Patient Navigation: Where did it come from and where is it going?

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Objectives

• Understand the history of patient navigation
• Identify at least 3 of the most common barriers to delivering cost efficient quality of care
• Learn the role nursing plays in oncology patient navigation through examples presented and discussed
• Understand the various navigation models in use by cancer centers today
• Learn at least 4 ways to measure navigation performance
So Where Did Navigation Come From?

- **History - Beginning with Utilization Review**
  - Began in 1970s when managed care implemented steps to reduce healthcare costs and convert more inpatient care to outpatient setting.
  - **Definition of Utilization Review**: a process for monitoring the use and delivery of services, especially one used by a managed care provider. Goal - cut costs.
  - How process worked: UR Nurses working for the hospital retrospectively reviewed medical records. UR nurses working for managed care did the same and issued denial letters for inappropriate utilization of hospital resources. An adversarial relationship at its best.
Next came Utilization Management

- Late 1980s/Early 1990s
- Definition – **Utilization Management**: is the evaluation of the appropriateness, medical need and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan.

Wikipedia.org/wiki/Utilization_management
How process works

- Hospital employed Utilization Management Nurses to concurrently review inpatient medical records to identify potential delays in treatment/discharge from hospital; overutilization of radiology resources. Contacted treating doctor to provide justification for medical necessity.
- Insurance company employed Utilization Management Nurses who came onsite to do same or obtained information via phone from hospital UM nurse.
- Preauthorization required for many health care services (i.e., CAT scans, referrals to another doctor, surgery, use of specific drugs that were more expensive than others in same drug category)
- Peer Review Organizations for Medicare and Medicaid implemented same review process.
Next Came Case Management

Began in mid 1990s

Definition: **Case Management** is the **collaborative** process, which assess, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual’s health care needs, using communication and available resources to promote quality, cost effective outcomes.

[www.cmsa.org](http://www.cmsa.org) – Case Management Society of America
Systematic Review of Case Management used to Optimize Cancer Care

- Pubmed search identified 654 unique papers of which 25 were retrieved for scrutiny. 7 were finally included.
- Since there was significant heterogeneity in the target group, intervention setting, outcomes measured and methodology applied, no conclusions could be reached about the effectiveness of case management.

Wulff CN, Thygesen M, Sondergaard J, Vedsted P. Case management used to optimize cancer care: a systematic review. BMC Health Serv Res. 2008 Nov 6;8:227
Case Management and older BC patients

• Obj- to evaluate the effect of nurse case mgt on the Rx of older women with breast cancer.
• 60 surgeons, 13 communities, 2 public hospitals.
• 335 pts– 166 control and 169 intervention
• Randomized trial
• Measurements–1st outcome was type and use of specific cancer therapies during first 6 months after diagnosis. 2nd outcome were patient satisfaction and arm function at 2 months after diagnosis

Results Showed
Case Management is Effective

- More women in the intervention group received
  - breast conserving surgery (28.6% vs 18.7%; P=.031)
  - Radiation therapy (26.0% vs 19.0%; P=.003)
  - reconstruction if mastectomy was performed (9.3% vs 30.0%; P=.057)
  - Axillary node dissection (71.4% vs 44.8%; P=.057)
  - Chemotherapy if they have advanced cancer (72.7% vs 30.0%; P=.057)
  - Return to normal arm function at 2 months post dx (93% vs 84%; P=.037)

- Among all of the women having breast conservation
  - More had adjuvant radiation in the intervention group (78.3% vs 44.8%; P=.001)

Dr. Harold Freeman created patient navigation concept in 1990 at Harlem Hospital.

His mission was to identify and reduce barriers to timely cancer diagnosis and treatment.

Focus on minorities and other underserved populations.

Navigation found to be successful- heavy focus on accessing screening services

www.hpfreemanpni.org
Government gets involved

- In 2005, President George W. Bush signed into law H.R.1812-the Patient Navigator Outreach and Chronic Disease Prevention Act of 2005

- Law authorizes appropriations through FY 2010 for the Dept of Health and Human Services to establish a competitive grant program designed to help patients access health care services.
Other funding sources

• American Cancer Society
• Komen for the Cure
• Livestrong
• National Breast Cancer Foundation
• National Cancer Institute– cancer disparities research partnership program
• Avon Foundation
• Other cancer organizations

Some institutions use it for marketing

- **Advertising to lure patients**—
  - You can have your own patient navigator
  - You will have your own “care coach”
  - We offer “care expeditors”
  - You will be immediately connected to a “care facilitator”
  - We offer “GPS nurses” to navigate you through your cancer care.
- In some cases these individuals are only scheduling the first appt; in other cases they truly are involved with the patient from beginning to end of care.
Definition of Patient Navigation

- A process by which an individual— a patient navigator— guides a patient from point of recruitment for a screening mammogram through to diagnosis of breast cancer and its treatment, identifying and removing barriers to care and treatment. This can be one individual or several individuals performing this function.

www.ncbc.org;
www.cancer.net/library/cancer.Net=Features/Patient+navigation
What is navigation?

- Depends on the setting and the needs. Definitions and functions can vary.
- It’s overall purpose:
  - reduce cancer incidence and mortality and improve the quality of life of people with cancer in health disparities regions.
  - Provide culturally targeted education
  - Provide access to early screening, diagnosis and treatment
  - Provide assistance and “navigation” through the complexities and barriers of the health care system

www.3cancer.gov/rrp/cdrnp/nav_purpose
The Patient Navigator is designed to

- Assist patients with abnormal findings or cancer in navigating and at times circumnavigating the hospital and human services bureaucracies.
  - Provide psycho-social support
  - Assist with treatment decision making through patient empowerment
  - Develop relationships with the community and service providers
  - Assist with insurance
  - Inform patients of services and resources
  - Coordinate transportation
  - Increase health awareness in individuals
  - Perform a needs assessment to identify barriers to care and provided the resources to eliminate them.

www3.cancer.gov/rrp/nav_purpose
Continued…

– Coordinate services
– Track interventions and outcomes
– Build relationships with other patient navigators

• Overarching role--
  – Stay in close communication with the patient across the continuum of care to ensure coordination of care,, efficient delivery of care, removal of barriers to care, and provide emotional support.

www3.cancer.gov/rrp/cdrp; www.ncbc.org
Barriers to delivery of quality of care:

- Financial and economic
- Language and cultural
- Communication
- Healthcare system
- Transportation
- Bias based on culture/race/age
- Fear

www.ncbc.org; www.cancer.net
Navigation process must factor in need for **culturally competent care**:

- Confidentiality maintained
- Respected at all times
- Compassionate delivery of care and services
- Mindfulness of the patient’s safety
Goals of Navigation

- **Save lives from cancer**— ensure all patients who have a suspicious finding get resolution through more timely diagnosis and treatment
- **Eliminate barriers to care**— help with follow up appts and access to care as needed
- **Ensure timely delivery of services**— efficiently help her move through the care delivery system
Who performs these functions?

- Depends on many factors.
- Everyone involved with the patient has some role however in navigation. This is not an isolated process.
- Role for navigation in recruitment process
- Role for navigation in screening/diagnostic evaluation.
- Role in navigation for the biopsy proven patient.
- Navigator may be a lay person, a nurse, physician assistant, nurse practitioner or social worker, or even another allied healthcare professional
Where should navigation be implemented?

- Organizations providing care within the cancer continuum—hospitals, clinics, screening facilities, community non profits, oncology offices…
- Organizations with an underserved population
- Organizations wishing to provide a premiere healthcare/cancer care center delivery model
A Recap

- **UR nurse**—retrospective chart review. No patient contact. Inpatient based. Adversarial relationship with providers. Mission—reduce healthcare cost by pointing out inefficient care.

- **UM nurse**—concurrent chart review. Inpatient based. No patient contact. Still a somewhat adversarial relationship. Mission—identify barriers that delay treatment or discharge and request provider to expedite treatment or discharge to home. Also identify patients who lack medical necessity for hospitalization and promote discharge.

- **Case manager**—nurse directly involved in patient’s care across the continuum. Mission—Expedite care and treatment as well as patient compliance. Focused on chronic illnesses and life threatening diseases.

## History over Time

<table>
<thead>
<tr>
<th>Era</th>
<th>Description</th>
<th>Type</th>
<th>Setting</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970’s Utilization Review</td>
<td>Monitor use and delivery of services</td>
<td>Adversarial</td>
<td>Inpatient</td>
<td>Retro chart review</td>
</tr>
<tr>
<td>1980’s Utilization Management</td>
<td>Evaluate appropriateness, medical need, efficiency</td>
<td>Adversarial</td>
<td>Inpatient</td>
<td>Concurrent chart review</td>
</tr>
<tr>
<td>1990 Case Management</td>
<td>Assess, plan, implement, coordinate, monitor, evaluate</td>
<td>Collaborative</td>
<td>Involved in Patient Care</td>
<td>Hands on care</td>
</tr>
<tr>
<td>1990 Patient Navigation</td>
<td>Identify, reduce barriers to access to care, dx, rx</td>
<td>Collaborative</td>
<td>Underserved Patients</td>
<td>Community outreach</td>
</tr>
<tr>
<td>2000 Patient Navigation</td>
<td>Identify, reduce barriers to access care, dx, rx</td>
<td>Clinical collaborative</td>
<td>Across continuum of care-hands on</td>
<td>Hands on care and coordination of care</td>
</tr>
</tbody>
</table>
Patient Navigation’s Guiding Principles

• The guiding principles of patient navigation are to ensure that quality, confidentiality, and professionalism are threaded throughout all aspects of care and programming. Inherent in the process is continuous quality care for patients from screening through diagnosis and treatment, based on the following tenets:
  – Culturally competent care
  – Confidentiality
  – Respect
  – Compassion
  – Patient safety

Where Should Navigation Be Implemented?

- Organizations providing care within the cancer continuum
  - Hospitals
  - Clinics
  - Screening centers
  - Community not-for-profits
  - Oncology and radiology offices
- Organizations with an underserved population
- Organizations wishing to provide a premier cancer care center delivery model

- www.patientnavigation.com
Responsibilities of a Navigator

• Meet with patients at point of suspicious finding
• Identify any barriers or potential barriers to care
• Streamline appointments and paperwork
• Maintain open communication with health care providers, caregivers, and patients
• Assist in increasing access to culturally appropriate, supportive care when and where possible
• Link patients, caregivers, and families with appropriate follow-up services
• Maintain personal contact with patients throughout the health care continuum and follow their progress

Non-Clinical

• **Volunteer**
  Can connect patients to information and community resources
  No cost to the institution; can assist clinical navigators
  High risk of position turnover; negatively impact care due to schedule

• **ACS Navigator**
  Trained by ACS and host, specific role, standardized information
  Low cost due to ACS funding
  Restricted in ability to provide clinical information and interventions

• **Lay/Survivor**
  Can connect patients to information and community resources
  Low cost; can assist clinical navigators
  Lack medical knowledge outside of experience;
  Restricted in ability to provide clinical information and interventions

The Advisory Board Company 2008: www.cancer.org
Clinical Navigators

- **Social Worker**
  Individual assessment and address of psychosocial barriers; counseling
  Less costly of clinical group and has some clinical knowledge: great knowledge of community resources
  Restricted in medical knowledge and ability to address treatment and symptom concerns

- **Nurse**
  Medically knowledgeable resources; trained for nursing assessment
  Play a larger clinical role; refer patients to support as needed
  More costly than social work and non-clinical; may lack community resource awareness

- **Advance Practice Nurse/Physician Assistant**
  Can bill for services; larger clinical role beyond RN capabilities; refer patients to support as needed
  Some institutions do not bill services; additional cost compared to RN may be difficult to justify
Navigator Types

- RN – 55%
- APN – 20%
- SW – 7%
- Non-clinical – 13%
- Other – 5%

The Patient Navigation Model

• The Cancer Care Continuum

## Group I: Navigators Designated by Tumor Site
(from Oncology Round Table, 2009)

<table>
<thead>
<tr>
<th>Description</th>
<th>Model I</th>
<th>Model II</th>
<th>Model III</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Navigator assigned to high-volume, low-acuity tumor site</td>
<td>Navigator assigned to low-volume, high-acuity tumor site(s)</td>
<td>Navigator assigned to provide coverage for all tumor sites</td>
</tr>
</tbody>
</table>
| Rationale   | Most commonly selected model as high patient volumes tend to warrant assignment of FTE1
|             | Patients with high levels of acuity tend to have a greater need for navigation services | Provides access to all cancer patients, Recognizing universal need, benefit across tumor sites |
| Site        | Site                     | Head and neck cancers, GI cancers | All cancer types                   |
|             | Breast cancer            |                                   |                                    |
| Caveat      | Caveat                   | Level of frequency, intensity of navigation services likely to be high; consider role modifications | Varying patient volumes across groups may necessitate assigning several tumor sites per navigator |
# Group II: Navigators Designated by Patient Entry Point
(from Oncology Round Table, 2009)

<table>
<thead>
<tr>
<th>Description</th>
<th>Model V Multidisciplinary Clinic</th>
<th>Model VI Physician Based</th>
<th>Model VII Community Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navigator assigned to tumor site–specific conference/clinic</td>
<td>Navigator assigned to work with several Physicians</td>
<td>Navigator assigned to subset of population experiencing disparities in care</td>
<td></td>
</tr>
<tr>
<td>Ensures timely case presentations, follow-up coordination</td>
<td>Provides assistance when need identified; opportunity to increase physician efficiency</td>
<td>Identifies, addresses gaps in access, utilization of cancer service(s)</td>
<td></td>
</tr>
<tr>
<td>Patient identified by referral, clinic visit</td>
<td>Patient identified by lead oncology Physician</td>
<td>Patient identified in community by Navigator</td>
<td></td>
</tr>
<tr>
<td>Navigator clinic preparation, follow up workload likely to vary by tumor site</td>
<td>Physician may request services beyond scope of navigator role</td>
<td>Funding commonly an issue; consider grant, foundation funding opportunities</td>
<td></td>
</tr>
</tbody>
</table>
Potential Benefits that can measure effectiveness of the navigation program

- Improved coordination of high quality care
- Enhanced access to services for all pts
- Removal of barriers to care
- More efficient delivery of care
- Improved outcomes
- Improved sharing of resources
- Enhanced relationships with the community
- Increased patient satisfaction
- Increase in referrals of new patients to the system
Examples of Measures

• More efficient delivery of care
  – Measure the time delays: screening mammo to diagnostic mammo to biopsy to path results known
  – Measure the time delays: confirmation of breast cancer on core biopsy to surgical consultation to surgery taking place
More examples

• Improved outcomes:
  – Adherence with NCCN treatment guidelines
    • % of patients receiving radiation following lumpectomy
    • % of patients receiving chemotherapy who had Stage II, or III breast cancer
    • % of patients receiving hormonal therapy who were hormone receptor positive
More examples...

- Enhanced relationships with the community:
  - Use of community resources tracked
  - Recruitment of patients for screening mammograms from the community through relationships built with PCPs and awareness efforts/events
Validation in some settings it is working effectively..

- Patient population: Urban minority women with abnormal mammograms
- Objective: need to expedite faster delivery of diagnostic results, lower anxiety levels, and greater satisfaction with care
- Results: women helped by navigator had shorter times to diagnostic resolution (avg 25.0 vs 42.7 days); only 6% of women in intervention group were still waiting for diagnosis at 60 days vs 22% in control group
Results

• Women helped by navigator had shorter times to diagnostic resolution (avg 25.0 vs 42.7 days);
• Only 6% of women in intervention group were still waiting for diagnosis at 60 days vs 22% in control group
• Navigator group had lower mean anxiety scores (decrease of 8.0 in intervention vs increase of 5.8 in control group)
• Navigated patients had higher mean satisfaction scores (4.3 vs 2.9)

Comparison of Time Lag by Making a Change in the Scheduling Process for Post Operative Medical Oncology Appointments

<table>
<thead>
<tr>
<th>Old Process</th>
<th>New Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery performed 4/30/2009</td>
<td>Surgery performed 4/30/2009</td>
</tr>
<tr>
<td>Pathology results available 5/5/2009</td>
<td>Pathology results available 5/5/2009</td>
</tr>
<tr>
<td>Patient scheduled for med onc appt 5/26/2009</td>
<td>Medical oncology consultation performed 5/13/2009</td>
</tr>
<tr>
<td>Medical oncology consultation performed 5/26/2009</td>
<td>Chemotherapy begins 5/18/2009</td>
</tr>
</tbody>
</table>

By making this change in timing of when the medical oncology appt is scheduled, the patient is able and ready to get underway with her chemotherapy 2 weeks sooner!
Another Research Study

- Patient population: minority women in Atlanta, Georgia
- Obj: to reduce mortality
- Results:
  - Their health advocacy and patient navigation program helped in diagnosing breast cancer at an earlier clinical stage.
  - Between 2001 and 2004 the proportion of breast cancers that were stage 0 increased from 12.4% to 25.8% while the proportion of stage IV at time of diagnosis decreased from 16.8% to 9.4%

What Happens when Patient is Done Treatment?

• The need to **address survivorship care**
  – With impending shortage of oncology specialists, the need to transition cancer survivors away from the surgical, medical and radiation oncologists must take place, and soon. (projects stats: 48% shortage of oncology specialists in US by 2020)
  – Navigator- can be responsible for transitioning patient to an NP or PA based on specific protocols developed by stage of disease. After appropriate interval patient can then be transitioned back to her PCP in the community.
    • Prepare the patient for the transition
    • Create the treatment summary document
    • Communicate with the PCP in advance of the transition happening.
Commitment to our patients

- Everyone involved in the cancer patient has a responsibility to facilitate his/her care across the continuum, identifying barriers, resolving obstacles, educating the patient and providing support.
Navigator’s role in Survivorship Care

Survivorship care must begin at the time of diagnosis

Learn what the patient’s life goals were before their diagnosis

Be proactive in making referrals as a means to prevent side effects, deconditioning, reduce risk of complications

Serve as a facilitator to help the patient “create/design” their “new normal” rather than being told to go “find it” or “accept/adjust” to their new normal post treatment

“It’s (supposed to be ) A Wonderful Life ppt slide deck to see an example how to do this.
Future directions…

The need for core competencies

Standardization of tasks and functions

Certification

Quality measurements

Clinical outcomes

Cost savings

Development of the most efficient models of performing navigation processes (ie, a nurse navigator should not be performing clerical tasks)
Additional measures for Validating Benefits of having Nurse Navigators

Clinical trials recruitment

Retention of second opinion patients seen (and what revenue it yielded)

Downstream revenue—other family members coming for screening/diagnostics

Reducing physician time with patient during consultations

Reducing phone calls to physicians’ offices post consultations

Recruitment of underserved patients for screening tests through community outreach efforts

Patient satisfaction

Philanthropy