Mount Sinai

Patient Navigation: Current Core Activities

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Navigation

- Individualized to patient and program
- Direct patient contact
- Relationship Building
- Knowledge of/Connection to resources
- Team-based approach

Navigation

- Some form since 2003
- Expanded to include community outreach
  - Supported since 2007 by grant funding
  - Now a team of 3 patient navigators (two outreach-based) and one care coordinator
- NY State DOH AIDS Institute funded program, funding allows for patient navigators to:
  - Increase appointment adherence
  - Improve care coordination
  - Increase treatment initiation

Navigation: Internal Perspective

- Clinic Management
  - Troubleshooting
- Weekly Clinic Emails
  - Pre-visit planning and post-clinic follow-up planning
- Patient Appointments
  - Taking Referrals, Scheduling appointments, Maintain people in care
- Medications
  - Smoothing the process from ordering to treatment support
- Bridge between Providers and Patients

Navigation: Internal Perspective

- Weekly Clinic Emails
  - Pre-visit planning and post-clinic follow-up planning
- Clinic Management
  - Troubleshooting
- Patient Appointments
  - Scheduling referral appointments, follow-up, informing CMs/proxies of plan.
- Medications
  - Filling prescriptions , scheduling deliveries, applying for co-pay assistance, applying for patient assistance programs
- Bridge between Providers and Patients

Weekly Clinic Email

- Patients scheduled for each clinic session
- Basic clinical information: genotype, latest viral load, latest imaging. Status of treatment evaluation.
- Co-morbid conditions
  - Helps to standardize the problem list in chart/help to set expectations, build argument for the patients treatment
- Any other concerns – Psychosocial issues to be addressed
- Continuity of care, particularly with patients lost to follow up
- Maintain clinical tracking database

Clinic Management

- Aiding patients with the check-in process (particularly with outside referrals)
- Tracking patients check-in
- Escorting patients to rooms with the provider and accompanying them through parts of the visit/translating
- Assuring patients see all service providers necessary (psychologist, nutritionist, social worker)
- Seeing the patients out to bloodwork and reinforcing the plan of care

Troubleshooting in the Clinic

- Changing PCPs
- Accommodating patient preference
- Helping with nurse visits on non-clinic days
- Assuring patients have medications/follow-up

Clinic Email Examples

- **New Patient**

-New patient referred from IMA

-GT: not performed, VL: 2,041,088 (last performed 2/10/2011),US set 1/12

-CKD stage 3, Actively using , uncontrolled DM A1C 12.9 (meet nutritionist)

- PREP C after GT is in to inform treatment discussion, meet w/ SW or PS

- **Patient in Work-Up**

-GT: 1a, VL: 6,154,330 (last performed on 9/30/14 Review 10/15 US "echogenenic liver compatible with non-alcoholic steatohepatitis. CT may be needed for further assessment of HCC."

-Further imaging ?

-Anxiety, Insomnia, Depression, COPD,

-PREP C today with Psychologist.

- **Patient on Treatment**

-Treatment Week 2 – labs, side effect monitoring and adherence

-GT: 1a, VL: 9,160 before treatment

-Pt would like to transition to weekly appts to help w/ adherence. Box for prefill.

-Check in with Dietitian, P or SW.

Clinic Email Examples

- **Patient in Post-Treatment Follow up**

  -GT: 1b, VL: Undetectable (last performed 6/4/14)

  -6 month post treatment visit, SVR check, follow-up imaging

  -Patient not adherent with psychiatric referral appointments made/escorts offered; see psychiatrist

  -Patient no longer well-established in care. Schedule for PCP, refer to HH navigation

Case Conference Examples

- **Initial Evaluation**

New IMA Pt. Treated 10 years ago w/ ifn self-DCd due to SEs. PREP C'd and cleared for treatment. Labs done. US 12/15. Dr. Liver, do we want to order? Plan for weekly follow-up to assist with SE coping.

- **Initial Evaluation**

New VIP Outreach Referral by Alabama MMTP. Treatment Naive, first time seeing a specialist. Labs done. US set for 12/28, Met w/ SW. RTC 1/6 to review results, discuss Tx.

- **Treatment Patient**

Pt started TW 0 of 12 Harvoni. Given schedule of treatment/follow-up visits. Baseline adherence and side effect monitoring. Given MEMSCap. RTC 12/23

- **Post-Treatment**

SVR 24. Pt informed, pleased.US set 12/29 to review w/ PCP 1/9 RTC 12/2015. HH navigation by Nayelis. Labs done. Invited to cure club!

- **Data Entry**

Done for funder reporting and patient management.

Patient Appointments

- Make specialty clinic appointments such as Renal, Podiatry and GYN for patients once they receive the referral from the provider
- Make appointments for diagnostic procedures such as ultrasounds, CT scans, MRCPs, and fibroscans (and obtain prior authorizations for those necessary)
- Provide practical support for patients that may otherwise not follow-up

Patient Appointments

- Call patients with date and time of appointments
- Mail patients appointment information
- Give patients procedure instructions such as fasting requirements
- Make reminder phone calls to patients the day before their scheduled medical visits and/or procedures

Treatment & Medications

- Assure all patients have PREP-C prior to ordering
- Fill out prior authorization paperwork
- Follow up with insurance company requests, denials and approvals
- Internal and External appeals process
  (Patient assistance applications, if necessary)
- Schedule medication deliveries
- Side effect monitoring and adherence

Support Group

- Recruit patients to attend
- Remind patients of upcoming monthly meetings
- Attend support groups
- Prepare the room before each meeting
- Assign a peer facilitator

Bridge between Providers and Patients

- Patients can call navigators first
- Field calls from patients and inform providers of issues that come up
  - Provide emotional and practical support
- Weekly case conferencing with providers
  - Based on weekly clinic email, developments
- Continuous email/phone contact with providers
- Follow up with the patient/provider regarding changes in plan of care

External Navigation

- Reduce physical and non-physical structural barriers to receive medical appointments and procedures, needed services, and health coverage
- Assist in obtaining information that could potentially affect ability to receive or continue HCV treatment
- Provide emotional and logistical support for patients

Navigation: External Perspective

- Accompaniment of Patients
- Maintenance and support of health coverage
- Integration of Health Coverage
- Community Resources
  - Identification
  - Referrals

Integration of Health Insurance/Coverage

- Assure patients have assistance with insurance issues (help choosing a plan, switching plans, switching providers)
- Maintain coverage for programs such as Medicaid/Medicare (Recertification)
- Assess eligibility for supplemental programs (transportation assistance, nutritional support)

Integration of Health Insurance/Coverage

- Understanding changing formularies of health care companies for medication coverage and communication of these to medical providers

  -Insurance policies and regulations in concern to new medications

  -Simeprevir/Sofosbuvir vs. Harvoni vs Pegylated interferon, ribavirin and sovaldi

Community Resources Identification

- Co-located service providers can identify patient's needs while the patient navigator can identify resources
  - Detoxification and rehabilitation substance use facilities, dual-diagnostic treatment centers (MICA), non-HCV support groups, and other supportive services such as Access-a-Ride, Ambulette Services
- Pharmaceutical assistance programs such as the Support Path, Genentech Access to Care program, Patient Access Network

Community Resources Identification and Referral Processes

- Referral processes externally can be made through mediums such as a "point person," a linkage agreement, referral lists/websites (HCV service locator through the NYCDOHMH), "cold calls" or referral forms
- Applications for services and pharmaceuticals need to be accompanied with financial and legal documents
  - tax returns, pay stubs, identification cards and health coverage status

Qualities of Patient Navigators

- Bilingual/multilingual capabilities
- Understanding of HCV care and treatment
- Detailed knowledge of entitlements, insurance plans, and assistance programs
- Interpersonal skills to help patients tolerate frustration of barriers
- Flexibility, persistence, creativity, and patience
- Invested in advocating for patients

Referrals

- IMA funded for Mono-infection (referrals/coordination done for co-infected individuals)
- Antibody (+)
- Accept most Medicaid and Medicare Managed care, exchanges, and private insurance
- Assess eligibility for HepCAP for uninsured

THANK YOU

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