Patient Navigation Programs
Leveraging Care Pathways

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Welcome

Thank you for joining us today for our webinar.

Patient navigation has become an important component in the landscape of cancer care delivery.

There are still many challenges to creating and growing a navigation program.

Understanding the challenges and solutions is key to program success.
Goals For Today

Review the history of cancer patient navigation and understand it’s origins.

Discuss the basic goals of a navigation program and how it is unique in the cancer care delivery system.

Learn about processes for initiating, growing and maintaining an efficient and effective patient navigation program.
We welcome your comments and will take questions or comments at the end of the presentation.

Your experience as patient navigators, cancer registrars, managers and administrators will contribute to building a valuable network to share ideas and information.

“A rising tide raises all ships.”
Take A Look At……..
How It All Began

In 1989, the American Cancer Society held "National Hearings on Cancer in the Poor".

The testimony was primarily provided by underserved Americans of all racial and ethnic groups who had been diagnosed with cancer.

These findings led to the concept of patient navigation.
American Cancer Society Report -1989

• Poor people face substantial barriers to obtaining cancer care and often do not seek care if they cannot pay for it.

• Poor people and their families often make extreme personal sacrifices to obtain and pay for care.

• Fatalism about cancer is prevalent among the poor and may prevent them from seeking care.

• Cancer education programs are often culturally insensitive and irrelevant to many poor people.

• Poor people endure greater pain and suffering from cancer than other Americans.
In A Nutshell

Poor and uninsured Americans meet significant barriers to obtaining timely diagnosis and treatment of cancer and other life threatening diseases.

Such barriers lead to late diagnosis and treatment and increased mortality.

Patient navigation has evolved as a strategy to improve outcome in vulnerable populations by eliminating barriers to timely diagnosis and treatment of cancer and other chronic diseases.
The National Cancer Institute (NCI) Patient Navigation Research Program (PNRP)-2004

The concept for the NCI Patient Navigation Research Program was derived primarily from the original patient navigation concept and model, which was pioneered by Harold P. Freeman in Harlem, New York.

This research program was designed to develop interventions to reduce the time to diagnosis and treatment of cancer after identifying an abnormal finding from a cancer detection procedure.

The basic goal of navigation is to facilitate timely access for all to quality standard care in a culturally sensitive manner.
Addressing Disparities

• PNRP targeted communities with a disproportionate share of the cancer burden.

• Nine sites were chosen for the 5 year study of breast, cervical, prostate and colorectal cancer.

• Study goals were to reduce or eliminate cancer health disparities and test the efficacy and cost effectiveness.

• Design patient navigation interventions to decrease the time between a cancer-related abnormal finding, definitive diagnosis, and delivery of quality standard cancer care services.
Moving Forward

• Patient Navigator Outreach & Chronic Disease Prevention Act was signed by President Bush in 2005.

• In 2005 the American Cancer Society Navigation program was implemented. By 2007, the ACS funded more than 60 patient navigation programs across the United States.

• In 2006, the Center for Medicare Services (CMS) funded six demonstration sites for pilot programs targeting minority Medicare beneficiaries with the goal of overcoming barriers in screening, diagnosis, and treatment of cancer.
Breast Cancer Led The Way

- The Avon Foundation for Women
- Susan G. Komen for the Cure
Professional Organization Support

• Oncology Nursing Society (ONS)
  • Certified Breast Care Nurse-CBCN
  • Oncology Certified Nurse- OCN

• Association of Oncology Social Work (AOSW)

• Academy of Oncology Nurse Navigators+ (AONN+)
  • Oncology Nurse Navigator Certified Generalist-ONN-CG
  • Oncology Patient Navigator Certified Generalist-OPN-CG
The ACoS Commission on Cancer


The standard mandates a patient navigation process be in place.

Standard 3.1 also mandates that a Community Needs Assessment be conducted every 3 years in order to assess the barriers to care within the hospital community and to focus efforts to overcome these barriers.

The CNA is used to focus the patient navigation program efforts in managing and overcoming barriers to care.
Let’s Get Going

Start
Goals for Patient Navigation

Eliminate barriers to care for patients traversing the cancer care continuum

Educate, advocate for and assist patients with needs and concerns throughout treatment and into survivorship or end of life.

Communicate patient and family needs to the care team on a regular and continuous basis through the trajectory of care.

“Patient navigation serves to virtually integrate a fragmented health care system for the individual patient.”

The Origin, Evolution, and Principles of Patient Navigation Harold P. Freeman Cancer Epidemiol Biomarkers Prev; 21(10) October 2012 AACR
Identify Your Program’s Goals

Facilitate the provision of patient-centered care

Manage treatment throughout the continuum of care

Address barriers to care

Improve patient satisfaction and outcomes
A Brief Look At Where To Begin
Collaboration is key to success

Assess the ability to support the navigation program with necessary resources

Align goals with the strategic plan

Secure commitment from key stakeholders for program support

Engage the multidisciplinary team in the development process

Choose a disease site as a pilot site e.g. breast cancer

Plan, Do, Check, Act is a good approach
PDCA

- What is good? What needs to change?
- Did the plan work?
- What are the goals?
- What steps do we take to get there?
Other Beneficiaries

The team of providers

The hospital or cancer center

The community
Models of Care
The Freeman Model

Patient Navigation Across the Health Care Continuum

Patient Navigation

Initial Target in Harlem Model

Outreach
- Abnormal Finding

Abnormal Results
- Diagnosis
- Treatment

Rehabilitation
- Resolution

Prevention
- Diagnosis/Incidence
- Treatment
- Survival and Mortality

Early Detection
- Post Treatment/Quality of Life Supportive Care

http://www.hpfreemanpni.org/patient-navigation
The Freeman Model of Patient Navigation

- Community Outreach
- Abnormal finding

Abnormal result

Leads to

- Treatment
- Diagnosis

Leads to

- Rehab
- Long term follow-up

Improved mortality and QOL
Other Navigation Program Models

- Disease site specific
- Treatment modality specific
  - Surgery
  - Chemotherapy
  - Radiation therapy
- Generalist - navigates multiple disease sites
- Social work and lay navigation
Navigation In The Ideal World

Nurse navigator

Patient and family

Lay navigator

Social worker
In The Real World

- Everyone does more with less
- Navigation is one of many programs and services
- Reimbursable services have more traction
- Nurses are willing to do it all
Care Pathways Can Be Helpful

- Visual representation of the process
- Defines steps that are expected and needed
- Manages expectations
- Promotes organization and efficiency
Map It Out

Pathways can:

- Determine where the process of navigation begins
- Use guideline based standards of care
- Develop an “if this then that” algorithm
- Demonstrate a systematic way to manage patient care
- Support collaboration among providers and team members
Navigator receives notification of newly diagnosed patient

Reviews all relevant patient information

Contacts patient same day or within 24 hrs to schedule intake appointment

Meets with patient and family to introduce navigation role/begin intake process

Develops preliminary schedule and follow-up expectations

Assists with scheduling appointments/completes distress screen/identifies barrier to care

Discusses patient/family concerns. Answers questions/provides written info and contact information

Provides education re: diagnosis/treatment team members/potential treatment options

Schedules follow-up call/meeting with patient in 1-2 days

Makes referrals for barrier interventions. Creates patient record. Documents patient encounter
Navigation Entry

- The navigator is the first or earliest point of contact for patient and family at time of diagnosis.
  - The patient may be referred to the navigator by a physician, e.g. the surgeon who did the biopsy.
  - The cancer registry may contact the navigator after reviewing daily pathology reports
  - The navigator may access pathology reports from recent biopsy appointments he or she is following.
  - Referral physicians can contact the navigator when they direct a patient who needs cancer care.
  - Clinics or the operating room schedule may be the referral source
Navigation Flow

Patient moves into first phase of active treatment

Navigator schedules regular patient contact either by phone or in person

Navigator assesses patient needs at each contact, initiates interventions and follow-up
Another View

- Referred by PCP or following abnormal imaging or test results
- Utilizes support services as needed
- Patient enters cancer care system post diagnosis
- Makes treatment decisions. Initiates treatment
- Has initial consults with multidisciplinary team
- Has additional diagnostic work-up for clinical staging and treatment planning
- Navigator
- Surgeon
- Medical oncologist
- Radiation oncologist
- Diagnostic imaging
- Labs
Pathways Facilitate Transparency/Accountability

- Navigators have a clear picture of how to plan patient care

- Administrators and managers can follow workload and manage process more seamlessly

- Return on investment of navigation program can be measured

- Patient care becomes more efficient and effective

- Patient outcomes are more predictable and improved
New Patient Intake

PCP

Oncology Social Worker

Plastic Surgeon

Patient Family Navigator

Radiation Oncologist

Medical Oncologist

Surgeon
Managing Barriers
Common Barriers To Care

- Financial - no insurance, high co-pays and deductibles, unable to work during treatment
- Psychosocial - child or elder care needs, emotional concerns, fear
- Transportation - distance, gas cost, unable to drive
- Medical literacy - unable to grasp medical language
- Cultural challenges - fear of medical treatment based on cultural beliefs
Barriers To Care Management

Navigator identifies barriers to care

Discusses potential solutions and resources with patient

Navigator makes resource referral and informs patient

Navigator documents barriers and interventions

Navigator reassesses barrier needs and success of intervention(s)

Navigator schedules follow-up with resource and patient
It’s A
Through The Care Continuum

- Patient moves from surgery to chemotherapy and/or radiation therapy
- Navigator provides education, reassesses barriers, answers questions and concerns
- Navigator attends pre-treatment consult, first treatment, contacts patient on day 2
- Navigator contacts patient weekly or as needed. Documents encounters.
- Navigator follows-up with social work/lay navigator for barrier intervention
Spinning Many Plates, Juggling Many Balls
Survivorship Care: The Newest Challenge
Survivorship Challenges

• When to end active navigation
• How best to transition care
• Survivorship care planning
• Letting go - patient and navigator
Transition From Active Navigation

1. Patient completes active treatment
2. Follow-up care begins
3. Navigator facilitates the patient transition to follow-up care
4. Navigator ends active navigation over a predetermined time frame
5. Navigator confirms patient has SCP and understands plan
There Are Many More Options
Learning Through Networking
Resources

• Oncology Nursing Society

• Academy of Oncology Nurse and Patient Navigators

• Association of Community Cancer Centers

• The Advisory Board: Oncology Roundtable
Questions/Comments
Thank you

We appreciate your time today.

Have a great day.

To schedule a demo of Oncolog Registry software or speak to someone, please call 800-345-6626.
Visit us at www.oncolog.com

To schedule a demo of OncoNav Nurse Navigation software or speak to someone, please call 888-369-1791
Visit us at www.onco-nav.com