Advanced Patient Navigation Certificate

2020

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If you have any questions, please contact us here in HLLN at 416 736 2100 X22170 or hlln@yorku.ca. Thank you, Tania Xerri

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Patient Navigation
Level 2

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Tertiary Care Nurse Practitioner Certificate

Welcome!

- A few housekeeping items before we get started...
- On-line with Zoom
- Agenda
- Ground-rules

Zoom orientation

- I hope you have read the information from HLLN (York University) on how to use Zoom.
- At the start, your audio will be automatically muted– but you can unmute (see the microphone icon)
  - I will do a Roll-call, so you can unmute or post (chat) for that.
- Video: remember, we can SEE you and what you are doing! My preference is that you to keep your video ON– you will see all the participants arranged in a gallery/tile across the top of the screen.
- The Chat function: you can post to the whole group or to anyone privately (just make sure if you do, that you remember to check the private function before you send that comment!)

Ground-rules

- Conduct Policy:
  - Every course through Health Leadership & Learning, York University (on or off-campus/non-degree or non-credit) follows the York University **Code of Student Conduct and Responsibilities.**
  - Students (participants) are expected to maintain a professional relationship characterized by courtesy and mutual respect.
- This includes:
  - the responsibility to behave in a way that does not harm or threaten to harm another person's physical or mental wellbeing
  - the responsibility to uphold an atmosphere of civility, honesty, equity and respect for others, thereby valuing the inherent diversity in our community.
  - the responsibility to consider and respect the perspectives and ideas of others, even when you do not agree with their perspectives or ideas.
- **HLLN reserves the right to remove any student who violates our conduct policy.**

Agenda for the On-line course

Session 1

- Orientation to course material/activities
- Introductions
- Build it, they will come...or will they? Collaborative Process Model
- Environment/map for navigation

Session 2:

- Mapping out the patient journey (Breakout rooms)
- Group debrief/discussion
- Patient Navigation at work
- Self Directed:
  - Support in Bad News Situations (recorded lecture/videos/activities)
  - Health Literacy: What do we mean & how do we achieve it?
    - Recorded lecture/videos/activities
  - Remember to respond to the discussion questions!

Agenda for the On-line course

Session 3:

- Live discussion/review of responses
- Developing structures for Patient Navigation

Session 4:

- Documentation/measurement
- Implementing Patient Navigation
- Wrap-up/Evaluation

My Objectives for this course:

Provide you with information/tools to develop an appreciation for the role of Patient Navigator:

- Components of the role
- The Healthcare environment
- Healthcare issues
- Challenges in patient navigation
- Communication
- Ethics/confidentiality



Introductions:

- A bit about me, a bit about you:
- Background?
- Goals?

Components of Level 2, Patient Navigation:

- How to navigate the health care system to provide guidance for patients with chronic diseases and complex health care needs
- Understanding the various roles of health care providers as members of the interprofessional team, and how a patient navigator can complement those roles and lead case conferencing
- Process for managing chronic diseases as the trajectory of disease evolves
- How to improve health literacy for patients
- Protocols for medical visits
- Advocacy for patients
- Understanding the impact of the "bad news diagnosis" and supporting patients through the process

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Let's talk about Care Integration: what does it mean?

Key priniciples of integrated care:

1. **Seamless Person-centred care across the continuum of care**
2. Quality services appropriate for patient needs
3. Health promotion and illness prevention
4. Equitable access to quality care and multi-sectoral policies to address the social determinants of health
5. Sustainability based on universal access to quality health services
6. Accountability by stakeholders — the public/patients/families, providers and funders — for ensuring the system is effective

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How does integrated care work?

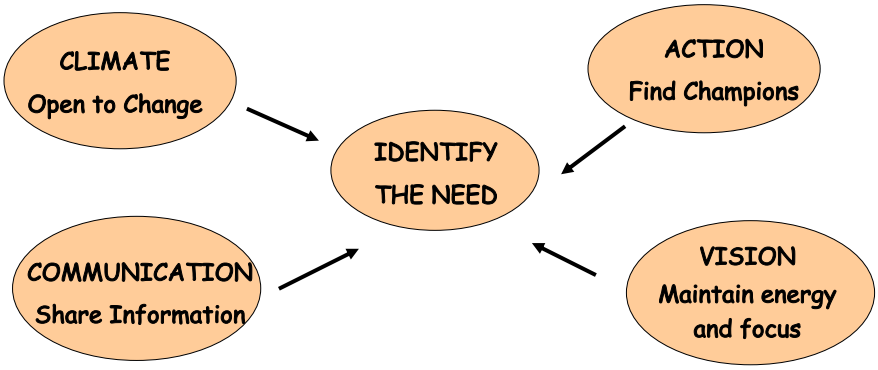
WHAT'S MISSING HERE?

Creating a framework for Patient Navigation:

- **Successful implementation of the role?**
  - 1. Build the role into the care team: workflow, work space and health data platforms.
  - 2. Make it a clear role, and provide the resources necessary to perform it.
  - 3. Navigators need to be a good fit with what both the community and the health care system require.
- What are the measurable goals?
- And how to get there?

Framework to go from idea to implementation to evaluation and sustainability:

THE COLLABORATIVE PROCESS MODEL:



CLIMATE: *OPEN TO CHANGE WITHIN THE COMMUNITY*

- Essential to identify how ready the community is for the change to occur.
- 'Community' can be defined as the population that will be participating in the change and impacted by the change (e.g., could be a nursing unit, an institution, a neighbourhood or a city, etc.).

- *What are stake-holder attitudes ?*
- *What is the legal view of this issue?*
- *What is the ethical/moral view?*
- *Are there conflicting points of view?*
- *What is the political perspective?*

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ACTION: *FIND THE CHAMPIONS !*

- Champions are essential to have in place to help energize and mobilize others to the project.
- They are the ones whose presence invites others to participate.
- They have the vision of the complete project and have passion and energy for the work.
- Champions have the ability to articulate the vision of the project.
- They have the power and authority to make the changes.
- Champions have the respect of all the players and work collaboratively.
- Champions have a sense of humour.

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- Participation in the project can be episodic or consistent. In either case, it is essential to identify communication issues which may affect the trajectory of the project from start to finish. In addition, the sharing of information can encourage others to think of using the project in their own setting, or in developing related projects.

- *What do people feel are the important issues ?*
- *Does everyone have the chance to share ideas?*
- *How is information shared ?*
- *How will the project become part of the community ?*
- *Is there room to make changes/evaluate?*
- *Who else should be part of the communication process?*

COMMUNICATION: *SHARE INFORMATION*.

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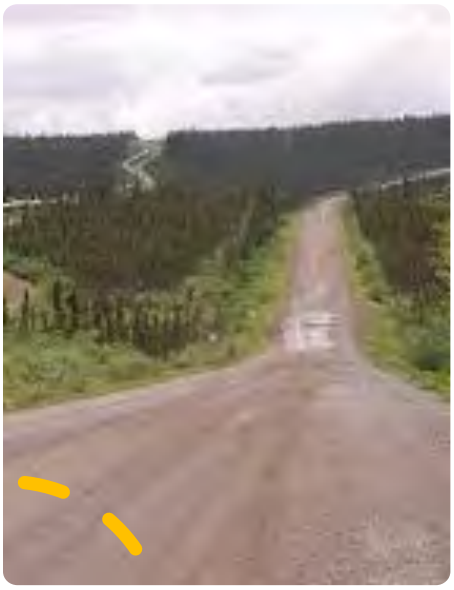

VISION: *AN IDEA FROM START*
to FINISHED PRODUCT, and THEN EVALUATE.

- Identification of the challenge is one piece of the process. But the most important part to include is the plan for sustainability. Many projects have a successful short run, but once the initial momentum is lost, the project fades.
- *How do we stay focussed ?*
- *How do we remain a working partnership?*
- *How do we support each other in the project?*
- *How do we maintain our energy?*
- *Where do we go from here ?*

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Patient Navigator: being efficient.

- Pays attention to the "in the moment" needs of the patient/family
- Understands the system structures and requirements
- Keeps track of patient flow through the system
- Responds to gaps by problem-solving
- Establishes and maintains excellent working relationships with healthcare colleagues
- Remains flexible
- Completes and then moves on.

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Discussion: Who is your population?

- What age/stage?
- What are their health/illness issues?
  - Acute
  - Chronic
  - Social/Economic
  - Combination

BREAKOUT GROUPS

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Discussion: Consider the environment.

- How does the setting/environment impact on your patient ?

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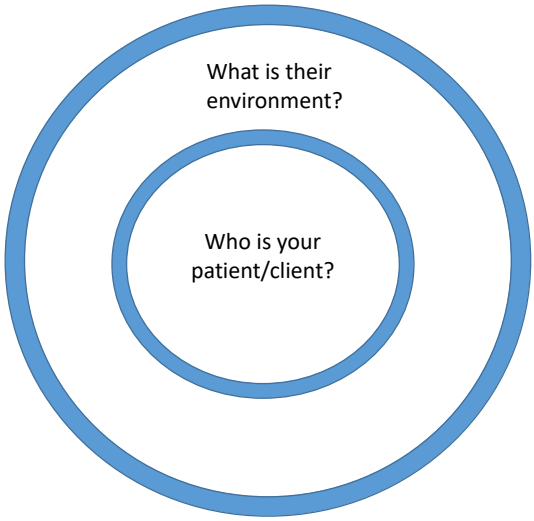
Creating the map for navigation



What are the barriers?
(see handout: Barriers List pdf)

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Patient Navigation in my setting:

1. Consider a typical patient.
2. Follow the steps this patient takes as they move through the healthcare system and your setting.
3. Identify how the Patient Navigator works with the patient to smoothly travel through the system/setting.
4. Identify where there are gaps/challenges.

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Breakout room Activity:

- In the breakout room you are assigned, you will work with your partner(s) to:
- 1. identify the steps taken by the patient to move through the system
- 2. identify how the Patient Navigator will work with the patient to smoothly travel through the system/setting
- 3. identify where there are gaps/challenges

You have 20 minutes to work on this

We will get back together and your team will have approx. 5 minutes to discuss the KEY FINDINGS of the activity.

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Debrief

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Finding the solutions involves team-work.

- Being clear on what Patient Navigation means to the team
  - What are the parameters of the role?
  - How does the Patient Navigator "fit" with other members of the team?
  - What do others expect me to do? (check for hidden agendas)

Finding the solutions involves team-work.

- What are the strengths and the challenges in implementing my role as a Patient Navigator?
- Are we fighting over territory (turf war) and who does what?
- Can we agree on what our roles are and work as a team?

WHAT ARE STRATEGIES YOU CAN USE TO ENGAGE AND COLLABORATE WITH THE TEAM?

Recognize the impact of **chronic conditions** at the **different stages of life**: what changes?

- Infant
- Pre-school
- Elementary school age
- High-school
- Young adult
  - Post-secondary education
  - Employed
  - Unemployed
- Adult
- Older adult
- Senior
  - Independent
  - Assisted living
  - Residential/Long Term Care
  - Hospice

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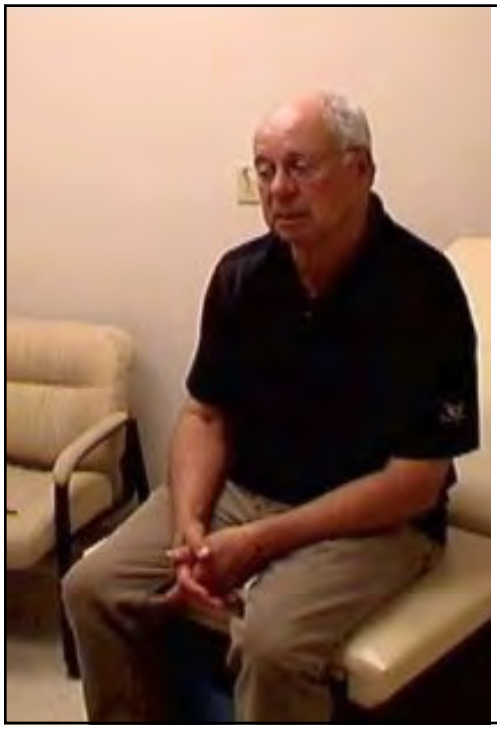

Meeting patients' individualized health and social needs:

- Gathering the information:
  - Team meeting
  - Patient/family
  - Primary Care Provider
  - ? ANYONE ELSE?
- Asking the "right" questions:
  - " What can I/we help you with?"
- Recognizing that patients may not even know what they need
- Recognizing social structure and impact of determinants of health

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Facilitating patients' transitions between care providers and organizations (case examples)

#1 An 80-year-old retired school teacher visited the emergency department four times in a month for exacerbations to a mild heart failure condition, twice requiring hospitalization. When provided with discharge instructions, she is able to repeat them back accurately.

However, she doesn't follow through with the instructions after returning home because she has not yet been diagnosed with dementia.

As the Patient Navigator working in the Emergency Department, how would you handle this situation?

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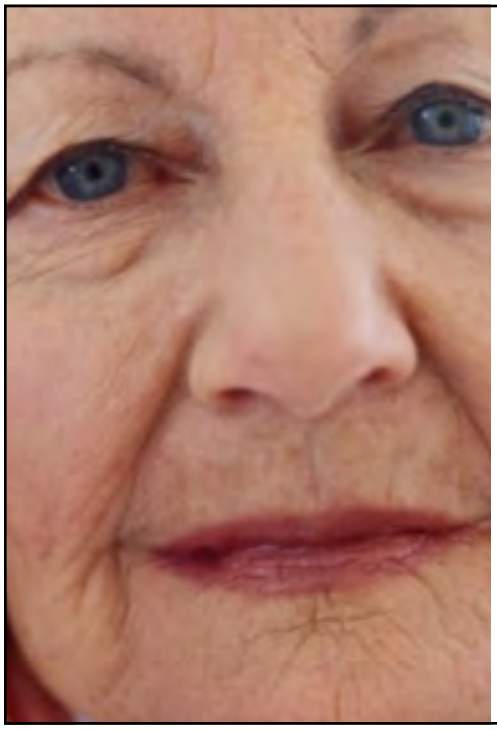
Facilitating patients' transitions between care providers and organizations

#2. A 68-year-old man is readmitted for heart failure only one week after being discharged following treatment for the same condition. He brought all of his pill bottles in a bag; all of the bottles were full, not one was opened.

When questioned why he had not taken his medication, he began to cry, explaining he had never learned to read and couldn't read the instructions on the bottles.

As the Patient Navigator, how would you handle this situation?



Facilitating patients' transitions between care providers and organizations

#3. After falling at home, a 78-year-old woman received three new prescriptions from her primary care physician because during the exam her blood pressure was 164/90. The doctor instructed her to start taking the new medication for hypertension the same day, and to stop taking her current blood pressure medication the following day.

When asked whether she had any questions about the new medications, she replied that she understood and didn't have any questions.

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Continued...

- Two days later, the home care nurse came to see her. The patient complained of a headache and dizziness, and the nurse noted that she had a blood pressure of 190/96. When the nurse asked what medications she was taking, the patient said she had stopped taking her "old blood pressure medicine, like the doctor told me to."

When the nurse asked about her new medication for hypertension, the patient became upset, and said that she didn't have them yet.

When the nurse asked why not, the woman's husband said, "We are waiting for the pharmacy to deliver them". The nurse called the pharmacy, discovering they did not have the new prescription in their system.

As the Patient Navigator, how would you handle this situation?

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These examples demonstrate patients falling through the cracks in the care setting, due to:

- Inadequate risk assessment
- Lack of communication
- Education breakdowns
- False assumptions made by care providers.

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What your role is NOT:

- Problem-solving is PART of your role;
- but you are NOT going to have all the solutions.

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“Homework”/Next steps:

Before we meet for the next live session, please watch the recorded presentations (links on the course page), and respond to the discussion questions. Your responses are part of your overall course attendance.

1. Stigma & Chronicity
2. Communication Breakdown
3. Examples of Patient Navigation models (creating efficiency)

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Stigma and chronicity:

Under the bridge: lost in plain sight.

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The need to recognize our changing envrionment.

- Those “under the bridge”: marginalized by poverty, frailty, culture, literacy, depression/mental health and other chronic conditions;
- On-going barriers in accessing appropriate healthcare support;
- Healthcare professionals and systems have challenges in understanding and addressing the needs of these individuals/groups;
- Costly (and often unsatisfactory) resource utilization.



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- “Chronicity” implies an on-going condition based on a medical model of disease state.
- The indvidual with a chronic condition becomes connected to the identity of the condition.


- The result can be a loss of personal identity, sense of isolation, powerlessness, depression, etc.
- Marginalized individuals may experience more significant losses as they are not only connected to the identity of the chronic condition, but also to the stigma of their marginalized state.

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Our patient population crosses over acute care, community and long-term care and all those cracks in between:

- Recognition of the impact of marginalization
  - For patient, family, community
  - For healthcare providers/systems

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Important to recognize, before offering services:

- Individuals who have been marginalized through the stigma of chronicity are less likely to successfully interact with healthcare providers/system to achieve healthy outcomes.
- Improved understanding and acceptance of marginalized individuals as collaborators in care planning and delivery will help drive system-change to ensure improved engagement and access to healthcare.

Living with multiple chronic conditions

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Relevance:

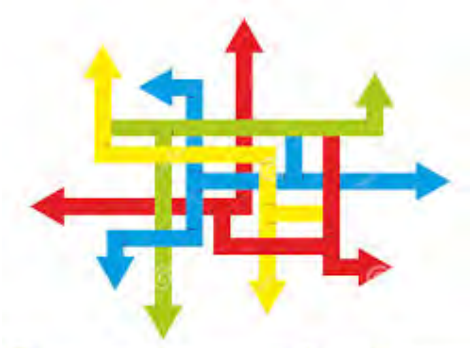
- The populations experiencing both stigma and chronicity are at high risk of requiring significant health resources over the course of their lifetime.
- In addition, these individuals may have significant challenges in establishing relationships with healthcare providers in a way that affords optimal support and engagement.
- Successful healthcare outcomes require authentic collaboration on the part of the healthcare team-- which includes the patient/family/community.
- Co-created interventions will serve to establish and support autonomy and self-actualization.

What do we need to prepare for?

- What are the complex healthcare needs of our population?
  - inclusion of factors such as: chronic disease, depression, poverty, other social determinants of health, substance abuse, culture, new immigrants, LGBTQ ...

What are the healthcare challenges facing your patient population?

- ❑DIABETES
- ❑MENTAL HEALTH
- ❑DEMENTIA
- ❑TECHNOLOGY DEPENDENCE
- ❑PALLIATION
- ❑SURGERIES



Consider who you have described as your patient/client population. Describe the challenges they face?

" The single biggest problem in communication is the illusion that it has taken place"

--George Bernard Shaw

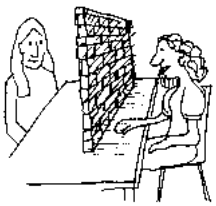
Communication Breakdown:

Communication method-- whether verbal, recorded, or written – is ineffective when:

- Expectations differ between senders and receivers of patients in transition
- Culture does not promote successful hand-off (e.g., lack of teamwork and respect)
- Inadequate amount of time provided for successful hand-off
- Lack of standardized procedures in conducting successful hand-off, e.g. use of SBAR (situation, background, assessment, recommendation)

Patient education breakdown

(more about this tomorrow):



- Conflicting recommendations
- Confusing medication regimens
- Unclear instructions re: follow-up care
- Patients and caregivers are often excluded in any meaningful way from the planning related to the transition process.
- Patients may lack an adequate understanding of the medical condition or the plan or care-- as a result, they do not buy into the importance of following the care plan, or lack the knowledge or skills to do so.

Accountability breakdown.

- Often, with episodic care, there may be no “Most Responsible Physician/Other” to ensure the patient’s health care is coordinated across various settings and among different providers.
- When multiple specialists are involved there may be no coordination or effective communication.
- Primary care providers may not even be in the loop, so lack the ability to know where the patient is in the healthcare system.
- This creates confusion for the patient and those responsible for transitioning the care of the patient to the next setting or provider.
- Minimal discharge planning/risk assessment does not ensure patient and family have both the knowledge and the resources set up to manage – either at home or at the next setting.

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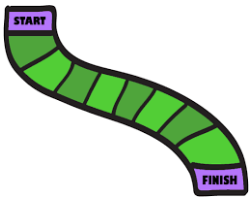
Patient Navigation role:



- Member of the multidisciplinary team: supporting communication, collaboration and coordination – including patient/caregiver education – from admission through transition.
- Could include (in hospital/clinic) regular roundings/meetings, follow-up with patient/family re: ensuring care plan is understood; connecting with team to identify gaps.
- Identification and contact info re: key members of the team (e.g., clinic nurse; Primary Care Provider office #).
- Discharge planning from the start, which includes risk assessment.

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Risk factors for patients:

- Low literacy
- Recent hospital admissions
- Multiple chronic conditions
- Multiple medications
- Limitations in the home environment (transportation, food, etc)
- Potential risk: transition access to medications or equipment as required.

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Discussion: Creating efficiency

"Navigators may fill some of the cracks in a system, but they cannot be expected to fix systems that are truly broken. We need to make sure our systems are facilitating the work of navigators so they can truly bridge some of those gaps." *Dr. L. Shulman, speaking at a U.S. national workshop on Patient Navigation in Oncology, 2018*

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Building Your Framework for Patient Navigation:

- facilitating patients' transitions between care providers and organizations
- creating efficiencies in care integration and coordination among multiple providers and organizations, and
- ensuring that a patient's individualized health and social needs are adequately met.

Let's go back to the examples we discussed this morning.

Consider how you can create efficiency and meet the patient's individualized health needs.

Where will HAND-OFFs be important?

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Organizations "should" have:

- Standardized transition plans, procedures and forms.
- Standardized training for staff.
- PATIENT NAVIGATORS to provide:
  - Timely follow-up, support and coordination after the patient leaves a care setting.
- Evaluation (Outcome Measures):
  - If a patient is readmitted within 30 days (track patient, not diagnosis).
  - Identify outcome measures to provide benchmark (patient/Primary care/organization-related): standardized patient surveys not always effective.

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Efficiency essentials:

1. Shared accountability across providers and organizations
2. Healthcare provider engagement
3. Patient & family engagement/education
4. Transition planning
5. Information sharing/transfer
6. Follow-up care (appointments, etc)
7. Medication management
8. Clear communication (documentation)

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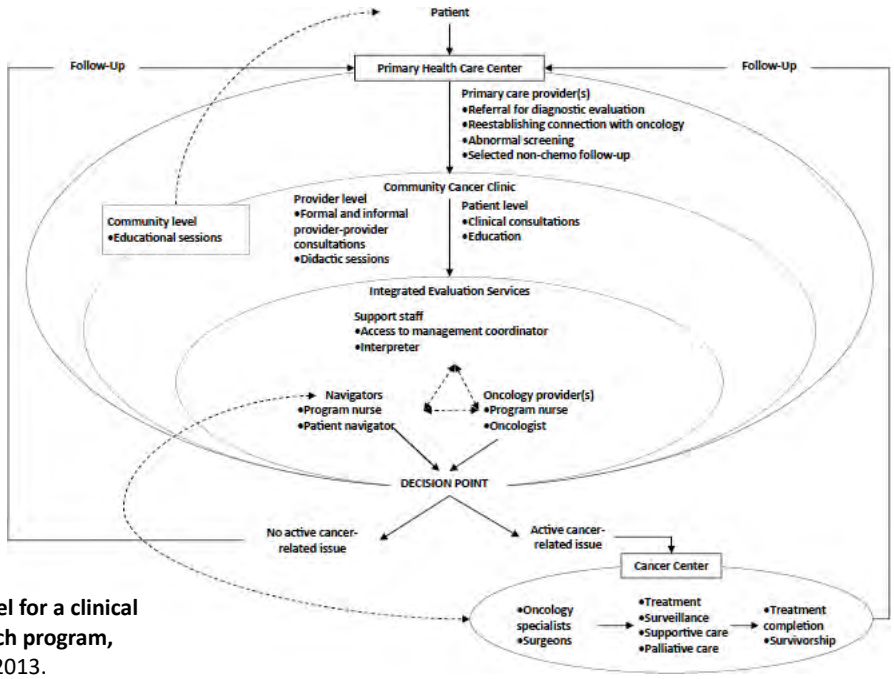

Conceptual model for a clinical oncology outreach program, Waldham et al., 2013.

Navigator Role

- Provide informational support
- Facilitate links to healthcare resources
- Facilitate decision-making
- Provide emotional support
- Facilitate seeking of practical assistance
- Identify & develop community supports

Informed by:

Patient and Family Needs

- As presented by patient & family
- Identified by navigator

Health System Gaps

- Initial diagnosis
- Reintegration into community
- Newly diagnosed palliative patients

Expected Outcomes:

- Improved patient emotional and informational preparedness for treatment and post-treatment coping
- Improved patient self-efficacy
- Greater patient satisfaction with health care
- Reduced patient use of emergency resources & specialist time

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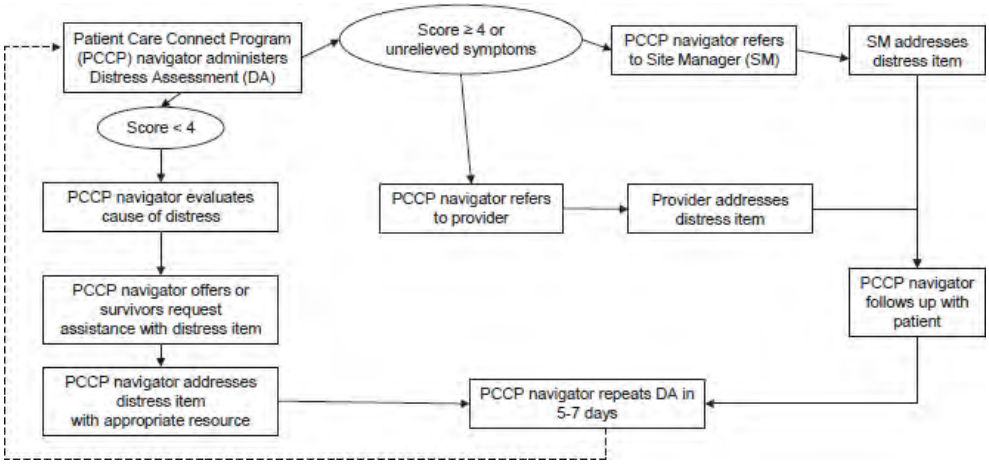
Patient Care Connect Program (PCCP) care map

Rocque et al., 2016



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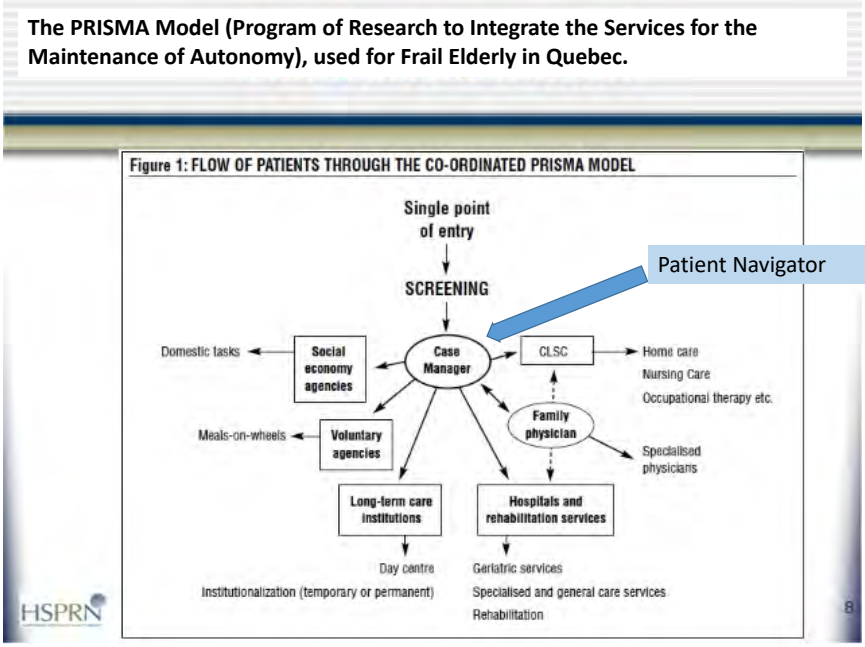
The PRISMA Model (Program of Research to Integrate the Services for the Maintenance of Autonomy), used for Frail Elderly in Quebec.



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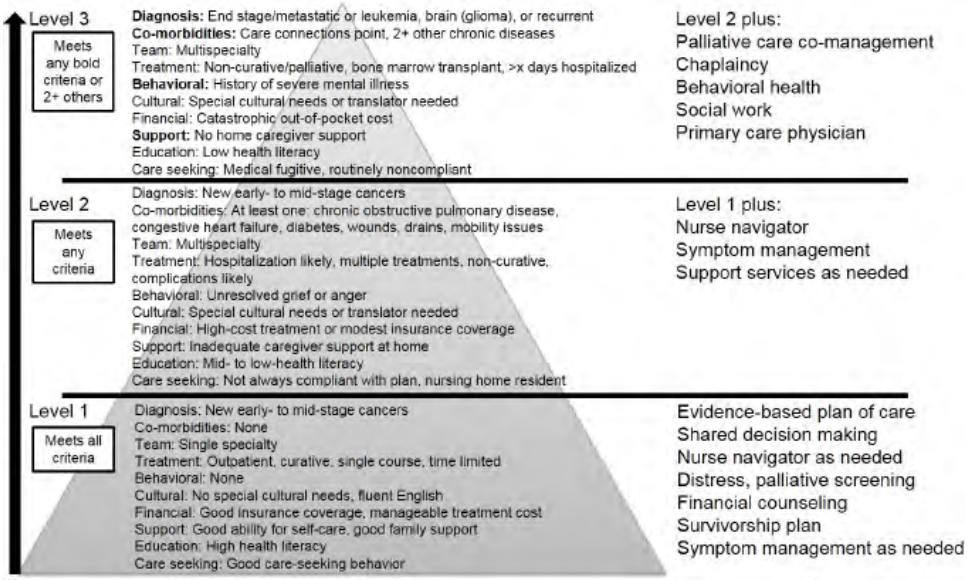
Risk-based model of care/Patient navigation



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Discussion point
Review the models described.

Select one (or more) of the models described in this lecture.

- In a sentence or two, briefly discuss the following factors:
  - Community served
  - Defining the navigation role
  - Communication
  - Sustainability
  - Efficiency
- Would one of these models be useful for patient navigation in your setting?
- If yes, which one(s)?
- If not, describe how your model would be different (e.g., what would be required).

Patient Navigation
Level 2

Session 3 & 4

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Agenda:

Session 3:

- Live discussion/review of responses
- Developing structures for Patient Navigation

Session 4:

- Documentation/measurement
- Implementing Patient Navigation
- Wrap-up/Evaluation

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Day 2, Level 2

Ensuring the patient's individualized health and social needs are met:

- Support in "bad news" situations
- Health literacy
- Protocol and communication structure for Patient Navigator (e.g., healthcare appointments, etc)
- Framing the professional relationship: from start to finish
- Documentation and responsibility in information sharing/confidentiality
- Wrap up/key take home messages

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Support in "Bad News" situations:

Dr. Robert Buckman stated, bad news is "any news that drastically and negatively alters the patient's view of his or her future."

Others suggest that "losses may take many forms:
a loved one's death; devastating diagnosis which shatters hopes, dreams, aspirations; disability; impairment; or poor prognosis confirming or confronting the recipient's worst fears."

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Recognizing response to stressors: Different for different people.

- What are the Social Supports:
  - Structural
  - Funtional
  - Subjective
- Educational level
- Emotional support
- Past experiences
- Locus of control (active/passive)
- Stage: going from “OMG” (emotional coping)→ problem solving

LIST SOME COMMON REACTIONS TO STRESS OR BAD NEWS

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Bad news...

- Go at their pace, with appropriate language, minimal use of medical and technical jargon.
- Pause. If need be, repeat the information.
- Allow time for people to express feelings. Be aware of your own and other people’s body language.
- Check regularly that information is understood and repeat when necessary.
- Information must be given honestly but sensitively, without euphemisms.
- It may be useful to use drawings, diagrams, or provide pamphlets (with discussion) to reinforce the information, if appropriate.

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Stressful situations:

- Any concerns raised are addressed
- Written information should be given with useful contacts and numbers
- Don't be afraid to say, "I don't know."
- Be empathic and also aware that casual or placating remarks (such as, "It's not so bad") are generally not helpful
- Reassure that the person is not expected to remember or understand all the information
- Encouraged them to connect with you if they need clarification
- If appropriate, follow-up meetings should be offered
- And, if appropriate, a check-in phone call/text might be useful

Videos to watch and respond:

The Patient Navigator role may be as a patient advocate, but with additional responsibility to help "unpack" bad news.

Watch these 2 videos.
Comment on ways in which the Patient Navigator can respond to diffuse the stressful situation.

Stress can make for a Difficult Patient

Delivering bad news: compare approaches

Health Literacy:
What do we mean & how do we achieve it?

"Health Literacy: The ability to access, comprehend, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-span."

Public Health Agency of Canada (PHAC)
Rootman et al. A vision for a Health Literate Canada, 2008

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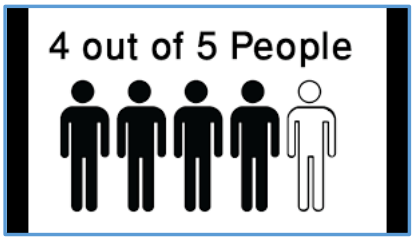
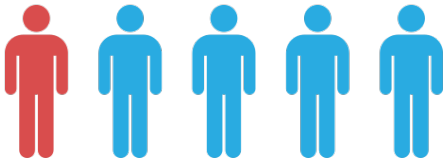
Importance of Health Literacy:



have at least one modifiable risk factor for chronic disease

47% of Ontarians have LOW health literacy

At least 1 in 5 Canadian adults



live with at least one of the major chronic diseases.

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Importance of health literacy:

In particular: cultural competence and stressful events

- the aging population
- immigrants
- individuals with issues re: social determinants of health

- Need for pay attention to prevention and chronic disease self-management, including:
  - lifestyle adjustments
  - understanding and using complex medical and medication regimen
  - knowing where and how to access health care services
  - communicating health care information across the health care system

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Health Literacy

- Individual health literacy:
  - Having the skills to find, understand, evaluate, communicate and use information.
- Healthcare professionals:
  - Present information in a way that increases understanding and the ability of people to act on the information provided.
- Systems are health literate when:
  - Access to healthcare/information is universally clear and stigma-free

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Consent to treatment: 1 or 2?

1.

"I, __ hereby authorize _____to perform the proposed procedure(s) described below (including all preliminary and related procedures, and any additional or alternative procedures as may become medically necessary during the course of the diagnostic procedure and/or treatment)."

WHICH ONE IS AT A HEALTH LITERACY LEVEL APPROPRIATE FOR MOST PEOPLE?
1 or 2?

2.

"Your doctor has proposed this treatment. You have the right to decide whether to accept this treatment or not. If there is anything you do not understand, ask the doctor or health practitioner.

- The doctor or health practitioner has fully explained to me:
- What the treatment is
- Why the treatment is needed
- How the treatment may benefit me
- What risk and side effects are possible
- What other choices for treatment I have; and
- What may happen if I do not have the treatment"

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Focus on the Key Messages:

- Limit to no more than 3
- Identify the "need to know" rather than the "nice to know"
- Include resources and other cues to help the patient build their knowledge and understanding.

CHECK IN: DID THE PERSON UNDERSTAND?

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Use patient-friendly materials to enhance teaching/information sharing/resources.

Given your patient population, what would be useful resources and methods to have available?

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Learner:	Preferred Method Of Learning:	List Major Learning Needs:	Possible Barriers to Learning:	Readiness to Change Stage:
❑ Patient ❑ Spouse ❑ Parent ❑ Children ❑ Significant Other ❑ Guardian ❑ Caregiver	❑ One to One ❑ Group Setting ❑ Classroom Instructions ❑ Demonstration ❑ Film/Video ❑ Written Instructions ❑ Brochures/Pamphlets ❑ Other	❑ Diet ❑ Physical Activity ❑ Diagnostic Tests ❑ Disease Process ❑ Medications ❑ Treatment Options ❑ ADL's ❑ Mental Health ❑ Medical/ Health Literacy	❑ Vision Impairment ❑ Hearing Impairment ❑ Cultural/ Religious ❑ Emotional ❑ Language ❑ Physical ❑ Cognitive ❑ Financial ❑ Time constraints ❑ Transportation ❑ Not interested ❑ Other _____	❑ Unaware of problem, no interest in change ❑ Aware of problem, recognizes need for change ❑ Beginning to think of changes to make and recognizes benefits of change ❑ Actively taking steps toward change

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The Impact of Health Literacy

- Health Literacy examples
- Health Literacy and cultural understanding

Watch these 2 videos.

Please comment on:

What aspects of health literacy are relevant for your role as a Patient Navigator?

In what ways could health literacy be supported in healthcare organizations/agencies ?

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Session 3

Developing structures: protocol and communication

- Identifying components of the role
- Prioritizing activities
- Recognizing limits
- Delegation

Components of the role

- What are the components of your role?
  - At what point do you interact with the patient?
  - What are you expected to be able to do?
  - Where is there "hand-off"?
  - How do you document what you do?
  - How do you ensure follow-up for the patient?
  - How do you evaluate the effectiveness of your interaction?

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Realistic Activities?

Yes/No

Which would be the most important activities to respond to the identified Patient Navigator function?

Poll:

Function	Activity
Facilitates communication between patient/family and healthcare providers	1. Provides or facilitates the provision of language interpretation
	2. Interprets clinical information to patients
	3. De-mystifies the healthcare system for patients
	4. Facilitates/provides patient/family/community/cultural/ historical information to enhance care planning
	5. Participates in rounds, bed meetings/discharge planning meetings
	6. Connects across service silos to help navigate the system
	7. Connects acute care with community based health services to ensure follow through with treatment plans

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"Diabetes is a major issue in the community.
The health centre wants to screen for diabetes and provide follow-up for those at risk.

Example of Objectives/ Activities

- Increase preventive screenings.
- Build one-on-one rapport with the target patients.
- Provide education to patients about the importance of preventive screening
- Decrease barriers to accessing the health care system
- Ensure that patients make it to the screening appointment
- Measure screening results outcomes over time

Breakout Activity

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Activities:

- Ensure informed patient consent
- Identify eligible/at risk patients
- Provide outreach to at-risk patients
- Meet with community networks to 'spread the word'
- Work with community members to identify availability/barriers such as transportation, child-care, etc.
- Network with members of the team to support patient attendance
- Follow-up with "no-shows"
- Review daily schedule/pull charts of appropriate/flagged patients
- Place referral or reminder in chart for MRP to complete (as needed)
- Educational materials geared to the needs of the patient (health literacy)
- Track screening results
- Meet with team members to review results
- Provide feedback to community networks

Prioritizing Activities:

e.g., streamline patient referrals/appointments

Goal: Assist patients with scheduling appointments

- Ensure referral goes & is received
- Provide patient with info to prepare for the appointment
- Provide education to patient re: screening/other procedure
- Provide clear directions to referral location.

WHO DOES THE JOB:

Navigator: Health Care Professional

Lay Navigator activities

- *Could also be automated*

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Reminders and Follow-up

- For scheduled appointments, phone call (2 days in advance; day of– if needed);
- Appointment not made: follow-up with referral and patient
- Document contacts, interventions and outcomes.

WHO DOES THE JOB:

Navigator: Health Care Professional

Lay Navigator activities

- *Could also be automated*

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On the path for treatment.

- ❑Assess patient's understanding of medical problems and treatment options.
- ❑Ensure timely treatment.
- ❑Empower patient to make informed decisions on their health care
- ❑Assess barriers to receiving recommended care (patient goals)
- ❑Assist patient in overcoming these barriers.
- ❑Facilitate communication: among patient, family members and healthcare providers.
- ❑Coordinate transitions of care between providers and sites.
- ❑Ensure follow-up on recommended procedures and treatment.
- ❑Provide compassionate support.

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What needs to be done for success and smooth access to care:

- Build trust and rapport with the patient through one-on-one interactions, to decrease fears/anxiety
- Assist the patient in managing treatments (clinic/medications, etc).
- Assess patient's best method of learning
- Provide education on treatment(s)
- Identify resources for financial assistance, medication needs, home health care, transportation and other concerns (connect with Team)

If relevant, encourage patient/family to take advantage of groups, classes and other programs for information and support.

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Session 4: On the path for success

The Patient Navigation Role requires:

- Documentation
- Measurement
- Implementation
- Evaluation

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Documentation:

It is the responsibility of the patient navigator to document pertinent information in the medical record*. Documentation in the medical record should include but not be limited to the following:

- Fears/concerns
- Cultural issues
- Religious issues
- Family issues
- Language issues
- Financial issues
- Work issues

- Patient refusal to comply with clinical recommendations.
- Side effects of diagnostic testing or treatment identified by the patient.
- Physical or mental problems expressed by pt.
- Inability of the patient to understand or confusion about recommended screenings, diagnostic tests and/or treatment.
- Inability to contact patient.
- Copies of all written communication to the patient.

**** All significant issues should also be reported to the Primary provider/Team.***

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Measurement: why/when/how?

Why Measure?

- Provides a picture of how effective and efficient something is.
- Helps determine what needs to be improved.
- Compares past to present or benchmarks with other similar settings.
- Can be used to predict utlization.

When should you measure?

- Regularly and realistically

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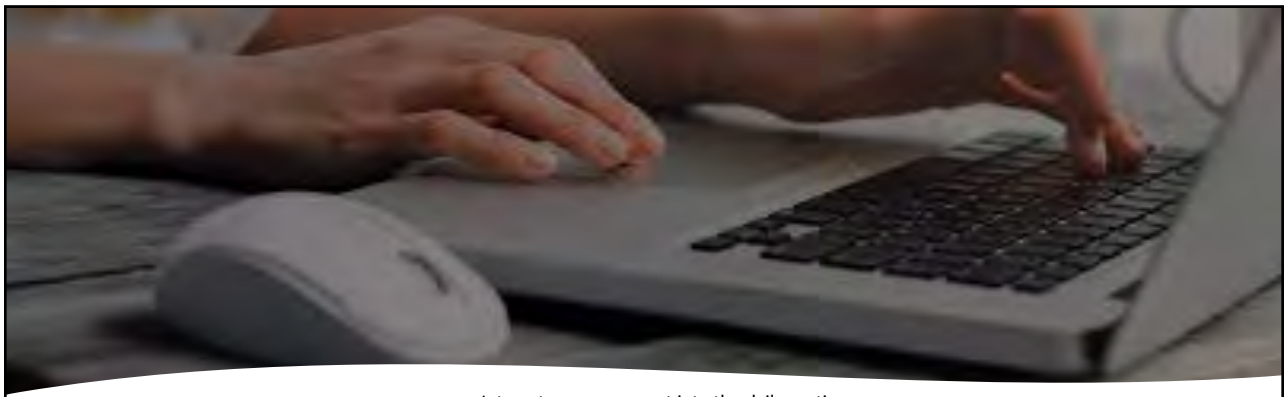

Tips for measurement

- Integrate measurement into the daily routine.
  - Useful data are often easy to obtain without relying on information systems.
  - Develop a simple data collection form and make collecting the data part of someone's job. Often, a few simple measures will yield all the information you need.
- Use qualitative and quantitative data.
  - In addition to collecting quantitative data, be sure to collect qualitative data, which often are easier to access and highly informative.
  - For example,in order to focus your efforts on improving patient and family satisfaction, ask patients and their families about their experience.

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Example of Data collection approach

MEASUREMENT	START DATE	6 MONTHS	1 YEAR
# PATIENTS SEEN			
# ER VISITS			
# MISSED APPTS			
# HOSPITAL ADMISSIONS			
LOS AVERAGE			
PATIENT SATISFACTION SCORE (AVERAGE)			

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Implementation of Patient Navigation

Goals of your program?

- ❑Improved health outcomes
- ❑Better patient experience
- ❑Improved quality measures
- ❑Accreditation
- ❑Other

What kind of Patient Navigation?

- ❑Outreach
- ❑Screening
- ❑Chronic Disease Management
- ❑Complex Medical
- ❑Maternal/child
- ❑Mental health
- ❑Marginalized populations
- ❑Other

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Implementing Patient navigation

Who is on the program team?

- ❑Physician champion
- ❑NP champion
- ❑Administrator
- ❑Allied Health
- ❑Nursing staff
- ❑Social services
- ❑Patient Navigator(s)
- ❑Patient/family advisory
- ❑Other

What is the perceived team commitment and understanding?

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Implementing Patient Navigation

Requirements for the role:

- ❑Training
- ❑Educational materials
- ❑Travel expenses
- ❑Software/internet
- ❑Computer/phone/fax/printer
- ❑Office space
- ❑Other

Current **supportive** resources:

- ❑Social services
- ❑Dietitian
- ❑Home Care
- ❑PT/OT
- ❑Other

Community Resources:

- ❑Support Groups (specify)
- ❑Transportation
- ❑Translation services
- ❑Food banks
- ❑Housing (shelters, etc)
- ❑Service/church groups
- ❑Other

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Implementing the Patient Navigator Role:

Who will provide the role of Patient Navigator?

- ❑Nurse
- ❑Social Worker
- ❑Occupational Therapist
- ❑Lay Person
- ❑Other

What are the primary functions?

- ❑Community Outreach & Education
- ❑Patient Education/Support
- ❑Coordination of Care
- ❑Social service resource
- ❑Other

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Implementing the Patient Navigator Role

Additional activities for the Patient Navigator?

- Quality/Process improvement
- Staff education programs
- Support groups
- Screening programs
- Health Fairs
- Other

Other considerations:

How will you measure the effectiveness of the program?	Patient health outcomesBe specific (e.g., use of ED services, appointment follow-up, etc)	Patient/family experience surveys	Diagnostic screening Follow-up rates
Other ?	**Will you need staff training prior to start of the program/role?**	If yes, who will provide the training?	**Do policies/procedures need to be created or updated? Yes/No**

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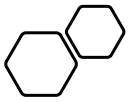

Other considerations:

1. Based on your patient population/demographics, are there any special considerations to meet their needs?
2. Is there anyone else needed at the table? If yes, who?
3. What are the outstanding challenges/barriers to a successful program?

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Putting it all together: Your role as a patient navigator

- What is your "elevator speech" that sums up your role as a Patient Navigator?
- What is your location?
- Who is your patient population?
- How will you share information (to patient/colleagues/other)?
- How will you document information?
- What are key factors identifying success with the role?
- What do YOU need to do to ensure sustainability & success?

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Wrap up

The Patient Navigator **supports patients** who have experienced system barriers and system failures in healthcare **to navigate the care system** and **improve the cultural safety** of their clinical encounters.

In various reports, patients and healthcare providers have identified better communication, better coordination of services and better discharge planning, which results in greater adherence to treatment plans and reducing re-admissions to hospital .

Multiple strategies are required to create effective Patient Navigation programs. The position needs to be clearly defined and supported, the organization must support the position to be effective and Patient Navigators need a forum to come together to learn from and support each other.

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What are your take-away key messages?

Wrap-up: "THE 5 C's"

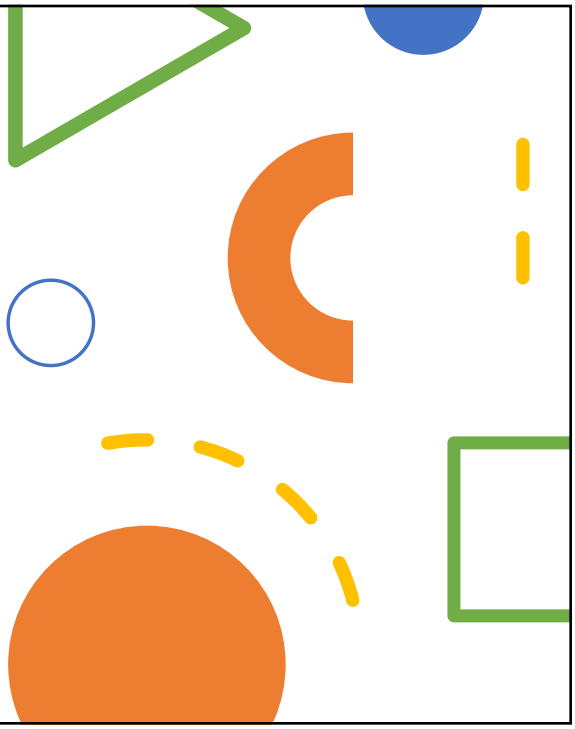
Navigation is a complex activity that requires:

- Communication
- Cultural Competence
- Collaboration
- Continuity
- And Creativity!

Evaluation

- Complete the Evaluation form Link located at the bottom of the course page

- Please refer to the HLLN Course Page for more information on the Digital Badges and Digital Certificate



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