Implementing an Oncology Care Management Program in a Rural Healthcare Setting

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Primary care providers in a rural health care setting are faced with lack of resources and coordination of care for their patients particularly when a cancer diagnosis comes into play. Oncology nurse navigator roles can aid in supporting coordination of care and connecting resources for patients thus providing support for the providers in caring for this vulnerable patient population.

Crete Area Medical Center's mission is, to advance the health of the communities and region we serve, through collaboration, prevention, innovation, and exceptional care. Leadership in the facility uses the mission as guiding principles for quality improvement, services offered, education, and performance expectations. Strategic plans are reviewed and established every three years by gathering feedback from team members, leaders, board members, and the community. Improvements in cancer care was identified by the community from feedback in a community needs assessment.

Problem Description

Cancer patients in a rural setting are particularly prone to poorer health outcomes due to multiple social determinants of health concerns (Hendershot, 2019). By implementing an oncology care management role within the rural healthcare setting, these at-risk patients and their families have coordination of care throughout the primary care setting as well as all aspects of care a cancer patient may need throughout the continuum of treatment and survivorship (Tonorezos & Conigliaro, 2017).

A Cancer Survivorship Team consisting of providers, leaders and front-line staff was developed after a community health needs assessment identified cancer care and resources were of high need for the local communities (Community Needs Assessment Report, 2018). The team identified that the biggest challenge for the rural health setting was providers did not have the time and access to resources that their patients with a cancer diagnosis need to ensure they have all their needs met holistically throughout the cancer care journey. After multiple team meetings, the decision was made to

implement an oncology care management role to ensure patients receive care coordination and have a single point of contact for both the patients and for the providers.

Available Knowledge

Population/Problem

Patients with a cancer diagnosis living in rural areas face unique challenges where multiple social determinants of health come in to play. These patients are at risk for poor healthcare outcomes associated with cancer survivorship due to the concerns with rural health, access to care, socioeconomic status, and behavioral patterns (Hendershot, 2019). Each cancer patient has a unique path through treatment and survivorship where coordination of care is of necessity to ensure there are no needs left unmet (Hendershot, 2019). Rural health care providers have the lead role in coordinating their patient's care throughout the cancer journey which can be challenging with limited resources available in rural settings. Studies have shown provider satisfaction as well as increased communication among the health care team when navigators are a part of the cancer patient's treatment team (Valaitis et al., 2017).

Intervention

With cancer treatment and ongoing survivorship comes a need for a multidisciplinary care and coordination. Communication is a key aspect of the cancer navigator role to ensure patient understanding of their plan of care (Ko et. al., 2018). Providing emotional support through the treatment process as well as eliminating barriers to care is part of the coordination of patient care plans that the cancer navigator role accomplishes (Palomino et. al., 2017). Navigator roles are needed for high risk, complex and vulnerable populations such as the cancer patients (Valaitis et al., 2017).

Comparison

Comparison studies have been completed to measure the necessity and effectiveness of the cancer navigator role as perceived by the primary care provider caring for cancer patients. One study

showed improved patient satisfaction as well as improved stress and anxiety when they had a cancer navigator component to their treatment plan compared to those who did not have navigator service (Helzlsouer, et. al., 2016). In another study, there was a significant improvement in patients' distress level when measured pre-navigator intervention to post-navigator intervention (Johnson & Bongiorno, 2018). In primary care settings, one of the biggest barriers to providing ongoing care to cancer patients is the lack of coordination of care with the patient's oncology provider (Chin & Rabinovich, 2017). "Nurse navigators involved in early cancer care had better experiences and were less likely to encounter barriers such as coordination of care, psychosocial issues, education about their condition, etc., compared with patients without nurse navigators" (Chin & Rabinovich, 2017, pg 76).

Outcome

Introducing a cancer navigator role into the cancer patients plan of care has proven in multiple studies to improve patient outcomes and their perception of their care. A meta-analysis was completed on fourteen qualitative studies who used patient navigation as an intervention in cancer care in low income areas (Dalton, et. al., 2019). All fourteen studies showed some degree of positive effect of patient navigation interventions for the cancer patients (Dalton, et.al., 2019). An additional systematic review by McBrian, et.al., showed in all studies that were reviewed, patient navigator programs improved processes of care, patient experience, clinical outcomes, or cost (McBrian et. al., 2018). Overall, study outcomes have proven that cancer navigator roles and teams increase patients' access to care, develop closer community connections, and improve clinical care (Henderson & Narvarte, 2019).

Methods

Context

At Crete Area Medical Center, a cancer survivorship team was established based upon the community health needs assessments and donation from a community member identifying the need for

improved cancer care. The team identified the top priority for the organization would be to improve coordination of care. Providers identified the biggest struggle in providing care to cancer patients is being able to connect all of the services that cancer patients need and the ability to spend the time with patients as they navigate the journey of treatment and survivorship. Based upon the team's priority identification, implementation of an oncology care management program was completed as the intervention for this project.

Intervention

The initial implementation of the oncology care management program took place in a multi-step approach throughout approximately a 30 day window. The first step was to develop a project charter identifying the goals and the stakeholders responsible for the development of the new program. An overall scoping document was created for documenting progress along the program implementation and review continuum.

Creating a new job role and job description for the role of the oncology care manager was completed as the next step in the intervention. Discussion with the established cancer survivorship team, made up of hospital administration, clinic providers and front line staff, was held to help develop the roles and responsibilities necessary for this role to achieve the desired outcomes. Job description core competencies were modeled after the Pfizer Oncology Patient Navigation in Cancer Care 2.0 program which is supported by the Academy of Oncology Nurse Navigators (Gentry, et. al., 2018).

The next step in implementation was hiring for the oncology care manager role. Ensuring the person assuming this role has the proper credentials, experience, qualities, and key relationships in place to build a navigator program was an important piece to achieving the desired outcomes. Included in the hiring process were the steps of requesting the position within the organization, posting, interviewing, selecting the right candidate, and offering the position.

After the hiring of the oncology care manager, orientation to the role and all necessary departments that this role requires, was completed. An orientation checklist was developed to validate all necessary responsibilities of the role as well as introduction to the organization and departments policies and procedures. Job shadow and preceptorships were set up with internal department key contacts as well as outside navigator program contacts for education and knowledge base opportunities.

Meetings were set up with oncology care manager, cancer survivorship team as well as clinic providers to set key focus areas for the program based upon the acquired knowledge of other successful navigation programs such as the Pfizer Oncology Patient Navigation in Cancer Care 2.0 program (Gentry, et. al., 2018). Prioritization of the focus items received from this meeting was completed and organized for the implementation timeline. Careful consideration was taken in choosing two to three priority focus areas at one time for implementation to allow for successful outcomes prior to taking on additional priority focus items for the program. The team also decided upon one or two focus goals for the navigation services dependent on the perception of the clinic provider's greatest need for their patients. This allowed for a small focus to allow for program development and growth.

Post hiring and onboarding of the oncology care manager, the navigator services was offered to all new diagnosis cancer patients. The oncology care manager educated the clinic providers on steps to initiating the navigator services for their patients.

Study of the Intervention

The success of the implementation of the oncology care management program was measured by assessing the clinic provider's perception of the coordination of care for their patients participating in the navigator services. Clinic providers were given a survey using a Likert scale question style to measure their perception of the coordination of care for their patients who were a part of the navigation services. This survey took place approximately 60 days post implementation of the program.

The collection procedures took place by paper survey after a clinic provider meeting and included all clinic providers who had patients using the navigator services.

Measures

A Likert scale survey was used for studying the oncology care mangement program and its effectiveness for improving the coordination of care for the patients. The survey consisted of four questions with two of the four questions consisting of a five point Likert scale, one filtering question for validity purposes, and one open ended question, allowing providers to suggest next steps for the program Likert scale survey questions allow collection of data to generate a holistic view of people's opinions or perceptions (QuestionPro, 2020). A five point scale was chosen to increase reliability of the data as studies have shown less reliability with the greater the number of scale choices (QuestionPro, 2020). It was determined that additional help was needed to coordinate the care for patients newly diagnosed with cancer and through the survivorship process. Coordination of care was identified as one of the top priorities for oncology nurse navigators (Palomino, et. al., 2017). In addition, seeking program validation of the benefit to their patients is key to determining success (Chin & Rabinovich, 2017).

Analysis

Manual data abstraction was used for data collection and analysis. Excel software was used for data documentation. Values of one through five was assigned to the Likert score questions with a score of five identifying the highest level of support for the improvement of coordination of care for the program and a score of one identifying disapproval of the program intentions. Statistical data was measured and reported using means, frequency, and standard deviations.

Ethical Considerations

Implementing an oncology care management program in a rural setting is a tactic to help decrease implications that social determinants of health add to this vulnerable population and lead to poor healthcare outcomes to improve their coordination of care (Valaitis et al., 2017). Each patient had

a unique plan and was guided through their unique process based upon their needs and diagnosis. All care plans and visit information was documented and kept private through the organization's electronic medical record and followed the organization's privacy policy.

Results

All providers completing the survey have verified that they have had a patient that has used the services of the oncology nurse navigator. A total of six providers completed the survey, or 60% return rate. There were no responses on the open ended question allowing for additional suggestions for the oncology care management role.

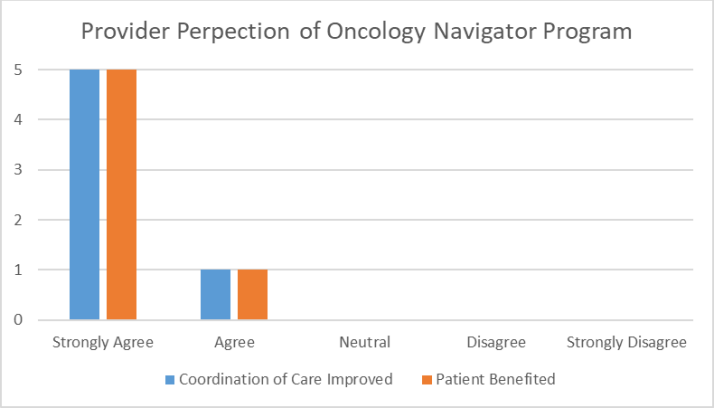
The two Likert style questions resulted in identical results. Provider perception of improved coordination of care for patients resulted in a mean score of 4.83 out of 5, with a frequency of 5 for strongly agree and a standard deviation of 0.41. Provider perception of program benefit for patients also resulted in a mean score of 4.83 out of 5, with a frequency of 5 for strongly agree and a standard deviation of 0.41.

Discussion

Summary

Provider perception of the oncology care management program was overall positive with all responding providers agreeing or strongly agreeing that the program both benefited their patients and improved coordination of care (Figure 2). With the program, patients have been connected to resources needed for their care and had a key points person for them to contact to minimize the time spent for them to be connected to those resources or questions they may have. The oncology care management program provided the patients emotional support necessary for them and their families to navigate their cancer journey in a rural setting.

Figure 2



Interpretation

The overall impact of the oncology care management program for patients and providers is positive. Providers have more resources they need to provide ongoing care to their oncology patients. When navigators are part of the cancer patient's care team, studies have shown improved provider satisfaction and an increase in communication with patients (Valaitis et al., 2017). Providers have voiced that they appreciate the consistency that the oncology care management role provides with cancer treatment of their patients.

Patients have that consistency of one person that they can reach out to for questions or help. Communication is a key aspect of the cancer navigator role to ensure patient understanding of their plan of care (Ko et. al., 2018). Providing emotional support through the treatment process as well as eliminating barriers to care is part of the coordination of patient care plans that the cancer navigator role accomplishes (Palomino et. al., 2017). The oncology care manager has been able to connect patients with many different resources in rural settings to help support them in their cancer treatment journeys after identifying barriers to their treatment such as transportation, financial, emotional support, or family support.

Additional implications from the implementation of this program resulted in an increase in outpatient specialty clinic visits for oncology and nurse visits related to oncology care. A goal to address

social determinants of health for rural healthcare patients is to keep as many visits close to home. Early intervention by frequent touch-bases from the oncology care manager has resulted in quicker turn-around time for necessary treatments as a goal to prevent oncology patients from having to go to the emergency room for treatment.

Limitations

Potential limitations of the project could be provider buy-in and provider education regarding the oncology care manager role (Hendershot, 2019). Education was and will continue to be provided to the providers on the program as well as up to date best practices in Oncology. One additional potential limitation could be the volume of participants for both the patients the navigator worked with, and the number of providers that participated in the survey of the program. In rural health setting, numbers tend to be smaller, so additional long term review of data will need to be completed for further validity of the data analysis.

Conclusions

The revised standards for quality improvement reporting excellence (SQUIRE 2.0) was used as framework for reporting this project. Implementing an oncology nurse navigator program in a rural setting, showed to improve provider perception of the coordination of care for their primary care patients who are currently in treatment or survivorship for a cancer diagnosis. Providers perceived that the program showed some benefit for their patients. Further studies will need to be done to determine patient satisfaction with their healthcare experience, as well as improved quality of care outcomes. Ideally, patients' overall cancer survivorship rates would improve as well as patients' quality of life post cancer diagnosis. Implications for practice could prove that all rural healthcare practices could benefit from the service of an oncology care manager program to improve coordination of care for cancer patients and to guide this vulnerable population through a life altering diagnosis.

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