The Transition from Treatment to Follow-up Care: A Critical Time for Patient Navigation

Sam Gaster, MA*; Jamie Arens, MSW; Rita Sanem, RN; Diane Jones-Larson, RN; Jordan Fiegen, MSW

Background

There are many points of transition in cancer care (Nekhlyudov, Levit, Hurria, & Ganz, 2014). These include the transition from treatment to follow-up care, or the transition from treatment to “survivorship.” This transition is important to cancer survivors’ long-term health (IOM, 2005). Every transition in cancer care presents a unique set of challenges to patients and providers (Nekhlyudov et al., 2014). For patients, challenges include anxiety and fear, dysfunction, and the need for continued education and communication with the cancer care team. For providers, challenges include management of late- and long-term effects, modification of health behaviors, and coordination of follow-up care with other providers (IOM, 2005).

These challenges can be overcome through patient navigation. The core competencies of patient navigators include educating patients and their loved ones, coordinating patients’ care, and communicating effectively with patients and their health care providers (Oncology Nursing Society, 2013). Together, these functions can improve patients’ transition from treatment to follow-up care. Unfortunately, patient navigation services are not universally available or accessible. To increase availability of, and access to, patient navigation for cancer survivors, a new process was introduced at a Midwest health care system. This evaluation describes the implementation and assessment of this process.

Method

Key stakeholders designed a protocol for survivors to receive patient navigation services after their transition to follow-up care. These services include outbound calls to new cancer survivors after completion of a needs assessment and receipt of a survivorship care plan (SCP).

Results

Frequency

Key stakeholders decided that new cancer survivors should receive a minimum of one outbound call from a nurse or social work navigator. However, additional contacts are made as required to address unmet needs.

Timing

Key stakeholders determined that new cancer survivors should receive outbound calls approximately two weeks after survivorship visits. Three attempts to contact survivors are made on different days and at different times of the day.

Format

Key stakeholders agreed that outbound calls should be patient-centered and personalized to the unique needs of cancer survivors. Follow-up occurs on issues identified in the needs assessment, current documentation in the patients’ chart, and any issues directly endorsed by patients during the calls.

Results (cont.)

Frequency

Key stakeholders elected to streamline communication to patient navigators from staff/providers who complete the needs assessment and deliver the SCP. There are several regional cancer centers in the Midwest health system. These cancer centers share a common electronic medical record (EMR). The EMR was configured to automatically send a notification to patient navigators upon completion of the needs assessment. These notifications are used to track and record outbound calls to cancer survivors.

Content

From August 2016 to January 2017, patient navigators contacted 140 (89.74%) survivors and loved ones in their transition from treatment to follow-up care. Sixteen (10.26%) survivors could not be reached. Contacted survivors expressed high satisfaction with navigation services. Many needs were identified and addressed, most commonly anxiety and fatigue.

Discussion

Results support the value of patient navigation services for cancer survivors. This evaluation describes the successful implementation of a protocol for the navigation of survivors after their transition to follow-up care. Results encourage further development and evaluation of this protocol, including its impact on symptom burden, healthy living, and patient education. Additionally, further work should include structured referrals to, and coordination of care with, patients’ primary health care providers.

References

References available upon request.