

# Building Team Capacity: Utilizing Care Navigators in Primary Care

**Sarah Thompson, PharmD, CDOE**  
*Director, Clinical Services*

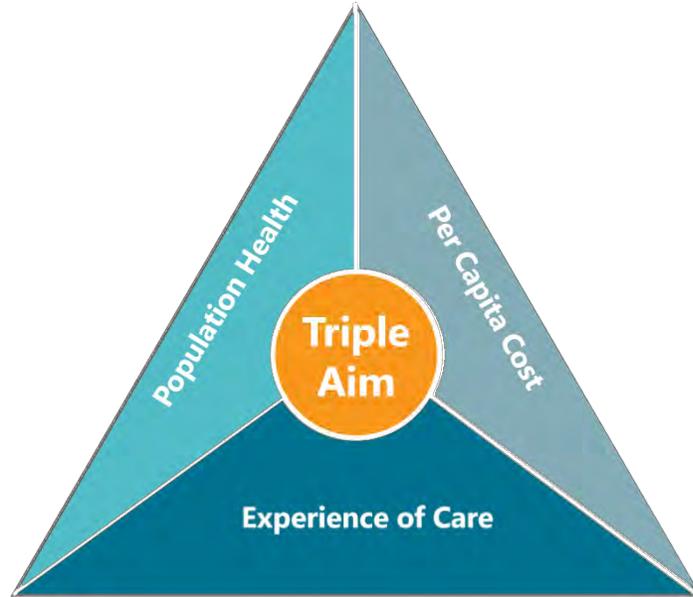
November 1, 2018



COASTAL  
MEDICAL

# Coastal's vision

## IHI Triple Aim

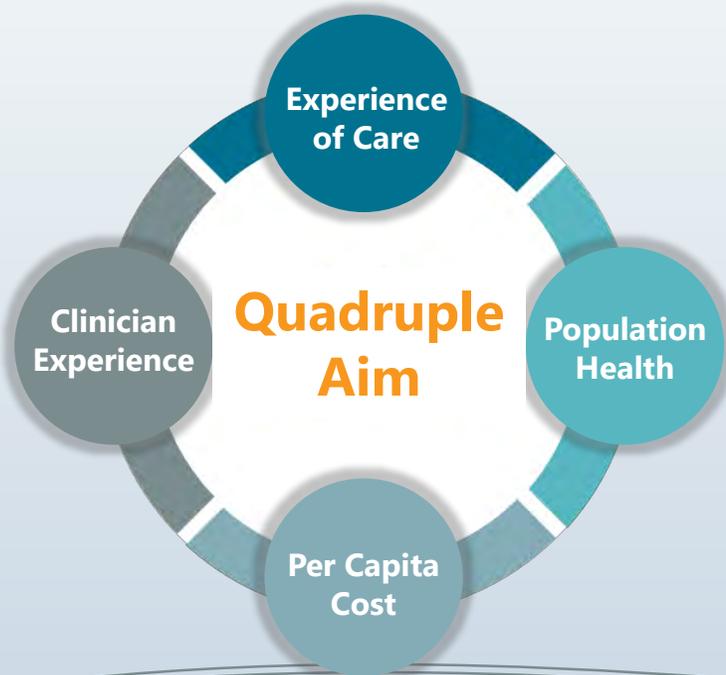


- Improve the patient experience of care (including quality and satisfaction)
- Improve the health of a population
- Reduce the per capita cost of health care

Institute for Healthcare Improvement, 2013

# Our vision has evolved

## IHI Quadruple Aim

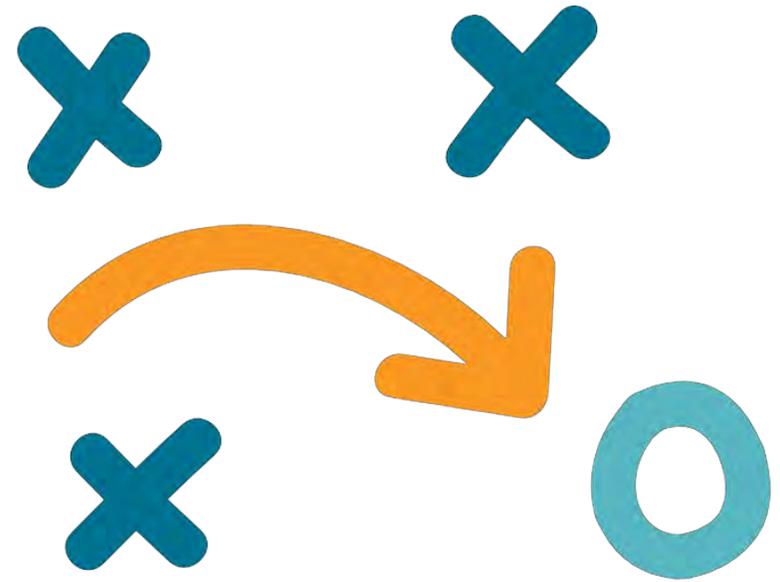


- Improve the patient experience of care
- Improve the health of a population
- Reduce the per capita cost of health care
- Improve clinician experience

Annals of Family Medicine, 2014

# Strategies to achieve the vision

- Create Systems of Care
- Utilize Data-Driven Population Health Management
- Broad Stakeholder Involvement



# Data-driven population health management

- Provide insights into cost of care
- Identify care coordination opportunities
  - High-Risk and Rising-Risk patients
  - High probability for utilization (predictive)
  - High ED and inpatient utilizers (historical)
  - Social Determinant of Health screening



# Population Health for High Risk Patients

- **Early priorities:**
  - Reduce ED utilization
  - Reduce inpatient admissions
  - Coordinate care for our sickest patients
- **5% of patients = 50% of the total cost of care**



# Segmentation & stratification creates efficiencies

*Use data to:*

- **Segment patients into populations**
  - Payer populations
  - Comorbidities
  - Chronic conditions
  - Adult vs. Pediatric
- **Stratify patients according to risk**
  - Low risk
  - Rising risk
  - High risk



# Building Capacity

- We needed to provide care management to more patients
- Expertise in stratifying patient care within teams
- Experience in identifying and connecting patients to programs
- Nurse-only model was inefficient
- NCM burnout rates were high

# Evolution of Care Management

- Expanded NCM program to include Care Navigators
- Utilized Navigators to identify high-opportunity patients for NCMs
- Created systems of care 7 pilot practices

# NCM/Navigator Pilot Experience

- Regular meetings to establish workflows and differentiate roles
- Expanded our reach to manage 12%+ of population
- Provided services patients need and matched level of licensure to patient needs
- NCMs have a higher level of job satisfaction

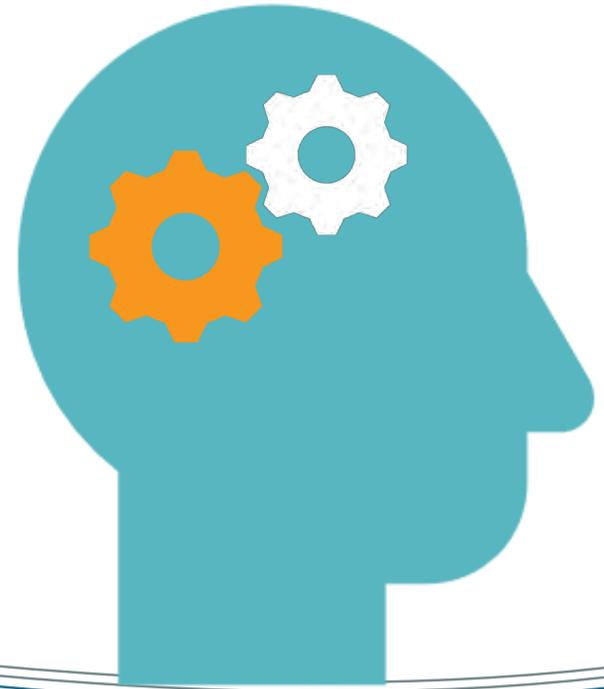
# Patient Care Story

- TBD



COASTAL  
MEDICAL

**How can you apply  
these methods to  
your organization?**



# Questions ?



COASTAL  
MEDICAL