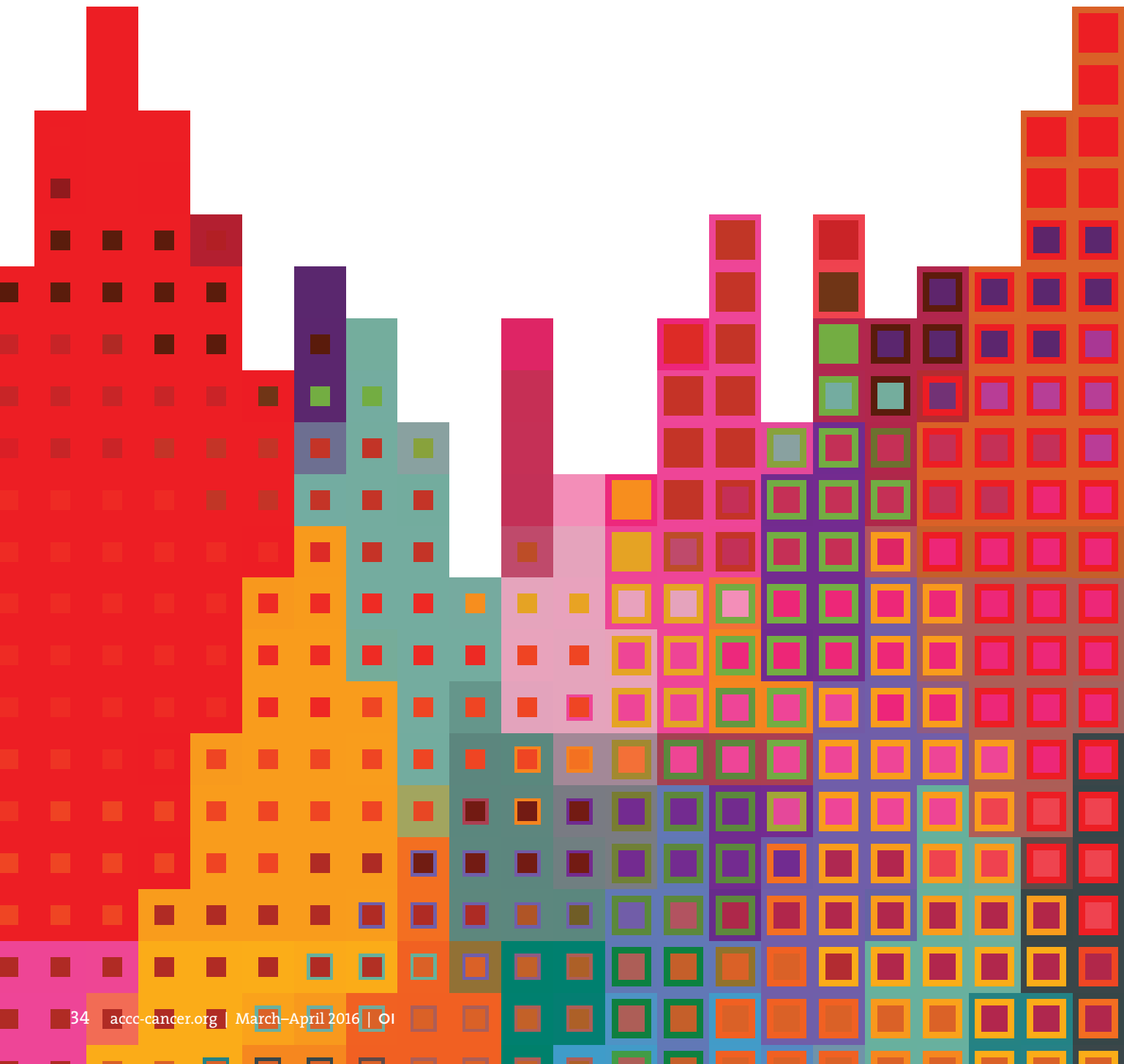
Building a Navigation and Psychosocial Support Program



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from the Ground Up

In 2009 Southside Regional Medical Center's administrative team committed to the development of an oncology service line that would not only meet the needs of the community, patients, families, providers, and facility, but also become accredited by the American College of Surgeons' Commission on Cancer (CoC). Identifying the oncology-related needs of the community was critical to this effort. As part of its facility and community health needs assessment, Southside surveyed patients, physicians, and staff to identify needs, barriers, and disparities in the community and within Southside Regional Medical Center. At the same time, Southside formed multidisciplinary oncology teams and reorganized the Cancer Committee to create an Oncology Steering Committee and an Oncology Quality Committee. Using the collected needs assessment data, these two committees developed and oversaw the implementation of the oncology service line plan.

Growing Patient-Centered Services

Two key components of the oncology service line plan were the development of a comprehensive oncology navigation program and a psychosocial program. Southside leadership determined that the best way to accomplish these two goals was to create an oncology nurse navigator role. The Steering Committee was tasked with creating the ideal job description based on identified potential navigator roles and responsibilities, including:

> The role of the oncology nurse navigator was defined as "an individual who is responsible for guiding patients and their families through their cancer journey and identifying and supporting all of their needs at any point along the way."

- Decreasing barriers and/or disparities across the care continuum (i.e., improving patient access to care)
- Acting as patient advocate
- Providing patient education
- Improving care coordination
- Conducting patient assessment, support, and referrals
- Coordinating distress management and psychosocial support.

This new staff position would not only "navigate" our oncology patients, but also act as "the face of Southside's oncology

program" in the community and lead all psychosocial-related services for the oncology program.

In 2011 hospital administration approved the hire of the FTE oncology nurse navigator. A panel of interviewers that included Southside's patient advocate/social worker, radiation oncologist, oncology service line director, and radiology service line director offered a broad perspective to assess the applicants, provided a well-rounded set of interview questions, and identified key attributes of an ideal candidate:

- Compassionate
- Knowledgeable
- Critical thinker and decision maker
- Independent
- Organized
- Flexible.

The Steering Committee's vision was to meet all of the psychosocial and physical needs of patients and families along the entire cancer care continuum. Thus, Southside formally defined its oncology patient navigation services as "assisting our cancer patients and families with everything they may need." The role of the oncology nurse navigator was defined as "an individual who is responsible for guiding patients and their families through their cancer journey and identifying and supporting all of their needs at any point along the way." Of course that is a lot to ask of one staff person, but the Steering Committee determined that initially the oncology nurse navigator could:

- Lead a navigation team
- Coordinate patient assessments, needs, referrals, and resources
- Act as the "go to" person for patients and families.

The Steering Committee identified an oncology nurse as the ideal person to fulfill this role in the startup phase, with a goal to add new staff—social workers, RNs, and/or lay navigators—to the navigation team as it grew. The oncology nurse navigator joined Southside's oncology team in January 2012.

Implementing Patient Navigation

With the oncology nurse navigator on board, the next step was to determine which oncology patients would be navigated (cancer sites and phase of care), which populations of cancer patients or entry sites would be included (inpatient versus outpatient), and which staff would be a part of the navigation team. Southside made the following decisions for its navigation program:

- The navigation program would encompass all actual and potential cancer diagnoses
- The navigation program would provide services in both the inpatient and outpatient settings
- Navigation team members would include navigator(s) and key oncology team and IT staff members.

Next, the Steering Committee defined patient and family needs as "all knowledge, support, or items that a patient is missing or barriers to care that have been identified for each patient and/or family." Southside committed to placing the patient at the center of its program and processes.

The Steering Committee then developed a navigation screening tool (Figure 1, right) that could be used not only by the oncology nurse navigator but also by any staff that has contact with patients. This screening tool is used to identify patients in distress and/or patients who need assistance with unmet needs. Identified patients are then referred to the oncology nurse navigator for further assessment and support as needed.

Another critical tool: Equicare, a software program that was approved and purchased concurrently with the hiring of the oncology nurse navigator. Although Equicare is marketed as a "survivorship" software program, Southside chose the software because it also met the psychosocial, navigation, distress screening, and patient education needs of the cancer program. With finite resources for the new navigation and psychosocial programs, all of this functionality in one software program was critical. The oncology service line director and the oncology nurse navigator

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Figure 1. Oncology Navigation Screening Tool

INSTRUCTIONS: Tool should be used for all cancer patients to determine if they would benefit from a referral to our oncology nurse navigator. Check all that apply.

- ☐ New cancer diagnosis
- ☐ First visit to Southside Regional Medical Center's oncology program
- ☐ Experiencing unrelieved pain at any time
- ☐ Experiencing decreased quality of life and/or suffering
- ☐ Displaying signs of distress
- ☐ Change in prognosis and/or treatment plan
- ☐ Nearing survivorship stage and no survivorship care plan in place
- ☐ Experiencing psychosocial issues
- ☐ Needs assistance with end-of-life decisions
- ☐ Uninsured, underinsured, financial distress
- ☐ Access to care issues
- ☐ Difficulty with compliance/follow-up

FOR A REFERRAL: Call the Oncology Nurse Navigator (NAME) at (NUMBER) or fax this form to: (Number) if the patient or their family meets any of the above criteria.

Date: .....

Patient name: ..... DOB: .....

Diagnosis: ..... Phone number: .....

Physician: .....

Person completing form: ..... Phone: .....
(please print)

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spent several months individualizing the software program to best meet all of Southside's needs. In June 2012 Southside began using Equicare, which resulted in an increase in the amount of time staff was able to spend with patients and reduced time spent on paper charting and manual spreadsheet for tracking data.

Meeting a Growing Need for Services

During the planning and implementation period, providers and patients requested the new (and as yet unadvertised) navigation services more frequently than anticipated. Based on these requests, Southside started offering its psychosocial and navigation services much sooner than expected—and patient volume grew very quickly. During the oncology nurse navigator's first year at Southside Regional Medical Center, she received 120 patient referrals for navigation. These referrals included an unexpected number of referrals for patients in the community who were not diagnosed or treated at Southside, but who were referred by phone to the oncology department, and patients and/or family members who contacted the oncology nurse navigator directly. This demand for services—coupled with the new CoC requirement for distress screening—helped Southside realize early on that the oncology nurse navigator needed help.

The Steering Committee was challenged to think "outside of the box" about how to structure the navigation and psychosocial programs to meet a growing need for services—without adding an additional FTE. In several brainstorming sessions, the Steering Committee and oncology nurse navigator came up with many great ideas, but each had an obstacle the Steering Committee could not overcome—mostly due to financial constraints. All agreed that adding a social worker to the team would help the oncology nurse navigator better meet patient needs; unfortunately, at that time, the cancer program did not utilize social workers.

Finding a Community Partner

A Steering Committee member who is also the hospital patient advocate and an MSW suggested partnering with the Good Neighbor Community Services, a local company committed to offering services to improve the overall health of individuals and families in the community through counseling and group homes. Good Neighbor Community Services had licensed clinical social workers (LCSWs) and psychologists who oversaw masters-level social work interns (MSWs). The patient advocate thought the agency would be open to partnering with Southside Regional Medical Center and using their staff and MSW interns to help meet the psychosocial needs of oncology patients and families. Possible benefits to this partnership for Good Neighbor Community Services included:

- Its staff would receive education and training in oncology care.
- Its staff would work side by side with oncology care providers to meet patient needs.
- The program's MSW interns would gain real-world experience in the outpatient setting of a hospital-based clinic.

The Steering Committee invited Good Neighbor Community Services to meet and brainstorm on how this partnership could benefit both organizations. After this successful meeting, the Steering Committee developed a formal plan that mapped out the partnership, including the distress screening process.

The next step was to sign a formal agreement with Good Neighbor Community Services, which included specifics on how Southside's oncology nurse navigator and Good Neighbor Community Services would work together to develop tasks and oversee the interns during their time at Southside Regional Medical Center. In the end, this partnership allowed Southside to offer additional services even as patient volume increased.

Implementing Distress Screening

When implementing comprehensive distress screening, Southside's goal was to screen patients at time of diagnosis and at other key distress points. Southside Regional Medical Center serves a large community and not all patients are referred to the program at diagnosis, so staff worked to identify other points of entry to the program.

When Southside Regional Medical Center first partnered with Good Neighbor Community Services and began its distress screening in the fall of 2012, staff used the NCCN Distress Thermometer (DT). The team soon realized that patients had difficulty with this tool, so the oncology team and Good Neighbor Community Services worked together to create a simplified tool (Figure 2, right).

In early 2013 Southside was asked to be a beta test site for an upcoming Equicare upgrade, which added a navigation section to the "survivorship software." As a beta test site, Southside was able to electronically implement its oncology distress screening tool across the continuum of care, increasing the number of staff using the tool. Outside of the psychosocial team, nutrition and outpatient infusion center staff most used the distress screening tools. It also gave Southside the capability to quickly compare patients' current distress screenings with previous screenings, allowing staff to identify areas of improvement or concern.

Today, the oncology nurse navigator is housed in the new

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Figure 2. Oncology Distress Screening Tool

INSTRUCTIONS: Thank you for taking the time to fill this out. We want to make sure we take care of all of your needs. Please circle the number for each symptom that best describes how you feel now.

(0 = No complaints; 10 = Severe complaints)

How would you rate your overall distress?	0	1	2	3	4	5	6	7	8	9	10
Appetite/Weight	0	1	2	3	4	5	6	7	8	9	10
Sexuality/Fertility	0	1	2	3	4	5	6	7	8	9	10
Sadness	0	1	2	3	4	5	6	7	8	9	10
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Financial Concerns	0	1	2	3	4	5	6	7	8	9	10
Insurance Issues	0	1	2	3	4	5	6	7	8	9	10
Family Concerns	0	1	2	3	4	5	6	7	8	9	10
Sleep Disturbances	0	1	2	3	4	5	6	7	8	9	10
Transportation	0	1	2	3	4	5	6	7	8	9	10
Spirituality	0	1	2	3	4	5	6	7	8	9	10
Pain (specify location)	0	1	2	3	4	5	6	7	8	9	10
_____											
Other (specify condition)	0	1	2	3	4	5	6	7	8	9	10
_____											

PLEASE CHECK all of the following oncology team members you would like to speak to

_____ Nurse Navigator _____ Therapist _____ Billing

_____ Financial Counselor _____ Dietitian _____ Chaplain

Date of last chemotherapy treatment: _____

Name: _____ Date: _____

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cancer center that opened January 2014. Specifically, the oncology nurse navigator is located in the lobby of the radiation therapy department, with easy access to one of Southside's two private medical oncology practices located one floor up. This physical proximity has streamlined distress screening, bringing together key staff to assist in the process.

The distress screening process continues to change and evolve, depending on work load and patient acuity. At present, the radiation therapy nurse completes the first distress screening at the patient's first consult visit. The oncology nurse navigator reviews completed forms with patients, identifying needs and making referrals to appropriate services and resources as necessary. This process allows radiation therapy patients to meet the oncology nurse navigator (the main point of contact for navigation and psychosocial support) at their first appointment—if they have not had the opportunity to meet prior to consult.

As follow-up and to identify any new areas of distress, patients are assessed again midway through their radiation therapy treatment and other times as needed. The midway re-assessment was established in order to assist patients at what appears to be one of the more critical points in their radiation treatment. The staff noticed that patients who had previously scored 3 or below on the screening tool may have increased distress due to symptom management needed from side effects of treatment or billing and/or financial issues that emerge as patients move through the treatment schedule. Re-assessment is determined by patients that verbalize or have signs and symptoms of increased distress, as well as those patients that score consistently greater than 3 on the 0-10 scale. This approach allows patients to easily access navigation staff at any point during their daily treatments. Once treatment is complete, staff lets patients know that they can contact the navigation team at any time via phone or in person.

The team also assists patients through distress screening via referral from medical oncology physicians and nurses in their practice settings, at their staff's discretion; other patients are referred to the distress screening program by radiologists and inpatient providers.

Outcomes

Patients and families often verbalize their needs differently to different disciplines. When patients and families communicate their distress or needs to a physician, radiation technician, nurse, or any other team member, they quickly refer the patient and/or family to the oncology nurse navigator. Staff is very aware that the navigation team is an integral part of the oncology team and that the oncology nurse navigator is the point of contact to assist patients with their needs. Southside physicians have championed navigation and psychosocial support services for patients and families. They recognize patients and families have distress that requires a multidisciplinary approach and often refer patients directly to the oncology nurse navigator at key points, noting that the navigation and psychosocial team is easily accessible.

Good Neighbor Community Services has counseled several patients in the oncology nurse navigator's office. Further, having the Good Neighbor Community Services interns available on site has allowed the navigation team to meet increased demand for services and allowed patients access to social work services.

An active member of many local and national oncology-related organizations, the oncology nurse navigator goes out to the community, staffing exhibit booths at health fairs and distributing information to community partners to help them guide patients and families to the new navigation and psychosocial services. Southside's Patient, Family, and Community Resource Center (housed within the cancer center) and its support of local public libraries' Healthy Living and Learning Centers also help to increase community awareness of these new patient-centered services.

In addition to meeting the needs and expectations of patients, the new navigation and psychosocial programs helped Southside Regional Medical Center meet CoC standards for oncology program accreditation, specifically, navigation, psychosocial services, psychosocial distress screening, palliative care, survivorship, cancer committee membership, and quality improvements. It is also believed that Southside's navigation and psychosocial program helped to increase referral sources and resources, which, in turn, helped the cancer program meet additional CoC standards related to community outreach, prevention and screening, clinical trials, rehabilitation, nutrition, public reporting of outcomes, risk and genetic assessments, and quality studies. As of May 2015, the team has grown by adding another FTE nurse navigator to focus on lung cancer patients, education, and low-dose CT screening for lung cancer.

Figures 3-6, pages 41-44, offer a summary of the navigation and psychosocial services delivered in 2015, including patient populations served, referrals made, and outcomes. To view Southside Regional Cancer Center's 2015 disparities priorities and key agency referrals, go to: accc-cancer.org/oncology_issues/MA2016.asp. OI

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Figure 3. 2015 Navigation Summary of Identified Issues

Identified Need and/or Issue	Disparity	Barrier	Resource Gap	Related Initiative	Care Phase	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD
Financial status	Yes	Yes	Yes	Yes	All	26	22	29	19	96
Addictive behaviors	Yes	Yes	Yes	Potential	All	19	17	36	20	92
Level of education	Yes	Yes	Yes	No	All	12	10	14	10	46
Patient & family education	Yes	Yes	Yes	No	All	94	94	99	82	369
Distress & psychosocial	No	Yes	Yes	Yes	All	94	94	99	82	369
Mental health	No	Yes	Yes	Yes	All	7	2	4	5	18
Transportation & gas	No	Yes	Yes	No	All	8	16	10	14	48
Uninsured	Yes	Yes	Yes	Yes	All	11	6	7	5	29
Underinsured	Yes	Yes	Yes	Yes	All	24	27	36	25	112
Medication payment assistance	Yes	Yes	Yes	Yes	All	6	3	5	6	20
Housing	No	Yes	Yes	No	All	1	5	2	1	9
Family support	No	Yes	Yes	No	All	12	21	38	27	98
Physical disabilities	Yes	Yes	No	Yes	All	5	4	6	4	19
Physical support	Yes	Yes	Yes	No	All	1	3	4	4	12
Nutrition & food	No	Yes	Yes	Yes	All	21	27	42	36	126
Bariatric & weight loss	Yes	Yes	No	Yes	All	0	0	0	0	0
Fertility & sexuality	No	Yes	Yes	Yes	All	24	26	42	28	120
Spiritual	No	Yes	No	No	All	17	12	24	22	75
Vocation & school	No	Yes	Yes	No	All	6	8	16	12	42
Smoking cessation	No	Yes	Yes	Yes	All	26	17	36	20	99
Legal assistance	No	Yes	No	No	All	2	4	6	2	14
Rehabilitation & activity	No	Yes	Yes	Yes	All	12	4	7	3	26
Pain control	No	Yes	Yes	Yes	All	15	28	66	56	165
Home assistance	No	Yes	No	No	All	6	8	10	7	31

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Figure 3. Navigation Summary

Identified Need and/or Issue	Disparity	Barrier	Resource Gap	Related Initiative	Care Phase	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD
Palliative care	No	Yes	Yes	Yes	All	12	18	21	15	66
End-of-life & hospice	No	Yes	No	Yes	End-of-life	6	10	8	8	32
Symptom management & medical support	No	Yes	Yes	Potential	All	94	94	99	82	369
Genetic counseling	No	Yes	Yes	Yes	All	0	0	3	1	4
Abuse	No	Yes	Yes	No	All	0	1	0	0	1
Oncology specialist(s)	No	Yes	No	Yes	All	0	3	2	2	7
Non-oncology provider	No	Yes	No	No	All	0	5	3	3	11
Medical equipment	No	Yes	No	No	All	5	2	5	3	15
Prevention & screening	Yes	Yes	Yes	No	All	0	30	0	95	125
Support of children	No	Yes	Yes	No	All	0	0	3	0	3
Obtaining medical information	No	No	No	No	All	0	2	2	1	5
Support group	No	No	Potential	No	All	94	94	99	82	369
Total # of Needs Identified						660	685	785	688	2,130
Total Referrals						1,025	1,085	1,312	1,011	2,110

Figure 4. 2015 Patient Navigation QA & Outcomes

Measure	Goal	1st QTR	2nd QTR	3rd QTR	4th QTR	YTD
Percentage of navigation patients compared to the number of analytic cases	50%	78%	59%	57%	52%	61.5%
Patient satisfaction	95%	100%	100%	100%	100%	100%

Figure 5. 2015 Patient Navigation Summary of Patient Population Served

GENDER	Male	Female
1st QTR	42	52
2nd QTR	48	46
3rd QTR	50	49
4th QTR	40	42
YTD	180	189

AGE	18-35	36-50	51-60	61-74	75+
1st QTR	2	10	13	55	14
2nd QTR	3	11	19	36	25
3rd QTR	0	8	21	45	24
4th QTR	0	7	22	36	17
YTD	5	36	75	172	80

DIAGNOSIS	Breast	Lung	Prostate	Colorectal	GYN	Lymphoma	Head & Neck	Multiple Myeloma
1st QTR	30	15	24	6	1	1	4	1
2nd QTR	23	17	27	2	2	3	7	1
3rd QTR	17	31	24	7	1	3	4	2
4th QTR	30	14	13	2	1	2	6	0
YTD	100	77	88	17	5	9	21	4
DIAGNOSIS	Glioblastoma	Skin	Bladder	Sarcoma	Pancreas	Testicular	Esophageal	Other
1st QTR	1	4	1	1	0	1	2	2
2nd QTR	2	6	1	0	0	0	3	0
3rd QTR	2	2	0	2	1	0	2	1
4th QTR	0	6	2	0	0	0	3	2
YTD	5	18	4	3	1	1	10	7

PHASE OF CARE CONTINUUM	At Diagnosis	Treatment Planning	Treatment	Survivorship	End-of-Life	Expired	Refused
1st QTR	2	17	41	27	6	1	0
2nd QTR	3	11	36	36	5	3	0
3rd QTR	2	16	44	28	5	3	1
4th QTR	2	12	34	26	6	2	0
YTD	9	56	155	117	22	9	1

Figure 6. 2015 Patient Navigation Summary of Referrals

	Pain Control	Symptom Management	Palliative Care	Spiritual Care	Distress Management	Fertility Care
1st QTR	15	94	12	17	94	4
2nd QTR	18	94	18	12	94	0
3rd QTR	14	99	14	18	99	0
4th QTR	16	82	12	22	82	0
YTD	63	369	56	69	369	4
	Hospice Care	Financial Counseling	Home Health Care	Oncology Specialist	Non-Oncology Provider	Medical Equipment
1st QTR	3	73	3	0	0	5
2nd QTR	8	62	2	3	5	2
3rd QTR	6	68	5	2	3	3
4th QTR	8	58	4	2	3	3
YTD	25	261	14	7	11	13
	American Cancer Society	Support Group	Rehabilitation & Exercise	Education Program	Nutrition Support	Smoking Cessation
1st QTR	52	94	0	0	21	26
2nd QTR	46	94	0	0	27	17
3rd QTR	53	99	2	1	30	20
4th QTR	42	82	3	1	36	20
YTD	193	369	5	2	114	63
	Transportation	Prevention & Screening	Dental	Social Work	Look Good, Feel Better	
1st QTR	8	0	4	94	52 invited (5 attended)	
2nd QTR	16	0	6	54	46 invited (3 attended)	
3rd QTR	10	0	4	18	49 invited (2 attended)	
4th QTR	14	0	6	36	42 invited (2 attended)	
YTD	48	0	20	202	189 invited (12 attended)	