



Geisinger

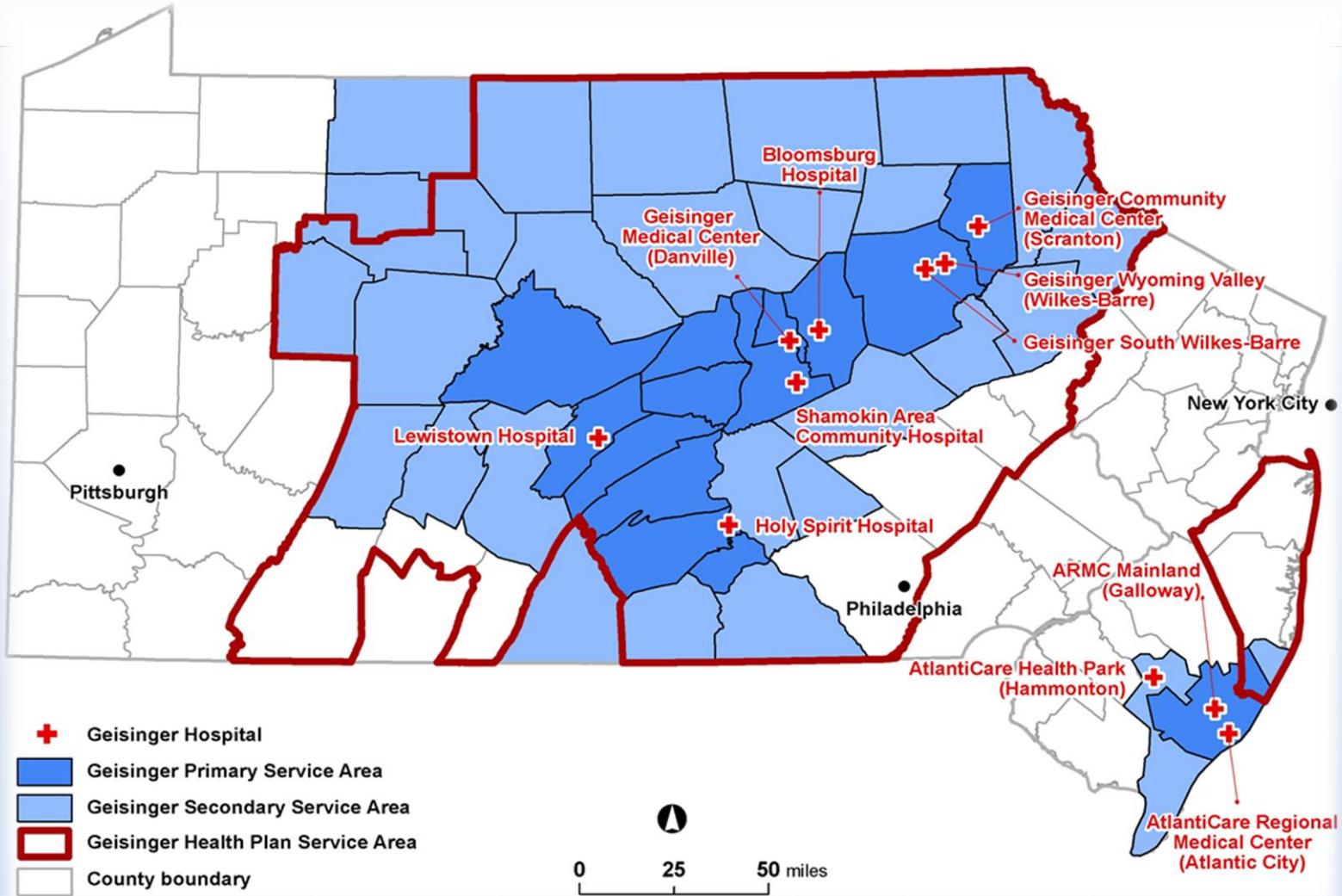
## **Impact of Patient Navigation in an Integrated Care Delivery System**

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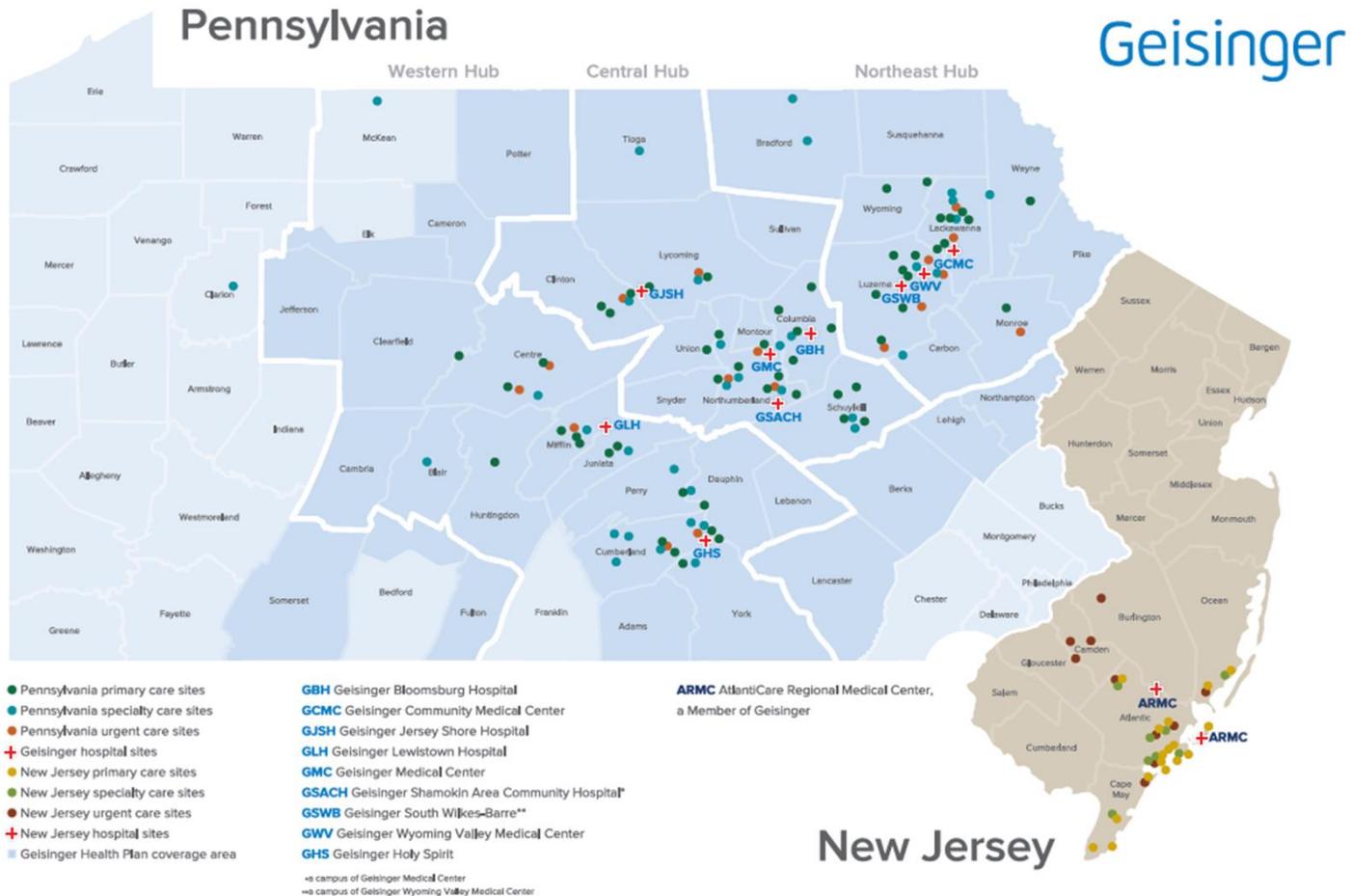
# Geisinger at a Glance

- 9 Hospitals in Pennsylvania covering 45 counties (of 67)
- 2 Hospitals in New Jersey covering 6 counties
- Serves 3 million Pennsylvania Residents
- 50 Primary Care offices
- 30,000 Employees
- RURAL
- 11 Hematology/Oncology specialty clinics in Pennsylvania
- 5 Radiation Oncology centers in Pennsylvania
- Geisinger diagnoses approx. 5000 cancers per year system wide

# Geisinger Health System service area



# Geisinger Specialty Care



# Geisinger Health Plan

- Covers 43 Counties
- 600,000 people insured

## Geisinger Health Plan-ProvenHealth Navigator

- 120 RN case managers
- Embedded within Community Practice Sites
- 26 Community Health Assistants (and their role)

# Geisinger's ProvenHealth Navigator®

Serving as the foundation for population health

## Patient Centered Primary Care

- PCP-led team-delivered care, with all members functioning at “top of the license”
- Enhanced access; services guided by patient needs and preferences
- Member and family education & engagement

## Population Health Care Management

- Population identification, segmentation and risk stratification
- Chronic disease and preventive care optimized with EHR, clinical decision support
- Care manager as core member within care team
- Automated interventions triggered by gaps in care

## Medical Neighborhood

- 360° care systems – SNF, ED, hospitals, home health, pharmacy, etc.
- Physician profiling, selective specialty/facility referral
- Transitions of care, community services integration

## Performance Management

- Patient and clinician satisfaction
- Cost of care, utilization, efficiency
- Quality metrics, addressing variations in clinical care

## Value-Based Reimbursement

- Bridging the journey between FFS and pay for value
- Embracing payment models that support population accountability – results share, upside risk, global budgets, etc.

# Geisinger's Oncology Navigation Beginning

National Cancer Institute-Community Cancer Center Program (NCCCP) awarded to Geisinger in late 2010

*Originally 2 years awarded, 2 additional received 2010-2014*

- Allowed for hiring of 4 RN Nurse Navigators to serve the community to bridge the gaps in care in our rural areas (suspicious findings routed to surgeon, oncologist, etc)
- Oncology Nurse Navigators placed in Geisinger Primary Care sites
- Nurse Navigators struggled to find ways to get new patient referrals and when to begin contact
- Data kept for NCI reporting purposes via Sharepoint

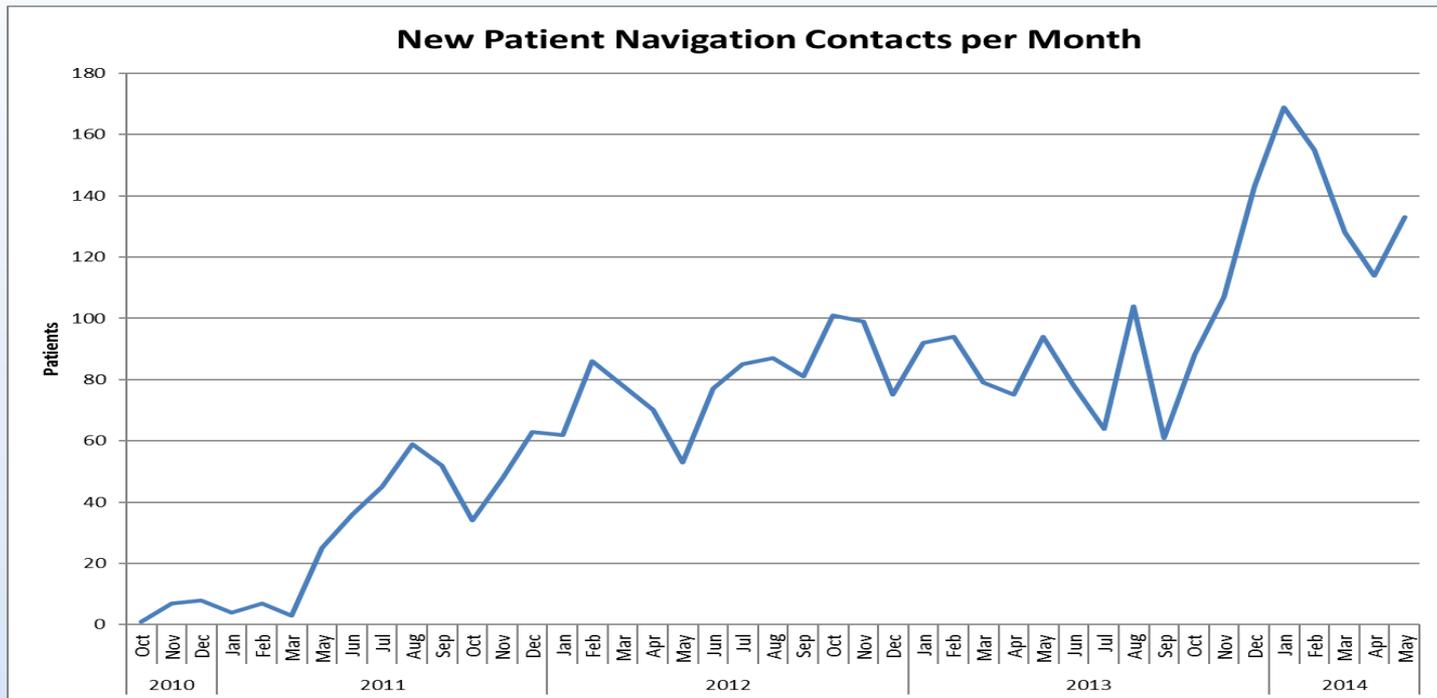
# Addition of Social Worker

- 2012 Departure of Nurse Navigator revealed need for more complex services for patients
- Departing nurse documented need for Medical Assistance, SSDI, psychosocial support, knowledge of community referrals, mental health assessment, medical crisis counseling, etc.
- Departing nurse replaced with MSW

# Addition of Social Worker

- This revealed need for changes associated with how navigation referrals received
- SW suggested move from Primary Care Sites directly into Medical and Radiation Oncology
- In 2013, all new patients were referred for navigation evaluation
- Change in documentation habits (DAP), began more formal assessment questions, community referrals

# NCCCP Navigation Stats 2010-2014



2010-2014 (4 navigators) total of 3343 contacts with patients

# Oncology Navigation Now

- 8 Total Navigators (5 MSW/3 RN)
- Covers 7 of 11 sites
- No direct data collection---currently capturing touches within Epic
- From 4/1/17 to 10/11/17----5976 touches!!! (this includes phone calls, documentation, orders, letters, etc within Epic)

# Role of Oncology Navigator

We “fill in the gaps in your cancer care”

- Transportation
- Lack of knowledge
- Financial Struggles
- Lack of insurance or *adequate* insurance
- Pain
- Mental Health (depression, anxiety, feelings of helplessness/hopelessness)
- Prescription Assistance
- End of life issues
- Bereavement/Coping
- Family Conflict
- Support Groups

Most Medical issues are covered by “specialty nurses”-RN’s assigned to each medical provider (chemo teaching, side effects, medications, refills, specialty pharmacies)

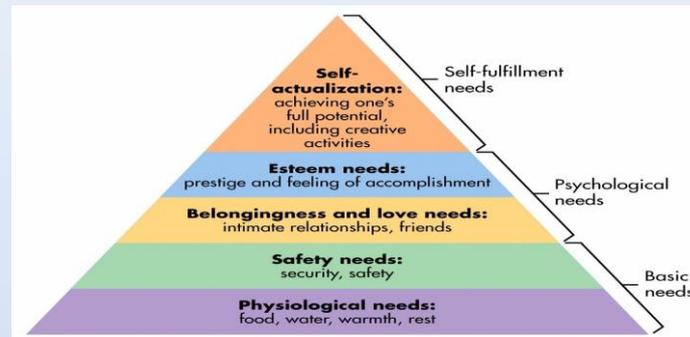
*There is an invisible line where one role ends and another begins*

# Navigation at Geisinger as a whole

- There are 60 Navigators (RN, MSW, lay) within the entire Geisinger System
- Most are funded and supervised within their own departments
- Some are scheduling (surgery/biopsies), gathering records
- Others are more of a supportive role

# Lessons Learned in Integrated Care

- Confidence that you are valued in the team—this requires BUY IN
- When people do not have their basic needs met, they are unable to achieve even the smallest tasks



- Gaining relationships with peers allows for better work flow, referral process—buy-in! (community involvement, medical home meetings, DOH work groups, suicide prevention task force)

# Lessons Learned in Integrated Care

- Unsure of needs? Focus on Community Health Needs Assessment (transportation, D&A, improving health behaviors)
- Learn resources in your community—you will need them! (where can you refer for D&A eval, MH eval)
- Peer support/supervision
- Self Care
- SATISFACTION
- Moving Forward---

# Pain Points

- Survivorship
  - Distress Screenings (and necessary follow up)
  - Not enough support services to care for EVERYONE
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## My Soapboxes

- Advance Directives
- Professional Boundaries

# Many Thanks!

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