Patient Navigation Certificate

2021

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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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ROSEMARY KOHR

BA, BScn, MScN, PhD, RN

Tertiary Care Nurse Practioner Certficate (1998)

San'yas Indigenous Cultural Safety Training Certificate (2015)

Dr. Rosemary Kohr, PhD, RN, is the Program Director (Wound Care and Patient Navigation programs), Health Leadership and Learning Network (HLLN), York University; Adjunct Associate Professor, Faculty of Health Sciences, Western University; and Instructor in the Masters of Health Sciences/Nursing, Athabasca University.

For nearly 2 decades, Dr. Kohr was an Advanced Practice Nurse/ Acute Care Nurse Practitioner and wound care specialist at London Health Sciences Centre (LHSC). Subsequently, she was the Corporate Program Lead for Wound Ostomy Continence with Saint Elizabeth Healthcare, prior to focusing her attention on teaching and consultation.

Dr. Kohr has a keen interest in improving care delivery across the continuum. Hands-on, clinically focused education for healthcare professionals is central to Dr. Kohr's work. She has travelled across Canada to deliver courses for physicians and nurses; and for the past 5 years, through HLLN at York University, the wound care (Level 1 and 2) courses have provided participants with a simple, standardized approach to dressing selection and best practice in wound prevention and treatment.

With a background in Mental Health (APN, Consultation-Liaison Psychiatry, LHSC) as well as years working the patients and their families from acute care to community environments, she developed and currently facilitates the Patient Navigation program offered through HLLN at York University. As well, much of her work has been informed by her role as subject-matter expert/consultant for government projects in Nova Scotia, Ontario and British Columbia for system-wide wound care revisions as well as consulting on development and implementation of Patient Navigation systems in Ontario.

Dr. Kohr has worked with First Nations/indigenous health centres and clients, to improve patient outcomes. In 2015, she completed the San'yas Indigenous Cultural Safety Training Certificate (Provincial Health Services Authority, British Columbia); and has created and delivered custom courses for First Nations healthcare providers.

Dr. Kohr is one of the founding members of the Ontario Wound Interest Group (ONTWIG). She was Co-Chair of the Seniors Health Knowledge Network group, developing the My Skin Health Passport for Older Adults. For six years, Dr. Kohr was on the Executive (including as President) of the Canadian Association of Advanced Practice Nurses.

Dr. Kohr has presented at over 70 national and international healthcare conferences, and published numerous articles in peer-reviewed journals. She is the author/editor of the Skin and Wound Chapter, Potter & Perry Canadian Edition of Fundamentals of Nursing, and the first Canadian Edition of Perry, Potter & Ostendorf Clinical Nursing Skills and Techniques. Dr. Kohr's PhD thesis, Hearts, hands and minds: The nurse's experience of changing a dressing, is available through the University of Alberta library e-holdings.

Dr. Kohr is a Registered Nurse, and member of the Registered Nurses' Association of Ontario (RNAO).

She can be reached at kohrconsulting@gmail.com

Patient Navigation Level 1

Rosemary Kohr, RN, PhD

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.**

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?

Setting the stage:

- Patients diagnosed with a serious illness today face a vastly different set of circumstances than did patients facing the same illness just a few decades ago.
- Medical care is increasingly sophisticated and more complex:
  - promise of successful treatment & outcomes for what, in the past, were often terminal diseases.
  - Successful treatment often means following complicated care regimens, return regularly to a variety of care providers and successfully cope with a host of challenges along the way.
- Multiple issues (on the bio-psycho-social-cultural-economic levels) may make it unmanageable for individuals to follow prescribed plans of care.

Role for patient navigators:

As medical care continues to grow more complex, care providers recognize the need for support beyond clinical care to achieve success with their treatment.

Where is a role for a Patient Navigator?

What's in a name?

- A consistent title provides better understanding of the role
  - Both for the public and for those working in the healthcare system.
- There are a variety of job titles to describe the role:
  - "health navigators," "patient navigators," "care navigators," "care coordinators," and "health coaches."
- Consider the location and role of the individual
- Need to be able to clearly articulate the role to avoid confusion.

So, what is patient navigation?

- a healthcare service delivery model built around the patient,
- created to reduce barriers to care through the use of individuals who can provide support as patients move through the continuum of healthcare
- Historically, the focus has been on specific disease (e.g., Cancer care) to ensure that barriers to care are resolved and that each stage of care is as easy for the patient as possible.

What are the benefits?

Evidence demonstrates that patient navigators can:

- increase patient satisfaction,
- reduce no-show rates,
- decrease over-use of healthcare system,
- Provide opportunities for new career paths.

What do Patient Navigators “do”?

- Patient navigators, **whose main job is to guide patients through the complex medical system and help them overcome any barriers to care,** are being used in growing numbers to ensure patients successfully complete their treatment.
- So, how does a patient navigator guide?
- How does a patient navigator “overcome barriers to care”?

Exploring your setting.

Pop up poll

1. What is the environment?
2. Who is the patient population?
3. Where does a patient navigator meet up with the patient?
4. When does the interface occur?
5. Who else needs to be involved?

Where do patient navigators work?

- Where there are patients.
- Settings can be: community, hospital, home, primary care, and tertiary care, etc.,
- Remember, the patient (and the system) may not recognize the specific needs of the individual

What can Patient Navigators(PNs) provide?

- For individuals whose chronic health conditions depend on close adherence to a treatment plan in order to be most effective, PNs can:
  - Understand and keep track of diagnoses, appointments, tests and other important information
  - Individuals already struggling to manage the physical and emotional aspects of their illness may find these tasks overwhelming

  - **The navigator provides a consistent point of connection and can work with patients to move around the roadblocks they may encounter.**
  - **Not being emotionally (or physically) impacted by the disease means the Patient Navigator is more able to problem solve objectively.**

“What does it mean?”:

- For patients, understanding a diagnosis and treatment can sometimes be difficult.
- a PN serves an important role in helping patients grasp the many components of their illnesses.
- Navigators can help by breaking down medical jargon so that patients can understand their disease and its treatment.
- As a result, patients can become more engaged in their own care and adhere more closely to their treatment regimen.

Helping patients/families with:

- Understanding treatment and care options
- Addressing barriers to care (e.g., transportation and child care)
- Applications/forms:
  - Insurance
  - Claims
- Finding Primary Care Provider (MD/NP)
- Being a link to the healthcare team
- Accessing resources
- Managing paperwork
- Attending medical appointments

Discussion:
What other situations can Patient Navigators provide help with?

What does a Patient Navigator do, exactly??

- Focus on **task** may create confusion with other healthcare roles
- Role of Patient Navigator more about a focus on perceived barriers to care.
- With this focus, navigation is not about a set of specified services, but about **recognizing barriers for individual patients and identifying strategies to eliminate them**.

Who is a Patient Navigator?

- Health Care Professionals:
  - Usually embedded in organizations
  - May have another title/components of the role in place
  - Focus on particular population (e.g., Labour & Delivery, Frail Elderly, etc)
  - Member of a Regulated Health Care Profession
- Lay Patient Navigators:
  - Supportive role; can straddle settings
  - Experiential knowledge of specific condition (e.g., cancer)
  - Require specific training/coaching
  - Clear parameters/limits to the role

Why have Lay Patient Navigators ?

- Without a lay navigator, many of the tasks that would be considered the navigator's domain are simply not done. Unfortunately, **leaving patients to fend for themselves can negatively impact patient experience and may cause patients to fall through the cracks.**
- Or, when a navigator is not available, it is up to the nurses, social workers or physicians to attempt to assist. While they may recognize the importance of navigation, they just don't have the time to spend...and less time providing clinical care or services that require their specialized training.

Cost effective use of the healthcare team:

- Relying on highly-trained, often costly clinical healthcare providers to asssit with non-clinical services is not efficient use of limited health-care resources (e.g. appointment follow-up, etc).
- Lay navigators are equiped to carry out these tasks, letting the clinicians remain focused on their role.
- Since navigators are not required to have a clinical degree, they are also a less expensive way for hospitals and healthcare providers to ensure their patients are accessing the treatment they need.

Break

We will be using the Zoom Break-out rooms to discuss the Scenarios (you will be assigned to either Scenario 1 or 2)

For each scenario, discuss what you, as Navigator, would do to address the needs of these patients.

You have 20 minutes to

CASE SCENARIOS:
What is the role for a Patient Navigator?

You are the navigator working at the Community Health Clinic where both Mr. and Mrs. Jones have been patients for the past 5 years...

You are the navigator working at the acute care centre where Mr. Powell has been seen in the Emergency Department today...

Scenario 1:

As the Patient Navigator, how will you respond?

- Mr. & Mrs. Jones live in their own apartment
- Mr. Jones has COPD (home Oxygen therapy)
- Mrs. Jones has Parkinson's Disease (medication helps control)
- Mr. Jones was diagnosed with Alzheimer's Disease several years ago and at his last visit to the clinic, it's clear he is deteriorating.

Scenario 2: in the Emergency Department... Or today, at your clinic...

- Aiden Powell, a 57 year old man presents with angina. This is your first encounter with this patient. From his medical history, you see that he suffers from asthma and has a history of high blood pressure.
- He tells you he has not been taking his blood pressure medication or using asthma puffers because he can't afford them (laid off 6 months ago).
- He has been living with his mother (age 85) who has recently been moved to a Long Term Care facility.
- He is anxious and difficult to calm down. He tells you he doesn't know what to do...

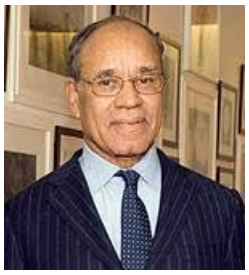
As the Patient Navigator, how will you respond?

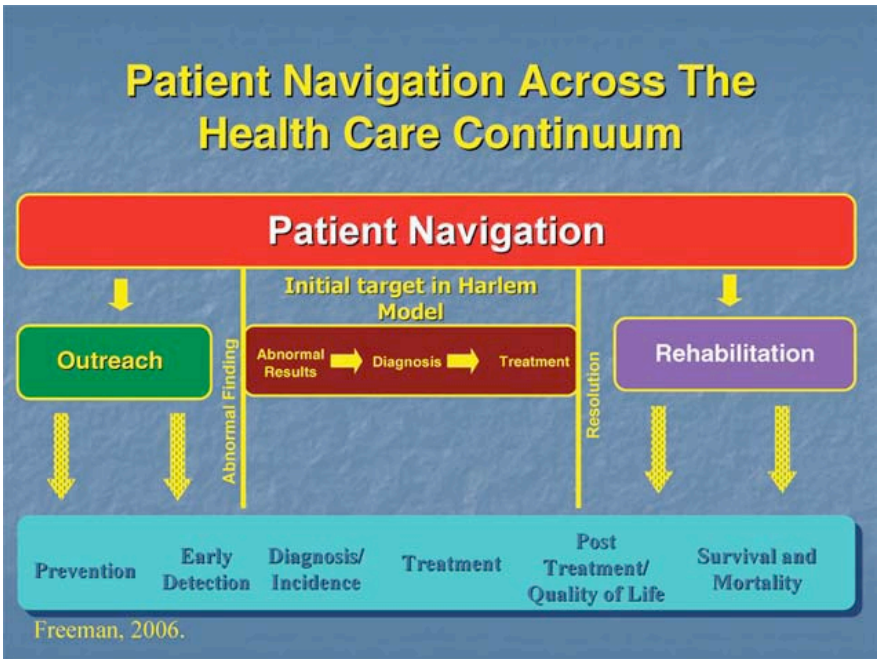
Responsive **and** reactive:

- Patient navigators actively **respond** to their patients' needs and guide them through the healthcare system.
- In patient navigation, relationship-building with the patient/family is the key to ensure patients will be comfortable seeking the help of the navigator when situations arise.
- Yet since patient navigators often respond to difficulties or barriers that have already occurred — or are anticipated — the role can be ***reactive*.**

History of Patient Navigation: The Harlem Model

History: The Harlem Model, 1990: “No patient should spend more time fighting their way through the cancer care system than fighting the cancer itself” Dr. Harold Freeman





Freeman, H. P. & Rodriguez, R. L. (2011). History and principles of patient navigation. *Cancer, 117*(15), 3539-3542.

History and role of navigators...

- Initially, patient navigators were introduced to assist cancer patients and their families deal with the complexity of the cancer care system.
- Research in the US and in Canada demonstrated that cancer patients five-year survival rate **increased from 39% to 70%** when patient navigators were involved in care.

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Expectations of a Patient Navigator: HCP or Lay Navigator– who does what/when?

1. Navigate the health care system
    - See the “big picture” for the patient
    - Coordinate referral appointments
    - Provide checklists and reminders

2. Navigate interactions/referral visits
    - Improve communication
    - Anticipate and overcome cultural differences
    - Help patient identify resources
    - Assist patient in developing a self-care plan
    - Document activities accurately and efficiently
    - Participate on the healthcare team

Patient-centred Integrative Care:

Going from:

- Fear
- Anxiety
- Mistrust
- Immobility
- Concerns
- Despair
- Passive Acceptance

Going to:

- Strength
- Courage
- Empowerment
- Engagement
- Confidence
- Ownership
- Hope

Smith Center for Healing and the Arts . (n.d.). *Our integrative navigation model*. Retrieved from http://www.smithcenter.org/integrative-patient-navigation/our-integrative-navigation-model.html

Self-directed learning
this afternoon and tomorrow morning

- Please watch/listen to the recorded lectures (with interactive components) before tomorrow's live session at 1pm
- There are questions following each lecture for you to respond to (see link on the web-page)
- Your response is part of your course attendance (in other words, please make sure you provide your response)

Overview of the Canadian Healthcare System

What do we need to know to navigate the “system”.

Healthcare in Canada:

- no single, national health system
- 14 single-payer, universal and public systems:
  - 10 provinces,
  - 3 northern territories
  - Federal government
- primary and supplementary health services are delivered to provincial/territorial residents and to specific groups: First Nations, Inuit and Métis, RCMP, veterans, military personnel and inmates in federal prisons
- Collectively, this is our Medicare system, with access to healthcare providers (MDs, hospitals, etc) and is paid for by governments **through Canadian tax contributions**
- **Medicare is NOT "free"!**

The Canada Health Act (CHA)

Goal of Medicare (embedded in the CHA):

- “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers” (Government of Canada, 1984).
- Provinces and territories must follow the CHA or risk losing federal transfers.

Acess for all Canadians re: *need* rather than ability to pay:

1. public, non-profit administration (although facilities and services are not necessarily publicly owned and operated)
2. comprehensive coverage (of the physician, hospital and dental services that are deemed 'medically necessary')
3. universality (everyone is covered and receives the same standards of care)
4. portability (everyone is covered wherever they go in the country), and
5. accessibility (or free at the point of delivery without co-payments, deductibles or annual limits).

Deep but narrow provision of services:

Focus has been on hospital & access to MDs

- Supplemental healthcare costs (e.g., prescription drugs, home care and long-term care) have varied combinations of payment:
  - Personal household out-of- pocket payments*, (14.4%)
  - Private/commercial/not-for-profit insurance (12.3%)
  - Direct public finanancing (approx. 70%)
- Supplemental coverage varies by province and territory
- Private insurance plans– costs have dramatically increased for these plans.

*Out-of-pocket health expenditure more than $970 per person (2017)

Reference: National Health Expenditure Trends, 1975-2019

https://www.cihi.ca/sites/default/files/document/nhex-trends-narrative-report-2019-en-web.pdf

Deep and narrow service leads to challenges:

- **Variable access** to non-core services such as rehabilitation and home care, depending on income and provincial funding;
- **Disjointed/non-existant transitions** between services;
- People with chronic illness, disabilities or on-going care needs, such as the elderly or those with disabilities, often need a range of services and ways to access at different times/points of care
- Disruption in care delivery, and/or requirement for individuals to pay for care directly (out of pocket), both the individual and the healthcare system suffers.

Canada Health Transfer

- Canada Health Transfer (CHT) is the support amount the federal government pays out (cash contributions and tax transfers) to the provinces and territories.
- If provinces/territories abandon the CHA principles (by imposing user fees or allowing extra-billing by physicians) the federal government can enforce a penalty.
- Federal health transfer payments to provinces and territories have grown steadily from $20.3 billion in 2005 to $40,373 billion projected for 2019-20 (base numbers, not including equalization/other additional payments)
- Reference: https://www.fin.gc.ca/fedprov/mtp-eng.asp

Impact of the ‘enrichment factor’:

- Population growth, population aging, income growth and inflation are measurable and predictable contributors to healthcare spending.
- Significant amount of **unmeasured growth**, called the ‘enrichment factor.’
  - advances in medical science and innovations in technology (e.g., robotics, MRI),
  - alterations in disease patterns (e.g. increases in chronic diseases and mental illnesses),
  - patient behaviours and preferences.
- **How does the enrichment factor effect value for service (and cost) of our healthcare system?**

More confounding issues:

- Federal government is responsible for collection and dissemination of health data, major funding of health research, some public health programs and health protection (including pharmaceutical regulation).
- Provincial/territorial responsibility is for majority of health service delivery, provided in a service delivery model that is 'discretionary' (e.g., "Super-groups", regionalized or decentralized).
- Change in healthcare delivery system is costly in the change-phase, but may reduce costs over the long-term.
  - E.G., Hospital/local boards replaced with regional authority mandated to better integrate and coordinate the provision of services across the continuum of care;
  - Ontario Health Teams (OHTs) to provide more holistic, collaborative care.

Health disparities in Canada

- Socioeconomic status, Aboriginal identity, gender (female) and geography (rural and northern communities)
- Most affected: lowest 20% on the socioeconomic scale and Aboriginal peoples, including First Nations and Inuit populations.
- Needs of the chronically ill and an aging population, especially at a time of fiscal constraint.

Result of the current state of healthcare:

- Increasing pressure to re-design care to respond to the growing need for community care, prevention services, and chronic disease management.
- Where Patient Navigation can be positioned...
  - Consider the CURRENT SITUATION:
    - GAPS
    - HOW CAN THE GAPS BE BEST MANAGED,
    - HEALTH-CARE NEEDS OUTSTRIPPING FUNDING PROJECTIONS.

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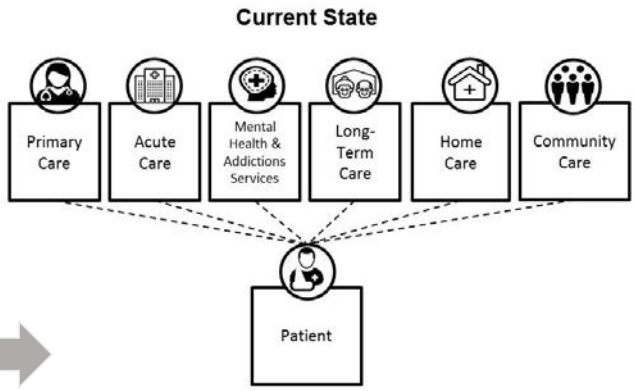
Ministry of Long-Term Care



Source: Ontario Ministry of Health and Ministry of Long-Term Care website

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Ontario Health Teams 2020:

- A new model of “seamless, integrated care” intended to address issues of gaps in service across the continuum of care, reduce wait-times, provide coordinated care for patients and improve patient outcomes.
- 24 OHTs have been identified, based on applications submitted to the Ministry of Health

•All Nations Health Partners
•Brampton/Etobicoke and Area
•Burlington Cambridge North Dumfries
•Chatham-Kent
•Connected Care Halton
•Couchiching
•Durham
•East Toronto (East Toronto Health Partners)

- Eastern York Region
- North Durham Guelph and Area Ontario Health Team
- Hamilton (Hamilton Health Team)
- Hills of Headwaters Collaborative
- Huron Perth and Area
- Mississauga (Mississauga Health)
- Muskoka and Area

•Near North Health and Wellness
•North Toronto
•North Western Toronto
•North York (North York Toronto Health Partners)
•Northumberland
•Ottawa (Ottawa Health Team/Équipe Santé Ottawa)
•Peterborough
•Southlake Community

Identifying GAPS in care.

Discussion:

- Looking at your setting, what gaps in care do you identify?

Needs and priorities of patients and families

"Complex" is not just a word...

What is the environment like?

- Decreased quality of care, compared with the acute illness patient
  - both patient experience and healthcare outcomes.
- Gaps in communication:
  - Healthcare providers don't share info across the continuum of care (including medications)
  - Coordination of treatment plans & appointments
  - Over-use of ERs to manage problems (multiple problems and care-providers)
- Increasing numbers:
  - increase in the next two decades as the baby boomer population continues to age and develop chronic diseases.
- Major users of health systems:
  - 5% accounts for over 65% of Ontario's combined hospital and nursing home costs, as well as 84% of combined acute care and home-care resources.

Examples of when/how navigation would help.

health navigator in heart transplant

Patient Navigator in cancer care

High-cost users who would benefit from Patient Navigation

SITUATION	Regulated HCP Patient Navigator	Lay Patient Navigator	Supports: On-going/sporadic
Repetitive crises, frequent hospital use not warranted			
Transition from one setting to another (e.g., Child to Adolescent- to Adult; home to LTC; to Palliative)			
Ongoing Medical Crisis where frequent hospital use is warranted			
Frequent hospital use due to too many providers without coordinated plan			

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1. **Repetitive medical/social/psychological crises:**

a) Frequent hospital admissions can be avoided

b) Management:

- Developing a deeper understanding of the person
- co-planning regarding access to care, crisis management, improved social context (housing, income, transport, relationships), or better services to offer more positive outcomes.

2. **Transition to Palliative:**

a) A 'frame shift' conversation and plan to help moving from acute care to a more palliative approach with advanced care planning

b) Careful transition to end-of-life.

3. Ongoing Medical Crisis where frequent hospital use is warranted:

a)The patient has a serious medical problem that does require a lot of active treatment or workup, and no outpatient options or prevention plans seem appropriate at this time.

b) **Management:**

- Frequent hospital use may be inevitable.
- Consider developing customized social/medical supports to improve quality of life
- Customized plan between providers to improve communication and coordination.

4. Poor links between providers (frequent hospital/healthcare use):

a) Many providers involved, no clear diagnosis or treatment strategy, providers generating excess investigations, referrals, interventions and not communicating with each other.

b) Management:

- Develop a 'stop the madness' conference and plan
- The patient's providers could be fewer or more coordinated in the face of health condition unlikely to improve

5. Medical problem could benefit from more workup and expertise

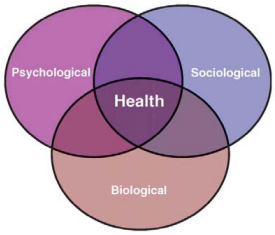
- The patient's needs warrant further investigation or expert opinion to improve their diagnostic accuracy or specific treatment.
- **Management:**
  - Accelerate focused specialist care and investigation towards the patient

6. Transitions are often critical "gap" item:

- From pediatric to adolescent to adult care settings/needs
- From couple to widow-hood (end-of-life)
- From home to LTC
- A new diagnosis of a disease
- ? Others?

Dealing with health disparities: the role of the Patient Navigator.

Vulnerable patients: Socially and Clinically vulnerable.



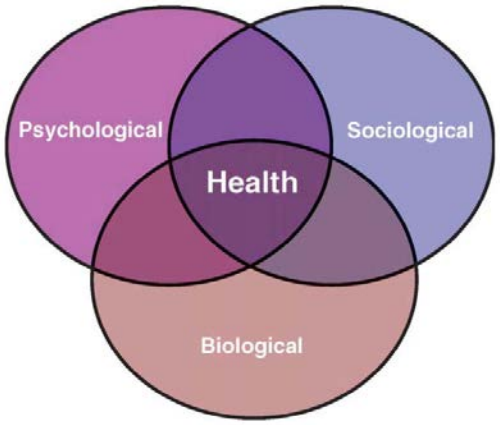
- Live in First Nations community
- Immigrant
- Live in impoverished neighborhood
- Have low incomes
- Have low levels of education
- Have low health literacy
- Reside in rural area
- Homeless
- Non-English-speaking
- Uninsured/underinsured
- Have low social supports

Racial/cultural/religious constraints

- Have complex chronic illnesses
- Have acute serious illnesses
- Have multiple chronic conditions
- Disabled
- Mental illness
- Substance abuse
- Cognitively impaired
- Frail elderly
- Nearing end of life
- Pregnant women
- Very young children
- High-healthcare use patients
- High-cost patients

Who would benefit from Patient Navigation to overcome healthcare system barriers?

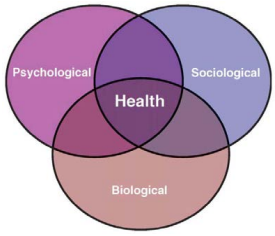
Psychological/Sociological/or Biological disruptions lead to alterations in health – and a driver for individual seeking help.



Bio-psycho-social model of healthcare

Dr. George Engel (1977)

Bio-psycho-social model:



Framework for better understanding of drivers affecting patients:

- taken individually and/or collectively, these factors (societal, psychological, and biological), influence disease morbidity and mortality
- sociological and psychological factors can contribute to the ability of the patient to access and/or adhere to treatment.
- A way to consider health disparities affecting individuals/communities.

Prevention and early detection:

- Bridge the gaps in prevention (early detection)
- Use of screening guidelines (family history and personal risk factors) to flag at risk individuals; increases patients' knowledge of risk/prevention.
- Focus on immigrants and those with lower incomes, with less education/language skills, and without a primary health care provider.
- Patient navigators can connect underserved populations by connecting them to resources most appropriate for each patient's individual needs.

Assessing Health care access

- **Access to care**: entry into or use of the health care system, or the factors influencing entry or use.
- **System factors**: proximity to health care settings/primary care provider;
- **Patient perceptions** of access to health care services (ie, difficulties or delays in obtaining care or receiving appointments for care as soon as desired);
- **Actual use** of health care services (e.g., MD visits, ambulatory care/walk-in clinics or inpatient care.

Patient Navigators: provide access and coordination:

- **Know the local environment**
- Function as *brokers* who can tackle system and environment barriers that disproportionately affect racial and and ethnic minorities.
- Barriers: financial and insurance issues, paperwork and documentation, cultural beliefs and language barriers, as well as issues related to transportation, childcare, and neighborhood resources.
- Coordinate access to services:
  - Focus on individual's needs
  - facilitating communication and cooperation between providers;
  - providing clear information and support to ensure access to care and compliance with prescribed therapies.

Access to Insurance coverage & continuity

- **Access to Disability Insurance**, etc. can be daunting.
- Navigators can play an important role in helping patients gain access to Disability insurance and other health/work-related supports.
- Navigators may play a role in advising patients—particularly those facing severe health literacy in completing necessary applications as well as follow-up.
- Important to know "who to contact": Social Worker, WSIB, etc.

Health Outcomes & health seeking behaviours

Affected by:

- cultural beliefs,
- language,
- acculturation, and
- health beliefs

- Distrust in health care services and providers
- Stigma/lack of respect creates environment where individuals are less likely to be compliant with treatment and are more likely to put off getting medical services.
- **Patient navigation services are ideal to address many of the disparities associated with diversity and culture because they foster trust and empowerment within the communities they serve.**

“Being there” for the patient...

- In a study of patients’ perception of Navigator roles, the providing of emotional support (“being there”) and providing helpful information were described as the most important services received.
- These findings highlight the importance of trust in the patient/navigator relationship. In the study, patients recognized the navigator as existing in two worlds, one as an **insider** to the health care system and the other as a **caring** companion.
- As an insider, the navigator is able to provide patients useful information to assist in accessing and navigating the health care system. In their other role, the patient navigator is a supportive ally to the patient

Developing Trust, decreasing anxiety:

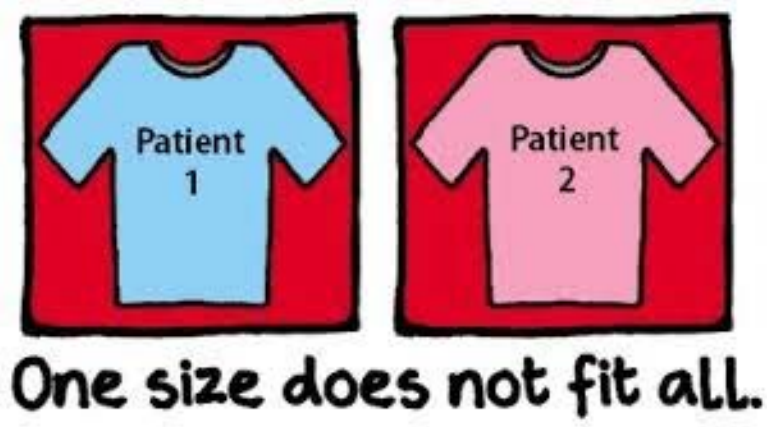
- Patient navigators are the link that will help to extend the **trust** from the patient/navigator relationship to the larger health care system.
- Patient navigator services have demonstrated decrease in anxiety re: medical treatment and have increased patient satisfaction with services received by underserved populations.
- These individuals with patient navigation services have fewer disruptions in care and are more likely to complete required treatment.

Patient Navigators in the community:

- Many of the studies attribute these positive findings to the use of **representative community members** as patient navigators.
- Community member (Lay) navigators can be a resource:
  - addressing issues related to language
  - instrumental in communicating and promoting acceptance of cultural differences to service providers.




Identifying Patient Navigation Roles: who needs what, when.



Different Levels of Navigators (start 0:28)

Assessing Health care access in your setting: what does it look like?

- **Access to care**:
  - how do patients enter the health care system?
  - What factors influence entry or usage?
- **System factors**:
  - What is your patient proximity to health care settings/primary care provider?
- **Patient perceptions:**
  - What are your patients' views of how easy/difficult it is to access health care services (ie, difficulties or delays in obtaining care or receiving appointments for care as soon as desired);
- **Actual use:**
  - What is patient actual use of health care services (e.g., MD visits, ambulatory care/walk-in clinics or inpatient care?
  - If you don't have this information, how could you obtain it?

Assessing healthcare access in your setting:

Access to care	System Factors	Patient perceptions	Actual use of healthcare
• How do patients enter the health care system? • What factors influence entry or usage?	• What is your patient proximity to health care settings/primary care provider? • Influencing factors?	• What are your patients' views of how easy/difficult it is to access health care services • Infuencing factors?	• What is patient actual use of health care services? • If you don't have this information, how could you obtain it?

Patient Navigation

Being a Patient Navigator:

Essential Skills

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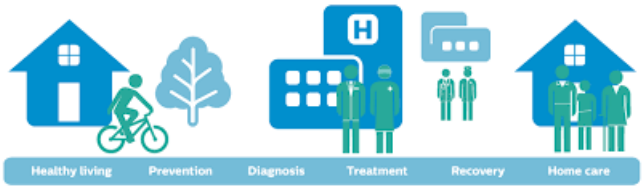
So Let's talk...



Key elements:

- Patient navigation is a **patient-centric** healthcare service delivery model.
- The focus of navigation is to promote the **timely movement** of an individual patient through an often complex healthcare continuum.
- An individual's journey through this continuum begins in the neighborhood where he or she lives, including the care settings **where the individual interacts** with healthcare providers.
- The journey continues with the patient navigator to **achieve the identified goals of the patient**.

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- Patient navigation serves to **virtually (and physically)integrate** a fragmented healthcare system for the individual patient.
- As patient care is so often delivered in a fragmented manner, particularly related to those with chronic diseases, patient navigation has the potential of creating a seamless flow for patients as they journey through the care continuum.
- Patient navigation can be seen as the guiding force promoting the timely movement of the patient through a complex system of care.

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Patient navigator systems need to be in place:

- Patient Navigation systems require **coordination**.
- In larger systems of patient care, this coordination is best carried out by assigning a navigation coordinator or champion who is responsible for overseeing all phases of navigation activity within a given healthcare site or system.
- It is important to distinguish a **system of patient navigation** from the patient navigator(s) who work within the system.

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The process of navigation:

- In a given system of care there is the need to define the point at which navigation begins and the point at which navigation ends.
- There is a need to navigate patients across disconnected systems of care, such as primary care sites and tertiary care sites.
- Patient navigation can serve as the process that connects disconnected healthcare systems.

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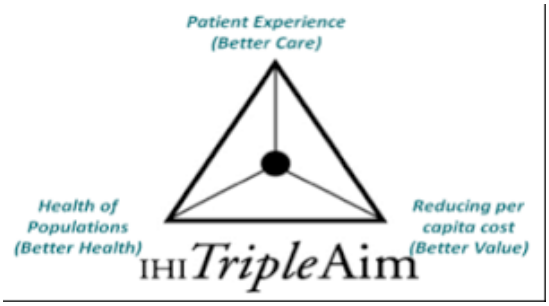
Patient Navigation Expected Outcomes:

- **Patient/family satisfaction:**
  - Decreased worry and frustration
  - Increased sense of partnership with professionals
- **Improved satisfaction with team communication**
  - Staff satisfaction
    Improved communication and coordination of care
    Improved efficiency of care
    Elevated challenge and professional role
- **Improved patient outcomes**
  Enhanced self-management skills
  Access to quality health care
  Increase in access to needed resources
- **Improved systems outcomes**
  Decreased duplication of services
  Decreased fragmentation of care
  Improved communication and coordination



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Conditions re: Patient Navigator role

- Ethical
- Legal
- Professional
- Organizational

- Personal

Patient navigator attributes:

- The Patient Navigator incorporates the following principles into their practice:

- Respect
- Patient Safety
- Confidentiality
- Compassion
- Patient Empowerment
- Cultural competence

(Code of Ethics handout)

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Patient Navigation Boundaries

- **Always work within the treatment recommendations of the provider.** The patient navigator should never give any recommendations contrary to the recommendations of the provider.
- Boundaries are important because the patient navigator is in a position of influence and the patient is in a vulnerable position.
- Over-involvement with a patient can be draining on the patient navigator and can interfere with the important tasks of the job.
- Assess cultural ideas and prejudices. Know your community.

BEHAVIOURS TO AVOID:

Some behaviors that can lead to blurry boundaries and should be avoided are:

- Self-disclosure
- Giving or receiving gifts
- Developing friendships
- Physical contact.

BOUNDARIES TO CONSIDER:

- Set limits on patient interactions (Remember that your involvement is temporary)
- Encourage self-reliance/independence
- Use your supervisor to check yourself
- Address the problem as soon as you recognize it.

Scope of Practice: Who Does What/When?

- Integrated as member of the healthcare team.
- Defined role and responsibilities of the navigator.
- Who should navigate: should be determined by the level of skills required at a given phase of navigation (e.g., lay navigators or nurse/social worker).
- Team roles need to be clearly articulated and understood by all members of the team.
- **Management must have a good understanding of expectations – and support for the Patient Navigation role.**

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Communication is the cornerstone of care.

Effective communication:

- reduces uncertainty
- Helps people feel understood
- Helps people to maintain a sense of control
- Gives people sense of hope
- Provides:
  - a direction to move forward
  - Symptom control
  - Understanding of information
  - Decision-making & abilities to cope

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7 Essential communication tasks:

1. build the navigator–patient relationship;
2. open the discussion;
3. gather information;
4. understand the patient's perspective;
5. share information;
6. reach agreement on problems and plans;
7. provide closure.

Communication challenges.

- **Examples from your clinical practice**
  - **Patient**
  - **Family**
  - **Team**
- Sharing information: who gets to know what/when?
  - What information is being shared or not shared between patient and family/caregivers/Team?

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Communication

- **How** do patients and family/caregivers **want to be involved in information sharing and decision-making?**
- What information about the patient and their family/ caregivers **would be helpful**?

What is this photo telling us?

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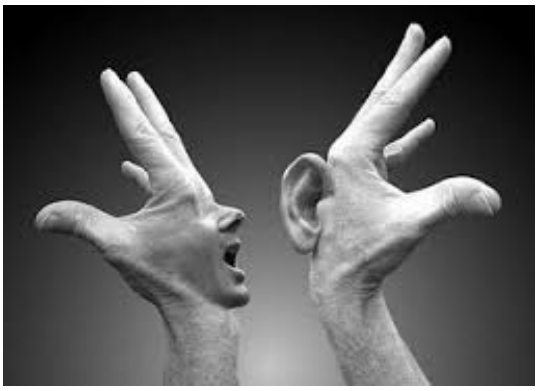
Keeping all this in mind...

You are the Patient Navigator in the following scenario.
How will you address this situation with this individual?
Consider the situation in the context of:
Individual
Family
Environment
Interactions

Case examples: Who needs to do what?

- Mrs. Abigail Santiago, an 84 year old woman with a history of Diabetes, high blood pressure and Peripheral Vascular Disease. Admitted to hospital re: cellulitis. Resolving with treatment. Imminent discharge home. Lives with son (recently widowed, just finishing treatment for prostate cancer).
- Mr. Robert Pinchus. 68 year old with history of falls; MS; lives alone. Referred by Family Practitioner with concerns re: home situation.
- Mrs. Margaret Anderson. 76 year old recent widow, recently moved in with adult daughter's family. Cognitive decline, indentified as dementia (awaiting further work-up). Difficulty managing IADLs.
- Mr. Harry Patel. 92 year old; Congestive Heart Failure; Dementia; End-of-Life. Lives with extended family.

Effective Communication



Effective Communication

1. Non verbal communication:

- Communicate roots in cultural & social traditions, values & beliefs
- Observing people's body language, posture, gestures & facial expressions can provide clues to people's feelings, emotions & capacities for coping
- "Environment of communication":
  - **83% sight**
  - **11% hearing**
  - 3% smell
  - 2% touch
  - 1 %taste

What's going on here?

Personal Space.

Effective Communication: Cultural Sensitivity.

- People's way of thinking, seeing, hearing, & interpreting the world is influenced by their beliefs, values, fears, social & cultural backgrounds

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Cultural Barriers to Communication:

- Language
- Stereotyping
- Behavioural Differences
- Difference in Displaying Emotion

Effective Communication Includes:

Active listening:

- A powerful therapeutic intervention
- Involves ways of listening, giving full attention, expressing empathy, & responding to another person
- Improves mutual understanding

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Active Listening: ensure you are aware of any cultural communication issues

What's appropriate?

- Attentive posture
- Nodding head
- Smiling (genuine)
- Making eye contact
- Be on the same eye-level as speaker

Verbal cues:

" I see…"

"Yes, go on…"

"Uh-huh..."

- Reflective questions
- Summarize "So if I understand correctly..."

Effective **Verbal** Communication:

Facilitating Conversation:

- **Open-ended questions** allow people the opportunity to **describe and express their feelings, thoughts, & concerns**

Effective Communication: Openings

Examples:

- “Many people feel overwhelmed by ... How are you feeling today?”
- “I understand that you have some questions & concerns about... Can you tell me more about that?”
- “What seems to be the biggest worry at the moment?”
- “It’s pretty tough... how have you been coping?”
- “What are your thoughts about next steps (e.g., in your treatment)?

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Effective Communication

Clarifying responses:

- "Can you give me an example of what you are talking about?"
- "Tell me more about …"
- "As you were talking I noticed (difference between words and body language). I wonder if this is actually more [worrisome] for you?

Effective Communication

Paraphrasing & summarizing:

- Let people know that they are being listened to & their experiences are understood
- Provides an opportunity to get clarification

Examples:

- "You said it makes you feel … Have I understood that correctly?"
- "Is there anything else you need, or I can help you with?"

- **Don't be afraid of silence.**
  - **Allow time for reflection, if needed.**

Practice:

- Partner in 2s.
- One person stands, other person sits.
- Person 1 (standing): “How are you feeling today?”
- Person 2 (sitting): *what is your response?*
- *Repeat with both sitting.*

Effective Communication

- Important to carefully & respectfully explore what information is needed; what we may be communicating & what the individual may not be verbalizing.
- Equally important to attend to our own non-verbal communication - how this may impact our attempts to convey respect, compassion & understanding.
- Pay attention to the cultural cues.
- Dealing with the angry/difficult patient

Dealing with angry patients

Communication includes:

Tools or resources to use when sharing information:

- Visual aids, written information, interpreters, presence of a loved one
- Keep in mind:
  - Unfamiliar/stressful setting
  - Cultural experience
  - Language
  - Education level
  - Visual, hearing deficits
  - Over-loading with information

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A Clinical Practice Checklist:

THE **RESPECT** MODEL

- ❑Rapport
- ❑Empathy
- ❑Support
- ❑Partnership
- ❑Explanations
- ❑Cultural competence
- ❑Trust

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Rapport: RESPECT

- ❑ Connect on a social level
- ❑See the patient's point of view
- ❑Consciously suspend judgement
- ❑Recgonize and avoid making assumptions

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Empathy RESPECT

- ❑Remember that the patient has come to you for help.
- ❑Seek out & understand the patient's rationale for his/her/their behaviour.
- ❑Verbally acknowledge and legitimize the patient's feelings.

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Support

RESPECT

- ❑Ask about and understand the barriers.
- ❑Help the patient overcome barriers
- ❑Involve family members if appropriate.
- ❑Reassure your patient you are and will be available to help.

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Partnership RESPECT

- ❑Be flexible with regard to control issues.
- ❑Negotiate roles when necessary.
- ❑Stress that you are working together to address health problems/issues.

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Explanation

RESPECT

- ❑Check often for understanding.
- ❑Use verbal clarification techniques.

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Cultural competence RESPECT

- ❑Respect the patient's cultural beliefs.
- ❑Understand that the patient's view of **you** may be defined by ethnic or cultural stereotypes.
- ❑Be aware of your own cultural biases and preconceptions.
- ❑Know your limitations in addressing medical issues across cultures.
- ❑Understand your personal style and recognize when it may not be working with a given patient.

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Trust RESPECT

- ❑Recognize that self-disclosure may be difficult for some patients.
- ❑Consciously work to establish trust.

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An example using the Empowerment Acutalization Model (EAM)

Case Study: Mrs. M.

- 86 yr. old retired RN, widowed x 10years
- lives alone (apt) in Seniors' Building
- presents in Emergency Dept. with bilateral lower leg cellulitis, ++pain
- hx of CHF
- appears dehydrated & malnourished
- "refusing admission"

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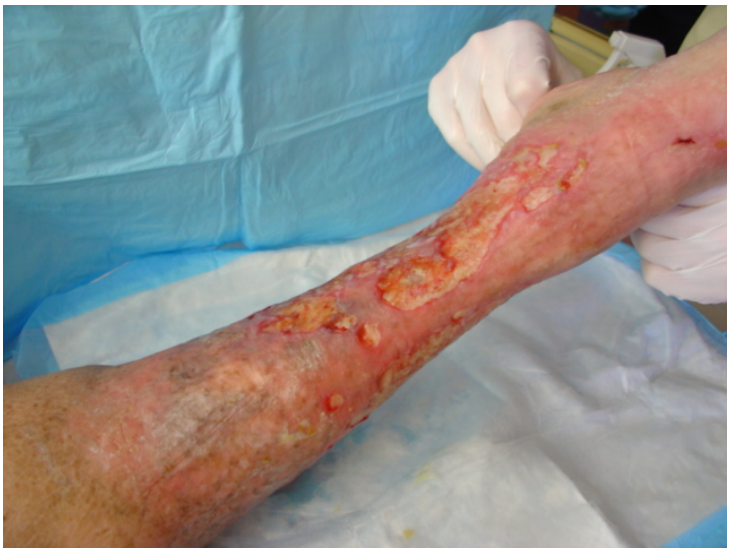
Mrs. M's leg in the ED.



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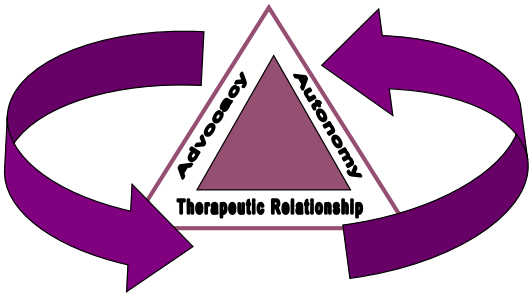
What to do?

- Communicate.
- Deal with the pain.
- Why is Mrs. M. refusing admission?

The Empowerment Actualization Model (EAM): Going from "No" to "Know"

Advocacy **Autonomy**



Therapeutic Relationship

The Empowerment Actualization Model (EAM): Going from "No" to "Know"

Advocacy

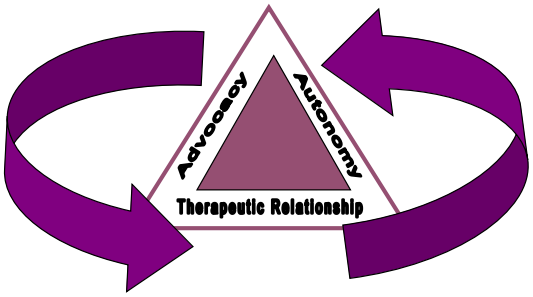
Do what's right for the patient

According to whose terms?

Autonomy

Patient/family chooses what is right

Or do they?



Therapeutic Relationship

Developing rapport, understanding where the patient is coming from;their fears, expectations. *What are they experiencing? How can you help?*

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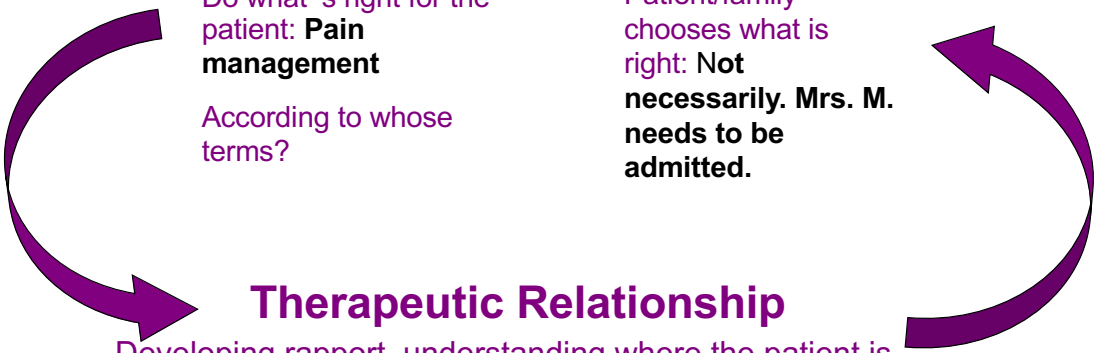
The Empowerment Actualization Model (EAM): Going from "No" to "Know"



Why Mrs. M. was refusing admission to hospital.

Considering Mrs. M, how was *Respect* demonstrated?

THE **RESPECT** MODEL

- ❑Rapport
- ❑Empathy
- ❑Support
- ❑Partnership
- ❑Explanations
- ❑Cultural competence
- ❑Trust

Consequences:

- Patient gets what they need re: medical care and follow-up
- Patient provided with support re: social needs (remember Engel's framework?)

Positive outcome:

- Mrs. M. can go home to her apt. and her cat, resume her independent life.

- **Short term goals:**
  - Admission to hospital
  - Infection and pain dealt with
  - Opportunity to assess risk factors (connect with Patient Navigator in community)

- **Long term goals:**
  - Recognize Mrs. M. will likely need increased help/support (e.g., homecare services)
  - Preventing re-admission
- **Kindness/caring** (interest in patient)
- **Collaboration:** communication with the team (everyone is on the same page and good role-modeling for future interactions like this one)

Communication and confidentiality

- What do we mean by “confidentiality”?
  - Who do we share information with?
  - What does “The Circle of Care” mean?
    - Circle of Care Govt of Ontario document

- As a Patient Navigator, can I discuss:
  - Advanced Directives?
    - Advance Care Plan
  - Power of Attorney for Personal Care (POAPC)?
  - Medical Assistance in Dying (MAiD)?
    - MAiD Min of Health Ontario documents

Team Communication

- Who is on your team?
- Does everyone know what they are doing on the team?
  - **Roles**
  - **Territory**
  - **Communication**
  - **Documentation**
  - **Follow-up**
- Anything missing?

Team Communication: Successful Outcomes

- What are we meeting for?
- Do we need to meet in a physical space?
  - Virtual attendees (phone/video)
- Structure:
  - Regular meeting time
  - Format (standardize)
  - Documentation
  - Chair: rotation
  - Start & end on time
  - Follow-up

Communication: Health Care Team:

Good communication within a team can improve patient care & satisfaction

- **What information gets shared between the team & how is this communicated and/or documented?**
- **What information do patients and family/caregivers want members of the team to know or not know?**

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Team support: the critical incident…

It is important that health care professionals pay attention to the range of feelings, responses & concerns they may experience after meeting with patients and family:

Sadness, frustration, anger, guilt, relief, uncertainty, helplessness, & disagreement

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Communication

Dealing with conflict & differences in a team:

- can often be challenging
- requires time commitment to developing a process to work through differences

What experiences have you had?

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Debriefing as part of Team meetings

Helps build good team communication:

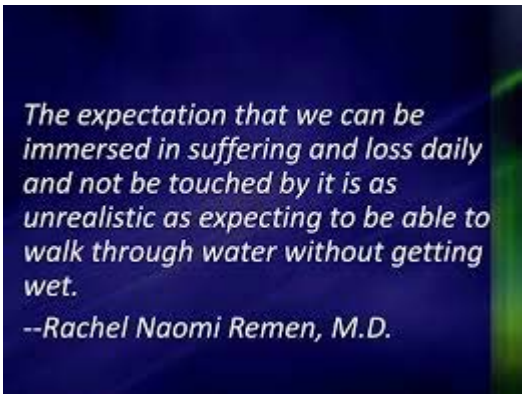
- Perceptions & concerns of the event,
- Support & suggestions from members of the team,
- Develop new skills & awareness

Offered in a safe, respectful & confidential envrionment.

Communication Summary:

- Personal beliefs, values, & assumptions impact the way we relate to & understand the experiences & needs of others,
- Specific communication skills can facilitate supportive conversations,
- Ensures “chain of information” is accurate and doesn’t get lost,
- Helps people get their needs met.

Compassion Fatigue & Burnout



Self Assessment Quiz:

Calculate your total score: /40 (Score of 25+ = high stress/burnout potential)

Scoring: Do you: a) almost always = 4 b) often= 3 c) seldom= 2 d) almost never= 1

1. Find yourself with insufficient time to do things you really enjoy
2. Wish you had more support/assistance
3. Lack sufficient time to complete your work most effectively
4. Difficulty falling asleep because you have too much on your mind
5. Feel people simply expect too much of you
6. Feel overwhelmed
7. Find yourself becoming forgetful or indecisive because you have too much on your mind
8. Consider yourself in a high pressure situation
9. Feel you have too much responsibility for one person
10. Feel exhausted at the end of the day

Compassion Fatigue and Burnout

Outcome of increased stress:

- Combined heavy workload, staffing shortages, budget cuts, increasing complexity of patient care
- Turning off feelings;
- A sense of helplessness
- Often linked with burnout
- Effect felt by family, co-workers and patients.

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Defining “Burnout”:

- Need to believe in meaningful work/life
- Progressive loss of idealism, energy, & purpose experienced by people in the helping professions as a result of the conditions of their work

- **Chronic** interpersonal stressors
  - Emotional and physical exhaustion
  - Detachment
  - Feeling of lack of accomplishment

Occupational Burnout

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At Risk for Burnout, when:

- Lack of support
- Lack of awareness of signs & symptoms of compassion fatigue and/or burnout
- Lack of time/ability to provide quality care to clients and self
- Co-existing stressors
- Over-involvement: excessive attachment

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Signs & Symptoms of Burnout

- ❑Fatigue
- ❑Physical exhaustion
- ❑Emotional exhaustion
- ❑Headaches
- ❑GI disturbances
- ❑Weight loss
- ❑Sleep disturbances
- ❑Depression

- ❑Boredom
- ❑Frustration
- ❑Low morale
- ❑Job turnover
- ❑Impaired job performance
  - ❑Decreased empathy
  - ❑Increased absenteeism

Burnout Behaviours

Professional:

- Working longer hours (belief that it will get better if I work harder)
- Absenteeism, reduced productivity
- Depersonalization: attempt to create distance between self & patients & co-workers
- Boundary 'de-regulation': inappropriate personal involvement with patients

Personal:

- Depletion of emotional & physical resources
- Negative self-image: feelings of incompetence & lack of achievement
- Questioning of previously held spiritual beliefs
- Neglect of self & others (family & social obligations)
- Anxiety, depression, substance abuse

WHAT ARE YOUR STRATEGIES TO DEAL WITH STRESS?

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Strategies to Prevent Burnout

- "write it out" (e.g., journal-keeping)
- "talk it out" : Discussion with peers/professionals
- "Walk/run it out": Attend to health (diet, exercise, rest)
- Plan activities that rejuvenate and focus on work-life balance
- Make time for yourself!

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Strategies to Prevent Burnout

- Identify stressors as short-term vs chronic
- Debrief emotional events
  - Reach out to colleagues
  - Seek out or strengthen a mentor relationship
  - Focus on positive relationships (don't go down the rabbit hole, holding hands with another stressed out person!)
- Seek professional help: Employee Assistance Program
- Depending on the severity of the situation:
  - Actively consider how you can change the picture: if not, consider moving out of the envrionment (changing jobs, etc)

And finally...In the role of Patient Navigator, or embarking on the role, ask the following questions:

- How is the role defined?
  - Clarity of reporting relationships
  - Scope
  - Responsibilities
  - Evaluation measures
- How realistic is the role?
- What supports need to be in place to have success and sustainability?
- What can YOU do to make it work?

Wrapping it up...

- Patient Navigation is a trend in healthcare
- Rapidly evolving as patients/systems become more complex
- Requirements across the continuum of care for individuals with knowledge, skill and experience with various patient groups
- Opportunities abound!

Important to continue to develop/refine skills in communication, organization and understanding your communities resources.

On-going networking and relationship-building is essential for this role.

Level 2, Patient Navigation:

Day 1:

- Identifying patient navigator roles:
- determining transitions in healthcare system experience
- understanding care integration and coordination with multiple providers and agencies/organizations
- creating a framework for the Patient Navigator role including measurable outcomes

Day 2:

- Ensuring the patient's individualized health and social needs are met:
  - health literacy
  - protocol and communication structure
- Advocacy
- Support in "bad news" situations
- Framing the professional relationship: from start to finish
- Documentation and responsibility in information sharing/confidentiality
- Case studies/examples (group work)