NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

The Power of Patient Navigation to Advance Equity in Cancer Screening Services

May 23, 2023 3:00-4:30 P.M. EDT

The "Enhancing Cancer Program Grantee Capacity through Peer-to-Peer Learning" project is supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $600,000 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

AGENDA

- Welcome and Introductions
- Housekeeping
- Chat Waterfall:
  - Name
  - State
  - Program (BCCP, CRCP, Comp)
  - What do you enjoy most about the work you do?

June Call Series

Continue the Discussion About
Patient Navigation to Advance Equity

The call series, facilitated by Strategic Health Concepts, is an informal space to get questions answered, share insights from the webinar, and engage with your peers.

Register | Jun. 12, 2:00 p.m. - 3:00 p.m. ET

Register | Jun. 13, 10:00 a.m. - 11:00 a.m. ET

Register | Jun. 14, 3:00 p.m. - 4:00 p.m. ET

Register | Jun. 15, 11:00 a.m. - 12:00 p.m. ET

Poll Question: Patient Navigation Programs

Describe your Patient Navigation Program

a) We don't have one and probably won't get one in the next year.
b) We want one but are still determining how to make it happen
c) We have one but the program is struggling.
d) We have one and have found much success with our patient navigators and the program itself.

Moderator:

Tiffany M. Young, MSW, MPH

- Webinar and Speaker Introduction
- Agenda and Objectives
- Housekeeping

Keynote Speaker:
Dr. Elizabeth Rohan

Health Scientist
Centers for Disease Control and Prevention

Cancer Prevention Works

The Power of Patient Navigation to Advance Equity in Cancer Screening Services

Elizabeth A. Rohan, PhD, MSW
Health Scientist

NACDD P2P Series for DCPC Recipients
5/23/2023

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Cancer Prevention and Control

Roadmap

- Central Domains of Sustainability for Public Health Programs

Roadmap

- Central Domains of Sustainability for Public Health Programs
- CDC’s Definitions of Health Equity, Health Disparities, and Health Inequalities

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- Oncology Patient Navigation's (PN) Roots in Health Equity

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- Community Guide Evidence/Task Force Recommendations

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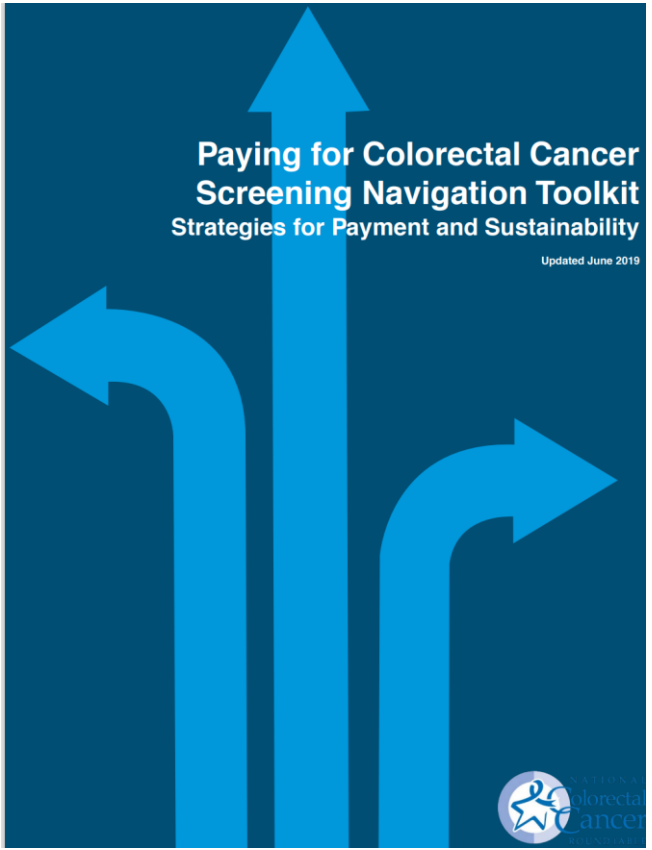
- National Navigation Roundtable and Additional Resources

Central Domains of Sustainability for Public Health Programs



Central Domains of Program Sustainability

1. **Funding Stability -** making long-term plans based on a stable funding environment
2. **Partnerships** - connection between program and community
3. **Organizational Capacity -** resources needed to effectively manage the program and its activities
4. **Program Evaluation -** monitoring and evaluation of process and outcome data associated with program activities
5. **Program Adaptation -** ability to adapt and improve in order to ensure effectiveness
6. **Communications** - strategic dissemination of program outcomes and activities with stakeholders, decision-makers, and the public
7. **Strategic Planning -** process that defines the program direction, goals, and strategies
8. **Environmental Support -** internal and external political environment which influences program funding, initiatives, and acceptance

Paying for Colorectal Cancer Screening Patient Navigation Toolkit & Interactive Website - National Colorectal Cancer Roundtable (nccrt.org)

CDC's Definitions of Health Equity, Health Disparities, and Health Inequalities

OHE Celebrates 35 Years of Baking In Health Equity

Print

About CDC's Office of Health Equity (OHE) | Health Equity | CDC

CDC Office of Health Equity

Health Equity

- Everyone has a fair and just opportunity to attain their highest level of health
- Requires focused and ongoing societal efforts to:
  - address historical and contemporary injustices
  - overcome economic, social, and other obstacles to health and healthcare
  - eliminate preventable health disparities

Definitions of Health Disparities and Inequities
(CDC Office Health Equity)

- Health Disparities
  - Differences in health outcomes and their determinants between segments of the population
    - Defined by:
      - social
      - demographic
      - environmental
      - geographic attributes

- Health Inequities
  - Health differences or disparities that are
    - systematic
    - unfair
    - avoidable

https://www.cdc.gov/healthequity/whatis/index

Oncology Patient Navigation is Rooted in Health Equity

Harold Freeman, MD
Breast Surgeon

Oncology Patient Navigation

- Pioneered by Dr. Harold Freeman in 1990 because of health inequities he saw in his breast cancer patients at Harlem Hospital
  - Oncology PN: “individualized assistance to patients, families, and caregivers to help overcome healthcare system barriers and facilitate timely access to quality health and psychosocial care from pre-diagnosis through all phases of the cancer experience.”
    - Definition endorsed by: Association of Oncology Social Workers, the Oncology Nursing Society, and the National Association of Social Workers

Navigator Types and Standards

The Professional Oncology Navigation Task Force announces

Oncology Navigation Standards of Professional Practice

The Professional Oncology Navigation Task Force is pleased to announce the release of the Oncology Navigation Standards of Professional Practice. These standards were created to provide clinical oncology nurse navigators, social work navigators, and patient navigators with clear information regarding best practices in the provision of professional care. This includes the knowledge and skills all professional navigators should possess to deliver high-quality, competent, and ethical services to people impacted by cancer. The standards also provide benchmarks for use by healthcare employers and information for policy and decision makers, health professionals, and the public to understand the role of professional oncology navigators. These standards are intended to provide guidance and may be applied differently, as appropriate, in diverse settings.

Scan this QR code to access the Oncology Navigation Standards of Professional Practice

The professional organizations responsible for the creation of the Oncology Navigation Standards for Professional Practice include

AONN Academy of Oncology Nurse & Patient Navigators

AOSW Association of Oncology Social Work

aphon Association of Pediatric Hematology/Oncology Nurses

ONS Oncology Nursing Society

Patient organizations involved in developing this document include

CANCER SUPPORT COMMUNITY

SMITH CENTER FOR HEALING AND THE ARTS

The foundational steps taken by the Biden Cancer Initiative Working Group on Patient Navigation also led to the creation of this document.

We would like to thank all individuals and organizations who reviewed and commented on the standards. A special thanks to the American Cancer Society National Navigation Roundtable for their review and dissemination support of these standards.

National Navigation Roundtable

PONT Definitions






Oncology Navigation	Professional Navigator	Clinical Navigators Oncology Nurse Navigator	Clinical Navigators Social Work Navigator	Patient Navigator	Patient

A Patient Navigator may also be a Community Health Worker

"A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."

Community Health Workers (apha.org)
Community Health Worker Resources | CDC

Standards

Standard 1: Ethics	Standard 2: Qualifications	Standard 3: Knowledge	Standard 4: Cultural and Linguistic Humility	Standard 5: Interdisciplinary and Interorganizational Collaboration
Standard 6: Communication	Standard 7: Professional Development	Standard 8: Supervision	Standard 9: Mentorship and Leadership	Standard 10: Self-care
Standard 11: Prevention, Screening, and Assessment	Standard 12: Treatment, Care Planning, and Intervention	Standard 13: Psychosocial Assessment and Intervention	Standard 14: Survivorship	Standard 15: End of Life
Standard 16: Advocacy	Standard 17: Operational Management	Standard 18: Practice Evaluation and Quality Improvement	Standard 19: Evidence-based Care	

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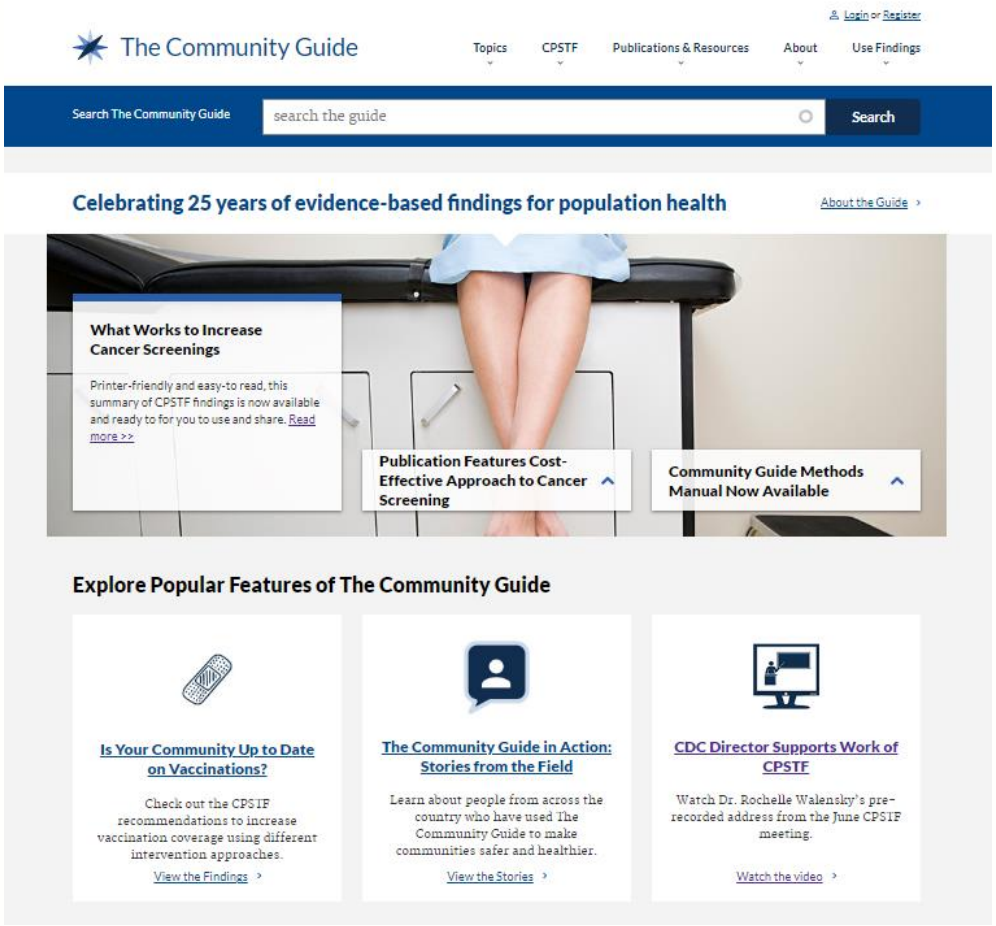
Standard 11: Prevention, Screening, and Assessment Oncology navigators provide education on cancer prevention, screening, and assessment.	
All navigators:	Exhibit knowledge about, promote, and advocate cancer prevention behaviors, early detection, screening, and healthy behavior education. Exhibit knowledge of available local, community, or national resources and the quality of services provided and establish relationships with the providers of these services. Assess population health factors such as common diseases and/or risk behaviors. Conduct risk assessments, including lifestyle factors Exhibit (and continue to seek) knowledge regarding communities served. Assist with the implementation of programs to improve access to cancer screening. Employ strategies to educate patients to integrate healthy lifestyle behaviors into daily living. Conduct culturally appropriate education about the potential benefits and limitations of contemporary genetic counseling and related genetic risk assessments. Support patients' adherence to holistic care plan.
Clinical nurse navigators:	Use appropriate screening and assessment tools and methods to provide holistic care plan. Assist in the identification of candidates for molecular testing and/or genetic testing and counseling and facilitate appropriate referrals.
Clinical social work navigators:	Use appropriate screening and assessment tools and methods to provide holistic care plan.

Community Guide Evidence/ Task Force Recommendations



What Is The Community Guide?

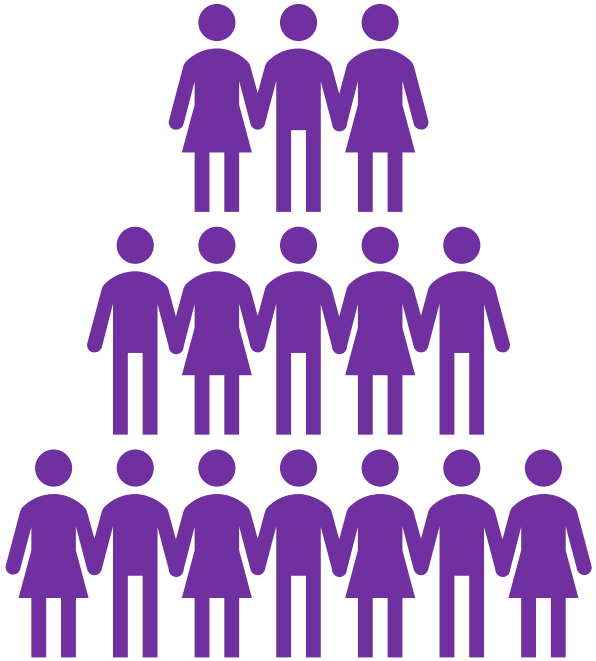
Credible source of systematic reviews and evidence-based findings of the Community Preventive Services Task Force (CPSTF) (www.thecommunityguide.org)

- 15 public health and prevention experts (independent, non-federal)

Reviews focus on population-based interventions

Community level

Health care systems



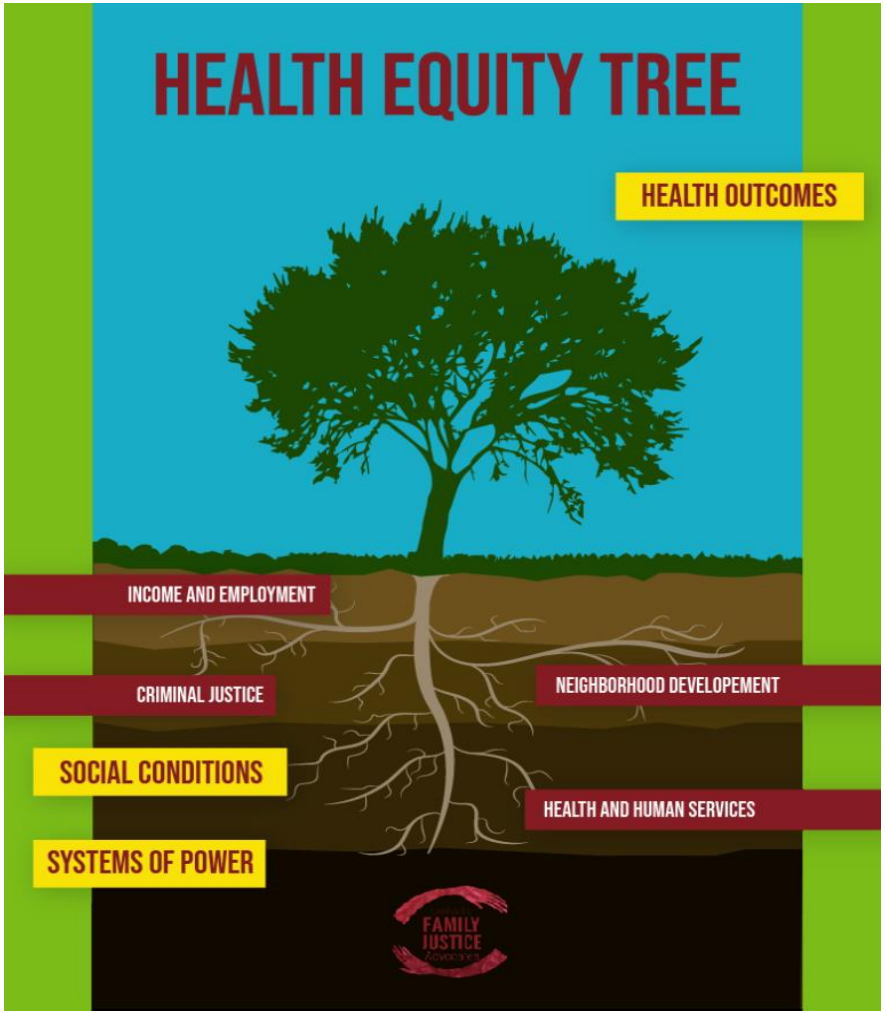
CPSTF Recommends Patient Navigation Services to Increase Cancer Screening | The Community Guide

The Community Preventive Services Task Force (CPSTF) recommends patient navigation services for historically disadvantaged racial and ethnic populations and people with lower incomes to increase:

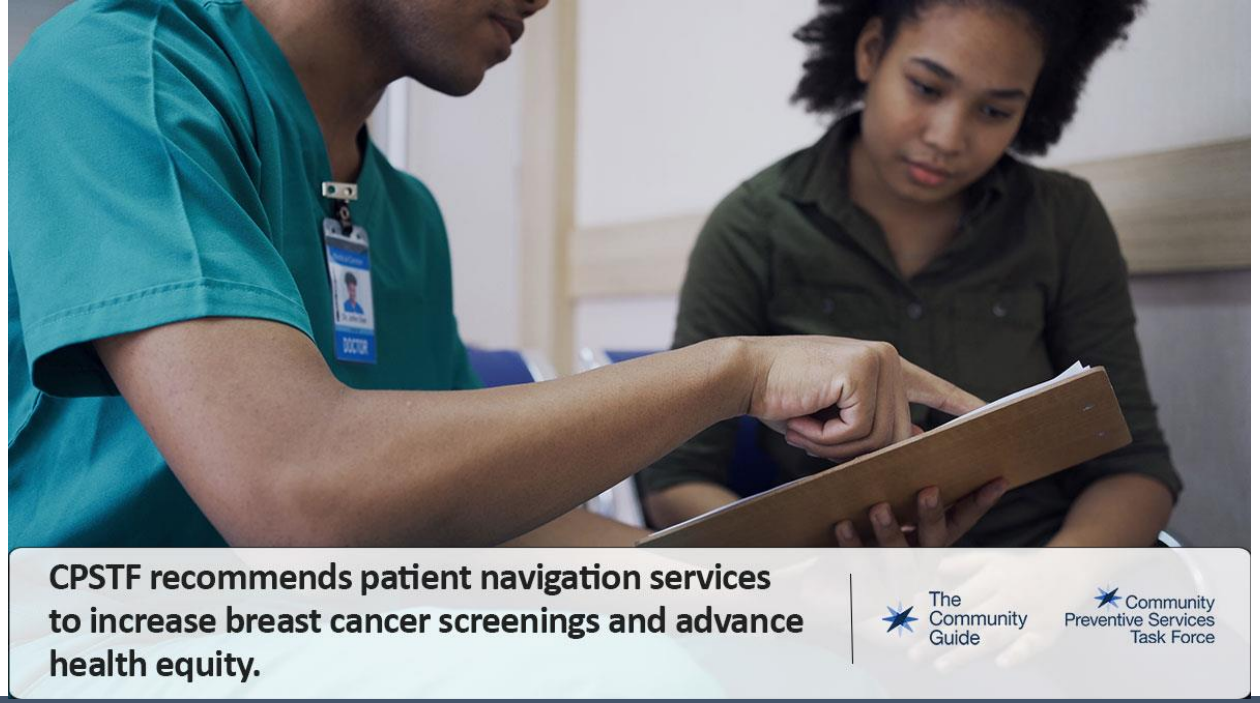
- **Breast cancer** screening by mammography (strong evidence)
- **Cervical cancer** screening by Pap test (sufficient evidence)
- **Colorectal cancer** screening by colonoscopy, fecal occult blood test (FOBT), or fecal immunochemical test (FIT) (strong evidence)

The Community Guide PN Health Equity Statement

"Patient navigation services are expected to advance health equity when implemented among historically disadvantaged racial and ethnic populations and people with lower incomes, who often have lower screening rates (Sabatino et al. 2021). With timely and appropriate follow-up care and treatment, patient navigation services may improve health and reduce cancer-related disparities for these groups."

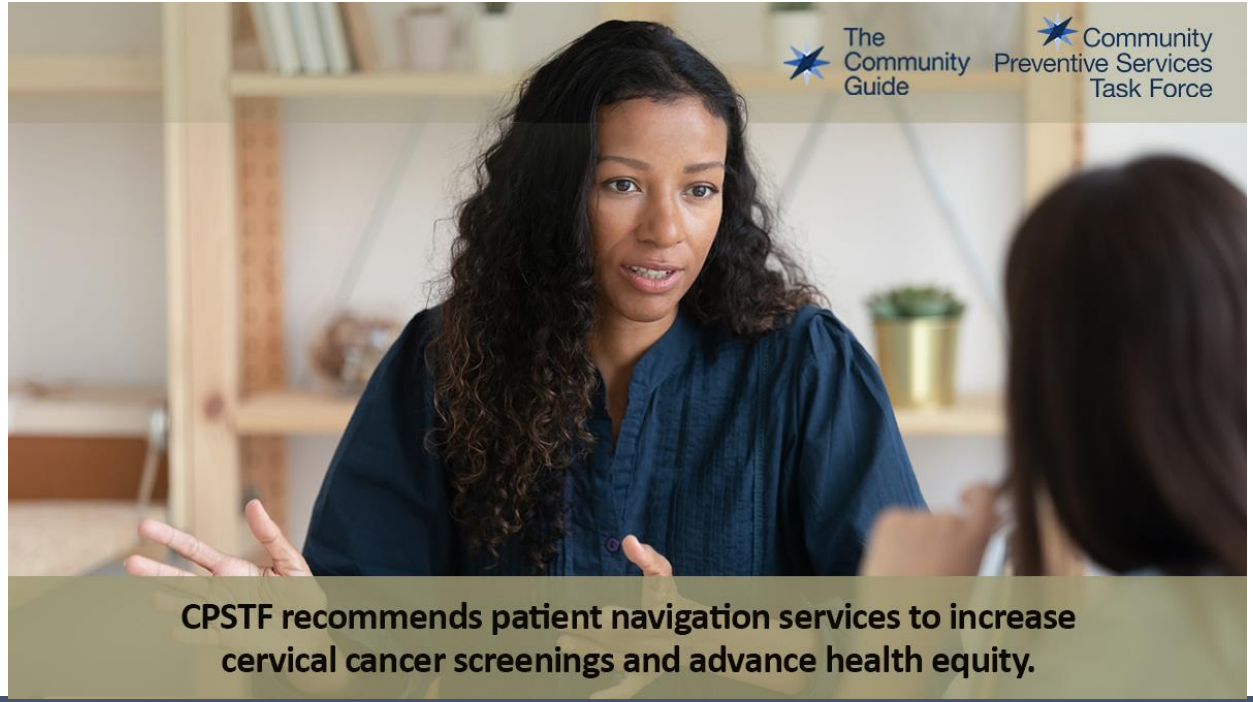


https://familyjusticeadvocates.org/2020/02/11/this-is-the-health-equity-framework-that-guides-us/



Breast Cancer

Breast Cancer Screening: Patient Navigation | The Community Guide



Cervical Cancer

Cervical Cancer Screening: Patient Navigation | The Community Guide

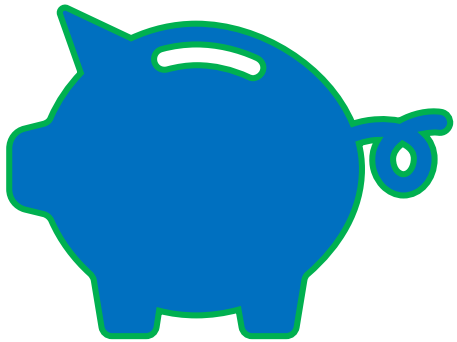
Colorectal

Colorectal Cancer Screening: Patient Navigation | The Community Guide

Community Guide PN Economic Review

Finding from the April presentation to the CPSTF and initially approved by the Task Force:

“CPSTF finds patient navigation services to increase breast cancer screening are **cost-effective.** Systematic review evidence shows estimates of **cost per quality adjusted life year (QALY) gained** are **below** a conservative threshold of **$50,000.”**



The finding will be formally disseminated after October.

PN in the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and the National Comprehensive Cancer Control Program (NCCCP)

Patient Navigation in NBCCEDP

Page 14 of DP22-2202 Program Manual

- "…individualized assistance provided to women to help overcome barriers and facilitate timely access to quality screening and diagnostic services, as well as initiation of timely treatment for those diagnosed with cancer."
- Required strategy
- Aimed at reducing disparities

https://amp.cdc.gov/Cancer/s/article/NBCCEDP-DP22-2202-Program-Manual-Part-1-Program-Implementation-v1-3

Patient Navigation is Required in NBCCEDP

Page 14 of DP22-2202 Program Manual

- Enrollees of NBCCEDP *must* be assessed for needs and barriers to screening, diagnostic services, and initiation of cancer treatment" (as needed)
- NBCCDEP recipients *may* offered PN to other women being served in screening clinics ("navigation only").

Patient Navigation Activities in NBCCEDP

Page 15 of DP22-2202 Program Manual

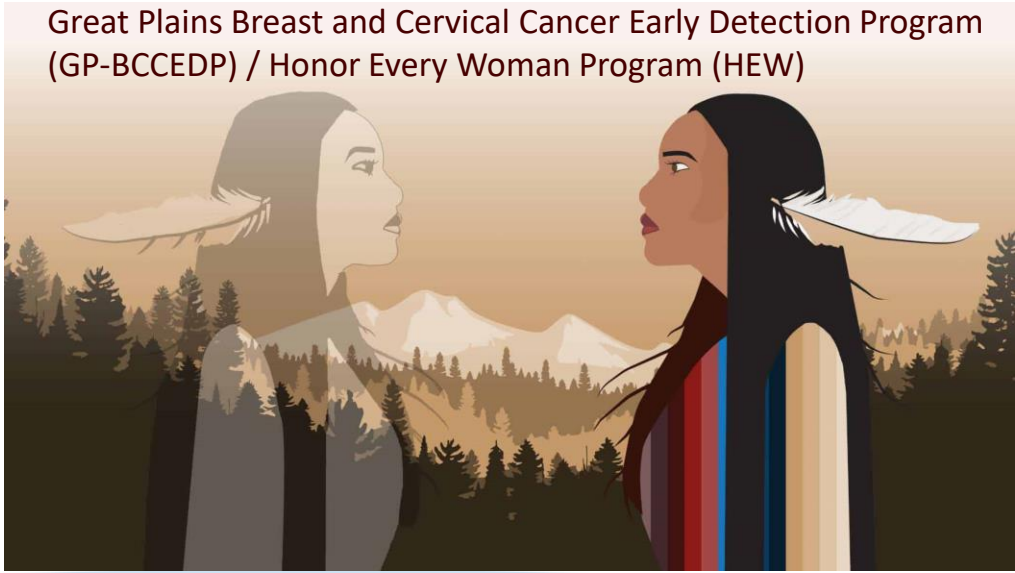
1. Assessment of individual patient barriers to cancer screening, diagnostic services, and initiation of cancer treatment
2. Patient education and support
3. Resolution of patient barriers (e.g., transportation, translation services)
4. Patient tracking and follow-up to monitor patient progress in completing screening, diagnostic testing, and initiating cancer treatment
5. A minimum of two, but preferably more, contacts with the patient, due to the centrality of the patient-navigator relationship.
6. Collection of data to evaluate the primary outcomes of patient navigation – cancer screening and/or diagnostic testing, final diagnosis, and treatment initiation if needed.
7. Linking women to other needed health, community, and social services.

PN also has associated Minimum data elements (MDEs).

Patient Navigation | ScreenOutCancer | CDC

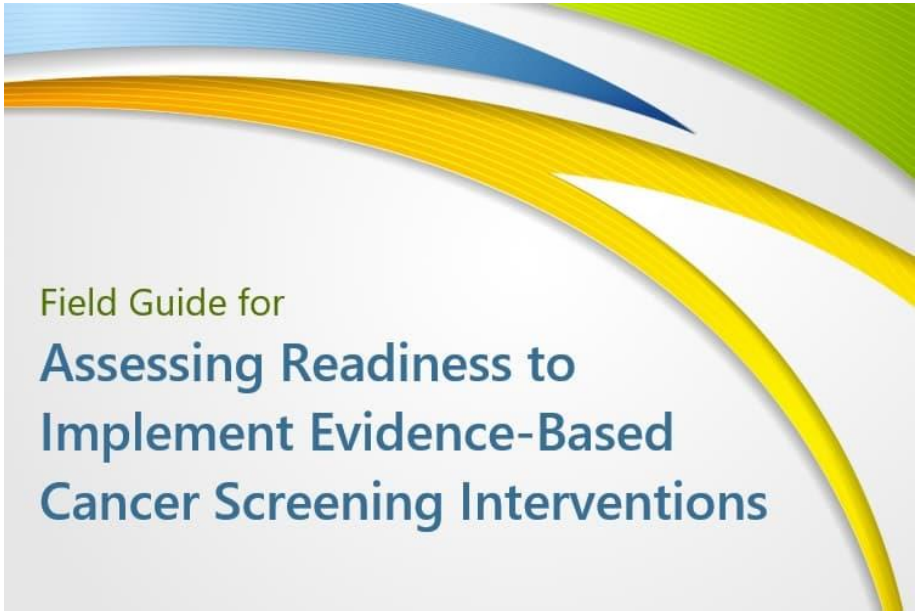
How to Create a Patient Navigation System
How to Support a Patient Navigation System


Patient navigator in Philadelphia/ Healthy Woman Program


Great Plains Breast and Cervical Cancer Early Detection Program (GP-BCCEDP) / Honor Every Woman Program (HEW)

Field Guide for Assessing Readiness to Implement Evidence-Based Cancer Screening Interventions | CRCCP | CDC

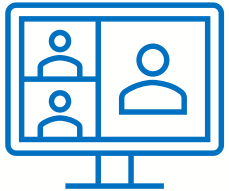
Developed for CRCCP, this guide can be adapted for use by cancer screening programs assess clinic-level readiness to implement EBIs.



National Comprehensive Cancer Control Programs/Coalitions Support & Promote PN – Work with them!

Collaborate

Assess Community needs



Train Navigators

Establish PN Networks

Monitor & Evaluate

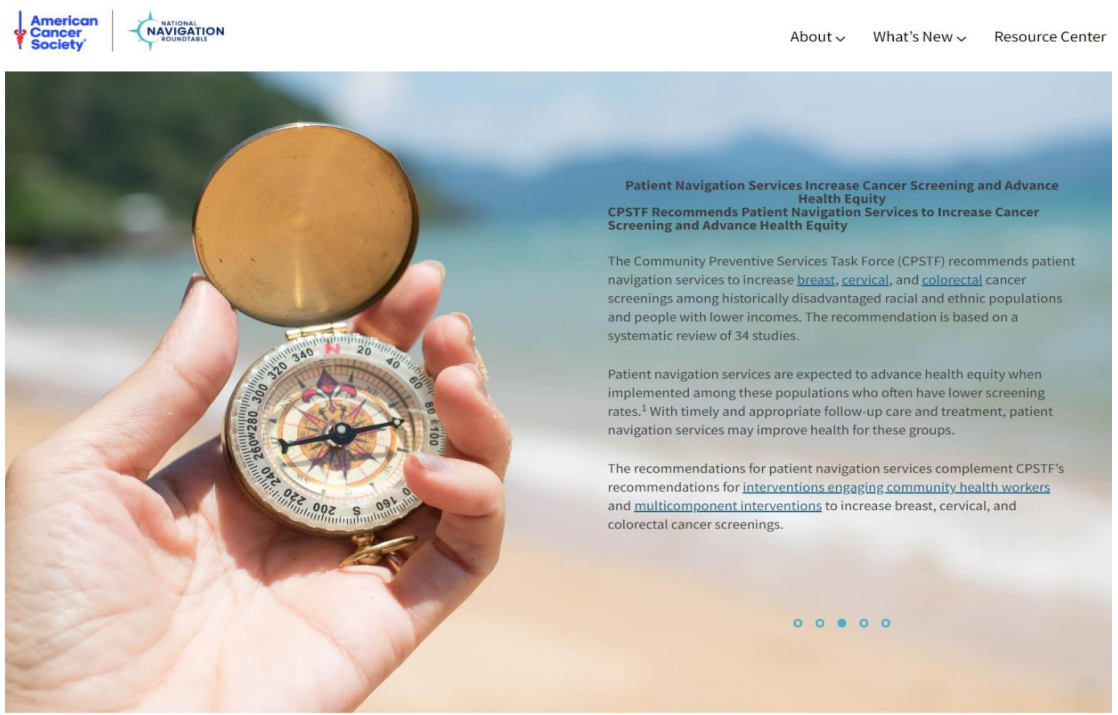
Educate Others

National Navigation Roundtable and Additional Resources

National Navigation Roundtable

https://navigationroundtable.org/

- Established in 2017
- National coalition of 80 member organizations to advance navigation efforts and foster health equity
  - Academia, public health, advocacy and survivor groups, professional societies, industry, training, and state and federal agencies
- Disseminates best practices, initiates work not already being done by member organizations



NNRT LEADERSHIP

Meet our Steering Committee

Tracy Battaglia, MD, MPH
Advisor to the Chair of the National Navigation Roundtable

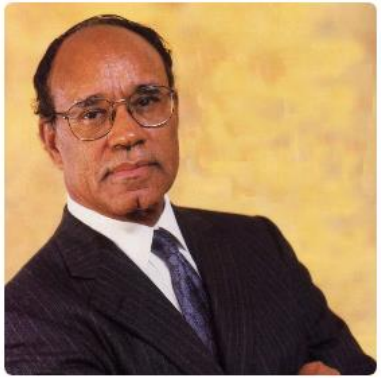
Boston University Schools Of Medicine And Public Health

Read more

Andrea (Andi) Dwyer, BS
Chair of the National Navigation Roundtable

University Of Colorado

Read more



Harold P. Freeman, MD
Honorary Chair of the National Navigation Roundtable

Harold P. Freeman Patient Navigation Institute

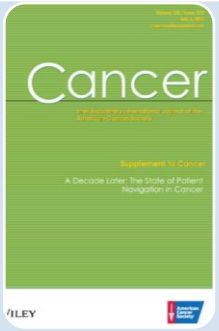
Read more

Linda Fleisher, PhD, MPH
Vice Chair of the National Navigation Roundtable

Fox Chase Cancer Center

Read more

National Navigation Roundtable: 2022/2023 Impact



Cancer Journal Supplement

- Delivered a high-quality proposal to the journal *Cancer* titled **"A Decade Later: The State of Patient Navigation in Cancer Care."**
- The supplement proposal was accepted, and 13 papers were written in 2020

Virtual Call to Action Series

- The 2022 annual meeting was a webinar series with a Call to Action on four of the Supplement papers, and one with the Oncology Navigation Standards of Professional Practice September through Dec 2022

Membership Growth

- The success of the Call to Action series led to significant growth in NNRT members.
- A key goal in sustaining the momentum and impact of the NNRT is engaging new and diverse members.

Original Article

Evaluating the sustainability of patient navigation programs in oncology by length of existence, funding, and payment model participation

Kathryn M. Garfield, JD[1]; Elizabeth F. Franklin, PhD, MSW[2]; Tracy A. Battaglia, MD, MPH[3]; Andrea J. Dwyer, BS[4]; Karen M. Freund, MD, MPH[5]; Patrick D. Wightman, PhD, MPP[6]; and Elizabeth A. Rohan, PhD, MSW[7]

BACKGROUND: For this study, the authors examined whether specific programmatic factors were associated with the sustainability of patient navigation programs. **METHODS:** This cross-sectional survey explored navigation programmatic factors associated with 3 measures of sustainability: 1) length of program existence, 2) reliance on sustainable funding, and 3) participation in alternative payment models. In total, 750 patient navigators or program administrators affiliated with oncology navigation programs in clinical-based and community-based settings completed the survey between April and July 2019. **RESULTS:** Associations were observed between both accreditation and work setting and measures of program sustainability. Accredited programs and larger, more resourced clinical institutions were particularly likely to exhibit multiple measures of sustainability. The results also identified significant gaps at the programmatic level in data collection and reporting among navigation programs, but no association was observed between programmatic data collection/reporting and sustainability. **CONCLUSIONS:** Navigation is not currently a reimbursable service and has historically been viewed as value-added in oncology settings. Therefore, factors associated with sustainability are critical to understand how to build a framework for successful navigation programs within the current system and also to develop the case for potential reimbursement in the future. *Cancer* **2022;128:2578-2589**. © *2022 American Cancer Society*.

KEYWORDS: cancer, navigation, nurse navigation, oncology, patient navigation.

INTRODUCTION

Over the last 30 years, patient navigation has emerged as an effective strategy to address many of the barriers that prevent equitable access to timely, high-quality cancer care.[1] Patient navigation has been shown to increase cancer screening rates,[2-7] increase adherence with follow-up for positive cancer screening tests,[2,7] shorten the time to treatment initiation,[2,7] improve patient satisfaction,[2,7,8] and reduce anxiety for vulnerable populations.[2] Studies have also shown that patient navigation decreases utilization of certain high-cost services, including emergency department visits and hospital admissions among older patients with breast cancer[9] and hospital readmissions among older, high-risk safety-net patients.[10]

The scope of patient navigation has historically been broad, involving various roles across the health care workforce—including nurse navigators, social workers, and nonclinical navigators—to meet a wide spectrum of patient needs.[8,11] Therefore, professional organizations (including the Oncology Nursing Society, the Association of Oncology Social Work, and the National Association of Social Workers) have defined patient navigation services in broad terms, describing them as assistance offered to patients as well as families and caregivers tailored to their individual needs to help overcome health care system barriers and to expedite their timely access to quality health care and psychosocial care through all phases of the cancer experience.[12]

This broad, flexible framework has allowed health care institutions and nonprofits to develop models of patient navigation tailored to their individual needs and patient populations[1]; however, it has also presented financial challenges. Despite the evidence supporting its value, patient navigation has not been integrated into traditional fee-for-service health care payment systems, which rely on narrowly defined roles and services. Medicare, Medicaid, and commercial

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[1]Center for Health Law and Policy Innovation, Harvard Law School, Cambridge, Massachusetts; [2]Cancer Support Community, Washington, District of Columbia; [3]Women's Health Unit, Section of General Internal Medicine, Boston Medical Center and Boston University School of Medicine, Boston, Massachusetts; [4]Colorado School of Public Health, University of Colorado Cancer Center, Denver, Colorado; [5]Department of Medicine, Tufts Medical Center, Boston, Massachusetts; [6]Center for Population Health, University of Arizona, Tucson, Arizona; [7]Division of Cancer Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia

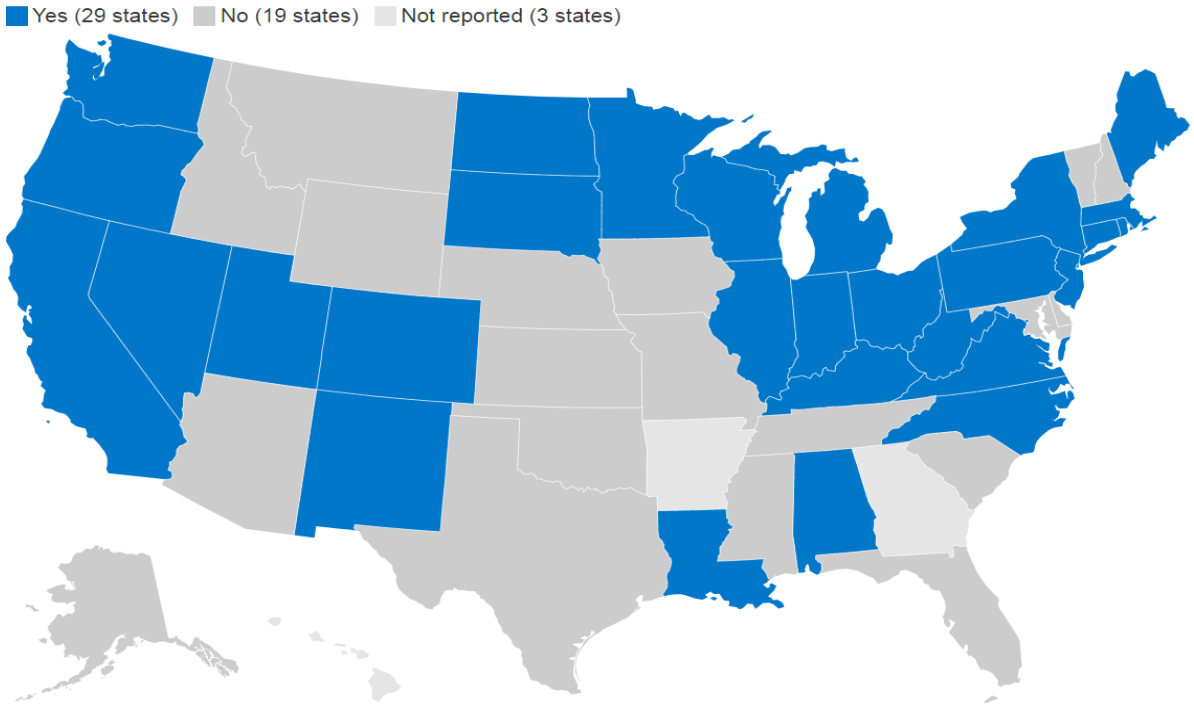
The findings and conclusions of this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Findings

- Associations between both accreditation and work setting and measures of program sustainability
  - Accredited programs and larger, more resourced clinical institutions were particularly likely to exhibit multiple measures of sustainability
- Significant gaps in data collection and reporting across navigation programs

Figure 1

States that Allow Medicaid Payment for Services Provided by Community Health Workers (CHWs) as of July 1, 2022

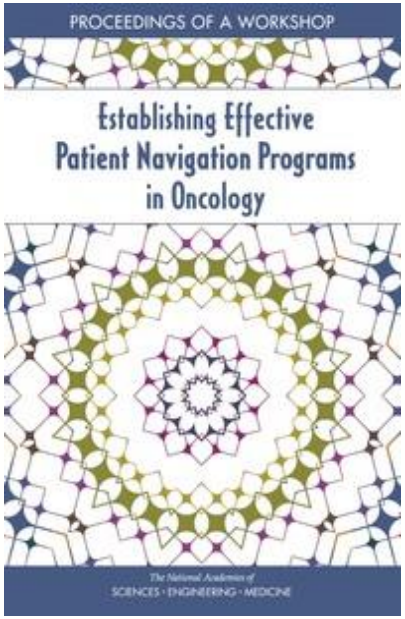


NOTE: Arkansas, Georgia and Hawaii did not provide responses to this question.
SOURCE: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2022. • PNG

KFF

[State Policies for Expanding Medicaid Coverage of Community Health Worker (CHW) Services | KFF]

National Academies of Science, Engineering, and Medicine PN Workshop (2018)



[Establishing Effective Patient Navigation Programs in Oncology: Proceedings of a Workshop | The National Academies Press]


Care delivery review

Patient Navigation in Cancer: The Business Case to Support Clinical Needs

Ronald M. Kline, MD[1]; Gabrielle B. Rocque, MD[2]; Elizabeth A. Rohan, PhD, MSW[3]; Kris A. Blackley, RN[4]; Cynthia A. Cantril, RN, MPH[5]; Mandi L. Pratt-Chapman, MA[6]; Howard A. Burris, MD[7]; and Lawrence N. Shulman, MD[8]

ABSTRACT

PURPOSE Patient navigation (PN) is an increasingly recognized element of high-quality, patient-centered cancer care, yet PN in many cancer programs is absent or limited, often because of concerns of extra cost without tangible financial benefits.

METHODS Five real-world examples of PN programs are used to demonstrate that in the pure fee-for-service and the alternative payment model worlds of reimbursement, strong cases can be made to support the benefits of PN.

RESULTS In three large programs, PN resulted in increased patient retention and increased physician loyalty within the cancer programs, leading to increased revenue. In addition, in two programs, PN was associated with a reduction in unnecessary resource utilization, such as emergency department visits and hospitalizations. PN also reduces burdens on oncology providers, potentially reducing burnout, errors, and costly staff turnover.

CONCLUSION PN has resulted in improved patient outcomes and patient satisfaction and has important financial benefits for cancer programs in the fee-for-service and the alternative payment model worlds, lending support for more robust staffing of PN programs.

J Oncol Pract 15. © 2019 by American Society of Clinical Oncology

INTRODUCTION

Patient navigation (PN), defined by various professional organizations as "individualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality health and psychosocial care from pre-diagnosis through all phases of the cancer experience,"[1,2,3,4,5] was originally designed to reduce barriers to care for those with cancer care disparities manifested as presentation at an advanced stage and/or decreased survival.[2,3] It has now been shown to bridge a variety of gaps and to address diverse needs in the cancer care system.[4,5] Reported benefits include improving access to screening,[6,7] patient care coordination,[8] symptom management,[9,10] and, ultimately, reducing cost.[9,11] The success of early programs resulted in a substantial body of literature supporting the positive impact of PN on patients, clinicians, and institutions. Ramirez et al[12] showed improved quality of life and treatment adherence for Latino survivors of breast, prostate, and colorectal cancers who received PN versus those who did not. PN has facilitated improved uptake in mammography among African American Medicare recipients[13] and has also improved guideline-concordant colorectal cancer screening.[14,15] PN has also benefited patients by reducing the time to diagnostic resolution[16] and providers and institutions by decreasing the number of patients missing clinic appointments.[17]

Despite the value shown, uptake and staffing of PN programs has been variable across cancer programs in the United States.[18] Patient navigators can be either nonclinical members of the community or health care professionals (usually nurses or social workers).[19,20] A lack of clarity about the navigator role, scope of practice, and the appropriate level of training for diverse navigation roles[20] contributes to the heterogeneity of navigation across the United States. Furthermore, adoption of PN programs is limited by uncertainty about sustainable financial models to support navigation programs (eg, coverage of PN services by Centers for Medicare & Medicaid Services [CMS] and commercial insurers).[21]

In 2012, the American College of Surgeons' Commission on Cancer (CoC) established a standard

Author affiliations and support information (if applicable) appear at the end of this article.

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Supportive Care in Cancer
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REVIEW ARTICLE

Establishing effective patient navigation programs in oncology

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Abstract

Purpose Recent advances in cancer treatment have resulted in greatly improved survival, and yet many patients in the USA have not benefited due to poor access to healthcare and difficulty accessing timely care across the cancer care continuum. Recognizing these issues and the need to facilitate discussions on how to improve navigation services for patients with cancer, the National Cancer Policy Forum of the National Academies of Sciences, Engineering, and Medicine (NASEM) held a workshop entitled, "Establishing Effective Patient Navigation Programs in Oncology. The purpose of this manuscript is to disseminate the conclusions of this workshop while providing a clinically relevant review of patient navigation in oncology.

Design Narrative literature review and summary of workshop discussions

Results Patient navigation has been shown to be effective at improving outcomes throughout the spectrum of cancer care. Work remains to develop consensus on scope of practice and evaluation criteria and to align payment incentives and policy.

Conclusion Patient navigation plays an essential role in overcoming patient- and system-level barriers to improve access to cancer care and outcomes for those most in need.

Keywords Cancer care barriers - Oncology - Patient navigation

Introduction

Recent advances in cancer treatment have resulted in greatly improved survival, and yet many patients in the USA have not benefited due to poor access to healthcare and difficulty accessing timely care across the cancer care continuum [1]. Recognizing these issues and the need to facilitate discussions on how to improve navigation services for patients with cancer, the National Cancer Policy Forum of the National Academies of Sciences, Engineering, and Medicine (NASEM) held a workshop entitled, "Establishing Effective Patient Navigation Programs in Oncology." The workshop, held in November 2018 at NASEM, brought together patients, navigators, clinicians, administrators, and other stakeholders, in a collaborative discussion regarding the history and future of patient navigation.

Some patient challenges are financial, but cultural differences and emotional distress can also create obstacles to timely, quality cancer care. Even in the best of circumstances, cancer care in the USA is often complex and fragmented. This can be a challenge for any patient and can result in delays or missed opportunities in care. The core role of a patient navigator in oncology is to mitigate barriers in access to healthcare, improve access to timely care, and provide patients with guidance and support throughout the cancer care continuum [2]. Patient navigation is fundamentally a patient-centered strategy that ensures that there is a liaison between the patient and the healthcare system. Patient navigators can play a key role in care coordination by streamlining care for patients across diverse clinical settings. Furthermore, the treatment complexities and emotional

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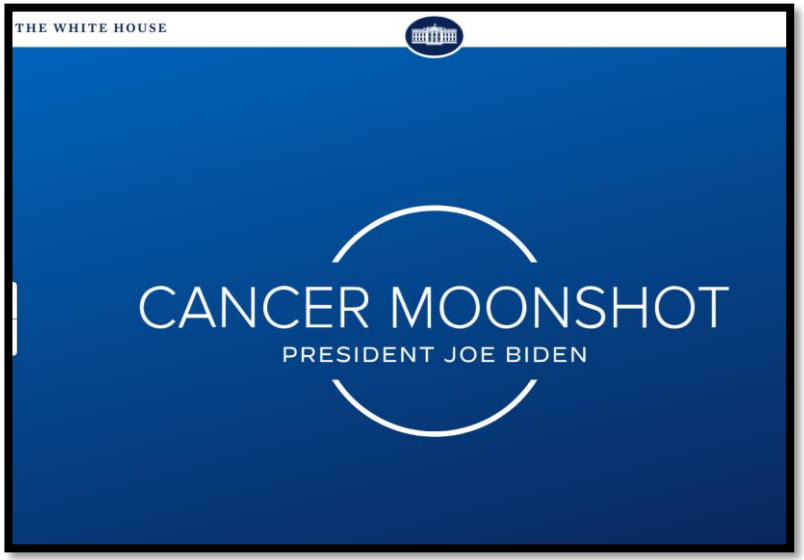
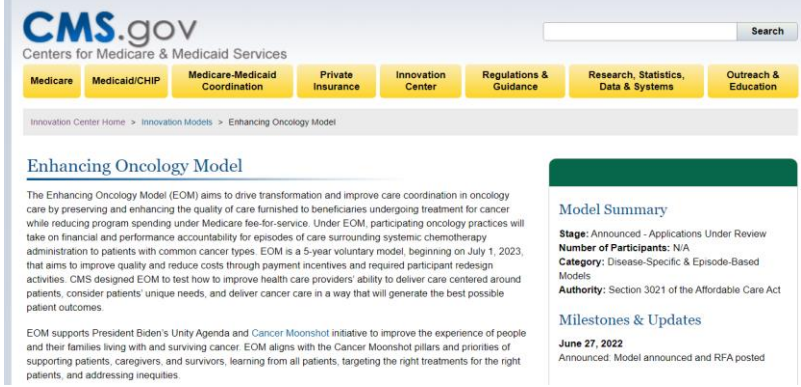
[https://link.springer.com/article/10.1007/s00520-019-04739-8]

Enhancing Oncology Model | CMS Innovation Center

- 5-year, voluntary reimbursement model; begins 7/1/2023
- Supports President Biden's Unity Agenda and Cancer Moonshot initiative to improve the experience of people and their families living with and surviving cancer
- Aligns with Cancer Moonshot pillars and priorities:
  - supporting patients, caregivers, and survivors
  - learning from all patients
  - targeting the right treatments for the right patients
  - addressing inequities



Enhancing Oncology Model



Includes:

- 24/7 access to an appropriate clinician with real-time access to medical records
- Patient navigation services
- A detailed care plan that involves patient engagement and preferences on discussions surrounding prognosis, treatment options, symptom management, quality of life, and psychosocial health needs
- Screening for health-related social needs (HRSNs)
  - needs related to food, transportation, housing, etc.
- Questions regarding overall cancer care experience and health outcomes
  - symptoms, physical functioning, behavioral health, and HRSNs.

Thank you!

Go to the official federal source of cancer prevention information:

www.cdc.gov/cancer

Cancer Prevention Works

Division of Cancer Prevention and Control

Reliable. Trusted. Scientific.

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Patient Navigation Spotlights

Georgia

Patient Navigation

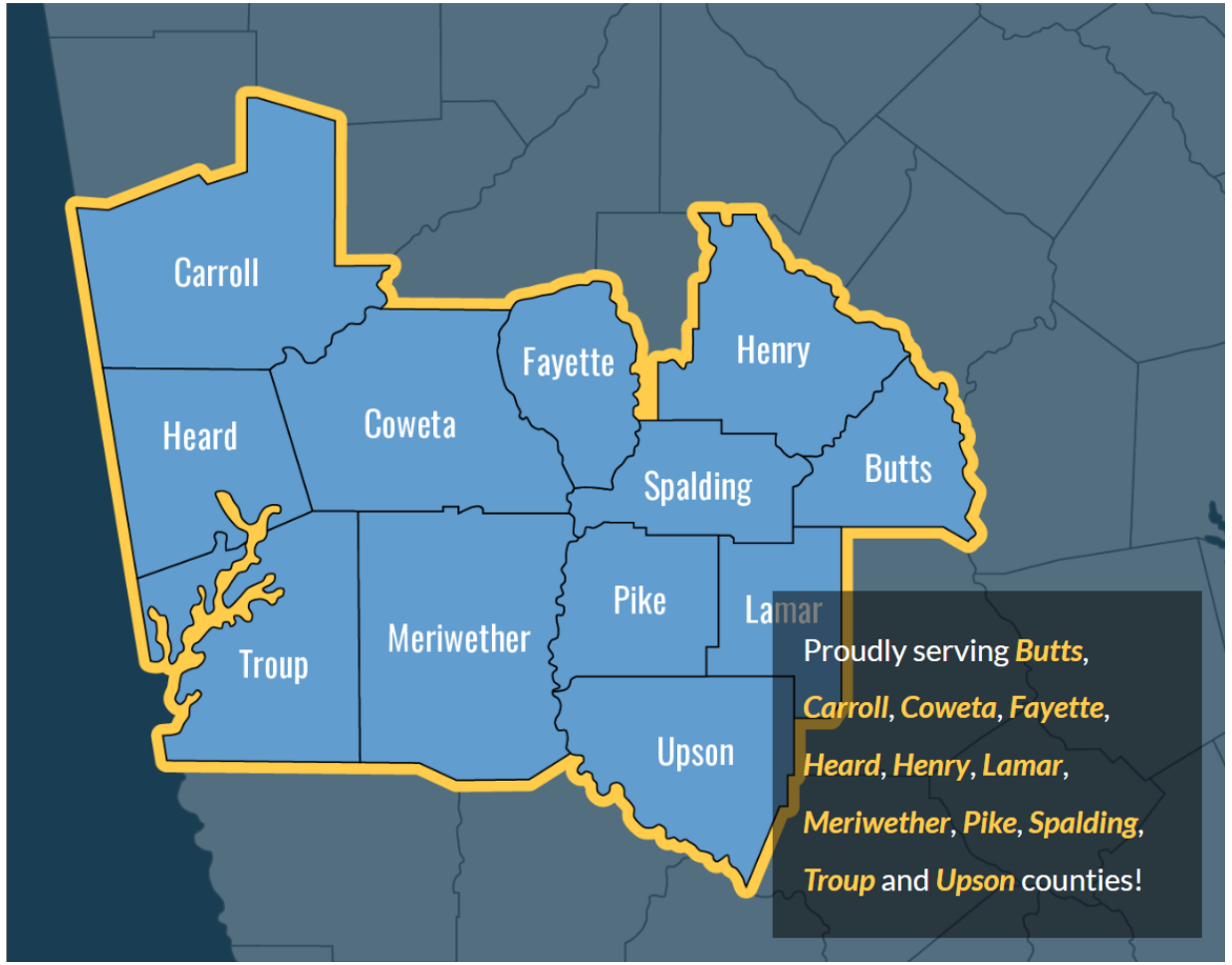
LaGrange Health District

P2P Learning SME Webinar / Roxanne Barnes, LPN / May 23, 2023

Demographics of Troup County

- 12 counties within the district
- Troup County is the lead county
- Population of 70,191
- 58.6% White
- 36.4% Black
- 4.0% Hispanic population
- 2.5% Asian
- 0.4% American Indian

*Population estimates as of July 1, 2022



https://www.census.gov/quickfacts/troupcountygeorgia

Service Delivery

FY22 Service Delivery

- 467 women were served by NBCCEDP (BCCP); 126% goal met

FY 23 Service Delivery

- 597 women have been served through May 2023
- 255 of the 597 women served in FY23 are Hispanic

Patient Navigation Services

- Client reminders
    - Calls and letters for in-clinic and provider appts.
- One-on-one education
- Group education
- Language interpretation made available through call center
    - Language line
    - Bi-lingual staff
- Community linkages to reduce barriers to care

Community Linkages and Referral Services

- Women are referred to a local Federally Qualified Health Center, Your Town Health, for other health issues.
- Women are referred to Pathways for concerns associated with mental health (i.e., depression).
- Staff attend community partner events to provide Breast and Cervical Cancer information and strengthen linkages.
- The LaGrange Health District partners with other health districts to provides program information about its services.
- Key partners include churches, schools, local extension offices, housing authorities, and community groups.

Impact of Patient Navigation Services

- Reduction in ‘no-show’ rates.
- Improved timeliness for patient follow-up.
- Client reminders have resulted in 88% of patients completing visits on the first appointment since the beginning of the year.
- Remaining patients were rescheduled with 97% having completed their rescheduled visits.

Project Pink Envelope

- Recall letters for annual appointments are sent using a **PINK** envelope.
- District began piloting the project this year to assess whether it increases the response rate compared to notices send in a white envelope.

Staff and Funding

- Funded a full-time patient navigator that served all 12 counties within the district in FY22.
- Supplemented the salary of staff providing additional responsibilities to support patient navigation in FY23.
- Nurses provide patient education, assessment of barriers, and referrals.
- Admin staff assist with client reminders and participate in community events.
- Key traits of patient navigation staff include being passionate about helping people and strong communication skills.
- Staff are trained by District BCCP Coordinator, LPN.

Training

- Review of Breast and Cervical Cancer Program manual.
- Evidence Based Intervention Training provided by DPH.
- Training on one-on-one client education forms.
- Training on assessment form for Potential Barriers.

Georgia Department of Public Health

BCCP Patient Navigation Program

Questions to Ask Clients to Find Potential Barriers

Removing barriers is one of the evidence-based interventions used to increase cancer screening. The BCCP Patient Navigation Program is implementing five evidence-based interventions to report to the enter for Disease Control (CDC). You must administer this assessment correctly and assist women in addressing their barriers.

Below there is a list of questions Patient Navigators can ask to complete the client barrier assessment during the client intake. It is important to ask open-ended questions as much as possible.

Cost	Do you have insurance? What is your household income? How many people in your family?
Family Issues	Who takes care of your children when you go to the doctor? Do you care for your parents or in-laws?
Fear	Are you afraid or concern about getting screened?
Homeless	Do you have a place to live?
Insurance Issues	Do you have insurance? Can you afford your insurance copays?
Lack of Information	Do you know where to get screened? Where do you regularly go for care?
Lack of Knowledge	Do you know when and how often you need to get screened? What do you know about breast cancer/cervical cancer?
Mental Issues	Are you feeling sad lately? Are you depressed or anxious? Do you have family near who support you?
Substance Abuse	Do you smoke? Do you use any illicit drugs? Do you drink alcohol?
Needs Interpreter	What is your native language? Do you speak English? Do you feel confident speaking to a provider in English? Would you like an interpreter on the day of your appointment?
Problem Scheduling Appointment	Can you call to make an appointment? Do you have language problems when calling to make an appointment?
Transportation	How would you get to the health department? Do you have someone that can bring you to the appointment? Do you know how to take the bus? How do you usually go to work or the supermarket?
Time Off	What day/time works best for you to schedule your appointment? Can you get time off to come during regular business hours?
Special Needs	Do you have any disabilities that we need to be aware of to be tter serve you? Do you require special accommodations?
Other	Is there any other reason that prevents you from getting screened? Do you know how to read and write in your language? Does your culture allow you to get routine screenings? Do you need to get permission from your husband to get the test done?

When holding conversations with your clients, please remember to listen. They sometimes give you clues as to what you should ask next. You can ask questions to open the conversation, such as "what's standing in your way to getting screened?" And to learn more, you can follow up with a question such as "can you tell me more?"

Here are a few samples of clarifying questions:

- Is this what you say...?
- Did I hear you say...?
- Did I paraphrase what you said?

To recap:

- Take time to reassure your client to build their confidence and facilitate full participation.
- Ask open-ended questions to identify potential barriers.
- Always ask for clarity. This will help you avoid misunderstanding and focus on the right priorities.

Challenges

- The lack of funding to hire full-time Patient Navigator in the District.
- Incorporating the activities of Patient Navigation into the nurses' everyday jobs can be time-consuming, especially in counties that are short-staffed.

Sustainability

- Utilize existing staff and create opportunities for shared responsibilities without creating burnout.
- Hire a part-time position for a patient navigator, preferably bi-lingual, to assist with patient navigation in all 12 counties.
    - Managing processes, training, language interpretation
- Identify grants that support patient navigation
- Continue to build relationships with key partners to promote and support navigation services.
    - Ex. Troup county has partnered with a Hispanic Church and has increased the number of Hispanic patients since the partnership has begun.

Wisconsin

Wisconsin Well Woman Program Patient Navigation

Presented by: Gale D. Johnson, MPA

Ana Karina Cuellar Montes, MSW, APSW

Tuesday, May 23, 2023

UW Health

Overview

- How can Patient Navigators help?
- Outreach and Education
- Challenges
- Successes

How Can Patient Navigators Help?

- Address barriers for patients to receive care
- Provides support to patients from screening, to diagnostic work-up, throughout treatment, and into survivorship.
- Assistance with insurance coverage.
- Assistance with billing issues
- Emotional support
- Advocacy
- Connect patients to community resources and social support services

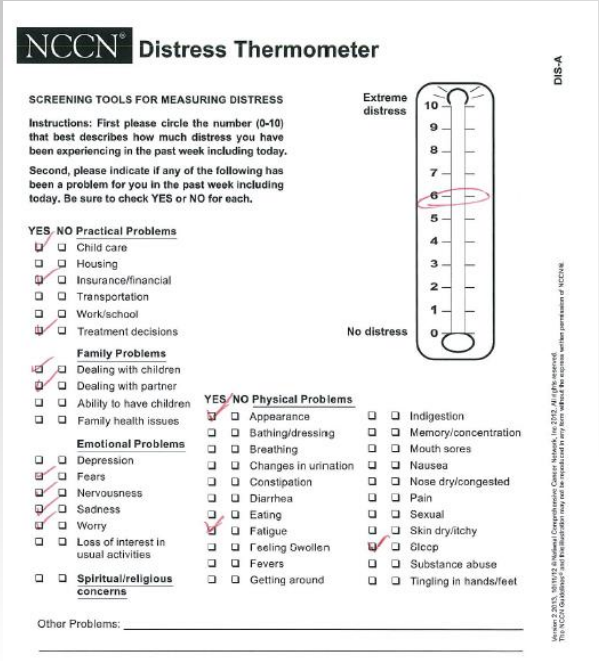
How Can Patient Navigators Help?

- Other Support
  - Case Management
  - Mental Health
  - Financial / Employment assistance
  - Lodging, and transportation assistance
  - Fear and Anxiety about screening
  - Communication between the woman and her health care provider
  - Child Care

How Outreach Navigation Helps Women in the Community

- Provide outreach and education
- Work in the community and with local free clinics to increase breast and cervical health awareness and education
- Increase Breast and Cervical Cancer Screening
- Ensure patients' abnormal screenings are followed up with appropriate care
- Help individuals navigate the health care system

Assessment



NCCN® Distress Thermometer

DIS-A

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

Extreme distress

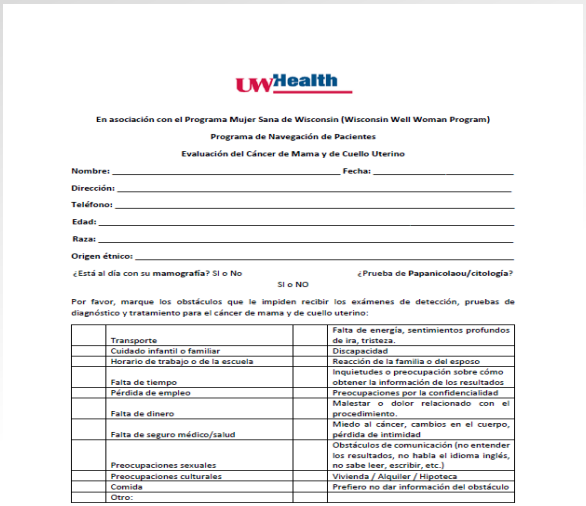
10 9 8 7 6 5 4 3 2 1 0

No distress

YES	NO	Practical Problems
☐	☐	Child care
☐	☐	Housing
☑	☐	Insurance/financial
☐	☐	Transportation
☐	☐	Work/school
☑	☐	Treatment decisions
		Family Problems
☑	☐	Dealing with children
☑	☐	Dealing with partner
☐	☐	Ability to have children
☐	☐	Family health issues
		Emotional Problems
☐	☐	Depression
☑	☐	Fears
☑	☐	Nervousness
☑	☐	Sadness
☑	☐	Worry
☐	☐	Loss of interest in usual activities
☐	☐	**Spiritual/religious concerns**

YES	NO	Physical Problems
☐	☐	Appearance
☐	☐	Bathing/dressing
☐	☐	Breathing
☐	☐	Changes in urination
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Eating
☑	☐	Fatigue
☐	☐	Feeling Swollen
☐	☐	Fevers
☐	☐	Getting around
☐	☐	Indigestion
☐	☐	Memory/concentration
☐	☐	Mouth sores
☐	☐	Nausea
☐	☐	Nose dry/congested
☐	☐	Pain
☐	☐	Sexual
☐	☐	Skin dry/itchy
☑	☐	Sleep
☐	☐	Substance abuse
☐	☐	Tingling in hands/feet

Other Problems: _____



UW Health

En asociación con el Programa Mujer Sana de Wisconsin (Wisconsin Well Woman Program)

Programa de Navegación de Pacientes

Evaluación del Cáncer de Mama y de Cuello Uterino

Nombre: _____ Fecha: _____

Dirección: _____

Teléfono: _____

Edad: _____

Raza: _____

Origen étnico: _____

¿Está al día con su mamografía? SI o No ¿Prueba de Papanicolaou/citología? SI o NO

Por favor, marque los obstáculos que le impiden recibir los exámenes de detección, pruebas de diagnóstico y tratamiento para el cáncer de mama y de cuello uterino:

	Transporte		Falta de energía, sentimientos profundos de ira, tristeza.
	Cuidado infantil o familiar		Discapacidad
	Horario de trabajo o de la escuela		Reacción de la familia o del esposo
	Falta de tiempo		Inquietudes o preocupación sobre cómo obtener la información de los resultados
	Pérdida de empleo		Preocupaciones por la confidencialidad
	Falta de dinero		Malestar o dolor relacionado con el procedimiento.
	Falta de seguro médico/salud		Miedo al cáncer, cambios en el cuerpo, pérdida de intimidad
	Preocupaciones sexuales		Obstáculos de comunicación (no entender los resultados, no habla el idioma inglés, no sabe leer, escribir, etc.)
	Preocupaciones culturales		Vivienda / Alquiler / Hipoteca
	Comida		Prefiero no dar información del obstáculo
	Otro:		

¿Es usted un paciente de UW Health? SI o NO

¿Le gustaría más información sobre el Programa de navegador de pacientes de UW Health? SI o NO

Education – Breast and Cervical Cancer

Cervical Cancer

Are there screening tests that can prevent cervical cancer or find it early?
Cervical cancer is the easiest female cancer to prevent, with regular screening tests and follow-up. A Pap test, also called a Pap smear, can help find cervical cancer early.

A **Pap smear** examines cells taken from your cervix or vagina. A Pap smear is done during a pelvic exam. During your pelvic exam, your health care provider will collect cells from your cervix or vagina. The cells will be sent to a lab to be tested for abnormal cells.

A Pap smear can be done at a doctor's office or clinic. Pap smear results can tell if you have an infection, unhealthy cervical cells or cervical cancer. If the test is abnormal, a colposcopy may be recommended. Every woman should start having Pap smears every year at age 21.

Where can I get more information?
The National Cancer Institute provides accurate and up-to-date information about cervical cancer, other cancer types, prevention, detection, diagnosis, treatment, survivorship and end of life care.
Phone: 1-800-4CANCER (1-800-422-6237)
Website: www.cancer.gov

The Wisconsin Well Woman Program (WWWP) provides preventative health screening services to women with little or no health insurance coverage. The program pays for mammograms and Pap tests. Please contact a WWWP Coordinator for more information about the WWWP, and income and age requirements.
Phone: 608-266-1865
Website: www.dhs.wisconsin.gov/womenshealth/wwwp/

The Rural Cancer Network (RCaN) offers other user-friendly, cancer educational handouts. For more information on questions to ask your doctor about cervical cancer screening, please see the "Cervical Cancer Screening: Questions to Ask Your Doctor" handout.
Website: www.ruralcancernetwork.org

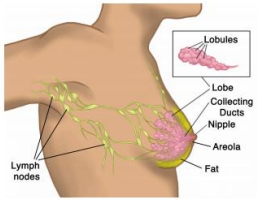
Carbone Cancer Center
UNIVERSITY OF WISCONSIN SCHOOL OF MEDICINE AND PUBLIC HEALTH

For more local information, please contact:

UW Health
Breast Center
In collaboration with the UW Carbone Cancer Center

Breast Cancer

Information Sheet



What is breast cancer?
Breast cancer is cancer that starts in your breast.

Breast cancer can affect the breast and surrounding area. The surrounding area extends to your breastbone, up to your collarbone and into your underarm.

In Wisconsin, breast cancer is the most commonly diagnosed cancer among women. Breast cancer affects 1 in 8 women during their lives.

Breast cancer can occur in both men and women, although male breast cancer is rare.

How can I prevent breast cancer?
You can lower your chance of developing breast cancer by making healthy choices.

- Eat lots of fruits and vegetables
- Limit foods high in saturated fat (red meat, fried food)
- Be active and have a healthy body weight
- Limit alcoholic drinks

What are the possible symptoms of breast cancer?
In its early stages, breast cancer may have no symptoms. As breast cancer develops, you may experience:

- A lump near your breast or underarm area
- Change in size or shape of your breast
- A nipple turned inward into your breast
- Fluid from your nipple
- Scaly, red or swollen skin on your breast

Talk to your health care provider if you experience any of these symptoms. These symptoms may be caused by something other than cancer, but the only way to know what is causing them is to talk with your health care provider about them.

Outreach & Education Event Photos

Lancaster resource fair,
Vesperman Farms

Community Connections
Free Clinic, Dodgeville

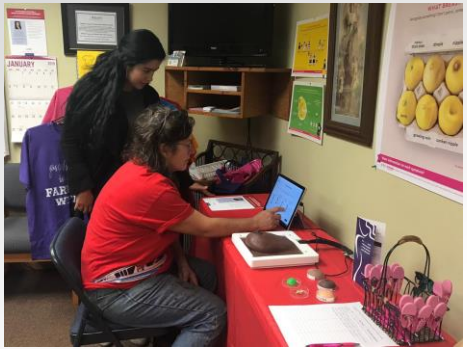
Black Women's
Wellness Day, Madison

UWHealth
Breast Center
In collaboration with the
UW Carbone Cancer Center

Outreach & Education Event Photos

CCFC Dodgeville

IHCWC, Boscobel

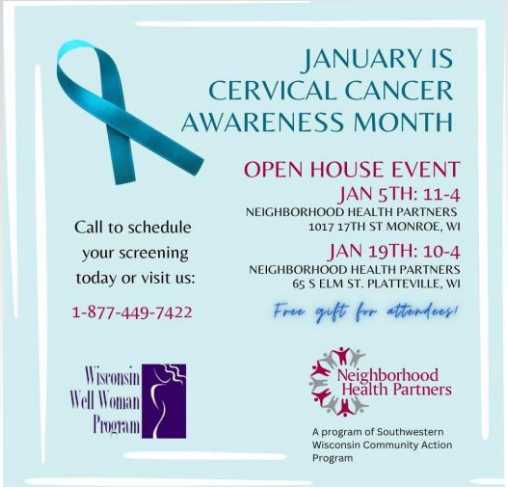


Mexican Store and
Platteville Public Library

UW Health Breast Center
In collaboration with the UW Carbone Cancer Center

Outreach & Education Event Photos

CCFC, Dodgeville



The 2nd Annual Pride in the Park, Platteville

UW Health Breast Center
In collaboration with the UW Carbone Cancer Center

Challenges

- General community mistrust of the medical community and basic screening
- Limited in resources, including high-speed internet, access to information, and education
- Distance between patient's home and clinic is often large and there is no public transportation available
- Provider selection and availability is limited

UW Health Breast Center
In collaboration with the UW Carbone Cancer Center

Successes & Opportunities

- Improve health care access and quality to underserved populations
- Address mistrust issues between patient and health care provider
- Engagement and the fostering of trust within the communities served
- Formed partnerships with food banks, hospitals, clinics and other organizations to help distribute information about screening.
- Increase promotion activities
- Outreach Free Clinics and Rural Outreach with a mobile clinic (FCOW)

UW Health Breast Center
In collaboration with the UW Carbone Cancer Center

Thank You

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Telephone: (608)445-0138

Adams, Crawford, Columbia, Dane, Dodge, Grant, Green, Iowa, Juneau, Lafayette, Richland, Rock, Vernon and Sauk counties.

UW Health Breast Center
In collaboration with the UW Carbone Cancer Center

Wrap-up

- Questions and Comments

Q&A

Peer-to-Peer Learning Resource Website

www.
https://www.chronicdisease.org/page/p2plearning