Navigating Standard 3.1

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Close Up is One Way to View It
Standard 3.1 Patient Navigation Process

A patient navigation process driven by a triennial Community Needs Assessment is established to address health care disparities and barriers to cancer care. Resources to address identified barriers may be provided either on-site or by referral.
How is Patient Navigation Defined?

• Specialized assistance for the community, patients, families and caregivers to assist in overcoming barriers to receiving care and facilitating timely access to clinical services and resources.

• Navigation processes encompass pre-diagnosis through all phases of the cancer experience.

Focus on Process and Impact vs. Role

This standard does not require hiring of a patient navigator, but rather focuses on the processes to understand health disparity populations and rectify barriers to care.
Community Needs Assessment Drives Process and Interventions

• A patient navigation process, **driven by a triennial Community Needs Assessment**...

• The results from the CNA serve as the building blocks for navigation process development, implementation and evaluation

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Community Needs Assessment

• “…a systematic process to define and identify health disparity populations in the community and to determine and address gaps in care or health care system barriers.”

What Must the CNA Identify?

- The cancer program’s community and local patient population
- Health disparities
- Barriers to care
- Resources available to overcome barriers on-site or by formal referral
- Gaps in the availability of resources to overcome barriers
Health Disparity

“a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

- Healthy People 2020

Example of Disparities in Outcomes

<table>
<thead>
<tr>
<th>Race and Gender</th>
<th>Mortality</th>
<th>Incidence</th>
<th>Ratio Mortality to Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian women</td>
<td>96.9</td>
<td>298.5</td>
<td>32.4%</td>
</tr>
<tr>
<td>White women</td>
<td>142.3</td>
<td>435.8</td>
<td>32.6%</td>
</tr>
<tr>
<td>All women</td>
<td>132.5</td>
<td>388.8</td>
<td>34.1%</td>
</tr>
<tr>
<td>Hispanic women</td>
<td>114.4</td>
<td>310.5</td>
<td>36.8%</td>
</tr>
<tr>
<td>White men</td>
<td>191.4</td>
<td>517.4</td>
<td>37.0%</td>
</tr>
<tr>
<td>All men</td>
<td>179.8</td>
<td>476.7</td>
<td>37.7%</td>
</tr>
<tr>
<td>Hispanic men</td>
<td>153.7</td>
<td>385.1</td>
<td>39.9%</td>
</tr>
<tr>
<td>Asian men</td>
<td>136.1</td>
<td>323.3</td>
<td>42.2%</td>
</tr>
<tr>
<td>Black women</td>
<td>176.1</td>
<td>410.7</td>
<td>42.9%</td>
</tr>
<tr>
<td>Black men</td>
<td>242.1</td>
<td>563.7</td>
<td>42.9%</td>
</tr>
</tbody>
</table>

Barriers to Care

Patient-Centered

Provider-Centered

System-Centered

Barriers to Care – A Few Examples

- Racism
- Cost of Care
- Availability of Care/Services
- Linguistic and Cultural
- Poor Communication Skills
- Insurance
- Hours of Operation
- Transportation
- Low Health Literacy
Primary Data: Our Community’s Perspective on Problems and Solutions

- Potential methods
  - Targeted interviews
  - Focus groups
  - Surveys
  - Community meetings
- Illuminates reasons for disparities and barriers to care
- Community helps identify solutions
- Facilitates creation of resource inventory – community assets

Secondary Data View of Disparities

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Los Angeles</th>
<th>Orange</th>
<th>Riverside</th>
<th>San Bernardino</th>
<th>Ventura*</th>
<th>SPA 3</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latino</td>
<td>72.6%</td>
<td>76.7%</td>
<td>79.9%</td>
<td>78.4%</td>
<td>77.8%</td>
<td>74.4%</td>
<td>74.7%</td>
</tr>
<tr>
<td>African American</td>
<td>83.5%</td>
<td>71.4%</td>
<td>56.3%</td>
<td>80.7%</td>
<td>96.5%</td>
<td>79.3%</td>
<td>73.5%</td>
</tr>
<tr>
<td>White</td>
<td>60.8%</td>
<td>62.4%</td>
<td>64.0%</td>
<td>67.6%</td>
<td>58.5%</td>
<td>66.7%</td>
<td>60.1%</td>
</tr>
<tr>
<td>Asian</td>
<td>41.0%</td>
<td>36.8%</td>
<td>33.8%</td>
<td>69.9%</td>
<td>6.6%</td>
<td>38.3%</td>
<td>44.0%</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey, 2014. [Link](http://ask.chis.ucla.edu/)  
* Obesity data for the Asian population in Ventura County not available.
Primary Data Illumines the “Why” of Health Disparities

• “Low-income communities don’t have the same access to healthy food in part because large grocery store chains don’t have locations in low-income neighborhoods. Consequently, lower-income neighborhood residents don’t have access to healthy, fresh food. Instead, they are limited to processed, calorie-dense food. The food environment is dismal.”

• “There aren’t a lot of parks in the area and people don’t feel safe to walk and exercise in the community. Areas are dark and feel unsafe. People go straight from work to their homes and lock the doors.”

Draw On the Great Work of Others

• Non-profit hospitals conduct triennial CNA that includes all components required by CoC
• Community Benefit requirement under Affordable Care Act and IRS section 501 (r)
  – Implementation plan also required
  – California has required triennial needs assessment and annual Community Benefit Report for two decades
Draw on Great Work of Others

• Use assessments conducted by neighboring non-profits
  - Tax-exempt hospitals required to make CHNA and implementation plan widely available to public – usually on institutional websites
• State and local health department data
• ACS data
• Rich reservoir of other public health data sources

Compliance Rating Standard 3.1

1. Conduct a Community Needs Assessment at least once during the three-year accreditation cycle to address health care disparities and barriers to cancer care.
   • Data and results of the CNA are presented to the cancer committee and documented in minutes
Compliance Rating Standard 3.1

2. Establish a navigation process and identify resources to address barriers that are provided either on-site or by referral to community-based or national organizations.
   - As part of establishing appropriate patient navigation to address results of the CNA, the cancer committee will construct a report that includes:
     - Population(s) to be served identified by the CNA
     - Health disparities and barriers identified by the CNA
     - Description of the navigation process to overcome barriers
     - Documentation of activities and outcomes of the navigation process
     - Areas for improvement, enhancement and future directions

Compliance Rating Standard 3.1

3) Each calendar year, barriers to care are identified and assessed, the navigation process is evaluated and documented, and the findings are reported to the cancer committee.

4) Each calendar year, the patient navigation process is modified or enhanced to address the barrier or additional barriers identified by the Community Needs Assessment.
Documentation

• The program completes all required standard fields in the SAR

• Each calendar year, the program uploads:
  – A copy of the results and findings of the triennial Community Needs Assessment
  – Documentation of the monitoring, evaluation and findings of the patient navigation process including the health disparity populations served and the barriers that are addressed

City of Hope’s Community

• Primary service area spans 5 counties and encompasses 18.5 million population

• 45% population is Hispanic/Latino, 33% White, 12% Asian and 7% African American

• 21% of City of Hope’s patient population is Hispanic/Latino

• *Spanish is spoken in more than one-third of homes* (35%), higher than state average (29%)*
Data Speaks *and*
Our Patients Have A Strong Voice

- Cultural and linguistic barriers identified through CNA

- Cancer Committee decided to focus on cultural and linguistic barriers impacting Hispanic/Latino patients and families

- El Concilio, our Spanish-speaking Patient and Family Advisory Council, helps us understand barriers faced by Hispanic/Latino patients and put a personal face on impact

El Concilio’s Mission

Improve the overall patient-family experience for Spanish-speaking Hispanics at City of Hope through education, translation, information, and easy navigation of resources and services to foster high-trust relationships and save lives.
El Concilio Contributions

- Campus map in Spanish
- New Patient and Family Orientation in Spanish
- Evaluation of City of Hope’s Spanish language website
- Buttons that identify Spanish-speaking City of Hope volunteers and staff (later expanded to any language)

Patient and Family Advisory Councils Contribute to Patients’ Choices About Their Care

- Instrumental in development of video on Advance Care Planning
- Key input for Advance Care Planning Website
- Identified National Health Care Decision Day theme and featured in awareness campaign
Specialized Assistance Begins With Screening

- Bio-psychosocial screening and referral
  - Identify physical, psychosocial and practical needs of patients
  - User friendly touch-screen
  - English, Spanish and Traditional Chinese
  - Patients complete on first or second visit
  - Automated referrals
    - Clinical Social Work
      - Patient Resources Coordinator
      - ACS and other external resources
    - Patient Navigators
    - Patient Financial Counselors
    - Patients immediately receive information

Screening Real-Time Outputs

- Improved Patient Outcomes
  - At Your Fingertips
  - English
  - Spanish
  - Automated referrals
  - Consultants
    - Community Resources Coordinator
    - Nutrition, Fluid Management, Patient Navigators, Pharmacy, Psychology, Rehabilitation, Spiritual Care
  - Summary Report
  - Individual Patient Responses Recorded
  - Research and Program Development

All of the content and outputs can be tailored to fit the individual setting.
Distress Screening, English and Spanish

Distress Screening, Chinese
E-Mail Summary Report Example

Aggregated Screening Data Useful for Program Development

<table>
<thead>
<tr>
<th>Top 10 Concerns Identified By City of Hope Patients Whose Preferred Language is Spanish</th>
<th>% Indicating Issue is Moderate, Severe or Very Severe Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finances</td>
<td>678</td>
</tr>
<tr>
<td>Worry about the future</td>
<td>515</td>
</tr>
<tr>
<td>Pain</td>
<td>650</td>
</tr>
<tr>
<td>Fatigue</td>
<td>638</td>
</tr>
<tr>
<td>Side-effects of treatments</td>
<td>562</td>
</tr>
<tr>
<td>Sleeping</td>
<td>740</td>
</tr>
<tr>
<td>Solving problems due to my illness</td>
<td>556</td>
</tr>
<tr>
<td>Feeling down or depressed</td>
<td>511</td>
</tr>
<tr>
<td>Feeling irritable or angry</td>
<td>561</td>
</tr>
<tr>
<td>Managing my emotions</td>
<td>700</td>
</tr>
</tbody>
</table>
Specialized Assistance: Patient Navigation Program

- Launched in January 2007, driven by patient and caregiver input
- Navigators offer personalized guidance, information and support
- Assist patients and caregivers in navigating the hospital system, from time they enter and throughout care

Specialized Assistance

- Significantly enhanced interpreter services
  - New coordinator position
  - Video interpreting added
- Improving patient and family education
  - Pilot project to connect more patients and families with Spanish Patient and Family Orientation
  - Partnered with El Concilio to develop culturally appropriate Spanish chemotherapy education class
I Picture It This Way...

Begin with Community Needs Assessment (CNA) → Review findings to understand disparities, who is most impacted and barriers to care faced by that population → Based on identified disparities, select population focus and at least 1 barrier to care → Identify internal and external resources available to address barrier(s)

Enhance process to address same barrier(s) or choose new barrier(s) → Review findings/outcomes → Evaluate navigation process → Monitor navigation process throughout year → Develop process that draws on resources to provide specialized assistance (navigation) that addresses barrier(s)

Next year’s cycle begins → Document

Achieving Our Goal - Health Equity

Attainment of the highest level of health for all people
Let's Talk

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