

# A Patient Navigation Model for Veterans Traveling for Cancer Care

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Cancer care navigation teams can address patient needs and break down barriers to care in veteran patients with cancer.

The VHA has a unique responsibility to provide excellent, patient-centered care to the veterans who have served the U.S. long after their active military service has ended. For veterans diagnosed with cancer, the physical, mental, and financial consequences can pose significant hardships and create barriers to obtaining timely and efficient health care. The need to travel for cancer care, sometimes for long distances over long periods, adds an additional disparity and puts veterans at higher risk for delays in care. Cancer care navigation teams (CCNTs) were established at the VA Puget Sound Health Care System (VAPSHCS) in Seattle, Washington, and throughout the Veterans Integrated Service Network, region 20 (VISN 20), which consists of a large geographical area that includes Alaska, Washington, Oregon, Idaho and one county in both Montana and California. These teams use an interdisciplinary approach to providing personalized assistance, support, and resources to veterans with cancer and their families who require travel for cancer care.

The CCNTs identify and minimize clinical and psychosocial barriers throughout the cancer care continuum. Although structured to address the unique needs and barriers of the veteran population within the VA, CCNT may also be used as a model for patients receiving cancer care within other complex and decentralized health care systems.

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## PATIENT NAVIGATION IN CANCER CARE

The term *navigation* in the context of cancer care originated in 1990 at Harlem Hospital Center in New York City. The term described an intervention to address barriers to care experienced by a population of low income African American women with breast cancer. By applying patient navigation in addition to offering free and low-cost breast cancer screening and exams for high-risk patients, the 5-year survival rate in this disadvantaged population of women increased from 39% to 70%.<sup>1</sup>

Since then, navigation programs in cancer care have been adopted in health care settings around the world. Many different models have been described within the literature.<sup>2-5</sup> Patient navigation is perhaps best recognized as a means to decrease health disparities by addressing barriers to health care, which may include lack of insurance, poverty, medical or psychiatric comorbidities, low health literacy, food insecurity, and homelessness. By identifying and addressing these barriers to care in high-risk populations, patient navigation programs have demonstrated positive outcomes, including improvement in cancer screening rates, timeliness of care, medication adherence, and patient satisfaction.<sup>6-10</sup> Although there is a large amount of literature on navigation in cancer care, there is minimal literature that focuses on navigation in the veteran population and health care system.

## BARRIERS TO CANCER CARE

The VA is a national health care system composed of community clinics, hospitals, and major referral centers that deliver comprehensive health care to veterans. For

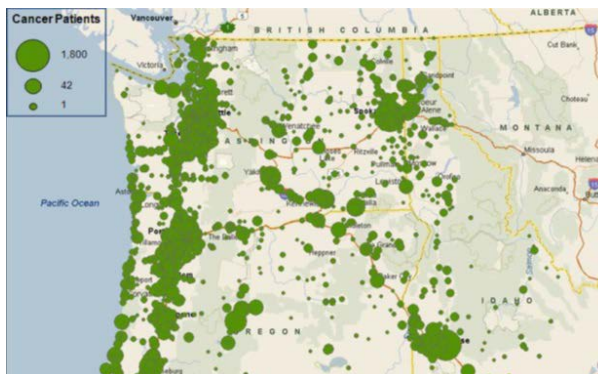
veterans diagnosed with cancer, the physical, mental, and financial consequences can pose significant hardships and create barriers to obtaining timely, efficient health care. Research studies have documented significant differences among veterans receiving health care through the VHA compared with veterans who receive health care from other sources. Veterans enrolled at the VA are more likely to be poorer, older, African American, less well educated, unemployed or underemployed, lack social support, and in poorer physical and mental health compared with the general population or with veterans who do not use VA health care.<sup>11-13</sup> Such health disparities have been linked to delays in timely access to health care.<sup>11</sup>

In a study comparing an age-adjusted ambulatory care population with veterans receiving care at the VA, VA patients were also found to be 3 times more likely to have ever been diagnosed with cancer.<sup>12</sup> Exposures to carcinogens during their military service, such as Agent Orange, may contribute to this difference.<sup>14</sup> Veterans have higher rates of posttraumatic stress disorder (PTSD) and other mental health disorders from military combat experiences or other traumas; these conditions can be exacerbated by the distress of a cancer diagnosis.<sup>15-17</sup>

Veterans requiring specialty care, such as cancer-related care, are referred within the VISN and may need to travel long distances in to access these specialty providers. Continuity of care is challenged during cancer diagnosis, staging, treatment, and surveillance when some aspects of care may be completed at geographically distant sites or by community providers if unavailable through the local VA. Appointments for care occur within each specialty service, and staff and clinic availability limit scheduling. There are no formal mechanisms for coordinating visits for efficiency or minimizing travel burden. The electronic medical record (EMR) at the VA can be helpful in accessing information from remote locations but does not easily integrate medical information from different facilities. Clinical data, such as recommendations for follow-up care, may take time and patience to access.

These challenges to the delivery of timely, efficient, patient-centered cancer care were documented in a cancer needs assessment performed in 2012 across VISN 20 (Figure 1). In response, a 3-year pilot program was initiated to implement a network of CCNTs in 8 VA facilities across the region.

**Figure 1. Cancer Patients Within VISN 20**



Data from 2012, by geographic location (excludes Alaska).

## PLANNING AND IMPLEMENTATION

The VAPSHCS is a major referral center for cancer care that serves veterans living in VISN 20. On average, about 1,000 new cancers are diagnosed, and VAPSHCS sees 2,000 unique veterans for cancer care annually (Figure 2). One-quarter of these veterans are from out of state. For veterans living in Washington, nearly half traveled 50 miles or more to access cancer services at VAPSHCS. VA Puget Sound implemented its CCNT in the fall of 2014 and consists of an advanced practice registered nurse practitioner (ARNP), registered nurse (RN), social worker (SW), and program support assistant (PSA).

Veterans in identified priority cohorts thought to be at highest risk for barriers to cancer care are enrolled in navigation services. These priority groups include those veterans referred from another regional VA facility, those living more than 100 miles from the VAPSHCS, those referred for multimodality care (eg, surgery with neoadjuvant chemoradiation), and those with significant psychosocial barriers to care. Veterans are identified by the CCNT through a formal consult, notification from the CCNT at another VA facility, a cancer conference, a review of pathology results, and in some cases by veteran self-referral.

As it develops further capacity, CCNT will add other high-risk groups. Ideally, CCNT will eventually be a resource all veterans referred to VAPSHCS for cancer care, so all veterans may be assessed for potential

barriers to care and be provided with much needed support and resources.

The CCNT is proactive and systematic in its navigation processes. Where possible, CCNT members are cross-trained to provide role coverage. The team reviews medical records for veterans actively enrolled in CCNT services weekly, to identify new barriers to care and address them in a timely manner. A robust data tracking system (created using a relational database) allows for storage of updated patient information and assigns tasks within the team, tracks upcoming appointments to support coordination, identifies travel and lodging needs, and assures follow-up care is completed. It also generates lists used for routine rounding on patient groups, treatment summary reports, and survivorship care plans.

The CCNT uses standardized assessment tools, including a navigation intake form, the National Comprehensive Cancer Network (NCCN) Distress Thermometer, and a functional assessment. Communication is an essential part of the navigation team, which addresses veteran's identified needs by conducting weekly rounds within the interdisciplinary team to share information and collaborate.

The team has weekly telephone calls with its CCNTs from referring facilities to discuss veterans at all stages of the cancer continuum and facilitate transfer of information between facilities and providers, including needed diagnostic services and follow-up recommendations. The CCNT also facilitates communication with PSHCS specialty services by actively participating in multidisciplinary rounds and cancer conference.

Finally, although the CCNT follows individual veterans, the team also recognizes its role in identifying and addressing system barriers to cancer care. Collaborating with its partners within the facility and across the network, the team has improved access to services, created teaching tools that can be shared across disciplines, and implemented new procedures and policies to meet the American College of Surgeons Commission on Cancer accreditation standards and improve the cancer care system as a whole.

### VAPSHCS CANCER NAVIGATION MODEL

The VAPSHCS cancer navigation model is divided into 4 main processes based on the cancer care continuum. To illustrate this navigation model, this paper follows the journey of a 57-year-old male veteran referred to PSHCS with newly diagnosed head and neck cancer. He is di-

vorced, with very little social support and lives in a remote area about 60 miles from his primary VA facility and more than 400 miles from PSHCS. His case was presented at the PSHCS facility cancer conference, where concurrent chemotherapy and radiation was recommended. This particular treatment consists of daily radiation and weekly chemotherapy over 6 to 7 weeks. The CCNT staff recognized that this veteran met criteria for navigation, entered him in the tracking database, and notified his referring facility CCNT of the plan of care.

### Preconsult

Prior to veterans traveling to VAPSHCS for a new diagnosis or suspicion of cancer, the first goal is to identify any potential barriers to travel. It is a financial burden for many veterans to travel, and in the past, travel has prevented veterans from attending their specialty consult appointments. It is the role of the CCNT PSA to contact the veteran by telephone, introduce their services, provide education about available travel and lodging benefits, and schedule a visit with the CCNT RN to coincide with the veteran's scheduled other specialty appointments.

In this case, the CCNT PSA contacted the veteran with information about the VAPSHCS, placed a lodging consult to arrange hotel accommodations for the veteran while in Seattle, and provided information regarding transportation from the hotel to the VA. The CCNT also identified that the veteran required a radiation oncology consultation and dental evaluation to proceed with a treatment plan. To decrease travel burden with additional trips to Seattle, the PSA contacted these specialty services to schedule the appointments. The PSA then assembled and mailed a packet of information to the veteran, which included details about how to pack and prepare for the trip, a facility map, and a hotel shuttle schedule.

### Consult Visit and Planning

When veterans arrive at VAPSHCS, the CCNT RN meets them and completes an intake form. This standardized questionnaire identifies potential barriers to cancer care and supports the need for referrals to services, such as a dietitian, chaplain, palliative care, social work, physical and occupational therapy, travel, or lodging.

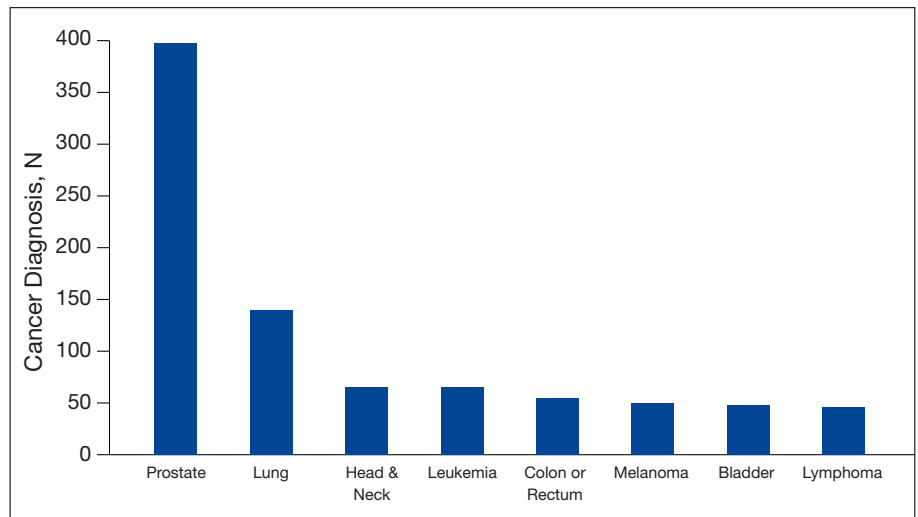
During this visit, the CCNT RN also asks the veteran to complete a NCCN Distress Thermometer. This thermometer assessment tool screens for physical, emotional, and practical needs that are specific to cancer. In this particular veteran's situation, the distress level was 7 out of 10 (a score of 4 or greater triggers

an automatic consult to social work once the results are entered in the EMR). Based on the outcomes information obtained from the intake form and NCCN Distress Thermometer, the CCNT RN made referrals to SW, chaplain services, and the oncology dietitian.

During the CCNT RN visit, nurse identified that the veteran's financial situation had changed significantly resulting in less income and causing financial distress. The veteran was encouraged to complete an updated benefit renewal form with the SW that would likely eliminate his required copays for medical visits and prescription medications during the 6 weeks of chemotherapy and radiation. This need was communicated to the CCNT SW. The RN provided the veteran with information about VA resources to support him during cancer treatment, including meal options and support groups for both veterans and caregivers. They discussed the likely plan of care, including disease progress, information on prescribed drugs, dental evaluation and extractions as needed, placement of a feeding tube and a central line, and gave the veteran written brochures to review at his convenience. The RN also reviewed the logistics of a prolonged stay for the recommended course of chemotherapy and radiation.

During the initial CCNT intake process, the RN identified that the veteran would be without a caregiver and would be staying alone in lodging throughout his cancer treatment. The RN then completed a functional assessment of safety risks while lodging alone during this extended time. This brief questionnaire identifies any deficits in a veteran's activity of daily living that may influence safety while lodging alone. The assessment is documented in the EMR, and if any concerns are identified, these are discussed with the veteran and a team of medical providers. If necessary, interventions are put into place before the veteran's return for treatment. Potential safeguards may include obtaining safety equipment (eg, walker and bath chair), identifying an appropriate caregiver, or referring the veteran to a skilled nursing facility for the duration of treatment.

**Figure 2.** Average Annual Number of Cancer Diagnoses by Site, VAPSHCS, 2010-2013



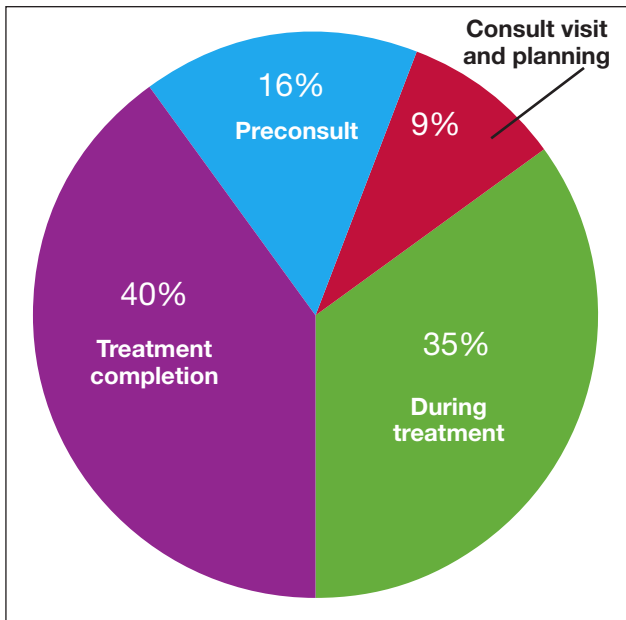
Following the veteran's consultation visits, he went home with a return date 2 weeks later to start treatment. The VAPSHCS CCNT discussed the plan of care with his local CCNT, which facilitated placement of his feeding tube and addressed other symptom management concerns. The local CCNT SW completed advanced directives with the veteran and coordinated his travel back to VAPSHCS to begin treatment.

**During Treatment**

Veterans traveling from other VA facilities are away from their primary care providers (PCPs) for a number of weeks. Other specialty providers see a veteran during cancer treatment; however, the CCNT ARNP supports primary care needs while the veteran is away from their home VA facility. The ARNP is able to address chronic or acute medical issues before the start of treatment to prevent delays in cancer care.

Once the veteran returned to VAPSHCS to initiate therapy, the CCNT ARNP completed a history and physical examination to identify and address any active medical problems and document past medical history and current medication list in the EMR. This provides easy access to a thorough and complete baseline to both the oncology and radiation oncology providers. The ARNP examination revealed a new neck wound on the veteran, likely related to his cancer, and an urgent consult was placed to wound care. The otolaryngology, oncology, and radiation oncology departments were alerted to this development so they could assess the patient and adjust

**Figure 3.** Veterans in Active Navigation Services by Continuum Status, 2015



treatment plans as necessary. The veteran also required a refill of his blood pressure medication and had a number of questions regarding his upcoming treatment, which were addressed during the visit.

Within the first 2 days of the veteran's return, he was scheduled to meet with the CCNT SW who reviewed and documented his advanced directive within the system, assessed his distress, provided therapeutic counseling, and completed the health benefit renewal form. Given the veteran's financial status, the SW was able to help him apply for financial hardship to cover the costs of the care he had already received and assisted him with securing an appointment with the Social Security Administration (SSA) for disability benefits. The CCNT SW then helped the veteran complete a phone interview with the SSA and complete the application process. The SW also helped him complete the application for VA service-connected compensation and pension disability benefits.

Throughout his treatment course, the CCNT continued to be a resource for the veteran. Because he had PTSD and was uncomfortable attending support groups, the CCNT SW met with him weekly to provide counseling and psychosocial support. He stopped by the CCNT office on several occasions to report how he was doing, and the team provided assistance in obtaining supplies for his feeding tube and managing a com-

plication that arose with his lodging. In preparation for his treatment completion and return home, the VAPSHCS CCNT communicated with his local CCNT to describe follow-up needs and ensure appropriate medical visits were scheduled. His travel home was arranged by the VAPSHCS PSA.

### Treatment Completion

Before leaving VAPSHCS, the veteran was scheduled and seen in the clinic by the ARNP, where he received a written comprehensive treatment summary. The summary documented his cancer diagnosis, treatment, complications, and recommendations for follow-up care. He had the opportunity to ask questions about his treatment, and a clinical assessment was made for adverse effects. Appropriate interventions also were identified and addressed. A comprehensive treatment summary note was documented in the EMR and sent to his PCP and other medical specialists at his home facility to assure continuity of care.

The VAPSHCS CCNT continued to communicate weekly with the veteran's home CCNT following his return, to ensure he received appropriate follow-up care and addressed questions and needs that arose. The veteran's home CCNT continued to monitor the veteran for 1 year post treatment and communicate with VAPSHCS CCNT.

### CONCLUSION

The VA is in a unique position to meet the needs of veterans by providing comprehensive care with sensitivity to military culture, access to a range of complicated benefits awarded to veterans, particularly those with service-related exposures or injuries, and specialists in diagnosis and treatment of physical and mental consequences of their service. Patient navigation helps ensure veterans can access these services, maintain continuity of care despite referrals across large geographic regions, and receive support while receiving cancer treatment at the VA.

Use of an interdisciplinary team, including an ARNP, RN, SW, and PSA is vital to fully address the wide range of physical, psychosocial, and practical barriers to care that a veteran may experience. Since September 2014, PSHCS has enrolled more than 500 veterans with CCNT, and nearly 200 are actively being followed and provided with navigation services at any given time (Figure 3). By proactively identifying and addressing barriers to care, the advocacy provided by CCNT has averted patient safety risks, made better use of limited veteran and VA



resources, and provided patient-centered care to veterans.

Evaluation is currently underway to measure the impact of the program and develop metrics for the CCNT. Given the needs of the patient population, the team hopes to see further expansion of CCNT in order to reach more risk groups. Institutional support and funding for patient navigation should be a high priority as the VA strives to provide excellent, patient-centered care. ●

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