
PATIENT CENTERED CARE
Next Generation Cancer Care Navigation
November 8
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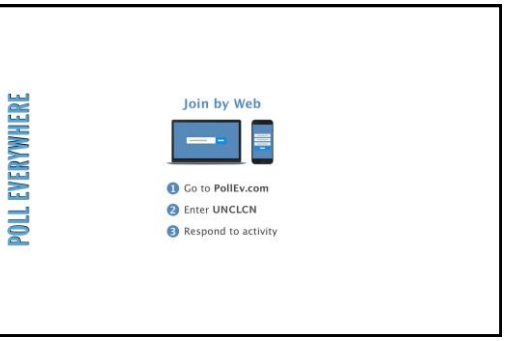
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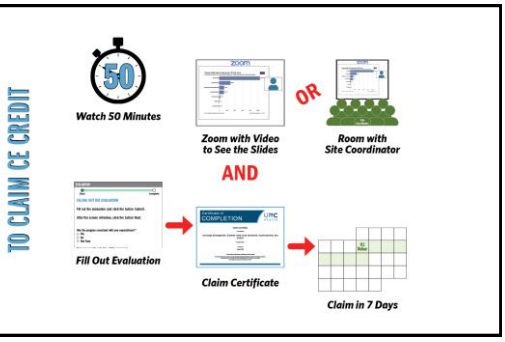
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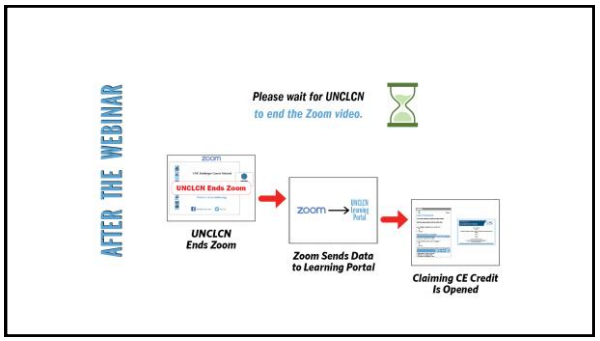
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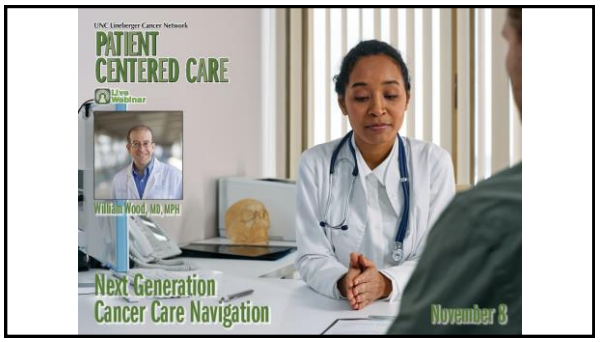
UNC Lineberger Cancer Network
PATIENT CENTERED CARE
Live Webinar
William Wood, MD, MPH
Next Generation
Cancer Care Navigation
November 8

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OUR PRESENTER

William A. Wood,
MD, MPH

Dr. William Wood, MD, MPH is a hematologist and oncologist with a clinical focus in blood cancers, hematopoietic cell transplantation and cellular therapy. Research interests include novel strategies to measure and intervene upon physical function during and after cancer treatment. Digital biomarker development, physiologic sensor integration, home-based functional assessments, patient reported outcomes implementation, and health coaching are areas of current efforts. A major goal is to leverage emerging technologies to improve the cancer patient experience.

He is involved in a number of local, state-wide, national and international digital medicine collaborations and research initiatives. He is also the current chair of the American Society of Hematology Research Collaborative's Data Hub Oversight Group. The ASH Research Collaborative Data Hub aims to become one of the world's largest repositories of research grade clinical data in selected benign and malignant hematologic diseases, starting with sickle cell disease and multiple myeloma, with expansion expected to other diseases over the next several years.

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5. William Wood, MD MPH, is a Professor at the University of North Carolina at Chapel Hill in the Division of Hematology in the Department of Medicine.

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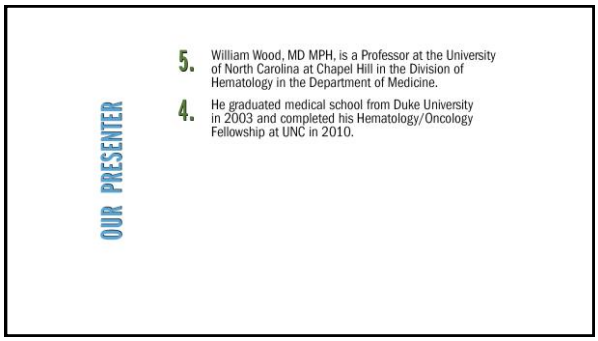
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4. He graduated medical school from Duke University in 2003 and completed his Hematology/Oncology Fellowship at UNC in 2010.

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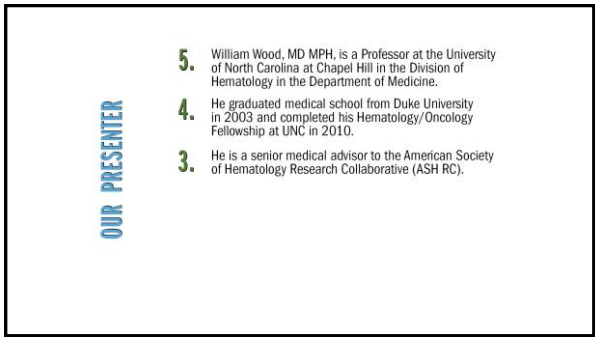
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3. He is a senior medical advisor to the American Society of Hematology Research Collaborative (ASH RC).

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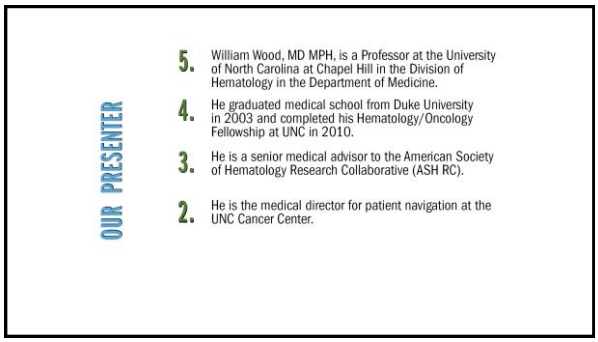
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1. He is the Medical Director for Education and Outreach

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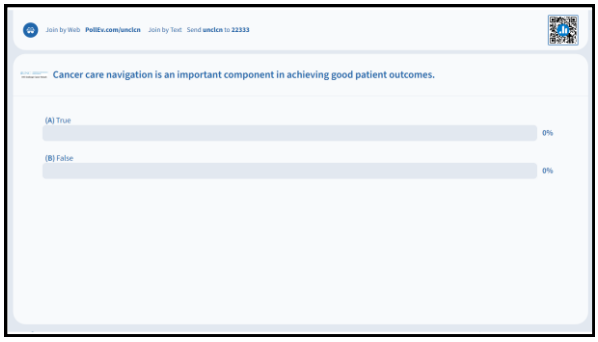

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UNC Health is approved as a provider of nursing continuing professional development by the North Carolina Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

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Cancer care navigation is an important component in achieving good patient outcomes.

True 0%

False 0%

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Next Generation Cancer Care Navigation

Bill Wood, MD, MPH
UNCLCN Presentation
November 8, 2023

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Objectives

Objective 1 Identify informatics tools that can facilitate population-based cancer care navigation.

Objective 2 Discuss how population-based cancer care navigation can be designed with equity in mind.

Objective 3 List current national initiatives that have been developed to support the development and sustainability of cancer care navigation.

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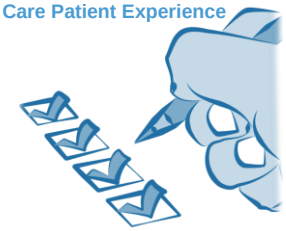
Background Needs

Consistency in the Cancer Care Patient Experience

- Status quo cancer care delivery is fragmented and chaotic
- Our patients are looking for stability and security, comfort and reassurance, equitable outcomes
- We need a consistent connection and data-driven care from the moment of referral through treatment and beyond



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Background Needs

- It is easy for patients to become "lost" or to miss scheduled appointments because of non-medical barriers to care (transportation, child care, financial strain, etc)
- Missed visits lead to delays in care, adverse clinical outcomes, and worsened disparities

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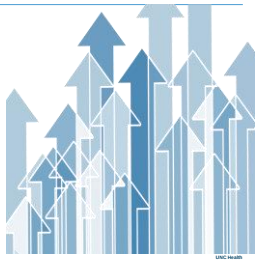
Background Needs

- Patients considering treatment will sometimes reach out to multiple cancer programs
- Programs that provide the best initial experience are the most likely to retain patients
- Retention is a key component of timely treatment initiation



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Background Needs

- An abundance of evidence shows that use of palliative care, psychosocial care, physical rehabilitation, and nutrition are associated with better outcomes and lower costs.
- Current referral processes are not centralized, leading to missed opportunities to delivery comprehensive supportive care.

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Navigation Value Proposition

HEALTHCARE TRANSFORMATION —An effective centralized navigation program can deliver a comprehensive population management experience that is patient-centered and focused on improving health outcomes at lower cost.

RISK STRATIFICATION — We can target resources more efficiently by assessing patients' social and clinical risk to direct the right level of care and services at the right time across the patient journey.

CARE VARIATION —Through designing structured care coordination pathways we can streamline care delivery and referral processes, optimizing access and reducing variation across the oncology continuum

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Central Navigation Program at the UNC Medical Center

Overview

- Centralized and standardized approach to early and frequent outreach
- New personnel (ONNs, OPNs) to complement and integrate with clinic navigators
- Patients are assessed before initial presentation, as treatment planned, and upon treatment initiation to guide implementation of cancer patient navigation services

Existing Components

- Social determinants of health and pre-existing medical needs proactively compiled
- Pathways for supportive care referrals and billable services
- Ability to collect patient reported outcomes

Current Scope (FY 2023)

- 1,910 new patients
- Average 5 touchpoints per patient, 10 interventions per patient

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New Roles and Responsibilities in Navigation

Cancer Care Navigator Definitions

Oncology Volunteer Navigators	Oncology Patient Navigators	Oncology Nurse Navigators
Community or student volunteers who are trained to identify and communicate patients and families' needs to the medical team. From a barrier assessment, they refer patients and families to appropriate resources, while offering emotional support. OVN oversight is provided by a Nurse Navigator who completes EHR documentation, data entry and referral.	Highly trained (and can be board certified) professionals who specialize in working directly with cancer patients and their families to identify and decrease potential non-medical barriers to care. They are resource specialists and their goal is to mitigate challenges by connecting patients with eligible resources and support services available both within UNC Health and in the community.	Experienced oncology registered nurses trained to specialize in identifying and decreasing clinical barriers to care for you and your family through the full continuum of your cancer treatment from diagnosis through survivorship. The ONN is embedded in the multidisciplinary clinical care team as a central point of contact for you and your family to assist in coordinating all components involved in cancer care and connect you to resources to help support you through your treatment.

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Background and Characteristics of New Personnel

Aligned at system level across entities Non-Medical Barriers: Virtual/Remote/Hybrid

Existing Clinical Nurse Navigation Program aligned to disease groups at entity level

ROLES & RESPONSIBILITIES

Pillars	Volunteer Patient Navigator (VPN)	Oncology Patient Navigator (OPN)	Oncology Nurse Navigator (ONN)	Clinical Nurse Navigator
Educate	Non-medical	Non-medical	Yes	Yes
Advocate	Yes	Yes	Yes	Yes
Resource	External Only	Yes	Yes	Yes
Referral	External Only	Yes	Yes	Yes
Licensure	No	No	Yes	Yes
Training / LMS	Yes	Yes	Yes	Yes
Certification	No	OPN-CG℠	OCN®	OCN®
FTE vs. PRN	PRN	Full-Time	Full-Time	Full-Time
EHR Capabilities	No	Yes	Yes	Yes
Cross-Functional	No	Yes	Yes	Yes
Evaluations/ Audits	No	Yes	Yes	Yes
Research / Data	No	Yes	Yes	Yes

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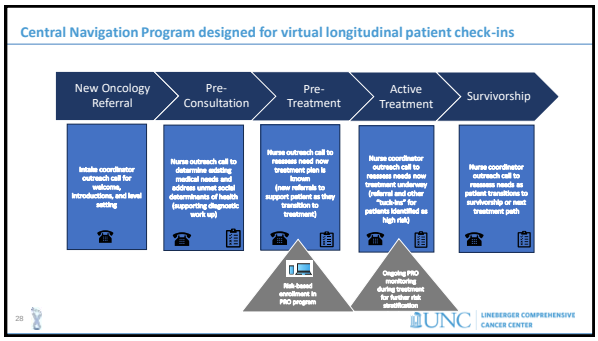
Central Navigation Program designed for virtual longitudinal patient check-ins
New Oncology Referral
Pre-Consultation
Pre-Treatment
Active Treatment
Survivorship
Intake coordinator outreach call for welcome, introductions, and level setting
Nurse outreach call to determine existing medical needs and address unmet social determinants of health (supporting diagnostic work up)
Nurse outreach call to reassess need now treatment plan is known (new referrals to support patient as they transition to treatment)
Nurse coordinator outreach call to reassess needs now treatment underway (referral and other "touch-ins" for patients identified as high risk)
Nurse coordinator outreach call to reassess needs as patient transitions to survivorship or next treatment path
Risk-based enrollment in PRO program
Ongoing PRO monitoring during treatment for further risk stratification
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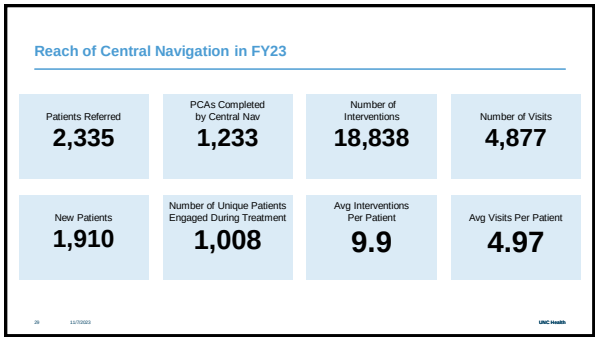
Reach of Central Navigation in FY23
Patients Referred
2,335
PCAs Completed by Central Nav
1,233
Number of Interventions
18,838
Number of Visits
4,877
New Patients
1,910
Number of Unique Patients Engaged During Treatment
1,008
Avg Interventions Per Patient
9.9
Avg Visits Per Patient
4.97
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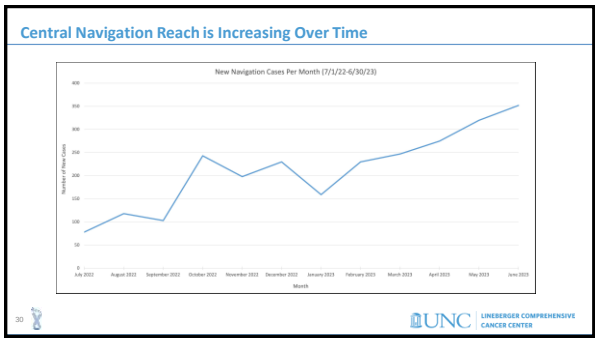
Central Navigation Reach is Increasing Over Time
New Navigation Cases Per Month (7/1/22-6/30/23)
Number of New Cases
Month
July 2022
August 2022
September 2022
October 2022
November 2022
December 2022
January 2023
February 2023
March 2023
April 2023
May 2023
June 2023
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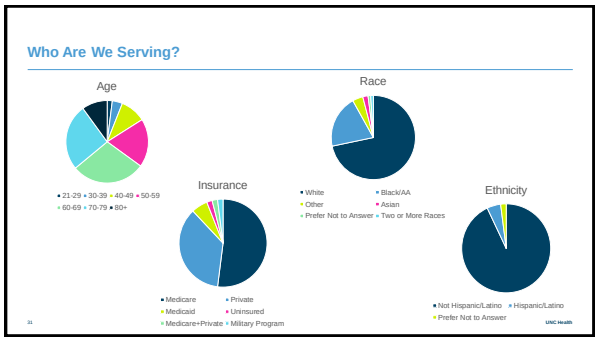
Who Are We Serving?
Age
21-29 30-39 40-49 50-59
60-69 70-79 80+
Race
White Black/AA
Other Asian
Prefer Not to Answer Two or More Races
Insurance
Medicare Private
Medicaid Uninsured
Medicare+Private Military Program
Ethnicity
Not Hispanic/Latino Hispanic/Latino
Prefer Not to Answer
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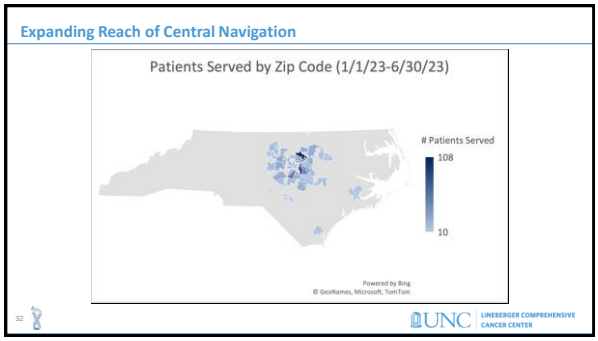
Expanding Reach of Central Navigation
Patients Served by Zip Code (1/1/23-6/30/23)
Patients Served
108
10
Powered by Bing
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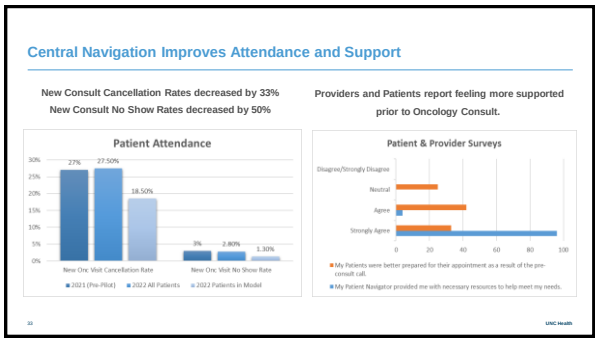
Central Navigation Improves Attendance and Support
New Consult Cancellation Rates decreased by 33%
New Consult No Show Rates decreased by 50%
Providers and Patients report feeling more supported prior to Oncology Consult.
Patient Attendance
27%
27.50%
18.50%
3%
2.80%
1.30%
New Onc Visit Cancellation Rate
New Onc Visit No Show Rate
2021 (Pre-Pilot) 2022 All Patients 2022 Patients in Model
Patient & Provider Surveys
Disagree/Strongly Disagree
Neutral
Agree
Strongly Agree
My Patients were better prepared for their appointment as a result of the pre-consult call.
My Patient Navigator provided me with necessary resources to help meet my needs.
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Central Navigation Supports Health Equity

Identified Black		Identified White
430	Patients	1376
4.2	Visits per Patient	3.5
8.39	Interventions per Patient	7.95
4.12	Risk Factors per Patient	2.93
$113,831	Funds Disbursed	$279,915
17.9%	% of Population w/ Funds Disbursed	10%
$1,478.23	$ per Patient	$2,028.37*
Financial Navigation Transportation Form Literacy	Top Interventions	Consultation Prep Financial Navigation Diagnosis Education

*Reflects higher co-pay assistance due to higher commercial payer mix

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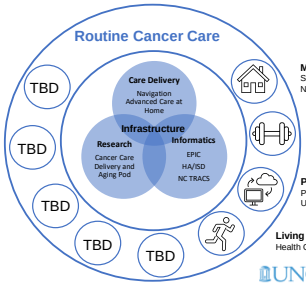
Embedded Cancer Care Delivery Research at UNC

- Research, care, and informatics infrastructure supports intervention development and implementation
- Interventions are supported by grant-funded research
- Program facilitates multistakeholder engagement and career development
- Evidence generation informs the learning healthcare system



Meeting Unmet Needs
Social Determinants of Health
New Patient Screening

Preparing for Care
Cancer Prehabilitation

Providing Treatment Support
Proactive Symptom Surveillance
Urgent Care at Home

Living Well With Cancer
Health Coaching with UNC HealthScore

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Population Health Management in Oncology Care

- **PHM works to improve outcomes among groups of individuals**
  - Identify patients in real time
  - Use risk stratification to proactively target service provision
  - Monitor care quality to support quality planning and improvement
- **Successful PHM infrastructure enables real-time insights for identifying care gaps that can be addressed to improve outcomes among groups of individuals**
- **Requires integration with Electronic Health Record (EHR)**

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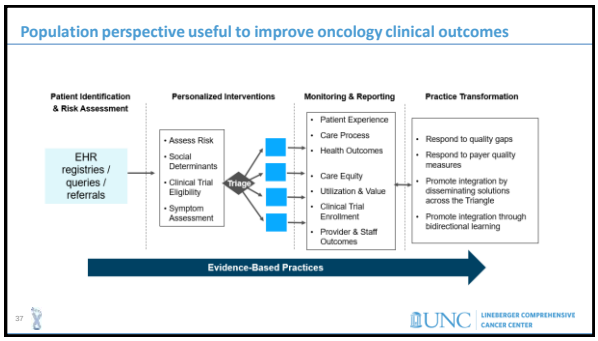
Population perspective useful to improve oncology clinical outcomes
Patient Identification & Risk Assessment
Personalized Interventions
Monitoring & Reporting
Practice Transformation
EHR registries / queries / referrals
Assess Risk
Social Determinants
Clinical Trial Eligibility
Symptom Assessment
Triage
Patient Experience
Care Process
Health Outcomes
Care Equity
Utilization & Value
Clinical Trial Enrollment
Provider & Staff Outcomes
Respond to quality gaps
Respond to payer quality measures
Promote integration by disseminating solutions across the Triangle
Promote integration through bidirectional learning
Evidence-Based Practices
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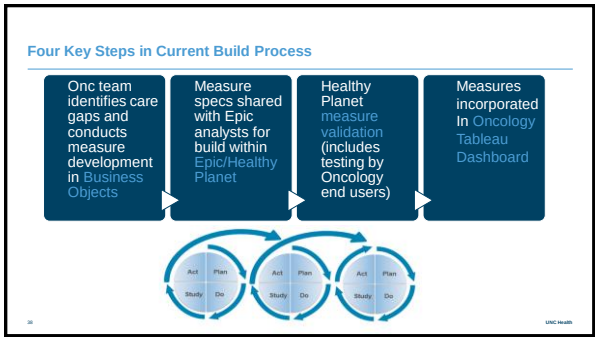
Four Key Steps in Current Build Process
Onc team identifies care gaps and conducts measure development in Business Objects
Measure specs shared with Epic analysts for build within Epic/Healthy Planet
Healthy Planet measure validation (includes testing by Oncology end users)
Measures incorporated In Oncology Tableau Dashboard
Act
Plan
Study
Do
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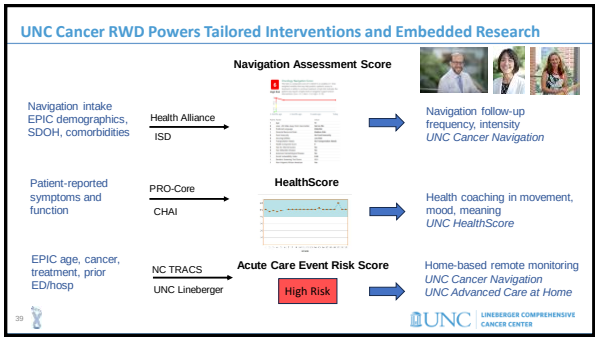
UNC Cancer RWD Powers Tailored Interventions and Embedded Research
Navigation Assessment Score
Navigation intake
EPIC demographics, SDOH, comorbidities
Health Alliance
ISD
Navigation follow-up frequency, intensity
UNC Cancer Navigation
Patient-reported symptoms and function
PRO-Core
CHAI
HealthScore
Health coaching in movement, mood, meaning
UNC HealthScore
EPIC age, cancer, treatment, prior ED/hosp
NC TRACS
UNC Lineberger
Acute Care Event Risk Score
High Risk
Home-based remote monitoring
UNC Cancer Navigation
UNC Advanced Care at Home
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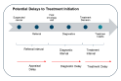
New Decision Support Tools for Navigation

Navigation Assessment Score

- Currently assessed prior to initial visit and again as treatment initiated
- Identifies pre-existing clinical and social vulnerabilities that often result in barriers to care

Time-to-Treatment Monitor

- Ticker starts after one of 5 triggering events
- Enables identification of patients who cross pre-set time thresholds



Acute Care Event Risk Score

- Update of previously published PROACT model (Grant et al 2019)
- Uses cancer diagnosis, therapy, age, and prior ED/Hosp event to predict risk of unplanned acute care event within 30 days of therapy initiation (Stein et al, JCO JOP)

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Navigation Assessment Score

Who: Navigation Team member

What: Risk stratification

Where: Patient in the comfort of own home, away from stressors of first clinic visit

When: Assessed during a pre-consult outreach call

Why: **Immediate needs mitigated** (i.e., transportation to consult appointment), **appropriate early interventions initiated** (i.e., early social work referral, financial assistance application), **ongoing support planned** (weekly check in calls to assess for treatment support needs, unreported symptoms, emotional support, etc), all leading to **better access and ability to continue treatment**

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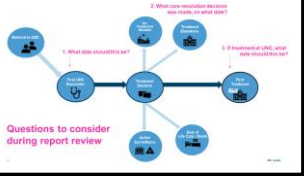
Time-to-Treatment Monitor

- **Goal:** To have a report that navigators/care teams can use to identify patients who may be at risk of having a harmful delay in treatment initiation
- **Time-to-Treatment Report Built and Being Tested**
  - Identifies first encounter with cancer diagnosis and counts each day that passes without indication of treatment
  - Report is being piloted with GI navigation teams
  - Simultaneously identifying ways to automate turning the ticker off (e.g, hospice enrollment, death)



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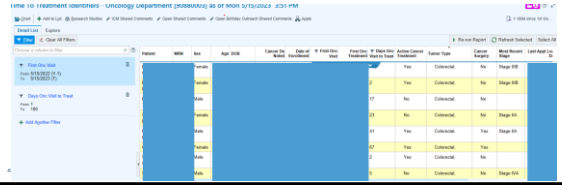
Time to Treatment Monitor Report

Incorporation of triggering events

First encounter with oncology provider, date of first path report, first date with cancer diagnosis, date of inpatient d/c with cancer dx, or central navigation enrollment date



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Unplanned Acute Care Events (ACEs) in cancer care are a problem

ACEs drive poor quality of life and costs.
Some ACEs are preventable with improved supportive care.

ACEs among high-risk cancers
30%

Marginalized (Black, Language-barrier Medicaid) Patients
33%

NC residents diagnosed with Thoracic Cancer
8,810

NC residents diagnosed with Colorectal Cancer
4,740

NC residents diagnosed with Leukemia/Lymphoma
4,660

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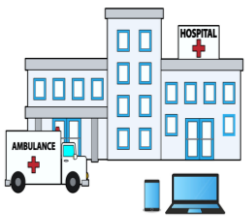
If we reduce ACEs, we can improve outcomes and equity

- Unplanned acute care events (ACEs) are a major driver of patient experience & cancer care costs
  - Well-established disparities in ACEs
  - UNC is no exception
- Implementing a symptom (PRO) monitoring, data-driven approach may equitably reduce unplanned ACEs
  - Improve treatment tolerability
  - Increase effectiveness of care delivery



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Who will benefit?

How can we know if she's at high risk for ED visit/ hospitalization, and avoid these?

If she is high risk, how can we be sure someone can help me watch out for her and help avoid complications?

She lives alone. How can we be sure she gets help when she needs it?

Mrs. Jackson is a 72-year-old healthy woman with metastatic pancreatic cancer. Previously fit, now she has weight loss, fatigue, and pain. She is widowed and lives independently in Clayton. Spending quality time with her family is her main priority. But she also wants to do what she can to live to see her grandchild graduate from NC State next year.

We plan for multiagent chemotherapy. But…

If she needs something, can she get help where she lives?

How can we make sure she gets the treatment she wants, without delays or interruptions?

How can we understand her experience with treatment along the way?

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Our prior, applied academic work provides important foundational knowledge

- **Adapted previously published predictive model**
  - based on 30-day ACE risk
- **Used 4 simple characteristics to predict 30-day risk**
  - Age
  - Prior emergency department/hospital use
  - Cancer type
  - Treatment type
- **Leaned into practice partnerships to**
  - Identify targeted improvement opportunities
  - Establish plausible workflow integrations for care innovation
  - Develop evaluation plans with built in rapid cycle tests of change for sustainment

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Risk-Stratified PRO Workflow Integration

- **Identifying Opportunities to Enhance Design for Improved Workflow Integration**
  - Predictors included in clinical risk model
  - Care coordination between Clinical and Central Navigation teams as well as care coordination between Navigation and Triage Nurse teams
- **PRO-survey Build Underway**
- **Pilot to begin in before end of year**

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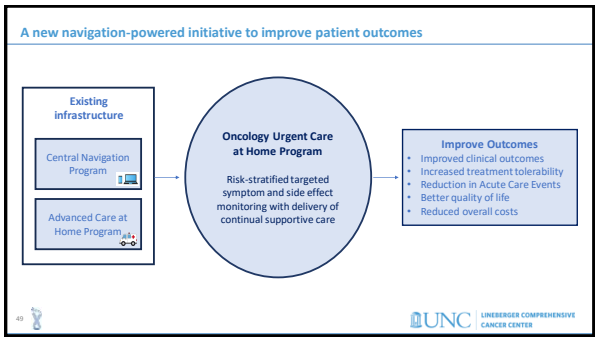
A new navigation-powered initiative to improve patient outcomes
Existing infrastructure
Central Navigation Program
Advanced Care at Home Program
Oncology Urgent Care at Home Program
Risk-stratified targeted symptom and side effect monitoring with delivery of continual supportive care
Improve Outcomes
Improved clinical outcomes
Increased treatment tolerability
Reduction in Acute Care Events
Better quality of life
Reduced overall costs
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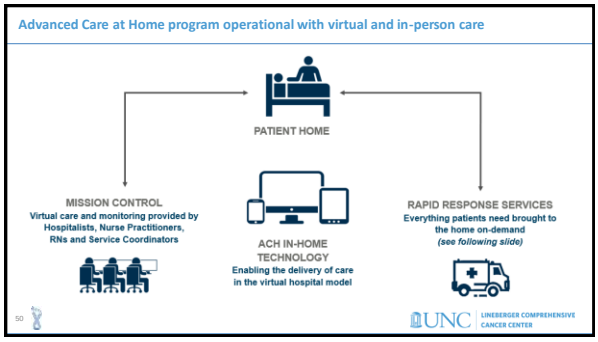
Advanced Care at Home program operational with virtual and in-person care
PATIENT HOME
MISSION CONTROL
Virtual care and monitoring provided by Hospitalists, Nurse Practitioners, RNs and Service Coordinators
ACH IN-HOME TECHNOLOGY
Enabling the delivery of care in the virtual hospital model
RAPID RESPONSE SERVICES
Everything patients need brought to the home on-demand
(see following slide)
50
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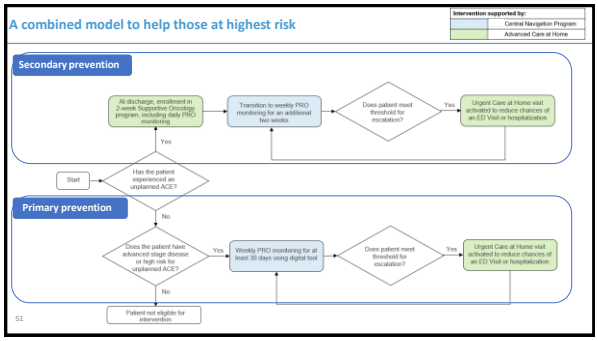
A combined model to help those at highest risk
Intervention supported by:
Central Navigation Program
Advanced Care at Home
Secondary prevention
At discharge, enrollment in 2-week Supportive Oncology program, including daily PRO monitoring
Transition to weekly PRO monitoring for an additional two weeks
Does patient meet threshold for escalation?
Yes
Urgent Care at Home visit activated to reduce chances of an ED Visit or hospitalization
Yes
Start
Has the patient experienced an unplanned ACE?
Primary prevention
No
Does the patient have advanced stage disease or high risk for unplanned ACE?
Yes
Weekly PRO monitoring for at least 30 days using digital tool
Does patient meet threshold for escalation?
Yes
Urgent Care at Home visit activated to reduce chances of an ED Visit or hospitalization
No
Patient not eligible for intervention
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Finalize protocols and infrastructure build with stakeholder engagement

Primary prevention

- Identify high-risk patients via predictive model
- Social determinants of health monitoring
- Symptom and function monitoring weekly for 30+ days
- Escalation alerts for activation of Urgent Care at Home

Secondary prevention

- Identify patients by unplanned acute care event occurrence
- Symptom monitoring daily for 2 weeks, weekly for week 3-4+
- Escalation alerts for activation of Urgent Care at Home

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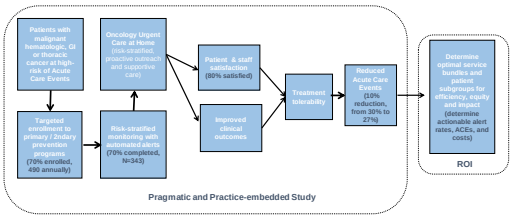
Pragmatic trial with ongoing monitoring for optimization and sustainability



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Navigation Capacity-Building Initiative Grants

Boston Medical Center
City of Hope
Fred Hutchinson Cancer Center
Harris Health System
Harold C. Simmons CCC, UT Southwestern
HIMA San Pablo Oncologico-Caguas
Huntsman Cancer Institute, University of Utah
Markey Cancer Center-University of Kentucky
Montefiore Einstein Cancer Center
Rush University Medical Center
Stanford Cancer Institute

Stephenson Cancer Center, University of OK
University Of Alabama Birmingham
University of Chicago Medicine
University of Colorado Denver
University of New Mexico CCC
University of North Carolina at Chapel Hill
University of Southern California
University of Texas Health
Virginia Commonwealth University, Massey Cancer Center

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Support & Capacity Building Initiative

Key Program Components: Provide capacity building and support to select health systems to advance high-quality cancer care through innovative, sustainable models of oncology patient navigation that address barriers to care for under-resourced populations.

Financial resources and capacity-building support

3-year grants to enhance institutional navigation, especially those from populations traditionally excluded

build upon, innovate & improve existing navigation programs

Learning Community

platform for grantees to share best practices, lessons learned, and access training and expertise.

multi-institutional

Comprehensive evaluation and data sharing

data will be harmonized and analyzed with the intent to:

- share with the larger oncology community and support the development of future programs and policy objectives

American Cancer Society

Every cancer. Every life.

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Sustainability: Eight domains of sustainability identified within the Patient Navigation Sustainability Assessment Tool

1. **Engaged staff and leadership** – having frontline staff and management within the organization who are supportive of the practice.
2. **Organization context and capacity** – the practice has the internal support and resources needed to effectively screen and navigate patients/clients.
3. **Funding stability** – the practice has established a consistent financial base.
4. **Engaged community** – the practice has external support and engagement beyond the clinical navigation team.
5. **Communication, planning and implementation** – using processes that guide the direction, goals and strategies of the practice.
6. **Workflow integration** – designing the practice to fit into existing practices and technologies.
7. **Monitoring and evaluation** – assessing the practice to inform planning and document results.
8. **Outcomes and effectiveness** – understanding and measuring practice outcomes and impact of the practice.

Citation: Dwyer, A., Weltzien, E., and Harty, N. (2019). Patient Navigation Sustainability Assessment Tool for Preventive Cancer Screening. Colorado School of Public Health and University of Colorado Cancer Center, Aurora, CO

American Cancer Society

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UNC Participation in ACS Navigation Learning Community

Aim 1:
- Decision support implementation and tests of change
  - Rapid Cycle PDSAs to optimize builds and implementation

Aim 2:
- Effectiveness evaluation
  - Treatment delays, tolerability, and PROs

Aim 3:
- Impact on navigator staff work-related well-being
- Job satisfaction, work engagement, and burnout

Aim 4:
- Communication strategy and spread

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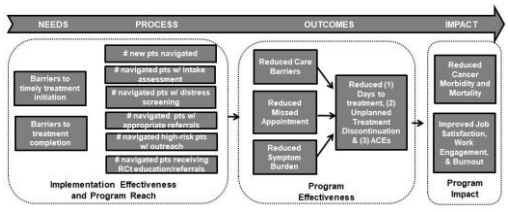
ACS Grant Evaluation Framework



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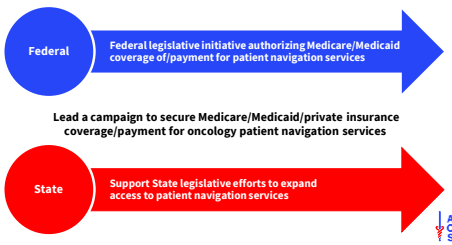
NAVIGATION SUSTAINABILITY & REIMBURSEMENT

Leading Policy Change: ACS CAN



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Coming Soon: EPIC tools and releases

Care Companion

- Digital Assistant throughout the care journey
- Education, PROs, calendar functions
- Available to UNC and used in other disease areas
- Other centers have explored (Ochsner, Mayo)

eSym

- PRO surveillance – tested in multicenter Cancer Moonshot-funded effort
- Included in EPIC Foundation Build in Aug 2023
- Will eventually replace our in-process temporary PRO surveillance solution

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Coming Soon: Navigation Reimbursement Opportunities

Proposed new codes for CMS
- Principal illness navigation
- Social determinants of health risk assessments
- Caregiver training services, community health integration services

Existing codes
- Remote patient monitoring
- Care coordination

Next steps
- Determine necessary workflows and feasibility for implementation

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The Future: Potential Navigation Reach Across North Carolina

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Thank you.

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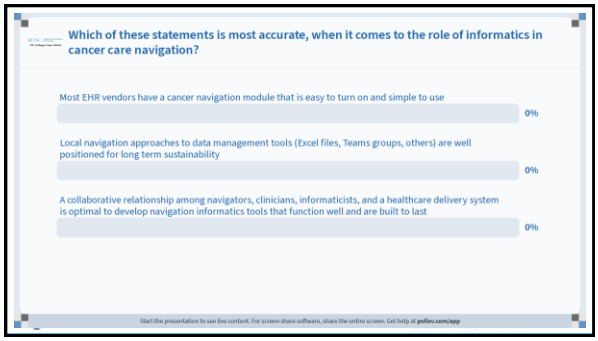

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What are some examples of initiatives or programs that are supporting availability and best practices in navigation at a national level?
The National Navigation Round Table
0%
The American Cancer Society Cancer Action Network
0%
EPIC Care Companion
0%
Proposed CMS codes for navigation reimbursement, such as PIN
0%
All of the above
0%
Start the presentation to see live content. For screen share software, share the entire screen. Get help at pollev.com/app

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Questions/Comments?
Nobody has responded yet.
Hang tight! Responses are coming in.
Start the presentation to see live content. For screen share software, share the entire screen. Get help at pollev.com/app

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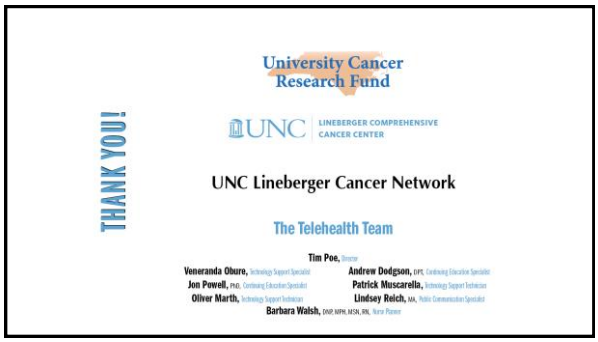
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UNC Lineberger Cancer Network
The Telehealth Team
Tim Poe, Director
Veneranda Obure, Technology Support Specialist
Jon Powell, PhD, Continuing Education Specialist
Oliver Marth, Technology Support Technician
Andrew Dodgson, DPT, Continuing Education Specialist
Patrick Muscarella, Technology Support Technician
Lindsey Reich, MA, Public Communication Specialist
Barbara Walsh, DNP, MPH, MSN, RN, Nurse Planner

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UPCOMING LIVE WEBINARS
ADVANCED PRACTICE PROVIDER
November 8
4:00 PM
Lung Cancer Screening Essentials
Jason Long, MD, MPH Kim Shoenbill, MD, PhD, MS
Michelle Ottersbach, MS, MS, DNP, RN, CNL, CRCR
RESEARCH TO PRACTICE
November 15
12:00 PM
Update on Prostate Cancer Screening
Marc Bjurlin, DO, MSc, FACOS
PATIENT CENTERED CARE
December 6
12:00 PM
Alternative Treatments for Keratinocyte Malignancies
Puneet Singh Jolly, MD, PhD
Complete details on upcoming Live Webinars:
learn.unclcn.org/live-webinars

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SELF-PACED, ONLINE COURSES
ADVANCED PRACTICE PROVIDER
Overview of Clinical Trials for the APP
Clarissa Urban, PA-C
RESEARCH TO PRACTICE
Sarcoma Management in North Carolina: Updates for 2023
Mark Woodcock, MD
PATIENT CENTERED CARE
Improving Recognition and Treatment of Cognitive Problems in Cancer
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