Sailing Stormy Seas: Care Navigation

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Everyone was fantastic from the ambulance crew, my GP right to the porter.

I keep getting stone walled. Slipping through the gaps.

When I’m running into problems I know who to call, they know me and I can get the right help.

No one seems to be talking to each other.
This morning

1. Introduce the concept of care navigation. Why now?
2. Describe some UK care navigation services.
3. What is the evidence this works?
4. Education and training aspects of ‘care navigators’
What is ‘care navigation’?
Who are care navigators?
What do they do?
Why now? Shifting tides

- Ageing population, complexity and multi-morbidity
- Ideas of health, well being and prevention
- Resource challenges
- Service and education and training implications
Person-centered care

The four principles of person-centred care

Care is... personalised
Care is... coordinated
Care is... enabling

person is treated with... dignity, compassion, respect
Integrating care

- Different perspectives shaping integrated care
  (Shaw et al, 2011)
Frailty fulcrum and CGA
Care Navigation

- Originates from different places
  - Freeman’s concept ‘patient navigator’ USA, to improve access, reduce inequalities in cancer care
  - London workforce transformation (health & social navigator)
  - UK Patient Liaison Officer in general practice
  - Voluntary care sector

- Challenges
  - Definitions, language and job titles vary
  - Is there any added value in a crowded service sector?
Definitions

- Macredie et al (2014)
  The assistance offered to patients and carers in navigating through the complex health and social care systems to overcome barriers in accessing quality care and treatment.

- Age UK
  - **Personalisation support** (assessment for social care with follow up to enable smooth running, advice and signpost personal finances)
  - **Coordination** (re-refer to services if needed, alert health professionals needing input, help, step up care)
  - **Integration** across health, social care & voluntary sectors.
What’s in a name?

Community connector

Key worker

Health champion

Health and social navigator

Carer

Care navigator

Link worker

Care coordinator
International examples

• Manderson et al (2012)  Canada
  ➢ Systematic review navigation services older people
  ➢ Heterogeneous models and evaluation methods
  ➢ Care plans, linked to community, elicit personal needs

• Ferrante et al (2010)  USA
  ➢ Patient navigator; pilot in primary care
  ➢ Based in surgeries, social work background
  ➢ Valued by patients, carers and doctors
Care Navigation in UK

Do you know of any examples?
Care Navigation in UK

- A complex seascape!
  - Who provides care navigation?
  - To whom?
  - Where do they work?
  - What do they do?
  - Is it effective?
Care Navigation

• Who?

  ➢ Clinicians
    • Nurses Barnsley navigation services

  ➢ Administrative staff
    • GP receptionists West Wakefield – trained to signpost to local services, determining patient need, saved 930 GP hours over 10 months

  ➢ Peer / lay navigators
Care Navigation

• To whom?

- Frail older adults (i.e. Tower Hamlets Together)
- Disease specific (i.e. stroke, HIV)
- Vulnerable hard to reach groups (homeless)
- Lived experience
Care Navigation

• Where do they work?

- Hospital
- Community groups and services
- Informal support networks
- Voluntary sector
- Social sector
- General Practice
What do they do?

- Integration, long term conditions, frailty agendas. Enabling person-centered care

<table>
<thead>
<tr>
<th>Logistical</th>
<th>Relational</th>
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<tbody>
<tr>
<td>Signpost to services</td>
<td>Advocate needs patient/carer</td>
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<tr>
<td>Connect to services</td>
<td>Promote self management</td>
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<td>F/U care plan actions</td>
<td>Emotional support</td>
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<tr>
<td>Information giving</td>
<td>Build relationships and trust</td>
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https://www.youtube.com/watch?v=Snr3g5bsUTE&list=PLGe38gpSF2BmuO-GcQxkg88WEa4QpiaH0&index=1
Example of care navigation

• Signposting roles
  - Non-clinical Homerton hospital, A&E and MAU
  - GP receptionist staff
  - Primary care navigators (dementia, diabetes)

• ‘Health and well being’ facilitation
  - Harrow, NW London health and social navigators
  - Islington Age UK locality navigators
  - Camden care Age UK navigators
Is care navigation effective?

- Variable outcomes measured, lack of control
  - Macredie et al (2014)

- Patient experience favourable
  - Levereuax (2012); Tavabie (2015)

- Unplanned hospital admissions?
  - Levereuax (2012); Tavabie (2015)

- Sharing / easing clinician workload?

- Cost effective?
Case 1 – Camden care navigator, Age UK

- 86 yr lady recently discharged from hospital, admitted with a fall
- Discharge summary scanty - ?UTI, off-legs
- Falls clinic requested ?when
- Lives alone, heart failure, macular degeneration
- 3rd time 2 months admitted to hospital, d/c within 24hr

What do you do next?
Care navigator input

• CN arranged to meet her at home; struggled make sandwich, poor lighting, unsteady gait
• Felt lonely, unconfident leave house, fear falling
• Referrals: OT, housing association, local council, physio, Age UK advice services (attendance allowance).
• Feedback to community MDT
• Taxi card, met 2 times in local café, attendance allowance, local falls prevention class, hand rail installed – no carers needed.
Age UK Camden navigators

- Patients >60 yrs
- Team of 6 with leader; range health/social backgrounds
- One-to-one, surgery, at home
- Signposting and complex case management
- Support access to community & voluntary services, goal setting, accompany people to appointments, create local directory, meet with team regularly to discuss; ‘pragmatic’, ‘problem solving’
Care navigation: 24 month pilot

AGE UK CAMDEN: works across three localities, six care navigators

Patients suitable for the care navigation service will be 60+ and either frail, or pre-frail. Patients may have one or more long term conditions, and may have had a non elective hospital admission in the last 12 months.

REFERRALS from GPs only via EMIS

Points of liaison between patients, the locality multidisciplinary teams (MDTs) and local community and voluntary sector providers.

Care coordination support and escorting
for frail elderly and patients with long term conditions at risk of ‘did not attend’ (DNA) and/or use of inappropriate services

Referral service for patients to voluntary/community providers
above the level of signposting volunteers in practices

Using online service directory resource

The coordination of referrals to volunteer networks, community groups and other voluntary/community services.

Dedicated support for practice and borough level multidisciplinary work, providing advice, information and coordination across clinicians and voluntary sector / community services.

Examples of referrals:
- Community organisations / associations offices or meeting halls
- Meal and social clubs
- Places of worship
- Befriending and ‘connector’ services
- Other local health and social care services (including GP practices)
- Residents associations
- Day centres and drop in centres
- Community events / activity days
- Private local services

Further information
- Contribute to care plans where appropriate.
- Care Navigation will be available to GPs and patients in each locality as a minimum between 09.00 and 17.00, Monday to Friday including phone, face-to-face and home visits.
- Phone service available on weekends.
- Work alongside integrated primary care team, and an existing base of volunteer navigators in GP practices, social workers in primary care and mental health teams around the practice.
- Care navigators will have access to the Camden Integrated Digital Records (CIDR) when it is live and will link together health and social care information for patients in Camden.
Case 2 - Health and social navigators, NW London

- 87 yr old man, recently discharged from hospital; frequently attends.
- Deemed ‘high risk’ with various risk stratifications score by GP
- No NOK, lives alone, widower
- Plans to determine how to ‘avoid admission’

- What do you do next?
Care navigator input

• MDT -> care plan -> navigator calls patient
• Concerns about isolation, overwhelmed with tablets, worried about memory, feeling ‘useless’; used to be a carpenter
• Would call LAS once fortnight – unspecified admissions
• Confided in navigator, anxious, lonely

• Plan – medication review GP booked,
• Suggested and helped refer to local area activities – carpentry classes, gardening, befriending service Age UK
• Point of contact – who to call, when (when not too) – uses coaching approach
• GP assess memory and consider memory clinic referral
Health and social navigators

- Harrow, North London
  - Integrated care programme
  - Proactive seek out ‘high risk’ GP registers
  - GP referrals
  - Arrange visit – write care plan
  - Administrates MDTs – actions and chase up
  - Database, directory building of ‘local wisdom’
  - Links to social care
  - Feedback to clinicians and commissioners services
Brighton and Hove pilot (2015)

- 12 months, community navigation in 16 GP surgeries
- Volunteers (health, social backgrounds)
- Mainly older people, socially isolated, low mood, housing and finance issues

- Outcomes
  - 393 patients; 98% satisfied, 93% had enough info
  - 89% GP, practice staff satisfied; 68% save time
  - Cost: potentially £1.36 million / yr GP time
  - Practice needs to be ‘navigator ready’
Education and training: project

- Aim: to explore and develop training and education opportunities for people providing care navigation
  - Understand skills, tasks, contexts
  - Develop core competencies and a framework for care navigation (purpose)
  - Lay foundations of education / career routes for non-clinical staff progression
• What are the important skills and knowledge people providing care navigation should have?
Core competency framework

1. Literature of navigation services
2. Interviews and focus groups
3. Workshops with group feedback
4. Consultation (online and face-to-face)
5. Job descriptions and person specifications

Primary Care, Voluntary Sector, Secondary care
Health Watch/patient representatives, Education providers
Findings (1)

- Plethora of roles/job titles
- Unclear job remit
- Training ‘ad hoc’ and variable
- Unclear line of sight for further training or career progression
- Common themes
  - E.g. Communication, networking, administration, support people with often complex holistic needs
Findings (2)

- Offer information of how to access services
- Some care navigation elements
- Work at the interface of many sectors
- A single point of contact
- Facilitate care plans, goals, follow up care plan
Findings (3)

Get **access to services**, take responsibility for **databases** and **follow up care plans**

We need more navigators – with **excellent communication, skills**, our navigator is so helpful when I have very limited face to face time with patients

Receptionists do a lot of signposting on the ground I think – training could help build up our confidence and recognise what we do

They should help people **connect and link up into what they need**

A ‘go to’ person who glues it all together, makes things happen

There are so many roles mushrooming up now, difficult to know who does what; as long as they can help you with what you need, and you know who to contact when – feels much safer
Core Competency domains

- Effective communication
- Enable access to services
- Personalisation care and support
- Coordination and integration
- Building and sustaining professional relationships
- Knowledge for practice
- Personal development and learning
- Handling data and information
- Professionalism
### Competency Levels

**Educational Qualification levels**

**Admin**
- Signposting to local service; inputting data to directory and databases; Supervised
  - e.g. GP receptionist, ward clerk, non-clinical navigator

**Essential**
- Greater level independent working
  - Enhanced communication skills
    - i.e. health coaching
    - e.g. care navigator, Locality navigators

**Enhanced**
- Developing services; Dealing with more complex cases; Advanced communication skills; mentoring other staff
  - e.g. Navigator team leader

**Expert**
Education and training approaches

- Reflection on practice, regular action learning sets
- Apprenticeship model
- Importance of mentors / supervisors
- Portfolio based
- Accredited courses, qualifications (higher levels)
- Importance of MDT and workplace mentorship
Next steps

• ‘Common ground’ to develop coherent recognised training and education programmes

• Working with education providers and CEPNs to develop and pilot training programmes using competency framework
Thank you

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References


Windle K (2015). What role can local and national supportive services play in supporting independent and healthy living in individuals 65 and over? *Government Office for Science*