Community Care COLLABORATIVE

Patient Navigation Personas

Personas are fictitious characters created to represent different user types within a targeted demographic.

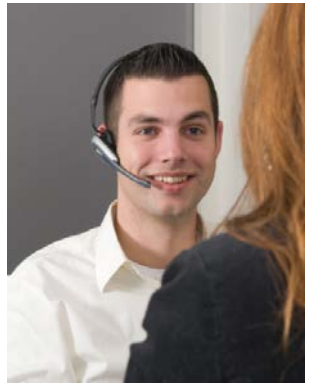
Community Care Collaborative (CCC) – Last Updated 10.27.2014

Community Care COLLABORATIVE

Patient Navigation Personas

Tired

TYLER



Experienced *Patient Service Representative* working hard to keep up with demand

Committed

COLLEEN

Skilled *Eligibility Specialist* helping connect patients with the care they need

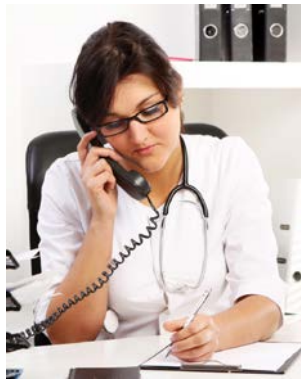
Helpful

HILDA

Trained *Community Health Worker* who serves patients in her own community

Tenacious

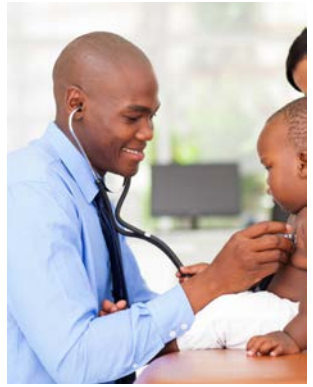
THERESA



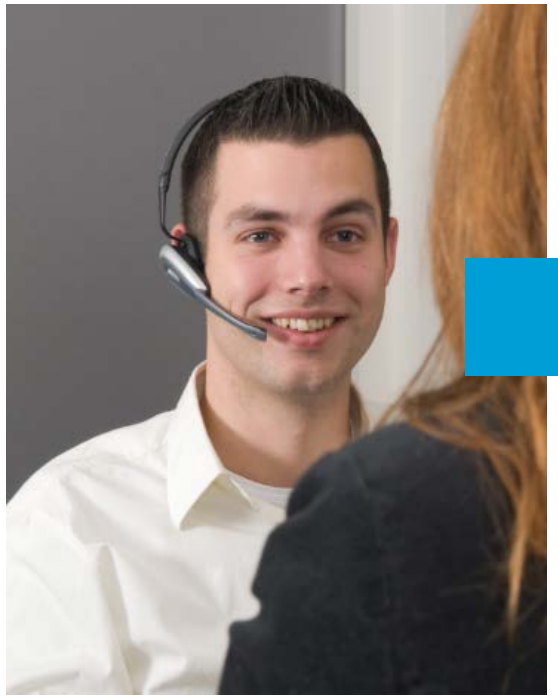
Tech-savvy *Case Manager* helping patients through multiple complex systems.

Motivated

MARK



Dedicated primary care *Provider* who wants to deliver the best care possible



Community Care COLLABORATIVE

Tired

TYLER

Experienced *Patient Service Representative* working hard to keep up with demand

Resourceful

Helpful

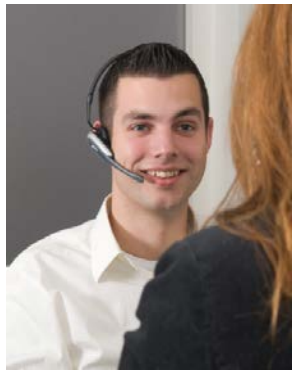
Attentive

Disheartened

"Being discouraged is natural, but giving up is not an option."

Tyler has worked for several years in a clinic designed to take care of patients who are uninsured or underinsured in the Travis county area. When Tyler first started working as a Patient Service Representative he was friendly, energetic and dedicated to helping patients. When patients complained to him he was careful to remember that they were not upset with him, but frustrated with a difficult to navigate system and concerned that they would not be able to get the care they need. Over time this has taken its toll on Tyler. He is starting to feel burned out and sometimes catches himself becoming annoyed with the very patients he should be helping.

Tyler receives a high volume of patient calls every day and is expected to handle each call quickly and efficiently. This is often not possible if he wants to answer the patient's questions and help them meet all their needs. He schedules appointments, answers questions, connect patients to resources within his clinic, and has been trained to advocate for patients and direct them to external community resources when needed. Finding community resources is one of the most difficult tasks he performs. He uses a list of community resources that another PSR created, but some of the information is no longer accurate which frustrates Tyler and the patients.



Community Care COLLABORATIVE

Tired

TYLER

Tyler's Perspective

Experienced *Patient Service Representative* working hard to keep up with demand

MOTIVATIONS

- Helping patients is rewarding.
- Feels like he has opportunities to make a difference in patient's lives.
- Enjoys the diversity of problems he gets to solve.

CONCERNS

- Call volumes and wait times for patients gaining access to needed services.
- Lack of community resources for uninsured and underinsured.
- Inability to track whether clients are able to follow up on referrals made (close the loop).

FRUSTRATIONS

- Patients take their frustrations out on him.
- Difficult to remember different organizations rules, policies and procedures for making successful referrals.
- Wishes there was a better list of community resources.
- Other members of the care team don't value his role in the patient's overall experience.

KEY ACTIVITIES

- Schedules appointments.
- Makes follow-up and reminder calls as needed.
- Listens to patients, determines needs, makes referrals.
- Obtains current demographic and payer information.
  - Accurately enters information into practice management system.
  - Verifies insurance eligibility, financial status and identifies payer source.
  - Assists patients with completion of paperwork.
- Communicates with patients on the phone and in the office.
- Scans or enters information into Electronic Health Record system as needed.

ISSUES

- Burn-out is a common occurrence in this job.
- Expectations of call length and the volume of calls expected to be handled by a PSR must be reasonable.
- Ongoing training needs:
  - Reinforce effective communication skills.
  - Improve understanding of services available to patients in the community.

OPPORTUNITIES

- With improved expectations and training, the number of positive interactions with patients will increase.
- Improving IT resources can:
  - Increase job satisfaction for PSRs.
  - Positively impact the patient's experience and outcomes within the safety net provider system.

Community Care COLLABORATIVE

Committed

COLLEEN

Skilled *Eligibility Specialist* helping connect patients with the care they need

- Detail-Oriented
- Helpful
- Caring
- Tech-Savvy

"Efficiency is key to my job."

Colleen has worked for the last nine months as an Eligibility Specialist at Central Health. She conducts interviews with 20+ families each day, helping to determine their eligibility for local, state, and federal healthcare programs. When possible, she certifies families for these programs during their appointment, otherwise she helps them complete and submit applications for these programs. Patients are usually very thankful for Colleen's help, and she feels rewarded in her job because she knows that she is helping underserved patients gain access to quality healthcare.

Because eligibility requirements are constantly changing, Colleen must spend time keeping herself up to date with the new requirements for federal, state, and local programs. She often wishes there was a faster and easier way to understand the changes so that she could spend more time helping patients.

The volume of patients that Colleen is expected to see each day means that she must be very efficient as she collects their data. One of the biggest barriers to her ability to complete interviews in a timely manner is duplicate data entry across the multiple screens and forms that must be filled out. Ideally, she would be able to enter the information once and have all similar fields instantly populate.

Community Care COLLABORATIVE

Committed

COLLEEN

Colleen's Perspective

Skilled *Eligibility Specialist* helping connect patients with the care they need

MOTIVATIONS

- Helping the public
- Promoting healthy individuals
- Making a difference in someone's life

CONCERNS

- Wants to avoid duplicate data entry.
- Making errors regarding a client's eligibility or potential program coverage.
- High volume of patients to be served with limited staff.

FRUSTRATIONS

- Differing policies among programs.
- Duplicated entry of information.
- Having to manually fax applications to the state instead of filing applications and documentation electronically.
- Keeping up with changes in program requirements.
- Inconvenient that patients must go to separate appointment/location to enroll in state programs

KEY ACTIVITIES

- Conducts informational interviews, gathers/processes documents, and explains services to customers.
- Use of Medicaider software for program screening, MAP enrollment, and patient document storage.
- Oversight/coordination of MAP electronic application processing and performance improvement.
- Resolves complex customer problems and complaints
- Interprets and applies complex program requirements.
- Explains benefits to customers and how they can access services.
- Monitors changes to program guidelines; identifies and coordinates implementation of changes to other staff.

ISSUES

- Expectations on the time allotted for each client interview must be reasonable.
- Lack of integrated systems often requires duplicate data entry.
- Barrier to care created by not allowing eligibility specialists to enroll patients in all programs (must go to Medicaid office).
- On-going training needs:
  - Reinforce effective communication skills
  - Ensure understanding of most current eligibility rules and requirements for federal, state and local programs.

OPPORTUNITIES

- Improved connectivity of systems and communication across systems could streamline processes and improve the customer experience.
- Enhanced IT capabilities and resources can improve efficiency and job satisfaction.

Community Care COLLABORATIVE

Helpful HILDA

Trained *Community Health Worker* who serves patients in her own community

- Compassionate
- Advocate
- Trustworthy
- Limited Tech Skills

"I love helping people in my community! I feel that I get to make a difference not only in their lives, but in their families and the community as a whole."

Hilda has lived in the same South Austin neighborhood for 17 years and loves helping others in her community. She received her certification as a "Promotora" (Community Health Worker) in December of 2013. Hilda spends time teaching "Healthy Living" that focus on wellness and prevention, working at primary care clinic, and going into the community to provide peer outreach and health promotion services.

While at the clinic, Hilda pulls information on patients with chronic diseases and follows up with them at their homes. She assesses for needs and often connects them with other resources to better manage their condition. Providers at the clinic often refer patients to Hilda for her support and to assist patients in better managing their chronic conditions.

When Hilda started as a Community Health Worker she was uncomfortable using a computer, but with time she has become more skilled. She now likes Excel spread sheets, and spends hours hand-gathering information before contacting her potential clients. She would like to continue receiving referrals from providers via sticky notes or word of mouth because she feels this is a more efficient use of her time.

Community Care COLLABORATIVE

Helpful

HILDA

Hilda's Perspective

Trained *Community Health Worker* who serves patients in her own community

MOTIVATIONS

- Giving back to people in her community.
- Being able to advocate for people who need it.
- Serving clients in a more holistic approach.

CONCERNS

- Time spent trying to "track down" clients.
- Time spent gathering referrals and information.
- Time spent looking up client's conditions to see if they are good candidates for classes.
- Barriers in communication.

FRUSTRATIONS

- Clients change addresses and phone numbers frequently, and she has no way of finding them.
- Clients information is spread among different areas in the EMR, paper records, and excel spreadsheets which makes it time consuming to pull together.

KEY ACTIVITIES

- Helps neighbors and other community members gain access to needed services.
- Builds individual, community and system capacity by increasing health knowledge and self-sufficiency.
- Provides outreach, navigation and follow-up services.
- Provides community health education classes.
- Provides informal counseling services.
- Provides social support.
- Advocates for the community.

ISSUES

- Difficult to keep up to date with all the different programs available at the different safety net providers and in the community.
- Inconsistent funding of positions.
- On-going training needs:
  - Cultural sensitivity
  - Education on common topics (eg. Diabetes) to ensure standardized and knowledgeable counseling and educational services are being provided to patients

OPPORTUNITIES

- Create a sustainable role for promotoras.
- Improve the electronic referral system so that patient information can be received and viewed easily.
- Enhanced IT capabilities and resources can improve efficiency and job satisfaction.
- Creation of educational materials and referral systems that can be accessed remotely and used while with patients in the community.

Community Care COLLABORATIVE

Tenacious

THERESA

Tech-savvy *Case Manager* helping navigate patients through multiple complex systems

Resourceful

Persistent

Considerate

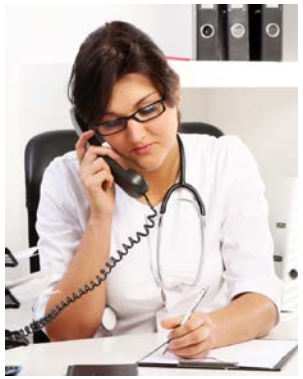
Holistic

"If it is this difficult for me to coordinate all the different systems for a patient, can you imagine what it is like for patients who are on their own?"

Theresa has been a case worker in Austin for 10 years. She primarily works with individuals who are homeless and have a mental illness. She meets with clients for one hour each week to coordinate all aspects of their care, but most of her time is spent helping them figure out how to get their basic needs met, such as healthcare and housing. Theresa is often frustrated by the lack of coordination and communication between the systems her clients rely on for care, and she hopes for the day when she will easily be able to get all the information she needs to help her patients.

Many of Theresa's clients cannot read and have difficulty processing the information they are given. This makes it difficult for them to follow through with all the different instructions they are given when they leave a provider. Theresa gets incredibly frustrated when questioned by others about what can be done differently to decrease her client's high utilization of emergency resources. "My clients don't want to go to the ER, but they have a hard time finding a doctor who will take their insurance or can see them at a time or place that works for them, so the only thing they can think to do is go to the ER."

Theresa is concerned because people slip through the cracks all the time. "There has to be a better way for everyone with the same mission to communicate with each other and keep up with these patients." Theresa envisions a day when she can easily access information related to her client's care from all providers in the community.



Community Care COLLABORATIVE

Tenacious

THERESA

Theresa's Perspective

Tech-savvy *Case Manager* helping patients navigate multiple complex systems

MOTIVATIONS

- Improving patients' quality of care and health outcomes.
- Increasing continuity of care.
- Advocating for patients who need it most.

CONCERNS

- Systems have become so complicated that patients without case managers have a hard time keeping up with everything themselves.
- Lack of shared system across agencies that provide the same type of services.
- Most EHRs are not intuitive for people who don't use them all the time.

FRUSTRATIONS

- Some clinics still use paper charts and do not share their information into the local HIE.
- Lack of coordination and communication between providers in the community.
- Minimal services available to the safety net population.
- Difficulty accessing all of the patients records from across the community.

KEY ACTIVITIES

- Manages the global view of the patient's care.
- Conducts interviews to collect and compile assessment data, social history and diagnosis data as needed.
- Works with the patient to set goals and develop a detailed plan of action to meet their goals.
- Find necessary resources to meet patient's needs.
- Acts as advocate and liaison for the patient while coordinating between multiple providers and agencies
- Helps patients follow through on provider instructions.
- Uses laptop and smartphone when in the field to document with the patient present so they are part of the process.

ISSUES

- Too much time spent calling, faxing, or searching for current and up to date information about patients from multiple safety net provider systems.
- On-going training needs:
  - Reinforce advocacy skills.
  - Improve understanding of services available to patients in the community.

OPPORTUNITIES

- Improving data sharing and system integration has the potential to provide more efficient and cost effective care, as well as improve health outcomes within the safety net population.
- Enhanced IT capabilities and resources can improve efficiency and job satisfaction.
- Creation of a community patient portal could allow patients to better self-manage their care.

Community Care COLLABORATIVE

Motivated

MARK

Dedicated primary care *Provider* who wants to deliver the best care possible

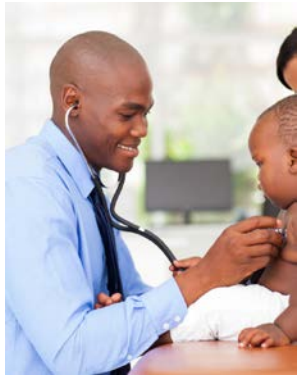
- Realistic
- Intellectual
- Trusted
- Invested

"I have such a short amount of time to give my patients the care they deserve … I really need technology to work for me, not the other way around."

Mark is a primary care provider who has worked with the safety net population of Central Texas for the last 3 years. He usually sees more than 25 patients per day, usually having 15 minutes or less with each patient. He feels that being able to provide quality care to patients in this time frame has been hampered, instead of helped, by the electronic health record system in his clinic that requires lots of "clicks".

A lot of his patients have chronic conditions that can be difficult to manage, and many of them also visit other clinics or emergency departments for care. "Getting records from other offices and hospitals while the patient is still in front of me is next to impossible". This often results in duplicate tests or improper treatments being provided. Mark wishes that he could easily see all that has been done for his patients so he could give them the best care possible.

Mark works hard to improve the health of his patients, but he recognizes that medicine can only do so much. Patients have other barriers that impact their health, such as access to healthy foods or reliable transportation. While Mark knows that there are navigators in the community to help with these issues, he wishes he has a simple view to quickly see what they have done for his patients. And occasionally he would like to be able to quickly connect patients with some of these resources, but he wouldn't even know where to start.



Community Care COLLABORATIVE

Motivated

MARK

Mark's Perspective

Dedicated primary care *Provider* who wants to deliver the best care possible

MOTIVATIONS

- Desire to improve patients' health
- Enjoys working as a team to help patients
- Appreciates challenges and constant learning

CONCERNS

- Inability to track whether patients follow through with referrals (connect the dots)
- Ordering duplicate tests when records aren't available
- Missed opportunities when patients can't get appointments on time
- Appointment times aren't always long enough to address everything the patient or provider wants to

FRUSTRATIONS

- Unable to quickly get outside patient records
- Not knowing when a patient has been seen elsewhere
- EHR moves too slow and requires too many "clicks"
- Meaningful Use and other programs are requiring providers to document more and more, not leaving enough time to actually care for the patient

KEY ACTIVITIES

- Performs acute, preventive, and chronic disease management visits, including history, physical, diagnosis and development of treatment plans
- Provides patients with both preventive and diagnosis-specific education
- Orders medications and sends prescription to pharmacy
- Orders labs/diagnostics, reviews results, and adjusts treatment plan as indicated
- Uses EMR to document and review all aspects of a patient's care
- Refers patients to other specialists when needed

ISSUES

- Local HIE is not robust enough to be meaningful to providers
- Facilities are slow to respond to record requests
- Ongoing training needs:
  - EHR review to improve understanding and speed
  - HIE review to ensure proper utilization

OPPORTUNITIES

- Increasing the amount of clinically-significant information and the speed of the information in the HIE would improve provider's access to accurate patient information, thus improving patient health outcomes
- Patient Navigation view for providers could allow them to reinforce referrals made, and make additional referrals if needed