

Colonoscopy Patient Navigator Program Orientation Manual



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Welcome to the Patient Navigator Orientation

Welcome to the Patient Navigator Orientation Program and congratulations on becoming a Patient Navigator. This training begins by reinforcing your mission as a Patient Navigator and the knowledge and skills you will acquire that will save the lives of patients in the community

New York City's Department of Health and Mental Hygiene developed this program with the assistance of experienced Patient Navigators. Its purpose is to provide a new cadre of Patient Navigators with the tools they will need to effectively help patients obtain cancer screening and to save lives.

As a Patient Navigator, you are embarking on an exciting career that will provide many rewarding experiences. You will help save lives by helping your patients deal with the challenges of obtaining the health care they need to prevent or diagnose colon cancer. To succeed in this undertaking it will be important to keep in mind that your actions can make a difference. These include:

- ◆ Maintaining enthusiasm for the work that you do;
- ◆ Keeping confidences shared by the patient and medical staff;
- ◆ Being open to learning new techniques;
- ◆ Being open to cultural differences;
- ◆ Being a good listener;
- ◆ Being empathic to the needs and concerns of your patients.

Acknowledgements

This Orientation Program has been designed to provide you with a practical implementation model that meets your and your community's needs. To accomplish this, many individuals have generously committed their time and effort to ensuring this program will help you accomplish your mission as a Patient Navigator.

Those involved in this project include: Eugenia Acuna, Lourdes Alomar, Paulina Alviz, Dr. Sulaiman Azeez, Barbara Blaise, Suzy Blumenthal, David Cabrera, Kevin Danenberg, Maryse Georges, Dr. Vivek Gumaste, Marian Krauskopf, Rosa Lopez, Desander Mas, Elithea Maysonet, Natalia Moreno, Susan O'Brien, Julie Ruckel, Elena Schwolsky-Fitch, Mencia Seri, Ephraim Shapiro, Bronwyn Starr, Dr. Gerald Villanueva, Brian Vaughn, Sonia Villegas, Dr. Harry Winters, Juliet Young, and many others.

Colonoscopy Patient Navigator Orientation

**DAY ONE:
Defining Your Role**



DAY 1: Defining Your Role

In this section, we will review the history of patient navigation, why it is important, the challenges inherent in patient navigation, your role as a professional patient navigator and ways to eliminate potential barriers that may prevent your patients from obtaining the health care they need. The modules included in this unit are:

A. The Patient Navigator Program

B. The Critical Importance of the Patient Navigator

C. Challenges Faced by Patient Navigators

D. Responsibilities of a Professional Patient Navigator

Throughout this manual, you will notice colored boxes. These colors are used to denote different learning tools.

- *The green boxes contain Case Studies. The case studies are based on interviews done in 2007 with patients at three New York City hospitals. You will read these on your own and discuss your thoughts with the whole group.*
- *The purple boxes contain Individual Exercises. You will work on these exercises by yourself and discuss them with the group afterwards.*
- *The blue boxes contain Group Exercises. You will work on these in groups of 2 or 3. You may present your results to the whole group afterwards.*
- *The orange boxes contain Facilitated Discussions. The facilitator will help lead these discussions with the whole group.*

A. The Patient Navigator Program

History

FOR MORE ON THE HISTORY OF PATIENT NAVIGATION, SEE THE APPENDIX.

- ◆ Patient Navigation was developed to address disparities in health care.
- ◆ The National Cancer Institute's Center to Reduce Cancer Health Disparities defines patient navigation as "an intervention that addresses barriers to quality standard care by providing individualized assistance to patients, survivors, and families."¹
- ◆ The New York City DOHMH Colonoscopy Patient Navigator Program partners with hospitals to ensure that populations that face greater screening obstacles receive a colonoscopy.
- ◆ Between 2003, the year the program started, and 2007, Colonoscopy Patient Navigators have helped more than 25,000 New Yorkers get colonoscopies. They have prevented potential cancers in more than 4,000 people who have had polyps removed.

Why Colon Cancer?

On Day 2 you'll learn more about colon cancer, but let's begin with an overview.

COLON CANCER IS THE MOST PREVENTABLE, AND LEAST PREVENTED, CANCER.

- ◆ Colon cancer—also known as colorectal cancer—is a cancer that starts in the colon or rectum.
- ◆ Usually colon cancer develops slowly over a period of several years and can be detected early by changes occurring in the lining of the colon.
- ◆ One change is a growth of tissue called a polyp. Early removal of the polyp can prevent it from becoming cancer.
- ◆ After lung cancer, colon cancer is the leading cause of cancer deaths in the United States.

¹ Center to Reduce Cancer Health Disparities. The Patient Navigator Program Background page. Available at: <http://crchd.nci.nih.gov/initiatives/pnp/background.html>. Accessed August 15, 2006.

- ◆ In 2002, 28,132 women and 28,471 men died from colon cancer.²
- ◆ Colon cancer is one of the most treatable of all cancers. For early stage cancers, the 5-year relative survival rate is 90 percent.³
- ◆ Colon cancer is one of the most preventable cancers. Regular screening colonoscopy could prevent most of these deaths by early detection and removal of both cancer and precancerous polyps.
- ◆ Colonoscopy is the only screening method that can actually prevent colon cancer. Colonoscopy allows a doctor to see the entire colon and rectum, enabling him or her to identify and remove precancerous polyps and cancerous tumors in a single examination.

² U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 1999-2002 Incidence and Mortality Web-based Report Version*. Atlanta: Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; 2005. Available at: www.cdc.gov/cancer/npcr/uscs/. Accessed August 8, 2007.

³ Ibid.

B. The Critical Importance of the Patient Navigator

Your responsibility will be to help your patients deal with and eliminate the many barriers they will encounter in obtaining health care. Many of these barriers relate to navigating a complex system. Other barriers are financial, cultural and personal (fear, for example). By helping your patients overcome these barriers, you will be saving lives and making a significant impact not only with the patient, but also with the patient's family, as well as the hospital and the community you serve.

Case Study: Jessica

Take a few minutes and read the following Case Study. As you read, write your thoughts below. Be prepared to discuss the case with the group.

Jessica was a single mother in her late 40's, whose doctor had referred her for a diagnostic colonoscopy due to symptoms she was experiencing. Sara first met Jessica after her exam, and after she had attempted to schedule an appointment. Sara noticed immediately that Jessica was crying and appeared very angry and agitated.

The first thing Jessica said to Sara was, "I need to have this procedure and I can't do it unless I can leave in time to pick up my children!"

Sara asked her to explain her situation more. Jessica explained that she was a single mother of two children. She was very concerned that, after the procedure, she be available to pick up her children after school. She told Jessica that there was no one else who would be able to meet them and bring them home. When Jessica had attempted to make her appointment for the colonoscopy a few minutes before, she had requested an appointment for early in the morning. However, the usual procedure at Hamilton Hospital was for patients to be informed of the time of their procedure only a day or two before the procedure itself, at the same time that a staff member called to confirm their appointment. The scheduling staff had told Jessica that they could not guarantee any patient a specific time for the procedure. Jessica was concerned that if her colonoscopy were too late in the day, she would not be able to meet her children. In this case, she would not be able to come in for the procedure.

Jessica added again that she felt that she really needed to have the procedure. Sara understood that Jessica was truly concerned, because she believed that she might be ill, due to the symptoms she was experiencing. However, Jessica did not discuss her symptoms with Sara, and Sara did not ask her to explain further.

Sara asked Jessica if it would help her if she were assured in advance that her appointment would be in the early morning. She explained to Jessica approximately what time she might be able to leave the hospital if she were to have the first appointment of the day at 9:00AM. She also made sure that Jessica understood that she would need to be escorted home after the procedure, and would need some additional time to recover from the anesthesia. Jessica agreed that having a procedure early in the day would meet all of her needs, and make it possible for her to pick up her children in time.

Sara then went to the scheduling department to request that they secure an early appointment for Jessica on the day she was scheduled to have the procedure in advance. Sara understood that the clinic could not accommodate the scheduling requests of all of the patients who needed colonoscopies. However, from her conversation with Jessica, she also felt sure that in this case, making a special scheduling arrangement could make a critical difference in ensuring that she would have this necessary procedure. The scheduling staff was willing and able to accommodate this request, and made an advance arrangement to secure the first procedure of the day for Jessica on the day of her appointment.

When Sara informed Jessica that she was scheduled for the earliest appointment of the day, Jessica appeared very relieved. She assured Sara that she would come for her appointment, and thanked her warmly.

C. The Challenges Faced by Patient Navigators

Working in teams, discuss and identify up to ten challenges you have experienced or that you anticipate experiencing as a Patient Navigator. Write them in the left column. In the right column, list action steps that can be taken to address these challenges. Be prepared to share and discuss your comments with the group.

Group Exercise: Challenges

<i>Challenges</i>	<i>Action Steps</i>

D. Responsibilities of a Professional Patient Navigator

During this training program, you will review three key responsibilities of a Patient Navigator:

1: Ensure Effective Colonoscopy Outcomes

2: Promote Effective Systems to Increase Patient Volume

3: Capture Program Outcomes

Individual Exercise: Patient Navigation Quiz

Let's start with a quiz to see how much you already know about your role as a Patient Navigator. Answer the questions below and be prepared to discuss your answers with the group.

As a Patient Navigator, I will:

1. Identify any barriers or possible barriers to care.	True	False
2. Streamline appointments and paperwork.	True	False
3. Get involved with direct "hands-on" care.	True	False
4. Assist with obtaining financial counseling and services and other resources as needed.	True	False
5. Keep communication open with providers, caregivers and patients in order to coordinate services.	True	False
6. Offer opinions about a diagnosis or health care services.	True	False
7. Provide recommendations or opinions on physicians.	True	False
8. Link patients, caregivers and families with needed follow-up services.	True	False
9. Provide counseling services.	True	False

SEE THE APPENDIX
FOR ANSWERS.

Now that you know how much you know, let's review each of the responsibilities.

1: *Ensure Effective Colonoscopy Outcomes*

- a. Support and Educate
- b. Address Barriers and Problem Solve
- c. Patient Advocacy

2: *Promote Systems to Increase Patient Volume*

- d. Promote Colonoscopy Referrals for People 50 and Older
- e. Encourage the use of a Direct Endoscopic Referral System
- f. Contribute to Endoscopy Suite Efficiency

3: *Capture Program Outcomes*

- g. Record Keeping and Data Collection.

In the following days we will spend more time discussing different techniques to help you fulfill these responsibilities. Today we will focus on **# 1, Ensure Effective Colonoscopy Outcomes.**

Facilitated Discussion: Support and Educate

Provide the information and support needed for your patients to understand and complete the screening process.

<i>What to do</i>	<i>How to do it</i>	<i>Points to keep in mind</i>
Assess patient's level on understanding and commitment		
Convey the importance of colon cancer screening		
Assist obtaining culturally appropriate, supportive care		
Direct patients to necessary resources		
Maintain contact with patients during the process and track their progress		

Facilitated Discussion: Address Barriers & Problem Solve

Deal with barriers relating to fear, culture, communication, as well as other issues.

<i>Barrier</i>	<i>Examples</i>	<i>Possible Solutions</i>
Fear	<ul style="list-style-type: none">• Afraid of diagnosis• Anxiety about procedure• Nonresident status	
Cultural	<ul style="list-style-type: none">• Lack of trust• Only want male or female doctor• Beliefs regarding treatment	
Communication	<ul style="list-style-type: none">• Difficulty understanding health care personnel• Difficulty expressing needs and concerns• Language	
Financial	<ul style="list-style-type: none">• No insurance or limited coverage• Unable to afford medication	
Health care system	<ul style="list-style-type: none">• Inability to navigate system• Inability to obtain care when needed	
Transportation	<ul style="list-style-type: none">• Inability to obtain transportation to treatment• Difficulty getting to appointments on time	

Group Exercise: Cesar

In this exercise you will read part of a case study. Your team will write a five minute script which will show how you could help the patient get a colonoscopy. Use the best practices just discussed to guide you. After reading the script, follow the instructions below.

Case Study: Cesar was a Latino man in his mid-fifties who had been referred for a routine screening colonoscopy by his primary care physician. Ana, the patient navigator, first met Cesar after his physical examination. She routinely met with all patients who were referred for a colonoscopy, to help them to arrange an appointment, to answer any questions that they might have, and to ensure that they knew how to prepare themselves for the procedure. As their conversation began, Cesar expressed resistance to having the procedure, saying "I don't need this procedure. I feel fine. Why should I have this procedure when I'm feeling absolutely fine?"

Ana listened to his questions patiently. She responded, first, by describing the procedure. She explained that the procedure involved a very small camera, and that the purpose of the test was to look for polyps or cancerous growths in the colon. She explained that the polyps could exist without causing any other symptoms.

Cesar responded "But I feel fine! Why should I do this?"

Step One: As a group, identify the main issues in the scenario. After your group has identified the issues, brainstorm, discuss and decide how, as patient navigators, you would approach and resolve the barriers faced by the patient. Remember there may be more than one way to eliminate or reduce barriers faced by the patient. Write out your solution in outline form.

Step Two: Now take the solution your group has outlined and write a five minute script. The script should demonstrate how a patient navigator can help resolve barriers faced by the patient in your scenario. Choose who will play the patient, the patient navigator, and any other roles you include in your script.

TO SEE HOW THIS
STORY REALLY
ENDED, SEE THE
APPENDIX.



TAKE 1: THIS
EXERCISE WILL BE
RECORDED SO YOU
CAN SEE HOW
YOU'RE DOING.

Facilitated Discussion: Patient Advocacy

Help patients manage the health care system.

Do this...

- ✓ Talk to your patients to understand their questions or concerns.
- ✓ Use plain-language to give information to your patients.
- ✓ Maintain the confidentiality of information shared with you.
- ✓ Accompany patient to get financial and medical clearance.
- ✓ Confirm patient is medically and financially cleared.
- ✓ Help arrange transportation to the hospital.
- ✓ Call patient before colonoscopy to confirm.
- ✓ Review the bowel prep procedure with patient.
- ✓ Ensure the patient knows when and where to go for the procedure.
- ✓ Keep the patient informed of any delays.
- ✓ Keep track of all your patient contacts.
- ✓ Enter data in a timely way.

Not this...

- ✗ Provide counseling services.
- ✗ Help with problems unrelated to colon cancer screening.
- ✗ Judge the quality of medical care given.
- ✗ Provide physical assessments, diagnoses or treatments.
- ✗ Deliver physical, occupational, or speech therapy.
- ✗ Offer opinions about health care.

Group Exercise: Carmen

In this exercise you will read part of a case study. Your team will write a five minute script which will show how you could help the patient get a colonoscopy. Use the best practices just discussed to guide you. After reading the script, follow the instructions below.

TO SEE HOW THIS STORY REALLY ENDED, SEE THE APPENDIX.

Case Study: Carmen was a sixty-two year old home health care worker. Originally from Nicaragua, she only spoke Spanish.

Carmen had received a colonoscopy at Hamilton Hospital after her doctor recommended that she have one for routine screening. Carmen's colonoscopy revealed that she had a cancerous growth in her colon. However, following the procedure, Carmen did not come for her follow-up appointment.

Each month, Ana, a Patient Navigator, received a list of patients who were scheduled to come in for a follow-up appointment. The list also included information about the patients' diagnosis, and any previous missed appointments. From this, she knew that Carmen had not come in for her previously scheduled follow-up appointment, and also that she had received a positive diagnosis.

Over the course of the next five days, Ana made six attempts to call Carmen, without success. Because Carmen did not have an answering machine, Ana was unable even to leave a message for her.

Step One: As a group, identify the main issues in the scenario. After your group has identified the issues, brainstorm, discuss and decide how, as patient navigators, you would approach and resolve the barriers faced by the patient. Remember there may be more than one way to eliminate or reduce barriers faced by the patient. Write out your solution in outline form.

Step Two: Now take the solution your group has outlined and write a five minute script. The script should demonstrate how a patient navigator can help resolve barriers faced by the patient in your scenario. Choose who will play the patient, the patient navigator, and any other roles you include in your script.



TAKE 2: THIS EXERCISE WILL BE RECORDED SO YOU CAN SEE HOW YOU'RE DOING.

**Colonoscopy Patient Navigator
Orientation**

**DAY TWO:
Colon Cancer and Colonoscopy**



DAY 2: Colon Cancer and Colonoscopy

In this section, we will provide you with the information you need to understand colon cancer and to help your patients. The following are the topics for Day 2:

- A. Colon Cancer 101**
- B. Day-To-Day Operations of the GI Clinic and Other Clinics**
- C. Respecting Patient Confidentiality**

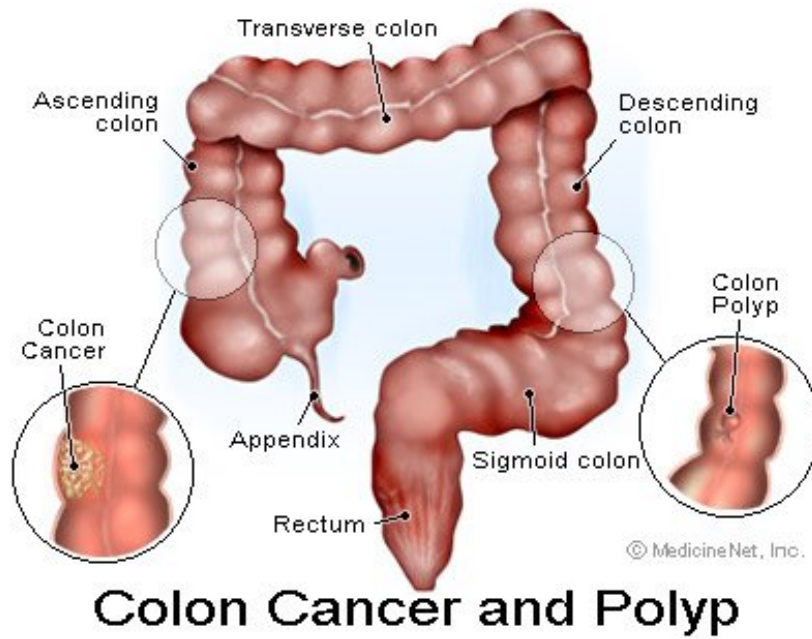
Individual Exercise: Colon Cancer Quiz

Let's start today with another quiz to see how much you know about colon cancer. Answer the questions below and be prepared to discuss your answers with the group.

1. Over a lifetime, about one in every nineteen people develops colon cancer.	True	False
2. Colon cancer affects the large intestine.	True	False
3. Colon cancer cannot be detected early.	True	False
4. Colonoscopy can prevent cancer.	True	False
5. Colon Cancer may take up to 10 years to develop.	True	False
6. Colonoscopy for screening must be done every year.	True	False
7. Who is at average-risk for Colorectal Cancer? a. People who are over the age of 50 with no family history or symptoms. b. People over the age of 50 with symptoms lasting more than 2 weeks. c. People who are 50 with a family history of colon cancer. d. All the above.		
8. Who is at increased risk for Colorectal Cancer? a. People with a personal history of colorectal cancer or polyps b. People with a family history of colorectal cancer or polyps. c. People with a history of inflammatory bowel disease d. People with certain inherited cancer syndromes e. All the above		

A. Colon Cancer 101

This portion of the workshop will be a slide presentation.



Group Exercise: Graciela

In this exercise you will read part of a case study. Your team will write a five minute script which will show how you could help the patient get a colonoscopy. Use the best practices just discussed to guide you. After reading the script, follow the instructions below.

TO SEE HOW THIS
STORY REALLY
ENDED, SEE THE
APPENDIX.

Case Study: Graciela was a familiar and friendly face to the staff at Hamilton Hospital even before she had her first medical appointment there. Graciela earned her livelihood by purchasing clothing wholesale at a factory, and then selling the clothing to local merchants and other people in the neighborhood surrounding Hamilton Hospital. She would often come to the hospital to sell clothing to staff who were interested, or would set up a table outside on the sidewalk. Sara, the Patient Navigator, had met and spoken with Graciela several times.

Graciela had arrived in New York City only two years before from Colombia, and decided that she would like to have a routine check-up. Although she did not have health insurance, she did not mind paying for medical services. She was proud to be a person who took care of her health, and since she was already on friendly terms with the staff at Hamilton Hospital, she felt comfortable receiving medical care there.

At her check-up, her doctor recommended that she have a colonoscopy. Graciela was in her late 40's, which made her somewhat younger than the age of patients usually recommended for a routine colonoscopy. However, because of her family history, the doctor felt it would be in her best interest.

When Graciela first met with Sara to discuss the preparation and arrangements for her procedure, she was surprised to learn that Sara was a patient navigator for the colonoscopy clinic. She and Sara were already acquainted, but she had not known that this was Sara's position. Perhaps because of their previous relations, and perhaps because of her naturally outgoing style, Graciela seemed quite comfortable speaking openly with Sara. However, Sara learned quickly that Graciela was very reluctant to have the procedure.

Graciela told Sara that she had heard that the procedure could be very risky. A friend of Graciela's in Colombia had told her the story of an acquaintance who had a colonoscopy that had torn her intestines. According to Graciela's friend, this acquaintance had lasting damage to her intestines as a result.

B. Day-To-Day Operations of the GI Clinic and Other Clinics

All GI clinics have similar characteristics and the same general patient flow. However, each hospital will set up their clinic and patient flow a little differently. As a patient navigator, knowing how your patients come to the clinic and the flow of the clinic is critically important. This will allow you to help troubleshoot problems and improve patient compliance. Knowing how the clinic functions can also give you a chance to pinpoint bottle-necks or other problems that might impede clinic flow.

Important time points (see Figure 1):

- ◆ **Primary Care Physician visit:** Before a patient can make an appointment with the GI clinic, they must get a referral from a doctor. Often, that doctor will be a patient's primary care provider (PCP).
- ◆ **Referral:** In some hospitals, the PCP will refer the patient directly for a colonoscopy, and in others, the PCP will refer the patient to the GI clinic for a consult and the GI doctor will make the colonoscopy referral. In either case, the referral will be for screening, if the patient has no symptoms, diagnosis, if the patient exhibits a GI problem, or surveillance, if the patient has a history of colon cancer or polyps. PCP referrals can come from inside or outside the hospital.
- ◆ **Patient Navigator meeting:** The navigator meets with the patient to explain the procedure, reinforce bowel preparation instructions, and address any questions or concerns the patient may have. In some cases, this meeting will take place over the phone.
- ◆ **Financial/Medical Clearance:** The patient often has to receive financial and medical admission clearance before getting a colonoscopy. Navigators may have to help patients with obtaining financial or medical clearance.
- ◆ **Pre-Colonoscopy:** Navigators call patients one or two days before the colonoscopy to remind patients of their appointment, review the importance of the prep, and go over any last minute concerns. This is an essential activity for navigators.
- ◆ **Colonoscopy:** The patient comes in for their colonoscopy, which is usually a 30 to 45 minute procedure. The patient must then stay

WHEN A PATIENT IS REFERRED FROM A PCP TO A COLONOSCOPY WITHOUT A GI CONSULT, THIS IS CALLED DERS, OR DIRECT ENDOSCOPIC REFERRAL SYSTEM. SEE MORE ABOUT DERS BELOW.

after the procedure to recover. Recovery time will vary by hospital. It can be as short as 30 minutes or as long as 4 hours depending on the procedure and medication used. In most hospitals, an escort must accompany the patient home. The navigator's role may be to make sure the patient has an escort and possibly to greet patients the day of the procedure.

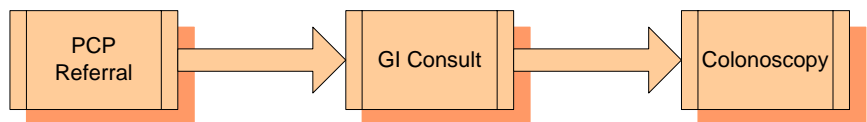
- ◆ **Post-colonoscopy:** If the patient is referred from inside the hospital, the PCP will usually receive patient procedure results from the hospital computer system. If the patient came from an outside hospital referral, the navigator will often fax, mail or phone results to the doctor in a timely fashion. Navigators should pay attention to confidentiality issues when giving results to providers. Navigators will also follow up with patients if additional appointments are needed.

Direct Endoscopic Referral System

Most patients (as many as 80%) do not need a GI consult before a colonoscopy. Many hospitals use a direct endoscopic referral system (DERS), in which PCPs refer eligible patients directly for colonoscopies. DERS is sometimes called open access, or direct booking.

DERS AND DON'TS:
SEE THE APPENDIX TO LEARN WHO IS ELIGIBLE FOR DERS, AND WHO ISN'T.

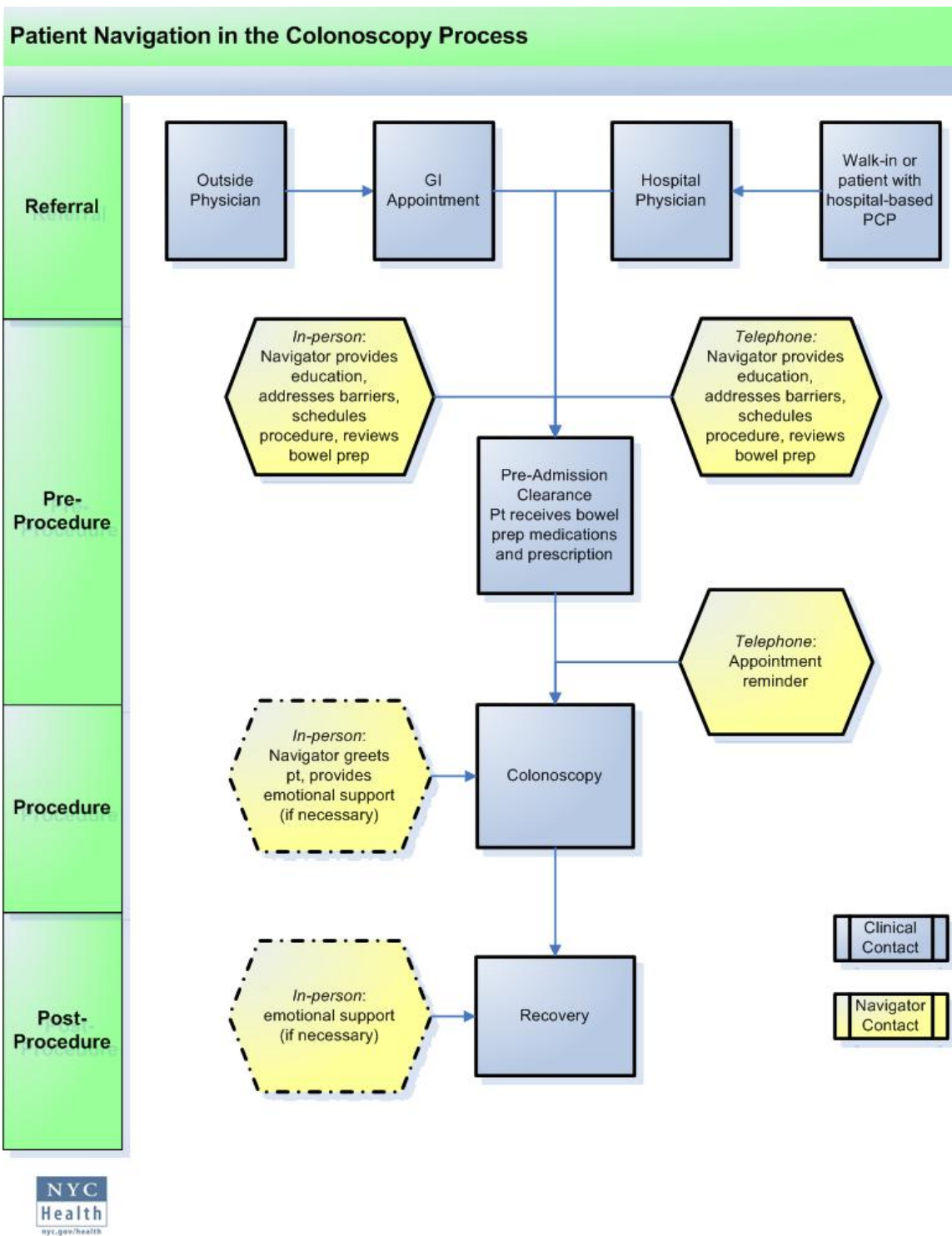
Traditional Colonoscopy Referral System



Direct Endoscopic Referral System



Figure 1:



Individual Exercise: Creating a Flow Chart

Use your homework, "Who's Who in GI," as well as the questions below to help you map out your clinic's flow. On the following page, use arrows to show how a patient moves through the system.

- Do patients come to your site from outside the hospital? If so, from where?

- Which clinics within the hospital refer patients for colonoscopies?

- How do you know if a patient has been referred for a colonoscopy?

- Who makes the patient's colonoscopy appointment? When?

- When do you make your first contact with patients? Do you meet them in person or call them on the phone?

- Do patients need medical or financial clearance at your hospital? If so, when and where does this happen?

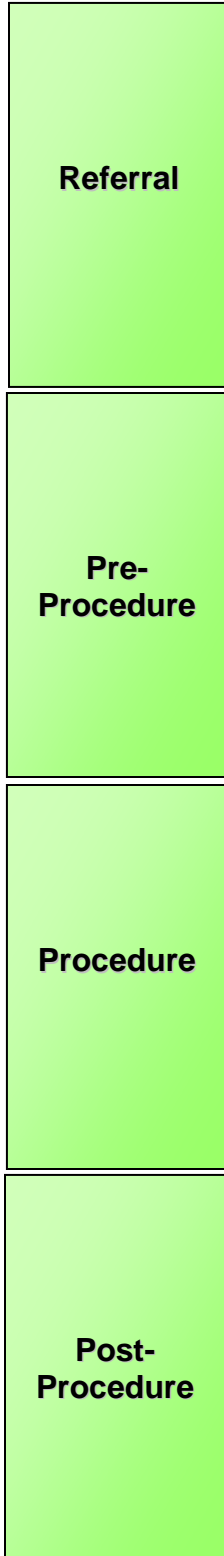
- When do patients receive bowel prep medications and instructions? What is your role in providing this information?

- When do you call patients to remind them of their appointment?

- How do you know if a patient has completed the colonoscopy? When and how do you get results?

- Who reschedules patients who have not kept their appointments or need repeat procedures?

My Hospital Flow Chart



Group Exercise: Differences in Clinic Operations

Working in teams, discuss the following questions. Be prepared to share and discuss your comments with the group.

- Are your offices housed in the GI department or another department? What are the disadvantages/advantages of each?

- Do you report to the GI chief, a hospital administrator or to another person? What are the pros and cons of each?

- If a patient without insurance calls up to get a colonoscopy, what do you do in your clinic? Whom do you call?

- At your hospital, can patients be directly referred?

- Which departments refer to the GI clinic?

- Do all navigators give out their phone number for additional patient questions?

- What materials do you distribute to patients regarding their colonoscopy?

- Do you ever have problems with finding a private space to talk to patients? If so, what do you do?

C. Respecting Patient Confidentiality

As a Patient Navigator you will have access to information that is confidential to your patient. Your responsibility is to ensure that this information is kept confidential and only shared with authorized personnel. This information includes patients' names and addresses as well as medical records and information shared by the patient and his or her family with you. It is absolutely critical and *it is the law* that this information is shared with no one else unless the patient has given written permission. In fact, in 1996 the Health Insurance Portability and Accountability Act (HIPAA) was signed into law stating that all medical records and other health information about a person are to be kept confidential.

Your hospital orientation will cover HIPAA in much greater detail. We want to mention the HIPAA law again here because patient confidentiality is an extremely important issue in the medical field.

Facilitated Discussion: Confidentiality and Navigator Work

Think about your interactions and how patient confidentiality may come into play.

<i>Scenario</i>	<i>Notes</i>
Leaving a phone message for a patient	
Faxing a colonoscopy report to a PCP	
Referring a patient for other services	
Discussing a hard-to-reach patient with your supervisor	
Talking with a patient in a waiting room	

**Colonoscopy Patient Navigator
Orientation**

**DAY THREE:
Communicating with Patients and
Communities**



DAY 3: Communicating with Patients and Communities

Your success as a Patient Navigator will largely depend on your ability to communicate – not just to your patients but to the medical community as well.

This unit will cover the following:

A. Building and Maintaining Trust

B. Health Literacy

C. Cultural Sensitivity

A. Building & Maintaining Trust

Gaining your patients' trust will be crucial to your work. It will greatly impact your ability to communicate effectively your message of screening and prevention to your patients. How to gain your patients' trust in a short amount of time is the challenge we will address in this section.

Here are some steps you can take that will help you gain your patient's trust.

- ◆ Have a Conversation with Your Patient. Engage your patient in a dialogue instead of a lecture. Patients are less likely to open up to you when they feel they are being talked at. You may want to begin by asking general questions regarding the patient's overall well being or if the clinic was easy to find. When you ask the patient questions, make sure they are non-judgmental, open-ended questions. Here are some examples:

Closed-ended questions

Did you take to subway here?

Are you nervous about getting a colonoscopy?

Open-ended questions

How did you get to the clinic?

How do you feel about getting a colonoscopy?

- ◆ Listen to and Assess Your Patient's Needs. Listening to your patient's frustrations and fears without judging them is one way to gain trust. When patients feel they are being listened to and you are paying attention to their concerns, they may feel cared for and that they matter. When patients feel acknowledged, they may be ready to hear your message regarding getting screened.
- ◆ Be interested. Express a genuine interest in your patient's welfare. Tailor your health message to their situation. Find out what barriers, issues and concerns they have, and together come up with solutions to address these.

Group Exercise: Rowena

In this exercise you will read part of a case study. Your team will write a five minute script which will show how you could help the patient get a colonoscopy. Use the best practices just discussed to guide you. After reading the script, follow the instructions below.

Case Study: Rowena is in her mid-fifties, married, and with a twenty-seven year old son who also lives with her. Rowena is originally from Guyana, but she has lived in the Bronx since 1990. She used to hold a job, but stopped a few years ago after she had an aneurysm, and the doctors recommended that she stop. She also has diabetes, and is very careful to care for her health.

One year Rowena decided to return to Guyana for a vacation. During her visit one morning, Rowena had trouble having a bowel movement. Normally her digestion is very regular, so she wondered right away if something was wrong. At first, she thought maybe the cause was the change in her diet, since she was traveling. However, the problem persisted for three days. By that time, Rowena was concerned. She knew her health very well, and she thought that she should contact her doctor.

When she returned to the Bronx, she went to see her OB/GYN, Dr. Wallace. After hearing about Rowena's symptoms, Dr. Wallace told Rowena that she should have a colonoscopy. Dr. Wallace was insistent that Rowena go to have the procedure right away, emphasizing the urgency of the test. When Rowena heard Dr. Wallace say that she should have the colonoscopy "right away," she began to feel frightened and worried. She had already been concerned about the symptoms she had been experiencing. She wondered, "What is wrong with me?"

Dr. Wallace arranged for Rowena to be scheduled for a colonoscopy at Hamilton Hospital, and Rowena was able to have the procedure without encountering any difficulty or obstacles. However, she still felt very anxious about what the test results would be.

A few days later, Rowena received a phone call from Jonathan, a Patient Navigator at Hamilton Hospital, reminding her to come in for her follow up appointment later that week. When Rowena heard Jonathan asking her to come back to see the hospital, she suddenly felt terribly afraid. The feeling came so suddenly that it was a shock to her and her head began to hurt badly.

TO SEE HOW THIS
STORY REALLY
ENDED, SEE THE
APPENDIX.

B. Health Literacy

Health literacy has a two-part definition¹:

- ◆ The ability of individuals to read, understand, and act upon health-related information.
- ◆ The capacity of professionals and institutions to communicate effectively so that community members can make informed decisions and take appropriate actions to protect and promote their health.

Health literacy comes into play in every interaction people have with the health care system—for instance, finding their way around a hospital, understanding prescriptions, applying for health insurance, understanding consent forms. People with low health literacy may also have difficulty understanding the need to be screened for a disease for which they have no symptoms.²

This section will take a look at techniques to improve your health literacy—your ability to present information in a way that your patients understand. Let’s start off with the following recommendations from the National Center for the Study of Adult Learning and Literacy³.

- ◆ Present a reasonable amount of information at one time.
- ◆ Use plain language; avoid using jargon or specialized words.
- ◆ Encourage questions.
- ◆ Assume the burden of clear communication by asking if the information or directions were clearly presented. For example, say, “Am I clear?” instead of, “Do you understand?”

PEOPLE WITH LOW HEALTH LITERACY ARE MORE LIKELY TO BE SICK AND LESS LIKELY TO SEEK PREVENTIVE CARE. SEE THE APPENDIX FOR MORE INFORMATION AND RESOURCES.

¹ Mayor’s Office of Adult Education. Available at <http://www.nyc.gov/html/adulted/html/health/health.shtml>. Accessed March 21, 2008.

² Rudd RE. Literacy and implications for navigating health care. Harvard School of Public Health: Health Literacy Website. 2002. Available at http://www.hsph.harvard.edu/healthliteracy/slides/2002/2002_01.html. Accessed April 16, 2008.

³Rudd, RE, Anderson, JE. (2006) *The Health Literacy Environment of Hospitals and Health Centers*. Boston, MA: National Center for the Study of Adult Learning and Literacy and Health and Adult Literacy and Learning Initiative, Harvard School of Public Health.

- ◆ When appropriate, ask patients to repeat key points as though they were telling what they learned to a family member or friend.
- ◆ Use visuals to present materials. Many patients with low English proficiency can understand your message better if you show them pictures of the information you would like to convey.

Facilitated Discussion: Health Literacy: Help Your Patients Understand

For some examples of how health literacy can affect real people, let's watch this video by the American Medical Association Foundation.

Use the space provided below to write your observations and comments on the vignettes you are about to see. Be prepared to discuss your observations with the group.



Facilitated Discussion: Brainstorming Plain Language Terms

This exercise will provide you with an opportunity to practice “plain language” or “living room language.” We will work as a group to come up with “plain language” alternatives for the medical terms and procedures listed below.

<i>Medical Term</i>	<i>Plain Language</i>
Polyps	
Colon	
Procedure	
Bowel Preparation	
Sedation	
IV	
Flexible Scope	
Recovery Room	
Fluids	
Consent Form	

Group Exercise: Developing Plain Language Messages

It will be helpful for you to think about how you will explain to your patients what to expect when they come in for their colonoscopy. As you have just heard, it is critical that this information be easy for your patients to understand. Below, we have provided a sample script for you to evaluate and improve using the techniques you just learned.

With your group, read the script out loud. Underline the words or phrases that might be difficult for patients to understand. In the space below, write the plain language translation. Then, using these new phrases, determine three key messages you will give to your patient to explain what to expect when they come in for a colonoscopy.

Sample Script:

Please arrive 15 minutes before your appointment. When you arrive at our clinic a nurse or a staff member will greet you and you will be asked to sign a consent form. You will then be taken to a changing room where you will change into a hospital gown and store your clothes in a locker. When you come out of the changing room a nurse will walk you to a prep room where the medical staff will take your blood pressure and temperature. You will be asked some routine questions about your bowel preparation. You will also be given an intravenous line (IV), so that later you can be given a sedative.

Next, someone will bring you to one of our colonoscopy rooms where you will meet the doctor and a nurse. You will also notice a heart monitor, blood pressure and computer screens. This is standard procedure and there is no need to be concerned. Your doctor will ask you a few routine questions and either the doctor or the nurse will give you a sedative through the IV. Both the doctor and the nurse will make absolutely certain that the sedative has taken effect before the doctor starts the procedure. The sedative you will make you relaxed and put you in pleasant sleepy state. You will not be unconscious since this is not general anesthesia. But a pleasant sleepy state just like at night when you are just about to fall asleep. The last thing you will remember is feeling very, very sleepy. The sedative leaves you with little or no memory of what happens next.

When you are in this sleepy state or twilight state, your doctor inserts a thin, soft and flexible tube through the opening of your backside and gently eases it into your colon. The tube has a tiny video camera,

THREE KEY MESSAGES

1.

2.

3.

C. Cultural Sensitivity

In this unit you will be provided with the knowledge and skills you need to more effectively understand and manage the cultural differences in your community. As a Patient Navigator, you will serve a diverse community and will be tasked with ensuring that all your clients are offered the proper cancer screening and care required.

Cultural Identity

Culture and language have a significant impact on health care. As a Patient Navigator you will address the cultural and language differences that can create barriers to quality health care. Some factors that affect a person's cultural identity are:

- ◆ Language
- ◆ Ethnicity or race
- ◆ Geography
- ◆ Socioeconomic status
- ◆ Age
- ◆ Gender
- ◆ Sexual Orientation
- ◆ Disability
- ◆ Religion

These factors will help us to frame our discussion as we attempt to identify and understand those cultural differences that can become barriers. The goal of the section is to help you become aware of issues your patient may face.

Cross-Cultural Communication Strategies

You can't be expected to know about every culture you encounter in your work, but there are some basic guidelines for cross-cultural communication.

Provide a safe environment:

- ◆ Be aware of situations and settings that are uncomfortable. For example, some patients may not feel comfortable asking specific questions about the procedure if they are not in a private space or room.
- ◆ Reduce power dynamics. Explain that your role is assisting them with getting screened and use plain, easy to understand language.
- ◆ Informal settings usually allow more open communication because it makes patients feel more at ease.
- ◆ Private settings generally contribute to feelings of safety.

Focus on understanding:

- ◆ Ask open-ended questions
- ◆ Be nonjudgmental.

Be aware of differences in nonverbal communication patterns:

- ◆ Eye Contact
- ◆ Space
- ◆ Touching
- ◆ Tone of Voice
- ◆ Facial expression

Group Exercise: Teresa

In this exercise you will read part of a case study. Your team will write a five minute script which will show how you could help the patient get a colonoscopy. Use the best practices just discussed to guide you. After reading the script, follow the instructions below.

TO SEE HOW THIS STORY REALLY ENDED, SEE THE APPENDIX.

Case Study: Teresa was a 52 year old woman. Born in the Dominican Republic, she had lived in New York for a few years but was undocumented. Teresa's doctor had recommended that she have a routine screening colonoscopy.

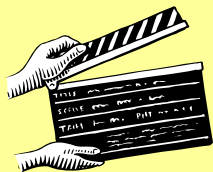
When Ana, the patient navigator first met with Teresa to help her arrange and prepare for her appointment, she learned that Teresa did not have insurance. Ana suspected that this might be an obstacle to Teresa having the procedure. However, she decided it would be better if she didn't show that she was concerned during this first conversation. She knew that Teresa would discuss fees for the colonoscopy and payment options later that morning when she met with the scheduling staff. Ana thought that if she mentioned the cost of the procedure at this point, Teresa might decide that she couldn't afford the colonoscopy, and might leave without discussing her decision further.

So, instead, Ana made a mental note to follow up with Teresa after her appointment with the scheduling staff. If it turned out that payment would be a problem for Teresa, Ana could help her explore her options then. If not, she would not have alarmed Teresa unnecessarily.

Later in the day, when Teresa had completed all of the testing and appointments she needed to schedule her colonoscopy, Ana met up with her as planned. When Ana asked Teresa if she had any questions or concerns, Teresa told her, just as she expected, that she could not afford the procedure.

Step One: As a group, identify the main issues in the scenario. After your group has identified the issues, brainstorm, discuss and decide how, as patient navigators, you would approach and resolve the barriers faced by the patient. Remember there may be more than one way to eliminate or reduce barriers faced by the patient. Write out your solution in outline form.

Step Two: Now take the solution your group has outlined and write a five minute script. The script should demonstrate how a patient



TAKE 5: THIS EXERCISE WILL BE RECORDED SO YOU CAN SEE HOW YOU'RE DOING.

Colonoscopy Patient Navigator Orientation

**DAY FOUR:
Increasing Referrals and Networking**



DAY 4: Increasing Referrals and Networking

In this unit, you will look at how to build and maintain networks within the medical and patient community and use those networks to increase screening referrals. These networks will be vital to your success in getting the services your patients need and increasing the numbers of patients screened.

This unit will cover the following:

A. Strategies to Increase Referrals

B. Principles of Effective Communication with Staff and Administrators

A. Strategies to Increase Referrals

One of your challenges will be to increase the number of colonoscopies that take place at your site. To this end, there are Best Practices¹ for GI suites that have been shown to be effective.

Individual Exercise: Inreach Resources

Your key goal is to ensure that people age 50 and older are referred for a screening colonoscopy every 10 years. Below are areas within your hospital that can help you increase colonoscopy referrals for patients 50 and older. As you review the list, identify and write in possible personnel, records, or systems that you can use to help you increase colonoscopy screenings.

<i>Ambulatory Care Clinics</i>	<i>Personnel, Records, or Systems</i>
Internal medicine	
Family medicine	
Geriatric medicine	
Radiology	
Ob-Gyn	
Smoking cessation	
Other	

¹ *A Practical Guide to Increasing Screening Colonoscopy*. Cancer Prevention and Control Program, Bureau of Chronic Disease Prevention and Control, the City of New York Department of Health and Mental Hygiene and New York Citywide Colon Cancer Control Coalition.

There may be other systems your hospital has in place that can help target people for screening.

As you review the list, identify and write in possible personnel, records or systems that you can contact that will help you expand colonoscopy screenings. As a navigator, you will probably not be able to implement these changes yourself, but think about who you can talk to about these ideas.

<i>Resource</i>	<i>Personnel, Records or Systems</i>
Electronic medical records: <ul style="list-style-type: none">• Patients turning 50• Patients 50–80 w/o documented CRC screening	
Program Physician Alert for patients 50 and older	
Chart ticklers for patients 50 and older	
E-mail alerts to physicians and nurse practitioners	
Paychecks & retirement checks	
Employee newsletter & bulletin boards	

Individual Exercise: Outreach Resources

It will also be important to reach out to organizations in your community to help you increase colonoscopy referrals for patients 50 and older. Your hospital might already have relationships with many of these organizations. As you review the list, identify and write in possible personnel, records or systems, inside or outside of your hospital, that you can use to will help you expand colonoscopy referrals from the community.

<i>Community Outreach</i>	<i>Personnel, Records or Systems</i>
Places of worship	
Community-based non-profit organizations	
Community health clinics	
Barbershops & beauty salons	
Senior centers	
Libraries	
Motor vehicle offices	
Others	

B. Principles of Effective Communication

Whether you are giving information to patients, or discussing the Navigator Program to clinic staff, it will help you to think ahead about how you'll present the information.

This section will focus on the two key principles and three main elements of an effective presentation:

1. Begin with an Objective or Purpose

2. Plan Your Presentation

- a. Gain Attention**
- b. Present Key Points**
- c. Close for Action**

1. Begin with an Objective or Purpose

A successful presentation or talk – whether it is one-to-one or one-to-a-hundred – begins with a statement of the purpose or objective of the presentation. Once that is in place, then you can effectively plan out your presentation. The better thought-out your objective is, the more comfortable you will feel, the more professional you will look, and the more successful you will be. Your objective or purpose should:

- ◆ Convey the specific purpose of your talk.
- ◆ State how long your talk will take.
- ◆ Communicate the action you want your audience to take.
- ◆ Tell your audience what they will gain by listening to you.

Here's a sample objective for a meeting with hospital administrators:

The purpose of our 30-minute meeting today is to show you how you can increase colon screenings by 50% over the next six months and increase revenues by 20% by hiring a patient navigator.

2. Plan Your Presentation/Talk

Once you know your objective/purpose, you are ready to plan the three key strategies to an effective presentation. They are:

- a. **Gain Attention:** The first step to an effective talk is to introduce your topic in a way that will get attention. This segment looks at four techniques for gaining attention.
- b. **Present Key Points:** The effectiveness of your talk will in large part be dependent on how credibly you have positioned your point of view.
- c. **Close for Action:** Every talk needs to have closure. In this step, you will learn ways to close your meeting for positive action.

a. Gain Attention

The first step to a great presentation is planning how to introduce your topic in a way that will get attention.

Facilitated Discussion: Attention Getting Techniques

There are four primary techniques that you can use to get the attention of your audience. After each one, write an example given to you by the facilitator or the group.

GIMME A CI
GIMME AN O!
GIMME AN LI
GIMME AN O!
GIMME AN NI

PEOPLE OFTEN
EQUATE YOUR
LEVEL OF
APPROPRIATE
ENTHUSIASM WITH
YOUR
COMMITMENT TO
YOUR TOPIC. SO
BE ENERGETIC, BUT
NOT TOO
ENERGETIC.

<i>Technique</i>	<i>Example</i>
Purpose Statement: State the reason for the presentation	
Startling Statement: Provide facts or situations that are unusual	
Human Interest Story: Present a story that affects the audience emotionally	
Humor: Relate an incident, situation, etc., that <i>appropriately</i> fits the topic of your presentation	

b. Present Key Points

A powerful way to deliver the purpose of your presentation is to:

- ◆ Define the key point(s) of your presentation.
- ◆ Illustrate these points with a story, data, or research to which your audience will relate.
- ◆ Provide evidence that justifies or proves your key points.
- ◆ Emphasize the potential benefits or drawbacks your audience needs to consider regarding your key points.

Facilitated Discussion: Get to the Point

Think about the key points you might use for a conversation with the Director of the Ob/Gyn about referring patients for screening.

What key points do you want the director to remember?

1. _____
2. _____
3. _____

What can you say to illustrate your key points?

What evidence do you have to back up your key points?

What is the potential benefit or loss if these key points are ignored?

c. Close for Action

Every meeting needs to have closure. In this segment, you will learn methods to close your presentation for *positive* action.

Facilitated Discussion: Now What?

Below are four steps you can take to reinforce the action you want your audience to take. After each one, write an example given to you by the facilitator or the group.

<i>Steps</i>	<i>Why do it?</i>	<i>How to do it...</i>
Thank the audience	Tells your audience that you are aware of the time and effort they've taken talk with you	
Summarize key points	Reinforces the points of your talk that you want them to remember	
Ask for action to be taken	Lets them know that they need to take action.	
Provide timetable (if appropriate) and thank audience again.	Lets them know when they need to take the action requested.	

Group Exercise: Creating a Navigator Program Sound Bite

When talking to medical professionals, it is important to keep your message short and to the point. Doctors, nurses and administrators are very strapped for time, so it is often best to prepare and tailor your message before your visit. You may often have less than five minutes of their time.

Apply the skills you have learned in this program in the following role-practice.

Working in groups, each team member will take turns being the following:

1. Patient Navigator
2. Medical Staff (Doctor, nurse, administrator)
3. Observer

The Patient Navigator will create a “sound bite” describing the Colonoscopy Patient Navigator program to a staff member in a hospital clinic. The sound bite should include an introduction of yourself, the purpose of your visit, and what you would like to accomplish. It should be no more than 2 minutes in length. The goal is to have the clinic refer patients for colonoscopies.

The Medical Staff person will listen to the presentation and ask questions when necessary. Your response is an important way for the Navigator to know if he or she is doing a good job.

The Observer will watch the interaction and write down feedback. After the role-practice is completed, the Observer will lead a discussion among the team in which each member shares his or her observations.

Colonoscopy Patient Navigator Orientation

**DAY FIVE:
Data Collection and Reporting**



Day Five: As you remember, capturing program outcomes is one of the key roles of the Patient Navigator. This unit will cover the following:

- A. The Importance of the Patient Navigator Database**
- B. Tour of the Database**
- C. Data Collection**
- D. Glossary of Database Terms**

A. The Importance of the Patient Navigator Database

The database is a critical component of the Patient Navigator work. The database serves not only as a central place for you to gather and keep track of patient information, but also to provide the hospital essential feedback on the program. Information the database will capture includes:

- ◆ The number of patients scheduled for colonoscopy
- ◆ The number of patients actually screened
- ◆ Cancer and/or polyps found
- ◆ Important demographic information

This information shows the hospital how successful the program is and areas where the program can be improved. For example, the number of patients screened at Lincoln Hospital increased 400% from the start to the end of the third year of the program. This information was directly gathered from the Patient Navigator Database. In addition, comparing the number of patients scheduled to the number of patients who kept their appointments will allow you to calculate the “no-show” rate of patients. In 2005, Lincoln, Woodhull, and Elmhurst all showed through the data they captured that their no-show rates were approximately 10%. This rate was a significant decrease from before the program began. Lastly, reporting the number of people with polyps found and removed ultimately shows that the program is helping to save lives. All this information shows the importance of your work. The database can show the success of the program and continued need for funding. The most important information the database captures is that the program is helping save lives.

B. Tour of the Database

The goal of this database tour is to define, explain and demonstrate the different aspects and functions of the Access database that you will use. At the end of this activity, you will have a chance to practice entering data.

Use the User's Guide in the Appendix during this section.

You can also access the User's Guide at the database support website-
<http://www.danenbergconsulting.com/support/apps/coscr/>.

Individual Exercise: Data Entry

At your computers, please enter the following three sample patients into the database.

Patient 1

Name: Slavia Zincak

Age: 52 years old

Address: 24 Bittersweet Trail, Jamaica Queens 11118

Phone Number: None given

Slavia was referred for a screening colonoscopy by her primary care doctor, Dr. S. Monahan, on February 16, 2008. Originally from Ukraine, she has limited English proficiency and prefers to speak in Ukrainian. She has no symptoms. Her medical record states that her father died of colorectal cancer at age 76. She has also had two FOBTs over the last two years. The pathology report for the colonoscopy completed on March 3, 2008, notes that Slavia had three polyps removed: one 1mm hyperplastic polyp near the rectum and two adenomatous polyps in the transverse colon, one 1.5mm, the other 3mm. Her GI, Dr. L. Vargas, recommends that she have another colonoscopy in 5 years. She is on Medicaid.

Patient 2

Name: Wu Chang

Age: 65 years old

Address: 6565 Perna Lane, Brighton Beach, Brooklyn 12256

Phone number: 718-555-8866

Wu Chang has never had a colonoscopy. His doctor, Dr. Moses Wolfowitz, recommended a colonoscopy after Wu found blood in his stool. Wu speaks only Mandarin and was born in Taiwan. Mr. Chang was a heavy smoker but quit 6 years ago, as noted in his medical

record. During the colonoscopy on January 6, 2007, Mr. Chang was found to have a suspicious tumor and was subsequently hospitalized. The biopsy revealed that the tumor was cancerous, stage 2. He is on Medicare.

Patient 3

Name: Juan Garcia

Age: 57 years old

Address: 78 Sunshine Lane, Bronx NY 11224

Phone number: 212-555-7890

Juan Garcia was born in Puerto Rico. He is coming in for a GI consult appointment for a colonoscopy and will then meet with the patient navigator. Juan has diabetes. Juan had his first colonoscopy five years ago and had six adenomatous polyps removed. His GI, Dr. Samantha Foster, suggested that he have another in five years. Juan is quite nervous about the procedure because his brother was diagnosed with colorectal cancer three years ago. When Juan was referred, he had no health insurance, but the navigator referred him to a financial counselor who found that he was eligible for emergency Medicaid. By the time he had his colonoscopy, he was enrolled in Medicaid.

Facilitated Discussion: Sources of Data

Hospitals have different systems to keep track of patient information. You will gather the information for the database from a variety of sources, from electronic medical records to patient interviews. With the whole group, discuss where you would find the information listed in the table below.

<i>Information</i>	<i>Source</i>
Patient's age	
Patient's contact information	
Prior history of cancer or polyps	
Family history of cancer	
Insurance	
Referral date	
Date of last reminder phone call	
Pre-admission clearance status	
Colonoscopy result	
Polyp type	
Cancer stage	
Next recommended colonoscopy	

Group Exercise: Database Review

As a group, show the facilitator how to perform the following tasks on the database.

1. Where and how would I add a new patient?
2. How do I add a new CRC assessment?
3. How do I delete a patient?
4. How do I delete a CRC Assessment?
5. How do I add a clinic?
6. Where would I add an insurance company?
7. How do I add a navigator?
8. How do I change a role of a person or organization?
9. How do I export a monthly report?
10. If a patient comes in for a colonoscopy and returns for a follow-up a year later, do I create a new assessment?
11. I don't have the referral date for a patient but have all the rest of the information to input. How do I move forward since I need the referral date to get to the next computer page?

C. Data Collection

There are a number of basic rules to ensure that the data you collect is consistent and accurate.

<i>Do this...</i>
✓ Ask every patient every question.
✓ Ask questions to clarify a response you don't understand.
✓ Be clear and specific in your questions.
✓ Use the drop-down menus in the database.
✓ Check for accuracy if you transfer data from another system.
✓ Learn basic GI terminology. If something doesn't make sense, ask questions.
✓ Change the database password periodically.
✓ Let us know immediately, via email, if you have any problems with the database or if something needs to be changed.
<i>Not this...</i>
✗ Assume the answer to a question.
✗ Leave check boxes blank unless the answer is "No."
✗ Leave spaces blank, unless appropriate.
✗ Enter information that is not on the drop-down menus.
✗ Let un-entered data pile up.

D. Glossary of Database Terms

The DOHMH requires data to help us successfully track the program's successes as well as provide information to your departments. This information also helps us sustain the program via our funders. Therefore, it is extremely important that we receive information correctly and comprehensively.

The following definitions may help you gather and enter accurate information.

Race:

American Indian/Alaskan Native, White, Black, Asian/Pacific Islander or Unknown.

Ethnicity:

Hispanic or Non-Hispanic.

We have separated out race and ethnicity as an individual can be of both Hispanic and Black origin or of Hispanic and White origin. This convention is by the state and city and we have adopted it for consistency.

Cancer Stage:

Determining the stage of cancer helps define how much cancer is in the body and where it is located. The DOHMH, to be consistent with the New York State Cancer Registry, uses Overall Stage Groupings (or Roman Numeral Staging).

Stage 0 – Also known as carcinoma in situ, the earliest stage of cancer found in the layer of cells where it originated.

Stage 1 (or I) – Cancer is generally localized and often curable.

Stage 2, 3 (or II, III) – The higher number indicates that cancer has progressed with greater tumor size and/or spread to the lymph nodes or adjacent organs

Stage 4 (or IV) – Also called metastatic cancer, cancer has spread to other organs.

Indication:

Screening – when a patient has no symptoms, but meets eligible criteria for a colonoscopy

Diagnostic – when a patient has symptoms and the test is needed to determine a diagnosis

Surveillance - when a patient has a history of colorectal cancer or polyps, and the test is done to monitor progress

ACS eligible – The American Cancer Society reimburses partnering hospitals that perform colonoscopies for the uninsured. ACS agrees to reimburse the hospital for a specific number of colonoscopies yearly. If an individual is ACS eligible, this means they are uninsured and can qualify to have their colonoscopy reimbursed. This should only be checked if your hospital is a part of this program.

ACS billed - The patient screened qualified for the ACS reimbursement program and ACS was billed. This information will be obtained from your hospital's billing department at the end of the fiscal year (June).

Insurance at time of referral – The type of insurance a patient has at the time of referral (when the doctor recommends a colonoscopy).

Insurance at time of colonoscopy - The type of insurance a person has on the day of the colonoscopy. This may differ from the patient's insurance at time of referral because the patient switched insurance companies or if the patient is uninsured, at the time of colonoscopy, they may now be covered by Medicaid or have emergency Medicaid (especially if the procedure is for diagnostic reasons.)

**Colonoscopy Patient Navigator
Orientation**

APPENDIX



Appendix

1. History of Patient Navigation
2. Patient Navigation Quiz answers
3. Colon Cancer Quiz answers
4. Colon Cancer Glossary
5. Direct Endoscopic Referral System Criteria
6. Health Literacy Resources
7. Outreach Strategies
8. Case Studies
9. Database User's Guide

1. History of Patient Navigation

In 1989, Dr. Harold P. Freeman, then president of the American Cancer Society, conducted a series of meetings across the United States looking into the conditions of cancer care for poor Americans. He discovered health care inequities for these Americans were created and sustained because of:

- ◆ Poverty
- ◆ Culture
- ◆ Bias due to race, ethnic background, or age

As a result of his findings¹, Dr. Freeman launched the first patient navigator program at Harlem Hospital Center in New York in 1990. This program, focusing on breast cancer patients, set out to address:

- ◆ Delays in the follow-up care
- ◆ Reasons why poor people were having trouble obtaining good cancer care
- ◆ Delays in diagnosis and treatment.

In an evaluation of this program, Harlem Hospital found timely resolution of suspicious findings and significant improvements in 5-year survival rates and stage of disease at time of treatment for breast cancer. These results were attributed partially to the patient navigator program.²

Since then, programs modeled on Dr. Freeman's have been implemented around the country, in St. Louis, Seattle, Arizona, Delaware, and other cities.³ In 2005, Congress and President George W. Bush signed into law the Patient Navigator, Outreach and Chronic Disease Prevention Act. The Act recognizes the challenges many Americans encounter obtaining the health care they need and provides

¹ American Cancer Society. *Cancer in the Poor: A Report to the Nation*. Atlanta, GA: American Cancer Society; 1989.

² Freeman, H. Patient Navigation: A Community Based Strategy to Reduce Cancer Disparities. *J Urban Health*. 2006; 82:139-140.

³ Dohan D, Schrag D. Using Navigators to Improve Care of Underserved Patients: Current Practices and Approaches. *Cancer*. 2005; 104:848-855.

funds to nine academic research institutions to create innovative patient navigator programs to test the efficacy and cost-effectiveness throughout the United States.

2. Patient Navigation Quiz

As a Patient Navigator, I will:

1. Identify any barriers or possible barriers to care.	<input checked="" type="radio"/> True	<input type="radio"/> False
2. Streamline appointments and paperwork.	<input checked="" type="radio"/> True	<input type="radio"/> False
3. Get involved with direct “hands-on” care.	<input type="radio"/> True	<input checked="" type="radio"/> False
4. Assist with obtaining financial counseling and services and other resources as needed.	<input checked="" type="radio"/> True	<input type="radio"/> False
5. Keep communication open with providers, caregivers and patients in order to coordinate services.	<input checked="" type="radio"/> True	<input type="radio"/> False
6. Offer opinions about a diagnosis or health care services.	<input type="radio"/> True	<input checked="" type="radio"/> False
7. Provide recommendations or opinions on physicians.	<input type="radio"/> True	<input checked="" type="radio"/> False
8. Link patients, caregivers and families with needed follow-up services.	<input checked="" type="radio"/> True	<input type="radio"/> False
9. Provide counseling services.	<input type="radio"/> True	<input checked="" type="radio"/> False

3. Colon Cancer Quiz

Let's start today with another quiz to see how much you know about colon cancer. Answer the questions below and be prepared to discuss your answers with the group.

1. Over a lifetime, about one in every nineteen people develops colon cancer.	<input checked="" type="radio"/> True	<input type="radio"/> False
2. Colon cancer affects the large intestine.	<input checked="" type="radio"/> True	<input type="radio"/> False
3. Colon cancer cannot be detected early.	<input type="radio"/> True	<input checked="" type="radio"/> False
4. Colonoscopy can prevent cancer.	<input checked="" type="radio"/> True	<input type="radio"/> False
5. Colon Cancer may take up to 10 years to develop.	<input checked="" type="radio"/> True	<input type="radio"/> False
6. Colonoscopy for screening must be done every year.	<input type="radio"/> True	<input checked="" type="radio"/> False
7. Who is at average-risk for Colorectal Cancer? a. <input checked="" type="radio"/> People who are over the age of 50 with no family history or symptoms. b. People over the age of 50 with symptoms lasting more than 2 weeks. c. People who are 50 with a family history of colon cancer. d. All the above.		
8. Who is at increased risk for Colorectal Cancer? a. People with a personal history of colorectal cancer or polyps b. People with a family history of colorectal cancer or polyps. c. People with a history of inflammatory bowel disease d. People with certain inherited cancer syndromes e. <input checked="" type="radio"/> All the above		

4. Colon Cancer Glossary

adenocarcinoma

Cancer in the cells that line the inside layer of the wall of the colon and rectum.

adenomatous polyp

Also called adenoma. A growth (polyp), usually benign, that protrudes from the mucous membranes, and may become cancerous over time.

anemia

Having less than the normal number of red blood cells, which lowers the oxygen-carrying capacity of the blood and can be a sign of blood loss.

anti-coagulant

A drug or substance that stops the blood from clotting.

anus

The opening at the end of the digestive tract through which feces are expelled. A set of sphincter muscles allows the anus to remain closed and to open for a bowel movement.

APC I 1307K

An inherited gene mutation (found with noteworthy frequency in descendants of Ashkenazi Jews from Eastern Europe but can occur in other individuals) that increases the risk of colorectal cancer.

ascending colon

That portion of colon on the right side of the body that ascends from the small intestine.

asymptomatic

Having no symptoms or signs of disease.

barium enema, double-contrast barium enema

An enema with a white, chalky solution that contains barium, given to outline the intestines on a series of x-rays and reveal abnormalities.

benign

Not cancer. Not malignant . A benign tumor does not invade surrounding tissue or spread to other parts of the body. A benign tumor may grow but it stays put (in the same place).

biopsy

Removal of a tissue sample to examine for diagnosis.

bowel

Another term for the lower intestinal tract, the large intestine, or the colorectum, These terms are often used interchangeably

CAT (computerized axial tomography) scan or CT scan

A computerized imaging method that takes multiple cross-section x-ray images of soft tissues.

cecum

A pouch about 2–3 inches long between the small intestine and the large intestine. The furthest point of a colonoscopy examination.

colectomy

Surgery to remove part or all of the colon.

colitis

Inflammation of the colon

colon

A term for the large intestine, lower intestinal tract, colorectum, or bowel. These terms are often used interchangeably.

colonoscope

A flexible, lighted instrument used to view the inside of the colon.

colonoscopy

Internal examination of the entire colon with an endoscope that is passed up through the rectum.

colorectum

A term for the large intestine, lower intestinal tract, bowel, or colon. These terms are often used interchangeably.

colostomy

A procedure in which an opening (stoma) is made surgically through the abdomen to allow waste to pass out of the body and into a bag.

co-morbid

A secondary condition that exists with another medical condition.

Crohn's disease

A chronic inflammation of the bowel that may increase the risk of developing colon cancer.

descending colon

That portion of the colon that descends down the left side, ending in the rectum.

DNA

Deoxyribonucleic acid, the biochemical polymer that encodes genetic information inside a cell. Some new tests can identify DNA from cancerous cells.

DNA fecal test

A new test that can pinpoint DNA from colon cancer cells in a person's feces.

dysplasia

A term that refers to cells that are no longer normal but are not yet cancerous.

endoscope

General term for a tube that is inserted into openings in the body to allow an internal examination without performing surgery.

familial adenomatous polyposis (FAP)

A rare hereditary disease that causes massive overgrowth of color polyps and leads to colon cancer in all who inherit the dominant genes. About 1% of all colorectal cancers are due to FAP.

fecal immunochemical testing (FIT)

A take-home test for hidden intestinal bleeding that is specific for human hemoglobin and does not require diet changes before and during the test.

fecal occult blood test (FOBT)

A take-home test for hidden intestinal bleeding. Requires some diet and drug restrictions before and during the test.

guaiac

A product that reacts to hemoglobin and is used in kits to test for fecal blood.

hepatic

Referring to the liver.

hereditary nonpolyposis colon cancer (HNPCC)

An inherited genetic predisposition found in 3-6% of people with colorectal cancer. Also called Lynch syndrome.

inflammatory bowel disease (IBD)

A chronic inflammation of the colon that may increase colorectal cancer risks. Often confused with the spectrum of symptoms known as irritable bowel syndrome (IBS) which does not appear to increase colorectal cancer risk.

large intestine

A term to describe the entire colon and rectum, from the cecum at the end of the small intestine to the anus at the end of the rectum. Other terms are colon, bowel, and colorectum.

lesion

An abnormal change in the a part of the body that is due to injury or damage

local excision

Operating through a colonoscope or sigmoidoscope to remove small, early-stage cancers.

lymph nodes

Small bodies of tissue that filter bacteria and foreign particles from lymph fluid.

lymphatic system

A system of organs (bone marrow, spleen, thymus) and tissues (lymph nodes, lymph vessels) that make, store, and then carry white blood cells to different parts of the body to fight infection and other diseases.

Lynch syndrome

See hereditary nonpolyposis colorectal cancer (HNPCC)

malignant

Cancerous

metastases, metastatic, metastasized

Terms to describe cancer that had spread from its original point and begun to grow in a distant site. The liver is the most common site of metastases in colorectal cancer.

median

Midpoint

neoplasia

Tumors or masses/growths in the body

occult

Hidden.

pancolitis

Inflammation that involves the entire colon.

pelvis

Area surrounding the hip bone area

plain language

Simple, everyday language that is used instead of more complex words or ideas.

polyp

A growth that protrudes from the skin or from a mucous membrane. Usually benign, some colon polyps can become cancerous. See adenomatous polyp.

polypectomy

Removal of polyps in the colon and rectum, usually during a colonoscopy or sigmoidoscopy.

rectum

The final 5 inches of the bowel, in which feces are stored before being expelled in a bowel movement.

resection

Surgery in which cancer is removed (resected) along with healthy tissue around it.

risk factor

A characteristic that causes a person to be at higher risk of developing a disease.

screening test

Tests used to check, or screen, for disease when there are no symptoms. Screening tests for colorectal cancer include: fecal occult blood test, flexible sigmoidoscopy, colonoscopy, and double contrast barium enema. (When a test is performed to find out why symptoms exist, it is called a "diagnostic" test.)

sigmoid colectomy

Surgery to remove part of the sigmoid colon.

sigmoid colon

The lower part of the colon right above the rectum. Is curved somewhat like the letter "S," which in Greek is called sigmoid.

sigmoidoscopy

An examination of the lower 25 inches or so of the colon and rectum with a flexible endoscope that is inserted through the anus.

sphincter

A set of muscles at the end of the anus that allow it to remain closed and to open to eliminate feces.

splenic flexure

That portion of the colon that makes a left-hand turn at the top of the ascending colon.

staging

A system developed by surgeons and researchers to assess the extent (or stage) of a cancer and its seriousness. Treatment options are often based on staging.

symptomatic

Having symptoms or signs of disease.

transverse colon

The middle portion of the colon, which goes horizontally across the body. Removal of this is called a transverse colectomy.

tumor

An abnormal mass of tissue. Tumors are a classic sign of inflammation, and can be benign or malignant (cancerous).

ulcerative colitis

A chronic inflammatory bowel condition that can increase the risk of developing colon cancer.

virtual colonoscopy

A popular term for a developing technology in which the colorectum can be examined with a CT scan.

5. Direct Endoscopy Referral Criteria

Patients meeting <u>one</u> of these criteria <u>ARE</u> eligible (Indications)	Patients who meet <u>one or more</u> of these criteria are NOT eligible for direct referral (Contraindications)
Colorectal cancer screen in patients 50 to 74 years old	Age 76 or older
Positive fecal occult blood test (FOBT) or rectal bleed in a patient < 75 years of age with no prior GI endoscopic workup	On anticoagulation therapy
Iron deficiency anemia in patients < 75 years of age with NO prior GI endoscopic workup	Has a prosthetic heart valve
Family history of colorectal cancer (provided patient is at least 5 years younger than the age at which relative was diagnosed)	Has a co-morbidity with a future life expectancy of less than 5 years
Personal history of adenomatous colon polyps in a patient aged 50 to 75 years whose last colonoscopy was at least 5 years prior to referral	Under treatment for any heart disease or heart failure (they should be referred to GI outpatient clinic)
Colonic mass lesion seen on barium enema or CT scan	Under treatment for diabetes, emphysema, or hypertension (they should be referred to GI outpatient clinic)(if coordination with primary care provider is limited)

6. Health Literacy Resources

- ✓ Institute of Medicine, Health Literacy: A Prescription to End Confusion.
<http://www.iom.edu/CMS/3775/3827/19723.aspx>
- ✓ Agency for Healthcare Research and Quality, Questions are the Answers
<http://www.ahrq.gov/questionsaretheanswer/>
- ✓ US Department of Health and Human Services, HHS Quick Guide to Health Literacy
<http://www.health.gov/communication/literacy/quickguide/default.htm>
- ✓ National Library of Medicine, Understanding Health Literacy and its Barriers
<http://www.nlm.nih.gov/pubs/cbm/healthliteracybarriers.html>
- ✓ LINCS Health and Literacy Special Collection
<http://www.healthliteracy.worlded.org/>
- ✓ Harvard School of Public Health, Health Literacy Studies
<http://www.hsph.harvard.edu/healthliteracy/index.html>
- ✓ National Center for the Study of Adult Learning and Literacy
<http://www.ncsall.net/>
- ✓ Literacy Assistance Center
<http://www.lacnyc.org/profdev/healthlit>
- ✓ U.S. Department of Education, The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy
<http://nces.ed.gov/pubsearch/pubinfo.asp?pubid=2006483>

7. Outreach Strategies

The activities should be tailored to your hospital's goals and objectives. The below list is sample of activities navigator programs may want to consider.

Ways to increase provider referrals from outside the hospital:

- ◆ Target outside clinics and providers who may refer their patients for colonoscopy by site visits to describe the hospital screening program and GI services
- ◆ Organize an open house for interested outside providers/clinics to tour facilities and learn more about what the GI department/navigation can do for their practice/clinic
- ◆ Organize a colonoscopy/patient navigator "grand rounds" at your clinic for outside providers
- ◆ Craft a letter for outside providers (but this can be done for inside hospital providers as well who refer) reminding their average risk patients over 50 about the timeliness and importance of screening
- ◆ Provide birthday colonoscopy reminder postcards to community providers

Activities in conjunction with hospital community outreach department:

- ◆ Conduct information sessions/workshops in key locations throughout the community, such as senior centers and housing communities
- ◆ Have information sessions include a "peer educator" - someone who had a colonoscopy to describe the experience and assuage fear
- ◆ Bring in a doctor at community sessions who is from the community to reinforce messages of early detection
- ◆ Send follow up postcards and make follow up phone calls after outreach sessions
- ◆ Table at community centers and health fairs
- ◆ Create a "birthday card/reminder" list for friends and family who would like to remind a family member to get a colonoscopy. (This

would be done at tabling events where the invitee fills out pertinent address information and navigators send out the card.)

- ◆ Develop a cancer survivor's day during March highlighting navigator activities and coinciding with other CRC awareness.
- ◆ Promote the navigator program through media (especially in March)

General community outreach efforts:

- ◆ Create navigator "cards" that include the navigator's phone number and location of clinic plus other necessary information emphasizing one on one follow up with the navigator
- ◆ Make sure patients know of other community services to help decrease activities that increase CRC (smoking, obesity, etc)
- ◆ Provide incentives/cues to action through posters/birthday cards and other give-aways
- ◆ Describe survivor stories in education and materials (This may be through interviewing a peer educator or survivor to capture their story for literature.)
- ◆ Throw "parties" as information sessions (This would involve recruiting volunteers to host parties in homes/community centers to provide information on the procedure and health in general.)
- ◆ Disseminate materials throughout hospitals, mammography vans, etc
- ◆ Outreach to pharmacies (This method would include displaying CRC information and providing locations for where to receive a colonoscopy.)

8. Case Studies

Jessica

Jessica was a single mother in her late 40's, whose doctor had referred her for a diagnostic colonoscopy due to symptoms she was experiencing. Sara first met Jessica after her exam, and after she had attempted to schedule an appointment. Sara noticed immediately that Jessica was crying and appeared very angry and agitated.

The first thing Jessica said to Sara was, "I need to have this procedure and I can't do it unless I can leave in time to pick up her my children!"

Sara asked her to explain her situation more. Jessica explained that she was a single mother of two children. She was very concerned that, after the procedure, she be available to pick up her children after school. She told Jessica that there was no one else who would be able to meet them and bring them home. When Jessica had attempted to make her appointment for the colonoscopy a few minutes before, she had requested an appointment for early in the morning. However, the usual procedure at Hamilton Hospital was for patients to be informed of the time of their procedure only a day or two before the procedure itself, at the same time that a staff member called to confirm their appointment. The scheduling staff had told Jessica that they could not guarantee any patient a specific time for the procedure. Jessica was concerned that if her colonoscopy were too late in the day, she would not be able to meet her children. In this case, she would not be able to come in for the procedure.

Jessica added again that she felt that she really needed to have the procedure. Sara understood that Jessica was truly concerned, because she believed that she might be ill, due to the symptoms she was experiencing. However, Jessica did not discuss her symptoms with Sara, and Sara did not ask her to explain further.

Sara asked Jessica if it would help her if she were assured in advance that her appointment would be in the early morning. She explained to Jessica approximately what time she might be able to leave the hospital if she were to have the first appointment of the day at 9:00AM. She also made sure that Jessica understood that she would need to be escorted home after the procedure, and would need some additional time to recover from the anesthesia. Jessica agreed that having a procedure

early in the day would meet all of her needs, and make it possible for her to pick up her children in time.

Sara then went to the scheduling department to request that they secure an early appointment for Jessica on the day she was scheduled to have the procedure in advance. Sara understood that the clinic could not accommodate the scheduling requests of all of the patients who needed colonoscopies. However, from her conversation with Jessica, she also felt sure that in this case, making a special scheduling arrangement could make a critical difference in ensuring that she would have this necessary procedure. The scheduling staff was willing and able to accommodate this request, and made an advance arrangement to secure the first procedure of the day for Jessica on the day of her appointment.

When Sara informed Jessica that she was scheduled for the earliest appointment of the day, Jessica appeared very relieved. She assured Sara that she would come for her appointment, and thanked her warmly.

Cesar

Cesar was a Latino man in his mid-fifties who had been referred for a routine screening colonoscopy by his primary care physician. Ana, the patient navigator, first met Cesar after his physical examination. She routinely met with all patients who were referred for a colonoscopy, to help them to arrange an appointment, to answer any questions that they might have, and to ensure that they knew how to prepare themselves for the procedure. Cesar spoke only Spanish, so he and Ana spoke in Spanish.

As their conversation begun, Cesar expressed resistance to having the procedure, saying "I don't need this procedure. I feel fine. Why should I have this procedure when I'm feeling absolutely fine?"

Ana listened to his questions patiently. She responded, first, by describing the procedure. She explained that the procedure involved a very small camera, and that the purpose of the test was to look for polyps or cancerous growths in the colon. She explained that the polyps could exist without causing any other symptoms.

Cesar responded "But I feel fine! Why should I do this?"

Ana listened to his question again, and went on to explain several other important reasons why having a colonoscopy was in Cesar's best interest.

She explained that non-cancerous polyps develop into cancerous growth over time. She also assured him that the colonoscopy was a procedure with minimal risk, and that would only take two days out of his regular routine of work and home life. She also noted that most patients find the discomfort associated with the procedure to be minimal. As she spoke, she was careful to speak gently to ensure that he felt that she was taking his concerns seriously.

After Ana had provided him more explanation, Cesar asked her, "Do you think I really need it?"

Ana reminded him that the colonoscopy is a procedure that is recommended for all women and men over the age of 50. She assured him his doctor had referred him for this procedure, because it was an important, routine screening. She also explained that colon cancer is a relatively prevalent disease, and that this was the reason for the screening intended to prevent it. She also explained that is also an illness that is easily treatable, especially if it is diagnosed early.

After this explanation, Cesar agreed to have the procedure. Ana noticed that by the time he had agreed, he appeared much more relaxed and at ease than he had at the beginning of their interview. So, she then explained what he would need to do to prepare for his colonoscopy carefully, ensuring that he was aware of the aspects of the preparation that might be more difficult, and knew what to expect.

Their interview had lasted about 15 minutes, which Ana noticed unusually long for an interview. She had needed this extra time to listen to his questions, and to convince him to have the colonoscopy. After their interview, following her usual procedure, Ana walked with Cesar him to the admissions office to make sure he arrived without getting lost, and without changing his mind. There, she introduced him to the Admissions staff. As she left, Cesar said warmly, "Thank you for helping me with this. I appreciate your kindness."

Later, when Ana was entering data on patients who had received colonoscopies, she encountered Cesar's records. According to the notes, Cesar's colonoscopy exam had detected colon cancer.

Carmen

Carmen was a sixty-two year old home health care worker. Originally from Nicaragua, she only spoke Spanish.

Carmen had received a colonoscopy at Hamilton Hospital after her doctor recommended that she have one for routine screening. Carmen's colonoscopy revealed that she had a cancerous growth in her colon. However, following the procedure, Carmen did not come for her follow-up appointment.

Each month, Ana, a Patient Navigator, received a list of patients who were scheduled to come in for a follow-up appointment. The list also included information about the patients' diagnosis, and any previous missed appointments. From this, she knew that Carmen had not come in for her previously scheduled follow-up appointment, and also that she had received a positive diagnosis.

Over the course of the next five days, Rosa made six attempts to call Carmen, without success. Because Carmen did not have an answering machine, Ana was unable even to leave a message for her. After her sixth attempt to make a call, Ana requested permission from Carmen's doctor, Dr. Rodriguez, to send a telegram to her home. Dr. Rodriguez granted this permission. The same day, Ana also decided to attempt to call Carmen in the evening, thinking that perhaps she might have a better chance of reaching her after work hours. So, Ana placed a call at 6PM, and this time, Carmen answered the phone.

Ana began their phone conversation by telling Carmen her name, and explaining that she was a Patient Navigator at Hamilton Hospital. Then, she asked Carmen why she had missed her follow up appointment.

Carmen replied that she had to work every day from nine to five, and could not miss a day of work, adding that she lived alone and did not have anyone else who could help her to pay her bills. Ana replied that it was very important to come for the follow up appointment, and that at the appointment the doctor would talk to her about the outcome of her test. Sounding worried, Carmen asked, "What is wrong? Is something wrong with me?" Ana replied carefully, stating that she was not a doctor and only that the doctor could tell her the results of her medical tests. Ana added that it is always very important for a patient to come to a follow-up appointment.

Ana responded that by expressing more concerns that taking a day off from work could cause her difficulties at her job. Carmen asked if it would help for her to write a note from the hospital to her employer, stating that she needed to be excused for medical reasons. With this reassurance, Carmen agreed to come for her appointment. Ana also told Carmen that when she came for her follow-up appointment she would be there to meet her in person after she met with the doctor.

In their phone conversation, Ana also encouraged Carmen to bring a family member with her to the appointment. Knowing that Carmen would receive upsetting news about her diagnosis, she felt it might be helpful to Carmen to have the support of a friend or family member. However, Carmen replied that she did not have anyone who could come with her to this appointment. Knowing this, Ana realized that the emotional support she could provide to Carmen after her meeting with the doctor might be especially important.

On the day of Carmen's follow-up visit, Ana went to meet with her after her appointment with Dr. Rodriguez. When she found Carmen, Carmen was crying and distressed, just as Ana expected she might be. Ana sat with Carmen, and listened to her as she expressed her feelings of fear and shock. Then, when she felt Carmen was ready, Ana talked to Carmen about Richard, the patient navigator from the American Cancer Society who worked at Hamilton Hospital. She asked Carmen if she could give Richard her name and phone number, so that he could help Carmen over the next few months.

After Carmen had completed her course of chemotherapy, she received a second colonoscopy. It was approximately one year after the first colonoscopy she had received. Her second colonoscopy revealed that she had no evidence of cancer. Carmen sent Ana a holiday card thanking her for all of her help, and they have remained in contact ever since.

Graciela

Graciela was a familiar and friendly face to the staff at Hamilton Hospital even before she had her first medical appointment there. Graciela earned her livelihood by purchasing clothing wholesale at a factory, and then selling the clothing to local merchants and other people in the neighborhood surrounding Hamilton Hospital. She would often come to the hospital to sell clothing to staff who were interested, or would set up a

table outside on the sidewalk. Sara, the Patient Navigator, had met and spoken with Graciela several times.

Graciela had arrived in New York City only two years before from Colombia, and decided that she would like to have a routine check-up. Although she did not have health insurance, she did not mind paying for medical services. She was proud to be a person who took care of her health, and since she was already on friendly terms with the staff at Hamilton Hospital, she was felt comfortable receiving medical care there.

At her check-up, her doctor recommended that she have a colonoscopy. Graciela was in her late 40's, which made her somewhat younger than the age of patients usually recommended for a routine colonoscopy. However, the doctor felt it would be in her best interest because of her family history.

When Graciela first met with Sara to discuss the preparation and arrangements for her procedure, she was surprised to learn that Sara was a patient navigator for the colonoscopy clinic. She and Sara were already acquainted, but she had not known that this was Sara's position. Perhaps because of their previous relations, and perhaps because of her naturally outgoing style, Graciela seemed quite comfortable speaking openly with Sara. However, Sara learned quickly that Graciela was very reluctant to have the procedure.

Graciela told Sara that she had heard that the procedure could be very risky. A friend of Graciela's in Colombia had told her the story of an acquaintance who had a colonoscopy that had torn her intestines. According to Graciela's friend, this acquaintance had lasting damage to her intestines as a result.

Sara listened to Graciela's concerns and to the story, and then explained her that the procedure is very safe, and the risk of complications is very small. She explained to Graciela that the camera used in the colonoscopy procedure is very narrow, and attached to a very flexible, narrow cord. Sara also showed Graciela the approximate width of the camera, so she would understand better. She also explained that the colonoscopy only examines the inside of the colon, and does not reach as far as the intestines. She told to Graciela that there is a very small risk that her colon could be perforated as a result of the procedure, and that this complication occurs in a very small percentage of patients who have a colonoscopy. She also showed Graciela a diagram of the colon so that Graciela would understand better the difference between the colon and the intestines.

Graciela suggested that perhaps the procedure was done differently in Colombia, and this might explain how her friend's acquaintance had ended up with an injury. However, Sara assured her that the procedure is probably done the same way in most locations, and respectfully suggested that the story Graciela heard might be exaggerated.

Sara's explanation reassured Graciela, and Graciela agreed to have the procedure. Sara continued with their discussion and with helping Graciela understand how to prepare for the procedure. During this conversation, Graciela also shared more about her life with Sara, telling her about her family back in Colombia and her hopes to bring her son to live with her in New York. Sara enjoyed speaking to Graciela in this comfortable, informal way, and she also felt that by having a friendly conversation she was helping Graciela to feel more confident and comfortable.

Graciela went on to have her colonoscopy, and the results of her test were negative. She remains a frequent visitor to the hospital, and she and Sara often have a chance to have a friendly conversation.

Rowena

Rowena is in her mid-fifties, married, and with a twenty-seven year old son who also lives with her. Rowena is originally from Guyana, but she has lived in the Bronx since 1990. She used to hold a job, but stopped a few years ago after she had an aneurism, and the doctors recommended that she stop. She also has diabetes, and is very careful to care for her health.

One year Rowena decided to return to Guyana for a vacation. During her visit one morning, Rowena had trouble having a bowel movement. Normally her digestion is very regular, so she wondered right away if something was wrong. At first, she thought maybe the cause was the change in her diet, since she was traveling. However, the problem persisted for three days. By that time, Rowena was concerned. She knew her health very well, and she thought that she should contact her doctor.

When she returned to the Bronx, she went to see her OB/GYN, Dr. Wallace. After hearing about Rowena's symptoms, Dr. Wallace told Rowena that she should have a colonoscopy. Dr. Wallace was insistent that Rowena go to have the procedure right away, emphasizing the

urgency of the test. When Rowena heard Dr. Wallace say that she should have the colonoscopy "right away," she began to feel frightened and worried. She had already been concerned about the symptoms she had been experiencing. She wondered, "What is wrong with me?"

Dr. Wallace arranged for Rowena to be scheduled for a colonoscopy at Hamilton Hospital, and Rowena was able to have the procedure without encountering any difficulty or obstacles. However, she still felt very anxious about what the test results would be.

A few days later, Rowena received a phone call from Jonathan, a Patient Navigator at Hamilton Hospital, reminding her to come in for her follow up appointment later that week. When Rowena heard Jonathan asking her to come back to see the hospital, she suddenly felt terribly afraid. The feeling came so suddenly that it was a shock to her system, and her head began to hurt badly.

When Jonathan asked Rowena to confirm that she would come in for her appointment, she told him that she couldn't come in, because she was feeling sick. It was true that she felt ill - but Rowena knew that this was just because she was so scared!

Jonathan responded by explaining to her the value and importance of early detection for preventing and treating colon cancer. He explained that often, even for patients who receive a positive diagnosis, the treatment is very simple, and it can prevent the disease from becoming much more serious. Jonathan did not tell Rowena anything about her diagnosis, but he did emphasize the importance that she come in to learn what her diagnosis was from the doctor.

After his explanation, he asked Rowena if he could schedule another appointment for her, a few days later when she might be feeling better. By this time, Jonathan had convinced Rowena that she should come back to talk to her doctor. Jonathan's suggestion that she make a new appointment helped Rowena save some embarrassment, because she did not have to admit that she wasn't really sick today. So, Rowena agreed to let Jonathan schedule the new appointment, and she promised that she would come.

Rowena did indeed come in for her new follow-up appointment. At that appointment, her doctor told her that her test had shown an ambiguous diagnosis, and that he wanted to schedule another colonoscopy to confirm that she was all right. Rowena agreed to have the second colonoscopy, and had the procedure a few days later.

Rowena's second colonoscopy resulted in a negative diagnosis, giving her a clean bill of health, and peace of mind. Now, she feels strongly that everyone should have a colonoscopy, and she feels comfortable coming back to Hamilton Hospital for any check-ups or treatment she needs.

Teresa

Teresa was a 52 year old woman. Born in the Dominican Republic, she had lived in New York for a few years but was undocumented. Teresa's doctor had recommended that she have a routine screening colonoscopy.

When Ana, the patient navigator first met with Teresa to help her arrange and prepare for her appointment, she learned that Teresa did not have insurance. Ana suspected that this might be an obstacle to Teresa having the procedure. However, she decided it would be better if she didn't show that she was concerned during this first conversation. She knew that Teresa would discuss fees for the colonoscopy and payment options later that morning when she met with the scheduling staff. Ana thought that if she mentioned the cost of the procedure at this point, Teresa might decide that she couldn't afford the colonoscopy, and might leave without discussing her decision further.

So, instead, Ana made a mental note to follow up with Teresa after her appointment with the scheduling staff. If it turned out that payment would be a problem for Teresa, Ana could help her explore her options then. If not, she would not have alarmed Teresa unnecessarily.

Later in the day, when Teresa had completed all of the testing and appointments she needed to schedule her colonoscopy, Ana met up with her as planned. When Ana asked Teresa if she had any questions or concerns, Teresa told her, just as she expected, that she could not afford the procedure. Ana then told Teresa about some of the possible payment procedures for patients without insurance. She arranged for Teresa to meet with the billing department to explore her options further. In some cases, patients can apply for an emergency Medicaid payment. In others, patients who are able to show that they are financially in need may qualify to pay a lower fee through the hospital's "sliding scale" system. Teresa learned that she did not qualify for emergency Medicaid, but she did qualify for a reduced fee on the sliding scale. The usual fee for the procedure was approximately \$800, but she would be charged \$150. In addition, she could pay the fee in three installments, and would need only to pay the first installment before having the procedure.

Ana was concerned that even with the reduced fee, the cost of the procedure would be prohibitive. She knew that for Teresa, \$150 was a significant amount of money. Teresa left that day without making an appointment saying that she would save up the money for the procedure fee, and return when she could pay the first installment.

Ana hoped that by encouraging Teresa to have an appointment, and by showing that she would support her in overcoming financial obstacles, this would encourage Teresa to go ahead and have her colonoscopy. However, she suspected that Teresa would never return for an appointment. She knew that patients often told her and the other staff that they would come back later, simply as a nonconfrontational way of ending the conversation.

However, Ana was pleasantly surprised a few weeks later when Teresa came in to make an appointment. She had saved the money she would need to pay the reduced fee, and went on to have the colonoscopy she needed.

Colonoscopy Screening Database

Version 1.0.0

User's Guide



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Preface

Introduction

This **User's Guide** accompanies the Colonoscopy Screening Database developed by **Danenberg Consulting LLC** for the **Fund for Public Health in New York, Inc.**

Reading this guide should familiarize you with the basic use of the application. Having the application open is recommended, as the illustrations within are not intended to replace hands on experience with the interface.

Getting Started

Installation

The installation of this software is detailed in the **Administrator's Guide**. For the purposes of the User's Guide, we'll assume that the software has been properly installed.

Launching the Application

There should be a shortcut on your desktop for this program. Simply double-click the icon and Microsoft Access will open the Front End application. The program starts at the *Main Switchboard* form. Before we move on, we need to verify that the application is configured for the correct Location.

Location

This software is designed so that it may be used at multiple sites and the data collected centrally for analysis. In order for this to function, each installation location (such as a hospital) must be configured properly. This allows the exported data to generate unique identifiers that are unique across all locations. The **Administrator's Guide** explains how to set up your location. If your location is not set up properly, you may still enter data, but data export is disabled.

Getting Started

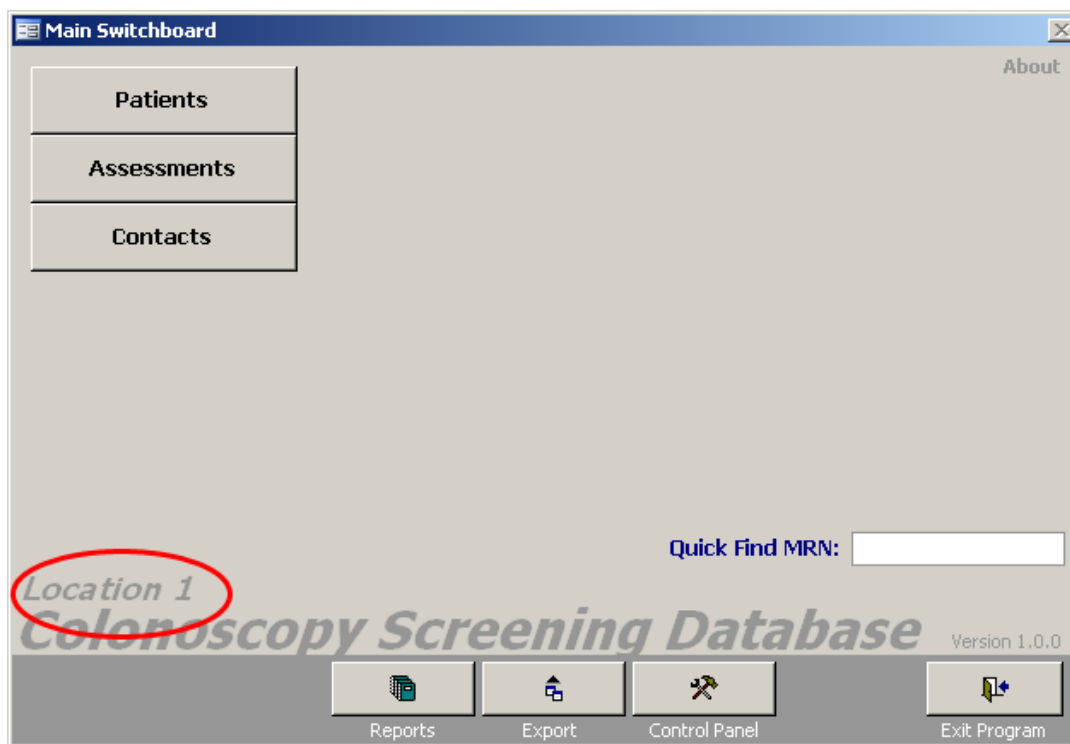


Figure 1.

You can tell that your location is properly set up by looking just above the application title “Colonoscopy Screening Database” on the *Main Switchboard* form. The currently configured location is displayed here (see *Figure 1*).

The Basics

Quick Tour

When you've launched the application as explained above, you're ready to take a look around. The first thing you'll see is the *Main Switchboard*.

Main Switchboard

The *Main Switchboard* is the central form of the application. The three buttons in the top left corner lead to the main data entry sections of the database. Patients, Assessments, and Contacts represent the bulk of the data tracked.

Patients – Self-explanatory, these are people who have entered the system for

The Basics

medical treatment and procedures.

Assessments – An Assessment (aka **CRC Assessment**) encompasses the series of events that a Patient experiences while receiving care, including Referral Appointments, Pre-Admission Testing, Colonoscopy Procedures, Fecal Occult Blood Tests, Follow-ups, and Navigator Activities. In evaluating the success of patient navigation, we look at this series of events as part of a larger storyline.

Be aware that a Patient may have multiple Assessments. This would happen, for instance, if a Patient visited for a Colonoscopy, was treated accordingly, and for whatever reason came back a year or two later for a new Colonoscopy. These would be considered two distinct Assessments for the purposes of data study.

A Patient who received a Colonoscopy and then a follow-up Colonoscopy a few months later would have both procedures included in the same Assessment. This is because the procedures were related to the same episode of patient navigation.

Contacts – All people or organizations tracked in the system are considered Contacts. This includes Patients, Navigators, Providers, Clinics, Referrers, Insurance Companies, and other “Roles” in the system. It is possible for the same Person or Organization to function as more than one Role. For instance, Dr. Clinton Furlow, a sample Provider in our database, could also have referred several Patients.

All Contacts are available in this central location for easy reference.

The buttons on the bottom of the *Main Switchboard* are [Reports](#), [Export](#), [Control Panel](#), and [Exit Program](#).

Reports – Any printed Reports in the application are available here.

Export – This leads to an interface for exporting a complete set de-identified data to a ZIP file.

Control Panel – Utilities for setting up the application are here.

Exit Program – Quits the application.

You'll also see the [Quick Find MRN](#) feature on this form:

Quick Find MRN:

This provides a speedy way to locate a Patient in the system using their Medical Record Number. Just enter the number and press <ENTER>. You can also double-click the field to clear it. (Double-clicking certain fields does various useful things throughout the application.)

The Basics

Patient Form

If the sample data hasn't been cleared, do a [Quick Find](#) from the *Main Switchboard* for the MRN 123456. This will pull up the *Patient* form for Ulysses Ackerly. Otherwise, search on another MRN you know is in the system.

The screenshot shows a web-based form titled "Patient" for a patient named Ulysses Ackerly. The form is organized into several sections:

- Patient Name:** Ulysses Ackerly (with an EDIT button)
- MRN:** 123456
- SSN:** (empty field)
- Demographics:** Includes fields for Date of Birth (with a "DOB Unknown" checkbox), Gender (Male), Race (White), Ethnicity (Non-Hispanic), Country of Origin, and Language.
- Contact Info:** Includes Address (Home Primary: 1 Long Ave., Apt 1A, New York, NY 12345) and Comm Points (Home Phone: (212) 123-4567, Work Phone: (212) 765-4321).
- Assessments:** A table with columns for Ref Date, Colo Date, and Complete. One assessment is listed: Ref Date 6/1/2007, Colo Date 6/15/2007, Complete True.

Buttons for "New" and "Edit" are visible at the bottom right of the form.

Figure 2.

The *Patient Form* is used for entering a Patient's demographic information. Other information, such as the Patient's name, Address, and Comm Point (phone, e-mail, etc.) are entered using the *Person* form. You can open the Patient's *Person* form by clicking the [EDIT](#) buttons next to the Patient Name and Contact Info sections of the form.

You'll also see a summary of Assessments here. For most Patients, there will probably be zero or one Assessments listed here. Our sample Patient has one Assessment listed in progress. You may double-click the Assessment record to open and edit using the *CRC Assessment* form. You may also click [NEW](#) to create a brand new Assessment for this Patient.

Let's double-click the Assessment record to see what the *CRC Assessment* form looks like...

CRC Assessment Form

This form is the focal point of the application. Most of the data you enter will be entered here.

The Basics

The screenshot displays the 'CRC Assessment' form for patient 'Ulysses Ackerly'. The form is divided into three main sections:

- Patient Info:** Contains fields for Patient Name (Ulysses Ackerly), Gender (Male), Age, Address (1 Long Ave. Apt 1A, New York, NY 12345), MRN (123456), SSN, Date of Birth, Country of Origin, Race (White), Ethnicity (Non-Hispanic), Language, Home Phone ((212) 123-4567), and Work Phone ((212) 765-4321). There are 'EDIT' buttons for each section.
- Event Index:** A table with columns 'Date' and 'Type'. It lists several events: 6/1/2007 Ref Appt (selected), 6/4/2007 Nav Act, 6/5/2007 PAT, and 6/15/2007 Colonoscopy.
- Event Detail:** A tabbed interface with tabs for 'Referral Appt', 'Pre-Admission Test', 'Colonoscopy', 'FOBT', 'Follow-up', 'Navigator Activity', and 'Status'. The 'Referral Appt' tab is active, showing fields for Appt. Date (6/1/2007), Clinic (Sample Clinic), Time (4:30:00 PM), Referrer (Furlow, Clinton), Referrer is PCP (checkbox), Navigator (Penwell, Elva), Insurance (Aetna), Smoker (checkbox), Date Quit, Family Cancer Hx, and Indication (Unknown). Below these are 'History' and 'Navigator Notes' sections with input fields for Type of Polyp, Size of Polyp, Last Colonoscopy Date, and Prior Colonoscopy. A record navigation bar at the bottom shows 'Record: 1 of 1 (Filtered)'.

Figure 3.

The basic layout of the CRC Assessment form is in three sections. The top part of the form displays the Patient's basic information. This information is not editable here, but you may use the EDIT buttons to launch the forms for entering this data.

The subform on the left shows a sequential index of all Events relating to this Assessment. This is sorted by Date and may display All records or only Filtered to the current Event Type.

The tabs at the bottom of the form represent the detail records of each Event recording for this Patient. The easiest way to navigate to these records is by clicking on the desired entry in the Event Index. This will automatically pull up the proper tab and record.

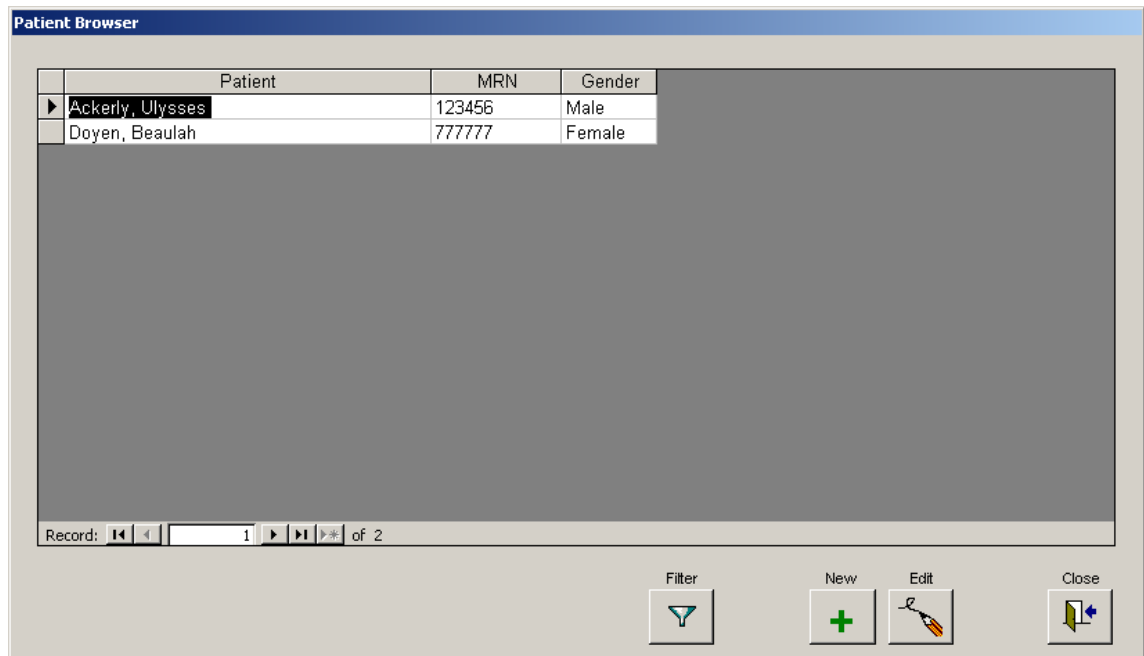
In addition to tabs for each Event Type, there is a Status tab. The Status tab shows a summary of the Patient's Assessment at a glance.

Click the Exit button in the top right to close this form and return to the *Main Switchboard*.

Patient Browser

Click the Patients button on the *Main Switchboard* to go to the *Patient Browser*

The Basics



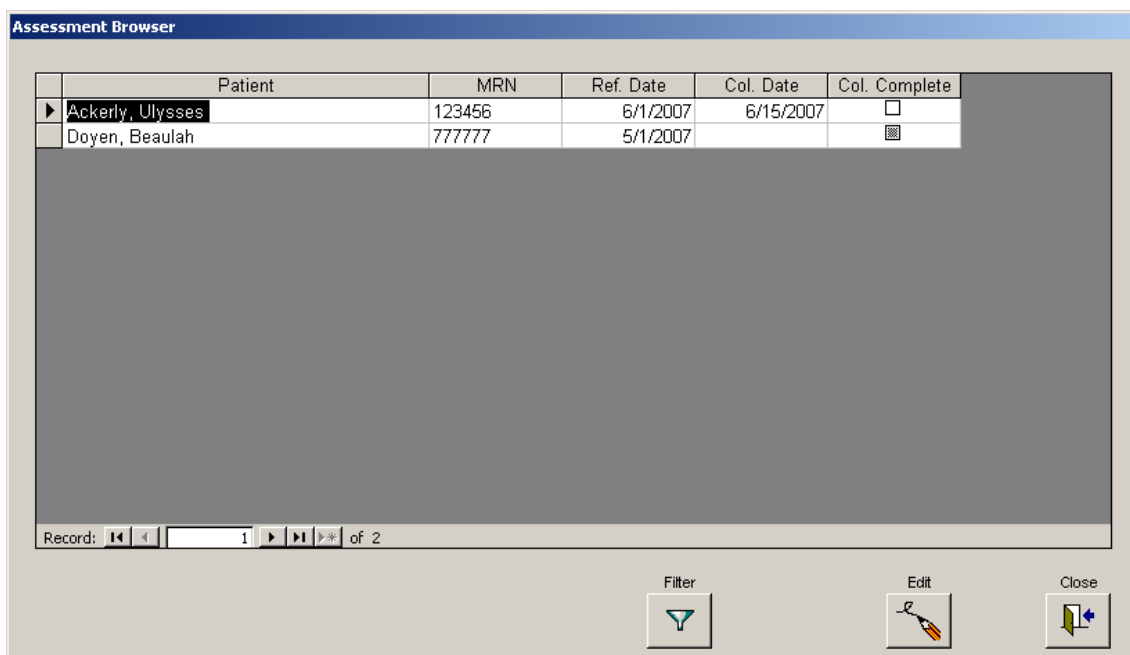
The *Patient Browser* lists all the Patients in the system. You can double-click any record to bring up its *Patient* form. You can also filter the Patient list by clicking the Filter button. This lets you search by name or MRN. The New button brings up an interface for creating a new Patient record.

Click Close to return to the *Main Switchboard*.

Assessment Browser

Click the Assessments button on the *Main Switchboard* to go to the *Assessments Browser*.

The Basics



The *Assessment Browser* is much like the *Patient Browser*, except that it lists all Assessments in the system. You may click Filter to limit the selection by name, MRN, Referral Date, Colonoscopy Date, or Colonoscopy Status. Double-clicking a record opens the *CRC Assessment* form for that entry.

Note: You cannot add a new Assessment here. This must be done from the *Patient* form. Also, Assessments with more than one related Referral Appointment or Colonoscopy event may be listed more than once in the *Assessment Browser*. This is in part to optimize speed and also offer searching by date for any of the component Referrals or Colonoscopies.

Click Close to return to the *Main Switchboard*.

Interface Notes

The Contact Chooser

There are many fields in the database interface that require the selection of a Contact of a specific Role. Examples include choosing a Referrer or an Insurance Company or a Clinic. A dropdown box allows you to choose any of the existing Contacts eligible for that Role. However, you may launch the *Contact Chooser* form to select a candidate from the desired Role, from a different Role, or to add an entirely new Contact to that Role.

This demonstration shows how to select a Navigator for a Referral Appointment

The Basics

record within a Patient's *CRC Assessment* record. Assuming you've opened an Assessment, you'll find a Navigator field on the Ref Appt tab:

The screenshot shows the 'Event Detail' window with the 'Ref Appt' tab selected. The form contains the following fields and options:

- Appt. Date: 6/1/2007
- Clinic: Sample Clinic
- Time: 4:30:00 PM
- Referrer: Furlow, Clinton
- Referrer is PCP:
- Insurance: Aetna
- Navigator: (highlighted with a red circle)
- Smoker:
- Date Quit: (empty)
- Family Cancer Hx: (empty)
- Indication: Unknown

Below these fields are two sections: 'History' and 'Navigator Notes'. The 'History' section includes fields for 'Type of Polyp', 'Size of Polyp', 'Last Colonoscopy Date', and 'Prior Colonoscopy'. The 'Navigator Notes' section is a large empty text area. At the bottom, there is a record navigation bar showing 'Record: 1 of 1'.

You can select or type the name of an existing Navigator in the drop-down box:

This close-up shows the 'Navigator' field with a list of names displayed below it:

- Referrer: Furlow, Clinton
- Navigator: (dropdown menu)
- Penwell, Elva
- Stooks, Earle
- Smoker:

Or you can *double-click* the field to launch the Contact Chooser form:

The Basics

The screenshot shows a software window titled "Contact Chooser" with a subtitle "Choose a navigator...". The interface is split into two main sections. The left section, labeled "Search", contains a text input field, a "Role:" dropdown menu currently set to "Navigator", and a table titled "Contacts found:". The table has a header "Name" and two rows: "Penwell, Elva" (which is selected with a blue highlight) and "Stooks, Earle". Below the table, it indicates "Record: 1 of 2". The right section, labeled "Detail", displays "Elva Penwell". At the bottom right, there is an "Actions" panel containing three buttons: "Cancel", "Create New Navigator", and "Choose Elva Penwell".

By default, the available Navigators in the system show up in the search results on the left. You can simply *double-click* or click the Choose button in the lower right corner to populate the Navigator control in the target form.

Entering text in the Search box limits the search results to names that match or begin with the text you enter.

You may also select from the Role drop-down box to return results from a different Role. You'll typically want to avoid this, but this feature is included so that if you know someone is in the system as a Provider, you can promote them to Navigator without creating a duplicate Contact record for them.

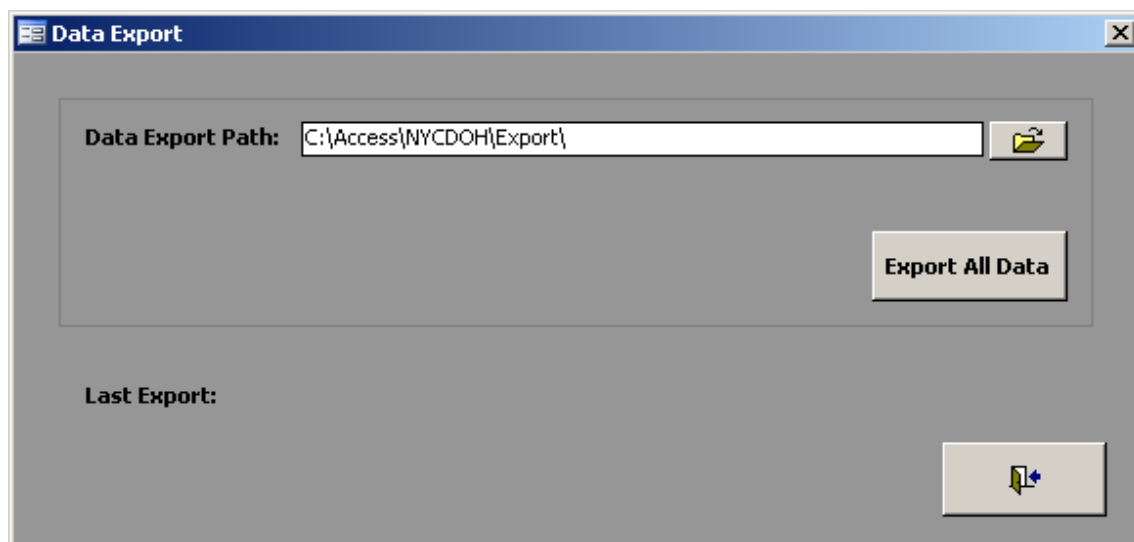
If any contact information is available for the selected Contact, this will display in the Detail section of the form. This should help discern between similarly named records.

Data Export

The application allows a complete de-identified set of existing data to be exported to a standardized ZIP file. This file may then be sent to a central location, combined with data from other Locations, and analyzed as a whole.

The *Data Export* interface is available by clicking Export on the *Main Switchboard*.

The Basics

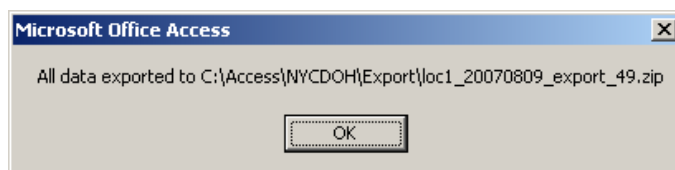


You'll be all set to export to the default Data Export Path. If you need to export to a different location, type in the path to the new folder or click the folder button and select using the folder dialog.

Note: You'll need to have read/write permissions on the specified export path in order for the data export to work. Otherwise, the program cannot create the necessary temporary files or final ZIP file.

If you've exported previously, the last export filename will display at the bottom of this form.

Click the Export All Data to copy the entire application data to a ZIP file. This may take a few minutes to run. When the export is complete, you'll see a message box stating the full filepath of the exported ZIP file:



Notice that the filename is encoded with the Location, the Date exported, and the ID number of the export. Consecutive ID numbers will not be sequential. This is because the ID's are selected to be unique across all installation Locations of this software.

The ZIP file contains several Excel XLS files. The structure of these files is documented elsewhere, but the important thing to note is that all Patient information contained within is de-identified.

How To

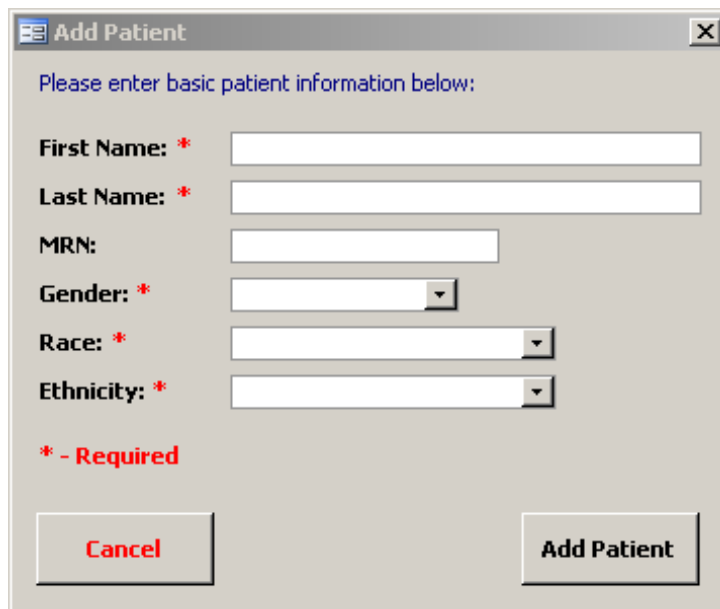
Common Operations

How Do I Add a Patient?

First, please verify that the Patient is not already in the system. The easiest way to do this is by going to *Main Switchboard* -> *Patient Browser* -> *Filter* and entering a partial Last name. You can then eyeball the filtered results and identify anyone in the system who might be the same person.

If the person is not in the system, you may add them following these steps:

1. Open *Main Switchboard* -> *Patient Browser*.
2. Click New and enter the basic Patient information:



3. Click Add Patient and continue editing on the *Patient* form.
4. Enter basic demographic information directly on the *Patient* form.
5. Click either the EDIT button next to the Patient's name or contact information to pull up the *Person* form. You may enter address, phone numbers, and e-mail addresses here.
6. When you finish entering the Patient's information, you may exit the Patient form or click New in the Assessments section to start a new

How To

Assessment record for this Patient.

How Do I Add a CRC Assessment?

To add an Assessment for a new Patient, please add the Patient as explained in **How Do I Add a Patient?**

For existing Patients, follow these steps:

1. First locate the Patient record. You may Quick Find MRN on the *Main Switchboard* if you know the Patient's MRN. Otherwise, try going to *Main Switchboard* -> *Patient Browser* -> *Filter* and searching on the Patient's name.
2. Quick Find, if successful will bring you directly to the proper *Patient* form. If you used the *Patient Browser*, then double-click the record to open the *Patient* form.
3. On the *Patient* form, click New in the Assessment section to create a new Assessment. Please do not create a new Assessment if there is an existing Assessment record listed that should properly contain the data you wish to enter.
4. You should be at a new *CRC Assessment* form record. The Patient information at the top should already be entered, but you may use the EDIT buttons to make any necessary modifications.
5. Enter any events related to this Assessment directly into the appropriate tabs at the bottom. Typically, you may start with a new Referral Appointment. Multiple events of the same type are possible, especially Navigator Activities. You may use the record navigation controls at the bottom of each tab to move to the "insertion point" for entering a new event. The button is marked >*.

How Do I Delete a Patient?

Warning: Deleting a Patient also deletes all CRC Assessments and related Events that belong to that Patient. Also, this operation cannot be undone.

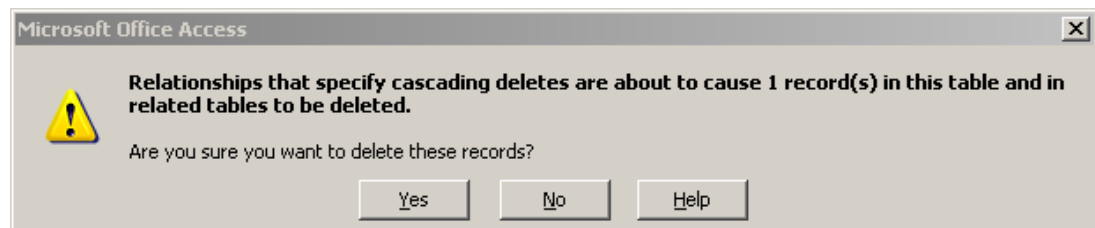
Check with your database administrator for guidelines regarding the deletion of data. Generally, deletions in this database should only be necessary to correct data entry errors.

Follow these steps to delete a Patient:

1. First locate the Patient record. You may Quick Find MRN on the *Main Switchboard* if you know the Patient's MRN. Otherwise, try going to *Main Switchboard* -> *Patient Browser* -> *Filter* and searching on the Patient's name.

How To

2. Quick Find, if successful will bring you directly to the proper *Patient* form. If you used the *Patient Browser*, then double-click the record to open the *Patient* form.
3. On the *Patient* form, choose *Edit -> Delete Record* from the top menu.
4. You are then asked to confirm the deletion. Click Yes to delete the Patient record and any related records.



5. The *Patient* form will blank out. Click the Exit button to close the *Patient* form.

How Do I Delete a CRC Assessment?

Warning: Deleting a CRC Assessments also deletes all related Events within that CRC Assessment. This operation cannot be undone.

This will not delete the Patient record or their contact information.

Follow these steps to delete a CRC Assessment:

1. Assuming you have the *CRC Assessment* form open and on the record you wish to delete, first make sure the form itself has the focus. Do this by clicking either the All or Filtered button of the Event Index.
2. Choose *Edit -> Delete Record* from the top menu.
3. You are then asked to confirm the deletion. Click Yes to delete the CRC Assessment record and any related records.

How Do I Add a Clinic?

You may add a Clinic in one of two ways. Adding from the *Contact Chooser* lets you add Clinics on the fly during data entry. The alternative adding from the *Contact Browser* lets you add contact information such as addresses and phone numbers.:

From the Contact Chooser

1. From the Referral Appt tab of the *CRC Assessment* form, double-click Clinic to open the *Contact Chooser* form.
2. Click Create New Clinic.

How To

3. Type in the name of the organization, press <Enter> and click Add.
4. The new clinic is now in the system. You may select it now from the *Contact Chooser* to fill in the Clinic field.

From the Contact Browser

1. Click Contacts on the *Main Switchboard* to open the *Contact Browser*.
2. Click New.
3. Select Organization and type in the name.
4. Select “Clinic” from the Role dropdown box.
5. Click Add.
6. The Organization form opens with the new record. You may add contact information now if you wish.

How Do I Add an Insurance Company?

Adding an Insurance Company is similar to adding a Clinic. You can add via the *Contact Chooser* as you enter Insurance Company data by double-clicking any Insurance dropdown box. The Contact Browser lets you add a new Insurance Company or any other kind of contact.

How Do I Add a Navigator?

Adding a Navigator is similar to adding a Clinic. You can add via the *Contact Chooser* as you enter Navigator data by double-clicking any Navigator dropdown box. The Contact Browser lets you add a new Navigator or any other kind of contact.

How Do I Change the Role of a Person or Organization?

Changing Roles is not supported by the application. For example, if you mistakenly enter a Clinic as an Insurance Company, you will have to delete the incorrect record and re-enter it properly.

Additional Help

In order to ensure successful use of this application, we provide user support in any of the following formats. Please note that beyond issues specifically warranted, all support is billed under terms of the current Maintenance Agreement.

How To

Online

Online support is available at **Danenberg Consulting's** support site:

Support Site URL:

<http://www.danenbergconsulting.com/support/apps/coscr/>

Your username and password was provided with the installation documentation specific to your Location. If you have lost this information, please e-mail us and we can provide this.

A downloadable version of this manual is also available online at this Support Site.

E-mail

E-mail support is available at support@danenbergconsulting.com

Phone

If you do not find the information you need online, please contact us at:
(646) 435-0947.

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