Gastrointestinal Multidisciplinary Cancer (GI MDC) Navigation
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History of Navigation

“you can’t know where you are going, unless you know where you came from”

“those who are unaware of history are destined to repeat it”

- George Santayana
DRG’s

Utilization Review Nurses

Oncology Nurse Navigators

Case Management

Patient Navigation

Utilization Management Nurses
1999 IOM Report “Ensuring Quality Cancer Care”

IOM report noted:

“For many Americans with cancer, there is a wide gulf between what would be construed as the ideal and the reality of their experience with cancer care”
1999 IOM Report “Ensuring Quality Cancer Care”

IOM defined Quality as “the degree to which health services for individuals and populations increase the desired likelihood of desired health outcomes and are consistent with current professional knowledge.”
2001 Institute Medicine “Crossing the Quality Chaism”: 6 Aims High Quality Care

• Timely (avoiding unnecessary delays)
• Efficient (avoiding or reducing unnecessary, or minimally beneficial studies)
• Patient-centered
• Effective (based best evidence)
• Safe (from avoidable errors)
• Equitable (regardless socioeconomic characteristics)
Future of Navigation

• American College of Surgeons Commission on Cancer
  - Standard 3.1 - Patient Navigation
    ▪ Focuses on health disparities and is driven by needs assessment of the community
  - Standard 3.3 - Survivorship care plans
    ▪ Comprehensive care summary and follow up presented to patients at completion of therapy

What is a navigator?

• Provider of services
• Barrier eliminator

• NCI CRHCD definition: to support and guide persons with abnormal cancer screening or a new cancer diagnosis in accessing the cancer care system, overcoming barriers; and facilitating timely, quality care provided in a culturally sensitive manner.


Navigation Types

• Outreach
• Diagnostic
• Treatment
• Survivorship
• Patient versus nurse
• All in one
• Outpatient versus inpatient
Poll the Audience

• What type of navigator are you?
  - Nurse
  - Social Worker
  - Lay Person
  - Other

• What is the primary setting in which you work?
  - Hospital
  - Clinic
  - Health Department
  - Other

• Do you navigate additional cancer types?
Harold Freeman Model

Patient Navigation Across the Health Care Continuum

Initial Target in Harlem Model

- Outreach
- Abnormal Finding
- Abnormal Results
  - Diagnosis
  - Treatment
- Prevention
- Diagnosis/Incidence
- Treatment
- Survival and Mortality
- Early Detection
- Post Treatment/Quality of Life Supportive Care
- Rehabilitation
  - Resolution


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One Size fits all???
I think NOT!
Goals of Navigation

- Identification and reduction of potential barriers to healthcare
- Enhanced quality of care
- Timeliness of services
- Ensure the best cancer care experience through coordinated services
Cancer Care

Diagnosis

Staging

Clinical Evaluation

Treatment

Surveillance

Survivorship

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Breast Cancer Care

Mammogram
Notification
Patient Evaluated
Appointment Arranged

Elapsed Time: 5 - 7 Business Days
Cancer Incidence by Primary Site, Michigan Residents, 2008

Cancer Incidence by Primary Site, Michigan Residents, 2008


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**Esophageal Cancer Care**

- Patient Presents to ER with Weight Loss/Dysphagia
- UGI shows mass

**Primary Care Notified**

- EGD Arranged with GI Doc
- Distal Mass Identified
- Biopsy performed
- Referral for EUS

**PET Scan**

- Surgical Evaluation
- Medical Oncology Evaluation
- EUS performed
  - Demonstrates T3, Node (+)
  - Abd CT ordered

**Radiation Oncology Appointment**

- Neo Adjuvant Chemorads Initiated

**Six Weeks Past ER Visit Showing Mass**

2 Days, 7 Days, 14 Days, 21 Days, 28 Days, 35 Days, 42 Days
Esophageal Cancer

STAGE

Tis or T1a

Medically fit, resectable Tis, T1-T4, N0-1, NX, or Stage IVA

T1b, N0, NX

MULTIDISCIPLINARY EVALUATION PREFERRED

T1b, N1 or T2-T4, N0-1, NX or Stage IVA

PRIMARy TREATMENT

Endoscopic mucosal resection (EMR)\textsuperscript{1} or Ablation\textsuperscript{1,3,6,7} or Esophagectomy\textsuperscript{4,8}

Esophagectomy\textsuperscript{4,8,9,10,11,12} (preferred for noncervical T1b disease)

Preoperative chemotherapy\textsuperscript{13,14,15} for adenocarcinoma of distal esophagus or GE-junction

Definitive chemoradiation\textsuperscript{16,17} for adenocarcinoma of distal esophagus or GE-junction

ADJUNCTIVE/ADJUVANT TREATMENT

Surgery

Observe/palliative surgery (optional)

No evidence of disease

CT scan with contrast

PET/CT (preferred) or PET scan (category 2B)

Preoperative chemoradiation\textsuperscript{18,19,20} (optional)

RT, 50-54.4 Gy + concurrent chemotherapy

CT scan with contrast

PET scan (category 2B)

Preoperative chemoradiation\textsuperscript{18,19,20} (optional)

RT, 50-54.4 Gy + concurrent chemotherapy

No evidence of disease

Persistent local disease without metastatic disease

Unresectable or Metastatic disease

Palliative chemotherapy\textsuperscript{10,21} and/or Best supportive care\textsuperscript{22}

Esophagectomy\textsuperscript{4,8,9,10,11,12} (preferred)

Esophagectomy\textsuperscript{4,8,9,10,11,12} if fit for surgery (preferred)

Palliative treatment, including chemotherapy\textsuperscript{21}

Surgical Outcomes after Esophagectomy (ESOPH-3)

Surgical Outcomes after Esophagectomy (ESOPH-3)

Follow-up

See Principles of Surgery (ESOPH-B)

See Principles of Multidisciplinary Team Approach (ESOPH-A)

See Principles of Systemic Therapy (ESOPH-C)

See Principles of Radiation Therapy (ESOPH-D)

See Principles of Best Supportive Care (ESOPH-E)

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
Value Based Healthcare

“Every step in the sequential health care process benefits from information exchange and coordination with other providers. In practice, however, this is cumbersome, time-consuming, and often left to the busy doctors, and often fails to occur.”

Michael Porter, Harvard Business School
Annals Surgery 2008
The Lacks Cancer Center

- NCCCP Site
- West Michigan’s only dedicated Cancer Center
- Community Teaching Hospital
- Member of Trinity Health
- Focus on minimally invasive surgery
- Patient Centered Model of Care
- Multidisciplinary clinics available for all solid tumors
Lacks Cancer Center GI Program

• Dedicated GI Cancer Nurse navigator
  - Specific Training in GI Cancer
  - Oncology Certified
• Prospective, Weekly GI Cancer Treatment Planning Conference
• Multidisciplinary, Same Day, GI Cancer Clinic
  - Surgical Oncology
  - Radiation Oncology
  - Medical Oncology
  - Cancer Resource Specialists
  - Oncology Nutritionist
  - Palliative Care
• Program of OUTCOME assessment and Measurement
  - Dedicated GI database
  - Dedicated program analyst
• Steering Committee with continuous feedback of Outcomes and Program assessment
5 Major Program Outcome Measures

• **Timeliness**
  - Rapid Contact with patient to identify needs, worries, and completed testing
  - Time measures for staging completion, Time to clinical evaluation, Time to TREATMENT initiation

• **Patient Centered**
  - Same Day Clinics where multiple physicians see patients in a single day
  - Coordinated diagnostic studies for patients, often in conjunction with clinic visit
  - Reduce patient time

• **Efficient**
  - Avoid unnecessary Testing
  - Avoid non-essential Biopsies

• **Effectiveness**
  - Appropriate Staging consistent with National Guidelines
  - Appropriate Stage specific cancer care
  - High Quality cancer care, evidence-based
  - *BENCHMARKED* Clinical Outcomes against National published standards

• **Equitable**
  - Fair and equal care for all patients
Multi-Disciplinary Team Approach

- Medical Oncology
- Surgical Oncology
- Radiation Oncology
- Survivor Network
- Pathology
- Clinical Research
- Familial Cancer Program
- Financial Counseling
- Prevention Program
- Nurse Navigator
- Social Services
- Palliative Care and Integrative Medicine
- Nutrition Services
- Specialty Physicians
- Cancer Education

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GI Disease Location – GI MDC Program to Date

Percent of Patients

- Colorectal: 20
- Esophageal/Gastric: 20
- Liver: 23
- Pancreatic: 36

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Diagnoses Type

- New Cancer Dx: 74%
- Cancer Recurrence: 7%
- Benign: 19%

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Inpatient vs. Outpatient Referrals 2011

**Percent**

**Inpatient**
- 2010: 10%
- 2011: 31%

**Outpatient**
- 2010: 90%
- 2011: 69%
Role of GI Nurse Navigator

- Goal = Timeliness of services
  - Patient contact < 2 days
  - Organization and coordination of timely diagnostic studies < 6 days
  - Coordination of multidisciplinary appointment < 10 days
  - Coordination of treatment initiation < 25 days
Average Business Days Until Contacted by Nurse Navigator

- 2010: 1.6 days
- 2011: 1.6 days

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Average Business Days Until Cancer Staging Completion

![Bar Chart](image_url)

- **2010**: 5.9
- **2011**: 5.4

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Average Calendar Days Until Patient is Seen in GI MDC Clinic

- 2010: 7.7 days
- 2011: 6.2 days

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Patients Seen in Clinic Within 10 Calendar Days

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Q1 2011</td>
<td>83</td>
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<tr>
<td>Q2 2011</td>
<td>100</td>
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<tr>
<td>Q3 2011</td>
<td>100</td>
</tr>
<tr>
<td>Q4 2011</td>
<td>88</td>
</tr>
<tr>
<td>2010</td>
<td>89</td>
</tr>
<tr>
<td>2011</td>
<td>93</td>
</tr>
</tbody>
</table>
Role of GI Nurse Navigator

• Goal = Ensure the best cancer care experience through coordinated services/
  Patient Centered
  - Shared and informed decision making
  - Single contact person through cancer journey
  - Decreased patient anxiety/ improved quality of life
  - Increased patient satisfaction
Role of GI Nurse Navigator

- Goal = Efficient and Effective quality care
  - Ensures that diagnostic studies are in concordance with NCCN guidelines
  - Works directly with physician lead to review diagnostic studies, clinical history and course of treatment.
  - Coordinates multidisciplinary evaluation and presentation at tumor board
Staging Compliance with NCCN Staging Guidelines

Percentage

2010: 74%
2011: 97%
Role of GI Nurse Navigator

- Goal: Equitable care/ Identification and reduction of potential barriers to healthcare
  - Comprehensive health assessment
  - Collaboration with multidisciplinary team members
  - Education
  - Continuous patient monitoring throughout cancer journey
  - Enhanced communication with patient and providers
Referrals
Number of Invasive Cancer Cases for Select Primary Sites, Michigan Residents, 2008

SMHC and GRG efforts to improve CRC screening

- Education and awareness
  - CRC pamphlets
  - CRC Banners from CDC and Marketing
  - Loop video from local physicians
CRC banners from CDC

Expect Something More
Transportation Navigation: Improving Colonoscopy Completion Rates

- The Lacks Cancer Center and Grand River Gastroenterology
- Main barrier to completion = transportation
- 30% Cancelations in 2010 due to lack of transportation
- Goal was to improve transportation rates by offering transportation as well as a responsible adults.
Methods of transportation Navigation

- Life EMS partnered with SMHC and GRG to provided discounted transportation.
- Direct billing was established to eliminate the patient being involved.

<table>
<thead>
<tr>
<th>Location</th>
<th>Roundtrip Cost</th>
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<tbody>
<tr>
<td>Urban</td>
<td>$48.00</td>
</tr>
<tr>
<td>Suburban</td>
<td>$56.00</td>
</tr>
<tr>
<td>Rural</td>
<td>$76.00</td>
</tr>
<tr>
<td>Super Rural</td>
<td>$42.00 plus $2.00/mile for each mile outside Kent County</td>
</tr>
</tbody>
</table>
110 round trips provided, Average cost per trip = $71.16
Colonoscopy Cancellations Due to Lack of Transportation

- 2010: 225 cancellations
- 2011: 122 cancellations

Decrease of 54%
## Return on Investment

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
<th>Patients</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>$1600.00</td>
<td>110</td>
<td>$176,000.00</td>
<td>100%</td>
</tr>
<tr>
<td>Transportation</td>
<td>$71.16</td>
<td>110</td>
<td>$7828.00</td>
<td>4%</td>
</tr>
<tr>
<td>Potential Cancellation Avoidance</td>
<td>$168,152.00</td>
<td>96%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Breakout Session**

- What type of Navigator are you?
- What types of GI cancers do you navigate?
- What are the outcomes or your needs assessment?
- Feasible strategies to address barriers identified?
- Who makes up your GI team? List out Key stakeholders.
- What are the goals or objectives of your program?
- What is your case load? What defines your case load?
- How do you document? (EMR/Navigation Software/ Shadow chart)
- How are you measuring your accomplishments?
- Do you measure the quality and outcomes of the care delivered?
- What are your favorite resources for patients/ yourself?
- Keys to success/ Lessons learned?

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Don’t cry because it’s over. Smile because it happened.

-Dr. Seuss