

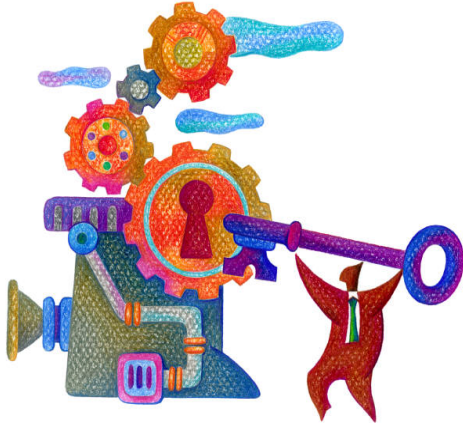
Cancer Patient Navigators: Improving The Cancer Journey

Sandra Cook,
Cancer Care Nova Scotia
Cancer Journey Action Group
Canadian Partnership Against Cancer

- Key components of the role
- Scope of Practice
- Qualifications and training required
- Integration of the role on the team

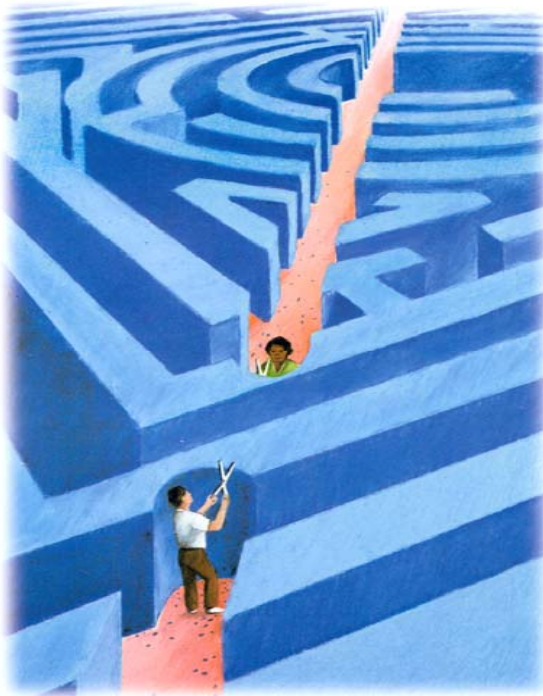


Introduction



The appointment of a cancer navigator, a position primarily focused on improving the cancer journey has been identified as an approach that could address problems related to integration, coordination and continuity in cancer care.

Cancer Care Nova Scotia Definition: Navigation



The individualized assistance offered, by a highly trained oncology nurse, to patients, families and caregivers to assist them through the maze of options and services needed to achieve the best possible outcomes and quality of life, throughout the cancer journey.

Impact of Navigators on the Experience of Living with Cancer (Evaluation findings CCNS 2004)

- Navigators are playing a significant role in supporting and guiding patients/families to meet the decisional, psychological, social, emotional and practical challenges associated with cancer, its treatment and life after treatment.
- Navigation has become an important component of supportive care.
- Patient navigation has had a positive impact on the quality and consistency of community cancer care.



Evaluation findings continued

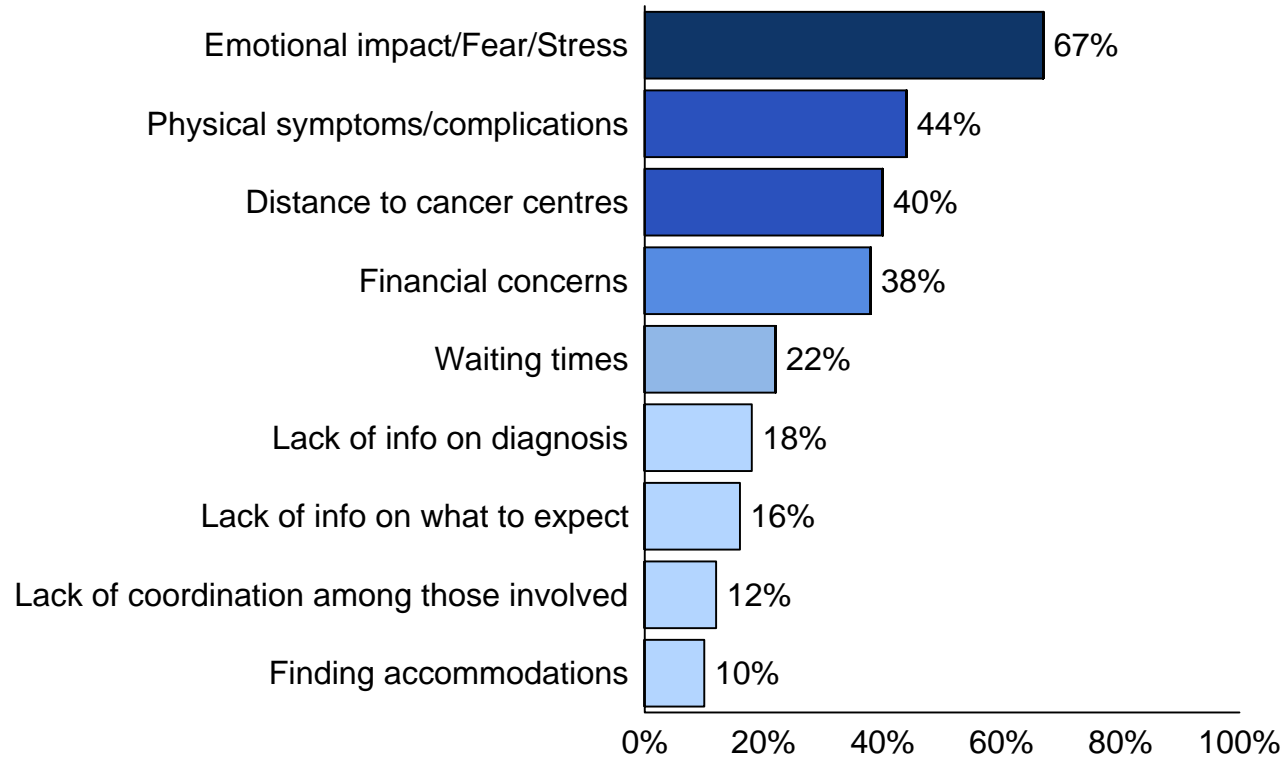
- Assisted cancer patients and their families in accessing services at critical times throughout their journey;
- Reduced duplication of services resulting in efficient and cost effective care; and
- Fostered communication and collaboration among health professionals.



The *CCNS* CPN model places great emphasis on patient empowerment. Through information, education, and encouragement, patients are supported in managing their own care. In addition to informational and decisional support, this model also improves access to psychosocial support.

What patients told us

Issues and Concerns During Cancer Experience % Saying Yes



Source: Patient Survey

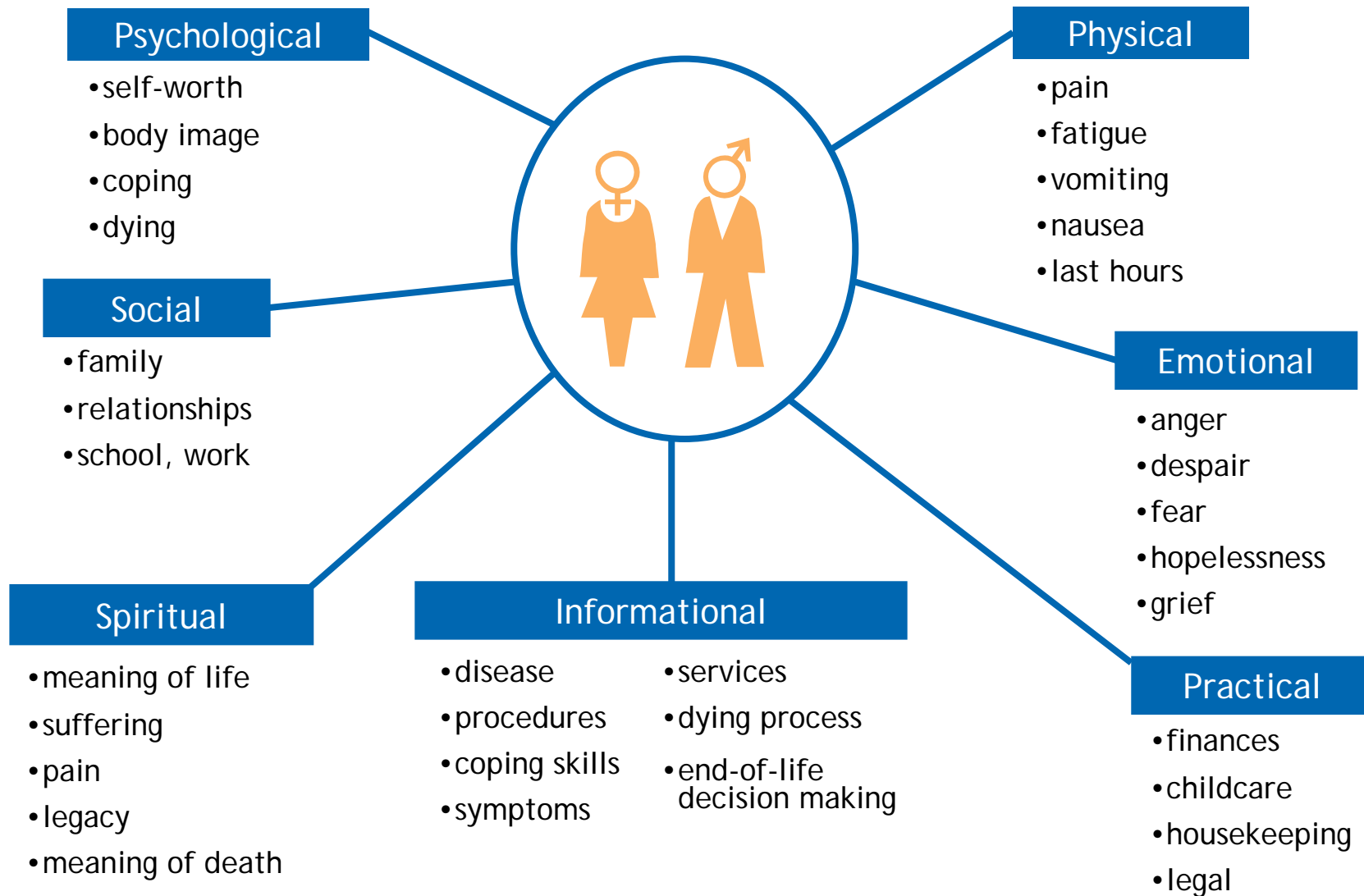
The Person with Cancer

- Significant emotional, informational, financial and logistical challenges;
- Individuals experience a range of reactions;
- Needs and responses can change over time;
- Interventions need to be tailored to the person's unique situation to be effective;
- Realities of cancer will be faced by patients and families in their own homes and communities;
- Finding their way through the cancer system is challenging at a time when patients are making major life decisions about care; and
- Information, support and communication are critically important

The voice of a patient

I don't think anyone deserves to face this illness without all the support that we can possibly have....that we have the best drugs available and the support that we need. Yes cancer can be beaten but most of the time it's a difficult and exhausting fight and with all the health care cut-backs the system is limping. The health care system has been affected and thereby affecting all of us. Simple things such as scheduling appointments for tests and visits to the cancer centre can be a nightmare. Knowing what services are available to help us is as important as the medication given to fight the illness. A patient's overall health, including mental health, is just as important as the strongest chemotherapy drugs that can be administered. I have been through the process both with a Navigator and without. It is my opinion that this service is a vital and very important position.

Needs and Examples of Patients with Life-Threatening Illness



What are the desired outcomes?

- ↑ consistency of care (coordination)
- ↑ continuity of care (collaboration)
- Patient/family feel “supported” and “empowered”
- Timely and appropriate access to psychosocial, supportive and palliative care services
- ↑ communication and collaboration among cancer care team
- Timely and appropriate access to cancer services
- Overcome barriers; reduce disparities
- Patient/family feel they have been guided through the maze

What is Continuity of Care ?

- Continuity of care has been defined as the delivery of services by different providers in a coherent, logical and timely fashion consistent with the patient's medical needs and personal context.
- Care coordination ,case management and care pathways are processes designed to promote continuity



What is Case Management

Encompass a very broad range of responsibilities:

- Assessment and screening
- of needs and goals,
- education, bridging gaps, promoting self efficacy
- enhancing self care capabilities
- coordination of care across settings
- brokering and developing networks of services
- advocating for patients and
- providing hands on care.



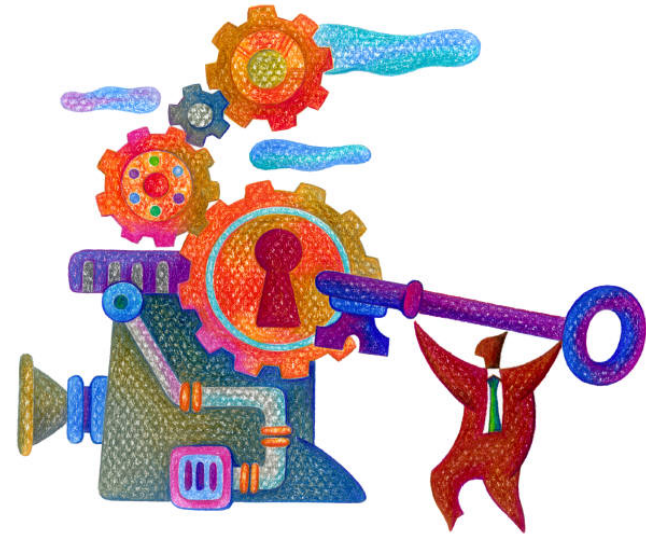
These definitions emphasize:

- that coordination is an integral component of continuity of care;
- that someone is managing the process, including the development and communication of the care plan to the team; and
- ensures that all of the care needed is arranged and delivered.



Key Components of the Role

- Clinical Expert
- Case Coordinator
- Counsellor
- Educator
- Leader
- Liaison /advocate
- Effective Communicator
- Team Builder



The Key Functions

- Assess and screen for clinical and supportive care needs.
- Facilitate continuity of care between the patient, health care professionals and across different settings; primary secondary and tertiary care by establishing timely communication and clear referral pathways.
- Provide a range of physical, social and emotional interventions as needed
- Promote active involvement of patient/family caregiver in their care and coordination of that care.
- Prepare patients to play a key role, with their health team, in their own care.

Key Functions

- Standardized and personalized cancer education
- Facilitated access to timely medical and psychological care by linking patients to other members of the inter-professional team and to services and resources
- Acting as a focal point of contact for patients and families throughout the journey
- Identifies strategies that improve collaborative care among primary health care providers and improve coordination and integration with other district health services.

Scope of Practice

The navigator must be able to:

- Identify patients' health and supportive care needs, and help patients and families anticipate and overcome barriers;
- Learn about the prognosis and consider the patient's knowledge about his or her disease;
- Establish a therapeutic relationship, build trust and confidence, and enhance the patient's own problem-solving abilities;
- Identify the significant features of the patient's physical and social environment, and the range of available services;
- Use a systematic, culturally appropriate assessment approach that is sensitive to language differences;
- Support patients in making informed decisions by providing access to and facilitating understanding of information;
- Identify and accommodate different literacy levels and learning abilities;
- Coordinate the range of resources available to patients and families, including advocacy, education, prevention

Formal Education/Experience

- Degree in a health profession
- Certification in an oncology program
- 5 years experience with cancer patients
- Demonstrated competence in team building, case management, conflict resolution and interpersonal effectiveness.

Special knowledge and Skills for a Cancer Navigator

- In depth knowledge of cancer care, including both clinical and supportive care
- In depth knowledge of both local community and provincial cancer services
- Excellent analytical skills
- Skilled in conflict management
- Excellent communication, facilitation and presentation skills.

Skills Continued

- Effective adult educator
- Posses knowledge of a broad spectrum of cultural beliefs in health issues
- Ability to assess biopsychosocial responses
- Critical thinker.

Orientation and skill development of the navigator

- Oncology certification
- Opportunity to work in the Cancer Centres
- Part of multidisciplinary team
- Connected to key people
- Part of all Oncology Continuing Education
- Connected with each other by conference calls for problem solving and peer consultation
- Evidence-based care pathways
- Clinical Guidelines

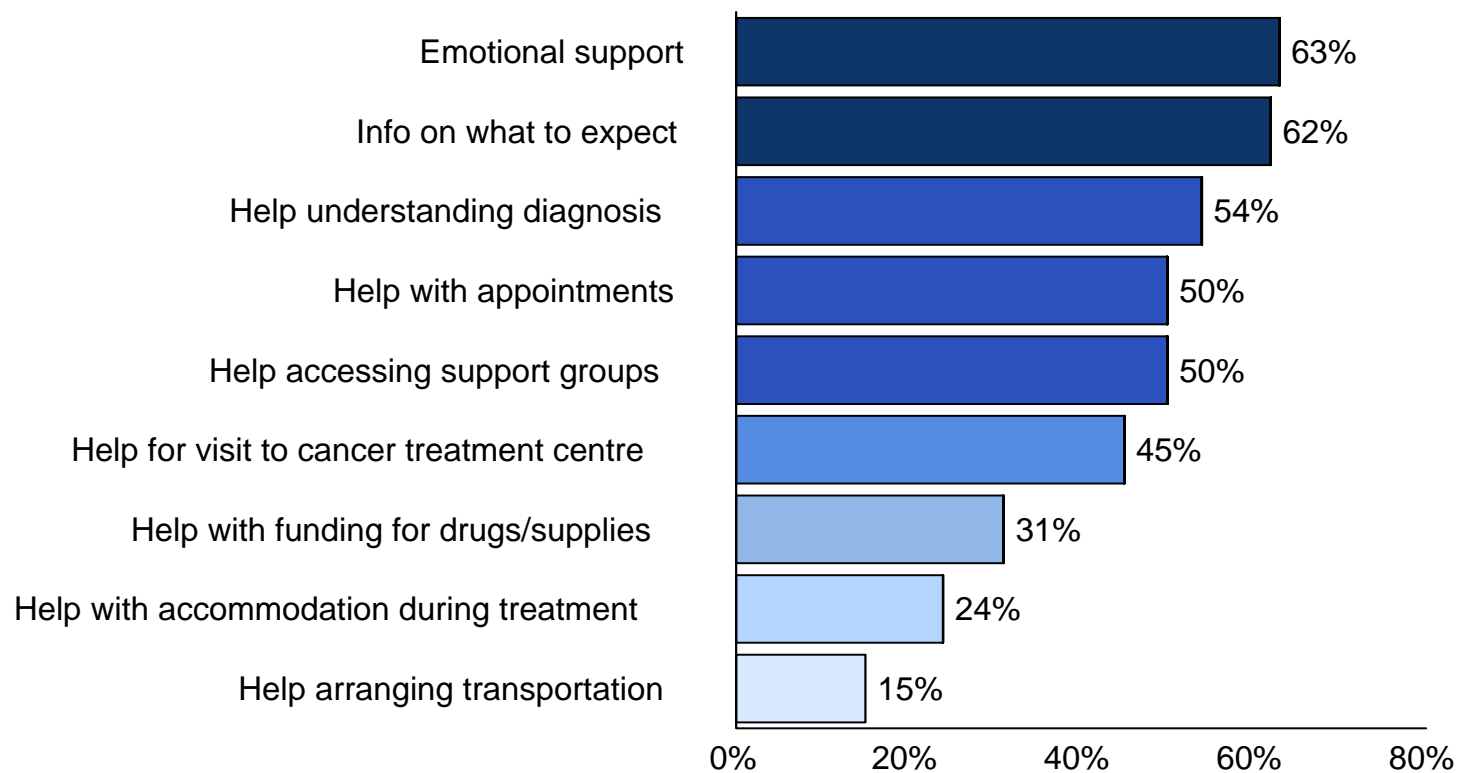
The navigator's involvement in the patient process should result in:

- A one-on-one relationship;
- Facilitated navigation of the system;
- A central point for information and support;
- Provide a direct link into the tumor board network for your system and all of the benefits that can be achieved through a multidisciplinary care model;
- Consistent standards of care; and
- The use of standard systematic screening, assessment and referral processes.

Evaluation Data

Assistance Received From the Patient Navigator

% Saying Yes



Source: Patient Survey

What changes would be present if successful?

- Someone is managing the process, including the development and communication of plan of care and that all the care needed is arranged and delivered
- Facilitated journey through the system
- One-on-one relationship
- Central point of information and support (patient/ family and other HCP)
- Direct link to tumor board network (multidisciplinary team access)
- Consistent standards of care (screening, assessment, intervention, referral)

