Case Studies

Case Study

Baylor College of Medicine-MD Anderson-Harris Health Cancer Patient Navigation Collaborative

Organization

The Baylor College of Medicine Dan L. Duncan Comprehensive Cancer Center (BCM), The University of Texas MD Anderson Cancer Center (MD Anderson), and Harris Health System (Harris Health) partner to care for underserved cancer patients in Harris County, Texas. Harris Health is an integrated safety net health system, and the third-largest safety net system in the country.

Contributors

- Aparna Jotwani, MD
- Susan Parker, MPH
- Maria Daheri, RN
- Helen Perez
- Martha Mims, MD, PhD
- Jane Montealegre, PhD

Tools Developed or Utilized

- Patient navigation integration model
- Case studies
- Guide to dashboard development
- Harris Health Cares
- EHR form for Barriers to Care

Contact

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Acknowledgment

This project was supported by the American Cancer Society Navigation Capacity Building Initiative Grant. Research aspects of the grant have been approved by the Baylor College of Medicine, Harris Health System, and The University of Texas MD Anderson Cancer Center Institutional Review Boards: (H-52529).

Project Description

This initiative created a new patient navigation program designed to meet the non-clinical-specific needs of lung cancer patients.

Primary PNSAT Domains

Engaged Staff & Leadership

Organizational Context & Capacity

Goals

- Integrate a lung oncology patient navigator into the oncology care team to decrease the days from diagnosis to treatment by 25% over 24 months - from 80 days to 60 days.
- Decrease time from entering the health system to financial eligibility determination by 15%.
- Decrease time from entering the health system to completion of diagnostic workup by 15%.
- Improve care plan compliance with Commission on Cancer's template by 20%.
- Discuss 100% of newly diagnosed lung cancer patients at Thoracic Tumor Board.
- Reduce no-show appointments by 15%.

Target Audience

The Collaborative provides individual patient navigation for pathology-confirmed lung cancer patients at Harris Health. An average of 2,200 new cancer patients are diagnosed and treated at Harris Health each year. Most of these patients are medically underserved, with 58% of them being uninsured and 27% having Medicaid or Medicare only.

Process

Organizational Context & Capacity

The lung navigation program was initiated by the Cancer Committee to meet Commission on Cancer Standard 8.1 and address barriers to care at Harris Health.

Engaged Staff & Leadership

Clinical and administrative champions supported full integration of the patient navigator into the health care structure and oncology care team, which includes oncology providers, nursing, and case management to effectively address patient and system-level barriers.

Workflow Integration

The patient navigator participates in the Thoracic Tumor Board, Quality Improvement and Barriers to Care Cancer Committee to ensure that new lung cancer patients are not vulnerable to fallout.

Outcomes/Key Metrics

- Increase in patients navigated
- Increase in patients given psychosocial supports
- Increase in patients provided with clinical trials education
- Decline in days from diagnosis to initial treatment

Results

For all cancer stages, the average time to treatment for lung cancer decreased after the implementation of the lung navigation program.

Questions

- **How has utilizing the domains/framework of sustainability helped you to accelerate health equity?**

  Our highest-scoring PNSAT domains are Engaged Staff & Leadership and Workflow Integration. Combined, these domains ensure that the barriers to care experienced by the patients are elevated to providers. Providing additional patient navigation and support to patients experiencing more barriers has the potential to facilitate health care access to them. By integrating patient navigation into the workflow, providers are given the opportunity to provide care for patients with additional barriers since those have been addressed by a dedicated patient navigator. Engaged staff and leadership ensure that the navigator receives support and positive reinforcement to effectively navigate patients.

- **What advice would you give to a program looking to improve Engaged Leadership or Organizational Concept & Capacity?**

  The following steps can be taken:

  - Offer examples of how patient navigation has been shown to improve patient outcomes, institutional metrics, and provider satisfaction.
  - Provide tangible opportunities to integrate the patient navigator into existing reporting and meeting structures (e.g., adding navigation updates to existing tumor board meetings).
  - Establish regular and positive touchpoints with project team, including providers of navigated patients
  - Establish a contact in the IT department for quick reporting and data extraction.
  - Provide regular updates to Cancer Committee and other relevant leadership groups, including metrics on the impact of patient navigation.

Case Study

Harold C. Simmons Comprehensive Cancer Center, University of Texas Southwestern Medical Center, Parkland Health, Children's Health

Organization

The Harold C. Simmons Comprehensive Cancer Center (SCCC) includes three clinical sites: University of Texas (UT) Southwestern Medical Center, Parkland Health (the safety-net provider), and Children's Health. UT Southwestern clinical sites include a central Dallas location and two regional locations: Richardson/Plano, Fort Worth and RedBird in Southern Dallas.

Contributors

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Primary PNSAT Domains

Engaged Community

Organizational Context & Capacity

Workflow Integration

Tools Developed or Utilized

Patient-facing clinical trial educational resources (English and Spanish):

- Frequently asked questions and decision-making flyer
- Importance of diversity in cancer clinical trial flyer
- Quick reference guide about cancer clinical trials
- Clinical trial navigation workflow process

Contact

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Goals

The overall goal of the project is to increase understanding of access to, and participation in, cancer clinical trials.
To address this, targeted goals are listed below:

- Expand and scale-up a cancer clinical trial navigation program for adult cancer patients.
- Provide navigation services to patients considering or participating in cancer clinical trials.
- Evaluate the impact of a cancer clinical trial navigation program on core metrics.

Target Audience

Our navigation program focuses on the adult cancer population. The SCCC catchment population (n = 8,136,730), catchment area cancer cases (N = 29,390), and new cancer cases diagnosed at SCCC (N = 8,238) are highly diverse with respect to gender, ethnicity, and race. The proportion of underrepresented minority (URM) cancer cases at Simmons exceeds the proportion of URM cancer cases in the catchment area.

Process

Workflow Integration

Developed standardized workflow and documentation for cancer clinical trial navigation

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Outcomes & Effectiveness

- Collected key metrics measuring social determinants of health (SDOH) and interventions supporting increased access to care and clinical trials
- Created clinical trial navigation reports, analyzed findings, and recorded trends and outcomes. This process included entering and reviewing data and documenting changes in program metrics.
- Focused on process improvement through regularly scheduled meetings

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Key Metrics

From January 1, 2024, to June 30, 2024, 188 patients were provided clinical trial education. This represents a 37% increase from the previous reporting period (July 2023 to December 2024). Clinical trial navigators continue to perform the following:

- Support patient education related to clinical trials.
- Educate providers and staff involved in clinical trials of cultural beliefs and practices that may affect patients' choices.
- Increase awareness of clinical trials among providers and staff through education and outreach efforts.
- Participate in community outreach events.

Results

- The clinical trial navigation program continues to increase the number of patients served via navigation:
  - July 2022 to December 2022, N = 52
  - January 2023 to June 2023, N = 95
  - July 2023 to December 2023, N = 137
  - January 2024 to June 2024, N = 188
- Clinical trial navigators address financial toxicity by facilitating patient applications for UTSW financial assistance and/or the institution's Financial Reimbursement Program (supported by the Cancer Prevention and Research Institute of Texas).

Questions

- **How has utilizing the domains/framework of sustainability helped you to accelerate health equity?**
  This funding allowed us to develop and implement the clinical trial navigation program and to create a business case for the benefits of clinical trial navigation within the SCCC. The program continues to advocate for its expansion to improve patient outcomes.

- **What advice would you give to a program seeking to impact the domain of Outcomes & Effectiveness?**
  The clinical trial navigation program was intentional about collecting data systematically within REDCap and internal tracking tools, through which clinical trial navigators enter and review data and document changes in program metrics. The continual focus on process improvement during monthly program meetings and biweekly clinical trial navigator meetings allows for opportunities to share lessons learned. The prioritization of process improvement and communication has led to an increase in patient education and referrals.

Case Study

Huntsman Cancer Institute

Organization

Huntsman Cancer Institute (HCI) is the only NCI-designated comprehensive cancer center in the Mountain West. It is on the University of Utah campus in Salt Lake City. In 2021, HCI committed to serving Utah, Wyoming, Nevada, Idaho, and Montana residents.

Contributors

- Donna Branson
- Jeff Yancey, PhD
- Liliana Mulato
- Amelia Thelin
- Bea Lingwall

Primary PNSAT Domains

Engaged Community

Workflow Integration

Organizational Context & Capacity

Tools Developed or Utilized

- ACS LION Bootcamp, ACS webinars
- Patient navigation dashboard
- Role descriptions
- Onboarding and training tools
- Case studies

Contact

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Goals

- Develop an evidence-based patient navigation program; incorporate patient and family feedback that contributes to improving access to care and treatment outcomes and returns patients closer to home for continued follow-up.
- Reduce health disparities among our navigated frontier and rural oncology patients.
- Develop a suite of educational and navigational tools to support patients and their loved ones during cancer treatment.

Project Description

The Innovation in Rural Oncology Navigation (IRON) Expansion to the Mountain West initiative is the creation of a patient navigation program targeted to address barriers faced by frontier and rural patients.

Target Audience

Frontier and rural patients face numerous barriers accessing equitable health care, including being uninsured or underinsured; challenges in transportation, travel time, travel cost, lodging; and the inability to drive due to treatment side effects and lost wages. The average patient travels 600 miles round trip. Rural patients are underrepresented in oncology care, having higher cancer mortality rates and have less access to clinical trials.

Process

Engaged Community/Engaged Staff & Leadership

- Key Informant interviews with patients, caregivers, and health care professionals to determine barriers faced and helpful services
- Incorporated feedback from the Frontier/Rural Leadership Committee to design the program and make modifications based on observed barriers
- Facilitated three focus groups to initiate a community advisory group
- Based on collected information, developed the rural and frontier patient navigation program and addressed the key barriers to care for this population

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Workflow Integration

- Established metric and data collection in Epic and other systems
- Maximized efficiency of patient navigation referral process by developing and implementing patient navigation flags and a patient navigation work queue in Epic

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Outcomes/Key Metrics

As of July 1, 2024:

- 300 frontier/rural cancer patients were navigated.
- The no-show rate dropped by almost 60%.
- Patients receiving treatment were routinely screened for psychosocial distress; the Frontier/Rural Leadership Committee's recommendation resulted in four times as many screenings being conducted.

Results

HCI Leadership has committed to funding this program after grant funding ends, and the program will expand to offer navigation to patients from Idaho and Nevada.

Questions

- **How has utilizing the domains/framework of sustainability helped you to accelerate health equity?**
  Using the domains helped us to engage our staff and leadership in examining our processes and looking at ways that we can refine them to improve health equity. HCI is aware that distance is a disparity and is committed to reducing barriers for frontier and rural cancer patients.

- **What advice would you give to a program seeking to impact the domain of Outcomes & Effectiveness?**
  It is important to invite others in your organization to be part of the planning process. Having a robust Leadership Committee comprised of a multidisciplinary group of professionals helped us solicit program feedback and led to "buy-in" by the committee. Having a community of engaged individuals helped us to align well with existing clinical systems like Epic.

Case Study

Peak Vista Community Health Center, Colorado Cancer Screening Program

Organization

The Colorado Cancer Screening Program (CCSP) aims to reduce disparities in access to cancer screening among Colorado communities by providing technical assistance to safety net clinic systems to implement evidence-based interventions for colorectal cancer (CRC) and other cancer screening and control initiatives. Peak Vista Community Health Center is a federally qualified health center based in Colorado Springs and surrounding communities with 15 clinic sites.

Contributors

- **Peak Vista:** Peak Vista Quality Assurance team
- **Colorado Cancer Screening Program:** Andrea Dwyer, MPH, Director; Elsa Staples, Senior Program Manager

Primary PNSAT Domains

Communication, Planning, & Implementation

Monitoring & Evaluation

Tools Developed or Utilized

- Quarterly presentation for medical and organizational leadership focused on patient navigation processes and outcomes
- CRC screening and patient navigation workflows
- Navigation evaluation data

Contact

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Acknowledgment

CCSP is funded by the Cancer, Cardiovascular, and Pulmonary Disease Grant Program.

Project Description

CCSP provided technical assistance to each of the participating safety net clinic systems to engage in a sustainability planning process. This included forming a sustainability team, assessing their current capacity for sustainability of patient navigation for CRC screening, including strengths and opportunities for improvement, and developing and implementing a sustainability plan. The Peak Vista Community Health Center sustainability plan focused on ensuring that leadership and staff at a system-wide level understood the role and value of patient navigators for reducing barriers to colonoscopy for CRC screening, the impact on patient outcomes, and improved consistency of the role across clinic sites. Starting in January 2020, the Peak Vista navigation team presented qualitative, quantitative, and financial outcomes to the internal quality, medical, and operational leadership teams quarterly, with the intention of consistently educating both operational and medical leadership on the navigation process and results.

Goals

Improve overall Communication, Planning, & Implementation; the core Peak Vista navigation team presented qualitative, quantitative, and financial outcomes to the internal quality, medical, and operational leadership teams on a quarterly basis, with the intention of consistently educating both operational and medical leadership on the navigation process and results using PNSAT.

Target Audience

Peak Vista serves primarily low-income individuals with Medicare, Medicaid, or those who are uninsured. The target population for colorectal cancer screening patient navigation is patients who are eligible for CRC screening between ages 45-75 and in need of a colonoscopy (both average-risk and high-risk patients). The target audience for the sustainability plan is Peak Vista's clinic leadership from the quality assurance, medical, and operational teams.

Process

Communication, Planning, & Implementation

- Peak Vista quality assurance and patient navigation teams prepared a quarterly presentation to quality, operational, and medical leadership sharing role/processes of navigators and evaluation data.
- These presentations continued through 2020, with periodic updates going forward.

Monitoring & Evaluation

- Peak Vista navigation and quality assurance teams received feedback from leadership following presentations that informed workflows or other elements of patient navigation (processes, training).
- The Peak Vista navigation team applied feedback to strengthen patient navigation processes for colorectal cancer screening and overall patient navigation workflows/evaluation elements.
- The Peak Vista navigation team used the PNSAT Sustainability Action Plan template to document their sustainability action plan and progress with implementation.

Outcomes/Key Metrics

- Patients navigated into colonoscopy for CRC screening
- Colonoscopy prep quality and complete exams (full examination of colon to cecum)
- CRC screening rate
- Number of quarterly presentations to quality, operational, and medical leadership
- Growth in size, roles, and responsibilities of the Peak Vista navigation team

Results

- Four presentations were made at leadership meetings.
- Better defined roles of care coordination navigators and clinic navigators were established for CRC, as well as the role of nurses and medical assistants for stool-based testing.
- 461 Peak Vista patients were successfully navigated into colonoscopy between July 2019-June 2022, with an 85% adequate bowel prep rate and 98% complete exams.
- Peak Vista's CRC screening rate increased from 27% in 2020 to 30% in 2022.

Case Study

RUSH University Medical Center – RUSH MD Anderson Cancer Center

Organization

RUSH University Medical Center is an urban, 671-bed Commission on Cancer-accredited academic health system medical center. The health system has three hospitals, multiple primary care and specialty care clinics, a network of providers, and a College of Health Sciences for education and research in health professions.

Contributors

- Claire Tobin, LCSW, OSW-C, CADC
- Bonnie Ewald, MA
- Ebony Henderson
- Kelly Aguilar

Primary PNSAT Domains

Engaged Staff & Leadership

Workflow Integration

Tools Developed or Utilized

- Cancer Center community health worker (CHW) standard operating protocol
- Job descriptions for CHWs
- Escalation and referral criteria
- Example EHR smart phrases with resource lists
- Individual-level dashboard

Contact

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Acknowledgment

We thank the American Cancer Society and The Coleman Foundation for their support in making this program possible.

Project Description

This initiative enhances the navigation partnership between RUSH University MD Anderson Cancer Center and RUSH's system-wide Community Health Worker Hub to integrate CHWs and address health-related social needs within cancer care at RUSH.

Integrating CHWs into the team provides higher-touch assistance to address social care needs through shared cultural and lived experience and community connection.

Goals

- Incorporate CHWs into oncology care navigation workflows to support the Cancer Center's rollout of system-wide social need screener.
- Develop workflow with standardized roles and responsibilities for navigation team members.
- Standardize timing of social determinants of health (SDOH) assessment and re-screening.
- Provide social care interventions to patients who screen positive for social needs.

Target Audience

In 2016, RUSH identified a 14-year life expectancy gap between Chicago's West Side neighborhoods and downtown communities, referred to as "the death gap." Research indicated this disparity in life expectancy was primarily attributed to chronic disease, including heart disease, diabetes, and cancer. By leveraging CHWs to reduce barriers to care and bridge clinic and community for disadvantaged and distressed patients, this project enhanced our cancer center's ability to contribute to health equity. CHWs focused on individuals who screened positive for distress or health-related social needs.

Process

Workflow Integration

- Streamed referral pathways for social care
- Optimized screening workflow and existing internal and external partnerships
- Created and curated list of relevant resources unique to individual needs
- Created a narrative documentation smart template
- Provided weekly CHW team support and case support discussions
- Designed to align with billing opportunities

Outcomes & Effectiveness

- Program-level monitoring of screening rates and outcomes
- Individual level dashboards

Key Metrics

- Program-level monitoring of SDOH screening rates and outcomes helped improve processes:
  - Monitoring positive responses allowed us to allocate direct resource funding to address most prevalent reported needs.
  - Monitoring screening and positivity rates helped catalyze further attention to social care across the Cancer Center as we continued to learn about how patients and families experience health-related social needs throughout their cancer journey.
- Program level monitoring of CHW intervention demonstrated:
  - Decrease in no-show rate
  - Increase in patient caseload
  - Increase in percent of patient population with screening on record
  - Increase in documentation of identified barriers to care
  - Increase in resources provided to address patient-reported barriers to care

Results

- Patients completed a SDOH screening; those who screened positive were flagged for CHW follow-up.
- CHWs facilitated the production of a community resources list. They also identified cancer patients' caregivers and referred them to supportive services.
- Standardized roles, workflows, and escalation protocols were incorporated into CHW proactive outreach to address select urgent needs like transportation.
- Each role was performed within defined scope/at top of licensure.
- A designated patient care navigator was utilized in collaboration with the CHWs to solve urgent transportation needs to help reduce no-shows and optimize utilization of appointment blocks.
- RUSH approved hiring for one additional CHW to supplement ACS-funded CHWs and approved funding the positions after grant funding concludes.

Questions

- **How has utilizing the domains/framework of sustainability helped you to accelerate health equity?**
  There are so many things it takes to implement and run a new initiative, including adding a new workforce to an existing team. It can be easy to get stuck in the details or feel overwhelmed. The PNSAT domains are a helpful reference for organizing these efforts and for continual revisiting to identify priority areas to address moving forward.

- **What advice would you give a program looking to impact the domain?**
  A provider may be confused by the different roles played by supportive oncology team members – including how the new CHWs fit in with existing patient care navigators and social workers. Instead of trying to make everyone understand who to go to for what, we have found success in streamlining the intake for other providers, so they only need to remember one referral mechanism to get what they need.

Case Study

The University of Chicago Medical Center / University of Chicago Comprehensive Cancer Center

Organization

The University of Chicago Medical Center (UCM)/University of Chicago Comprehensive Cancer Center (UCCCC) is an NCI-Designated Cancer Center and Chicago's first freestanding comprehensive clinical cancer center. It includes a 128-bed facility on its medical campus in the South Side of Chicago, Illinois.

Contributors

- Nita Lee, MD, MPH
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Primary PNSAT Domains

Engaged Community

Engaged Staff & Leadership

Organizational Context & Capacity

Workflow Integration

Tools Developed or Utilized

- Patient Journey Map
- Job Descriptions

Contact

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Project Description

This initiative expanded an existing patient navigation model across the UCM/NCI cancer network to improve the needs of the most vulnerable South Side patients during their cancer journey.

Goals

- Address fragmentation of care and care coordination gaps by developing a cohesive, system-wide navigation model.
- Prioritize the patient and caregiver experience.
- Increase the equitable use of technology.
- Improve health outcomes.
- Develop the current and future state map of the patient journey.
- Optimize existing nurse navigation workflows and functions.
- Enhance metric tracking, as well as identify ways of finding AI-supported technology to support patients in inpatient and outpatient care settings as they navigate throughout the health system.
- Ensure the patient and family voice remains central across all phases of work.

Target Audience

In the communities surrounding the University of Chicago, cancer is the second-leading cause of death, and residents are nearly twice as likely to die from the disease. Patients served are historically underserved patients; 43% are Black, 6.2% Hispanic, 2.8% Asian, and 44% receive Medicare and 23% Medicaid. UCM focuses efforts on newly diagnosed oncology patients in high-need, high-volume cancer populations.

Process

Workflow Integration

- Convened community engagement team and core multidisciplinary clinical team, emphasizing the importance of ongoing communication and coordination of care
- Charted the current patient journey, identifying barriers with input from the Patient Family Advisory Council and the Community Advisory Board
- Developed navigator job descriptions with defined roles and responsibilities
- Charted the current state of UCM Care Coordination, which helped drive optimization initiatives within Care Coordination
- Leveraged patient journey and planned interventions for identified barriers and gaps that would be enhanced by navigation or care coordination
- Developed optimal communication channels for patients, including printed materials
- Currently developing Oncology Navigation Dashboard with UCM IT
- Trained new nurse navigator on enhanced navigation process
- Carved out navigation spaces within new cancer pavilion blueprint

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Outcomes/Key Metrics

- 76% reduction in diagnosis to treatment date – 137 days to 33 days
- 48% increase in breast cancer clinical trials accrual

Results

- Optimized workflows, consistent tracking of patients, and development of our community health worker dashboard
- Created an Office of Patient Navigation with a dedicated physical space for navigation resources and navigation teams
- Built an EMR-integrated dashboard for performance tracking, patient outcome measures, and programmatic decision-making

Questions

- **How has utilizing the domains/framework of sustainability helped you to accelerate health equity?**
  Focusing on the Organizational Context & Capacity and Workflow Integration domains throughout this project has proven to be the right framing for us to grow our navigation efforts beyond our original intent. When planning for this project, UCM wanted to focus its effort on high-acuity/high-risk patients within the breastcancer population. Once we began assessing workflows, streamlining process, appropriately orienting patient touchpoints, and developing the REDCap tracker, we found that our nurse navigators were able to better address the needs of high-acuity patients. This clear tracking opened their capacity to provide support to all new breast cancer patients regardless of acuity or risk.

- **What advice would you give a program seeking to impact one of the domains highlighted? What obstacles or barriers were unexpected or unanticipated? Or were there unexpected consequences or successes from your focus on sustainable practice?**
  Within the Organizational Context & Capacity domain (which is currently a huge focus throughout the organization), the biggest obstacle was the lack of awareness of all the stakeholders and operational areas, which impacted or caused bottlenecks within the existing navigation process. At UCM, it is easy for operational areas to be siloed or for individuals to lack an understanding of the full picture. As a project team, we had to conduct numerous stakeholder meetings to understand the “off-ramps” within the process; however, when we assumed that we had covered an operational area, we often realized or learned that there was another group we had to engage with that wasn’t previously on our radar. While we may have done numerous stakeholder meetings to understand the existing navigation process, it was important to engage with everyone involved as they helped us make headway in optimizing and improving our oncology navigation system.

Case Study

University of North Carolina at Chapel Hill

Organization

Each year, over 18,000 patients from across the state of North Carolina are evaluated and treated for a malignancy at one of two University of North Carolina (UNC) Health facilities: the North Carolina Basnight Cancer Hospital and UNC Health REX. Among these cases, over 8,000 are analytic cases.

Contributors

- Jennifer Elston Lafata, PhD
- William Wood, MD, MPH
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- Jaime Richardson, BSN, OCN
- Danielle Rogers, BSN
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- Kayla Justham, BSN
- Caroline Deal, MSW

Primary PNSAT Domains

Workflow Integration

Monitoring & Evaluation

Tools Developed or Utilized

- Navigation assessment tool and related dashboard summary to summarize patients' social determinants of health (SDOH) and other needs
- Time to treatment report to track patients from initial presentation to treatment initiation
- Clinical risk model to estimate patients' risk of an acute care event as they initiate systemic cancer treatment
- Workflow schematic for UNC Health's nurse-integrated remote symptom monitoring program
- Patient needs assessment and program satisfaction survey (currently under development)

Contact

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Project Description

This initiative is an enhanced navigation program utilizing technology to equitably identify patients at high risk, target needed support services, and maximize the efficiency of navigation staffing.

Goals

- Provide a uniform experience for all patients seeking oncology services at UNC Health.
- Utilize decision support capabilities to enhance the ability to risk stratify the care delivered by the navigation team and enable equitable patient outcomes.
- Offer services specifically targeted to meet the needs of each patient.
- Implement efficient care processes without compromising staff well-being.

Target Audience

The North Carolina Basnight Cancer Hospital is the largest public hospital in the state; 57% of patients receiving cancer care are uninsured (3%) receive insurance via Medicaid (6%) or Medicare only (48%). Approximately 48% reside in rural communities, and 5% reside in one of 10 persistent poverty counties (i.e., counties that have had poverty rates of 20% or greater for at least 30 years) in North Carolina. Furthermore, 25% of those served by UNC Health are people of color, including 20% who are Black or African American. The initiative is initially serving patients treated for hematologic and gastrointestinal malignancies because of their disproportionate impact on Black/African American men, one of the most marginalized populations in the US.

Process

Workflow Integration

- Developed uniform outreach telephone calls and standardized assessments and reports to support a team-based approach to supportive care
- Used data from assessments and reports to mitigate patient needs and initiate early support services when needed
- Piloted a nursing integrated symptom monitoring program for patients identified as high risk for acute care events

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Monitoring & Evaluation

- Using data compiled via the assessments, reports and EHR monitor program reach, services delivered, and outcomes

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Outcomes/Key Metrics

Key outcomes of interest include missed appointments, retention, time to treatment, and acute care events stratified by patient race, health insurance status, and primary language. We are also using surveys to track staff well-being and met/unmet patient needs.

Results

- Development of a centralized informatics structure increased the ability to target patients for needed support services equitably
- Increased proportion of people seen who went on to receive their cancer treatment at UNC (improved patient retention)
- Improved timeliness of the care delivery
- Hired two additional oncology patient navigators to support a rapid access initiative in part through this centralized and standardized navigation program

Case Study

University of South Carolina Colorectal Cancer Prevention Network

Organization

The University of South Carolina (CPPN) is dedicated to reducing colorectal cancer through awareness, education, and screening. The South Carolina Communities Unite to Increase Colorectal Cancer Screening Program, works with partnering primary care clinics, gastroenterologists, pathologists, and anesthesiologists to offer free screening options to low-income, uninsured, or underinsured South Carolinians. CCPN provides patient navigation to support individuals in addressing barriers to ensure timely screening and follow-up to abnormal results. Additionally, CCPN is currently a recipient of the Centers for Disease Control and Prevention's CRCCP DP20-2002, partnering with health care systems to implement at least two evidence-based interventions, utilizing continuous quality improvement (QI), following the Institute for Health Care Improvement's Model for Improvement, bolstered by a structured technical assistant plan to improve colorectal cancer (CRC) screenings.

Contributors

- Lisa Scott, BS
- Tracie Lewis, MS
- Mark M. Macauda, PhD, MPH
- Annie Thibault, MS

Primary PNSAT Domains

Workflow Integration

Monitoring & Evaluation

Outcomes & Effectiveness

Tools Developed or Utilized

- Leadership check-in meetings
- Lucidchart team license to facilitate and document monthly technical assistance with primary clinics
- Interactive Technical Assistance (ITA) Plan
- Institute for Health Care Improvement's Quality Improvement Essentials Toolkit
- CCPN's Interactive Technical Assistance Plan: Facilitating Quality Improvement Activities for Process Improvement

Contact

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Acknowledgment

The South Carolina Communities Unites to Increase Colorectal Cancer Screening Program is funded through a cooperative agreement between the CCPN and the Centers for Disease Control and Prevention's CRCCP DP20-2002.

Project Description

Partnering health care systems include:

- AnMed Medical Group
- Cooperative Health
- Fetter Health Care Network
- Foothills Community Health Care
- Little River Medical Center

Goals

Increase CRC screening and complete follow-up to positive/abnormal findings in clinics with low screening rates through the implementation of evidence-based interventions.

Target Audience

Insured, underinsured, and uninsured individuals ages 45-75

Process

Leadership check-in meetings:

- The CCPN scheduled annual one-hour meetings with system leadership to discuss deliverables and progress of project clinics. This meeting helped ensure leadership was fostering a QI culture and providing the necessary support and resources needed for clinics to fully participate in each step of the process. The CCPN created a PowerPoint to guide the meeting agenda, which included an overview of the past year and the upcoming year's deliverables and deadlines. This was helpful to provide time for blocking clinic staff schedules so they could attend TA sessions. Time was allocated for system leadership feedback and suggestions.

Documentation of monthly technical assistance with primary clinics:

- CCPN set up individualized documents for each partnering clinic that were shared with all designated project team staff. The staff had shared access to both view and edit their document, setting the precedent for collaboration and utilization of information collected to be used freely.

ITA plan:

- Utilizing the structured ITA plan, the CCPN facilitated clinic teams through designated activities, progressing them through QI steps. To support the facilitation of the ITA sessions, the CCPN developed a Current State Process Pre-Work Worksheet, as well as dialogue questions for both evidence-based intervention (EBI) selection and plan-do-study-act (PDSA) cycles.

Outcomes/Key Metrics

- Monthly ITA survey administered using Qualtrics
- Monthly Azara DRVS reports (numerator, denominator, population health, and social determinants of health [SDOH] data points)
- Monitoring ITA participation of requested clinic staff
- Monitoring progress and outcomes of PDSA cycles

Results

Interactive Technical Assistance:

- Clinics appreciated the accountability that regular 1:1 check-in with CCPN staff provided.
- Clinics reported EBIs are a worthwhile investment for systems change to increase CRC screening rates; 48% of the participating clinics selected three or four EBIs to implement.
- Clinic staff felt that they were able to accomplish their goals, that their teams worked well together, and were able to implement their intended interventions.
- Clinics found that having a newfound structure and standardization in their screening process was valuable.

Data Outcomes:

- Clinics that started with lower CRC screening rates experienced the largest improvements.
- Evaluation showed improvement in CRC screening rates for both African Americans (+11%) and White non-Latinos (+6%).
- There was an increase in screening for all payor categories (private, uninsured, Medicaid, Medicare, dual). The uninsured had the lowest screening at baseline, as well as the lowest uptake (+1%) in screening during the measurement period.
- Hispanic/Latino, unhoused, and language were the top three SDOH contributing to lower screening rates.
- During the initial year of available Uniform Data System data (April 2023 to April 2024), 23 partnering federally qualified health center clinics showed an 8% (18% to 26%) increase in screening for patients ages 45-49.

Case Study

Virginia Commonwealth University, Massey Comprehensive Cancer Center

Organization

As an NCI-designated cancer center, Virginia Commonweath University, Massey Comprehensive Cancer Center's (VCU MCC) mission is to reduce the state cancer burden for all Virginians by addressing the confluence between biological, social, and policy drivers through high-impact, cutting-edge research; person-centered care across the continuum, from prevention through survivorship; community integration; and training the next generation of community-centric researchers and health care professionals. Informed by its "community-to-bench" model, the cancer center's strengths are reflected in its scientific expertise in community-engaged research and efforts to eliminate health disparities and ensure equitable access to cancer prevention, screening, care, and survivorship service. As a leading academic medical center within the Commonwealth of Virginia, Massey serves a 66-locality catchment area spanning central, southern, and eastern Virginia.

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Primary PNSAT Domains

Workflow Integration

Monitoring & Evaluation

Outcomes & Effectiveness

Tools Developed or Utilized

- REDCap database to capture all project metrics
- Social determinants of health (SDOH) screening tool in the electronic health record
- Responsible, Accountable, Consulted, and Informed (RACI) chart to develop the roles and responsibilities of individuals involved in the project
- Clinical trial workflow

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Acknowledgment

This project is supported by the American Cancer Society Navigation Capacity-Building Initiative Grant Program.

Project Description

This project aims to implement an integrated, multimodal and multiskilled navigation team structure, thereby expanding the traditional nurse navigator model to fully identify, address, and sustain SDOH resources for patients with sociocultural, economic, individual, and system-level care needs to ensure equitable cancer care services.

Goals

- Implement an integrated, multimodal, and multiskilled navigation team structure, thereby expanding the traditional nurse navigator model to fully identify, address, and sustain SDOH resources for patients with sociocultural, economic, individual, and system-level care needs to ensure equitable cancer care services.
- Hire a clinic-based, SDOH navigator to address SDOH by linking and securing the uptake of existing resources and services available to all MCC patients.
- Extend navigation capacity by incorporating a successful VCU Health community health worker (CHW) navigator into the community to sustain SDOH resources.
- Increase capacity by expanding the nurse navigation model by adding two SDOH navigators.
- Co-locate a nurse and SDOH navigator for fluid communication/coordination.
- Ensure that the role delineation of an SDOH navigation program and procedures is clearly identified.

Target Audience

Patient target audiences are:

- Uninsured/underinsured, covered by Medicaid, and/or fall below 200% of the federal poverty level
- Patients with gastrointestinal, genitourinary, lung, and breast cancers
- Screened and referred for social drivers of health needs

Target clinical audiences are:

- Clinical care team
- Social worker
- Hospital "without walls" feedback loop

Process

Workflow Integration

- Established a tri-navigator model expanding beyond the hospital walls
- Completed a workflow and role delineation in support of a developing workforce multimodal/multiskilled SDOH and RN navigator team
- Established a process and equipped the SDOH navigator with readily available resources

Outcomes/Key Metrics

- Clearly identified role delineation of SDOH navigation program and procedures
- Increased capacity by expanding the nurse navigation model by adding two SDOH navigators
- Instituted an empowerment system for SDOH navigator to be equipped with readily available resources
- Increased clinical trial patient education and engagement
- Decreased patient no-show rate

Results

- Enhanced the nurse navigation model to be a comprehensive, multimodal approach, and increased the capacity of the navigation structure and improved service coordination
- Fully integrated the MCC-NET core project team, including the nurse navigator, SDOH navigator, and CHW navigator, with the health system's social worker team and other staff, such as clinical trial coordinators, physicians, and ancillary staff
- Improved multidirectional communication among MCC NET navigators has expanded, and institutionalized the delineated roles and working structure of the nurse navigator, SDOH navigator, CHW navigator, and social worker
- Developed a plan to fully capture navigation metrics in the electronic health record of the health system
- Engaged commitment of cancer center leadership to SDOH FTE funding and its alignment with CMS competencies and PONT standards

Case Study

University of Colorado Cancer Center and UCHealth Oncology Navigator Programs

Organization

University of Colorado Cancer Center, UCHealth South, UCHealth Metro, and UCHealth North partner to improve navigation services through aligning job descriptions, workflows, and data tracking across the UCHealth system.

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Primary PNSAT Domains

Tools Developed or Utilized

- Standardized patient navigator job descriptions
- Implemented patient navigation workflows for each clinic site
- Developed Power BI real-time data dashboard

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Acknowledgment

The funding for this project was from several grant and foundational sources, including the American Cancer Society Patient Navigation Capacity Building Grants, and the support of professional societies such as NCCN and AONN+.

Project Description

This project builds on established networks of the University of Colorado Cancer Center and UCHealth's existing cancer navigation programs. It focuses on enhancing job descriptions, workflows, and data tracking across all UCHealth and Cancer Center service lines to provide more effective patient navigation and improved access to care during treatment. This initiative encompasses three major sites and their affiliated clinical locations, which serve patients throughout Colorado.

Goals

Enhance and grow existing capacity for oncology patient navigation, integrate navigation into clinical workflows and improve data tracking and outcomes related to clinical trial navigation.

Target Audience

- UCHealth Oncology Patient Navigators work with patients across the continuum of cancer care and have an annual caseload of ~13,500 patient encounters. UCHealth navigators across Colorado may have the most impact with patients who are medically underserved or facing barriers related to the social determinants of health.

Process

Completed

Monitoring and Evaluation, Outcomes and Effectiveness

- Developed real-time data dashboards for patient navigators and the clinical team using Power BI business intelligence tools. This data dashboard offers several key features:
  - Continuous integration of live data, with automatic refreshes, replacing the need for multiple one-time data downloads.
  - Flexible data filtering and extraction from multiple sources.
  - Effective tracking of patient barriers to improve how navigators can address patient needs.
- Developed standardized job descriptions for patient navigator roles across UCHealth major clinic sites and affiliated locations.

Planned

Monitoring and Evaluation, Outcomes and Effectiveness

- The initial Power BI data framework is in place, with plans to enhance it by:
  - Adding data on navigation timelines and improved capturing of patient demographics for deeper insights into the patient population served.
  - Fine-tuning live updates to provide more detail on navigation caseloads and workloads.
  - Adapting the tool to align with nursing teams and the broader clinical network, ensuring it provides data to support the entire care continuum.
- Patient navigator training modules aiming to equip patient navigators with the skills needed to identify and share clinical trials and resources with their patient populations are in development.

Workflow Integration

- Developed clinical workflows with patient navigation integrated into the care process.

Outcomes/ Key Metrics:

- Integration of data to ensure stronger connection to show outcomes and effective of navigation. Key metrics now being tracked through Power BI include:
  - Navigation caseload
    - Existing patients vs. new starts in a designated time period
  - Psychosocial support rate (distress screenings)
  - Barriers to care
  - No show rate*
  - Clinical trials education
  - Clinical trials referral
  - Diagnosis to treatment timeline
  - Treatment compliance rate
  - Patient key demographics
  - Patients navigated by zip code*
  - Primary cancer type*
  - Insurance status*

*Metrics points are not yet standardized across all clinic sites, fine-tuning these metrics is in process with the Power BI data analytics team and is expected to be completed before December 2024.

Results

This project developed specialized workflows and data-gathering approaches specifically tailored to improve navigation services for UCHealth patients following a cancer diagnosis. Workflows were designed to reduce delays in treatment, improve communication between patients and providers, and identify and address barriers to accessing care. By refining data collection and reporting methods, the project enabled more accurate tracking of patient outcomes and time to treatment, leading to more enhanced patient-centered care. These processes have been adopted by 40 navigators working at the three main UCHealth sites, as well as multiple smaller UCHealth affiliate sites. Improved data collection and standardized reporting has allowed for better tracking of new metrics that were previously inaccurate or not reported, for example:

- Total patients in navigation caseload for January 2024 through June 2024: **7890**.
    - Of reported navigation caseload for this time, 6150 patients were new starts/new to UCHealth oncology.
- Top barriers to care identified through navigator administered risk assessment and entered into the EHR (then pulled by Power BI) in January 2024 through June 2024 are **social, transportation, and housing**.
- Patients that received education on clinical trial opportunities from patient navigators in January 2024 through June 2024: **346**.
- Average time from diagnosis to treatment for navigated patients in January 2024 through June 2024 across all participating clinic sites: **50.0 days**.