

Community Health Team Wellness Navigation Framework

September 12th, 2012
Capital Health
Primary Health Care – Community Health Team

Community Health Team Wellness Navigation Framework

Introduction

The Wellness Navigation Framework will serve as the structure for the wellness navigation initiatives of the Community Health Team (CHT). Wellness Navigation is one of the two components of the overall Health and Wellness Program Framework. The other component is Wellness Programming. Wellness Navigators will help community members define and prioritize health and wellness needs and develop a plan to meet their needs by using their internal personal resources and linking them with health and/or community resources. Wellness Navigators will also link key components of the community together and build capacity of the knowledge base within the CHT community.

In developing the framework for Wellness Navigation, a comprehensive literature search was completed and information was gathered from navigators in Nova Scotia. The literature and the process of exploring navigation provincially revealed a lack of a Wellness Navigation framework. Therefore, frameworks that included a similar philosophy to the Community Health Team were explored and used to create a Wellness Navigation framework. This process is described in detail below.

Literature Review of Navigation

A comprehensive literature review was completed in 2010 using the following databases and terms: Pubmed: health promotion [mesh], navigat*, wellness, wellnes navigat* Pubmed: models of practice, model*, practic*, Primary health care [mesh], community health services [mesh], community health planning [mesh]; CINAHL: primary health care, community health care, navigat*, wellness, models of practice; Psych Info: navig*, wellness, wellness navigator. Other terms searched included: community based, community development, health promotion. The databases of ProQuest, Embase, Google Scholar were also searched.

Using the above search strategy, approximately 35 articles were identified that related to navigation. Most of the articles were related to cancer care. Two key articles were a qualitative synthesis of literature in cancer care (Wells, Battaglia, Dudley, Garcia, Greene, et al., 2008) and a systematic review of patient navigation outcomes in breast cancer (Robinson-White, Conroy, Slavish, & Rosenzweig, 2010). The reviewers found 16

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articles and 12 articles respectively that examined the effectiveness of patient navigation. Patient navigation was described as a barrier-focused time limited intervention, whereby navigators worked with individuals to remove barriers to accessing cancer care and reduce delays in accessing cancer care services (Wells et al., 2008). Additionally, patient navigators also provided education about cancer care and provided psychosocial support. The reviewers concluded that there is some evidence that patient navigation in cancer care is effective in terms of increasing participation in cancer screening and adhering to follow-up (Robinson-White et al., 2010 & Wells et al., 2008). Wells and colleagues found only two studies that examined non-medical outcomes. More specifically, a group ($n = 50$) who received patient navigation experienced lower anxiety and higher satisfaction after diagnostic resolution compared to usual care group ($n = 55$) another group ($n = 29$) who received patient navigation experienced fewer trauma symptoms and an increase in emotional well-being and cancer self-efficacy at nine month follow-up. Therefore, there is preliminary evidence that patient navigation in cancer care may reduce anxiety and improve well-being and self-efficacy. However, as most of the studies had methodological limitations, more research is needed to evaluate the effectiveness of patient navigation in cancer care.

Information for Provincial Navigators

Information was gathered from the following navigators within Nova Scotia: Acquired Brain Injury Navigator (CDHA), Stroke Navigator (CDHA), Breast Screening Navigator (CDHA), Geriatric Navigator (CDHA), Cancer Care Navigator Manager (Cancer Care Nova Scotia), Healthy Minds Navigator (Healthy Minds Cooperative). After a review of roles of the provincial navigators, the following themes emerged:

- 1) Many of the navigators did not have an electronic resource available to list all the resources and supports available to their target populations in the community. These resources were often kept in binders and are often a challenge to keep up to date.
- 2) Navigator roles are broad and specific. For example, some navigators are responsible for in depth biopsychosocial assessment and others are involved in research and developing healthy public policy. This is consistent with the results of a systematic review which revealed that "... the role of patient navigation is diverse with multiple roles and targeted populations" (Robinson-White, et al., 2010)
- 3) Many navigators have a target population (eg. people with a stroke or other brain injury, cancer, mental illness, or seniors) and also a geographical boundary (eg. CDHA, Dartmouth only, other health districts).
- 4) A holistic approach is a common theme among all the navigators in that they look at emotional, physical, and social aspects of health.

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- 5) Many navigators stated that patient navigation in Nova Scotia originated with the cancer care navigators.
- 6) There are no navigators existing that serve all the health and wellness needs of a community such as the proposed role of the wellness navigator for the CHTs.

Conclusion from the Literature Review and Review of Provincial Navigators

Patient navigation in the literature is focused on cancer care. There is some evidence that patient navigation in cancer care is effective in terms of screening and adherence to follow-up. In Nova Scotia, navigators have emerged from cancer care navigators and work with specific target populations. At present, there are no Wellness Navigators in the province or in the literature. It appears that Wellness Navigation is a new concept and therefore a framework for Wellness Navigation does not exist.

Guiding Frameworks

There is no existing framework for Wellness Navigation, therefore related frameworks were reviewed to help create a Wellness Navigation Framework. A *Framework of Support* and the *Supportive Care Framework* were reviewed as these two frameworks focus on the health and wellness needs of a community of people which is in keeping with the philosophy of the CHT.

A Framework of Support

A *Framework of Support* is a guiding framework for working with individuals with mental illness in the community (Trainor, Pomeroy, & Pape, 2004). This framework was chosen for review as it focuses on enhancing existing personal and community capacity and knowledge, which matches the philosophy of the CHT. The three core pillars of the *Framework of Support* are community, knowledge and personal resource bases. The community resource base shows that formal services are only one of the important influences that affect people's lives. It suggests a shift from a service paradigm to a community paradigm. The knowledge resource base is made of the various types of knowledge that Canadians use to understand and make sense of mental illness. The knowledge resource base implies that communication among the various components is needed to transform the way we understand mental illness. There is often a discrepancy between the importance of the knowledge the treatment system holds compared to the knowledge community members may hold about the illness. The aim is to bridge this gap so there is a better balance of the information available. The personal resource base creates a new model for how people with mental illness can see themselves and how they are seen by others. It is based on a balance between the reality and challenge of illness and the resources that are needed to deal with it and live

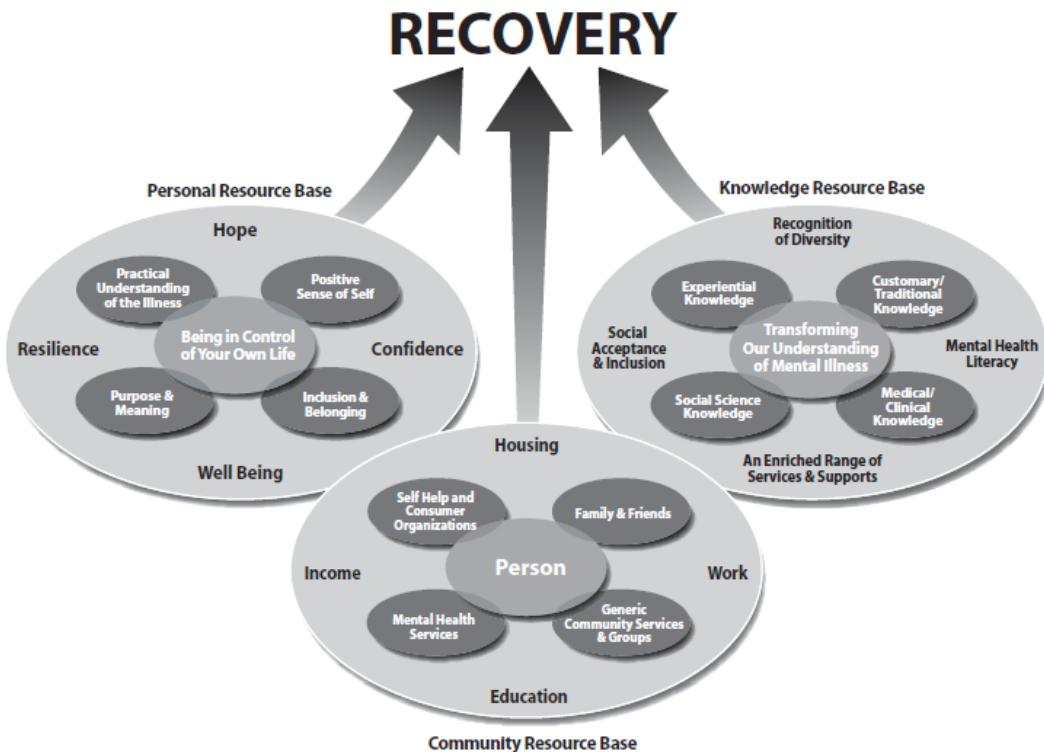
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a full life. It illustrates a fuller view of people with mental illness by emphasizing more than just their mental health problem. The components, considered together describe someone who feels a sense of control over their life, a critical element of mental health for all people.

The *Framework of Support* has many elements in common with health promotion, which aligns with the overall model of the CHT. “The Framework model, although developed largely outside the mental health promotion field, has many elements in common with mental health promotion. It recognizes the importance of the knowledge and experience of people with mental illness and their families, emphasizes participation in decision making as well as power and control, and focuses on the promotion of mental health and the journey to recovery rather than on simply treating the illness.” (Trainor et al., 2004, p.5). This Framework was recognized in the 1997 report on Best Practices in Mental Health Reform as best practice in mental health policy. The framework has been used to launch discussions about promoting the health of other target groups by re-placing the person in the centre of the model with other target populations. (Trainor et al., 2004). By using this framework it implies a shift from the service paradigm to the community process paradigm, a fundamentally important component of the CHT.

Three Pillars of Recovery



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Supportive Care Framework

The *Supportive Care Framework (SCF)* was created by Margaret Fitch and is the foundation for person-centred cancer care in the community (2008). “The most important role that the Supportive Care Framework serves is to ensure a patient-centric system of care that meets the needs of the cancer population and their families irrespective of where they live” (Fitch, 2008). Fitch explains further that “Supportive care seeks to improve and preserve the quality of life, autonomy and dignity of those living with and affected by cancer. It is aimed toward empowerment and optimizing wellness”. Additionally, interventions must consider the individual’s frame of reference and desired goals for interventions to be successful. The person’s individual needs are the driving force in their own lives. A range of expertise may be required to help a person along their wellness journey. The patient might require emotional support, education, and referrals to other supports or community groups. There may be a need for a network of organizations and agencies, professional and volunteer, working collaboratively to provide the full spectrum of support. It is not only the health care sector that provides supportive care, but also community organizations, family physicians, self-help agencies, churches, and other community groups may provide a person support. The *SCF* and its application’s in health care provided in the community have been extensively researched (Fitch, 2008).

Cancer Care Nova Scotia has the *SCF*, aligned with the Continuity of Care literature, to develop a patient navigation model called the Cancer Patient Navigator (CPD) Program currently being used throughout the province. The report entitled “Navigating the Cancer Care System” highlighted the following as a means to enrich the patient and family’s journey through the cancer care system: relationship with his/her doctor, accessibility to resources and information, support systems, level of interaction with the health care system, and the communication among health professionals (Cancer Care Nova Scotia, 2001). The Cancer Patient Navigator (CPD) program consists of two dimensions: 1) health system oriented and 2) patient-centred. The first dimension describes the continuity of care and includes informational, management and relational continuity. The second dimension refers to empowerment, including active coping, cancer self management and supportive care (Abstracts of the IPOS 12th World Congress of Psycho-Oncology, 25–29 May 2010, Quebec City, QC, Canada).

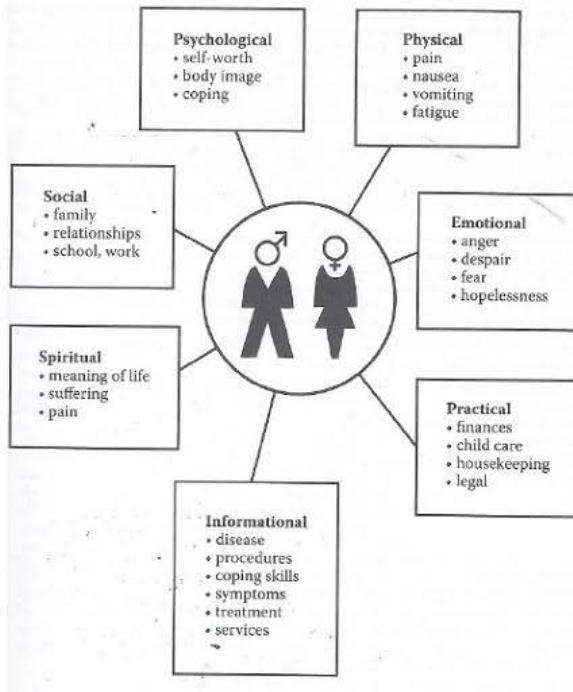


Figure 2: Supportive Care Needs for Individuals with Cancer

Although the *SCF* was created for use with individuals with cancer, it has been successfully used with groups with other chronic health conditions (Blackadar & Houle, 2009; Egan, Anderson, & McTaggart, 2010). The key components from the *SCF* that will be used in the wellness navigation framework in the CHT are to acknowledge that as individuals and family members live through their journey to wellness, they will experience physical, emotional, social, psychological, spiritual, informational and practical changes that impact on the needs that they experience (Figure 2).

Wellness Navigation Framework

As stated in the beginning of this document, Wellness Navigators will help community members to define and prioritize health and wellness needs and develop a plan to meet their needs by using their internal personal resources and linking them with health and/or community resources. Wellness Navigators will also link key components of the

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community together and build capacity of the knowledge base within the CHT community.

The following is the proposed model for Wellness Navigation for the Capital District Health Authority Community Health Teams. The model is adapted from CMHA's "A Framework for Support."

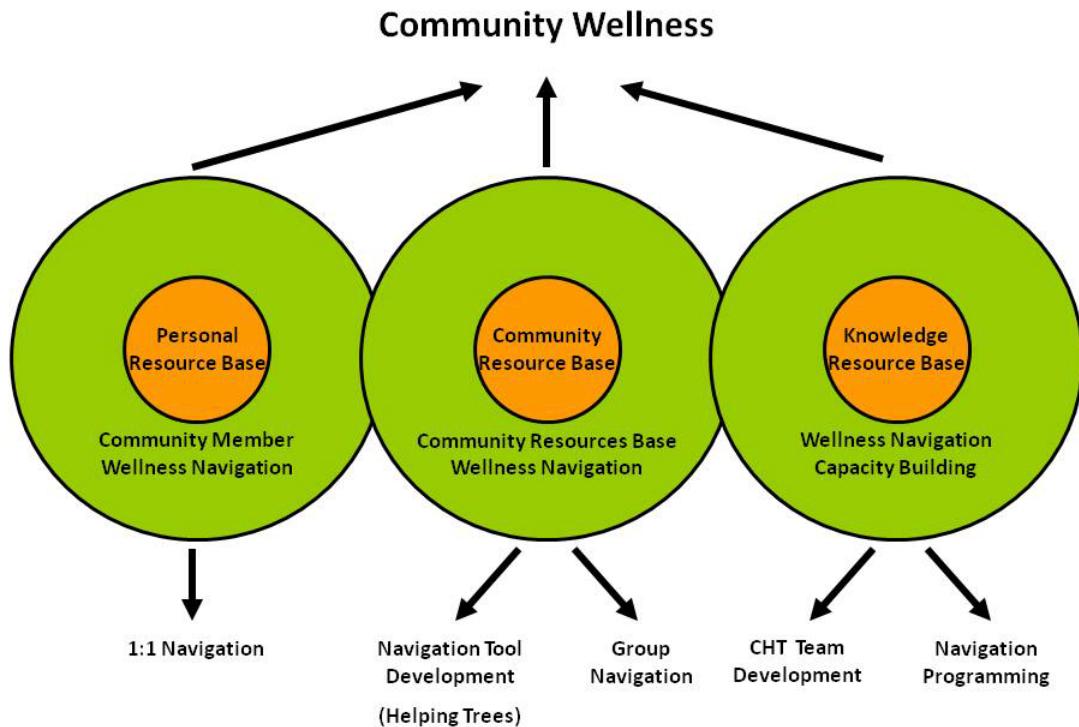


Figure 3: Community Health Team – Wellness Navigation Framework Model

Objectives of Wellness Navigation

- 1) To work with individual community members to define and prioritize his/her health and wellness needs and develop a plan to meet his/her needs by helping individuals to use his/her internal personal resources and linking him/her with health and/or community resources.
- 2) To decrease barriers community members experience when trying to access health and/or community resources.
- 3) To create partnerships and relationships between individuals, family, friends, community resources and groups, health services, and self help organizations.
- 4) Building capacity of community members, groups, organizations and the CHT in navigation skills by increasing knowledge and access to health and wellness resources.

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Process of Wellness Navigation

Wellness Navigation consists of 3 components:

- 1) Community Member Wellness Navigation
- 2) Community Resource Base Wellness Navigation
- 3) Wellness Navigation Capacity Building (Programming and Team Development)

Each of these components was designed to enhance each of the resources bases and is outlined in Figure 3.

1) Community Member Wellness Navigation (Appendix F)

Step 1: Referral

The CHT promotes self management in all its programs. Self referral to wellness navigation is encouraged to ensure the community member is engaged in the wellness navigation process. Therefore, community members can self refer for wellness navigation and arrange an appointment to meet with the Wellness Navigator by:

- Phoning the Wellness Navigator or the CHT office
- E-mailing the Wellness Navigator or the CHT office
- Dropping into the CHT

Additionally, family members, staff of community organizations, family physicians, other health professionals, and other support persons can refer a community member to the Wellness Navigator by:

- Phoning the Wellness Navigator or the CHT office
- E-mailing the Wellness Navigator or the CHT office
- Dropping into the CHT
- Faxing a request (usually occurs by family physicians)

The community member will then be contacted by the Wellness Navigator to insure that he/she is in need of and agrees to see the Wellness Navigator and an appointment will be made.

Step 2: Registration

At the initial appointment with the Wellness Navigation, the Community member will be registered with the CHT in STAR. Each subsequent contact with the community member will be registered.

Step 3: Informed Consent/Confidentiality

The Wellness Navigator will ask the community member to read the informed consent and confidentiality document (see consent form Appendix E). The Wellness Navigator will offer to read the consent out loud if necessary. He/she does not need to sign this consent. An opportunity will be given to ask questions about the consent.

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Step 4: Release of Information

- Information will be gathered from the community member's support system if deemed necessary.
- Consent to share information can be obtained verbally (documented in the community members' electronic health record) or in writing (Release of Information) consistent with policies and procedures of Capital Health.
- It is not legally necessary to obtain written or verbal consent to speak to a support within Capital Health, IWK or Primary Care (family physicians), however it is a good practice to ask permission to speak on someone's behalf.

Step 5: Documentation

- A summary of the work will be documented in the community member's electronic record (HPF) and a copy sent to the family doctor in accordance with CDHA documentation policy and procedures. This will be documented on a Capital Health progress note or written as a "Community Health Team Visit Summary" (see Appendix B).
- Guidelines for topics to document are highlighted in the CHT Visit Summary Guidelines (Appendix C).
- Significant interactions with the community members will be documented in the community member's electronic record (HPF)

Other:

Telephone Practice

- Telephone practice is carried out by the Wellness Navigator consistent with Policy & Procedure CC 90-050 *Interdisciplinary Telephone Practice*.
- Telephone practice is documented according to CDHA documentation policy and the standards of the Health Care Professional.
- It is important to note for the purpose of this policy and the CHT that "generic requests for information not related to individual client specific care do not constitute telephone practice (e.g. a request for community resources)."
- Telephone practice can be documented on form CD0895MR_10_08 entitled "Telephone Consultation/Documentation." Telephone practice can also be documented by dictating if it is explicitly stated in the beginning of the dictation that it is a telephone intervention/consultation. Telephone practice can also be documented in a CHT visit summary if it clearly stated in the report that the interaction with the client was through telephone.

Email Correspondence Guidelines

- Clients can use the CHT email address (cht@cdha.nshealth.ca) or the Wellness Navigator e-mails (DartmouthWellnessNavigator@cdha.nshealth.ca & ChebuctoWellnessNavigator@cdha.nshealth.ca) to send general questions; however, clients cannot use this email address to send personal information. If the CHT

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receives an email with personal information, they are not to reply to the email but must create a new email, asking them to call the CHT. We cannot reply to an email with personal information in it as the history will be attached and that makes the CHT liable for not responding to any medical related issues.

Department of Health is in the process of creating guidelines to govern e-mail correspondence with clients in a health care setting. When these are completed the CHT will follow these guidelines.

Barriers: Any barriers that prevent or limit access all health and community resources and services

Wellness Navigation Support Type - services Provided by the Wellness Navigator

- Referrals to community resource
- Interim Follow-up (if on waitlist)*
- Registration for CHT program
- Behaviour change support
- Education provided
- Advocacy
- Outreach (phone calls, e-mail, home visit, community visit)**
- Emotional Support
- Practical needs addressed (help with transportation, filling out forms)

*In rare incidents someone requires ongoing support whole on a waitlist.

** Follow-up and home visits occur on a rare basis.

Types of Navigation Outcomes

- Internal CHT (referral to programs or team members within the CHT)
- Internal Health (referral to CDHA including family doctors and IWK)
- External Health (referral to other health authorities, private practice, dentists)
- Internal Community (referral to community organization or resource within the CHT community)
- External Community (referral to community organization or resource outside the CHT community)
- Other

There are two methods a person can be connected to a community resource:

- Formal link created (referral completed)
- Informal Link created (provide information on resource)

Summary of client needs: the identification of health and wellness needs. The following are examples of needs that may be identified by the client with the wellness navigator.

- Behaviour Change
- Management of a chronic condition
- Emotional wellness

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- Physical Activity
- Nutrition
- Referral to an external resource
- Social Connections
- Weight management

2) Process of Community Resource Base Wellness Navigation

Community Resource Base Wellness Navigation will focus on developing community tools and resources to promote self management and to improve the ability of community members to connect to health and community resources. The Wellness Navigator will build relationships and partnerships with community groups and organizations and provide group navigation to expand the CHT's relationship with the Community Resource Base.

Community Wellness Navigation - Tool Development

The provincial government has approved the development of a 211 service in Nova Scotia. 211 is a three digit telephone number that links people to community, social, health and government services and programs easily and quickly. Combined with an on-line service, 211 is free, multi-lingual and is available 24/7. It is anticipated that 211 will be operational in 2013.

Helping Trees

Three helping trees have been developed for Dartmouth and Chebucto (Appendix D).

- 1) General Dartmouth Helping Tree – Developed in partnership with the Dartmouth Community Health Board, Self Help Connection and Halifax Regional Municipality Community Developer.
- 2) Seniors Dartmouth Helping Tree – Developed in partnership with the Geriatric Navigator (CDHA) and Senior community members.
- 3) Spryfield Helping Tree – Developed in partnership with Bayers Road Community Mental Health, Healthy Minds Cooperative, Public Health, and Chebucto West Community Health Board (not a project of the Chebucto Community Health Team).

Community Group Navigation

Community groups can access the Wellness Navigator or other CHT staff to navigate through the community resource base. Groups can access the Wellness Navigator through e-mail, phone, or drop-in. Group navigation occurs when any community group is linked to another community group through the CHT. For example: a self help group may contact the CHT to be linked to a part of the health service system in order to receive education. The Wellness Navigator or CHT staff maintains contact with the two community groups until it is determined that additional group navigation is no longer required.

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3) Wellness Navigation Capacity Building: Programming and Team Development

Wellness Navigation Group Programming

Wellness Navigation Programming is consistent with group programming guidelines of the CHT. The focus of this programming is to promote community capacity building around navigation skills. The Wellness Navigator is responsible for implementing the development of these programs. These programs can be implemented by partnering with other community members or organizations with expertise in Wellness Navigation. For example: The first wellness navigation program titled “Navigating Seniors Resources and the Pharmacy System” was developed and delivered in partnership with the Geriatric Navigator/ Geriatric Assessor and Patient Care Pharmacist with Capital Health.

CHT Team Development (Wellness Navigation)

The purpose of team development around Wellness Navigation is to increase the capacity of the CHT staff to support community members with navigation needs. The Wellness Navigator will assess the educational needs of CHT staff to determine team development needs regarding wellness navigation. The Wellness Navigator will design and implement workshops & education sessions to CHT staff around Wellness Navigation on an as needed basis. CHT staff will be encouraged to attend Wellness Navigation programming to increase skills and knowledge base around navigation.

Wellness Navigator Role versus CHT Staff Role

The Wellness Navigator is responsible for implementing the *Wellness Navigation Framework* of the CHT. Within this framework there are key responsibilities for CHT staff. The Wellness Navigator supports CHT staff with these responsibilities by building the capacity of the team and acting as a resource to the team around Wellness Navigation.

Role of Wellness Facilitators (WF)

1) Community Member Wellness Navigation

All Wellness Facilitators perform wellness navigation when it is within their ability and scope of practice to do so. When WFs work with people who have complex needs and/or needs outside of the Wellness Facilitator’s expertise, these community members are referred to the Wellness Navigator for his/her expertise in wellness navigation.

2) Community Resource Base Wellness Navigation

Group Navigation – WFs may be involved in navigating groups within the community resource base. If WFs take the lead in navigating groups, they are responsible for maintaining contact with the groups until it is determined that the two groups no longer require further navigation. WFs are responsible to inform the Wellness Navigator about group navigation so duplication of services does not occur.

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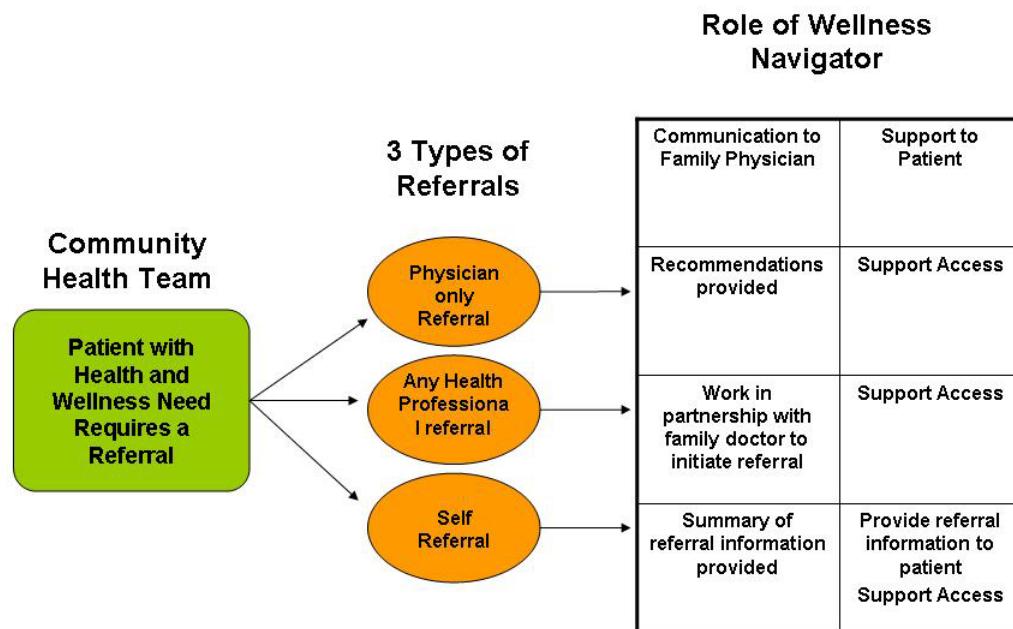
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3) Wellness Navigation Capacity Building (Programming and Team Development)

Wellness Navigation Programming can be done collaboratively between Wellness Navigators and Wellness Facilitators. For example, if WFs have expertise in an area of Wellness Navigation programming, WFs can design, implement and co-facilitate the program with the Wellness Navigator. WFs can inform the Wellness Navigator of team development needs around Wellness Navigation on a regular basis to guide creation of team development initiatives.

Communication Plan – Primary Care

Wellness Navigation is designed to support and compliment the on-going work of primary care providers. The CHT completed a physician engagement around Wellness Navigation to determine the best methods to promote communication between Family Doctors and Wellness Navigators. On-going conversations and developing relationships is required to further create guidelines around communication with family physicians as the engagement was limited in numbers of physicians who could attend. See figure below for an outline of the role and process of the Wellness Navigator in supporting primary care providers in referrals.



During wellness navigation with individual clients, referrals to other services may be recommended. This information will be shared with the client's family doctor using the following guidelines:

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1. Physician-only referrals: The Wellness Navigator (WN) will share observations or make suggestions to the family physician. This can be done through faxing documentation or calling the physician directly. The physician can then choose whether or not they will conduct a medical assessment to determine the most appropriate referral. The WN will offer support in completing referral forms where appropriate.

Example: Client presents with signs and symptoms of an eating disorder. The WN will share these observations with the physician over the phone. Possible resources may be discussed. Services that require a physician-only referral will not be discussed directly with the client so that the patient is not set up with specific expectations (such as the Eating Disorders Clinic). If the physician intends to refer to another service, the WN may offer to print the referral form and fill out non-medical sections, and then fax it to the physician for completion and final referral.

2. Health Professional or Self Referral: The WN and/or the client will make the referral. If the client's presenting problem is of an urgent nature, the WN will phone the physician to inform him/her of the issue and the referral that was made. If it is non-urgent, the referral will be communicated to the family doctor in the form of a progress note or CHT visit summary and sent by fax within 72 hours of contact.

Evaluation

- Wellness Navigation Evaluation will be aligned with the Evaluation Framework for the CHT.
- Evaluation Tools are outlined in the document "Requirement Specification Document for CHT Wellness Navigation"
- Shared Point/ Infopath is currently the program being used for collecting on-going data on group and one on one wellness navigation.
- Review of the literature on evaluation tools is on-going.

Appendix A

(Wells, et al., 2008) Outcomes of Published Patient Navigation Efficacy Studies.

Citation	Cancer	Design	Participants, Location	Outcome Measures	Results
Cancer Screening Studies					
Dignan et al., 2005 ²⁹	Breast	Prospective RCT (face-to-face navigator intervention, telephone navigator intervention, control)	157 Native American women, Denver, Colorado	Adherence to mammography screening guidelines.	Participants in either intervention group more likely to receive mammography according to guidelines after intervention than before intervention. Telephone intervention more effective than face-to-face intervention.
Fang et al., 2007 ³⁵	Cervical	Prospective comparison of cervical cancer screening intervention plus patient navigation or control group that received 2 hour general health education session	Korean American women (50 in control group; 52 in intervention group)	Difference between intervention and control in receipt of pap screening at follow up.	39 of 52 intervention participants requested navigation services. Intervention participants more likely to receive pap smear than control participants ($p<.001$).
Jandorf et al., 2005 ⁴⁵	Colorectal	Prospective RCT (patient navigation or control)	40 participants in control group; 38 participants received patient navigation, East Harlem, New York	Colorectal cancer screening adherence	1. At 3-month chart review more patient navigation participants scheduled endoscopy appointments ($p=.005$) 2. At 6-month chart review, more patient navigation patients had completed an endoscopy ($p<.02$)
Nash et al., 2006 ⁴⁸	Colorectal	Retrospective, comparison of patients who received care before and after patient navigator plus gastrointestinal suite improvement intervention.	1,767 patients who received diagnostic or screening colonoscopies either before or after intervention; Patients who completed preadmission testing. Bronx, New York	1. Rate of colonoscopies 2. Rate of broken appointments	1. Increase in number of people who received screening colonoscopies. 2. Broken appointment rate declined from 67.2% to 5.3%.

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Citation	Cancer	Design	Participants, Location	Outcome Measures	Results
Rahm et al., 2007 ⁵²	BRCA1/2 genetic	Prospective RCT	125 participants referred for genetic counseling, Kaiser Permanente, Colorado	1. Genetic counseling participation within 9 months of referral 2. Time from referral to completed genetic counseling appointment.	1. No significant difference in appointment attendance between navigation and usual care. Not enough power to detect differences. 2. Patient navigator intervention participants had appointments scheduled significantly sooner than usual care participants.
Tingen et al., 1998 ⁵⁷	Prostate cancer	Prospective RCT. Sites randomized to traditional prostate cancer education, peer-educator only, client-navigator only, or combination of peer-educator and client-navigator.	1522 participants in a prostate cancer screening program, southeastern state	Participation in free prostate cancer screening.	In multiple logistic regression, participants who received either client navigation intervention or combined intervention more likely to participate in screening program than prostate cancer education participants.
Weinrich et al., 1998 ⁵⁸	Prostate cancer	Prospective RCT. Sites randomized to traditional prostate cancer education, peer-educator only, client-navigator only, or combination of peer-educator and client-navigator.	1717 participants in a prostate cancer screening program, southeastern state	Participation in free prostate cancer screening.	African-American and total study participants who received either client navigation or peer education intervention more likely to participate in screening program than traditional intervention participants. Participants who received education alone were as likely to participate in screening as combined peer education and client navigation intervention participants.
Cancer Care Following Abnormality					
Battaglia et al., 2007 ²⁷	Breast	Retrospective comparison of women seen before and after navigation intervention	1332 women with abnormal screening, Boston, Massachusetts	Timely follow up from referral to diagnostic resolution	Navigation participants more likely to have timely follow-up than participants screened before intervention. Intervention effect remained after (1) controlling for race, age, insurance status, reason for referral and source of referral; and (2) using propensity score analysis to adjust for differences in

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Citation	Cancer	Design	Participants, Location	Outcome Measures	Results
Ell et al., 2002 ³²	Breast	Prospective, study enrollees compared to non-enrollees. Intervention included health education, navigation, and counseling	Women who received abnormal mammograms. 605 participants were compared to 695 nonenrollees, Los Angeles, California; and New York, New York.	1. Adherence to follow up care following abnormal mammogram. 2. Timeliness of diagnostic resolution. 3. Timeliness of initiation of cancer treatment.	pre and post intervention samples. 1. Intervention participants more likely to adhere to follow up recommendations than non-enrollees. 2. Enrollees more likely to get to diagnostic resolution in a timely manner than non-enrollees. 3. Non statistically significant difference in timeliness of initiation of cancer treatment between enrollees and nonenrollees.
Ell et al., 2002 ³³	Cervical	Prospective, study enrollees compared to non-enrollees. Intervention included health education, navigation, and counseling	Women with low grade and high grade squamous intraepithelial lesions prescribed follow up repeat screening. 196 women enrolled in study compared to 369 non-enrollees, Los Angeles, California	Adherence to follow up appointments.	Intervention participants had significantly better rates of adherence to at least one follow up appointment ($p=.0002$ and $p=.0001$).
Ell et al., 2007 ³⁴	Breast	Prospective RCT (patient navigation plus counseling or usual care)	Women who received abnormal mammograms (96 in intervention group; 108 in control group), Los Angeles, California	1. Adherence to diagnostic follow up through diagnostic resolution. 2. Timely adherence from index screen to diagnostic resolution 3. Timely entry rates for cancer patients.	1. Intervention group participants more likely to adhere to diagnostic follow up than usual care participants or women who did not participate in study. 2. Intervention group participants had more timely adherence than usual care participants and non-participants. 3. Intervention participants diagnosed with cancer were more likely to have timely entry rates

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Citation	Cancer	Design	Participants, Location	Outcome Measures	Results
Ferrante et al., 2008 ⁶⁵	Breast	Prospective RCT (usual care or usual care plus patient navigation)	Women with suspicious mammogram results (BIRADS 4 or 5). 50 participants assigned to usual care, 55 participants assigned to usual care plus patient navigation. Newark, New Jersey	1. Time from abnormal mammogram to date of diagnostic resolution. 2. Differences in anxiety and satisfaction between usual care and intervention groups	(diagnosis, treatment) than usual care participants. 1. Mean diagnostic interval less in intervention group than usual care ($p=.001$) 2. One month after diagnostic resolution, anxiety lower and satisfaction higher in intervention group when compared to usual care ($p<.001$).
Freeman et al., 1995 ³⁷	Breast, cervical, prostate, colorectal	Prospective, patients who received navigation compared to patients who did not receive navigation	1. Patients with an abnormal screening test for breast, cervical, prostate, or colorectal cancer (n=1136). 2. Patients with cancer (n=8). Harlem, New York.	1. Whether participants obtained a biopsy following a suspicious/abnormal finding. 2. Amount of time to complete biopsy.	1. Non significant finding that 85.7% of navigated patients obtained a biopsy whereas 56.5% of non-navigated patients completed a biopsy. 2. 71.4% of navigated patients completed biopsy in less than 4 weeks whereas 38.5% of non-navigated patients completed the biopsy in less than 4 weeks ($p=.047$)
Giese-Davis et al., 2006 ⁴¹	Breast	Prospective, pre-post comparison of navigation participants	29 women recently diagnosed with breast cancer, Santa Cruz, California	Change over time (baseline, three months, six months, nine months) in depression, trauma symptoms, desire for information on breast cancer, emotional and social quality of life, self-efficacy to cope with cancer, and doctor-patient	Trauma symptoms and desire for breast cancer resource information decreased and emotional well-being and cancer self-efficacy increased.

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Citation	Cancer	Design	Participants, Location	Outcome Measures	Results
Nash et al., 2006 ⁴⁸	Colorectal	Retrospective, comparison of patients who received care before and after patient navigator plus gastrointestinal suite improvement intervention.	1,767 patients who received diagnostic or screening colonoscopies either before or after intervention; Patients who completed preadmission testing. Bronx, New York	relationship 1. Rate of colonoscopies 2. Rate of broken appointments	1. Increase in number of people who received screening colonoscopies. 2. Broken appointment rate declined from 67.2% to 5.3%.
Oluwole et al., 2003 ⁵³	Breast	Retrospective, comparison of patients who received care before and after intervention that included patient navigation, free cancer screening, and health education	12,480 patients seen following intervention implementation from January 1995 to December 2000; 324 patients diagnosed with breast cancer. Comparison group received care from 1964 to 1986. Harlem, New York	1. Stage at diagnosis 2. Survival	1. Reduction in late stage (III and IV) disease at presentation, from 49% before intervention to 21% after intervention ($p<.001$). 2. Significant increase in early stage diagnosis (0 and I), from 6% before intervention to 41% after intervention ($p<.001$). 3. Crude 5-year survival rate of patients treated after intervention was 70.2%, compared with 39% 5-year survival rate of women with surgically treated cancer before intervention
Psooy et al., 2004 ⁵¹	Breast	Retrospective, comparison of patients who received care before and after patient navigation program	536 patients who underwent core breast biopsy. Nova Scotia, Canada	Time from screening abnormality to diagnostic resolution.	Patient navigator intervention participants had significantly less time from screening abnormality to biopsy ($p<.001$).

RCT=randomized controlled trial

From: [Cancer. Author manuscript; available in PMC 2009 October 15.](#)

Published in final edited form as:

Cancer. 2008 October 15; 113(8): 1999–2010.

doi: 10.1002/cncr.23815.

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Appendix B
Community Health Team Visit Summary

To: _____

From: _____

Re: _____ DOB or HCN: _____

Visit Date: _____ Referral Source: _____

Identified Health & Wellness Needs:

Readiness to Change:

Barriers to Accessing Resources:

Ability to Self Manage:

Plan:

Suggestions/ Recommendations to family doctor:

CHT Staff Signature: _____

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Appendix C

Visit Summary – Guidelines

- To be completed by Wellness Facilitator when doing one to one navigation. Ensure the date of actual contact with the client is the same as date on the form so it corresponds between STAR and HPF.
- Complete the form; then stick ID label with patient information in upper right hand corner; then stick bar code sticker “correspondence” in lower left hand corner.
- Fax to family doctor, within 24-48 hours of visit.
- After faxing, place in internal mail envelope, addressed to HPF.

Factors to Consider:

Identified Health & Wellness Needs:

- > behavior change > management of chronic conditions
- > social connection > emotional wellness > physical activity > nutrition
- > weight management
- > referral to external resource (eg. employment support, housing agency, etc.)
- > discrepancy between intent of provider referral and client's identified needs/plan

Readiness to Change:

- > Red, yellow or green light based on following questions: i) Do I consider my ____ to be a problem? ii) Am I bothered by my ____? iii) Am I interested in changing my ____?
- iv) Am I ready to change now?

Barriers to Accessing Resources:

- > transportation > financial > childcare > literacy/education
- > physical/social environment > mobility > job responsibilities
- > mental health disability > physical health disability

Ability to Self Manage:

- > independent personality type > resilience > good cognitive ability
- > high health literacy > strong support network
- > adaptive coping skills > demonstrated resourcefulness
- > past successes > “green light” readiness for behavior change

Plan:

- > Provided Education > Provided Emotional Support
- > Referrals such as: CHT Program, Internal Health, External Health, Internal Community, External Community
- > CHT Follow Up

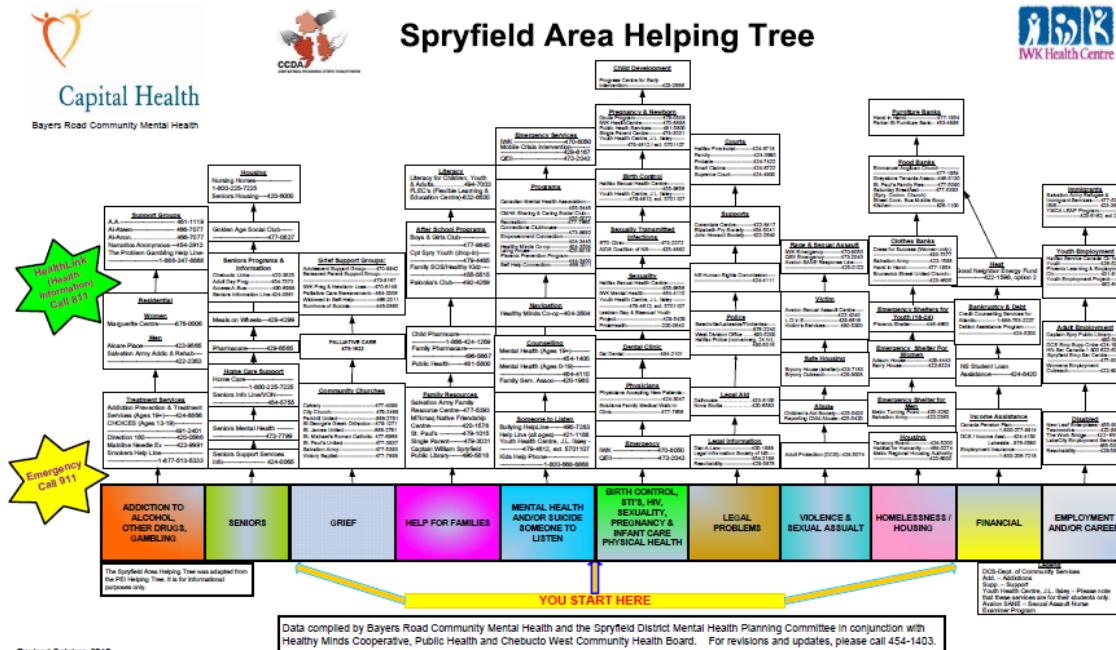
Suggestions/ Recommendations: A follow up recommended to physician or care provider.

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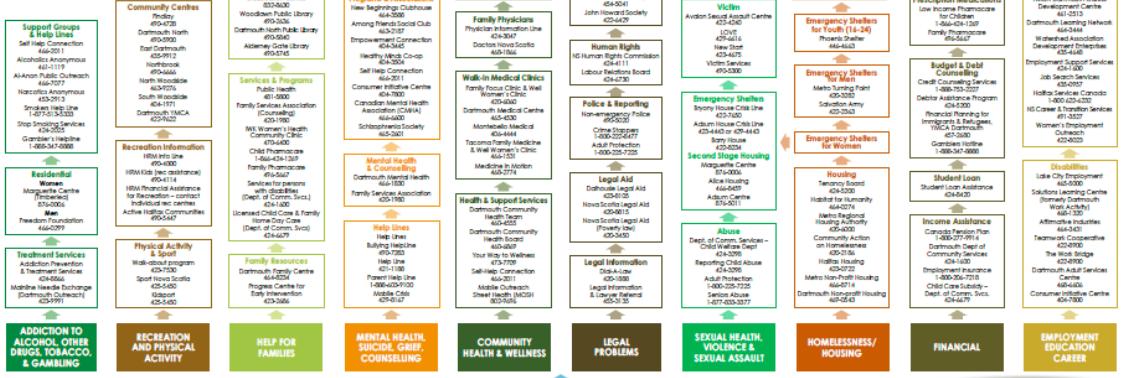
Appendix D

23



DARTMOUTH HELPING TREE

This tool was designed by the Dartmouth Community Health Board, Community Health Team, HEM Community Development, and The Self-Help Connection to assist service providers and inform residents of the many helping resources available. If you or someone you care about is experiencing a problem in any of the areas listed, follow the arrows on the flow chart to find resources that may help.





For pdf copy of helping trees please see www.communityhealthteams.ca

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**Appendix E –
Informed Consent / Confidentiality**

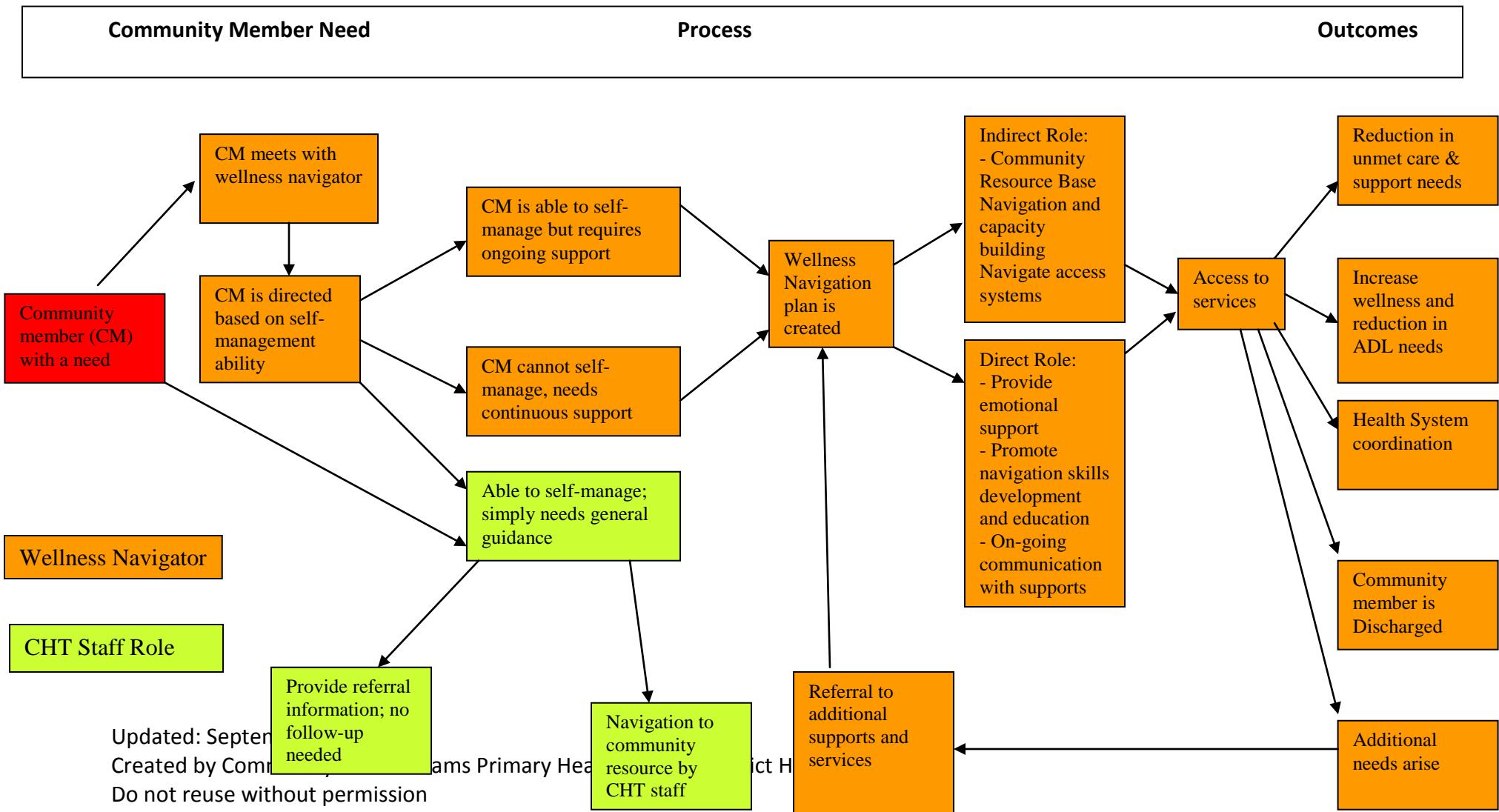
The Community Health Team (CHT) provides health and wellness services in the form of group programming and when needed, individual help connecting with community resources (wellness navigation). During your participation in these services, records will be kept of the referrals provided and the information you provide that is relevant to your care.

This information will be held in your Health Record. Your Health Record is kept confidential. No information from your Health Record will be shared unless you sign a release of information form. Please be advised of the following exceptions to this rule:

- Your Health Record may be shared with your family doctor and/or other healthcare providers involved in your care.
- If circumstance arise where there is a risk of serious injury or harm to yourself or others, some confidential information from your Health Record may be released to ensure your safety and that of others.
- In certain circumstances, we may be required by law to disclose what would otherwise be confidential information, such as when we are served with a court order, or where there is suspicion of child or adult abuse.

Please be advised that the communication of your Health Record complies with all Capital Health policies in relation to the protection of your confidential personal health information. If you have any questions regarding the above information, please do not hesitate to ask, and a CHT staff member will be happy to answer your questions.

Appendix F – Wellness Navigation Logic Model



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