Workflow Integration and Sustainability: Implementation within Existing Systems and Technology

American Cancer Society

NATIONAL NAVIGATION ROUNDTABLE

October 28, 2024

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MISSION

High quality cancer care for all through evidence-based patient navigation

VISION

NNRT is a collaboration that advances patient navigation efforts to eliminate barriers for quality care, reduce disparities in health outcomes and foster ongoing health equity across the cancer continuum.

Five-Year AIM (2021-2026)

To support the creation of a sustainable model for oncology patient navigation to achieve health equity across the continuum of cancer care.

https://navigationroundtable.org/

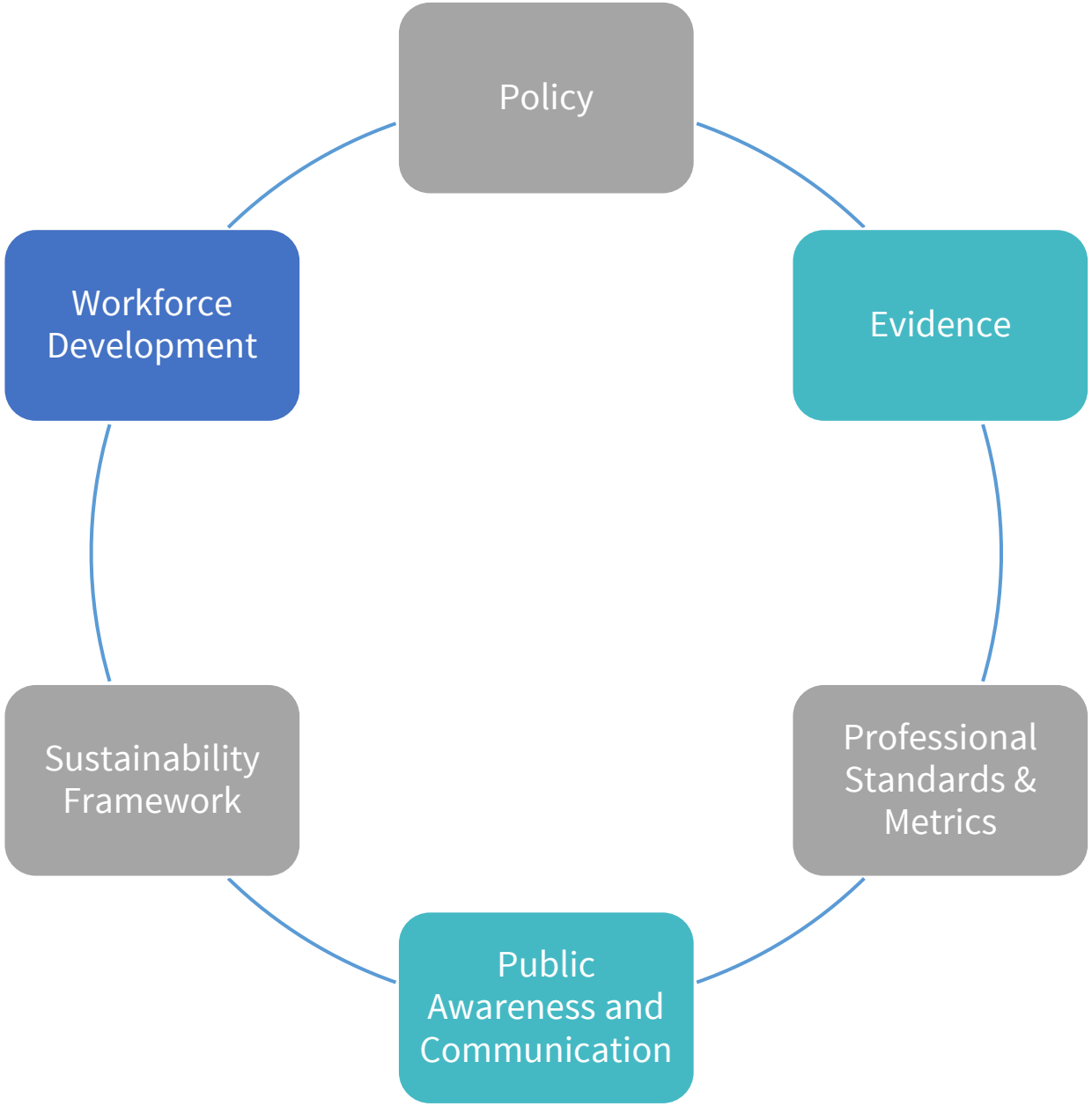
Today's Presenters

Andrea "Andi" Dwyer, MS
Director of the Colorado Cancer Screening Program (CCSP)
University of Colorado Cancer Center

Tracie Lewis, MS
Operations Director
Colorectal Cancer Prevention Network
College of Arts and Sciences
University of South Carolina

Jo Henning, MPH
Senior Coordinator,
Colorado Cancer Screening Program
Colorado School of Public Health
University of Colorado Cancer Center

NNRT in Action



CCSP Sustainability Planning

Introducing the PNSAT Short Version

Funding:
CCPD Grants Program

Colorado Cancer Screening Program

Mission of CCSP:

- Partner with local, state, and national clinical and community partners to implement evidence-based interventions and population-based research in cancer prevention and control in order to promote health equity.
- Facilitate training and technical assistance for healthcare teams to implement cancer prevention and control initiatives aimed at reducing barriers and increasing access to care.
- Convene partners at the local, regional, and national levels with a shared interest in cancer prevention and control to align efforts for increased reach and effectiveness.

MUST SUSTAIN PATIENT NAVIGATION

Purpose of CCSP PN Sustainability Planning

- Evidence base for patient navigation (PN) is well established.
- Grant support for patient navigation is diminishing as its evidence base continues to build. Payer reimbursement is on its way.
- Important for clinics to consider how to build capacity and make the business case for maintaining patient navigation practices for cancer prevention, chronic care, and other evidence-based clinical practices.
- CCSP is providing dedicated support to clinic systems in efforts to sustain PN practices within their setting and exploring strengths and opportunities for improvement

Sustainability…More Than a Word and More than Money….

sus·tain·a·bil·i·ty

Partnership with Washington University

- CCSP piloted the Program Sustainability Assessment Tool (PSAT) with subset of CCSP clinics
  - Received feedback that the tool didn't entirely capture the landscape of clinical setting and navigation work
- Support from Wash U team to adapt tool
  - At this time Wash U was also piloting clinical tool – Clinical Sustainability Assessment Tool (CSAT)
- Continued support with implementation including technical assistance, facilitation, etc.
  - Wash U piloting shortened versions of the PSAT and CSAT; guidance and analysis support for CCSP's pilot of a shortened PNSAT

Adapting the Wash U Sustainability Domains

Wash U PSAT

PSAT Domains	Definition
Environmental Support	Supportive internal and external climate for the program
Funding Stability	Establishing consistent financial base for program
Partnerships	Cultivating connections between program and stakeholders
Organizational Capacity	Internal support and resources to effectively manage program
Program Evaluation	Assessing program to inform planning and document results
Program Adaptation	Adapting program to ensure ongoing effectiveness
Communication	Strategic communication with stakeholders and public about program
Strategic Planning	Using processes to guide program's directions, goals, strategies

Wash U CSAT (Pilot version)

CSAT Domains	Definition
Engaged Staff & Leadership	Having supportive frontline staff & management within the organization
Engaged Stakeholders	Having external support and engagement for the practice
Monitoring & Evaluation	Assessing the practice to inform planning & document results
Planning & Implementation	Using processes that guide the direction, goals & strategies of the practice
Outcomes & Effectiveness	Understanding & measuring practice outcomes and impact
Workflow Integration	Designing the practice to fit into existing practices & technologies
Organizational Context & Capacity	Having the internal support and resources needed to effectively manage the practice

CCSP PNSAT

PNSAT Domains	Definition
Engaged Staff & Leadership	Having frontline staff & management within the organization who are supportive of the PN practice
Organizational Context & Capacity	The PN practice has the internal support & resources needed to effectively navigate patients/clients
Funding Stability	The PN practice has established a consistent financial base
Engaged Community	The PN practice has external support & engagement (beyond the clinical navigation team)
Communication, Planning, & Implementation	Using processes that guide the direction, goals, & strategies of the PN practice
Workflow Integration	Designing the PN practice to fit into existing processes, policies, & technologies
Monitoring & Evaluation	Assessing the PN practice to inform planning & document results
Outcomes & Effectiveness	Understanding & measuring practice outcomes and impact of the practice

Patient Navigation Sustainability Assessment Tool (PNSAT)

Staples ES and Dwyer AJ. (2023). Patient Navigation Sustainability Assessment Tool – Short Version. Colorado School of Public Health and University of Colorado Cancer Center, Aurora, CO.

PNSAT Domains	Definition
Engaged Staff & Leadership	Having frontline staff & management within the organization who are supportive of the PN practice
Organizational Context & Capacity	The PN practice has the internal support & resources needed to effectively navigate patients/clients
Funding Stability	The PN practice has established a consistent financial base
Engaged Community	The PN practice has external support & engagement (beyond the clinical navigation team)
Communication, Planning, & Implementation	Using processes that guide the direction, goals, & strategies of the PN practice
Workflow Integration	Designing the PN practice to fit into existing processes, policies, & technologies
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Outcomes & Effectiveness	Understanding & measuring practice outcomes and impact of the practice

Navigation Capacity

–

Building Initiative Grants

CCSP Sustainability Planning Process

1. 3-5+ individuals from a variety of roles and perspectives, the sustainability planning team, each complete the PNSAT from their individual perspective.
2. Individual score reports are emailed to respondents (if completed online) or can be calculated manually. Your team may choose to additionally calculate the overall average scores of the sustainability team for use in discussion.
3. Develop and implement sustainability action plan:
   - Meet with sustainability team to discuss results, including strengths and areas for improvement
   - Identify 1-2 PNSAT domains that are feasible to address in a time-bound sustainability action plan
   - Develop sustainability action plan, including SMART goal, steps, timeline, resources needed, partners to engage
   - Implement the sustainability plan, and re-evaluate sustainability capacity with the PNSAT at least annually

Changes in Sustainability Capacity – CCSP Clinics

Average PNSAT scores of CCSP Clinics									
	Overall	Engaged Staff & Leadership	Org. Context & Capacity	Funding Stability	Engaged Community	Comm., Planning, Implementation	Workflow Integration	Monitoring & Eval	Outcomes & Effectiveness
AVG. TOTALS Round #1 FY19-20	**5.2**	5.5	5.4	4.9	5.4	5.1	5.3	5.0	5.3
AVG. TOTALS Round #2: FY21	**5.4**	5.8	5.6	5.1	5.5	5.2	5.6	5.3	5.4
Change	**+0.2**	+0.3	+0.2	+0.2	+0.1	+0.1	+0.3	+0.3	+0.1

Domains addressed in sustainability plans:

- Workflow Integration (10)
- Communication, Planning and Implementation (9)
- Funding Stability (5)
- Monitoring and Evaluation (4)
- Outcomes and Effectiveness (3)
- Organizational Context & Capacity (1)

Do you feel that your clinic's capacity to sustain patient navigation for preventive cancer screenings has improved since the start of your clinic's participation in CCSP during the current grant cycle (2018-present)?

- Yes to a great extent – 32.0% (n=8)
- Yes, a moderate amount – 48.0% (n=12)
- Yes, a little bit – 12.0% (n=3)
- Not sure – 8.0% (n=2)

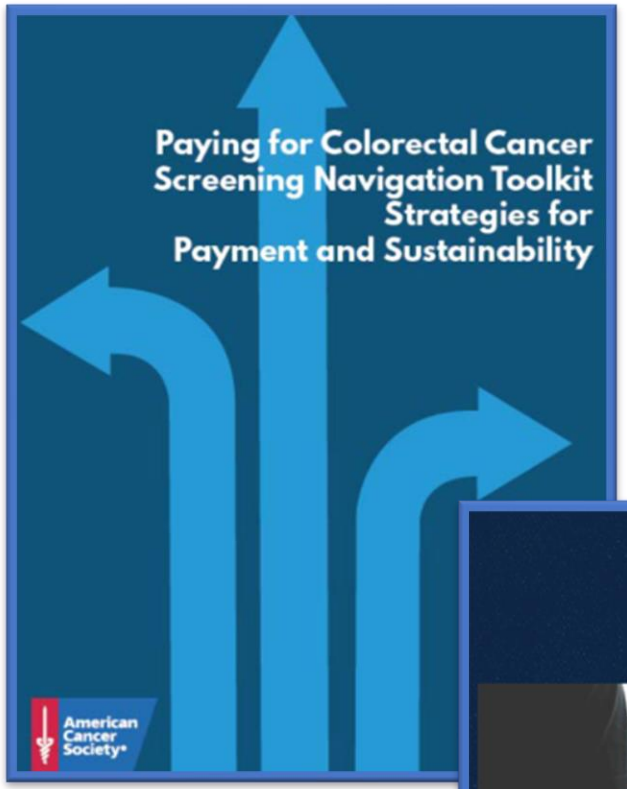
Dwyer AJ, Staples ES, Harty NM, LeGrice KE, Pray SLH, Risendal BC. What makes for successful patient navigation implementation in cancer prevention and screening programs using an evaluation and sustainability framework. Cancer. 2022;128 Suppl 13:2636-2648. doi:10.1002/cncr.34058

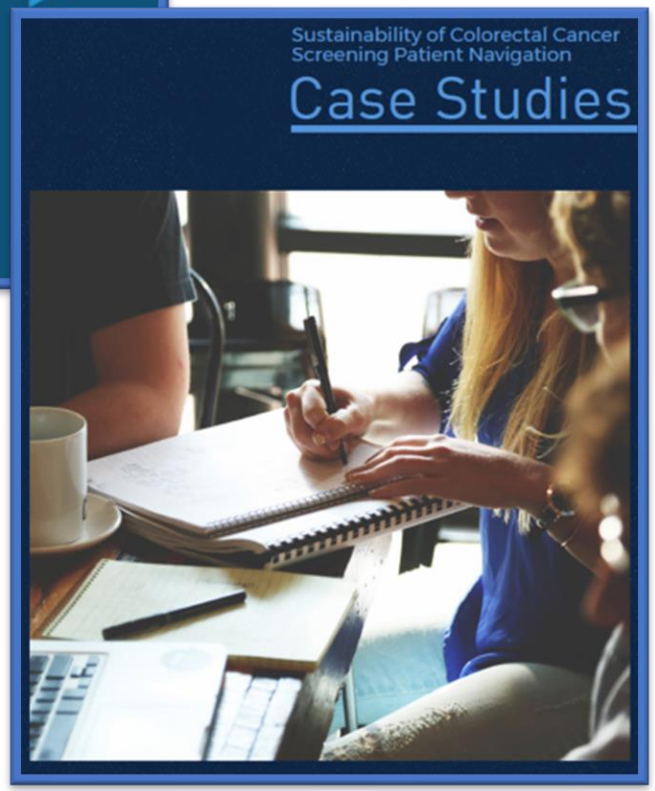
Tips for Successful Sustainability Planning

- Identify a sustainability planning team that includes people who can bring about change – champions, leadership, admin
- **There are no right or wrong answers – Do your best to answer PNSAT questions from your perspective even if not an 'expert' on all domains**
- Focus on what you can change – sustainability planning is an iterative process beyond scores alone
- Importance of working together – maintain regular team communication and follow-up
- Align sustainability planning with larger organization goals and initiatives
- Monitor progress and reassess – anticipate challenges, capacity building doesn't happen overnight

CCSP Sustainability Planning Process

- An iterative process
- Paying for Patient Navigation Sustainability Toolkit
- CCSP Sustainability Capacity Building Case Studies
- Piloting and adaptation of Washington University sustainability assessment tools and sustainability planning process
- Implementation of sustainability planning process with each clinic system





Resources

- **CCSP PNSAT website:** https://sites.google.com/view/pnsat
  - Take the PNSAT and create a sustainability action plan
- **2022 article in *Cancer* on CCSP navigation implementation and sustainability planning:** Read the article.
  - Dwyer AJ, Staples ES, Harty NM, LeGrice KE, Pray SLH, Risendal BC. What makes for successful patient navigation implementation in cancer prevention and screening programs using an evaluation and sustainability framework. *Cancer*. 2022;128 Suppl 13:2636-2648. doi:10.1002/cncr.34058.
- **CCSP website:** implementation resources for cancer screening navigation and EBIs: https://sites.google.com/view/colorado-cancer-screening-prog/

Implementing evidence-based interventions through the lens of quality improvement

Tracie Lewis, MS
Colorectal Cancer Prevention Network
Operations Director

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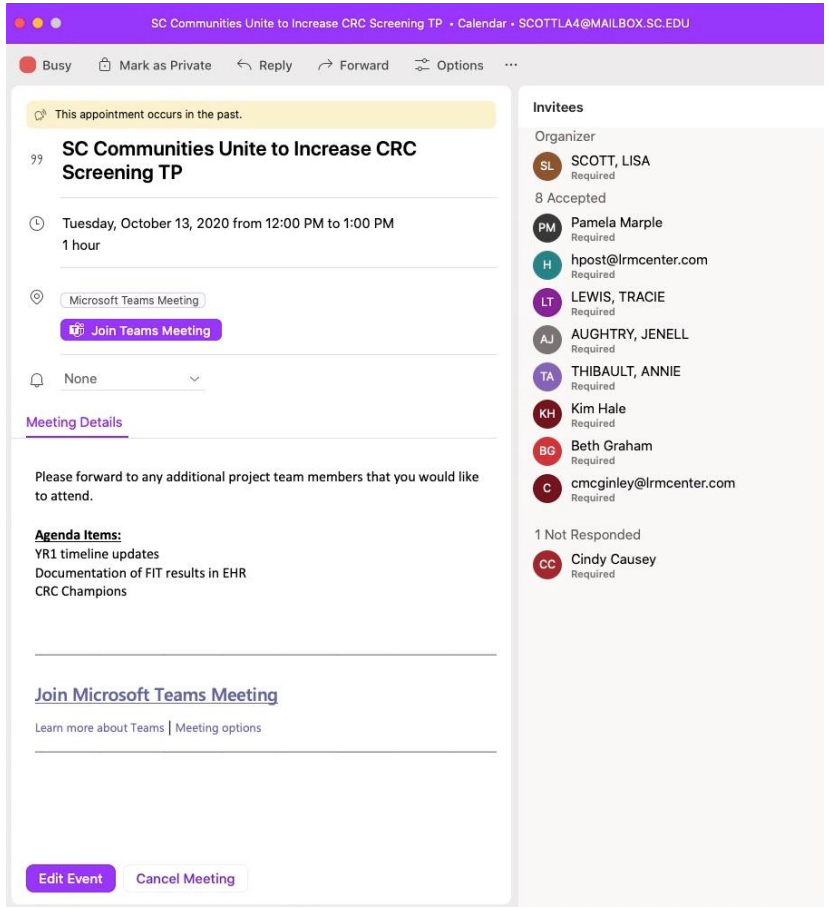
Build support: System Leadership Meeting

- Project Timeline
- Deliverables



Action Items	Due by	Submit to
Select project team members to attend LC Boot Camp • 1+ representative from each clinic • 2+ QI Team/Leadership representatives	11/13/2020	Lisa Scott Scottla4@mailbox.sc.edu
Identify clinic CRC Champion • 1 per participating clinic site • 1 per organization level	11/13/2020	Lisa Scott Scottla4@mailbox.sc.edu
Schedule Jan-March Interactive TA January: 1/4/2021-1/15/2021 February: 1/22/2021-2/16/2021 *Is there a clinic-level CRCS Current State Process Map?* March: 2/19/2021-3/13/2021	11/13/2020	Lisa Scott Scottla4@mailbox.sc.edu
Submit completed assessments: • Readiness Assessment • Capacity Assessment • COVID-19 Assessment	12/8/2020	Online via Qualtrics

Scheduling Interactive TA for January 2021 – March 2021

January Date Range: 1/4/2021-1/15/2021. **Focus: AIM Statement and QI Action Plan**

Required staff attendance: Project lead, identified clinic lead and health system's leadership (CMO, COO, QI director)

February Date Range: 1/22/2021-2/16/2021*. **Focus: Current State Process Map**
*Only needed if there is **NOT** a clinic-level CRCS Current State Process Map*

Required staff attendance: All key staff involved in current CRC screening process. This could include but not limited to: front desk, referral specialists, CNA/MA, charge nurses, providers, lab representatives, office manager, caseworkers, QI and billing staff.

March Date Range: 2/19/2021-3/13/2021. **Focus: Root Cause/Gap Analysis**

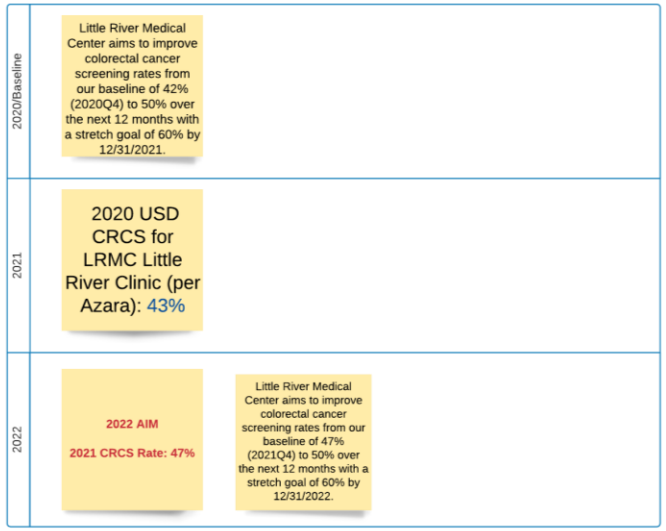
Required staff attendance: Staff representation from each department, including patient/Health System Board member (include staff attending clinic/health system QI meetings).

Trust the Process: Start with an AIM Statement

AIM Statement Worksheet	
Clinic Name	
What is our specific numerical goal?	
What is the target population?	
Where will do it?	
What is the time period to achieve this AIM?	January 1, 2023 – December 31, 2023
Why is it important to do it now?	
Combine the above into a single AIM statement.	

Purpose: An AIM statement clearly defines a specific plan to improve a targeted quality improvement measure (Clinic CRC screening rate) and guide your work by defining what success will look like for your clinic.

Target clinic staff: Project lead, identified clinic lead and health system's leadership (CMO, COO, QI director)



Little River Medical Center aims to improve colorectal cancer screening rates from our baseline of 47% (2021Q4) to 50% over the next 12 months with a stretch goal of 60% by 12/31/2022.

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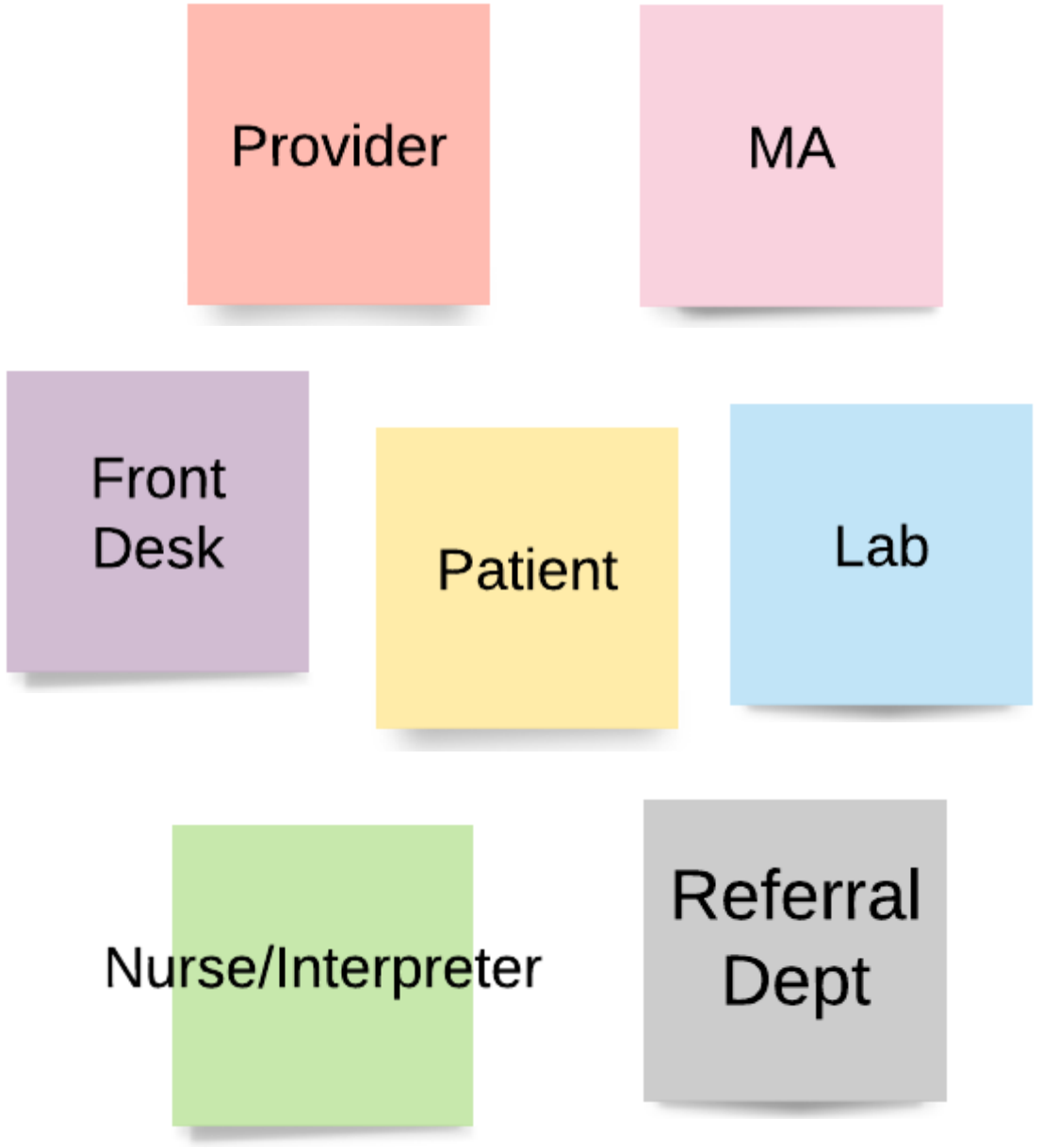
Sticky Note Exercise

Purpose: Validate clinic's current state process map for specific UDS Measure. Using a sticky note exercise in LucidChart, document a patient encounter and identify clinic staff responsible for each step. These sticky notes will be converted into swim lanes to show process flow between clinic staff.

Required Staff Attendance: All key staff involved in current CRC screening process.
This could include but not limited to: front desk, referral specialists, CNA/MA, charge nurses, providers, lab representatives, office manager, caseworkers, QI and billing staff.

The "WHY"

- If possible, have someone not involved in the process facilitate the discussion and documentation
- Each staff person gets a different color sticky
- Only 1 step per sticky note
- Alert words/phrases: I think, I'm pretty sure, maybe, probably



Sticky Note Exercise

Personal Task List during a colorectal cancer screening patient encounter	
Staff Name	
Staff Title	
Responsibilities/Tasks/Interactions you personally touch during a patient encounter including colorectal cancer screening. **List 1 task per line**	

Scope of Current State Process Map

- Start of Process: Identification of patient
- End of Process: Test completion and results in EMR

Interactive TA Session: Current State Process Map

Target clinic staff: All key staff involved in current CRC screening process.
This could include but not limited to: front desk, referral specialists, CNA/MA, charge nurses, providers, lab representatives, office manager, caseworkers, QI and billing staff.

Interactive TA Pre-work	
Process	**Colorectal cancer screening patient encounter.**

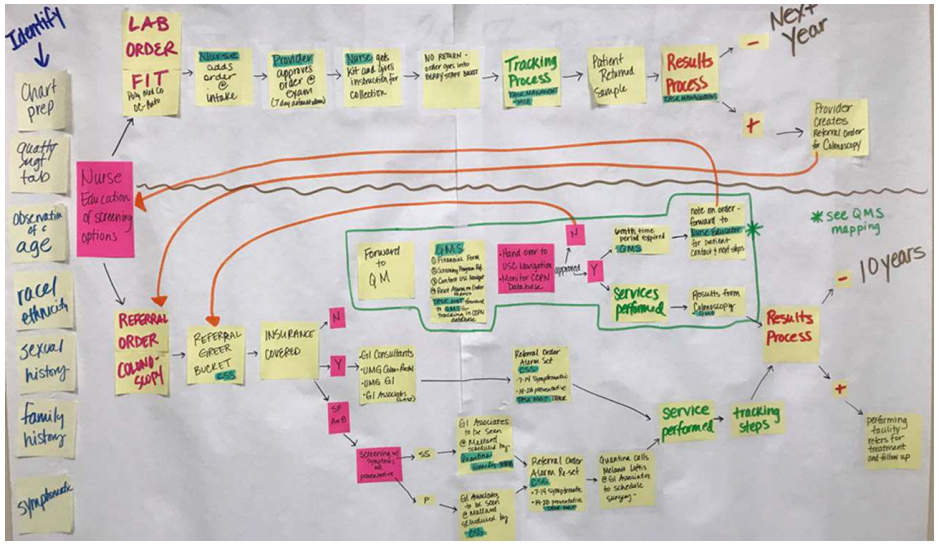
Validate current process for colorectal cancer screening:
 	
Use these dialogue questions to help guide you in identifying your personal tasks in a CRCS patient encounter
	○ When are patients identified for colorectal cancer screening? (This will be the start of the process and could start prior to patient arrival at clinic)
	  ○ Is there an alert/reminder for the patient to schedule appointment?
	  ○ Identified during daily huddle?
	  ○ Identified at check-in?
	○ Identify Staff responsible for ordering CRC screening test.
	○ Identify if, when, and how CRC screening is discussed with the patient. (this could be multiple staff)
	○ Identify if education is included pertaining to CRC screening referral and screening completion.
	○ When patient leaves the clinic:
	  ▪ Identify follow-up communication to ensure screening is complete
	  • Identify if EMR alert is utilized
	  • FIT: patient reminder (calls/alerts/text) -who's responsible and how many attempts
	  • Colonoscopy: what instructions do they leave clinic with
	  • Cologuard: what instructions do they leave clinic with
	  ▪ Identify if process includes follow up on positive screening results. Do patients leave with understanding of possibility of next steps? Who provides this information?
	  ▪ At any time during visit is the patient educated on what next steps would be if there is a cancer diagnosis? Who provides this information?
	○ Identify how results are acquired and who enters results into EMR (Colonoscopy, FIT, Cologuard)
	○ Identify how CRC screening test results are disseminated to patients.
	  ▪ By Phone: who makes the call
	  ▪ By letter: who mails the letter
	  ▪ EMR alert: what data is entered to trigger alert and who is responsible for data entry.

Sticky Note Exercise

The "WHY"

Look at the number of sticky notes under each staff position.

This can visually identify where balance in the process may need to be adjusted.



Places order in EMR for colonoscopy; goes to Referrals or Nurse

If nurse needed to order colonoscopy; will send Nurse case file or personally speak with Nurse

Colorectal cancer screening patient encounter.

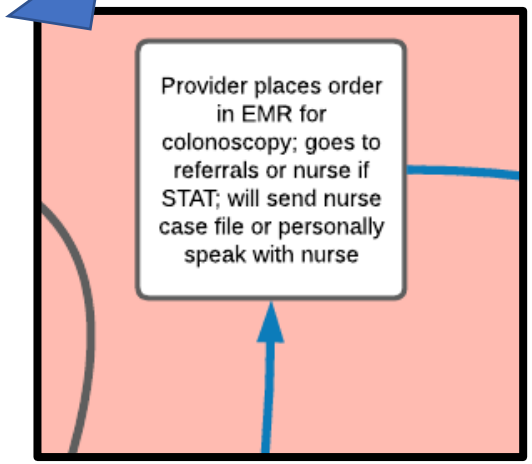
Eastover Family Practice

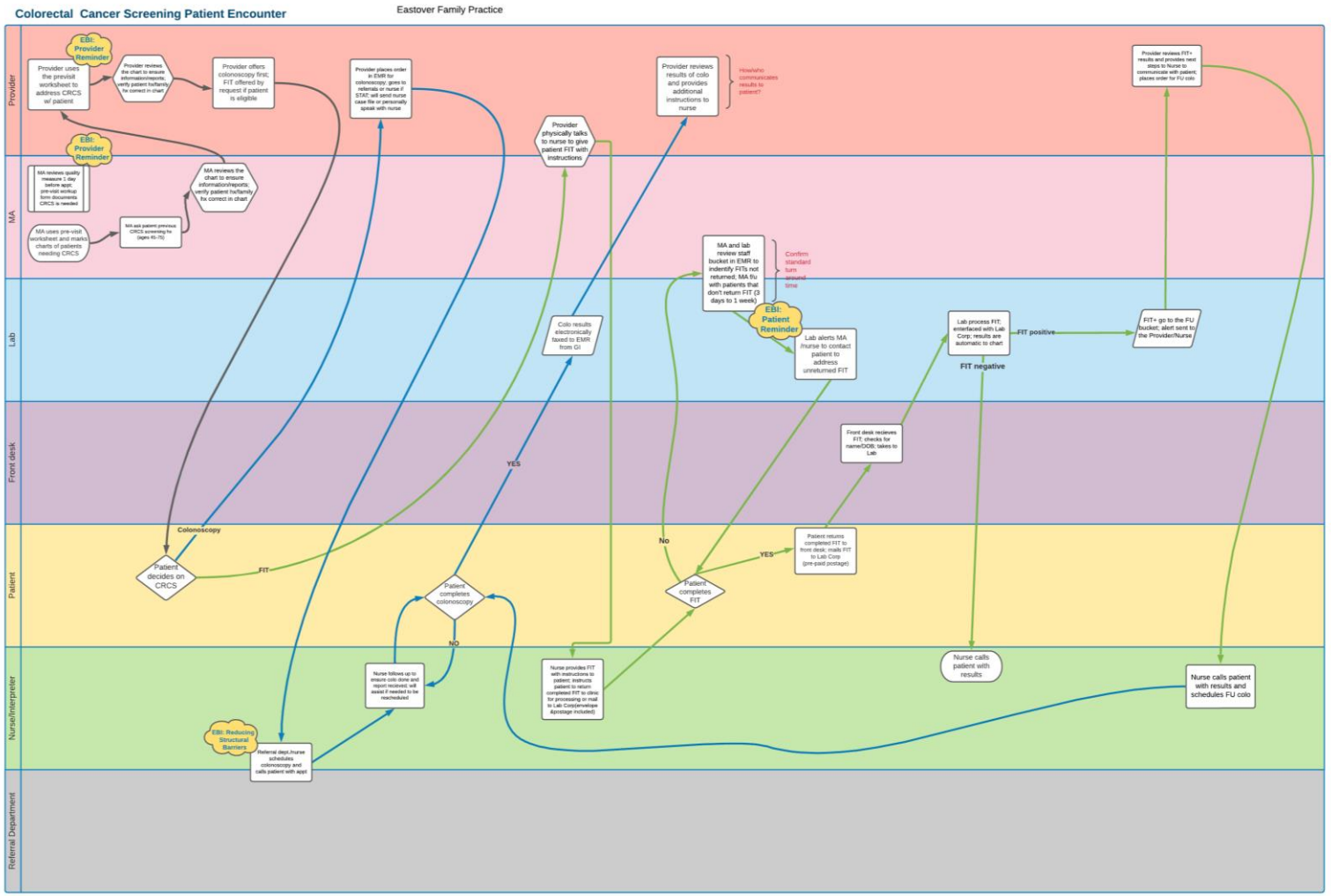
Provider	MA	Lab	Front Desk	Patient	Nurse/Interpreter	Referral Dept
review/Use the visit work	Review quality measure 1 day before appt	Reviews staff bucket for FITs not returned; not contacting patient	recieves FIT; checks for name/DOB; takes to Lab	Returns FIT to clinic	Provides FIT with instructions to patient	schedule colonoscopy and calls patient with appt (verify who calls pt)
Reviews personal/family hx; past couple months any symptoms/issues	Pre-visit worksheet; mark CRCS in needed	Alert MA or Nurse to contact pt if FIT not returned		Mails FIT to LabCorp	Instruct patient to return to clinic to be processed; envelope addressed to Lab Corp	
Colonoscopy typically offered first; FIT offered by request is eligible	Ask previous screening hx (45-75)	Process FIT; enterfaced with Lab Corp; results are automatic to chart			For FIT+: calls patient with results and schedules FU colo	
Provider physically talks to Nurse to give patient FIT with instructions	Reviewing the chart to ensure information/reports; verify patient hx/family hx correct in chart	FIT+ go to the FU bucket; alert the Provider or Nurse			Will call patient to provide results of FIT (postive/negative)	
Places order in EMR for colonoscopy; goes to Referrals or Nurse	Review staff bucket in EMR to indentify FITs not returned				Follows up to ensure colo done and report recieved; will assist if needed to be rescheduled	
If nurse needed to order colonoscopy; will send Nurse case file or personally speak with Nurse	Follows up with patients that don't return FIT (3 days to 1 week); verify standard					
Put order in EMR for FIT						
Provider reviews FIT+ results and provides next steps to Nurse to communicate with patient; places order for FU colo						
Reviews results of Colo and provides next step to Nurse if additonal FU or communication is needed with patient						

Current State Process Map (Swim Lane)

Places order in EMR for colonoscopy; goes to Referrals or Nurse

If nurse needed to order colonoscopy; will send Nurse case file or personally speak with Nurse

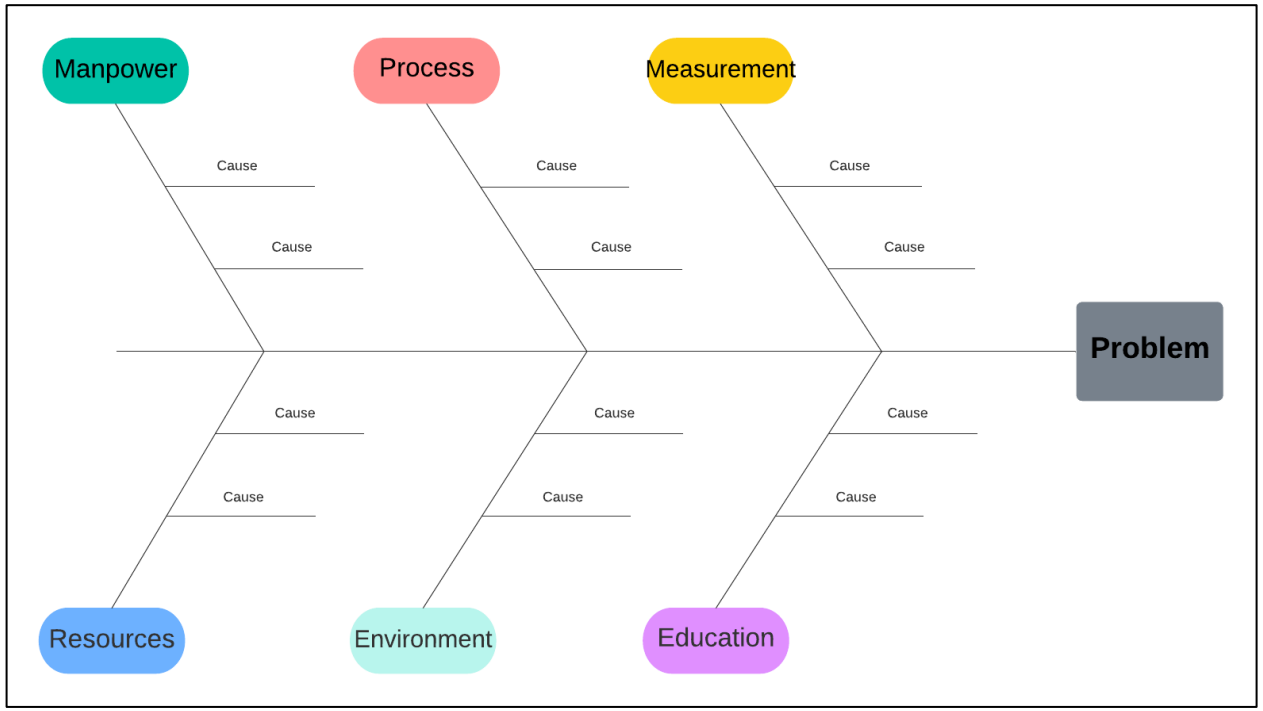




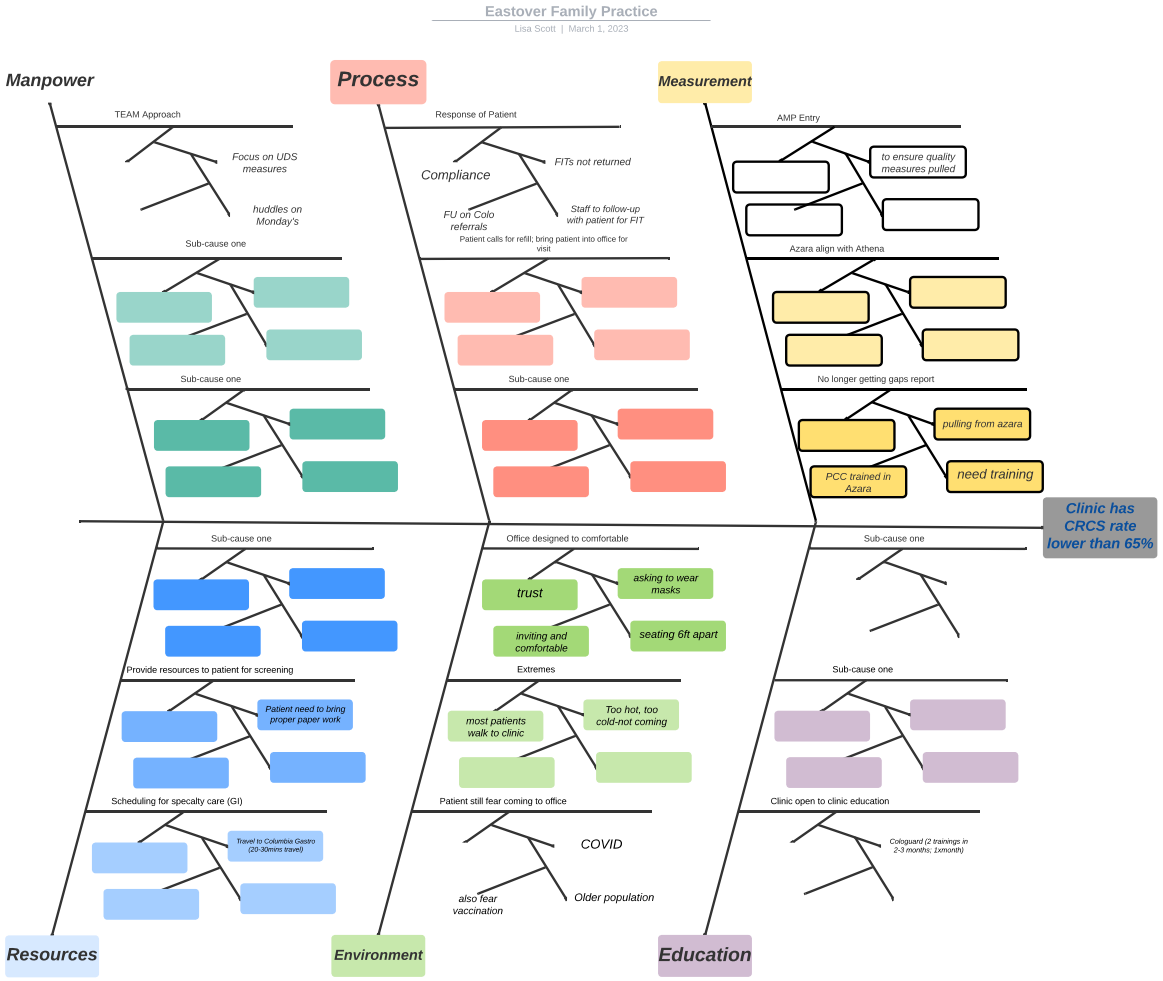
Next Step: Root Cause Analysis (Fish Bone Diagram)

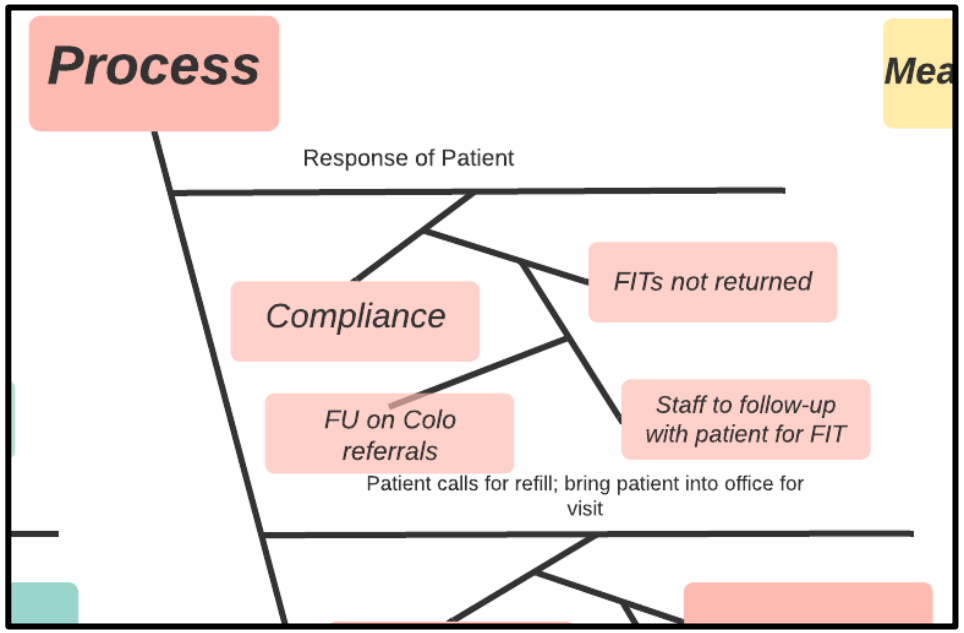
Purpose: To determine the cause(s) of identified problem(s) that impact the CRC screening process to determine area(s) of improvement(s) at the clinic level. It can be considered root only if the final negative effect is prevented for good after the cause is removed. A fish bone diagram exercise will be facilitated in LucidChart.

Required Staff Attendance: Staff representation from each department, including patient/Health System Board member (include staff attending clinic/health system QI meetings).

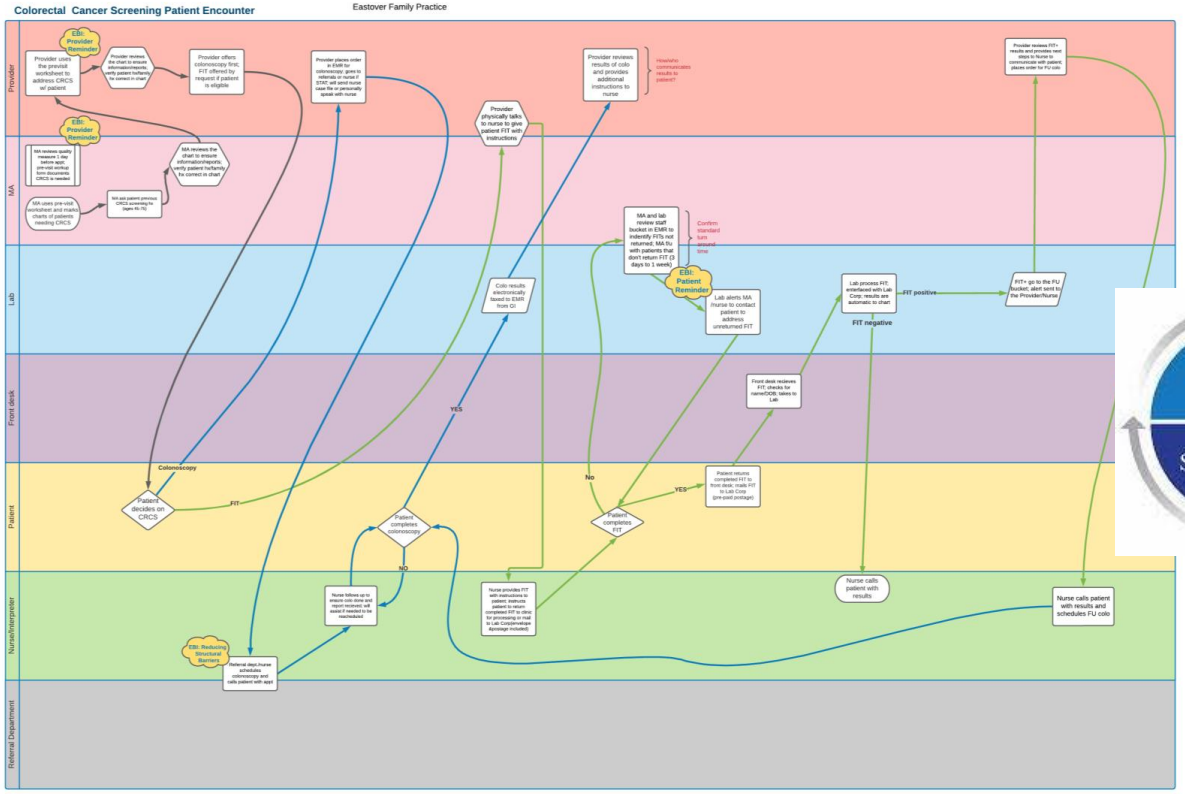


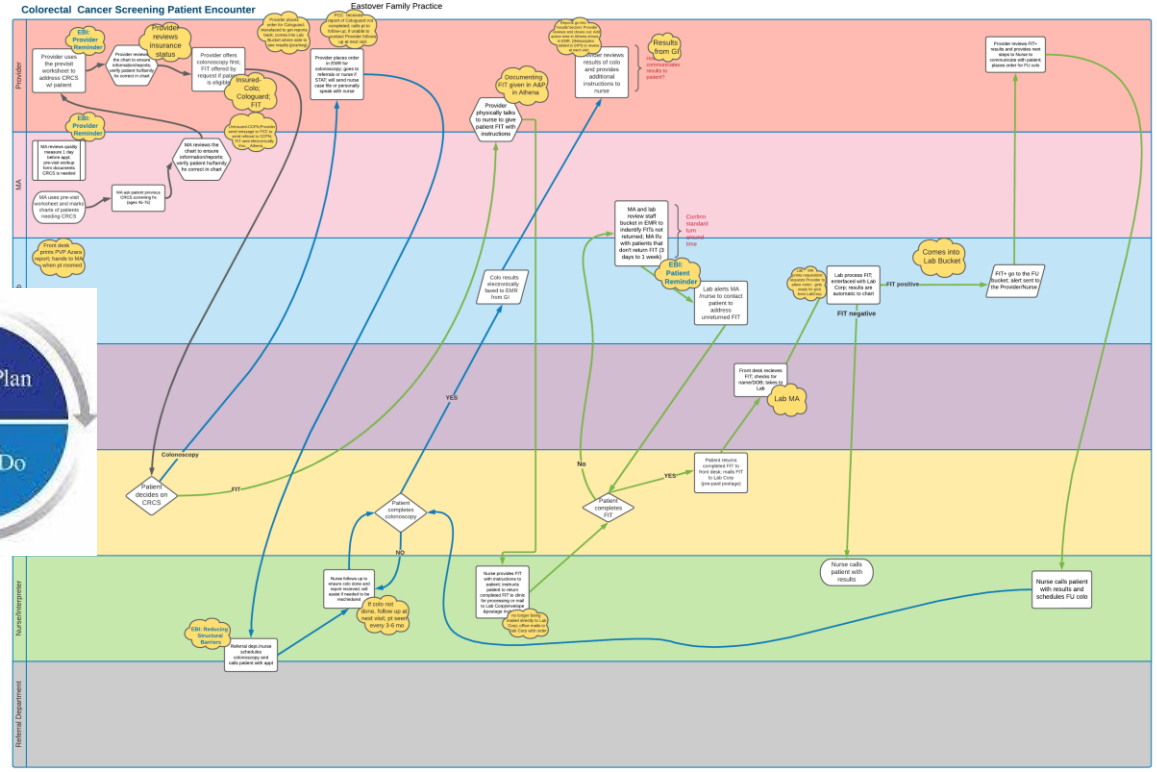
Fish Bone Diagram – Finding the gaps





From Current State to Future State





Represents adjustments in process after PDSA

Integrating Patient Navigators into Existing Colorectal Cancer Screening Clinical Workflows

Jo Henning, MPH
Colorado Cancer Screening Program
Senior Coordinator

Role of Patient Navigators in Colorectal Cancer Screening

Pre-Screening

- Patient education (screening options, importance of timely screening)
- Scheduling assistance
- Barrier reduction/addressing concerns

During Screening

- Reminders
- Coordination during transition of care (clinic to gastroenterology)

Post-Screening

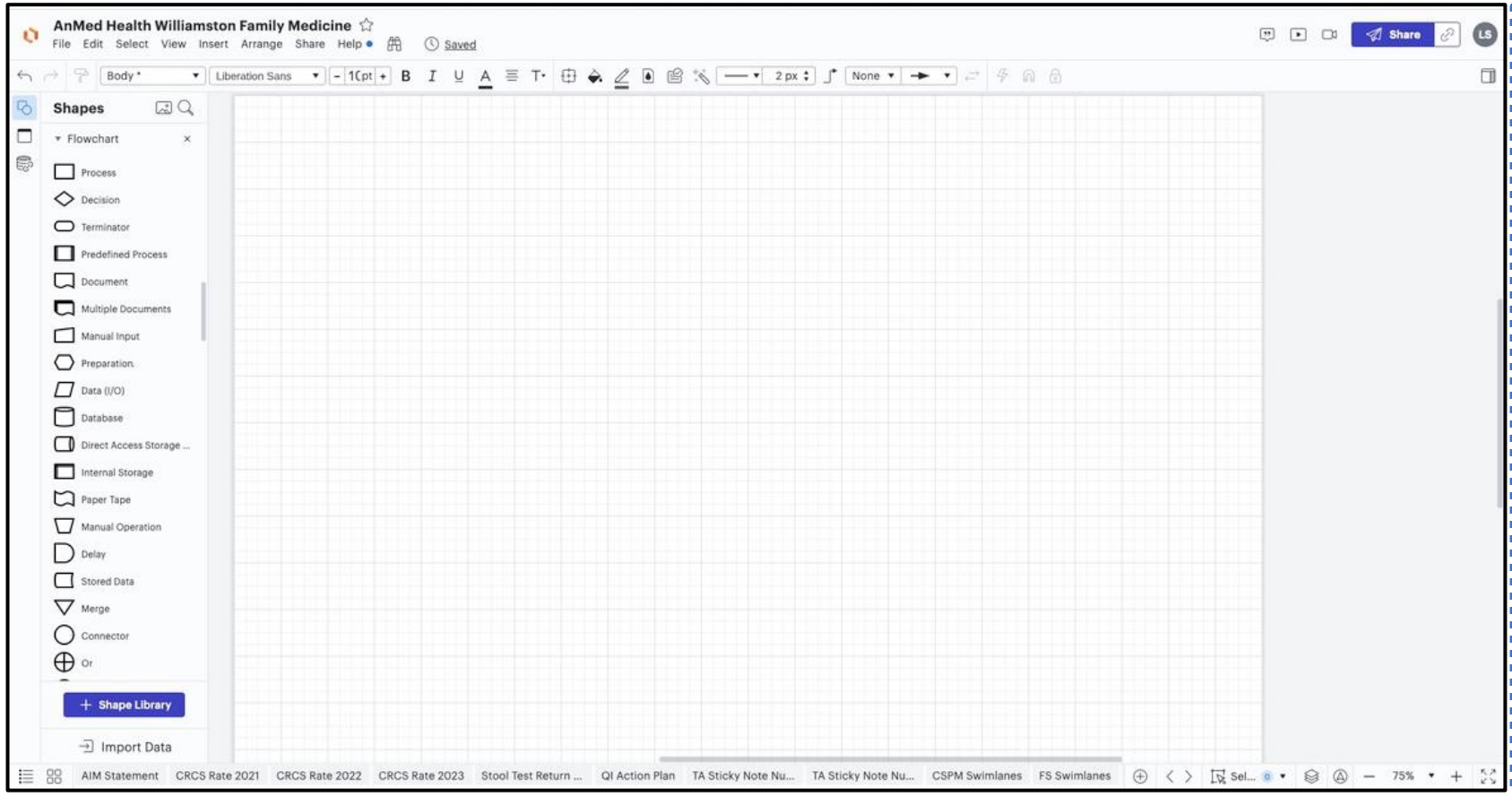
- Ensuring follow-up on results, and coordinating next steps
- Patient support

Implementation of Evidence-Based Interventions for Colorectal Cancer Screening

CCSP Process

1. Sticky Note Exercise
   - Workflow – Emphasis on where the Navigator fits
2. Gap Analysis/Fishbone Diagram
3. AIM Statement and EBI Selection
4. Quality Improvement Action Plan/PDSA Cycle
5. EBI Action Plan

Visually Collaborate with LucidChart

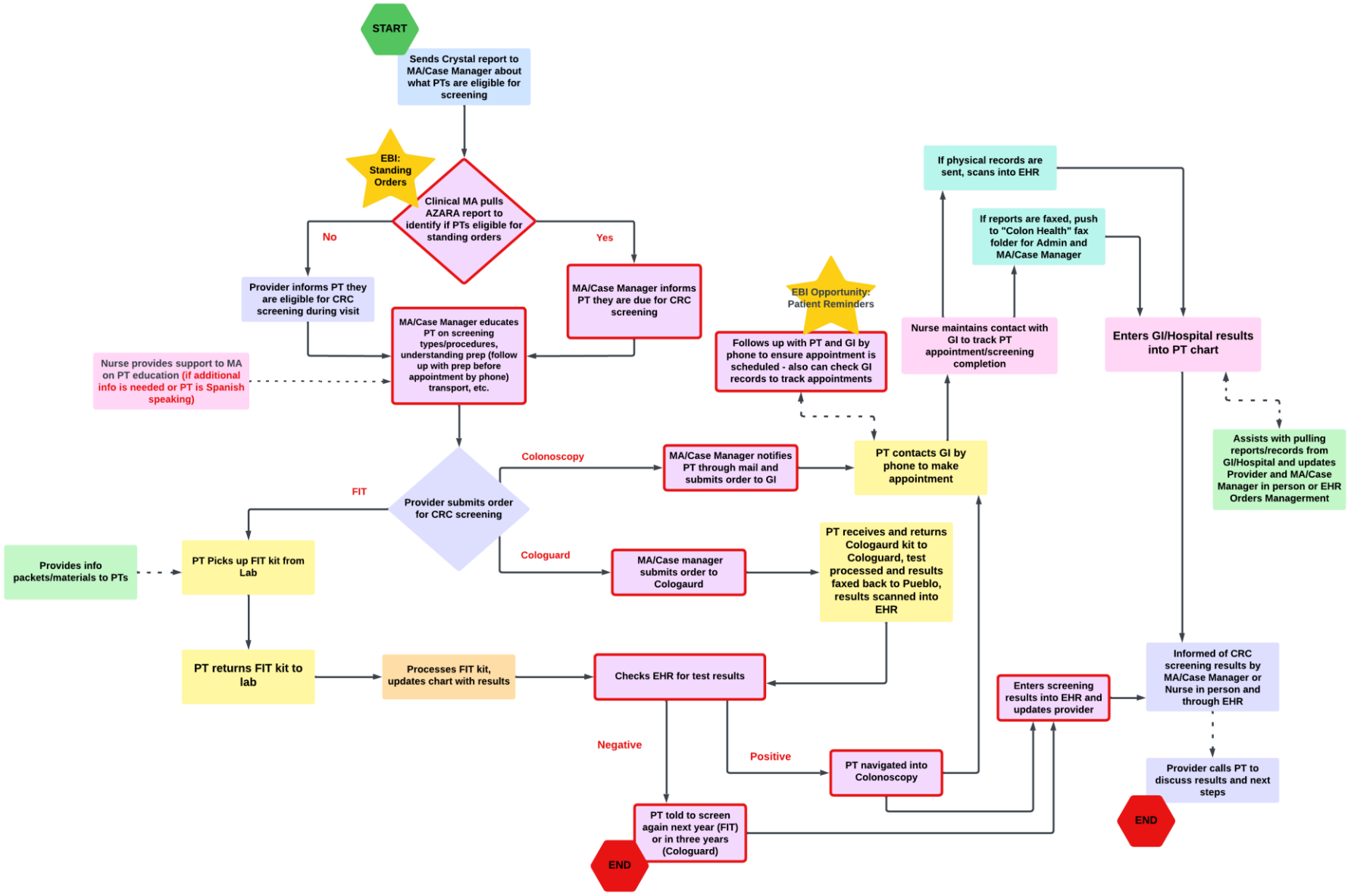


The "WHY"

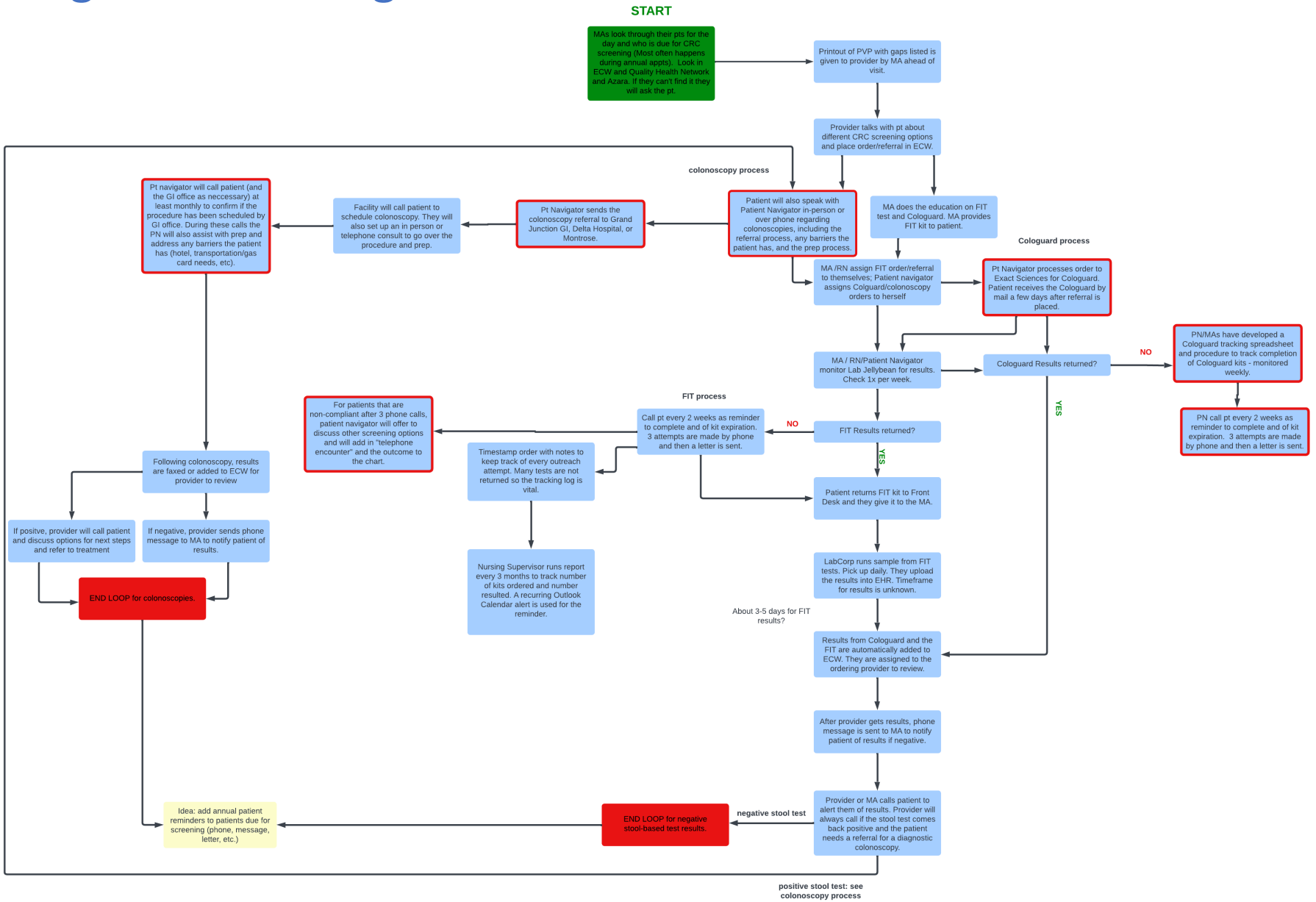
- Work "live" in a document
- Document each step
  - Each step gets a tab
- Share with project team members
  - Give rights to edit or view
- Templates (charts, fishbone)
- Customizable
- Easy drag and drop flow chart shapes

Sticky Note Exercise

Integrating Patient Navigation



Integrating Patient Navigation



Outcomes of Integrating Patient Navigators into Clinical Workflows

Benefits

- Inclusion of Navigators frees up time for Providers to focus on direct patient care
- Navigators may lead to fewer missed appointments and procedures, improving use of resources
  - Navigation services can lead to improved bowel prep for colonoscopy
- Success of Navigators can secure stronger relationships with endoscopy/specialty services/providers, leading to improved communication and patient outcomes

Challenges

- Lack of dedicated funding and current limited reimbursement models
- Unclear/inconsistent role boundaries
- Training and standardization
- Sustainability

Dwyer AJ, Staples ES, Harty NM, LeGrice KE, Pray SLH, Risendal BC. What makes for successful patient navigation implementation in cancer prevention and screening programs using an evaluation and sustainability framework. *Cancer*. 2022;128 Suppl 13:2636-2648. doi:10.1002/cncr.34058

Please post any questions in the Question box located in the ZOOM panel at the bottom of your screen.

American Cancer Society®

NATIONAL NAVIGATION ROUNDTABLE

Question and Answer

Next ACS NNRT Call To Action Webinar

November 19, 2024

Leveraging Technology to Benefit Patient Navigation Capitol

November 19, 2024
2:30 - 3:30 PM ET

https://navigationroundtable.org/news-events/events/

Thank You!

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