Positioning an organization to maximize the value of a patient navigation program

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Director of Oncology and Women’s Services
ProHealth Care
Your Life Changes Forever
Three Words…..

You have cancer…..

Cancer does not discriminate
Patients experience a high level of anxiety, fear and uncertainty, a sense of helplessness, feeling overwhelmed and lost

Cancer is a complex and scary disease

- Patients see multiple physicians to determine their treatment plan
- Treatment plans can include surgery, radiation, and/or chemotherapy depending upon the diagnosis
- Patients listen, but most often don’t hear what is being said
  » Resulting in confusion, lack of understanding
  » Not always comfortable asking physicians to clarify
  » Patients & families want answers immediately to know what lies ahead of them
Building the foundation, a disciplined approach

Articulate the vision

Engage champion’s

- Leadership
- Physicians
- Thought leaders with ability to execute complex change

Conduct program needs assessment

- Listen to voice of patient and family
- Interview physicians and care team
- Complete process mapping...current & ideal state
- Gather Baseline data
  - Patient leaving organization; gaps in care
  - Redundancy / Delays in care
  - Unplanned admissions /ER visits
Navigation framework

Evidence based clinical practice model

• Research, discover best practice

• Standardized

• Rigorous, consistent requirements for nurse navigators
  » Oncology experienced
  » OCN certification
  » Standardized orientation and mentoring program
  » Documentation

• Diligence in Measurement
  » Goals
  » Baseline performance
  » Return on investment ;return on value

• Balanced framework... Value proposition
  » Exceptional clinical and service experience/ cost effective
Balanced Framework: Return on value...
Return on Investment

Clinical excellence

- Timeliness of treatment planning
- QOL
- Multidisciplinary care
- Symptom management
- Unplanned episodes of care

Service Excellence

- Patient satisfaction
- QOL
- Patient retention
- Referrals to support /ancillary services
Navigation will not cure all issues, however it is an approach that will definitely facilitate that patients get the very best care which they so deserve
Nurse Navigators: Empowering Patients to Optimize Care

Assessment of the Need for the Nurse Navigator Role in Health Care

Gail N Davis, RN BSN ACM
Director Care Management North Market
Objectives

- The history of Nurse Navigators in healthcare
- The Nurse Navigator optimizes outcomes
- Benefits
  - Patient
  - Healthcare System
- An assessment of St Joseph Hospital’s ED
- The expected outcomes of Nurse Navigators in the ED
History of Nurse Navigators

1990
- Dr. Freeman & American Cancer Society
- Harlem Hospital; Cancer in the Poor Research
- Nurse Navigators assist w access barrier to care

2001
- U. S. Cancer Report *Voices of a Broken System*
- Socioeconomic status ≠ Barriers to Care
- Nurse Navigators assist all patients with cancer

2005
- Patient Navigator, Outreach and Chronic Disease Prevention Act = Government Funding
- Patient Navigator Program to reduce Health Disparities

Today’s Nurse Navigator Program

evidence-based care for chronic illness

- Lower mortality
- Lower ED visits
- Lower 30D Readmits

- Reduced charges
- Savings per patient

- Self-care Confidence
- Patient satisfaction
Optimal Care Trends

- Fee for service
- Prevention
- Health Promotion
- Disease Management
- Self-Management
Nurse Navigator Models

Chronic Care Model

Transitions of Care
Dr. Mary Naylor

Guided Care®
Dr Chad Boult

Lower Costs

Care Transitions Program
Dr. Eric Coleman


• 538 beds.
• Affiliated with the Medical College of WI.
• Magnet® Designation since 2008
• Busiest ED in Wisconsin
• Over 80,000 visits annually
• Urban safety net hospital
• 77,000 non-urgent ED visits
• 23,000 visits = no primary care provider
• 6% visit the ED \( \geq 3 \) times in 6 months
• 15% of visits \((\geq 3)\) have no insurance
• Chronic Conditions
  ◦ Asthma, Bronchitis, Heart Failure, COPD
  ◦ Diabetes
  ◦ Hypertension
  ◦ Mental Health and Substance Abuse
Strategic Interventions

Self Care
- Disease Education
- Medication Education
- Acute Triggers
- Healthy behaviors
- Self advocacy

Cultural Brokerage
- Community Services
- Knowledge of appropriate care setting

Barriers to Care
- Transportation
- Home Health Services
- Health Literacy
- Support Groups
Transitions of Care ED & Hospital

Goals

Align with a Medical Home

Decrease hospital 30-day readmissions for Heart Failure

Decrease visits to the Emergency Department for acute exacerbations

Qualify uninsured patients with chronic disabling conditions for government insurance.

Reduce direct cost of ED care for uninsured patients
WFH St Joseph Hospital
Transitions of Care:
Nurse Navigator/Community Health Worker

Nurse Navigator + Community Health Worker + Medical Home = Optimal Outcomes
Goals

Cancer Nurse Navigator

- **Guide** patients through the cancer trajectory
- **Educate** patients regarding cancer diagnosis, treatment options, research, and end-of-life
- **Advocate** for the unique needs of each patient to assure all care needs are met using facility and community resources
- **Support** patient/family by actively listening and providing reassurance
- **Encourage** and coach patients to be engaged in their care planning and to embrace their essential role of the decision making team
Overview
Aurora Health Care’s Cancer Program

6,500 new patients annually

15 hospitals, 13 (1 pending) ACOS accredited with commendation as well as CoC Outstanding Achievement Award

27 NAPBC accredited breast centers

21 outpatient infusion centers

35 medical oncologists

10 Radiation Therapy Sites

24 Cancer Nurse Navigators
Overview

24 Cancer Nurse Navigators (CNNs) across AHC

- All RN’s experienced in oncology
- Most are certified: oncology nursing (OCN) breast certified
- Embedded in hospitals & clinics
- Disease focused and generalists (solid tumors)
- 2012: 573 patients connected with CNN
  15,086 patient contacts (direct & phone)
Overview

Aurora Sinai Medical Center 2012

~279 new cancers

1 Cancer Nurse Navigator-generalist

~124 patients

~722 total patient contacts

ACCC: 1 FTE for 25-30 patients under treatment and 75-80 post treatment patients


Acuity: stage of disease, complexity of treatment & identified barriers

Referral Process

- Surgeons
- Imaging
- New Consults (Medical Oncology and Radiation Oncology)
- In-Patient Staff
  - Social workers
  - RN managers & staff
  - Hospitalists
  - PT/OT
- E-path
Interventions

Education
- Be a Survivor Book-Breast, GI, Lung
- Standardized patient education sheets
- Advanced Directives

Team appointment expectations
- Information, options & plan

Referrals
- Oncology social worker, dietician, PT/OT, behavioral health, chaplain, community resources

Support
- Compassion & Time
Database Documentation

Intraprofessional communication tool

Data collection:

#new patients & contacts/CNN
Distress Assessments
Patient reported problems
Referrals
Disease type, stage, treatment
### Case History

<table>
<thead>
<tr>
<th>Date</th>
<th>Initials</th>
<th>Contact Type</th>
<th>Contact Made Followup</th>
<th>Select Comment</th>
<th>Additional Comment</th>
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<tbody>
<tr>
<td>01/29/2013</td>
<td>MS</td>
<td></td>
<td></td>
<td></td>
<td>Distress has increased to 7 (0-10) this past week due to self identified emotional problems, housing (moving between daughter's house and niece's house), issues and transportation. She has considered support groups, however transportation is a problem (no care), and she has not yet secured transit. She gave information regarding Stillwaters and 4th Angel and encouraged to contact them (Stillwaters may be able to make arrangements to meet her a day that she is at ASUC). She was also given information for Aurora Family Services which she is agreeable to contact. Theresa, social worker, will be asked to reconnect with patient.</td>
</tr>
</tbody>
</table>

**Edit:** 01/29/2013

**Notes:**
- Distress increased to 7 (0-10) due to emotional problems, housing issues, and transportation difficulties.
- Considered support groups but facing transportation challenges.
- Referred to Stillwaters and 4th Angel for assistance.
- Provided information on Aurora Family Services.
- Social worker, Theresa, to follow up.

**Contact Count:** 2
### Database Documentation

#### Cancer Coordinator Web App - Distress Management

**Patient Name:** AMANDA ZTEST  
**Care Phase:** At Diagnosis

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<thead>
<tr>
<th>Practical Problems (Side Effect Management)</th>
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<tr>
<td>Child Care</td>
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<td>Housing</td>
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<tr>
<td>Insurance/Financial</td>
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<td>Transportation</td>
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<td>Work/School</td>
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<tr>
<td>Treatment</td>
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<td>Decisions</td>
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<table>
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<tr>
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<table>
<thead>
<tr>
<th>Emotional Problems (Psycho-Social)</th>
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<td>Depression</td>
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<td>Fears</td>
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<tr>
<td>Nervousness</td>
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<td>Sadness</td>
<td>No</td>
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<td>Worry</td>
<td>No</td>
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<td>Loss of Interest in Usual Activities</td>
<td>No</td>
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<tr>
<td>Spiritual/Religious Concerns</td>
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<tr>
<td>Other</td>
<td>No</td>
</tr>
</tbody>
</table>

### Pre Intervention (required)

- Distress Number: 7  
- Date: 01/22/2013  
- Interventions:  
  - CNN Education  
  - Match unmet patient/family needs to support services  
  - Facilitate patient/provider communication  
  - Contact Comment:  
    - Introductions made and role of Cancer Nurse Navigator explained. Written information provided on colon cancer and supportive services offered at Aurora. Distress Thermometer Tool administered; she rates her...

### Post Intervention (not required)

- Distress Number: N/A  
- Contact Comment:  
  - Contact Type: - Pick one -
Advantages-
• Embedded Distress Management Tool
• Retrievable Distress flowsheet
• Clarity reports-some similar reporting
• No longer double charting

Challenges-
• Transition role-out over 2-3-years
• Unable to include personal notes
• Not all the same data is retrievable
• CNN documentation is not distinct
Outcomes

• Patient Satisfaction
• Diagnosis to time of definitive treatment
  2012 = 17 days
Outcomes

Med/Surg Provider ⇒ 234
Genetic Counselor ⇒ 192
Psychological Cancer Counseling ⇒ 320
Dietician ⇒ 183
Survivorship care ⇒ 171
Cancer Rehab ⇒ 255
Financial Assistance ⇒ 121
Lymphedema Clinic ⇒ 19
Second Opinion ⇒ 47
Smoking Cessation ⇒ 50

Support Groups ⇒ 829
Community Services ⇒ 641
Social Services ⇒ 277
Spiritual Care ⇒ 88
Advanced Directive Planning ⇒ 728
Palliative Care ⇒ 33
Hospice Care ⇒ 46

System CNN referrals (24 RNs)
Timeframe 1/2012 ⇒ 12/2012
References


• McDonald, J. (n.d.) Our journey to patient-centered care. Power point presentation, Aurora Health Care.

Nurse Navigator Role Implementation

Kirsten Hastings, RN, BSN
Goals

- **Guide** patients with heart failure diagnosis

- **Educate** patients regarding heart failure diagnosis, treatment options and research

- **Advocate** for the unique needs of each patient to assure all care needs are met

- **Support** patient/family by actively listening and providing reassurance

- **Encourage** and coach patients to be engaged in their care
Goals

• To provide access to resources within the community that allow for optimization of living situation and health practices

• To reduce unplanned admissions/readmissions
Overview

• Hours - Monday-Friday 8-5
• Telephonic approach- no face to face interactions
• Scope - all HF patients within the Aurora System
• Number in Role - 1
• Degree - BSN
• Certification - not required
• Number of Patients - ~300
Referral Process

- Electronic Case Finding - 2 IP HF hospitalizations in rolling 12 months
- Aurora insured population triage
- Direct request from caregiver
- Patient/Family request via intranet
Referral Process

• Not a traditional direct referral source

• Patients should be managed with standard HF resources- AVNA, Aurora Teleservices, Aurora Community Based Case Management

• Goal is to follow those patients that despite standard strategies continue to have unplanned utilization for HF
Interventions

- Patient Education - lifestyle modifications, what to do when symptoms change, medication management
- Behavior Modification - self management strategies
- Community Referrals - AVNA, DME, Rehab, Smoking Cessation, educational classes
- Provider appointment discussion planning
- Telephonic Monitoring via IVR program
- Ongoing support
Database Documentation

- Stand alone database (Access) developed by Aurora
- Provides an overview of clinical situation at a glance
- Rapid HF medication review with notes on issues related to meds
- Linked to daily IP census for monitoring
- Links to calendar for follow up
Database Documentation

- Admission history reports 30 day readmit status with same or different diagnosis
- Allows for narrative documentation of pertinent information and plan
- Database able to query claims data for utilization reporting
- Tracks interventions for reporting
- Tracks referrals to other services
### Clinical Information

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Admission History</th>
<th>Clinical Information</th>
<th>Medication</th>
<th>Interventions</th>
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<td>Past Medical History</td>
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#### IV Medications

- Dopamine: [Dropdown]
- Dobutamine: [Dropdown]
- Primacor: [Dropdown]
- Natrecor: [Dropdown]
- Other: [Input]

#### NSAIDS

- [ ] Yes
- [ ] No
- Name: [Input]
- Frequency: [Input]
- Condition: [Input]

#### Vaccines

- [ ] Flu
- [ ] Pneumonia

### Comments

[Input Area]
# Documentation Transition (Moving to Epic)

**Advantages:**
- HF NN interventions available for other providers to view
- Identification as part of the care team - can be an identified resource
- Ability to generate letters within the EHR record (population management)

**Challenges:**
- Inability to use database to report outcomes related to utilization (at this time)
- Inability to track personal notes which provide rapport
- Rapid record review for phone continuity
Outcomes

• Utilization
  – 30 day readmission (all cause) ↓18%
  – # of IP admissions ↓16%
  – # of IP days ↓10%

• Clinical Data (unable to capture contraindications)
  – Use of ACE-I/ARB 88%
  – Beta Blocker Use 85 %
  – Documentation of EF 98%
  – Referral to smoking cessation program 100%
    • Positive smoking status 10%