Clinical care coordination. One of the navigator's key roles is to help coordinate a patient's care both within the dialysis unit and outside of it. Navigators communicate with the unit's clinical providers through weekly meetings and on an ad-hoc basis to share concerns about their patients' medical and mental health needs and to supply context about their patients' nonmedical challenges. Navigators also meet with the unit's social workers weekly to discuss their patients' health-related social needs and to determine who will coordinate any additional support services. In addition, navigators help patients to schedule appointments with specialists and ancillary services, remind them to keep their appointments, and help them to understand and comply with follow-up instructions.

Referrals to community resources. Navigators work with patients to identify and address the health-related social needs that may prevent them from complying and coping with dialysis treatment. Housing instability and food insecurity are common among RDC's patients, and these urgent needs often create a barrier to treatment. Navigators maintain a list of community-based resources that help patients to access services and address their health-related social needs. By supplying their patients with details about community resources and services—including location, hours of operation, transportation, and whom to contact—navigators empower patients to get help on their own.

"It's very difficult for a person who has to go to dialysis three times a week, go to doctors the other two times in the week, and try to eat and then try to find... a place to live, to keep the roof over their head."

—Dawn Lowery, Patient Navigator

Family and caregiver engagement. Navigators include families and caregivers in their conversations with patients when possible. This support for families and caregivers can encourage patients to engage in treatment. For example, patients may rely on their families and caregivers for transportation, emotional support, and other resources when they are in dialysis. Navigators educate family members and caregivers about dialysis treatment, ESRD management, and the associated emotional impact on patients to help them not only to understand the patient's experience but also to promote compliance with treatment. Family members and caregivers may also choose to meet with patient navigators, who provide emotional support by listening and offering suggestions about coping with the demands of dialysis.

Transitioning patients out of the program

The duration of the program is based on each patient's needs. New dialysis patients typically meet regularly with their navigator for three months. When patients feel confident enough to fully engage in their dialysis care and manage their needs on their own, they transition out of the program. For patients who prefer ongoing support, navigators use a stepwise approach to the transition by gradually reducing the frequency of meetings. Navigators assure these patients that they can return for additional support if new challenges arise. They also share friendly greetings in passing with patients and informally check in with them even after the transition is complete, thus establishing a culture of support.

"When they [patients] are self-sufficient, they feel more powerful and have more control over their health."

—Dawn Lowery, Patient Navigator

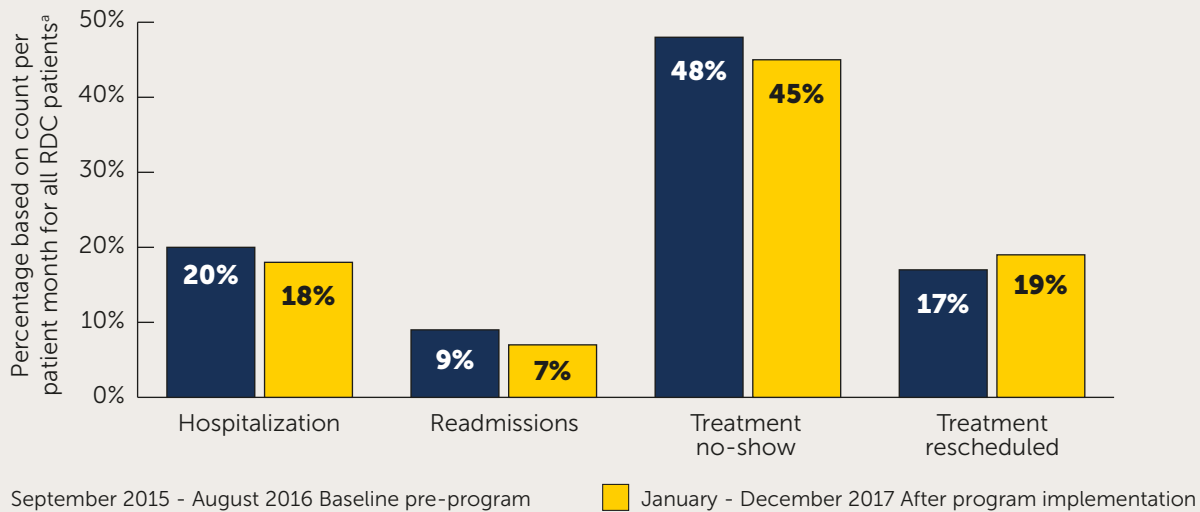
FINDINGS

Atlantic analyzes EHR data on all patients treated at RDC to understand how the navigator program might affect utilization. The company looks at multiple metrics over time, including the number of hospitalizations, readmissions, ED visits, and appointment no-shows to observe changes in key measures before and after the program inception. Additionally, the program advisor, the RDC administrator, and navigators gather to review the unit's metrics and consider program performance during annual meetings with stakeholders, including RDC staff and the ESCO's executive director.

Despite these efforts, data limitations restrict Atlantic's ability to determine the impact of the patient navigator program. For example, Atlantic cannot isolate data for the subset of RDC's patients who participated in the program because some patients cycle in and out over the years. RDC also conducted concurrent care improvement interventions and, therefore, cannot attribute findings specifically to the navigator program.

Regardless of these constraints, Atlantic compared RDC's data in the year before it launched the navigator program (September 2015 to August 2016, or the baseline pre-program time frame) to data from a year of full program operations (January through December 2017, the most recent full year data available). Although these data are preliminary and limited, Atlantic sees promising trends, as shown in Figure 4. Atlantic noted a reduction in hospitalizations (from 20 percent to 18 percent), readmissions (9 percent to 7 percent), and treatment no-shows (48 percent to 45 percent). At the same time, the share of appointments that were rescheduled increased from 17 percent to 19 percent.

Figure 4
Preliminary findings on Atlantic’s patient navigator program after implementation



^a The average panel at RDC is 280 patients. For each year, the patient month represents the number of patients at RDC per month multiplied by 12 months. Note that these data represent all RDC patients, including those who did not participate in the patient navigator program.

Atlantic also used reductions in hospitalizations and readmissions as markers for cost savings to measure the program’s financial impact. Atlantic estimated that in 2017, the reductions were enough to offset the annual cost of the patient navigator program.

Other indicators of the program’s success include a large increase in the patients’ interest in the program and positive feedback from patients and staff. Thirty patients were interested in the program when it began in 2016, and 100 were interested in 2019. Patients noted that they often feel relieved after meeting with a navigator and that they value meeting with someone who can answer their questions in plain language. Social workers and other clinical staff had positive feedback about the program, noting that patients appear to trust navigators and to share information that they do not typically share with a social worker or provider.

“We’re in between the doctor and the patient, the nurse and the patient, and the social worker and the patient because a lot of times, a patient will tell us things that they won’t tell a doctor or a social worker.”

—Dawn Lowery, Patient Navigator

REFLECTIONS AND LESSONS LEARNED

After three years of operating the patient navigator program, Atlantic reflected on its successes and challenges, and on lessons it has learned. This insight may be helpful for organizations

considering a similar initiative.

Obtain leadership’s support. Identifying a leader at Atlantic to champion the program as well as clinical leaders in the dialysis unit who were invested in applying a patient-centered approach to care benefited the program. This level of support allowed the staff to both engage in and successfully manage the initiative through the challenges of planning and implementation. Atlantic also shared the results of its analysis with key stakeholders to maintain their support.

Define the scope of the patient navigators’ work to more easily integrate them into a unit’s operations. Defining the parameters of the navigator role up front was a key component of planning. Atlantic and RDC found that creating opportunities for interdisciplinary staff to discuss and refine the boundaries between their responsibilities fostered smoother integration of the navigators into the unit’s workflow. RDC leaders continue to engage the unit’s social workers and navigators in order to reinforce their sense of ownership in the program and to prevent the duplication of services.

Train navigators to document encounters in the EHR. Atlantic recommends training navigators to document their encounters with patients in the EHR early in the implementation process. This facilitates the flow of information among navigators and clinical staff, informs shared decision-making, and improves care coordination.

Define metrics and expectations. Atlantic focused on defining realistic targets in evaluating the success of the program. It also values the qualitative feedback from the patients' stories and the staff's reflections, as these anecdotes point to the value of the program from the patient's and the staff's perspective. Atlantic is considering not only developing a method to collect qualitative data more consistently but also adapting an existing survey to systematically track patient satisfaction with the program. Atlantic will also continue to use EHR data to assess the impact of the program on utilization and cost.

NEXT STEPS

Atlantic plans to expand the patient navigator program to two additional ESCO units in early 2020. Recognizing that each unit has its own culture, patient population, and challenges, Atlantic has intentionally adopted a flexible implementation strategy so that the program can be customized to each unit. Atlantic also plans to use RDC's current navigators to model the role at the new sites as it continues to track, collect, and analyze utilization metrics while exploring new ways to collect patient feedback. By expanding and continuously refining the program, Atlantic is moving closer to its goals of responding to patients' needs, improving the patient experience, and reducing preventable risks and costs.

About the ACO Learning Systems project

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For more information, contact the ESCO Learning System at ESCOLearningActivities@mathematica-mpr.com.

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