Patient Navigation Integrated in Primary Care and Information Continuity

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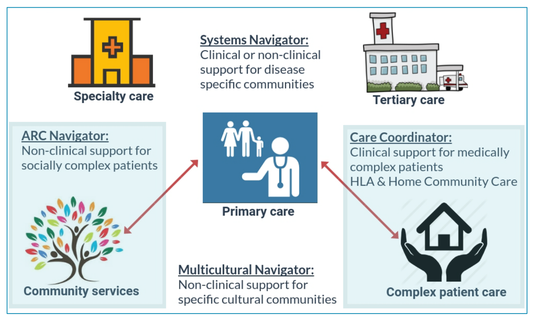
Background

- The Access to Resources in the Community (ARC) study instituted a non-clinical patient navigation model in primary care practices to optimize equitable access of heath-enabling community resources for primary care (PC) patients with social challenges.



- The ARC Patient Navigator met with patients to help them identify priorities for their health and barriers to access community resources, and to provide navigation support to address barriers.
- Four PC practices and 35 primary care providers (PCPs) were recruited in Ottawa, Canada. Since August 2017, 131 patient referrals for navigation have been received.

Objective

- Describe strategies for the flow of information between PC practices, community programs, and the Navigator to support patient access.

Methods

- Three communication tools were developed to facilitate information continuity:
  1. Standardized referral form: used by PCPs to identify patient needs that can be potentially addressed by community resources (CR).
  2. Navigator Log: Access Database designed for comprehensive documentation of patient encounters including an action plan (e.g. patient priorities, access barriers, information about CR; communication among Navigator, PCP, and community programs).
  3. Navigator Feedback Form: detailed information for PCP about CR, patient access status for each priority need, and description of resource.
- Post-intervention surveys and interviews with PC providers were administered to evaluate continuity of information for patient navigation.

Findings

Provider Surveys (n=17)

Item	Agree (%)	Neither Agree or Disagree (%)	Disagree (%)
1. The **role of the Navigator** was clearly defined within the primary care team.	11 (64.7%)	2 (11.8%)	4 (23.5%)
2. The Navigator **communicated effectively** with the primary care team.	10 (58.8%)	3 (17.6%)	4 (23.5%)
3. The **information** provided about patients' participation in community resources was appropriate and useful.	9 (52.9%)	3 (17.6%)	5 (29.4%)
4. The **scope of navigation services** met the needs of referred patients.	7 (43.8%)	5 (31.3%)	4 (25.0%)

Provider Interviews (n=7)

Patient Referral

Some PCPs incorporated the referral form in the electronic medical record; others faxed the referral to ARC.

- ❖ "The form was simple to fill out." (ST)
- ❖ "It is important to ask PCPs about their EMR for compatibility with the referral form." (MC)
- ❖ "It was sometimes hard to think about the referral on the spot, we [PCPs] need to remind each other to refer patients to ARC." (FM)

Patient Encounters

- ❖ "The Navigator intervention went smoothly. They had an empty room in the practice...the Navigator could approach me to ask a question about a patient." (CB)

Navigator Feedback

- ❖ "I check the form and if the Navigator wrote that they tried to reach the patient a number of times without success, I will ask the patient the next time I see them about this. I may need to prompt the patient." (CB)

Communication Tools

Standardized Referral Form

ARC Community Resource Referral Form

ARC Research Team Contact information:
Tel: 613-562-6262 ext. 2920 Fax: 613-782-2777

Complete this form ONLY if the patient consents to be contacted by a member of the study team at Bruyère Research Institute in Ottawa, Ontario.

Name:	Telephone #: (__ __ __) __ __ __ - __ __ __ __ Best time: ☐ AM ☐ PM ☐ Evenings ☐ Weekends ☐ Other _____
☐ Male ☐ Female ☐ Other	Age: _____ years

☐ The patient agrees to have their name and telephone number sent to the researchers in Ottawa so they can be contacted to receive more information about the ARC study.
☐ The patient was provided with the study information package and the research team's contact information.

Please select one option:
☐ Able to communicate with research team in French or English
Preferred language for contact: ☐ French ☐ English
☐ Requires interpretation services *please specify:* _____
☐ Requires support from parent or proxy. *Proxy Contact Information:*

Name: _____ Telephone #: _____

Seeking resources to address the following needs:

☐ Chronic pain	☐ Diabetes education	☐ Mental health
☐ Physical activity	☐ Stop smoking	☐ Addiction
☐ Healthy eating	☐ Parenting and family support	☐ Self-management

☐ Other (specify):

Additional Comments

Main Responsible Provider's name: _____
Referring Provider's name (Please Print): _____
Signature: _____ Date: 201_/__ _/__ __ (Year / Month / Day)

Navigator Feedback Form

ARC NAVIGATOR FEEDBACK FORM

Patient Name:
Main Responsible Provider Name:
Referring Provider Name:

REFERRAL FORM INFORMATION

Date of referral:
Resource/Program:

REPORT TIME

☐ Initial contact ☐ Interim ☒ Final

Date:

DETAILS:
The navigator and patient initial met IN PERSON, 'IN-PRACTICE/OFF-SITE'/BY TELEPHONE on DATE. The navigator provided the patient with the following resource by TELEPHONE/E-MAIL/MAIL on DATE:

- NAME OF ADDRESSED NEED (I.E. MENTAL HEALTH): *Repeat this for each addressed priority
  - Name and short description of organization and service
  - Location, telephone number, website link
  - Any additional pertinent information (including referral process, fax number, etc.)

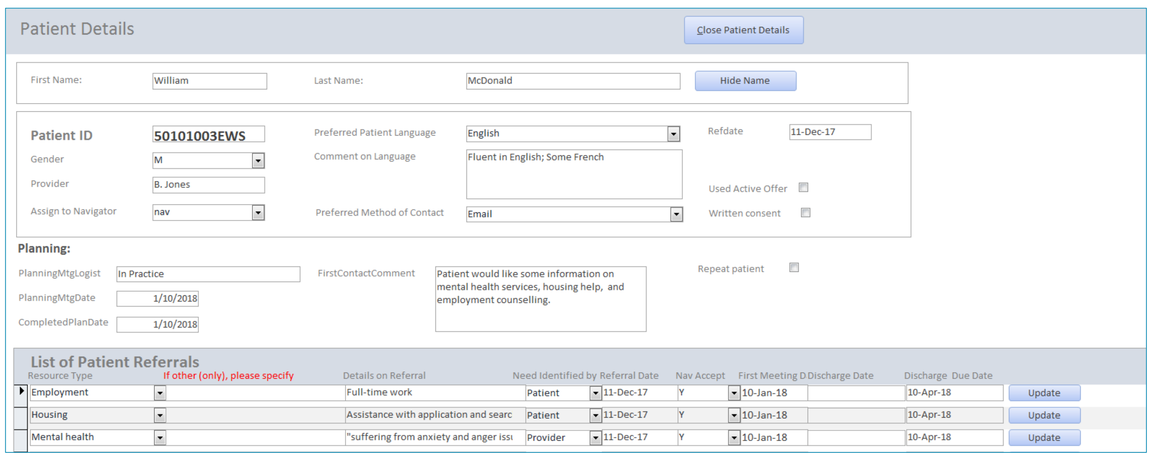
ADD ANY PERTINENT UPDATES TO STATUS OF ACCESS FOR EACH PRIORITY.

List of the encounters had between the patient and navigator.
"Navigator followed-up with patient by (TELEPHONE/E-MAIL) on (DATE), a voice message was left requesting callback."

Navigation services have ended on (DATE).

PROVIDER RESPONSE TO ARC TEAM (OPTIONAL) – FAX: 613-782-2777

Navigator Log



Conclusion

- The Referral Form was an effective tool to facilitate communication between PCPs and the Navigator about patient needs and potential CR.
- The Navigator Log enabled detailed data collection about patient encounters and CR. Based on this information, a comprehensive list of CR was shared with each PC practice to facilitate ongoing referral to community care.
- The Navigator Feedback form provided appropriate and timely information to PCPs about patients' participation in CR, their needs beyond the scope of ARC navigation, and completion of navigation services.
- The Navigator's physical presence within the PC practice provided an opportunity for on-site collaboration around patient care and assisted with navigation.
- Establishing and maintaining informational continuity between primary care and community care is complex. Collaborating with PC practices to tailor strategies to meet their informational needs, and creating relationships with community programs is required for effective communication.

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