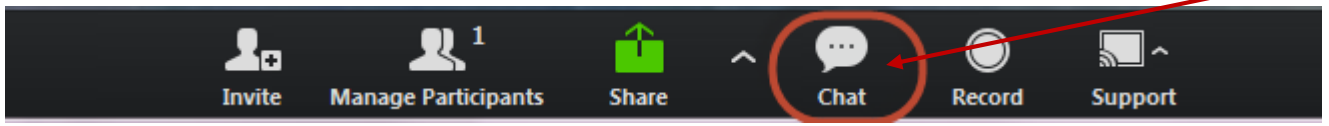
Welcome to Project ECHO Cancer Patient Navigation

This meeting will begin promptly at 3:00pm

Please mute upon entry

Enter your name, credentials, organization, and email address in the Chat



If you are experiencing any technical difficulties, please type in the Chat or call Maine Cancer Foundation at 207-773-2533 and reference you need Project ECHO assistance

Ground Rules

- Always MUTE microphone when not speaking – do not put your call on hold because it will play music
- Please show yourself on your video
- Never disclose protected health information
- To speak:
  - Raise hand (physically or click the option in Zoom)
  - Message in Chat
- Speak loudly and clearly
- Please keep questions and comments related to the topic

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Project ECHO
Cancer Patient Navigation

Navigation Work Flow:

MaineGeneral's Harold Alfond Center for Cancer Care Point of Entry Nurse Navigation

By

Kerri Medeiros RN, BSN, OCN, ONN-CG (T)

TeleECHO May 22nd 2019

Learning Objectives

- Define navigation
- Brief history on navigation
- HACCC model of navigation
- The roles of point of entry navigation (POEN)
- Review current outcomes
- Challenges & opportunities

The Definition of Navigation

The Commission on Cancer (CoC), definition of patient navigation:

“Specialized assistance for the community, patients, families, and caregivers to assist in overcoming barriers to receiving care and facilitating timely access to clinical services and resources.”

History of Navigation

Patient navigation began in 1990 with Harold Freeman a surgeon in Harlem, New York.

- Survival rate of breast cancer was lower than national average.
- Almost half of women diagnosed with breast cancer, were found in stages III and IV

History of Navigation (cont.)

His goal was to eliminate barriers to timely cancer screening, diagnosis & treatment.

- Placed navigators in the community to provide education and eliminate barriers
- Provided free & low cost screening mammograms

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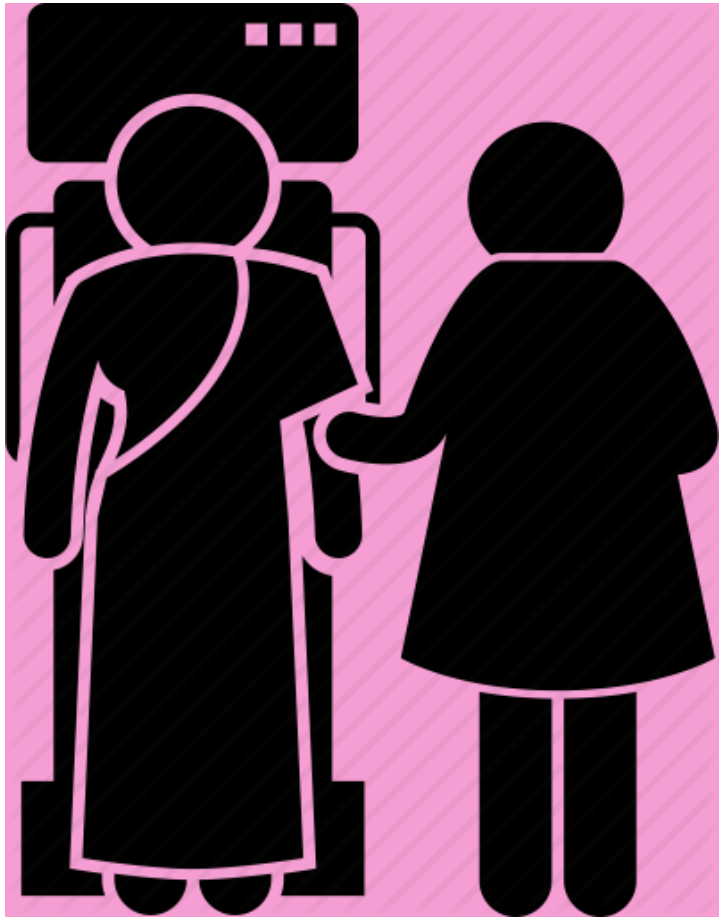
Freeman's results:

- Stage I diagnosis, went from 6% to 41%
- Stage III & IV diagnoses went from 49% to 21%
- Survival rates from 39% to 70%



- The United States (U.S.) Government signed into law the Patient Navigator and Chronic Disease Prevention Act in 2005 (United States Congress, 2005).

- Commission on Cancer implemented standard 3.1 in 2015.- All cancer programs in the U.S. must have a patient navigation process (Freeman, 2013).

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Standard 3.1
Patient Navigation Process

- A patient navigation process, driven by a community needs assessment, is established to address health care disparities and barriers to care for patients. Resources to address identified barriers may be provided either on-site or by referral to community-based or national organizations.

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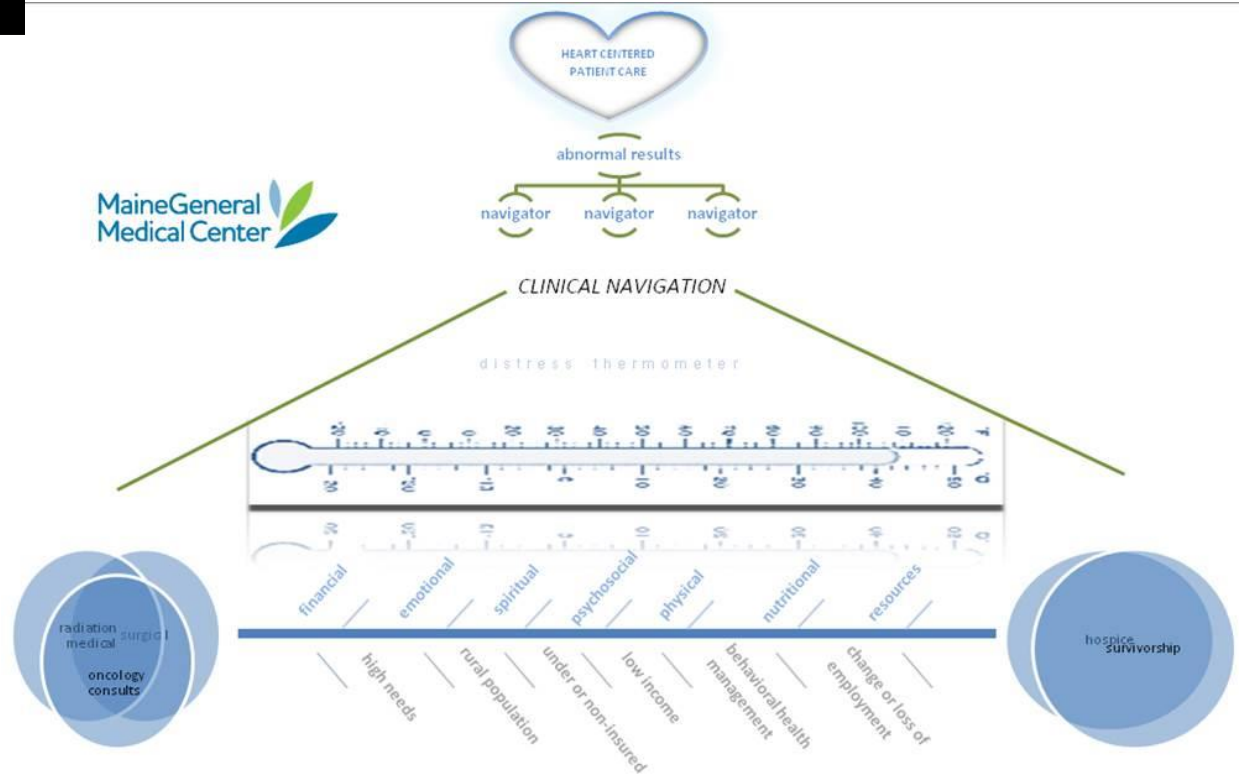

HACCC POINT OF ENTRY NAVIGATOR ROLE

- Point of Contact
- The right appointments at the right time
- Education, Support & Advocacy
- Assess for barriers-referrals
- Complete oncology intake
- Review ancillary services + resources
- Survivorship
- Community outreach

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TIMELY CARE

- Diagnosis & staging
- National Comprehensive Cancer Network guidelines
- Multidisciplinary guidance
- Right appointment at the right time

Point person in place at day one that is skilled and knowledgeable in cancer care

- Assess barriers to care
- Determine resources needed
- Provide education
- Most importantly listen and offer support

Education & Coordination of Care

- Tests & procedures
- Proactive care
- Treatments
- Informed decision making
- Answer questions

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- Advance directives → Social work
- Smoking history → Smoking cessation
- Transportation → ACS & Social workers
- Insurance &finances → Financial counselors
- Nutrition &weigh loss → Oncology dietician
- Emotional needs → Social Work

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- ADLs, falls &safety → Cancer Recovery / Prehab
- Swallowing → Speech &Swallow
- Research → Clinical trial, JAX , Biobank
- Hereditary risk → Genetics
- Spirituality → Spiritual care
- Stage IV & chronic pain → Supportive care & Palliative care
- Curative intent → Survivorship
- Head and Neck RT → Dental evaluation

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COMMUNICATION

- Patient is not surprised with appointments
- Informed health care team
- Hand off to care team of specialty clinics, oncologists, nurse and ancillary services

The PATIENT is the focus at hand off, NOT the disease

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Lunch and Learns

- POE navigators
- LDCT
- MDC clinic
- Pulmonary nodule clinic

PCP and surgical staff meetings

Prevention and screening events
Awareness months- TV/radio/papers
Cancer Survivors Day
Prostate Support Group

OUTCOMES

Since December of 2015 we have grown from one POE navigator to four.

- Most robust LDCT program in the state
- Survivorship standard met
- Growth in the number of patients that seek care at MGMC for POE navigated diseases
- Lung cancer & GI cancer- DX to TX reduced by two days

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Challenges and opportunities

- Physician buy in
- Clerical duties
- Gaps in care
- Growth-more diseases + trajectory of care
- Awareness
- EMR
- Metrics

Questions?

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Case Study:

Community Needs Assessment and Assessment of Barriers to Care

By

Kaitlyn Umphrey, RN – Cary Medical Center

TeleECHO May 22nd 2019

Background/Setting the Scene

The Jefferson Cary Cancer Center is in the process of developing a navigation program to be of better service to our patients. Our Oncology Nurse Navigator program is a new program made possible by a Maine Cancer Foundation grant. References state the first step in establishing a navigation program are to create a community needs assessment to assess needs of the patients we serve and as a starting point for the areas that are lacking in the community.

Interventions to Date

Our initial instinct is to have our patients take the assessment after they are first established with oncologic care then reevaluate in a month, 3 months, 6 months and in a year from initial appointment. We have not initiated this process as of yet as we are unsure if this is too much to ask of our patient undergoing so much in this part of their lives. We currently utilize the NCCN Distress Thermometer tool to assess our patients on day 1 of each treatment cycle to help capture symptoms and barriers to care. Our needs assessment mostly assesses where patients could have used more help and if they would like additional services at different stages of their diagnosis and treatment.

Factors Enabling or Inhibiting the Case to Progress

Lack of experience in knowing what works for other navigation programs or lack of data to show at which intervals are most appropriate at assessing community needs has kept this issue from progressing. The purpose of the assessment is to obtain useful information while not burdening the patient unnecessarily with frequent surveys.

Case Study Questions

- What are the intervals in which community needs assessments are done in your facility?
- What population do you assess?
- Who is responsible for data received with the assessment?
- How do you document the evaluation of barriers to care/needs?