

The Boston Medical Center Patient Navigation Toolkit

1st Edition



The Boston Medical Center Patient Navigation Toolkit

PATIENT NAVIGATION AT BOSTON MEDICAL CENTER

Since its inception in the year 2001, the AVON Breast Health Initiative at Boston Medical Center has provided breast health navigation services for more than 20,000 women, most of who are in low-income households and/or members of racial/ethnic minorities.

Early on, we developed a model of patient navigation designed to ensure that vulnerable women receive timely diagnostic breast health services and demonstrated improvements in follow-up rates.¹ We expanded that patient navigation model within the general medicine practices to include outreach to ensure timely adherence to routine screening mammography, and again showed an improvement in adherence rates.²

Our work revealed that women seeking care from local community health centers were less likely to attend follow up appointments than those referred from hospital-based practices. The Boston Medical Center Patient Navigation Research Program was funded in 2005 by the National Cancer Institute's Center to Reduce Cancer Health Disparities and the American Cancer Society as one of nine programs to participate in the Patient Navigation Research Program (PNRP) Cooperative Group.³ The Boston PNRP developed a unique Community-Based Participatory Research Program, partnering with six Community Health Centers that serve a high proportion of Boston's racial and ethnic minority and low income populations. These practices worked together to design, implement and evaluate a primary-care-based lay patient navigation program, targeting women with both breast and cervical cancer screening abnormalities. The Boston PNRP along with our CHC partners enrolled more than 4,000 women in the project.

Over time, the same navigation model was adopted in other departments across the Medical Center including medical oncology, urology and otolaryngology. And with support from the Massachusetts Department of Public Health, Boston Medical Center directs a comprehensive chronic disease patient navigation program based within the hospital's three primary care practices. The health disparities targeted in this program include screenings for breast, cervical, colorectal, and prostate cancers, cardiovascular disease, and routine primary care services. These patient navigators are now being integrated into the evolving medical home model at Boston Medical Center. Most recently, we are exploring patient navigation in the community setting, where navigators will assist public housing development residents to access primary care.

OUR TEAM

Collectively, the toolkit authors and contributors have more than four decades of experience designing, implementing and evaluating patient navigation programs targeting urban, underserved populations across the spectrum of cancer care and more recently in chronic disease. In addition to their extensive experience training community health workers, they work collaborative with partners from across the country to ensure the science, dissemination and sustainability of navigation programs nationwide.

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Elaine Campbell Lowe

October 6, 1978 - October 17, 2011

This toolkit is dedicated to the memory of Elaine Campbell Lowe a courageous patient navigator for the AVON Initiative at Boston Medical Center. Elaine lived her life with determination, spirit and courage. Despite her own cancer diagnosis, Elaine was relentless in her commitment to the underserved, gaining the trust and respect of our most vulnerable patients. Her fierce determination to live a full life was matched only by her passion for patient care. Her memory lives on as our model patient navigator in the case studies presented in this Toolkit. She is deeply missed.

Photo credit: Gretje Ferguson

THE BOSTON MEDICAL CENTER PATIENT NAVIGATION TOOLKIT

INTRODUCTION

This toolkit is designed to help you plan and implement a Patient Navigation program *with the best chance of reducing health disparities and improving health outcomes for your patients*. It contains evidence-based and experience-based examples, case studies, practical tools, and resources to help you:

1. Establish an evidence-based patient navigation program tailored to reduce barriers for your patients
2. Incorporate best practices to enhance current patient navigation programs or services
3. Implement a patient navigation model to address any targeted medical condition where disparities exist
4. Hire, prepare, supervise, support and retain effective Patient Navigators
5. Navigate patients who experience health disparities
6. Evaluate patient navigation programs with the aim of continuous quality improvement

Our experience has been mainly with cancer, so the examples presented in the toolkit are all cancer-related, in keeping with what we know best. However, the information and tools included are readily adaptable to other diseases and conditions.

AUDIENCE

The toolkit was designed specifically for three distinct audiences:

- Program planners and administrators
- Supervisors of patient navigators
- Patient navigators

Policy advisors, researchers and others interested in Patient Navigation may also find the content and resources presented here useful.

USING THE TOOLKIT

As the name implies, the toolkit provides a selected set of tools and resources that are useful in different phases and aspects of navigation programs. Like a physical toolkit, you may not need to use every tool, or even read every chapter and volume; you'll use only the tools you need for your specific situation. This is particularly the case if you are already experienced in developing navigation programs. Thus, we encourage you to begin by scanning each volume's list of chapters in order to see what will be most relevant to your situation and needs.

The toolkit is comprised of three comprehensive volumes. Each volume is designed to be used in conjunction with the others, but can serve as a stand-alone guide for specific users:

Volume	Title	Audience
I	<i>Developing Your Patient Navigation Program</i>	Program initiators/planners
II	<i>Supervising and Supporting Patient Navigators</i>	Supervisors of navigators
III	<i>Patient Navigation in the Field</i>	Patient Navigators

Each volume contains a set of chapters describing the key elements of Patient Navigation relevant to its audience. You may choose to read our toolkit straight through, or pick out the volumes or chapters relevant to your cause and start from there—complete read through is not required to benefit from this toolkit.

Each chapter is organized into printed resources, online resources, tasks, tools, templates, and case studies so that you can:



- **Read more about it** – *Recommended published materials* that address patient navigation in more depth or from other perspectives than those presented in the toolkit, including scientific articles, books, and journal articles, training curricula and websites



- **Find it online** – *Recommended online materials* that supplement reading resources with free online information, tutorials, and other navigation program websites



- **Stop and do it** – *Interactive tools* where you will be asked to complete a task, reflect, or answer questions to guide learning and decision-making processes, such as checklists and Q&A sections



- **Use it “as is” or adapt to your needs** – *User-friendly instruments* that are adaptable, task-specific and linked to evidence-based recommendations, such as diagrams, monitoring and evaluation tools, case and other practical materials that you can use without alteration



- **Customize for your needs** – *Easy-to-adapt structured documents* that you can use for your own purposes as a tool to generate ideas or a template to mold to your needs, including blanks, ‘fillable’ forms, and example protocols
- **For example..** **See it in action**– *Case studies and descriptions based on true stories* that illustrate a concept, explain how a tool is used, or identify pitfalls and solutions using lessons learned from our experience as well as observational research conducted on navigation programs

THE EMERGING MODEL OF PATIENT NAVIGATION

The first patient navigation program was started in 1990 in Harlem, New York by Dr. Harold Freeman to help low-income women overcome barriers to breast cancer screening and follow-up care.⁴ Since then, medical science has made continuous strides in cancer care. However, patient, provider and system barriers continue to cause delays in care, affect the quality of care, and lead to poor health outcomes in low-income, underinsured and racial/ethnic minority populations.^{5,6}

Over the past two decades, patient navigation has emerged as an innovative, community-based approach to reducing cancer health disparities along each step of the cancer care continuum; screening, diagnosis, treatment, and outcomes.⁷ Early success^{1,4} in patient navigation has led to the creation and dissemination of many versions of “patient navigation,” employed not only in cancer care but in the health care of patients with other targeted chronic or acute diseases.⁸

As a result, a wide variety of health programs and services have been developed under the umbrella of “patient navigation” in the absence of any generally accepted definition of patient navigation or established parameters for best practices in patient navigation. Both a review of the published literature about patient navigation and the experience of Boston Medical Center with patient navigation suggest that patient navigation programs vary widely in three areas:

- The “problem” or target disease (health disparity)
- Community characteristics and “needs” (barriers to care)
- The type of health care system in which navigation is implemented (e.g. primary vs. specialty care, community vs. clinic setting, different insurance payers, regulations, etc.)

Clearly, patient navigation is not a “one-size-fits-all” model. In fact, differences among navigation programs are desirable when informed by local variations in these central aspects of care. However, there are some consistent principles that provide the foundation of successful patient navigation programs. This toolkit is intended to support appropriate variations in program implementation while also preserving the integrity of what patient navigation was designed to accomplish—to *reduce health disparities*. Accordingly, it offers

case studies, tools, and resources from cancer care navigation that can be applied to reduce the impact of the target disease, health disparities, and barriers to care unique to your own community.

Our foundation and experience is in cancer. Our intent is to provide framework and principles that are applicable to other disease areas. In fact, there is growing interest in understanding how to navigate a *patient* and not a specific disease. For example, if a woman develops breast cancer and has pre-existing diabetes, how can navigation meet the needs of this patient as a whole?

DEFINITION OF PATIENT NAVIGATION

To maximize the usefulness of the toolkit, we offer the following general concepts to provide a working definition for patient navigation and the framework for the toolkit.

- Patient navigation is a model of care that aims to reduce an existing health disparity as defined in a particular community.
- Patient navigation addresses a patient’s individual barriers to care by linking them to existing local and regional resources, not by creating new resources or services.
- Patient navigation is not just a patient navigator; navigation requires a team approach: administrators to champion the program, supervisors to provide clinical and administrative support, *and* patient navigators with a defined role within the healthcare team.

These concepts have guided us as we put patient navigation into operation within our own institution and our community. Although variations in the definition of patient navigation exist, we found that patient navigation is generally defined as a *barrier-focused intervention* (in this case, for cancer care) with seven common characteristics:

1. Navigation is provided to individual patients for a defined episode of care (e.g. through the evaluation of an abnormal screening test)
2. Navigation targets a defined set of health services that are required to complete an episode of care
3. Navigation has a defined endpoint when the provision of services is complete (e.g. when the patient achieves diagnostic resolution after a screening abnormality)
4. Navigations serves to bridge gaps in the existing healthcare system for individual patients
5. Navigation systems require coordination among members of the health services team
6. Navigation services focus on the identification and reduction of individual patient-level barriers to accessing and completing care
7. Navigation aims to reduce delays in accessing the continuum of care services, with an emphasis on timeliness of diagnosis and treatment and a reduction in the number of patients lost to follow-up

Our definition of patient navigation is consistent with the recently published “principles of navigation” by Dr. Freeman⁹. This working definition also works well within the current movements in health care deliver reform to promote patient-centered care and coordinated care. Accordingly, patient navigation is now a requirement for certain accreditation standards by the following organizations and movements:

- Commission On Cancer
- Joint Accreditation Commission on Hospital Organizations
- Patient-Centered Medical Home

As interest in the patient navigation model continues to grow and new programs are developed and implemented to address a variety of health concerns with a variety of patient populations, we hope this toolkit will help program initiators to incorporate:

- Essential elements of an evidence-based patient navigation model
- Best practices in patient navigation from lessons learned in the field and through research
- Patient-centered approach to care delivery

DEVELOPMENT OF THE TOOLKIT

The content of this toolkit is drawn from published and public information about patient navigation. Its sources include:

- Literature review of relevant scientific articles
- Review of existing patient navigator training curricula
- Exploration of on-line patient navigation resources
- Participation in professional conferences relevant to patient navigation
- Key informant interviews and focus groups with stakeholders such as: patient navigators, supervisors, clinicians, medical directors, program coordinators and investigators
- The experiences and expertise of the Boston Medical Center Women’s Health Unit, the Boston Patient Navigation Research Program (PNRP), the AVON Safety Net Grantees, and the Central Massachusetts Area Health Education Center’s Outreach Worker Training Institute.

FINAL THOUGHTS

We hope that you find this toolkit to be a beneficial and easy to use resource to development and improvement of your patient navigation program. Good luck!

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The Boston Medical Center
Patient Navigation Toolkit

**Volume 3: Patient Navigation in
the Field**

For Patient Navigators

What the icons mean

Throughout these three volumes, you will find resources. They are marked by icons to give you another way to quickly find the kinds of materials you want.

This icon...	...flags a resource that you can use to...
	<i>Read more about it</i> Summaries of books, research journal articles and other written materials you can read if you want to go deeper into the topic. Includes full citations so you can locate the complete text.
	<i>Find it online</i> Descriptions of websites and other online resources with links (URLs). Includes information about how you might use the site's contents.
	<i>Stop and do it</i> Reminder to pause and do the task described in the section you just read <u>before</u> you continue reading.
	<i>Use it "as is" or adapt to your needs.</i> Resources that will help you do the task discussed in the section you just read.
	<i>Templates & forms</i> Blanks, stationery, "fillable" online forms and other materials you can use as is or customize to meet your needs.
For example..	<i>See it in action</i> Scenes from the story of a fictitious healthcare program. These snippets show how the processes and tools being described might look in the real world.

***Volume 3: Patient Navigation in the Field
For Patient Navigators***

Contents and Goals of Volume 3

Chapter	Topic	Goal: When you have finished this chapter you will have the information, tools and resources you need to:	Page
1	Defining your Role in the Patient Experience	Define your job responsibilities. Understand how your job fits within the current patient experience.	9
2	Building Skills for Patient Navigation	Define basic skills you need to navigate. Understand the health issue you navigate for including: 1) Clinical services available 2) The health system you navigate in 3) The resources available to help	23
3	Understanding Barriers to Health Care	Identify barriers patients face when they go for health services. Know what you can do to break them down. Recognize what resources you need and how to get them so patients overcome barriers.	35
4	Helping Patients Take Charge of Their Health	Understand and use the tips in the chapter to improve your listening skills. Use these skills to motivate your patients to seek and complete care.	53
5	Meeting Your Goals and Taking Care of Yourself	Understand your program goals, and how your day to day work helps the program. Identify job expectations your supervisor has for you. Define your personal goals as a Patient Navigator. Know how to care for yourself to avoid stress and burnout.	65

INTRODUCTION

Volume 3 is written for those who are already Patient Navigators, or those soon to become Patient Navigators. The goal of this volume is to help you understand the role of a Patient Navigator in the patient experience. We provide you with the tools you need to effectively navigate patients through the health system, and support the needs of the community by addressing barriers to health care. Volume 3 may also help experienced Patient Navigators strengthen their skills and prepare them to teach these skills to others.

What will you find in this volume?

This volume will take you through five major topics. When you have read each chapter and used the tools, you will have the information you need to be a successful Patient Navigator in any setting. We also include a Glossary of words that relate to navigation. Words that can be found in the Glossary will appear ***bold-italicized*** the first time they are used in the text.

1. *Defining your Role in the Patient Experience*

Define your responsibilities. Understand how your job fits within the existing patient experience.

- a. What is Patient Navigation? What is a Patient Navigator?
- b. How do I fit into the patient's experience?

2. *Building Skills for Patient Navigation*

Define the core navigation skills and program specific skills for your program. Help you learn about the health issue you navigate including: 1) health services available within your program, 2) the health system you navigate in, and 3) the resources available that may improve the patient experience.

- a. What core navigation skills do I need to develop?
- b. What else do I need to know before I can start navigating?
- c. How do I get these skills?
- d. How do I figure out what resources are available to the population I serve?

3. *Understanding Barriers to Health Care*

Identify and describe barriers to getting health services. Know what you, the Patient Navigator, can do to break them down. Recognize what resources you need to help patients to deal with their barriers. Explain how to access these resources.

- a. What is a "Barrier" to care?
- b. How do I identify barriers for a specific patient?
- c. How do I understand what barriers are in my community?
- d. What do I do when I have identified a barrier?
- e. How do I identify and access internal and external resources for patients?
- f. How do I know if I've addressed a barrier?

4. *Helping Patients Take Charge of Their Health*

Understand and use the tips described in the chapter to improve your listening skills. Help you use these skills to encourage your patients to seek and complete care without you.

- a. How do I get my patients to take charge of their health?
- b. What can I do to be a good listener?
- c. How do I build a trusting relationship with my patients?
- d. How do I get patients to reflect on how they handle their own health care?
- e. How do I help patients find reasons to take charge of their health?
- f. What is resistance?
- g. How do I develop patient interaction skills?

5. *Meeting Your Goals and Taking Care of Yourself*

Understand the program goals and how your day-to-day activities help to meet the program goals. Identify job expectations your supervisor has for you. Define your personal goals as a Patient Navigator. Know the resources to help yourself to avoid stress and burnout.

- a. Performance of the program: what am I trying to change/improve?
- b. Performance of Patient Navigator: what are my day to day goals/quotas?
- c. What is “burnout” and what are some ways to avoid it?

List of Tools

Each of the tools listed below is its own file separate from this text.

TOOL 3.1: Areas of Patient Navigator Activities

TOOL 3.2: Contact Web

TOOL 3.3: Examples of Navigator Activities

TOOL 3.4: Key Questions List

TOOL 3.5: Definitions of Barriers and Actions

TOOL 3.6: Identify the Barriers!

TOOL 3.7: Helpful Hints for Building your Resource Binder

TOOL 3.8: A Few Ways to Know the Barrier has been Addressed

TOOL 3.9: 12 Steps to Becoming a Better Listener

TOOL 3.10: Open vs. Closed questions – Examples

TOOL 3.11: Ideas for Stress Relief at Work

Glossary

Abnormal Result: Findings from a medical test that do not fall within the range of what is considered normal. If a test result is abnormal, more tests may need to be done to see if the patient has a health problem. It is important to remember not all abnormal tests result in an actual health problem. In fact, most abnormal results simply require more testing that ultimately find the patient to be healthy.

*Example: The cervical Pap test Louisa was given last week had an **abnormal result**. Her provider wants her to come back for follow-up testing.*

Action: A task the Patient Navigator performs to help the patient get the care he or she needs.

*Example: Elaine's **action** was getting a cab voucher for Ignacio who needed a ride to his doctor's appointment.*

Administrative: The area of patient navigation relating to management or organization of the program. This includes things that relate to: human resources, such as vacation and sick time and documentation on patients being navigated.

*Example: For supervisors, **administrative** duties include: managing work schedule for Patient Navigators, their sick and vacation time, and mentoring Patient Navigators. For Patient Navigators, administrative tasks include completing documentation of actions and barriers of cases they are following.*

Barrier: A problem or obstacle that makes getting recommended care difficult. Barriers are very individualized, so that each person should be assessed for their own unique barriers to care.

*Example: Carol wanted to make an appointment for a mammogram, but she did not have a way to get to the hospital. Transportation is one **barrier** to care for Carol.*

Barrier Identification: Figuring out what problems or obstacles are making it difficult for a patient to get the care he or she needs.

*Example: The more Elaine worked with patients the better she got at **barrier identification**. For example, asking the question "how are you going to get to your appointment?" helps Elaine identify transportation barriers.*

Burnout: Being emotionally or physically exhausted after doing a stressful job for a long period of time.

*Example: Navigating patients can be challenging. Patient Navigators may experience **burnout** and need to remember to take care of themselves, so they in turn can be in the best state of mind to help their patients.*

Care Process: A series of recommended actions or steps a patient must go through as part of receiving comprehensive health care for a specific health issue or disease.

*Example: After having an abnormal mammogram result, Nancy's **care process** was to get an ultrasound, then a biopsy, and finally meet with her provider to find out her diagnosis.*

Case-finding: To identify patients or 'cases' that need navigation. This is the first step in any navigation program, though the process may differ for each program.

*Example: Elaine spends every Monday morning **case-finding**. She looks at all of Dr. Jones's patients from the week before to see if any had abnormal results, and then starts navigating those who did.*

Caseload: The number of patients or 'cases' a Patient Navigator is working with at a given time. Caseload can also be the amount of time a Patient Navigator spends working with their patients.

*Example: Lately, Elaine has been carrying a larger **caseload** working with 25 patients this month compared to the 10 patients she was navigating last month.*

Community: A group of people with a common characteristic, such as culture, interest, or shared neighborhood, within a larger society.

*Example: The Health Center was able to better serve its Hispanic/Latino **community** by hiring additional Spanish interpreters.*

Community Health Center (CHC): Community-directed health care organizations serving patients in the local area, often targeting low income and medically underserved populations. Health centers provide high quality, affordable primary and preventive care, and many provide specialty care such as dental, mental health and substance abuse, and pharmacy services.

*Example: The **Community Health Center** where Elaine works offers healthy cooking classes taught in English and Spanish, in addition to primary care and other specialized care.*

Contact Web: A visual representation of different departments, services, and/or people that are part of the program's navigation team, and who Patient Navigators can use as contacts to find resources for patients.

*Example: Elaine refers to her **contact web** when she needs to contact the financial office about an insurance barrier.*

Core Navigation Skills: The basic set of knowledge and skills anyone working as a Patient Navigator needs. Skills most commonly identified as “core skills” for navigation include: organization and time management, barrier identification, resource identification and utilization, and cultural responsiveness and sensitivity.

*Example: During her first two weeks as a Patient Navigator, Elaine had training sessions on the following **core navigation skills:** barrier identification, finding resources to help patients, organization, effective time management, and cultural sensitivity.*

Culture: The set of shared attitudes, values, goals, beliefs, and practices that characterizes an institution, organization, or population.

Example: When Ming was diagnosed with cancer, she incorporated her Chinese culture into her care plan by including traditional acupuncture therapy in addition to radiation and chemotherapy.

Cultural Responsiveness: Reacting in an appropriate and sensitive manner to individuals with different beliefs, values and customs than you. For a Patient Navigator, this means acting without judgment, focusing on understanding the patient and their needs, respecting their beliefs and values.

*Example: Due to the conservative norms of her culture, Aisha was not comfortable having a male provider as her doctor. Elaine practiced **cultural responsiveness** by always making sure Aisha’s appointments were scheduled with a female doctor.*

Diagnosis: Identification of a disease or illness based on patient symptoms, clinical assessment, and usually confirmed by test results.

*Example: After an abnormal mammogram result, ultrasound, and a biopsy, Nancy’s provider explained her final **diagnosis** of a breast cyst, telling Nancy that she did not have cancer.*

Health Services Team: All providers and staff involved in providing health care to patients, including the Patient Navigator, are part of the health services team. Together, this team provides care for patients in all types of health-related appointments and works to coordinate their care.

*Example: The **health services team** at the clinic is made up of 6 doctors, 4 nurses, 2 medical assistants, a nutritionist, and 3 administrative staff.*

Outreach: When a program or member of a program goes out into the community to educate people about their health and/or to tell them about the services and goals their program offers. Health-related outreach activities often provide education around health topics, share information about the program, and perform health screenings.

*Example: For the **outreach** part of her job, Elaine held a meeting at a local church to tell community members about the services available at the health center.*

Patient Navigator: An individual who provides support and guidance to patients in need of assistance in accessing the health care system. Patient Navigators do this by helping patients overcome barriers and facilitating timely and quality care in a culturally sensitive manner.

*Example: When Savita was told she had cancer, she was overwhelmed by all of the appointments and different doctor offices that she had to go to. Elaine, the **Patient Navigator**, was there to help her figure out where to go, and helped her to organize her appointments to get the treatment she needed.*

Patient Navigation (program): A system of care that includes a team approach to guiding patients through the often confusing healthcare system to get the care they need for a specific disease or health issue (like cancer). The Patient Navigator is only one member of that team.

*Example: When the health center realized that mammogram screening was low among immigrant women, the center implemented **Patient Navigation** to help these women obtain mammograms.*

Primary Care: Primary care is health care services that address most preventive and personal health care needs by a single health care provider, where the patient has a personal relationship with the care provider who organizes all other specialty care and patient needs.

*Example: At his annual appointment, Joe's **primary care** provider told him he should exercise more and that it was time for his colonoscopy.*

Program Specific Navigation Skills: The specific skills a Patient Navigator needs to work in a particular navigation program, based on what the supervisor wants the Patient Navigator to do. While the core skills of navigators are always the same, program goals and needs will determine program specific skills.

*Example: During her first two weeks as a Patient Navigator, Elaine had training sessions on the following **program-specific navigation skills**: documenting her work in the electronic medical record, how to identify the patients who need navigation, information about breast cancer, and how the care process at her health center works.*

Provider: A licensed medical professional, usually a physician, who is involved in providing medical care and helping patients make decisions. Provider can also be used to refer to other members of the health services team, such as nurses, physician assistants, etc.

*Example: George's cancer **provider**, Dr. Wilson, helped George choose the best treatment for his prostate cancer. But the final decision was made only after input from all of his providers, including Dr. Battaglia, his primary care provider and Wanda, his nurse.*

Resource: A source of information, support, and/or assistance that Patient Navigators can use for, or offer to, their patients.

*Example: A Patient Navigator helps patients access **resources** related to barriers such as housing, utilities assistance, transportation, and more to help them overcome the problem they are experiencing.*

Resource Identification: Finding existing information, support and/or assistance programs to meet the needs of a patient.

*Example: Kate was having trouble finding daycare she could afford for her 3 year old and had to miss her appointment at the gynecology clinic. Elaine did online research to find a local mom with a good reputation who charged by the hour for childcare. Elaine used **resource identification** strategies to help Kate overcome her childcare barrier.*

Resource Utilization: Using information, support and/or assistance programs specifically to help a patient. This can mean referring patients to outside organizations or groups that have the resources they need.

*Example: When Sam was having trouble getting insurance after losing his job, Elaine called the financial office at the health center to get information on how to apply for free health care. This **resource utilization** helped Elaine get the right information to her patient.*

Survivorship: The physical, psychological, social/cultural, and economic issues of cancer, from diagnosis until the end of life, including issues relating to the ability to get health care and follow-up treatment, late effects of treatment, second cancers, and quality of life.

*Example: Keisha joined a breast cancer **survivorship** support group, where she found emotional support, tips on dealing with chemotherapy, and how to talk to your children about your disease.*

Target Population: The community or group of patients a program focuses on. A patient navigation program is geared towards serving a target population who is known to have a health disparity and works to reduce that disparity.

*Example: While the patient navigation program serves all of our female patients with abnormal mammograms, the **target population** is Vietnamese immigrants; therefore the Patient Navigator is bilingual in English and Vietnamese.*

Chapter 1: Defining Your Role in the Patient Experience

Goal: When you have finished this chapter you will have the information, tools and **resources** you need to understand how your job fits into the patient experience. You will learn how your job fits within the current delivery of **health services** in your **program**. It describes **5 Steps** you should take to figure out where you fit into the patient experience.

Note: The Glossary at the beginning of this volume contains definitions for many words you will see in Chapter 1. These words appear in **bold-italicized** print the first time we use them. This should trigger you to look them up in the glossary if it is not a word you are familiar with.

1. What is Patient Navigation? What is a Patient Navigator?

It is important for you to have a clear understanding of what “Patient Navigation” means. A definition helps you understand why your job matters and what the program is trying to do.

Patient Navigation is a way of guiding patients through the often confusing healthcare system to get the care they need for a specific health issue (like cancer or even **primary care** to prevent a health issue).

Patient Navigators do this by uncovering the things that prevent patients from getting the care they need. Patient Navigators then help patients overcome these obstacles by finding resources that may help.

- Patient Navigators are becoming an expected part of care.
- Patient Navigators may be volunteers from the community or be hired and paid to navigate. Patient Navigators can come from many different education backgrounds, ranging from simply a high school diploma to a professional nursing or social work degree.
- People consider Patient Navigation to be many different things. One important difference between patient navigation programs and other community outreach programs is that Patient Navigators bring patients in for medical care and appointments. Outreach programs serve people out in the **community** only.
- Some defining *Principles* of navigation have been created- to help guide our understanding of what navigation is meant to be. These **9 ‘Principles of Patient Navigation’** have been developed through the experience of Dr. Harold P. Freeman in his article, “*History and Principles of Patient Navigation*”. These principles are:

1) Patient navigation is a patient-centric healthcare service delivery model.

*Translation: Hospitals and Health Care systems can be complicated and confusing for patients. The idea is to focus on each patient as an individual. Understanding their own issues will help them move through the health system as quickly as possible, starting from the **community** where they live, to getting a **diagnosis** using health services, and continuing all the way through treatment and **survivorship** if needed.*

- 2) Patient navigation serves to virtually integrate a fragmented healthcare system for the individual patient.

*Translation: Making the connections between **providers** and the community. Once you have gotten the patient in for a health service appointment, there may be many other appointments that follow, with different departments and different doctors, which can be overwhelming for patients. Navigation can guide the patient throughout their care, making the **care process** easier on the individual.*

- 3) The core function of patient navigation is the elimination of **barriers** to timely care across all segments of the healthcare continuum.

*Translation: The one-on-one relationship you will build with your patients will help you to see what **barriers** an individual patient has to getting care, and to work with them on overcoming these barriers as soon as possible. The point here is that new barriers can always come up, and that getting a patient into one appointment does not mean your job is finished—in fact, it means it is just beginning.*

- 4) Patient navigation should be defined with a clear scope of practice that distinguishes the role and responsibilities of the Patient Navigator from that of the other **providers**.

*Translation: To make the patient experience the best possible for individual patients, the Patient Navigator should work as part of the **health services team**, but have specific jobs to do that are different from the rest of the team.*

- 5) Delivery of patient navigation services should be cost-effective and commensurate with the training and skills necessary to navigate an individual through a particular phase of the care continuum.

Translation: Navigating patients through different types of health services may require different skill-sets, education, and experience levels for Patient Navigators to have. It is important that the program appropriately match Patient Navigators with tasks that fit with their personal abilities.

- 6) The determination of who should navigate should be determined by the level of skills required at a given phase of navigation.

Translation: The program may need a nurse or social worker to do some navigation jobs, while others can be done by trained lay-Patient Navigators. The other consideration is that, having Patient Navigators allows healthcare providers to work on the health care side of the patient experience, while the Patient Navigators can work on the socio-economic barriers.

- 7) In a given system of care that there is the need to define the point at which navigation begins and the point at which navigation ends.

Translation: All Navigation programs are a little different, so you will need to learn the protocols the program has in place to know how you will identify and make first contact with patients. Also, you can't navigate a person forever, so the protocol for the program should also tell you when you are supposed to close their case and stop navigating them.

- 8) There is a need to navigate patients across disconnected systems of care, such as primary care sites and tertiary care sites.

*Translation: Patient Navigation can be the process that connects patients from primary care to more **specialized care** depending on what they need. Patients may need to go different places to get different things done, so a Patient Navigator can help direct them to where they need to be.*

- 9) Patient Navigation systems require coordination.

Translation: This 'system' means the whole navigation team as a system—that is, everybody involved in an individual's care that is being navigated. The point of this principle is that it's not just the Patient Navigators that need to be coordinated in their day-to-day activities, but also the entire team as one system which includes doctors, nurses, front desk administrators etc., and this coordination will come from the leadership staff. This leadership staff may differ from site to site.

CASE STUDY: How do the 9 Principles of Patient Navigation work in real life?

For example..



*Meet Elaine. Elaine is an experienced Patient Navigator. She has been working in a **community health center** (CHC) for 3 years. She knows her patients and their community well. She speaks Haitian Creole and Spanish, just like some of her patients. Elaine knows a lot about the cultural mix in the area. Elaine had one year of experience as a Community Health Educator before taking her position as Patient Navigator. Elaine tries to get to know each patient as an individual, so that she can mold her navigation activities to fit their specific needs (Principle 1). Elaine was hired as a Patient Navigator for many reasons, 1) experience working with diverse populations 2) language skills, and 3) enthusiasm for helping people (Principle 5).*

The people who come to the CHC Elaine works at have all different kinds of needs. They often have barriers that get in the way of their health care. Elaine looks for patients who are in need of navigation. According to her program protocol, she looks for patients who missed an appointment after they had an abnormal test (Principle 7). She then tries to investigate what happened to them. In this program, navigation ends when the patient has completed treatment or has a normal test and returns to routine care. For example, Jenna had an abnormal finding on a mammogram, but then missed her follow-up appointment for a biopsy. Elaine tries to reach out and guide Jenna through the care process (Principle 2), because one appointment is usually not enough to reach conclusion on a health issue. Elaine knows that Jenna's care should continue through diagnosis and treatment if needed.

Elaine called Jenna to ask why she didn't come to her appointment. Jenna admitted she was too afraid to come to the appointment and just didn't show up. Elaine now knew that fear was the barrier that stopped Jenna from getting to the appointment. Elaine talked to Jenna about the importance of getting this procedure done. Elaine explained more about what the test was and what she could expect. After talking with Elaine, Jenna felt more informed and understood why it was important for her to get the biopsy done (Principle 3). Jenna said that she would schedule another appointment, and that this time she would go.

A few days before Jenna's appointment, Elaine spoke with Jenna's surgeon to talk about Jenna's fear (Principle 8). The week of Jenna's appointment Elaine called Jenna to see if she would like Elaine to go with her to the appointment (Principle 4). Elaine called Jenna and the surgeon because this is part of her role as a Patient Navigator. This helps out the rest of the navigation team - providers, nurses, and front desk staff. They don't have to worry as much about what happened to Jenna. It is Elaine's job to follow up and find out what happened to Jenna when she missed her appointment (Principle 6).

Another way to think of Patient Navigation is in terms of patient barriers (or issues) and the **actions** Patient Navigators take to break down these barriers.

Different programs address different types of barriers. Navigation programs should be specific to the needs of the community members. This depends on the health issue the **community** needs help with as well as the environment where they live.

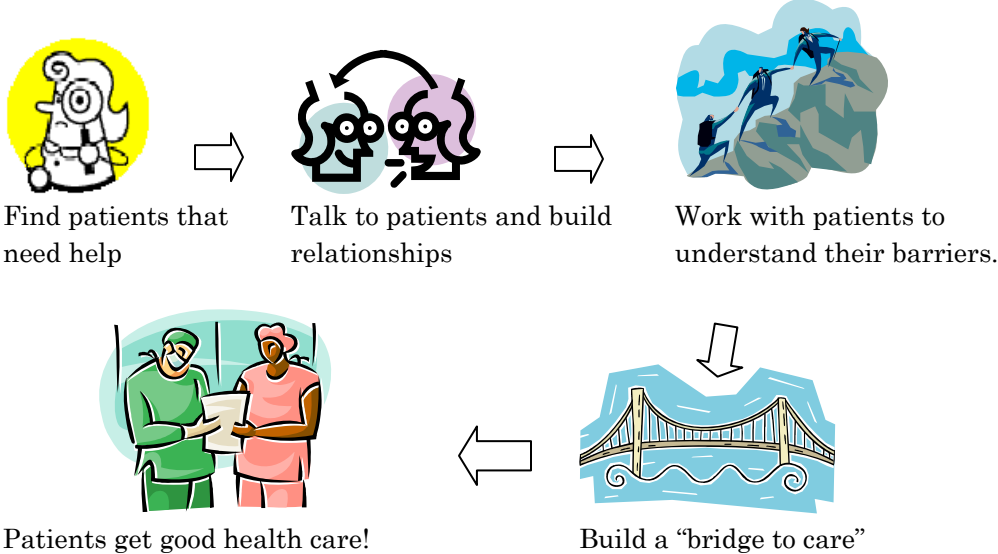


Patients may have one or more barriers that stop them from getting health services

What can I do?

As a Patient Navigator, you can help by taking these simple steps:

- 1) Find patients who need help getting care
- 2) Talk to them about barriers and how you can help
- 3) Take Action! Help patients communicate with their doctors and get help to overcome barriers
- 4) Think outside the box to come up with creative solutions!



Remember!

Each patient is different. What worked in one case might not work in another. Bridging patients to care is a never-ending process. When a new barrier comes up for an individual, you have to do this process all over again!

CASE STUDY: How does Elaine “Bridge Barriers”?

For example..

Elaine called Shirley to remind her that she has an appointment at the CHC in 3 days. Shirley says she remembers she has an appointment, but that she can't go now because her boyfriend can't drive her anymore. Elaine tells Shirley about the Cab-Voucher program her hospital offers. The hospital also provides free rides in hospital vans to patient appointments. Elaine also looks up what buses run from Shirley's neighborhood to the CHC. Now that she knows she can get reimbursed for her cab fare, take a free shuttle, or ride the bus, Shirley says she can probably make it to the appointment. Elaine offers to meet her at the bus stop before her next appointment.

2. Where to I fit into the patient experience? Your job is to improve the patient experience. Patient Navigators do this by making it easier for patients to get the care they need. This means supporting patients both emotionally and practically, with **resources** to overcome barriers throughout all the steps in their care..

But, how does this work?

- When you support patients, you give them an overall better experience using health services, by making it just a little easier to get care.
- In the long run, you also help patients better understand the care they need so that it becomes easier for them to manage their health on their own.

CASE STUDY: How does navigation improve the patient experience?

For example..

When Elaine found out Shirley was going to miss her appointment because she couldn't get a ride, Elaine offered solutions to break down that barrier. Elaine told Shirley about some resources that could help. Elaine took action to bridge this transportation barrier by looking up the bus schedule and telling Shirley about the Cab-Voucher Program and the hospital van service. In giving Shirley 3 good options for getting to her appointment, it was now much easier for Shirley to find a way to get there. Her patient experience was improved because without Elaine's help, Shirley would not have gotten care at all.

- Your job is to help out where there are “gaps” in the patient care experience. Let your Supervisor be your guide to see where these gaps are. Ask your Supervisor to explain these gaps to you.

- Patient Navigation is a team process. The health care team existed before the Patient Navigator position was created. A lot of tasks are already completed by providers, clinical team members, and other staff. You should learn about the roles of others on the navigation team, as well as your own, so you don't duplicate efforts.

Follow these steps to help you understand the patient experience and where exactly you fit in.

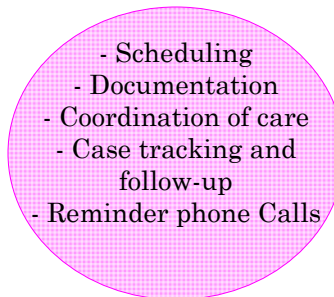
5 Steps to Understanding the Patient Experience

- 1) Talk to your supervisor about the main areas of navigation**
- 2) Ask for an Organization Chart**
- 3) Shadow (follow) Navigation Team Members as they do their work**
- 4) Make a list of Patient Navigator activities**
- 5) Ask supervisor & other team members for advice**

Step 1: Talk to your Supervisor about the 4 main areas where navigation activities may take place: *Administrative, Health Service, Community, & Resource finding* to understand what they mean.

Read about the 4 areas of patient navigation below. Then ask your supervisor(s) about the tasks they want you to do and figure out what area they fit in.

Administrative: The *Administrative* Area is the 'desk side' of your activities. This "desk side" includes all of your paper or electronic record keeping; phone calls you make from your desk; and research you do to find new resources to help patients. The Administrative part of the navigation team can include your supervisor(s), other leadership staff or administrative support staff (such as front desk staff or scheduling coordinators).

- 
- Scheduling
 - Documentation
 - Coordination of care
 - Case tracking and follow-up
 - Reminder phone Calls

Health Service: The Health Services Area is all about the ‘medical side’ of your activities. This includes things that are related to patient clinical care. This part of the navigation team can be made up of people such as medical assistants, nurses, and doctors from multiple departments or clinics.

- 
- Communicate with health services team
 - Provide emotional support
 - **Case-finding**
 - Follow-up with providers and patient notes

Resource: The Resource Area is basically any type of resource (or help) you need to navigate your patients around their barriers and into care. You can find resources within your program or you may have to go outside the program to find resources you need. For example, you might need to use: departments of transportation, social work, employment services, insurance companies, food pantries, or interpretation services, depending on what the barrier is that is stopping a patient from getting health services.

- 
- Resource identification
 - Access resources
 - Communicate with internal & external organizations that have resources your patient needs

Community: The Community Area means the people you serve, the neighborhoods your patients come from, or where you work, and the different **cultures** you find in the **‘target population’**. The ‘target population’ includes any patients using the health services of your program. It also includes any populations that your program wants you to find by going into the community. A good starting point for reaching out to a community is to look for health fairs at places of worship and other community meeting places.



CASE STUDY: What areas did Elaine work in with her patient, Shirley?

For example..

Administrative: *Made a reminder call about upcoming appointment & researched transportation resources for the patient*

Resource: *Identified internal program & external transportation resources for patient*



TOOL 3.1: Areas of Patient Navigator Activities

Not every activity you do will fit nicely into one of the four areas. Tool 3.1 may help you to understand what parts of the patient experience you might fit into. The picture in Tool 3.1 represents 4 main areas of navigation that you may be working in. As you can see, these areas may overlap at times. Put an X on the picture where you think you sit, or where you think most of your job activities fit.

Step 2: Ask your supervisor to help you make a *Contact Web*.

A ***Contact Web*** is a picture representation of different departments, services, and/or people that are part of your program's navigation team. It also includes contacts of people or organizations that are not part of the regular navigation team who you commonly need to contact.

CASE STUDY: How is a Contact Web used?

For example..

Elaine needs to make an appointment for Latoya to see a surgeon. Latoya's provider wanted her to get a biopsy after she got her mammogram results. Elaine uses her Contact Web to remind her of who the contact person is in the surgery department and the phone number she needs to call to make the appointment.



TOOL 3.2: Contact Web

You can use this tool as a template (model). Our Contact Web will help you start thinking about what yours should look like and how you could use it. It can help to remind you who to contact when you have questions or need help with a patient and their barriers. Use this Contact Web as an example to help you draw your own if your program doesn't already have one. After you draw your own Contact Web, meet with your supervisor to see what else should go on your chart.

Step 3: Ask to shadow (follow) staff members that interact with patients in the areas where you will be navigating.

This helps you see the entire care process. By ‘shadowing’ we mean following different navigation-team staff to see how the process works in real life. It's good to shadow different staff members doing their different jobs along the course of care.

The basic idea is that you cannot understand the whole ‘care process’ until you have followed a Patient Navigator or health services staff through it. You have to be able to understand the care process so that you can navigate patients through it. This also requires that you get permission from the patient(s) to participate in and learn from their care.

*If shadowing is not an option in your program, make sure to at least seek out advice from different navigation team members regarding the flow of care process.

CASE STUDY: Who will I be interacting with?

For example..

Elaine works with many different people in the course of navigating a patient. She interacts with the front desk staff when scheduling appointments and checking to see if the patients she is navigating showed up for their appointments. Elaine talks to providers and other health services staff who are managing the health care of patients she is navigating. Elaine does this so she can document what tests or treatments her patients got and what their health plan will be. She also looks in the electronic record system and makes calls to other departments and providers to find test results so she can update her patient tracking notes.



Step 4: Make a list of possible Patient Navigator activities.

There are many ways the Patient Navigator position can fit into a navigation program. Find out where you will do most of your navigation work so you know who you will be interacting with and what activities you will be expected to complete. After you know your general job description and have spoken to your supervisor about program goals and tasks you will be responsible for, make your own more detailed list of activities that you may be completing.

Remember!

It is your job to improve the patient experience. You do this by making scheduling appointments easier, educating patients about their health issue and their care plan, and supporting the patient’s needs with the resources you offer to them.



TOOL 3.3: Examples of Navigator Activities

Once you have made your own list of Patient Navigator activities you think you'll be doing, take a look at the list of examples we came up with in Tool 3.3 to see how they match up. It's okay if the two lists are different. These are just a few examples and your supervisor will be there when you have questions about what you need to do.

CASE STUDY: What activities did Elaine do when navigating Shirley?

For example..

- 1) *Called Shirley to remind her about her upcoming appointment*
- 2) *Educated Shirley about free transportation programs*
- 3) *Provided alternative option of taking the bus by looking up the schedule for her*

CASE STUDY: What activities did Elaine do when navigating Latoya?

For example..

- 1) *Followed up with Latoya's provider to get results of mammogram*
- 2) *Communicated with provider about Latoya's care plan to see what the provider wanted Latoya to do next*
- 3) *Coordinated surgical appointment for Latoya by calling the administrator in the Surgery Department and getting an appointment time that fit Latoya's schedule*
- 4) *Communicated back to Latoya to keep her in the loop of what's happening with her care*

Step 5: Ask your Supervisor and other Team Members for advice.

Your supervisor or fellow Patient Navigators (if your program already has Patient Navigators) will be your best resources to help you fit in.

Ask you supervisor and other team members to:

- Help "map" or walk you through the patient care process and explain how the health system works within your program or population
- Help you identify your daily and ongoing activities
- Point out meetings you could attend to get connected with health services team members and network with the other navigation team members
- Introduce you to people you will be interacting with in health services
- Help connect you with contacts for resources you may need. Some of these will be the same people you shadowed. It is useful to know as many people as possible and build relationships so that your navigation team will be strong.

Chapter 1: Review and Summary

You should now have the information, tools, and resources you need to define your role in the navigation team. You should know your responsibilities and understand how your job fits within the existing patient experience. When you have read through all of Chapter 1, use the checklist below to summarize what you've learned.



Checklist

___ Patient Navigation in *my program* means:

___ The main areas I will work in are:

___ I fit in the patient experience...

___ I plan to shadow/get advice from...

___ Key people I can go to for help/advice are:

Notes/Reminders:

Chapter 2: Building Skills for Patient Navigation

Goal: When you have finished this chapter you will be able to define the different types of navigator skills need to do your job: *core navigation skills* and *program specific skill*. Chapter 2 will help you understand *how* you will learn about the health issue you navigate, the services offered by your program, the health system you navigate in and the resources available that you can use to improve the patient experience.

1. What core navigation skills do I need to develop?

Core navigation skills are the basic set of skills that any Patient Navigator working in any program needs to get the job done. You may already be familiar with some of the core navigation skills listed below. If not, that's okay. This chapter of the toolkit will explain what these skills are and will help you understand how they apply to your new role as a Patient Navigator.

Some programs may send you somewhere to get training. Other programs may have on-site training. Some programs may provide no training at all.

This toolkit is a great training resource for any Patient Navigator, but especially for those with no formal training as part of their program.

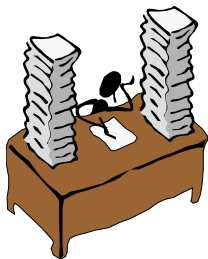
Remember!

You were hired for a reason. Do not be discouraged if your program does not provide training. The people who hired you thought you had what it takes to be a Patient Navigator. They understand there will be a period of time where you are still just learning. This toolkit will help you understand what skills your program needs you to have & how to meet your employers' expectations.

Core Navigation Skills: There are four major 'Core Navigation' skills that every Patient Navigator should have. These are basic skills ANY Patient Navigator needs to help patients. These include the basic skill categories:

- Organization
- Time management
- *Barrier identification*
- *Resource identification*
- *Resource utilization*, and
- *Cultural responsiveness* and sensitivity.

General Organization & Time Management



Good *Organizational Skills* means being able to see the whole picture. Organizational skills help you understand how everything needs to work together to complete a project, or organize your schedule, or manage your current group of cases (your **caseload**). The purpose of staying organized is so that you can manage your time, keep your workspace clutter-free, prioritize patients, and stay on top of your schedule.



Feng Shui and Office Organization/Improving efficiency by respecting your work space and yourself

Go online to get some tips on organizing your workspace from this website:

http://www.ergoindemand.com/about_feng_shui_and_office_organization.htm FREE



Good *Time management* means you have control over the amount of time you spend on specific activities. Time management skills help you to increase efficiency or productivity. Activities that help you manage your time include: planning, allocating, setting goals, thinking about how your time is spent, monitoring, organizing, scheduling, and prioritizing.



Time Management: *Beat Work Overload. Be More Effective. Achieve More.*

This website has an entire page just for tips and tools on improving your time management skills. Even if you think you have great time management skills already, this website is filled with great tips for enhancing those skills

http://mindtools.com/pages/main/newMN_HTE.htm FREE

In Patient Navigation, organization and time management also mean:

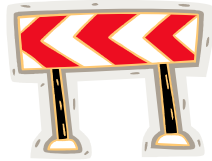
Prioritizing your *caseload*:

- i. Identify what the most pressing issues are in an individual's care. Follow-up on those first.
- ii. Pay attention to the patients who miss appointments regularly. Follow-up first with these patients before you follow-up with more reliable ones.
- iii. Track patients considered to be 'high risk' in either of the above meanings

Organizing your activities schedule

- i. Have a plan but be flexible! Things change all the time. Think on your feet and be willing to adapt when your order of activities or schedule requires a change.
- ii. For example, plan out when you will spend time making reminder calls about appointments. Also plan when you will spend time talking to patients and navigating within health services areas.

Barrier Identification (For more on Barriers, see Chapter 3)



Know what a *barrier* is in the context of Patient Navigation. Figure out what barriers are stopping your patient from getting care. You have to learn how to recognize a barrier when you see one! Oftentimes, the patient will not tell you directly, so you'll have to figure it out.

Resource Identification and Utilization to Address Barriers (For more on Resource Identification in bridging barriers, see Chapter 3)



Understand generally what resources could be used to overcome common barriers in the community you serve. Get to know the resources available in your program for patients.

Get to know outside resources you can find for patients in the area. You must learn how to access and use these resources, not just what they are. The goal is to cultivate a network of resource support over time.

Cultural Responsiveness and Sensitivity (For more on Cultural Responsiveness and Sensitivity, see Chapter 4)



Know the cultural make-up of the community you work with. Learn at least a little about the cultural background of each patient you navigate. Having awareness of other cultures and knowing something about an individual person's culture can increase your overall understanding of the person.

This understanding can help you customize navigation to each individual. Customizing improves the patient experience. Being aware of cultural differences does not mean knowing everything about all cultures. Awareness means being open to learning about cultures different than your own as well as understanding your own culture.



Creating and sustaining a culturally responsive health care organization: Reflections and recommendations from the field
This is a Webinar (online PowerPoint presentation) from the National Conference Series on Quality Health Care for Culturally Diverse Populations. It goes more in depth on cultural responsiveness in the health care field, which you may find helpful if you are interested in learning more about cultural responsiveness.
<http://www.diversityrxconference.org/Your-Voice/Webinars/Webinar-8-Culturally-Responsive-Organizations/188/> FREE



Cultural Responsiveness Teaching Resources
This website offers training courses as well as cultural responsiveness resources and articles used in training. To find more articles on cultural responsiveness, try this website:
<http://www.culturallyresponsiveteachingresources.org/> FREE



How to be Culturally Responsive
This document is a 'How to' guide on cultural responsiveness and has many points relevant to Patient Navigation, although its specific focus is on working with disabled populations.
http://www.dds.ca.gov/Publications/docs/Culturally_Responsive.pdf FREE

2. What else do I need to know before I can start navigating?

Every program is a little different, so you will need to learn some basics about your specific program. These basic skills range from knowing about the health issue(s) you are navigating, to knowing how to use the computer systems in your program. Let's call these 'Program Specific' Skills.

Program specific skills are skills that a Patient Navigator needs to work in their specific environment. These skills can be grouped under the 4 main areas discussed in Chapter 1: Administrative, Health Services, Resources, and Community (See Chapter 1 for descriptions). Below you will find some general skills you will need to have before you can start navigating in your program.

Program Specific Navigation Skills:

These are some of the specific skills you will need for your program. These specific skills may differ a bit from program to program. Use these examples as a guide.

Administrative



Electronic Medical Record Systems

Learn your health system's electronic medical record system so you can check your patient's charts and watch for updates on results and their care plan.

You may also be able to use it to communicate with providers



Documenting what you do

By 'documenting', we generally mean keeping a written record of what you do.

Knowing what to document, when to document, where to document and how to document should be a part of the initial employee training you receive and will be different from program to program.

Health Services



Case Identification, tracking, and follow-up

By ‘case identification’ we mean figuring out which patients you are supposed to be navigating.

This will depend on your program. For example, some programs have Patient Navigators watch for patients who get an abnormal test result, while other programs have Patient Navigators call everyone who misses a certain number of appointments.

By ‘tracking’ we mean checking the patients chart to find out the provider’s plan for care and to see any new test results or new appointments scheduled.

By ‘follow-up’ we mean communicating with patient’s you are tracking in person, over the phone, or through letters to make sure they have what they need to get the right care. This means making sure they can get to their appointments and that they are not confused about what is happening with their health. This also means finding out what happened to a patient when they miss an appointment.

Your supervisor should give you protocols (instructions) to follow for case identification, tracking, and follow-up.



Health Knowledge

By ‘health knowledge’ we mean understanding the basics about the disease or health issue your patient’s fact. This includes risk factors for the health issue, the tests and treatment your patients might need. Become familiar with the kinds of tests and treatments patients may experience during navigation so that you can be a resource for them. Also, you should understand the different type of medical providers who may provide that care and be familiar with each of their role in the patient experience.

Resources



Resource Identification and Utilization

By ‘resource identification’ we mean knowing which resource might help a certain barrier, as well as finding new resources to overcome barriers

Part of your initial training will be learning how to research new resources and getting to know the resources already available locally and in your program



Conducting Outreach Activities (if applicable)

Learn what these activities are, where they will take place, and how to complete each type of activity

Community



Community Knowledge

Learn about the demographics (personal characteristics) of the population you work with

Learn about the cultures of your patients



Identifying and Addressing Barriers

Although this is a core navigation skill, there may be barriers that are common in the community you serve.

Learn what the specific barriers are for your community and what to do to overcome those barriers.

3. How do I get these skills?

Navigation coordinators and supervisors understand that if you have never been a Patient Navigator before, there is a lot to learn before you can get started. There is also a lot you will learn on the job as you go along.

If you have been a Patient Navigator before, and you are starting in a new program or if your program is changing, you will need to develop new program specific skills.

Even if you are an experienced Patient Navigator, refresher training courses (even in the core navigation skills) can help to keep you working at your best level.

There will be training and education opportunities to learn these skills on site. The people running the navigation program understand there is a lot to learn in becoming a Patient Navigator. They want you to succeed.

At the beginning of your training, your supervisor will probably ask you to fill out a 'Baseline Assessment' (See Volume 2, Chapter 4). This is simply a tool that helps your supervisor figure out which trainings you will need and what strengths you already have personally, or from your previous experience.

If your supervisor wants you to get certification training or to go to other outside training courses, those are available as well.



If you want to look at course curriculums on your own, here are some available programs:

- Patient Navigator Training Collaborative, Denver, CO:

<http://www.patientnavigatortraining.org/>

Website contains free online tutorials and webinars. Four-day on-site training course or 6-week online training course are \$400 each and are geared towards level 1 and level 2 Patient Navigators respectively (see website for details).

- The Harold P. Freeman Patient Navigation Institute Patient Navigation Program New York, NY: <http://www.hpfreemanpni.org/>

Three-day intensive training course includes 10 modules, a practicum, and case studies. Program cost is \$1500 and requires application and acceptance to enroll.

- Massachusetts Department of Public Health Community Health Worker Certificate Course Boston, MA:

http://cmahec.org/index.php?option=com_content&view=article&id=66&Itemid=105

Courses offered through MDPH include one in-person session to begin the course, followed by 9-weeks to complete online training modules. A course for supervisors is available as well as a course for Patient Navigators. These courses are free. Check your local department of health for course offerings in your area. FREE

- Breast Patient Navigator Certification Program, National Consortium of Breast Centers (NCBC), Las Vegas, NV: <http://www.bpnc.org/>

This is a breast-specific patient navigation training course and certificate program, which is awarded after sitting for an examination. Attending the course is not required to sit for the exam, but the cost is the same. The course is a day and a half long program and includes background on breast patient navigation and information on the validity and importance of the navigation role. It incorporates presentations with case studies and peer discussion.

*Application requires Patient Navigator to have at least two years of experience navigating breast patients. The cost is \$300 for current NCBC members for non-NCBC members for registration after acceptance into certification program.

4. How do I figure out what resources are available to the population I serve?

Finding out about currently available resources takes some investigation. You will get better at locating new and pre-existing resources over time. Start with doing some digging to find out what resources are already available to patients. Some patients may not know about these and it is your job to educate them about what is out there.

Ask your supervisor(s)

Ask your supervisor(s) what general internal and external resources they already know about. Ask them how they can connect you with these resources

Ask another Patient Navigator

When specific barriers come up with your patients that require outside resources you haven't accessed before, you can try asking experienced Patient Navigators who may have encountered these barriers before. They may know of some resources that will help you help your patient overcome that barrier

Do online research

Aside from asking other Patient Navigators and your supervisors, it may be useful to do a Google search of the resource you think you need to address a specific barrier and see what is available in your program or in your area

Start your own resource file or binder

Many resources are based on funding opportunities, so what is available may change frequently.

Chapter 2: Review and Summary

You should now have the information, tools, and resources you need to understand and begin developing Core Navigation Skills and Program Specific Navigation skills. You should now know what to expect from your training sessions. As you help navigate patients, you will learn what skills you need to develop to make you a better Patient Navigator. After reading this chapter you should know where to go to find out about health services available within your program. You should also know the health system you navigate in, and the resources available that may improve the patient experience. When you have read through all of Chapter 2, use the checklist below to summarize what you've learned.



Checklist

___ Core navigation skills are:

___ Program specific skills I need to work in my program are:

___ I plan to attend training with...

___ Internal resources I have already learned about from my supervisor and other Patient Navigators etc. are:

Notes/Reminders:

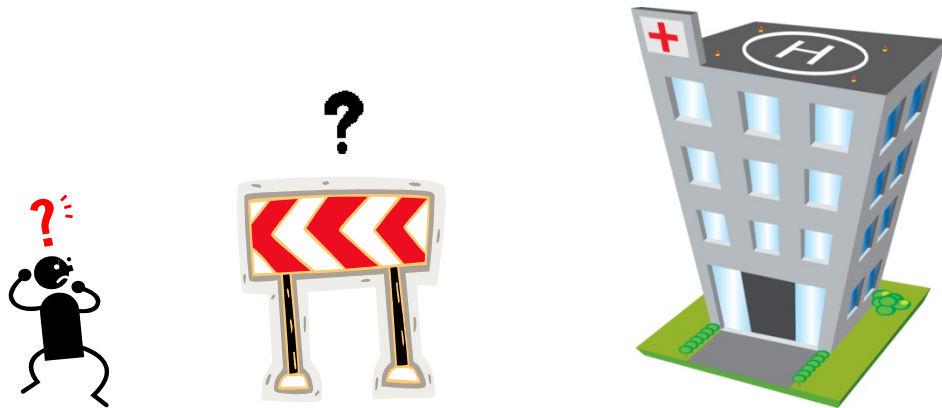
Chapter 3: Understanding Barriers to Health

Goal: When you have finished this chapter you will have the information and tools you need to understand what a barrier is. You will learn how to identify barriers that affect individual patients. You will identify common barriers found in your target population. Chapter 3 will describe ways you can help patients to overcome these barriers and get you thinking about what resources you can access to help you do this.

1. What is a “Barrier” to care?

It is important to understand what “barrier” means in terms of patient navigation so that you can learn to identify barriers when you listen to patients explain why they couldn’t get care, or you identify a patient who needs care and isn’t getting it.

A barrier to care is a problem that gets in the way of a person getting the health care they need.



For example..

Not being able to make an appointment with health services because you don't have health insurance

Barrier = No Insurance

Not being able to go to an appointment because you can't get out of work

Barrier = Employment Issues

Missing an appointment because you can't find a babysitter

Barrier = No Day Care

There are many different types of barriers that can interfere with patients getting prevention, screening/early detection, follow-up, and treatment care.

Patients can have 1 barrier, lots of barriers, or no barriers at all (unless your program only uses patient navigation for patients who have barriers). A patient's

barriers can change over time. They may also develop new barriers during their course of care.

Knowing some main barrier categories will help you understand what a barrier to care is. The American Cancer Society identifies 3 main categories of barriers:

Main Barriers Categories



Financial Barriers

Examples:

Patient doesn't have health insurance, so she doesn't know how she will be able to pay for health services.

Patient cannot afford day care for her two children and cannot find anyone to watch them while she goes to health services appointments.



Logistic Barriers

Examples:

Patient does not own a car and does not know how he will get to his appointment because there is no direct bus line from where he lives to the CHC.

Patient cannot get time off from work to get to a daytime appointment.



Social/Cultural Barriers

Examples:

Patient doesn't understand what the doctor said about her diagnosis because her English is just okay. She doesn't see why she has to come back, so she doesn't come to her follow-up appointment.

Patient didn't know the doctor would be a man when she made her appointment. Now that she's in the room she does not feel comfortable being examined by him because in her culture it is not appropriate, so she refuses care.

CASE STUDY: How do Sonia's barriers fit into the main barrier categories?

For example..

Sonia is a 28 year old Latina woman with 3 kids. She works the day shift as a housekeeper. Her husband works nights so that someone is always home to watch the 3 children. Neither of their jobs offers health coverage and they are afraid to apply for public insurance because they are not legal American citizens. Sonia never goes to the doctor because she doesn't think she will be able to afford a babysitter or the medical bills.

Financial Barriers:

No insurance, Can't afford to pay

Logistic Barriers:

Nobody to watch kids

Social/Cultural Barriers:

Illegal immigration status

CASE STUDY: How do Michelle's barriers fit into the main barrier categories?

For example..

Michelle is a 49 year old English-speaking African American woman who grew up in one of the communities that Patient Navigator Elaine serves. Last year, she reduced the number of hours she works per week as a medical assistant in order to take care of her mom, who is very ill. Her mother's sickness has made it a requirement for her to have around-the-clock care. A few months before she went down to a part-time shift at her job, Michelle's doctor found a concerning lump in her breast. The doctor asked Michelle to make an appointment to get a biopsy with a surgeon the doctor referred her to. Michelle decided she didn't have time for another appointment at that time, so she hasn't made one yet. Michelle thinks maybe she won't make the biopsy appointment because she's really just too busy with work and taking care of her mom. She knows that even if she could find a little bit of time, she has no way to get to the appointment because her car broke down last week. Michelle does not have enough money to fix the car. Because she cannot use her car, she has to commute by bus. It would take Michelle 2.5 hours to commute by bus.

Financial Barriers:

Living on ½ her normal salary, after moving to part-time hours

Logistic Barriers:

Mom needs 24 hour care and she can't afford a home-visit nurse service

No car and a bus would take too long

Can't get time off of work because she only does part-time hours as it is

Social/Cultural Barriers:

Puts mother's health ahead of her own, regardless of potential health consequences

Some barriers may be very obvious, while others may not become apparent until something goes wrong.

For example..

A patient tells you he does not have insurance and cannot afford to pay for care. Because of this, he did not schedule a follow-up appointment even though he was supposed to do so within the next 3 months. This barrier is easy to see because the patient told you a specific reason why he did not get care. You know exactly what the barrier was for getting the follow-up appointment.



Barrier = No Insurance/can't pay (financial)

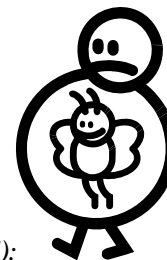
Other barriers are less obvious, so you may not realize they are a barrier at first.

For example..

A patient keeps scheduling appointments and then missing them. When you call to ask why she didn't go this time, she always has a different excuse why she couldn't come. Eventually you understand that this patient may not want to come in because of low motivation. The patient may also be afraid of what will happen if she does go to see her provider. This may be something you just don't see right away. This type of barrier may take a little while to identify and understand. Also, the patient may not be willing to open up to you right away. Building a trusting relationship between you and your patient over time is important so the patient will feel comfortable talking openly with you



This is what she said, and you saw:



This is really how she felt inside (butterflies in her tummy!):



Barriers to care will be different from person to person and community to community. It is important to learn what barriers generally affect your target community. Then try to figure out the barriers that affect the individual you are navigating. Do not assume that everyone has the same barriers just because they come from the same population.

As you become more experienced at identifying and addressing barrier(s), you may start to notice that there are a set of barriers commonly found in the community you serve. You may see the same barriers again and again in patients from this target population.

Patient barriers are personal and unique to that individual, but there may be some barriers that you see much more often than others, and with certain populations. If you are aware of the community barrier(s) that tend to affect people in your target population (the community your program serves), you will be better prepared to serve each individual. These community barrier(s) may play a role in the individual's barriers, may be the only barrier(s) they have, or may not exist for a particular individual.

2. How do I identify barriers for a specific patient?

Learning to identify barriers takes time. This section will give you some ideas about how to get better at identifying your patient's barriers. The more experience you get, the better success you will have. Most Patient Navigators are more successful as they gain more experience.

4 steps you can take to identify barriers efficiently

- 1) Look through provider notes to identify underlying issues that may not be obvious during your brief interactions with patients. Provider notes also help you track what is going on with their care plan.
- 2) Look in patient's charts, medical record, or enrollment form to get information about what is going on with a patient you are tracking. Depending on how your program is set up, you may be able to access patient information in different ways.
- 3) Look for patterns of missed appointments by checking appointment schedules. When you see a pattern of a patient who missed a few appointments in a row, this should be a red flag to you that there is something going on with this patient and you need to find out what. Get in contact with the patient and try to figure out why they missed the appointments. Ask what you can do to help them get to their next appointment.
- 4) Listen to your patient and try to understand what they think is the problem. Building a connection with the patient will make it easier to identify barriers. Some ways to build a connection with your patient are:
 - Ask your patient directly. Talk to the patient and ask them what they think the barrier is to getting care.

- Ask them what would help them get to the appointment next time. Then offer your help to make whatever that is happen.
- You could try making a checklist of ‘key questions’ you need to ask every patient so you don’t forget what to ask. Your supervisor and other Patient Navigators in your program can help you develop your key questions list. This list of key questions can be used over the phone or in person. Do not leave the questions on voicemail messages.



TOOL 3.4: Key Questions List

Tool 3.4 is a list of key questions that can help you identify common barriers. Use these questions to give you ideas on some of the important questions to ask the patient to help you identify their individual barriers. Use these scripted questions as a learning tool. Use this as a tool to get ideas and for practice so you don’t need to use a script when it comes to the real thing!

If you don’t know a patient very well, you need to be aware of how you say things. Always be respectful. Once you build up a trusting relationship with a patient, they will be more likely to tell you about the barriers getting in the way of their care. Showing genuine care and concern will help you build this trust.

Remember!

Other navigation team members notice patient barriers too!

When you are stumped and cannot figure out what the barrier(s) are for a specific patient, you can look to your fellow navigation team members. Seek help from anyone who interacts with a patient you are navigating. Use your team as a resource because they may see something you don't see.

- 1) Start with other Patient Navigators if your program has others. They may know the patient's history. They may help you uncover the barrier if you tell them about the case and can look through notes together.
- 2) Try talking to your supervisor about the patient if she is not new to the program. Maybe she knows about the patient already through past Patient Navigators.
- 3) Ask if you can do a case review at a meeting with providers and other care team staff. Maybe one of them will know more about the patient's history and be able to give you some idea of what their barriers might be.
- 4) Knowing what is going on health wise with your patient will help you to know if they are on track or if they are not getting the care they need. Use the list below to help you think about how to talk to providers about their patients so you know important questions to ask the providers.

Navigation team members may come to you with concerns about a patient. Make sure that it is well known that the biggest part of your job is identifying and addressing patient barriers. Let team members know that you welcome this type of feedback. This can alert you to a patient in need of your assistance when you might not have known they were having issues with getting the care they need.

CASE STUDY: How does Elaine identify barriers?

For example..

Cassandra, a 27-year old woman new to the community Patient Navigator Elaine serves, had never been to see a doctor in the U.S. Cassandra had also never had a gynecological Pap test in her life. Elaine met her at the community center where Elaine does outreach work to find people who might benefit from navigation, increase health awareness, and spread the word about the Patient Navigation Program which provides screening for cervical and breast cancer. After talking with Cassandra for a few minutes, Elaine encouraged Cassandra to make an appointment at the CHC. Elaine asked Cassandra if there was a reason she did not go to see a doctor. Cassandra said that she did not feel sick. Cassandra said she did not really know where to go because she had only moved to that neighborhood a year ago. She said she also wasn't sure how to make an appointment because she does not know very much English. Elaine knew right away what to do, because she listened to Cassandra to try to understand why she wasn't getting health care. She assured Cassandra that she could make an appointment for her and arrange to have a medical interpreter during the visit so that language would not be a problem. Elaine also told Cassandra that it was a good idea to go in for a physical exam just to check on things even if she wasn't feeling sick. Elaine told Cassandra it will be comforting to know that she is in good health after she gets the overdue Pap Test. Cassandra agreed that this sounded like the right thing to do and Elaine helped her make an appointment.

Elaine checked Cassandra's medical record to see what happened at the visit because the day it was scheduled for was on Elaine's day off. She read that the provider had wanted to do a Pap test, but it was noted that Cassandra had her period that day and the procedure could not be completed. The next note said that Cassandra had been told to reschedule for the following week. Elaine found that no other appointments had been booked. She called Cassandra to see what was up, but got no answer and had to leave a message. Elaine tried calling three more times over the next two weeks and could not get in contact with Cassandra.

Weeks later, back at her outreach post at the community center where she does screenings, Cassandra approached Elaine. Elaine asked her how everything was going and why she had not returned any of her phone calls. Cassandra admitted that she was nervous about the Pap test procedure and didn't want it. She said that her friend told her it was weird and painful. Elaine comforted her, saying that many women are nervous about getting Pap Tests. She told Cassandra that it's not the most comfortable procedure, but it can be a life saving one.

Cassandra told Elaine the interpreter did not show up for her appointment. Without an interpreter, Cassandra was confused about what the provider was saying. Elaine told her this time, she would go with her to the appointment and make sure a medical interpreter was there. This was enough to convince Cassandra to go and get the Pap Test.

Take a minute to write down barriers that Cassandra had:

What are some ways that P.N. Elaine identified Cassandra's barriers?

Next, write some of the actions that Elaine took, and resources she used to help Cassandra overcome these barriers:

Remember!

The more practice you have identifying barriers from case studies, the better you will be at identifying patient barriers for your patients!



TOOL 3.5: Definitions of Barriers and Actions

Tool 3.5 provides you with definitions of barriers and actions as our program defines them, and examples to help you understand those definitions. When using this tool, please keep in mind the following:

- Programs may define barriers differently.
- Some barriers will be more common than others depending on your patient population's needs.
- When documenting barriers, it is important that everyone on the navigation team works with the same definition of a given barrier.



TOOL 3.6: Identify the Barriers!

Tool 3.6 is a worksheet for you to fill out to practice your barrier identification skills. Using the barrier definitions of your program, what are the barriers occurring in each example? When you have finished the worksheet, go over it with your supervisor to see how you did.

3. How do I understand what barriers are in my community?

There may be some barriers that are particularly common in your target community. Learning what this set of community barriers is will help you get ahead of the game. Then you will be prepared to address these common barriers when they come up again and again.

Identify the community

Who you consider your community to be will be determined by the population served by your program

You may only target one community or you may work with a few different communities within the population you work with in patient navigation

What do you already know about the community?

Think about what you already know about the community. Identify what barriers exist that could potentially interfere with people getting care.

Talk to your navigation team members (e.g. supervisors, providers)

They will probably already know a lot about what barriers affect this community

Once you identify some of the common community barriers, work on strategies to address these barriers (more on this later in this chapter!).

Be careful not to assume too much about community barriers. Meaning, do not assume everyone from this community has what you identify as the common set of community barriers. In fact, be careful not to assume everyone has barriers at all (some people may not have any).

Remember!

Identifying barriers is a tricky balance between working with your patient to identify barriers, knowing they are more likely to have certain barriers common to their community, and not seeing a barrier where there actually is none.

CASE STUDY: What is a “community” and what does it mean to have a “community barrier”?

For example..

One of the larger communities Elaine works with is Somalian, and about 2/3 speak only Somali. The majority of this community population lives in two neighborhoods. One of the neighborhoods has a bus line that stops close to the CHC. The other has no direct bus lines that go to the CHC. What makes this group a ‘community’ is that they all have one thing in common- they are all Somalian. Even though some speak English and others do not, some were born in the U.S. and others were born in Somalia, some live in one neighborhood and some in the other, they are still a community because of this one common thread that binds them- their Somalian heritage.

Because Elaine has worked with this community for a while, she knows that a good number of people from this community will have a language barrier when it comes to getting care. This awareness of language as a community barrier allows her to prepare resources in advance that address the barrier for anyone who comes in from this community. Elaine knows to ask anyone from this community if they feel comfortable using English during health services appointments. She also asks if they would prefer to have a medical interpreter there. This lets them know the option is there if they want it, though not all of them need it.

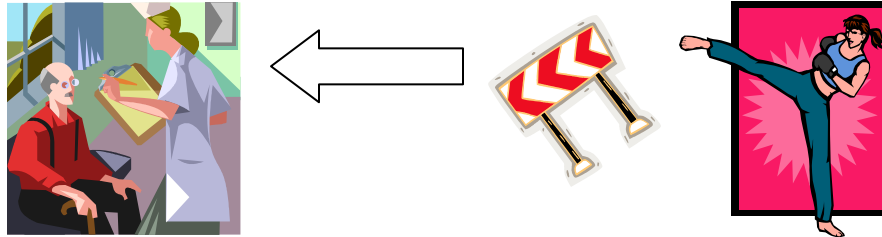
Elaine also knows from experience that more people from the neighborhood with the bus line that stops at the CHC make it to appointments than people who live in the other neighborhood. Some people from the neighborhood with no direct bus line to the CHC will have a transportation barrier. Most people from the neighborhood with the bus that stops at the CHC will not. However, some people who live in the neighborhood with no direct bus line to the CHC own a car. Therefore not ALL people who live in the neighborhood with no direct bus line to the CHC have transportation barriers. Elaine’s awareness of this community issue with transportation helps her realize it is a problem for some, but not all. Elaine always asks the individual if they have issues with getting transportation to their appointments. If they do, she is prepared with resources to help them overcome this barrier. She helps them get transportation to appointments so they can get care.

Reflect

Take a few minutes to think about this case study. Think about what set of common barriers this particular community, or target population, contains. Then think about different individuals in that community and the possible combinations of barriers they could have. Try to understand how knowing about a common set of community barriers helps you to prepare for individual interaction with patients and addressing their barriers.

4. What do I do when I have identified a barrier?

By now you should know that your job is not just to identify barriers, it is to *address* the barriers you identify and take action when needed. When we say ‘address barriers’, we mean find a solution to the problem that is the barrier. Overcoming the barrier helps the patient get the care they need. Keep in mind you may not be able to address all of the barriers you identify.



Some barriers you will find are easy fixes

For example..

If someone doesn't know how to schedule an appointment with radiology, you can either tell them how, show them how, or do it for them. Take care of the barriers you have the power to fix on your own. Know that when barriers are more complex, you may need outside help.

Many barriers will require you to seek out resources to help you solve them

For example..

A patient has no insurance and does not have the money to pay out of pocket for a health services visit. For this situation, someone on your navigation team (supervisor, other Patient Navigators) should know of options for the uninsured in your program. If your program does not offer services for uninsured patients, you will need to dig deeper to find out why they don't have insurance, and then use external resources to find out if and how they can qualify for health insurance. Connect patient to financial services if your organization offers them.

It is your job as a Patient Navigator to connect patients to the right resource(s).

Many patient resources are already there, but your patient may not know about them until you tell them about it.

Once you know what the barrier is that is getting in the way of their care, you should be able to identify a good resource that can help you and your patient work to overcome this barrier.

The Goal is to Address Barriers!

5. How do I Identify and access internal and external resources for patients?

Talk to navigation team members

Talk to navigation team members about patient resources within your program

Ask your supervisor what contacts they already have for external resources your patients may need

Network with other Patient Navigators in your organization to build relationships to encourage sharing of experience



Start a 'resource binder'

This will be a place for you to keep all the key information about each resource you identify including what it is, how you can use it, and how to make contact

Add to this binder over time—whenever you find a new resource, make a new entry

It will be helpful for you to first focus on resources for the most common barriers you see; if you learn from others on the navigation team that the target population has a set of common barriers, start with these.



TOOL 3.7: Helpful Hints for Building Your Resource Binder

Tool 3.7 is a list of helpful hints to get your resource binder started!

For example..

Quick List of Known Barriers and Resources – *Example*

Transportation

Resource: LocalBusByYou
Contact Person: Mrs. Bus
Phone #: 555-555-5555
E-mail: bushelp@yourbus.org

Insurance

Resource: Get-Insurance
Website: ineedinsuranceformypatient.com
Local Contact: your hospital billing office
Phone #: 777-777-7777

Language

Resource: Medical Interpreter Services at my clinic
Contact Person: Mr. Language
Phone#: 444-444-4444
E-mail: speak@lang.org

Here are some links to REAL RESOURCES you can use to start your binder



Insurance

- This site will help you find out about the different health insurance coverage options for a patient, based on the state they live in and various other socioeconomic and health factors you enter into the search engine
<http://finder.healthcare.gov/> FREE
- This is a guide for navigating uninsured patients *in Colorado*. This is a state specific resource, but your state may have a similar resource.
<http://patientnavigator.wikispaces.com/file/view/Guide%20to%20services%20for%20uninsured.pdf> FREE



Education/Health Literacy

- Talking to patients about health can be difficult, but with the adequate information they can make better decisions for their own health management. This link will take you to a PowerPoint presentation about ways to communicate information about health and disease to your patient
- <http://patientnavigator.wikispaces.com/file/view/Making%20Health%20Information%20More%20Accessible.pdf> FREE



Financial Issues

- The Patient Advocate Foundation has a Co-Pay Relief Program some of your patients may qualify for. The Patient Advocate Foundation (PAF) Co-Pay Relief Program (CPR) provides direct financial support for pharmaceutical co-payments to insured patients, including Medicare Part D beneficiaries, who financially and medically qualify.
<http://www.copays.org/> FREE
- Here are some more resources for financial assistance with co-pays or medication:
<http://www.needymeds.org/> FREE
<http://www.managedrxplans.com/> FREE
<http://www.cancercarecopay.org/> FREE
<http://www.gooddaysfromcdf.org/patients/process> FREE
- This one has disease specific qualifications:
<http://healthwellfoundation.org/apply-for-patient.html> FREE
- If your patient has a rare disease they may qualify for financial assistance from this program, including co-payments, deductibles, travel reimbursement, diagnostic testing and more.
<http://www.rarediseases.org/patients-and-families/patient-assistance> FREE

▪ Christina Applegate’s Foundation, Right Action for Women, provides financial support for genetic testing for women at high risk for breast cancer as well as other support services.

<http://www.rightactionforwomen.org/Financial-Support.php> FREE

▪ Colorectal Care Line is a national resource you can use if your program navigates for colorectal cancer. It has a Financial Aid Fund to help with temporary housing, transportation, child care, food costs.

Phone: 1-866-657-8634

Website: <http://www.colorectalcareline.org/> FREE



Stress/Emotional Issues

▪ Christina Applegate’s Foundation, Right Action for Women, has some information on various forms of patient emotional support services

<http://www.rightactionforwomen.org/Emotional-Support.php> FREE



Patient Navigator Networking Resource

▪ Patient Navigators are linked online! This is an online forum for sharing resources over discussion boards and linking with Patient Navigators across the country

<http://patientnavigator.wikispaces.com/> FREE

At some point, you may identify a barrier that currently has no resources that apply. It is not your job to create a resource where there isn’t one. Creating resources is a community issue and responsibility. You help the community by identifying a weakness where a resource needs to be implemented.

6. How do I know if I've addressed a barrier?



You may be asking yourself:

“How do I know if I addressed the barrier”?

“Did what I tried to do really work”?

Sometimes it can be hard to tell whether or not you've really addressed the barrier you wanted to address

If your patient received the care they needed, then maybe you did

The issue may have worked itself out without you addressing the barrier

Perhaps your patient never showed up for their appointment even though you thought you addressed all of the barriers you could identify

You may have helped a patient to overcome all of their barriers, but they still didn't come

Maybe there was an underlying barrier you didn't identify or a barrier you took action on, but the action did not fix the barrier

You can consider a barrier to be “addressed” when the patient gets the care they were supposed to get after you take action to help the patient around their barrier.



TOOL 3.8: A Few Ways to Know the Barrier has been Addressed

Tool 3.8 is a list of different ways to know if the barrier has been addressed for a specific patient.

Chapter 3: Review and Summary

You should now have the information and tools you need to identify and describe patient barriers. You can now begin to understand how barriers can affect getting health care. You learned how you can identify resources. You learned how resources can be used to address patient barriers. You learned how you know when a barrier has been addressed. When you have read through all of Chapter 3, use the checklist below to summarize what you've learned.



Checklist

___ The main barrier categories are:

___ Some common barriers are:

___ Make a 'Questions for Patients Checklist'

___ Ask my Supervisor and others on the navigation team about resources I should know about inside & outside the program to start my resource binder

___ Make my 'Quick List' of barriers and the resources that go with them

___ I am starting my resource binder by:

Notes/Reminders:

Chapter 4: Helping Patients to Take Charge of their Health

Goal: When you have finished this chapter you will have the information and tools you need to understand what ‘taking charge of your health’ means and how to help patients do this. Chapter 4 describes ways you can improve your listening skills to better understand your patient’s needs. The chapter describes methods to help patients get or stay motivated to make good choices for their health. This chapter also touches on the technique of motivational interviewing. This is a complex but useful tool for motivating patients to make the right health choices. If you would like to learn more about this intricate conversation technique please see the appendix.



1. How do I get my patients to take charge of their health?

There are a number of different ways of doing this. We will outline some basic steps you can take here. Note that some of these points will overlap, since the overarching goal is the same. The goal is to have patients engage in care, and quickly. The problem is that changing patient behavior is hard. It’s hard to get patients to want to do things they already know they should be doing to get healthy or stay healthy.

Ways to help patients take charge of their health:

1) Be a good listener

When you listen to understand patients, you can identify where the gap is in their care, thinking, or behavior that causes them not to be in charge of their health. You then should be able to identify and address their barriers so that they can take charge.

2) Build a trusting relationship with your patients

When you build trust over time, patients will feel more comfortable being honest with you about their care and issues they may have with getting care.

3) Ask patients to reflect on how they handle their own health care

Once you have gotten to know a patient and have a relationship with them, begin conversations that get them thinking about whether they consider themselves to be in charge of their health. If they don't feel in charge, ask how they can gain control and what was stopping them from doing so before now.

4) Help patients find reasons to take charge of their health

Getting care requires that you take action. To get your patients to take action, you have to give them reasons that they think are important. Help them think of their own reasons why it’s important to them to take action to improve their health.

Defining ‘take charge of health’:

When we say ‘take charge of their health’ we mean a number of different things, such as being aware of:

- Current illnesses they have
- Factors that put them at higher risk for certain illnesses
- Preventive measures they should be taking to get healthy or stay healthy
- What their illness means for their future, including next steps and treatment plan

In addition to being aware of these important personal health aspects, by ‘take charge of their health’ we also mean that patients should take control of their own health by:

- Setting goals to get healthy or stay healthy
- Following through with provider recommendations
- Keeping appointments so they get the care they need in a timely way
- Making good choices for diet/exercise/screenings/follow-up/treatment, based on what they know about their health and health risks



2. What can I do to be a good listener?

You may already be a good listener because we all practice listening every day. But everyone has room for improvement when it comes to listening skills. Listening to patient’s stories can help you figure out what barriers are affecting their care. Ask if motivation has been difficult for them lately or in the past. Ask if motivation plays a role in overcoming their barrier(s) to care.



TOOL 3.9: The 12 Steps to Becoming a Better Listener

Tool 3.9 is made for you to use continuously over time to remind you of things you should be doing to listen *well*. It is an active tool, meaning you should *read* and then *do*. Read through the steps once. Then try them out in practice when you talk to patients, or anyone! You can always improve your listening skills. Use this tool to figure out where to start.



Listening Improvement Resources:

- This website gives a brief but more comprehensive look at the following topics: active listening, classic “communication blockers”, and ‘the art of questioning’ <http://www.mindtools.com/CommSkill/ActiveListening.htm> FREE
- This is an article about barriers to good listening and how to overcome those barriers to become a better listener <http://www.womensmedia.com/grow/167-be-an-effective-listener.html> FREE

3. How do I build a trusting relationship with my patients?

Building a relationship with your patients takes time, but is well worth the effort.

Having a trusting relationship with your patient benefits them because it helps them to realize there is someone looking out for them. They trust you are working to improve their health by making sure they get timely care.

A trusting relationship makes your job easier. Once you have built this relationship, your patient will be more likely to be honest with you about their situation. With this knowledge, you can more easily identify barriers. In turn, your patients will be more likely to trust your advice on how they can take charge of their health.

Building a relationship with a patient should be somewhat natural. Even though you may not have done this with patients before; you have probably done this in your daily life. Building a relationship starts with a foundation of genuine compassion and an attempt at understanding the patient. This cannot be faked. The patient will sense it if you don't really care.

Some ways of building up trust between you and your patients can be found in basic principles of motivational interviewing (MI). We'll touch on MI again later in the chapter. These are:



- ❖ **Affirm patient's independence** – Each patient is the master of their own health and in control of health decisions. You don't make the choices for them. They make their own choices about their health care. This helps the patient feel more comfortable when they realize they are actually in control. They understand they don't have to follow what you say if they don't want to.

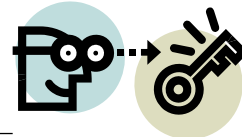


- ❖ **Idea that you and the patient are a team** – Emphasize that you are a team in improving the health of the patient by navigating them around their barriers and into care. Let them know that you are not a dictator of their health choices. Instead you are a facilitator for helping them to make and carry out behavior changes that lead to better health.

- ❖ **Resist trying to force patients to make the right health choices –**



Actively trying to fix someone's life/barriers can actually increase resistance and decrease the likelihood of change towards taking charge of their health. The Patient Navigator is not the reason a patient changes their behavior. The patient has to figure out what reasons motivate them to change.



- ❖ **Be genuinely interested in your patient –** When you become interested in your patient's story, they will feel more inclined to let you into their lives a little further. Then you will have a better chance of uncovering a barrier that needs to be addressed or understanding the many reasons why they might not be taking charge of their health.



- ❖ **Listening to your patient –** As discussed above, listening is a great skill to help you understand your patients and their barriers. It is also a way to convey your interest in what the patient is saying. If the patient doesn't think you're really listening, they may just stop talking to you.



- ❖ **Show you are not judging –** This encourages a good relationship by making the patient feel they are in a safe environment. A safe environment makes the patient feel more comfortable discussing their health with you.



- ❖ **Empower your patients –** You can do this not only by encouraging the patient to come up with their own ideas, but also truly believing that they can make changes to take charge of their health.

4. How do I get patients to reflect on how they handle their own health care?

Patients are the expert on their own lives, circumstances, and therefore barriers, even if they don't have the words you do to describe and identify them. It's your job to listen to their story and try to understand their feelings and perspectives in a nonjudgmental manner. Then you can help them to reflect on how they are taking charge of their health and help them with their health decision making. Using MI principles is just one way to go about this.

Basic MI Principle: O.A.R.S.

O: Open-ended Questions

A: Affirmations

R: Reflective Listening

S: Summaries



- ❖ **Use Open-ended questions** – Asking open-ended, rather than closed-ended questions allows the patient to answer with any possible statement. Open-ended questions allow patients to tell a story, instead of just answering with a yes/no to a closed-ended question. A yes or no response may hide what their real problem is. You may misinterpret their barriers. Encourage your patient to tell their whole story by using open-ended questions. Tool 3.9 has examples of open vs closed questions to help you see the difference.



TOOL 3.10: Open vs. Closed questions – Examples

Tool 3.10 has examples of open versus closed questions to help you see the difference.

- ❖ **Use Affirmations** – Use of affirmations can improve your relationship with the patient. Affirmations encourage patients to continue working through their barriers. They become motivated to take charge of their health. What are affirmations? Here are some affirmation tips:

Statements of respect or admiration

- “Thanks for talking with me.”
- “You value your job. I admire that.”
- “Obviously, you are a smart person.”

Reinforcing positive actions/thoughts

- “That sounds like a great plan.”
- “I’m impressed with the way you overcame that obstacle.”

Be genuine, not fake! If you don’t mean it, don’t say it

- ❖ **Use Reflective listening** – This means when the patient is done talking, repeat what you think you heard in a summary. This lets the person confirm that this is what they meant.

Steps in Reflective Listening

- 1) **Repeat** – repeat back to the patient what they just told you, trying to use the same words
- 2) **Rephrase** – Put what they said in your own words to tell them what you think they’re saying
- 3) **Paraphrase** – Tell them what you understand about what they meant. That way you make sure you know what they really meant. Talk about a deeper meaning behind the words. Emphasize emotional aspects to encourage the patient to reflect on what they’ve said.

- ❖ **Summarize** – By summarizing the conversation for the patient you can reinforce what they said. You help them develop their own reasons for change. You present back to them the reasons they already came up with. This will help them remember what they said they would do. Hopefully this will motivate them to follow-through with their plan for taking charge of their health.

Examples for how to start your summary:

“Here is what I’ve heard so far.....What did I miss?”

“We’ve been talking for a while now. Let me make sure I understand you...”

5. How do I help patients find reasons to take charge of their health?

All patients need reasons to start or continue getting care. This motivation may come in the form of personal health goals, their family, their illness, their family history of illnesses, and/or their job demands. The long-term goal of navigating a patient is to get them to manage their own care and help them to take charge of their health.



“People are generally better persuaded by the reasons which they have themselves discovered than by those which have come in to the mind of others.”

-Blaise Pascal, Philosopher

Translation: It won't always work to just tell patients what to do. In fact, they will be much more likely to go through with getting care and take steps to become healthier if they have come to the decision on their own, and in their own time.

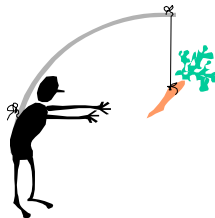
You are probably thinking, ‘Okay...but how can this help me or how do I do this?’

Reflect

Get patients to **Reflect** on their own health, health issues, and behavior. Ask them if they are in charge of their health. If they don't feel in control of their own health, ask why they are not taking charge of their health. Try to have them identify behavior(s) stopping them from getting care and becoming healthy or maintaining health.

In doing this reflective exercise with patients ask them questions about how they think about their health and what they want for their health. Encourage and allow them to think of goals for themselves on their own. You should not tell them what their goals should be. This ability to motivate patients to change their behavior to get healthy and get care will only come after much experience. Remember this is your end goal.

This is a very general description of what a lot of people call motivational interviewing (MI). Once you begin to understand the role of motivation in a specific patient's care, you can start thinking about how you might go about increasing their motivation to get care now. One way to do this is using the MI technique. If you want more information on this subject than what is found below, please see listed resources and appendix.



6. What is resistance?

You will inevitably come up against resistance in working with some patients. When you do, you need to be able to recognize it and know how to diffuse the situation.



Resistance is:

- When it becomes difficult for you to help your patient, possibly because of their attitude, past experience, or personality
- Absence of collaboration between you and the patient
- Result of interpersonal dynamics. There may be a personality clash.
- Cue to try something different

What does it look like?

Arguing, ignoring/tuning out, opposition, conflict, interruption

How do I deal with it?

You may not be able to completely eliminate resistance

Your goal is to minimize resistance because less resistance makes it easier to change

Different techniques to try:



Shift focus

Shift focus to a different topic. A new topic helps get the conversation back on track to a more positive, and therefore productive, dialogue.

For example try:

“How about you *fill me in on ...*”

“*Tell me a little more about...*”



Reframe

Put a positive spin on a negative idea or attitude to try and reframe what is happening in a more productive light.

For example: Instead of saying “you complain a lot about the difficulties you have getting health care, which doesn’t really help your situation”

Reframe to say: “You’re very persistent, even in the face of disappointment. Let’s talk about how we can work together to overcome the difficulties you face in getting care”



7. How do I develop patient interaction skills?

This is a life-long learning process. Keep in mind you can always improve don’t get overwhelmed if you don’t really get it at first. Know that everyone could use a lesson on listening. Do not expect to become an amazing listener overnight. It will take time and lots of practice.



Reading about these skills will help you get the main concepts of how motivating patients really works. The following articles contain higher-level information on MI. If you are interested in learning more about MI, read these recommended articles.

▪ Battaglia, McCloskey, Caron, Murrell, Bernstein & Bernstein 2011. *Feasibility of Chronic Disease Patient Navigation in an Urban Primary Care Practice Designing and Managing Programs*. J Ambulatory Care Manage Vol. 34, No. 4, pp. 1–12
ACCESS RESTRICTED

▪ Apodaca, T. R. & Longabaugh, R. 2009. *Mechanisms of change in motivational interviewing: A review and preliminary evaluation of the evidence*. Addiction, 104(5), 705-715

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2756738/?tool=pubmed> FREE

▪ Brug, J., Spikmans, F., Aartsen, C., Breedveld, B., Bes, R., & Fereira, I. 2007. *Training dietitians in basic motivational interviewing skills results in changes in their counseling style and in lower saturated fat intakes in their patients.* Journal of Nutrition Education Behavior, 39(1), 8–12.

<http://www.sciencedirect.com/science/article/pii/S1499404606005872> FREE

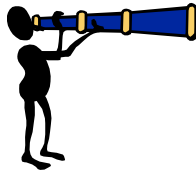
▪ Bundy, Christine 2004. *Changing behavior: using motivational interviewing techniques.* J R Soc Med. 2004; 97(Suppl 44): 43–47.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1308798/?tool=pubmed> FREE



Formal training can also help you develop these skills. This website offers more general information on MI, as well as training online opportunities for a fee.

<http://www.motivationalinterview.org/> FREE



Observe navigation team members interacting with patients. Asking these team members for advice will teach you a lot about navigating individual patients and how to be successful at it.



Another way to start learning how to interact with, listen to, and motivate patients to get care and to take charge of their health is through role playing or using scripts. Your supervisor may have example scripts from practiced Patient Navigators working in various situations, or may be willing to use their experience to set up role play scenarios for you.

Chapter 4: Review and Summary

You now have the information and tools you need to develop better listening skills. You should understand the role of motivation in health care. You know how to develop the complex technique of helping your patients stay motivated or find the motivation needed so that they can take charge of their health. Use the checklist below to summarize what you've learned.



Checklist

___ The way I understand the term 'take charge of your health' is:

___ Steps I am going to take to become a better listener are:

___ I will try out some ideas from the MI technique including:

Notes/Reminders:

Chapter 5: Meeting Your Goals and Taking Care of Yourself

Goal: When you have finished this chapter you will have the information and tools you need to understand how to set your own goals. You will learn how your personal goals can fit into the overall goals of your program. You will learn how to work with your supervisor in goal-setting. This chapter also touches on evaluation, which is part of any job, and how to make yourself aware of your supervisor's expectations. Chapter 5 also discusses some ways to take care of you. Self-care is a very important task of Patient Navigators. Stress and *burnout* can affect you and impact your work. Burnout will affect your patients. Self-care should be a personal goal so you avoid burnout and its consequences. Use the discussion on burnout in this chapter to learn how.

1. Performance of program: what am I trying to change/improve?

The general goal of any navigation program is to get patients into health care in a timely manner. This is done by addressing barriers that are getting in the way of their care. Patient Navigation by definition links patients to health services. The way each program accomplishes this goal may be very different.



Understand the goals of your program

Know what disparity your program is attempting to address

Understanding the target population to better understand what the program is trying to improve upon or change

Talk to your supervisor about the program goals until you understand what they are. Then you can start to think about what your role is in meeting the program goals in the long term.



Develop short-term goals for yourself that help achieve the program goals in the long term. Work with your supervisor to make sure you're on the right track.

Remember!

You are the one working on the ground, navigating, advocating for, and helping your patients overcome barriers, with the help of the rest of the navigation team. The ability of the program to meet its goals directly depends on your success in getting patients to seek and complete care. Completing care helps improve their personal health, which adds up to better overall health in the community.

2. Performance of Patient Navigator: what are my day to day goals/quotas?

Along with developing organizational skills you want to develop prioritization skills. In order to prioritize your daily tasks, you first need to define your goals and know if your supervisor will be evaluating you on meeting any quotas.



Talk to your supervisor about goals they have in mind for you. Ask them if they have any quotas that they will be expecting you to meet on a daily, weekly, or monthly basis. Your supervisor may set day-to-day goals and quotas for you up front, since they will be the ones evaluating your performance.



Some goals will be clinical, for example:

Goal: Identify patients who are overdue for a routine mammogram screening

Quota: Proportion of the number of mammograms attended by your patients per month out of the number of mammogram appointments scheduled



Other goals will be non-clinical, for example:

Goal: Follow-up with a phone call with all patients who missed 2 or more consecutive appointments. Then send a letter if no response after 3 phone calls

Quota: 30 follow-up phone calls per week & 5 follow-up letters per week

Once you have this initial conversation with your supervisor, you should try to come up with some goals of your own to help you meet their expectations and work at achieving the program goals.

3. What is “burnout” and what are some ways to avoid it?

Burnout is the experience of long-term exhaustion and diminished interest. Patient Navigator burnout can occur when Patient Navigators feel over-worked, and experience increased stress because of high work load and sometimes difficult patients.

Take care of yourself

Listen to your body and know your mental limits so you don't get to the point of burnout.

Self care is never a selfish act – it is simply good stewardship of the only gift I have, the gift I was put on earth to offer others. Anytime we can listen to true self, and give it the care it requires, we do so not only for ourselves, but for the many others whose lives we touch.

Parker J. Palmer

Figure out what helps you to relieve stress. Make time to do that. People have all different ways of relieving stress so do what works for you. It might also be a good idea to ask other Patient Navigators what they like to do when they are having an extra tiring day.



TOOL 3.11 Ideas for Stress Relief at Work

Tool 3.11 will help you to think about little things you can do to de-stress while you are at work. These are just a few examples to get you started. Test them out and see what helps you relax.

Maximize your comfort at work

It is important to be comfortable at work, and there are things you can do to reduce the physical impact of your job.



This website explains how correct positioning of your body and your comfort during the day can affect work performance. Get tips on making your work space ergonomically sound here.

http://ergo.human.cornell.edu/ErgoTips2002/where_it_hurts/where_it_hurtsmain.htm FREE

Protect yourself and your feelings

Learn how to deal with patients who are stressed, angry, upset etc.



Healthcare Providers Service Organization/Handling the Angry Patient

This article lends insight on what to do when a patient you are working with becomes distraught or loses control and takes it out on you:

<http://www.hpso.com/resources/article/3.jsp> FREE

Tips from the article referenced above:

Keep your cool when patients take their frustrations out on you

Even patients who are normally calm may quickly reach the boiling point when illness threatens their health, mobility, and independence

Pain and fear can lead to increased stress, anxiety, and frustration, which can result in anger and even loss of control

Spot your patient's anger early and defuse it

Learn from other Patient Navigators about what they do to relieve stress and maintain motivation. You can do this by connecting with other Patient Navigators in your program, seek out Patient Navigators online to talk with, and network to meet Patient Navigators from anywhere.

Chapter 5: Review and Summary

You now have the information and tools you need to set your own goals and to understand the goals of your program and your role in achieving them. You should also be able to take an active role in your self-care in order to avoid burnout so that you continue to be a great Patient Navigator even under high stress. Use the checklist below to summarize what you've learned.



Checklist

___ The goals of my program are:

___ My personal goals as a Patient Navigator are:

___ I plan to “de-stress” and take care of myself by:

Notes/Reminders:

CONCLUSION

Congratulations! You've done a lot of hard work to get here, but if you've done it thoughtfully, you are well on your way to becoming a successful patient navigator. You have begun to develop skills you will use to help your patients get the care they need and to meet the challenges barriers present. You have:

- Defined your role in the patient experience
- Built skills for Patient Navigation
- Learned how barriers affect health care
- Figured out how to help patients take charge of their health
- Found understanding of how to meet your goals AND take care of yourself