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Patient Navigation: Holistic, Person-Centered Care



Lesson Learned

2013-2018: Chicago Patient Navigation Project

- Patient navigators as an indispensable Band-Aid
 - screening mammography increased by 200%
 - PAP and HPV testing increased by over 160%
 - BUT standard 1-on-1 models have proved difficult to implement, scale, and sustain.
 - intensive labor and monetary costs
 - challenges along cancer care continuum
 - generates further inequities when programs cut short
- This becomes financially untenable
- We are in urgent need of a paradigm shift



Reimagining Patient Navigation: Scaling through Remote Coaching

Remote Coaching Navigation Model

- Coaching as a tool of ***patient empowerment***
- Patient navigators as integrated, ***trusted community members***
- Centered on learning health system strategies, ***team-based checklists***
 - patient: appointment checklists, community resources
 - providers: educational, culturally-relevant resources to bolster quality-of-care
- ***Multi-site model & Remote Design***
 - scalable and replicable, navigators move freely through community institutions
 - greater workflow efficacy, sustained program resilience
- ***Community-based, design-thinking approach:***
 - stakeholders are active participants in program design, driving change and knowledge production

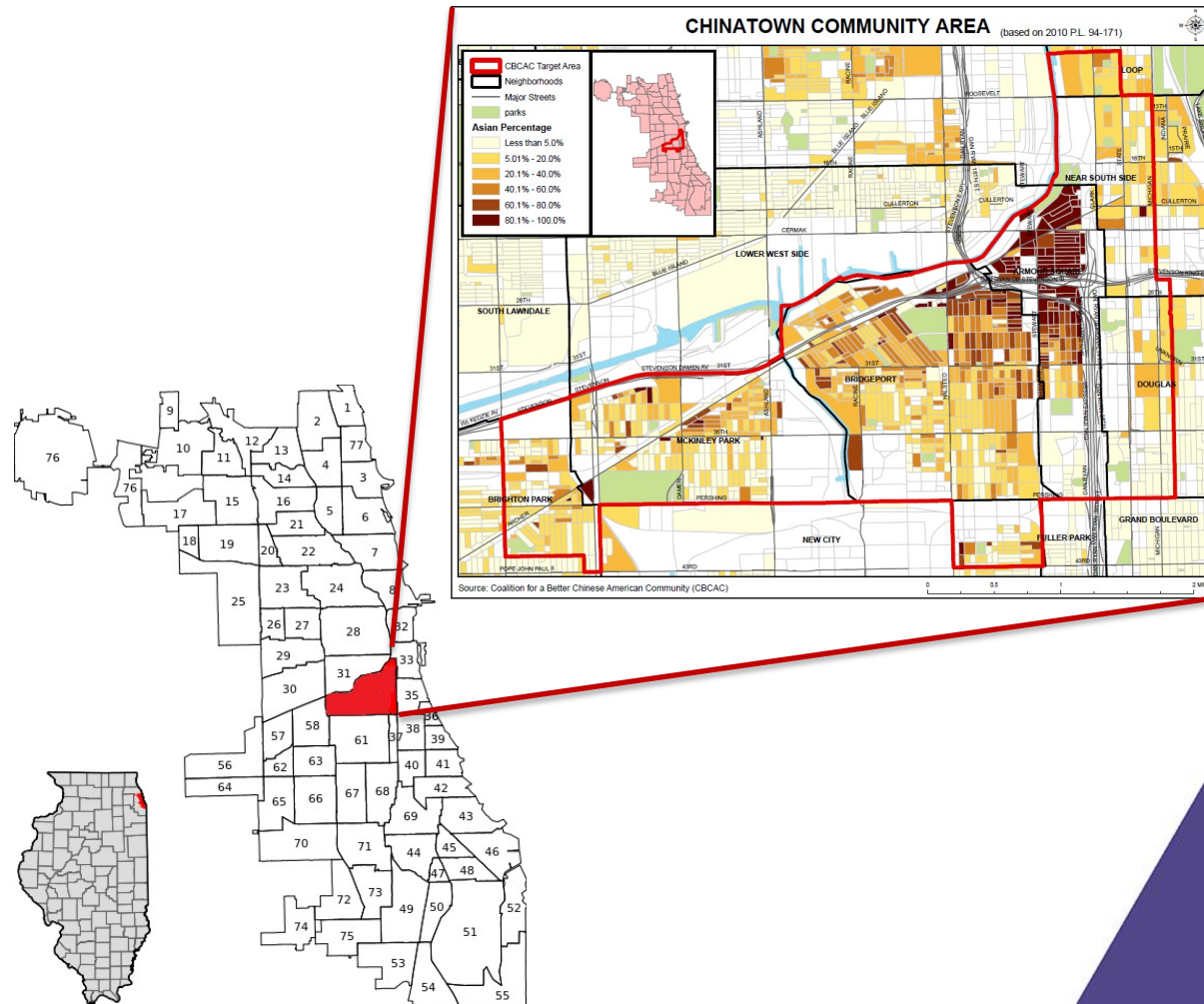
 - ***goal:*** a sustainable health systems change that would significantly improve health outcomes for medically underserved populations



Case Study: An Invisible Community

Asian Americans have the lowest cancer screening rate of all ethnic groups.

- Chicago's Chinatown: low SES
- 1st generation immigrants living in multigenerational linguistically isolated households
- Poor English proficiency
- Poor health outcomes: among the lowest cancer screening rates of all ethnic groups
- Median income of \$26,000 (50% below Chicago's median)
- SDoH barriers: linguistic, cultural, stigma, insurance, documentation, transportation, discrimination, housing and food insecurities, etc




Thank you!

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