Break Barriers:
Year 2 Interventions and Navigation

April 5, 2024
• All participants are muted during the webinar

• Questions – including technical issues you may be experiencing – should be submitted through the question pane

• Questions will be answered as time permits; additional questions and answers will be posted on the website

• Please complete the post-webinar evaluation you will receive via email
Introducing our Moderator

Dr. Laurie Kirstein, MD, FACS
Attending Breast Surgeon
Memorial Sloan Kettering Cancer Center
Associate Professor
Cornell University Medical College
New Jersey
Introducing Our Panelist

Lauren Janczewski, MD, MS
ACS Cancer Program Scholar

Sharon Gentry, MSN, RN, HON-ONN-CG, AOCN, CBCN
Program Director Academy of Oncology Nurse & Patient Navigators
Editor in Chief Journal of Oncology Navigation & Survivorship®
Editor in Chief CONQUER: the journey informed™
Agenda for today

• Welcome
• Reviewing Year 1
• Looking Ahead to Year 2
  • Timeline
  • Toolkit
• Leveraging Navigation to Address Barriers
• Q and A
Breaking Barriers
A look back at what we have learned so far

Lauren Janczweski MD, MS
A National Quality Improvement Collaborative through the American College of Surgeons Identifying Barriers to Completion of Radiotherapy

“Breaking Barriers” Quality Improvement Collaborative

Disruptions in Planned Radiotherapy

Modifiable Barriers?
Psychosocial, Geographic, Financial, Etc.

Disparities in Oncologic Outcomes

Enrolled 342 accredited-cancer programs across US

Pre-Intervention Period:
5 separate, 60-day data collection periods (March-December 2023)

Prospectively identified patients scheduled for a 15–45-day course of curative radiotherapy

Primary Outcome: Patients who missed ≥3 radiation treatments and reasons for missed treatments

332 (97.1%) programs identified patients who missed ≥3 treatments

Median per program: 9.4% (IQR 4.5-16.5)

5,221 patients who did not complete radiotherapy as prescribed

Differences based on:

Geographic Region

↑ Northeast median 11.3%
[IQR 5.4-17.3] p=0.014

Disease Site

↑ Rectum (13.0%)
↑ Gynecologic (11.4%) p<0.001

Reasons for Missed Treatments:

Illness 91.0%
Transport 71.7%
Conflicting Appointments 54.2%
Stopping Treatment 53.0%
Looking to Year 2

Laurie Kirstein, MD, FACS
Breaking Barriers Year 2

- Identify at least one barrier
- Develop a problem statement and goal
- Implement an intervention from the toolkit
- Report Data (via REDCap)
- Meet with small group cohort based on barrier
Year 2
Participants

• Of 300 participants
  • 15% are new to the project this year
  • 44% intend to address transportation
  • 20% intend to address conflicting appointments
  • 16% intend to address patient sick (not due to toxicity)
  • 11% intend to address why patients no longer wish to seek treatment
Problem Statement

• A brief statement on why your program is pursuing the project
  • Who does the problem affect?
  • When was the problem found?
  • Where is the problem happening?
  • How often is the problem happening?
  • What is happening that shouldn’t be?
  • What didn’t happen that should be?

Smart Goal Statement

• A statement on what you want to achieve by when:
  • Specific
  • Measurable
  • Achievable
  • Relevant
  • Timely

*Don’t forget to consider limitations and stakeholder involvement!
*You will be asked to report these on the June data collection
Breaking Barriers Quality Improvement Collaborative

The American College of Surgeons (ACS) Cancer Programs has developed the Toolkit to help you and your colleagues to work together to identify and remove barriers to quality care for cancer patients. The Toolkit is based on the findings of the American College of Surgeons (ACS) Cancer Programs’ Collaborative Project and is designed to help you and your team to identify and remove barriers to quality care for cancer patients.

The goal of this project is to:

- Build program capacity to identify barriers to cancer patients receiving timely and complete care.
- By the end of the improvement period, reduce the rate of “no-shows” to the cancer center.
- Build and maintain a high level of engagement with patients, caregivers, and health care professionals at the cancer center.
- Build a high level of engagement with patients, caregivers, and health care professionals at the cancer center.

Table of Contents

- Barrier #1 Transportation Issues
- Barrier #2 Illness Unrelated to Treatment Toxicity/No Longer Wishing to Pursue Treatment
- Barrier #3 Conflicting Appointments
- Appendix/Supplemental Documents

Not all interventions may need to be implemented. Consult with your local quality improvement team to prioritize barriers to care experienced by your patients.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Transportation Issues</th>
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| Strategies   | Just Ask: If a patient unexpectedly or regularly misses radiation therapy (RT) treatments, it is important to follow up with a phone call and ask if transportation to appointments is a barrier to their care. Implement this strategy by clearly designating the responsibility of patients follow-up to a member of the cancer center team (e.g., advanced practice provider, clinic nursing staff, or navigation staff). Document and record the reason for missed treatment in the patient’s chart.
| Patient Education: For any patient documented as a missing treatment, administer a “Modified Distress Tool” to record the patient’s needs and identify appropriate resources and referrals. A sample “Modified Distress Tool” can be found in Appendix 1 and Appendix 2.

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<thead>
<tr>
<th>Intervention</th>
<th>Leverage RiderShare/Hospital-Based Transportation</th>
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| Strategies   | Local Resources: Local transportation resources identified on your local community can be leveraged to assist patients in your program, including patient transportation via local public transportation system or available resources. Implement this strategy by clearly designating the responsibility of identifying transportation resources to a member of the cancer center team (e.g., advanced practice provider, clinic nursing staff, or navigation staff). Document and record the reason for missed treatment in the patient’s chart.
| National Resources: Several national resources and programs are available to assist patients with transportation:

- Medical Transportation through Medicaid:
- Uber/Lift Health Programs:
  - [https://www.uberforhealth.com/](https://www.uberforhealth.com/)
  - [https://www.lift.com/](https://www.lift.com/)

Additional Transportation Resources:

- [Cancer and Transportation Resource Center](https://www.cancer.org)
- [Transportation and Other Cancer Support Services](https://www.cancer.org)
- [Help with Transportation for Cancer Patients](https://www.cancer.org)
- [Implementing A Transportation Plan](https://www.cancer.org)
Data Collection Tools

• Sent to primary contact on April 2\textsuperscript{nd}
• Due April 30\textsuperscript{th}
• Participant Info
  • Email, FIN, Hospital name, etc
• Identify your barrier
• Data collection by disease site
<table>
<thead>
<tr>
<th>Tentative date</th>
<th>Task Description</th>
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<tbody>
<tr>
<td>Jan-Feb</td>
<td>Convene as a team Identify barrier Revisit community scan Write your problem and goal statements</td>
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<tr>
<td>March</td>
<td>Data collection for new program close March 1* Review toolkit and develop plans to operationalize intervention</td>
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<tr>
<td>April 30</td>
<td>First data collection due (patients seen Feb 1- March 30)</td>
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<tr>
<td>May</td>
<td>Small group call</td>
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<tr>
<td>June 30</td>
<td>Data Collection (patients seen April 1-May 31)</td>
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<tr>
<td>July</td>
<td>Small group call</td>
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<tr>
<td>Aug 31</td>
<td>Data Collection (patients seen June 1-July 31)</td>
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<tr>
<td>Sept</td>
<td>Small group call</td>
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<tr>
<td>Oct</td>
<td>Data Collection (patients seen Aug 1-Sept 30)</td>
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<tr>
<td>Nov</td>
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<tr>
<td>Dec</td>
<td>Wrap up Webinar</td>
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More on Oncology Patient Navigation Involvement

Sharon Gentry, MSN, RN, HON-ONN-CG, AOCN, CBCN
Academy of Oncology Nurse & Patient Navigators
Editor-In-Chief for Journal of Oncology Navigation & Survivorship® (JONS)
Editor-In Chief CONQUER: the journey informed™
Professional Responsibility

- It is imperative that oncology clinical navigators and patient navigators understand that active participation in data collection, analytics and reporting outcomes is not added responsibilities but is already a part of the professional role.
Patient Navigation defined and qualifications

Oncology Navigation: Individualized assistance offered to patients, families, and caregivers to help overcome healthcare system barriers and facilitate timely access to quality health and psychosocial care from prediagnosis through all phases of the cancer experience.

| Oncology Patient Navigator | Clinical Navigator/Oncology Nurse Navigator | Clinical Navigator/Oncology Social Work Navigator |

The Professional Oncology Navigation Task Force announces the Oncology Navigation Standards of Professional Practice.
Standard 12: Treatment, Care Planning, and Intervention
Oncology navigators provide support and information to patients and caregivers to navigate through all phases of active cancer treatment.

All navigators:
Identify potential and realized barriers to care (eg, transportation, childcare, eldercare, housing, language, culture, literacy, psychosocial, employment, financial, insurance) and facilitate referrals as appropriate to mitigate barriers.

Advocate for the resources, supports, and services necessary to address barriers and facilitate access to timely and quality cancer care.
Support a smooth transition of patients across screening, diagnosis, active treatment, and survivorship working with the interdisciplinary team.
Provide patients and caregivers evidence-based information to support understanding and decision-making at all points along the care continuum.
Coach patients to identify their goals and communicate their preferences and priorities for treatment and follow-up care to their healthcare team.
Prepare patients to engage in shared decision-making processes with their healthcare team.

Assess unique environmental, cultural, and other factors that could impact specific patient communities, such as safety of community environments, and employ resources to assist.
Advocate for, educate, and prepare patients to complete advance directives.

Clinical nurse navigators:
Coordinate the plan of care with the interdisciplinary team, promoting timely follow-up on treatment and supportive care recommendations (eg, cancer conferences/tumor boards) during each episode of care and transition in care.

Monitor and facilitate interventions to address symptoms and side effects.
Employ strategies to attain patient adherence to treatment plan.
Use knowledge of molecular and genetic testing to facilitate patient understanding of ongoing testing results.

Patient navigators:
Refer to nurse, nurse navigator, and physician colleagues to answer questions about clinical information, treatment choices, and potential outcomes.
Navigation is a Solution for Health Equity

FIGURE 2. Domains of the Cancer Care Continuum with Examples of Activities in Each Domain

Prevention and Risk Reduction
- Tobacco control
- Diet
- Physical activity
- Sun and environment exposures
- Alcohol use
- Chemo-prevention
- Immunization

Screening
- Age- and gender-specific screening
- Genetic testing

Diagnosis
- Biopsy
- Pathology reporting
- Histological assessment
- Staging
- Biomarker assessment
- Molecular profiling

Treatment
- Systemic therapy
- Surgery
- Radiation

Survivorship
- Surveillance for recurrences
- Screening for related cancers
- Hereditary cancer predisposition/ genetics

End-of-Life Care
- Implementation of advance care planning
- Hospice care
- Bereavement care

Acute Care
- Palliative care
- Psychosocial support
- Prevention and management of long-term and late effects
- Family caregiver support

The blue arrow identifies components of high-quality cancer care that should span the cancer care continuum from diagnosis through end-of-life care. The green arrow identifies 3 overlapping phases of cancer care, which are a way of conceptualizing the period of the cancer care continuum that is the focus of this report.

Value and clarification led to Navigation Reimbursement in 2024!

Centers for Medicare & Medicaid Services (CMS) Principal Illness Navigation Services (11.02.23)
- Under the new schedule patient navigation services, caregiver training services, community health integration services, and expanded access to telehealth services will be reimbursed.
- Direct impact to patient navigation:
  - Caregiver training
  - Telehealth
  - Behavioral & mental health services
  - Dental care for individuals with head & neck cancer

- Updated guidance on the appropriate use of CPT codes, which are used by all insurers in reporting clinical navigation services.
- Clinical navigation focuses on clinical care, coordination, and education, and is typically provided by clinical staff, including nurses and licensed clinical social workers.
Return on investment (ROI)- Business performance metrics

Making the case for nurse navigators
Method – Gap analysis on why patients were leaving the healthcare system
The retention of 212 patients resulted in an increased diagnostic imaging procedures alone and $125,000 in total net revenues. Incorporating all the services the 212 patients would generate in non-cancer services, as well as the breast cancer services, the potential total net revenues would be $350,000.

Using a nurse navigation pathway in the timely care of oncology patients
A medical oncologist could see an additional patient each day due to the time reduction associated with the navigation visit. $485,312 total cost savings and revenue (4 med oncs; new patient consult was reduced by 24 minutes = medical oncologist could see an additional patient each day due)
And time between oncology referral to the start of treatment was reduced by 7 days; 75% patients have advance directives completed

Navigators reduce no-shows
Method - Each patient is contacted at least once a month, with the most at-risk patients being contacted as often as three times a week.
In 3 months, the reduction in no-shows in those receiving radiation therapy equaled a navigator’s annual salary. The overall return on investment was $5 for every $1 spent
Also, readmissions were cut by one-third, with a similar reduction in emergency visits


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Managed Healthcare Executive March 1, 2013
More than barrier removal

Coordinating care/communications between the oncologists and other physicians (primary care/other specialties) - 71%

Emotional/psychosocial counseling needs of the patient - 60%

Referrals to other medical professionals (ie, fertility preservation, cancer rehabilitation, genetics counseling, etc.) - 59%

Transportation and appointment scheduling barriers/issues - 55%

Financial barriers/issues - 51%

Caregiver support needs - 42%

Survivorship care planning - 42%

Palliative/end-of-life care planning - 37%
Thank you for the opportunity to share the world of oncology patient navigation with you today!

Sharon Gentry, MSN, RN, HON-ONN-CG, AOCN, CBCN
sharon.gentry@amplity.com
Q and A

Reach out to cancerqi@facs.org