mFOCUS Patient Navigation Program Procedures Manual

Massachusetts General Hospital

Updated: June 7, 2021

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mFOCUS Patient Navigator Outreach

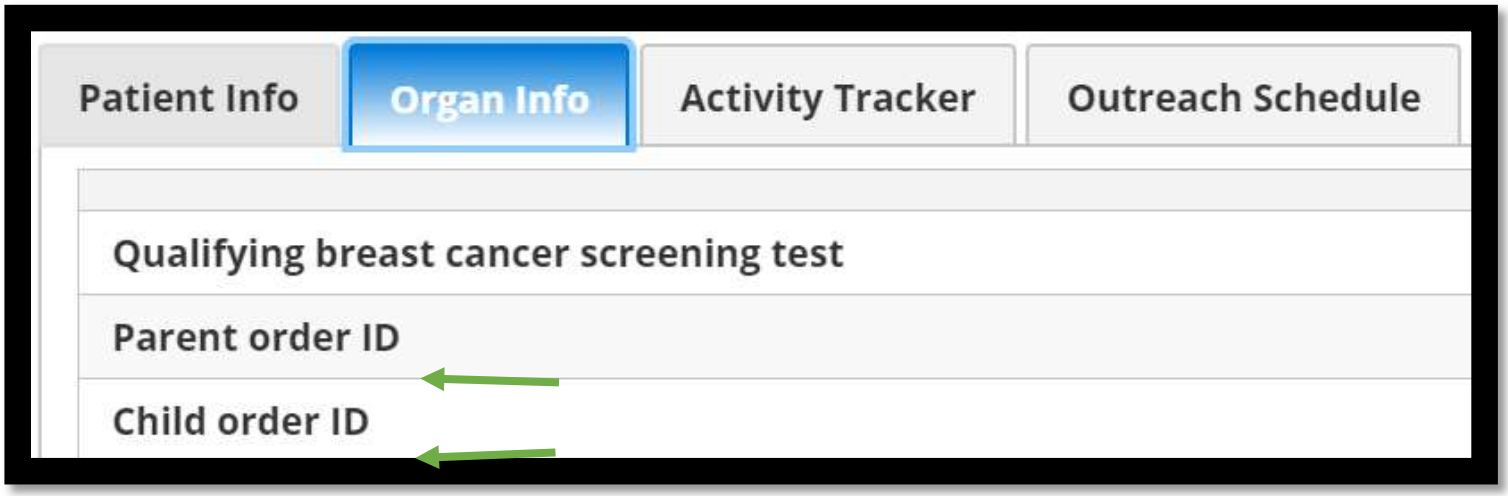
mFOCUS patient outreach schedule

1. Outreach 1: Day 1-Day 30: PG Message/Letter
    a. If they get a PG message and don't open it, then they get a letter a week after
2. Outreach 2: Day 31-Day 60: CRC call
3. Outreach 3 (only Arm 4 patients): Day 61-Day 90: PN intial call

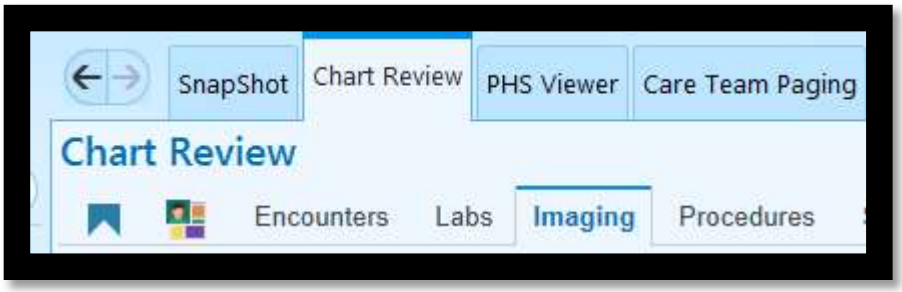
SideCar/Chart Review

*See the mFOCUS Study Coordinator manual for a step-by-step explanation of chart review in the SideCar (page 3). Note that this step will most often be completed by each patient's assigned Study Coordinator, but this is still useful information that the Patient Navigator should know and understand and chart review may need to be updated by the patient navigator before contacting a patient

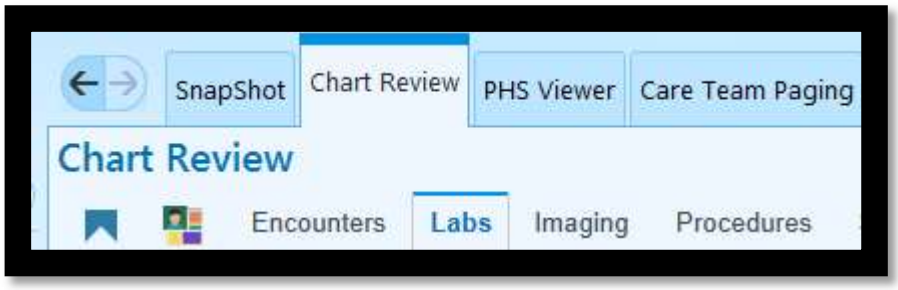
Go to Epic and open the desired patient's chart. Click "review," which will take you to the patient's chart review. Find the procedure corresponding to the ParentOrderID (and ChildOrderID) listed in the SideCar under "Organ Info:"



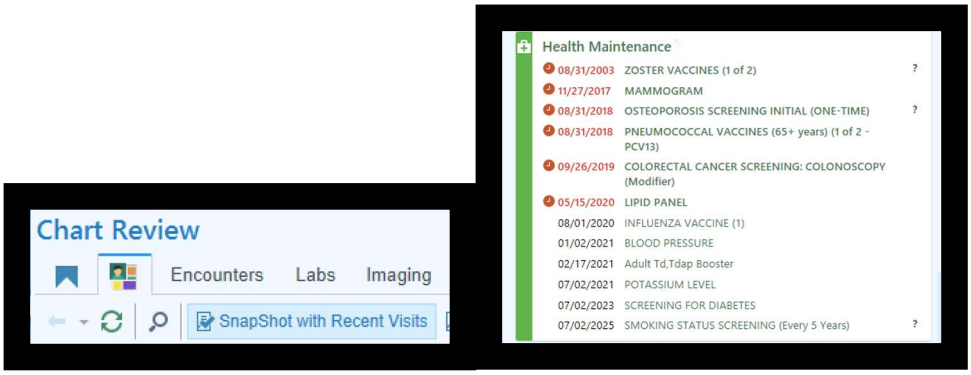
For mammograms and LDCTs, navigate to the "Imaging" tab:



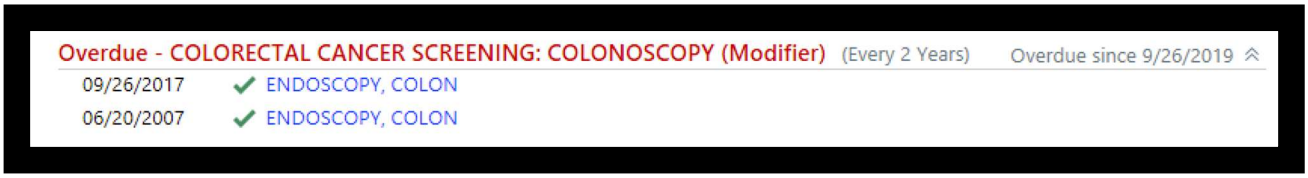
For pap smears and FITs, navigate to "Labs" tab:



For colonoscopies, navigate to the "Health Maintenance" window from the main chart review page to find the corresponding Health Maintenance Modifier:

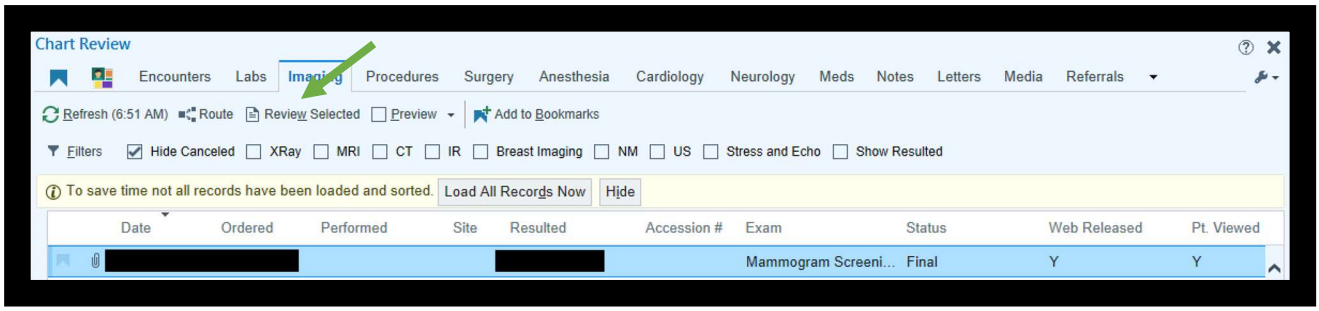


Click the relevant Colorectal Cancer Screening: Colonoscopy item to open more details.



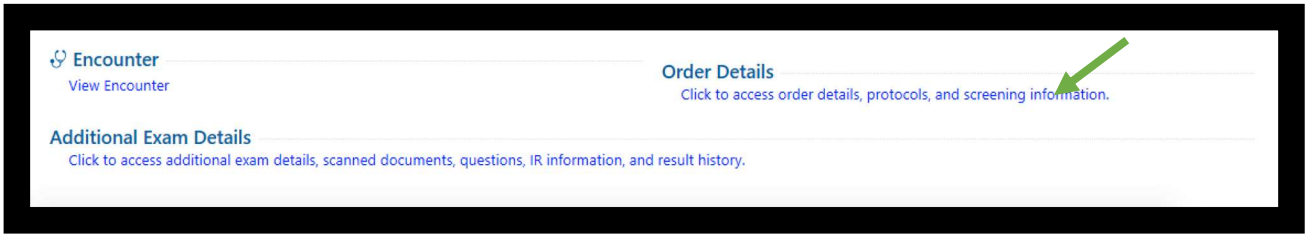
Open the procedure report, and verify that the test information matches what is in the Side Car.

First verify that the OrderID on the report matches the one listed in the SideCar. Select the test matching the procedure description and date performed and click "Review Selected" to open the report.



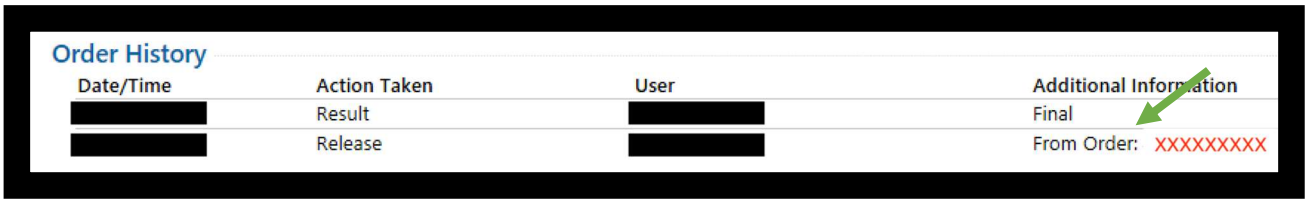
For mammograms and LDCTs:

Scroll to the bottom of the report, and click the link under "Order Details."

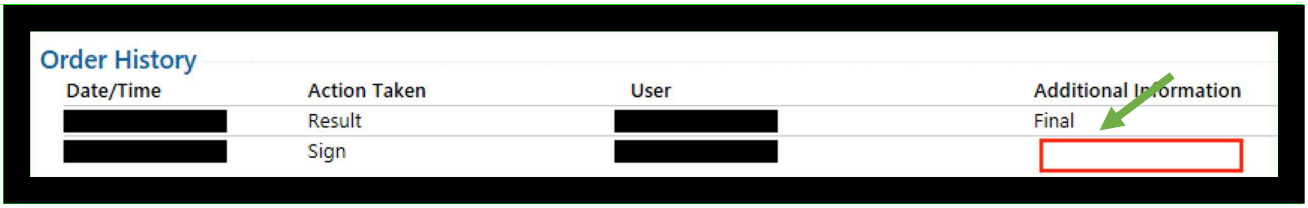


At the top of the page, the CHILDORDERID will follow the procedure name.

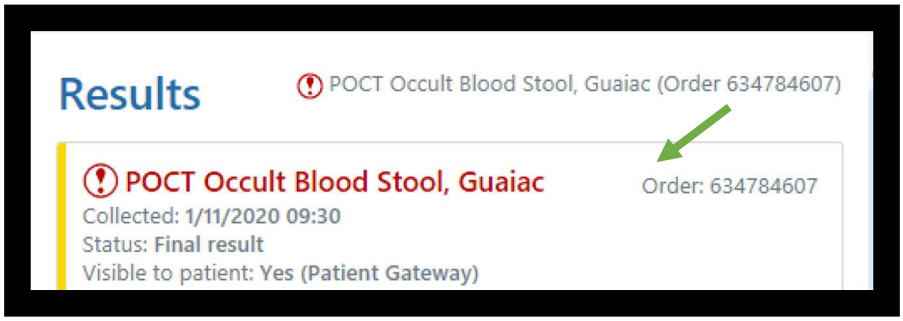
At the bottom of the page, the PARENTORDERID will be in the "Order History" section.

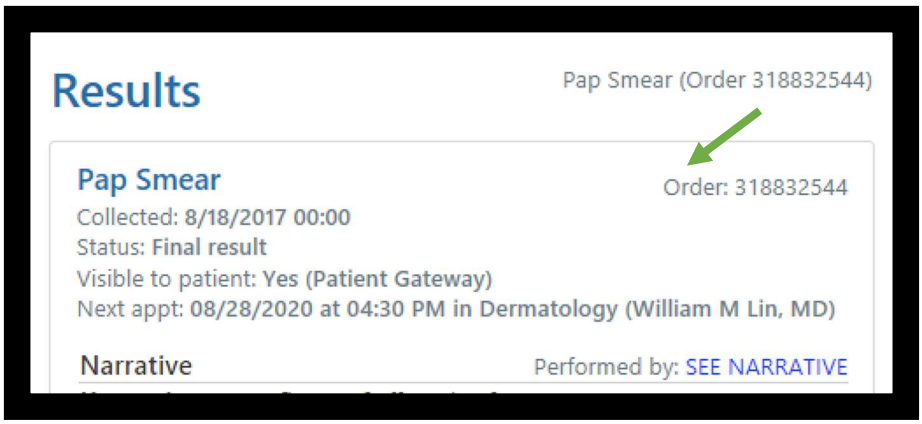


If NO ordered is present in the "Order History" section, the CHILDORDERID is the same as the PARENTORDERID.



For FIT/FOBTs and Pap Smears:
The OrderID will be present in the top right corner of the report.





For all procedures: next, verify that the test result matches what is present in the SideCar.

Confirm the recommended follow-up procedure(s) for [XXX] test result, and double check to see if the patient has already had the necessary follow-up procedure for [XXX].

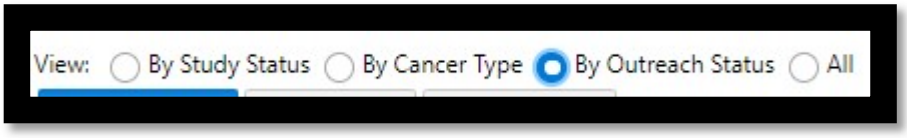
Most follow-up procedures will be documented in either the "Procedures" or "Labs" tabs, but some may be found in the "Imaging" tab (ex: LDCT, mammogram), as shown above. Also, check CareEverywhere for tests done outside of Partners.

Verify that the date of the follow-up procedure is AFTER the index screening test date, then make note of the status of the follow-up procedure: ordered, scheduled, or already completed.

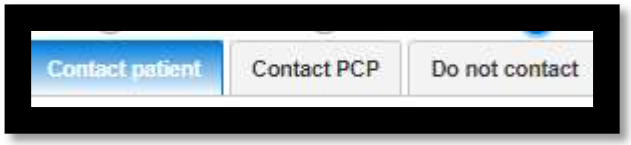
Identifying mFOCUS patients that need to be contacted

Go to the Patient Outreach tracker in the mFOCUS Side Car: https://stage-mfocus.partners.org/index.html

First, select view by "Outreach Status:"



Below the view options, three lists of patients will be available to view:

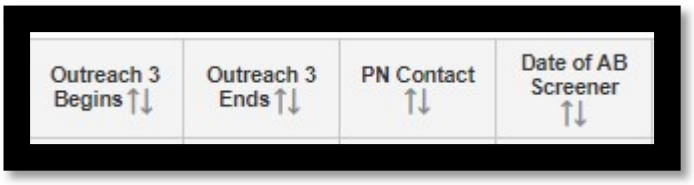


- Patients whose charts have been reviewed and look correct will be listed under "*Contact patient*." They will remain in this section until they complete follow-up, or they time out of their mFOCUS window.

- Patients whose charts have been reviewed and contain some type of discrepancy (i.e. their MD recommended follow-up that is not in accordance with guidelines, and there is no clear documentation as to why this decision was made) will be listed under "*Contact PCP*." For these patients, the study PIs will have to reach out to each of their PCPs/ordering MDs for clarification on the aspect of their chart in question.

- Patients whose charts have been reviewed and contain some type of discrepancy which has been clarified by their PCPs/ordering MDs will either go back into the "*Contact patient*" list, or be moved to the "*Do not contact*" list. Patients on the "*Do not contact*" list are still considered eligible for the study, but are not to be contacted due to some type of extenuating circumstance.

In the Outreach tracker's "*Contact patient*" list, timeframe windows for each point of outreach will be listed for each patient. Pertinent to the Patient Navigator's point of contact, the following categories will appear:

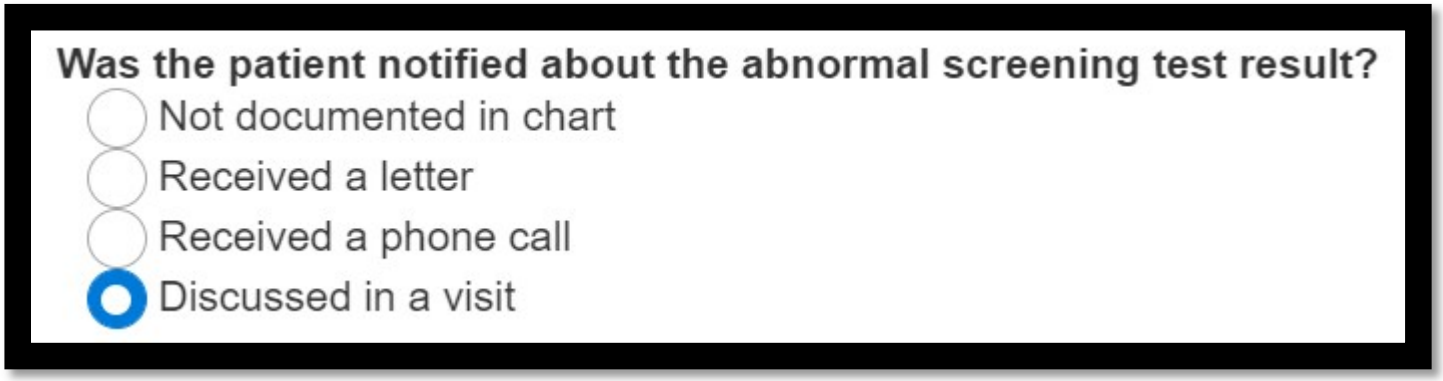


Outreach 3 is the 30-day period during which a Patient Navigator must call an eligible patient. This section shows when that window begins and ends, the first date of contact from the Patient Navigator, and when the Patient Navigator completes the Social Determinants of Health screener in Aunt Bertha with each Arm 4 patient.

If the follow-up test has been ***ordered or scheduled***: when you call/speak with the patient, please remind them of the appointment specifics. Note where they are scheduled to receive the test or where the provider has ordered the follow-up test/visit.

Is there documentation that the patient was notified of their abnormal screening test result?

Search the patient's chart to find out whether or not they were made aware of their test results. This information may be in the pertinent test's report, or it my be under the "Encounters" or "Notes" tab in the chart review section.



Confirm timeframe of intervention for mFOCUS Patients:

Did patient receive a call/voicemail from the study coordinator as noted in the Side Car?

Did patient receive PG message or letter as noted in the Side Car?

When to exclude patients

During chart review, you may find that a patient is not eligible for mFOCUS. These circumstances will often be automatically caught by the database, or already be documented by the Study Coordinator. However, the Patient Navigator should prepare to encounter some patients in these scenarios.

Patients may be excluded for the following reasons:

- Chart notes that the index test was normal.
- Chart notes that the follow-up test was completed ***before*** mFOCUS eligibility.
- Chart notes that they do not speak English or Spanish.
- The patient died before mFOCUS eligibility.
- The patient had a prior target cancer diagnosis.
- The patient has transferred care to a non-Mass General Brigham facility.
- Patients who receive the CRC modifier SOLELY due to poor bowel prep: INELIGIBLE
- Patient is overdue, but the modifier was set due to the wrong procedure: INELIGIBLE
- If a patient is found in side car and not in the workbench, the study staff should verify that the proper HMM and timing is on their chart. If they find it has been postponed or removed they should indicate this in the side car and deem them "Ineligible – clinical review"
- For CRC patients: If the HMM and GI recommendation mismatch and there is no presence of an upcoming test, the RA's will make them ineligible.

If not already noted by the Study Coordinator, document the exclusion in SideCar as a part of the Chart Review. Any of the above reasons will automatically move a patient from the "eligible" to the "ineligible" tab.

When patients should not be contacted (but are eligible for the study)

During chart review, you may find that a patient has a condition that does not make them ineligible, but would preclude the need to contact them for the intervention. These circumstances will often be automatically caught by the database, or already be documented by the Study Coordinator. However, the Patient Navigator should prepare to encounter some patients in these scenarios.

Patients should not be contacted for the following reasons:

The patient has limited life expectancy (<12 months) or is receiving hospice care.
The patient has been diagnosed with cancer related to the mFOCUS eligibility screening test.
The patient died during the follow-up period.The patient is on active chemotherapy and/or radiation therapy for any cancer diagnosis.

If not already noted by the Study Coordinator, document the exclusion in SideCar as a part of the Chart Review. Any of the above reasons will create a "Do not contact" label for the patient in the Outreach Tracker.

Patients with non-standard care paths

Patients with nonstandard care paths should still be contacted per protocol, unless there is documentation of the patient and their physician discussing/agreeing upon a non-standard care plan.

Pregnant patients

Pregnant cervical patients in their 1st trimester (weeks 1-12) are eligible to get a Pap. RA's should contact these patients to schedule/tell them to remind their doctorof this at next prenatal visit. Pregnant cervical patients in their 2nd trimester (weeks 13-26) or 3rd trimester (week 27+) cannot get a Pap, but RA's should contact them to remind them to have this done post-partum.

We will create a checkbox in Sidecar for pregnant cervical patients. If patients are in their 2nd trimester and due for a colpo, we will check that box.

Emily will not navigate pregnant cervical patients, with the exception of pregnant patients who are in the last 30 days of their pregnancy – she can remind these patients that they need to have a Pap or colposcopy at one of their post-partum vists.

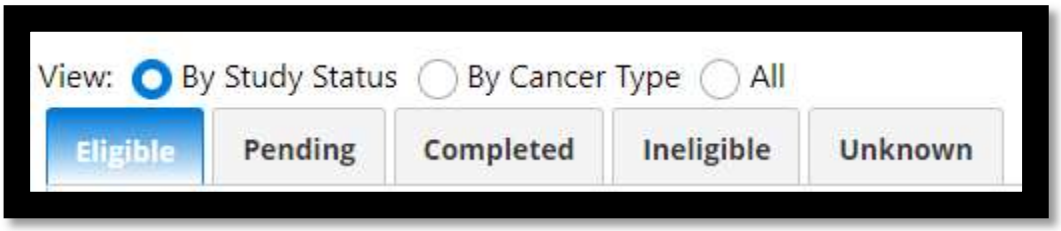
Patient Navigator Patient Outreach for Study Arm 4

Prior to contacting a patient, check the primary care provider's last few notes to familiarize yourself with the patient's current health status and potential barriers, such as: recent hospitalization, vital status, cancer dx., etc.

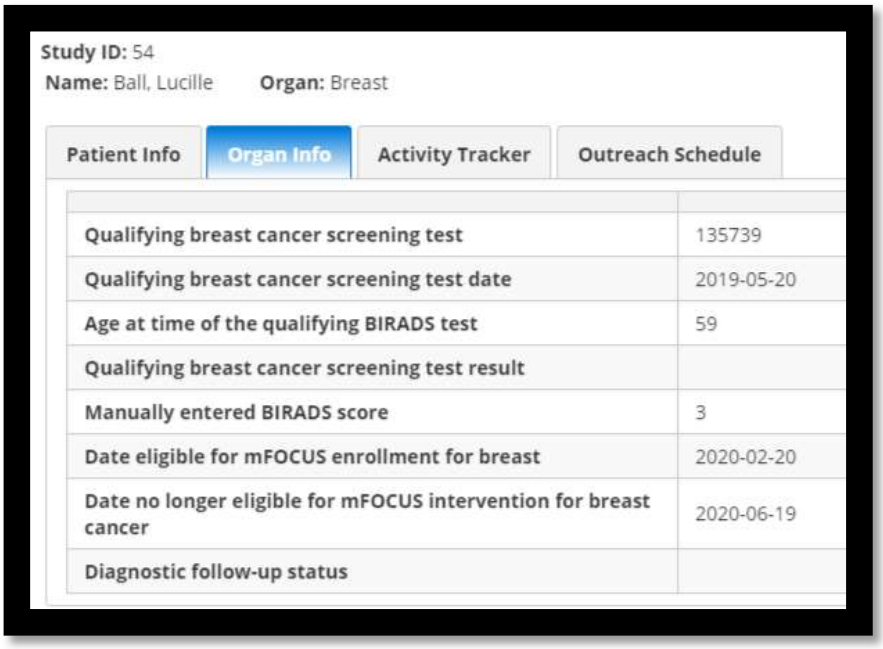
Call patients that are due for contact according to SideCar. These patients should be identified weekly. Patients will be called by the Study Coordinator first, 30 days after their mFOCUS eligibility begins. Study Arm 4 patients will be contacted by the Patient Navigator 60 days after eligibility begins, once they have already spoken to the Study Coordinator.

Review the Eligible tab and performing a chart review before a patient navigator phone call

From Study Status View, open the **"Eligible"** tab and review patient information for patients who are in Study Arms 3 and 4.



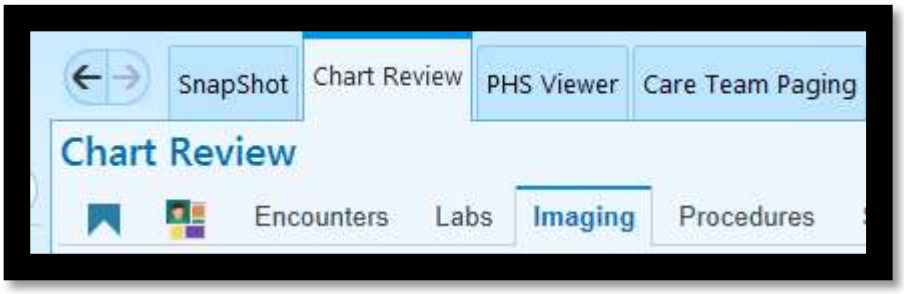
1. Click on a patient name and view the "Organ Info" tab.
2. Confirm a value for "Qualifying [XXX] cancer screening test" and a value for "Qualifying [XXX] cancer screening test result" matches what is in the reporting workbench in Epic.



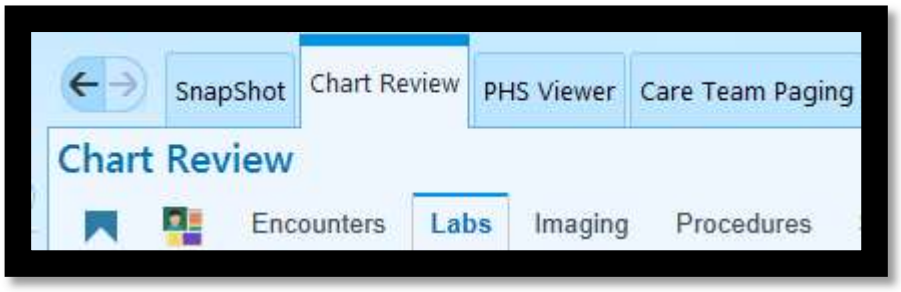
3. Perform a **Manual Review** in Epic to verify that the abnormal test and test result noted in the Side Car are correct.

a. Go to Epic and open the patient chart by searching on the patient's MRN. Verify that the name and date of birth match before entering the record. Click "review," which will take you to the patient's chart review.

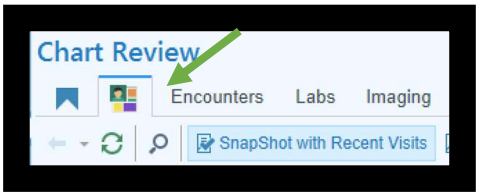
b. Find the procedure corresponding to the order number listed in the Side Car under “Organ Info.” For **mammograms and LDCTs**, navigate to the “Imaging” tab:



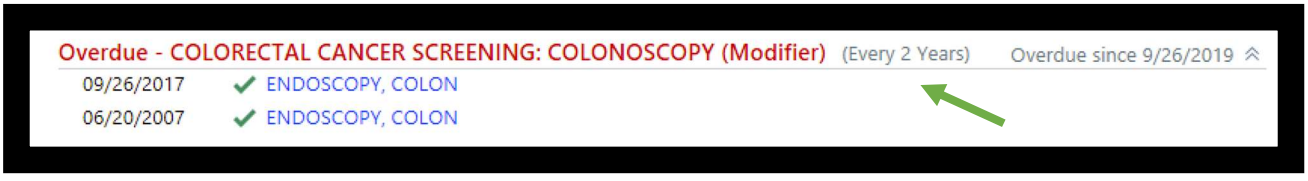
For **Pap smears, FITs, and FOBTs**, navigate to “Labs” tab:



NOTE: For **colonoscopies**, we are checking for a Health Maintenance Modifier, not a specific procedure. Check the Health Maintenance Window from the main Chart Review page.

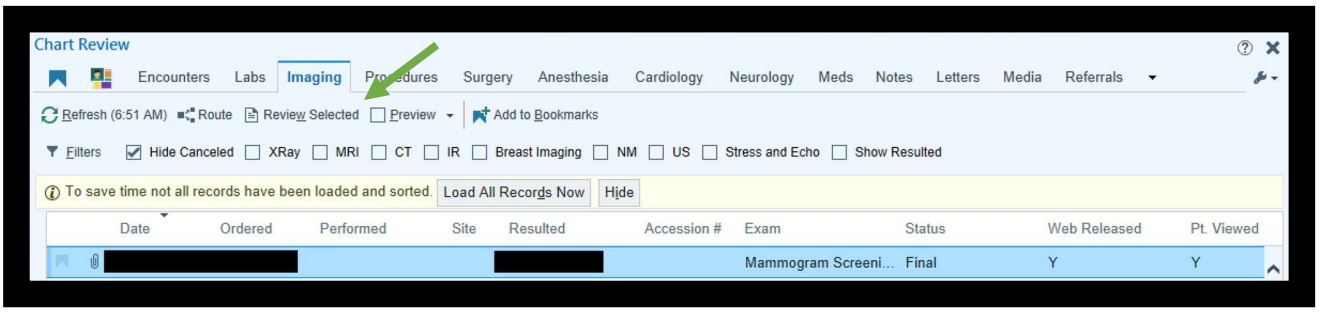


Click the relevant Colorectal Cancer Screening: Colonoscopy item to open more details.



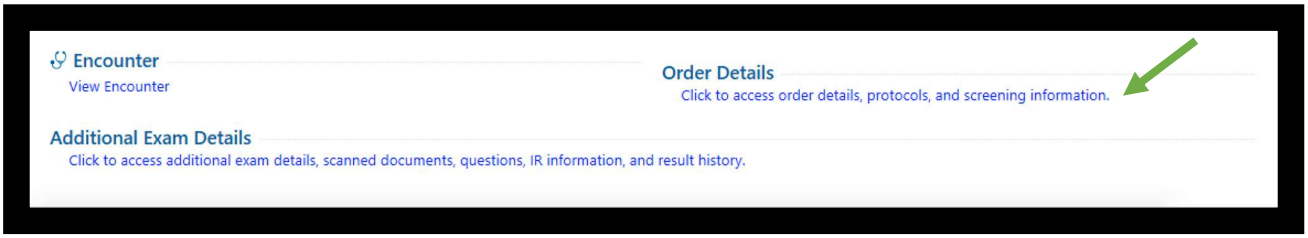
Make note of whether the HM Modifier present matches what is in the SideCar. Proceed to result review below.

c. Open the procedure report and verify that the test information matches what is in the Side Car. First verify that the OrderID on the report matches the one listed in the SideCar. Select the test matching the procedure description and date performed and click “Review Selected” to open the report.



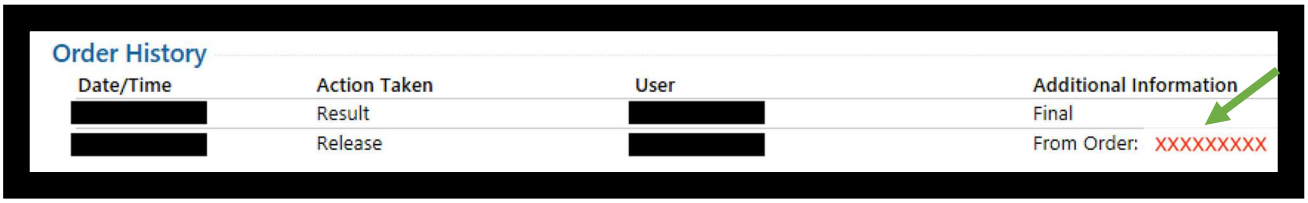
For mammograms and LDCTs:

Scroll to the bottom of the report, and click the link under “Order Details”

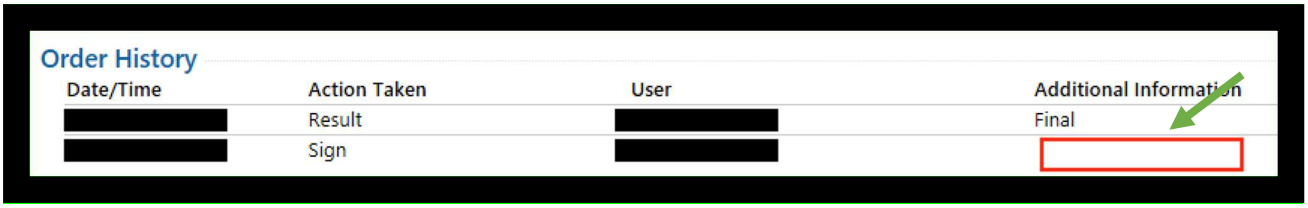


At the top of the page, the CHILDORDERID will follow the procedure name

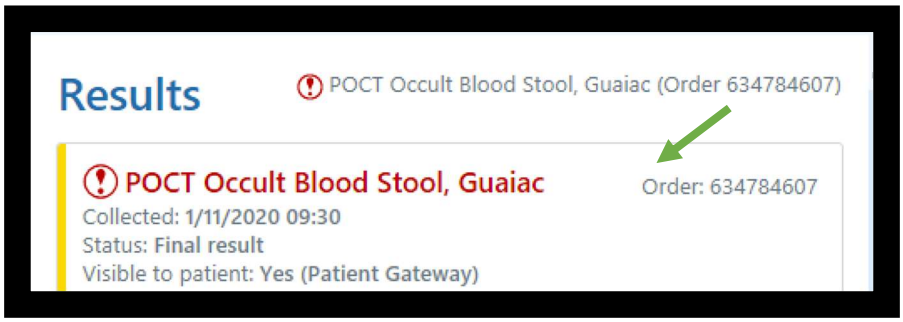
At the bottom of the page, the PARENTORDERID will be in the “Order History” section

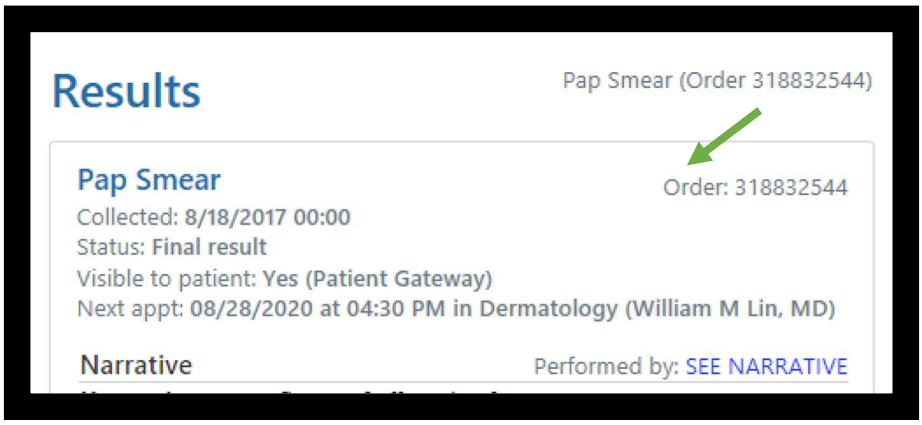


If NO ordered is present in the “Order History” section, the CHILDORDERID is the same as the PARENTORDERID



For FITs and Pap Smears:
The OrderID will be present in the top right corner of the report.





For breast, lung, and cervical procedures: next, verify that the test result matches what is present in the SideCar.

For colonoscopy: verify if the HM modifier and GI recommendation on the patient's chart matches what is listed in SideCar.

- **If the HM Modifier matches SideCar**:
    - Open the results of the latest colonoscopy. Verify the GI recommended follow-up interval matches the HM modifier. To find the GI recommendation, open the "Encounters" tab and scroll to the date of the procedure. There should be a letter sent out by gastro with a time interval recommendation for the patient's next follow-up.
    - If the GI recommendation and HM Modifier match: proceed with patient contact.
    - If the GI recommendation and HM modifier DO NOT MATCH:
        - If the GI recommendation is SHORTER INTERVAL than the HM modifier/SideCar: the patient is still overdue, and should still be contacted. Add the patient's information to the "HM Mismatch" list for tracking purposes.
        - If the GI recommendation is LONGER INTERVAL than the HM modifier/SideCar: verify that the patient is NOT overdue based on the colonoscopy date and recommendation.

They should be made INELIGIBLE in SideCar based on chart review. Add the patient's information to the "HM Mismatch" list for tracking purposes.

- **If the patient has MULTIPLE HM Modifiers on their chart:**
  - Identify which is overdue, and assess if it matches the latest GI recommendation. Follow instructions described above.
- **If the HM modifier does NOT match SideCar:**
  - The PCP or another provider has recently changed the modifier on the patient's chart. Use discretion to determine if this patient is now on an alternate care plan, or is no longer eligible for the study.

Colonoscopy follow-up recommendations are messy and errors can occur at many places in the process. If you have a novel scenario or any questions, bring to the clinical team for discussion.

d. Confirm the recommended follow-up procedure(s) for the given test result and check to see if the patient has already had the necessary follow-up procedure.
Most follow-up procedures will be documented in either the "Procedures" or "Labs" tabs, but some may be found in the "Imaging" tab (ex: LDCT, mammogram), as shown above. Check the "other orders" tab to see if something was ordered. Also check "procedures". Also for some cervical colpos, will just be an encounter in the Encounters tab.Be sure to check CareEverywhere for tests done outside of Mass General Brigham.

Verify that the date of the follow-up procedure is AFTER the index screening test date, then make note of the status of the follow-up procedure: ordered, scheduled, or already completed

Telephone scripts and guideline for outgoing calls

Answering machine script

Good morning/afternoon. This message is for Mr./Ms. [patient's name] and I'm a Patient Navigator calling from Mass General Hospital/Brigham Health/Dartmouth Hitchcock Medical Center on behalf of your primary care team. Our records suggest that you may have had an [organ] screening test in [month/year] that requires follow-up. I can help you schedule this. I would appreciate if you could call me back at your earliest convenience at [phone number], again that's [phone number]. I look forward to speaking with you. Have a nice day.

Live person script

Good morning/afternoon. My name is _____ and I'm a Patient Navigator calling from Mass General Hospital/Brigham Health/Dartmouth Hitchcock Medical Center, may I please speak with Mr./Ms. [patient's name]? (Proceed to the script below)

Patient already on the line

Hello Mr./Ms. [patient's name], I am calling on behalf of your primary care team. We are reviewing our records to make sure all patients are up to date on cancer screening tests. Our records suggest that you had a [mammogram/pap smear/colon cancer/lung cancer] screening test on [DATE] and it was recommended that you have follow-up testing. I want to know if I can help you get this scheduled now.

Proceed with Questions below:

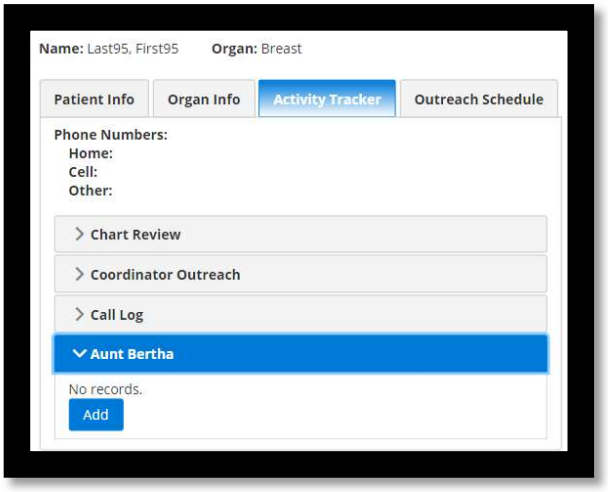
What did your health care team tell you about your result? – Confirm abnormal result.
What follow-up testing did your care team tell you that you need?
When did they tell you that you would need follow-up?
Why didn't you have the follow-up? – Reinforce importance of the follow-up and the timeframe.
How can I help you to arrange for your testing? (Proceed to logistics screen below)

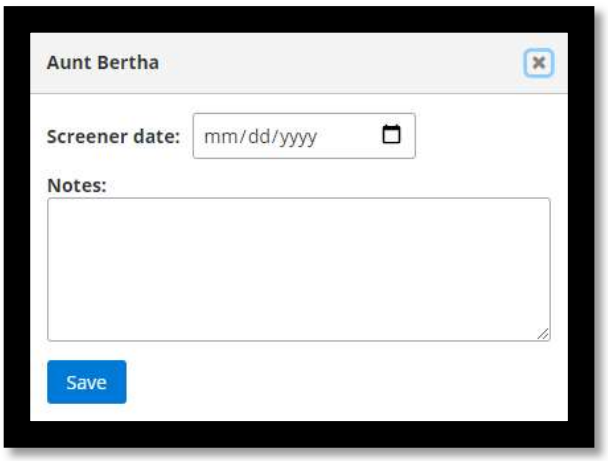
Screening for social determinants of health

For patients that have not yet received the follow up test. This includes patients who have a test already scheduled for a future date:

We understand that sometimes, people face barriers in receiving the care that they need because of other life circumstances – especially in the context of the pandemic. I want to try to help ensure that you have the resources that you need to receive your follow-up care as deemed necessary by your care team. If it's alright with you, will go through a few questions regarding particular things that you may need assistance with. Some or all of these questions may not apply to you, but if any do, I can help you to find free or low-cost resources in your community that may be of assistance to you. If you would like, I can give you the names and phone numbers of [places/resources/programs] nearby where you live or work. You can decide if you want to use any of these programs and you can follow up with them directly.

After explaining this step to and completing the Aunt Bertha screening questionnaire (see appendix) with the patient, document the date of the screener, and indicate any pertinent notes in the Side Car. To do this, go to the Activity Tracker tab, and select the "Aunt Bertha" option, and "add:"





(See Appendix C, Aunt Bertha Instructions)

(See Appendix D, Aunt Bertha Questions)

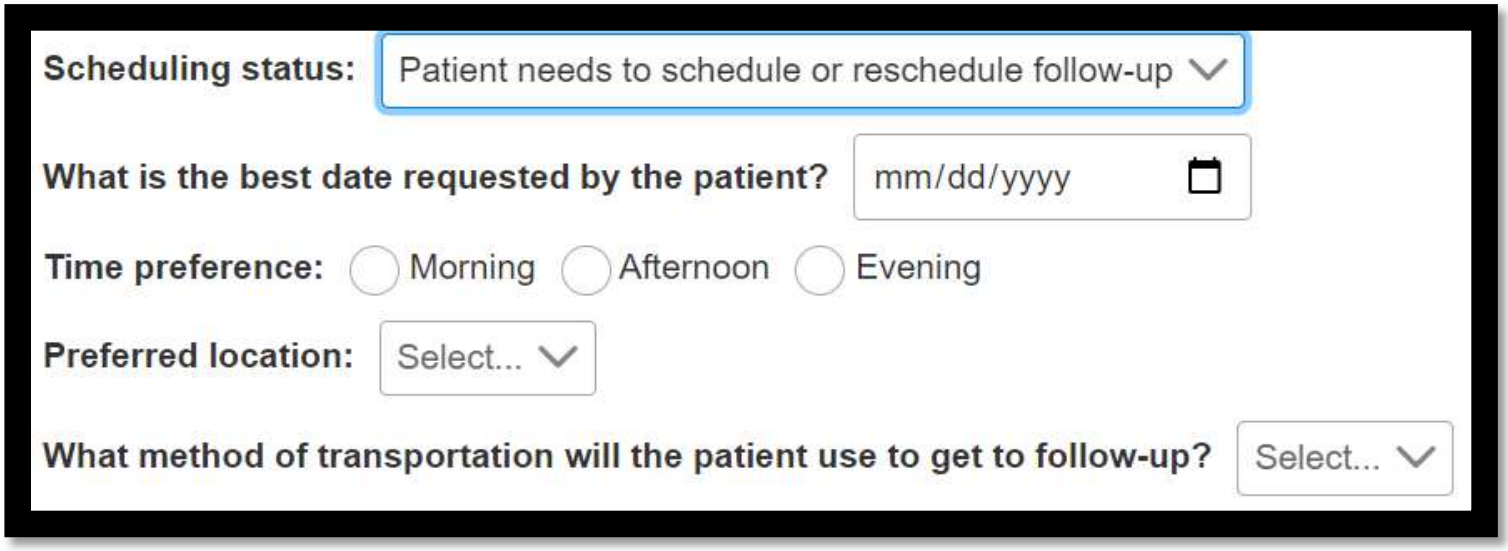
If the test is already scheduled in Epic:

I see that you already have this test scheduled on [DATE]. I want to remind you about this test and see if there is anything that I can help you with to make sure that you can get to this appointment.

If the test is not already scheduled and a patient accepts help arranging for follow-up testing.

Ask the patient the following questions and document in Side Car:

What is the best date/time/location to book an appointment?
How would the patient get to appointment (transportation)?
Would he/she be able to find an escort (colonoscopy)?
Will the patient need interpreting services? (Spanish speakers only)



Discussing logistics before booking an appointment will help you, the Patient Navigator, anticipate any barriers to care and coordinate the appointment properly.

If the patient says that the follow-up testing has already been done but it was not documented in Epic

Ask when/where the follow-up testing was completed. Record the test type and the date that the test was done in the Side Car.

If the patient has a copy of report, ask them to mail or fax it to the study coordinator. Let them know that we will update their medical record with this information upon receiving a copy.

If the patient does not have a copy of the report, tell the patient to contact the office where the test/procedure took place, and to ask for a copy of the report to be sent to their PCP's office and to you.

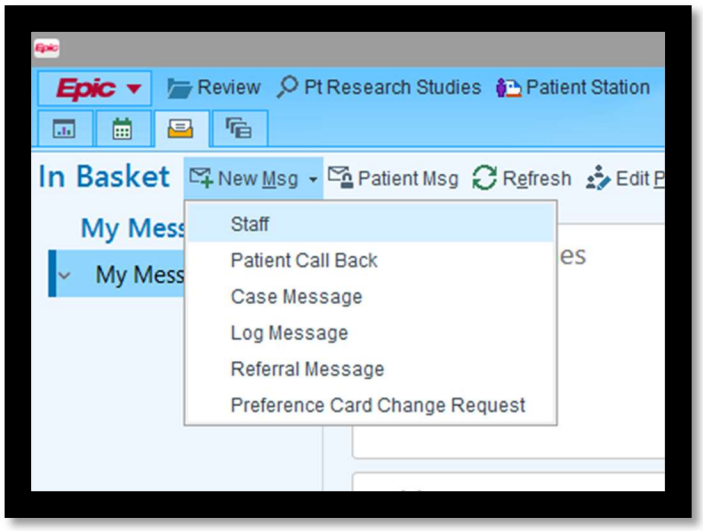
If the patient declines follow-up testing

Would you mind if I asked why you do not want to complete this testing?

Listen carefully and try to assess what the barrier is. Being respectful of patient's decision, take the opportunity to educate the patient by providing quick, relevant facts on the importance of follow-up testing (find educational materials in the share drive or in drop box if necessary).

I will make a note of this and let your provider know that you are not interested in scheduling this follow-up test now. Please feel free to contact us if you change your mind in the future.

Send message via in basket messaging to provider.



In Basket Message:

Subject: Pt declines follow up testing

Hello Dr. X,

I'm writing to inform you that I spoke with [name and MRN of patient] today because [he/she] was eligible for our mFOCUS research study that helps patients obtain follow up testing from abnormal cancer screenings. [Patient name] has informed me that they are not interested in scheduling their follow up exam. I told them I would inform you of this decision.

Please let me know if you have any questions.

Thank you,

[Name of Patient Navigator]

If patient voices concerns related to COVID-19

Q: I do not feel comfortable travelling to this appointment/test due to the COVID-19 outbreak/I do not think that this appointment is urgent enough for me to risk exposure to COVID-19.

A: We understand your concerns. Our number one priority is maintaining your safety, which is why we also want to stress to you the importance of this follow-up appointment/test. You are [xx amount of time] overdue for the evaluation of your abnormal [lung/breast/cervical/colorectal] screening, and we want to ensure that you are properly taken care of. While COVID-19 is certainly a valid health concern, so is this aspect of your health. By following up on your last screening test result, you may be preventing/detecting a more serious health concern down the line.

Q: Why does this appointment have to happen now? Can it be postponed?

A: This follow-up appointment/test is so important because it has the potential to play an important preventative role in your health and wellbeing. We are contacting you as a way to ensure that the abnormal findings from your most recent [lung/breast/cervical/colorectal] cancer screening performed on [xx date] are taken care of as recommended. While this may seem like a simple appointment that can be completed at another time, a vital aspect of this appointment is its timeliness.

Per the American Cancer Society's website, it is important for patients to continue to receive cancer screening and evaluation as their care team deems necessary, even in the midst of COVID-19. We are reaching out to you now with this appointment, because your health care team feels that a follow-up is the best course of action, and the best way to advocate for your long-term health.

Q: If this leads to a more serious diagnosis, what can I do to protect myself from COVID-19?

A: If, after you are brought in for evaluation of your [lung/breast/cervical/colorectal] screening result, and you receive some sort of cancer diagnosis, there are extra measures you can and should take in order to protect yourself from COVID-19, in addition to the practices that everyone should follow such as wearing a mask, frequent handwashing, and social distancing. These can/should be discussed with your care team upon diagnosis. Per the American Cancer Society's website these include: staying home as much as possible; ensuring that you have several weeks' worth of medications/medical supplies, should you have to be at home for prolonged periods of time; staying in touch with your health care provider(s)/team in regards to your treatment schedule.***Q: What can I do to ensure my safety when travelling to my appointment? What are the public health/CDC recommendations for being out in the public at this time?***

A: Per the CDC, social distancing (aka maintaining a distance of 6 feet from person to person) is encouraged whenever possible. To further ensure your own personal safety, we recommend only using public transit (if necessary) outside of peak travel time.

Boston has mandated face masks be worn in public. There are guidelines you can find on the internet for making your own masks at home, and the type of materials you can use to do so. You should thoroughly wash your hands frequently for at least 20 seconds – especially after touching surfaces that others use. If this is not possible, hand sanitizer (with at least 60% alcohol content) is an acceptable substitute to use.

On the official CDC website, you can find in-depth instructions and recommendations for how to protect yourself in the face of the coronavirus, symptoms of the virus, and what to do if you think you are sick. The website recommends maintaining an appropriate social distance, wearing a homemade mask when out in public, practicing frequent handwashing, covering coughs and sneezes appropriately, avoiding touching your face whenever possible, and using disinfectant at home and on surfaces you may touch.

Q: What safety and sanitary measures is the institution taking in light of the COVID-19 outbreak?

A: The institution is mandating that all patients being seen onsite make an appointment ahead of time. Walk-in appointments are currently not available. This decreases the risk of exposure, as less people will be onsite. Visitors are not permitted to attend appointments with patients at this time for the same reason. Before a visit, every patient will be called to screen for symptoms of COVID and if any symptoms are reported, the visit will be postponed. A surgical mask will be provided to you at the hospital or clinic, and it must be worn for the duration of your visit. Hand sanitization will also be made available to you. Entrances at each of our buildings have been restricted to monitor traffic in and out of the institution. There are guidelines about particular entrances to use for different buildings on our website.

The department of infection control has created careful cleaning procedures/protocols that have been put in place by the institution. Appointments are being booked less frequently to allow for cleaning of all rooms and equipment between patients.

If patient expresses feelings of sadness/distress/being overwhelmed related to their situation and/or COVID-19:

A: We understand that this is a stressful time for many people right now, and we want to be a resource for you in the best way possible. Our team is here to help you take care of yourself, even in these unprecedented times. I want to be

respectful of how you are feeling. If you are not comfortable answering my questions (for the mFOCUS assessment) right now, is there another time we can plan on speaking to each other? Great, let's plan on speaking at/on [xxx time or date] so that we can move forward with finding you the resources you need.

The circumstances surrounding COVID-19 are overwhelming and ever-changing. The CDC recommends taking breaks from social media and reading/watching the news regarding the pandemic. Maintaining physical and social well-being (through virtual resources in particular) at this time is another way to keep up with your mental/overall well-being. There are resources at your disposal if you are struggling at this time, and we are here to help and make you feel at ease as best we can (Appendix C).

Scheduling a follow-up test and reminder Calls

Scheduling follow-up appointments with patients

Scheduling Logistics

The following should be considered when assisting a patient to schedule a follow up exam:

Availability: What days/times are convenient for patient?

Provider Availability: What days/times are the various providers within that disease group available? Does the patient prefer a specific provider?

Questions/Concerns: Solicit any questions or concerns regarding first appointment (necessary preparations, information/documentation, etc.) Barriers to attending the appointment, transportation, time at work, language/interpreter, etc.

Location of appointment: Provide directions if necessary – so the patient can plan how they will get there.

Contact Information: Provide patient with appropriate contact information for Patient Navigator. Inform patient that this person will serve as point of contact for any additional questions/concerns and if they need assistance upon arrival to MGH campus to please call.

> *You are confirmed on [date] at [time] for your [lung/breast/cervical/colorectal] screening follow-up. If you have any questions before then, please do not hesitate to call me. My number is [phone number] and I would be happy to help with any problems you might have before your appointment. Thank you and I hope you have a nice day.*

If the patient asks you a question that you cannot answer, refer patient to the appropriate Patient Services Coordinator. Inform the patient that someone will be reaching out via phone shortly to answer their question. In cases that the patient is describing a **medical issue** or has a question outside of a routine scheduling or labs question, refer the patient to their primary care provider.

Scheduling a follow-up test for abnormal mammogram.

1. Check if referral is in Epic. If not, send an in-basket message to PCP office (see list of numbers at end of manual).
    a. Follow up in 1 – 3 days to see if the exam is ordered, if not contact office again.
2. If order is placed for follow-up mammogram, call radiology.
3. If order is placed for a biopsy follow-up with breast clinic, call and schedule an appointment.
4. If order is placed for a biopsy at radiology department, call phone number, and schedule an appointment.

Abnormal mammogram reminder calls

Please keep in mind that the following guideline for reminder calls refers to the "least" amount of reminder calls; you may determine on a case by case basis if more contact will be necessary depending on a patient's barriers and needs.

1. First reminder call: 1 week prior to follow-up appointment
2. Second reminder call: 2 days prior to follow-up appointment

Scheduling a follow-up test for an abnormal lung cancer screening

1. Check if referral is in Epic. If not, inbasket PCP office.
    a. Follow up in 1 – 3 days to see if the exam is order, if not contact office again.
2. If order is placed for follow-up chest CT, call radiology.
3. If patient needs a biopsy with a surgeon, schedule visit with the provider.

Lung cancer screening Reminder calls

Please keep in mind that the following guideline for reminder calls refers to the "least" amount of reminder calls; you may determine on a case by case basis if more contacts will be necessary depending on a patient's barriers and needs.

1. First reminder call: 1 week prior to appointment
2. Second reminder call: 2 days prior to appointment

Scheduling a follow-up test for an abnormal cervical test

1. Check if referral for follow-up GYN visit is in Epic. If not, inbasket message PCP.
    a. Follow up in 1 – 3 days to see if the exam is order, if not contact office again.
2. If for repeat pap smear, look in Epic to find out who did the most recent one, and book an appointment to see that provider
    a. 1 year follow up for abnormal pap, should be done by PCP/NP/GYN who follows patient.
3. If for colposcopy, send them to either the MGH or the BWH colpo clinics.
4. If patient needs a biopsy, call gynecology clinic and schedule test.
5. If not clear, then send an inbasket message and ask the provider what they want to do.

Abnormal pap smear reminder calls

Please keep in mind that the following guideline for reminder calls refers to the "least" amount of reminder calls; you may determine on a case by case basis if more contacts will be necessary depending on a patient's barriers and needs.

1. First reminder call: 1 week prior to follow-up appointment
2. Second reminder call: 2 days prior to follow-up appointment

Scheduling a follow-up test for an abnormal colorectal cancer screening

1. Check if referral for follow-up colonoscopy is in Epic: If not, inbasket message PCP
    a. Follow up next 1 – 3 days to see if the exam is order, if not contact office again.
2. Schedule the colonoscopy with GI clinic.

Colorectal cancer screening Reminder calls

Please keep in mind that the following guideline for reminder calls refers to the "least" amount of reminder calls; you may determine on a case by case basis if more contacts will be necessary depending on a patient's barriers and needs.

1. First reminder call: 2 weeks prior to follow-up appointment
2. Second reminder call: 1 week prior to colonoscopy appointment
3. Third reminder call: 2 days prior to appointment
    a. During this phone call, remember to remind the patient of their colonoscopy preparation. Ensure that they have picked up the bowel prep and have it at home and ask if they have questions about it.

NOTE: Study coordinators will often have already reached out to a patient's PCP via InBasket to ask for follow-up test orders to be entered into Epic. If this is not the case, something like the following message can be sent to a patient's PCP to ask for orders:

> Dear Dr. X,
>
> I am working with Dr. [Jennifer Haas/Steve Atlas] on the mFOCUS research project. I spoke with/reached out to patient [patient name] about their overdue [index test] and noticed that the order for the follow up test has expired/not been entered. Could you please renew/enter an order so I can assist [patient] with scheduling?
>
> Thank you!
>
> [Name of Patient Navigator]

Unsuccessful phone call attempts

In cases where the Patient Navigator must leave a message/can't reach a patient, it is appropriate to mamek 3 to 5 phone call attempts over the 30-day period of Patient Navigation outreach. It can be deemed necessary to complete additional outreach attempts at the discretion of the Patient Navigator (due to outstanding circumstances such as: complex medical history, psychiatric issues, etc.).

First week, 5-7 days: Make an initial phone call attempt and leave a message. Set up a tracking date for the following week.

Second week, 12-14 days: Make a second attempt and leave a second message. Set up a tracking date for the following week.

Third week, 19-21 days: Make a third attempt and leave a third message. Set up a tracking date for the following week.

Fourth week, 26-28 days: Make a fourth attempt and leave a final message. If patient does not answer at this point, there will be no further outreach, unless it is deemed necessary to do so due to outstanding circumstances (as noted above).

Reaching the patient's emergency contact

If you are unable to reach the patient/leave them a voicemail at any of the phone numbers on file for them, you may try to reach the emergency contact person and verify the patient's contact information at any point after an initial unsuccessful attempt.

Whether you are speaking with or leaving a voicemail message to the emergency contact, the purpose of the call is ***solely*** to verify the patient's contact information. A patient's private information, including the type of screening for which a patient is overdue, should ***not*** be disclosed to the contact person.

Telephone script for calling a patient's emergency contact

> *Good morning/afternoon. This message is for Mr./Ms. [contact person] and I'm calling from the Mass General Hospital/Brigham Health. Your name is listed in our system as the contact person for [patient's name]. I'm calling to verify if we have the correct contact number for [patient's name]; it seems like we may have the incorrect phone number listed for him/her. Would you mind helping us verify his/her phone*

number? Thank you! Could you pass along my contact information to [patient's name] and ask them to call me back at [contact]?

When a patient does not speak your language

1. If appropriate, call:
    a. MGH Interpreter Services
        i. (617) 726-6966
        ii. https://www.massgeneral.org/interpreters/contact
    b. BWH Interpreter services
        i. (617) 732-6639
        ii. https://www.brighamandwomens.org/patients-and-families/patient-resources/interpreter-services
    c. DH interpreter services
        i. *Lebanon, Heater Road, Lyme* (603) 650-5792
        ii. *Keene* (603) 354-6656
        iii. *Manchester/Bedford, Concord, Nashua* area patients, and other DH locations: to request interpreter services, please inform the scheduling secretary when you schedule your appointment or call the department directly.
        iv. https://www.dartmouth-hitchcock.org/supportive-services/interpreting.html
2. If there is not an on-site interpreter available, you will be connected to an outside vendor. Use PIN #1010.
3. You should be with the interpreter at the time of the call so that they can assess any barriers and answer any questions the patient may have.
4. If a family member offers to interpret the call, or if a patient asks you to coordinate the appointment with a family member, ensure that the patient has been educated about the follow-up testing and has agreed to it before booking the appointment.

Other

When to contact a provider

If medication reminder is needed for colonoscopy appointments.

Appendix A: Helpful contact numbers

Primary Care Practices

MGH

Ambulatory Practice of the Future (APF)	(617) 724-1100
Assembly Row	(857) 282-0777
Back Bay	(617) 585-7403
Beacon Hill	(617) 726-4900
Bulfinch Medical Group (BMG)	(617) 724-6610
Charlestown	(617) 724-8168
Chelsea 100	(617) 887-4600
Chelsea 151	(617) 889-8580
Everett	(617) 394-7500
Internal Medicine Associates (IMA1)	(617) 726-2374
IMA 2	(617) 724-6200
IMA 3	(617) 726-2368
MGH Downtown	(617) 728-6000
Mass General Medical Group (MGMG)	(617) 726-3558
MGH West (Waltham)	(781) 487-4346
North End Waterfront	(617) 643-8000
Primary Care Associates, Waltham	(781) 487-4040
Revere Adult	(781) 485-6000
Revere Broadway	(781) 485-6441
Women's Health	(617) 724-6700

BWH

800 Huntington	(857) 307-2200
Brigham Circle	(617) 983-7003
Brigham Physician's Group (BPG)	(617) 732-9900
Brigham Primary Physicians -Faulkner	(617) 983-7300
Brookside Community Health Center	(617) 522-4700
Family Care Associates	(617) 983-7025
Faulkner Community Physicians	(617) 469-4000
Fish Center	(617) 732-9300
Foxborough	(508) 718-4010
Jen Center	(617) 732-6040
Newton Corner	(617) 796-7100
Norwood	(857) 307-3900
Primary Care Associates of Brookline	(857) 307-4400
South Huntington	(857) 307-3300
Southern Jamaica Plain Health Center	(617) 983-4100

Gynecology Practices

Gynecology Practice	Contact information
Brigham and Women's Gynecology Practice	Phone: (617) 732-4806

75 Francis Street, CWN-3 Boston, MA 02115	Fax: (617) 730-2830
Yawkey Center for Outpatient Care, Suite 4E General Gynecology Department 55 Fruit Street Boston, MA 02114	Phone: 617-724-6850 Fax: 617-724-5843
Mass General Waltham, Gynecology 52 Second Avenue Suite 400 Waltham, MA 02451	Phone: 781-487-3860 Fax: 781-487-3870
Chelsea HealthCare Center, Gynecology 151 Everett Avenue Chelsea, MA 02150	Phone: 617-889-8561 Fax: 617-887-3708
Revere HealthCare Center, Gynecology 300 Ocean Avenue Revere, MA 02151	Phone: 781-485-6450 Fax: 781-485-6391
Charlestown HealthCare Center, Gynceology 73 High Street Charlestown, MA 02129	Phone: 617-724-8208 Fax: 617-724-8149

For a list of individual Gynecology providers, please refer to the U01 Abnormal SFA, Patient Navigator folder.

Appendix B: Education Materials

Educational materials can be found on the U01 Abnormal SFA in the Patient Outreach folder.

Appendix C: COVID-19 patient resources

Educational/outside resources:

American Cancer Society – COVID-19 and cancer screening info	https://www.cancer.org/latest-news/common-questions-about-the-new-coronavirus-outbreak.html
Mass. Department of Health – guide for emotional health and well-being	https://www.mass.gov/resource/maintaining-emotional-health-well-being-during-the-covid-19-outbreak
Suffolk County DA – COVID-19 resource guide	https://www.suffolkdistrictattorney.com/press-releases/items/2020/3/29/0mcptaq8zn6o8hwutdpey0teo96ur8
Disaster Distress Line	1-800-985-5990

Partners/MGB mental health resources:

MGH psychiatry access line	617-724-7792
BWH psychiatry access line	617-732-6727

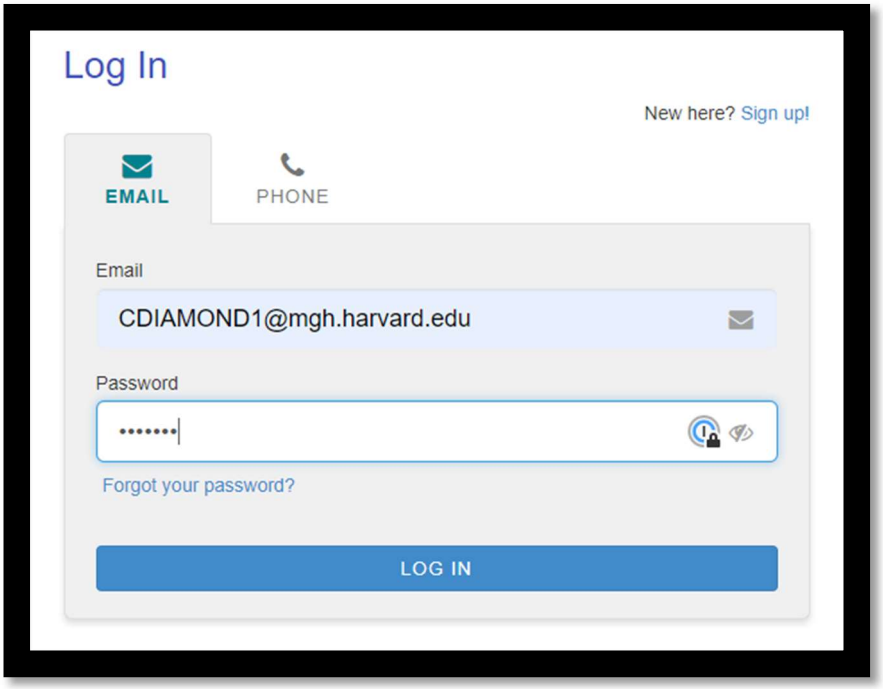
Appendix D: Aunt Bertha Instructions

Contents

Getting started

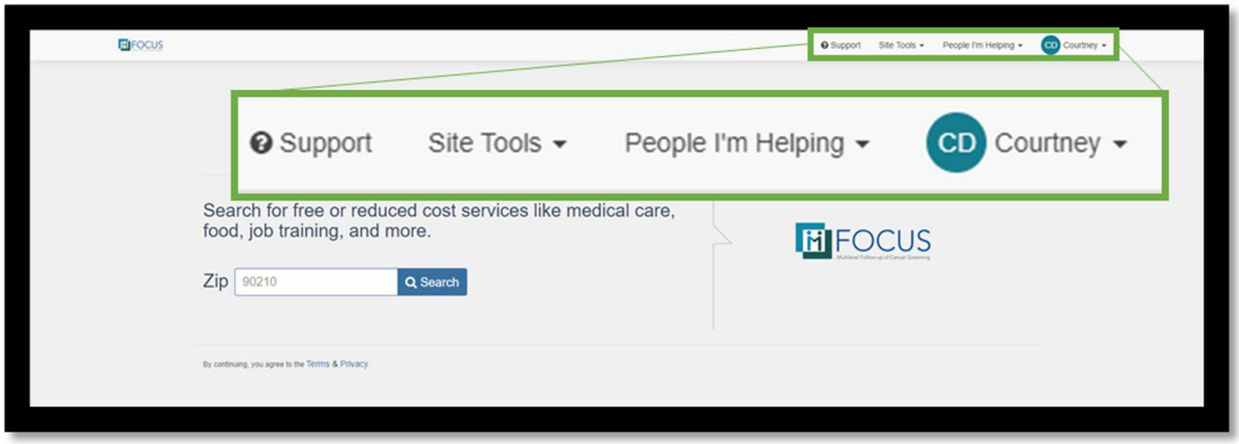
- Patient navigators can access the Aunt Bertha mFOCUS website directly by entering the following link into their web browser: https://mFOCUSteam.auntbertha.com/.
- Patients can access Aunt Bertha via the following link: https://mFOCUS.auntbertha.com/.
- Aunt Bertha can be accessed on a desktop, laptop or mobile device.

If you have not yet created a user account, please do so by clicking the 'Sign Up' link in the right-hand corner. Please ensure that you use your hospital email address (e.g. cdiamond1@mgh.harvard.edu) to log in, as this email will grant user access to the mFOCUS team Aunt Bertha website.



Aunt Bertha Homepage tools

Upon login, you will be directed to the mFOCUS Project homepage. The taskbar in the upper right corner of the homepage has 4 options.

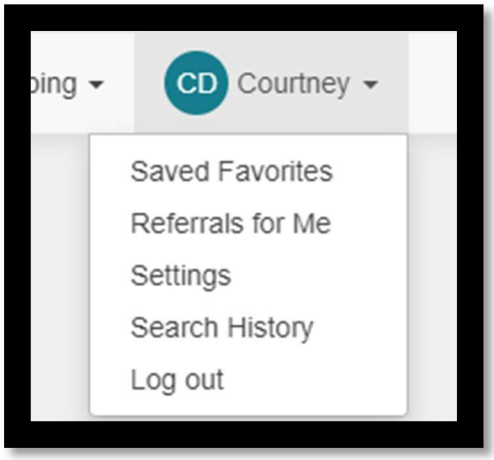


1. **Support:** Click this link to search Aunt Bertha's Frequently Asked Questions, get helpful tips for adding, saving and sharing programs, and access additional training resources.

2. **Site tools:** Click this link to customize search results, and view site analytics (for more details on reports), including your most recent search activity and recently added resources in your area.

3. **People I'm Helping:** Click here to –
    a. Click through to 'People' to search for a previously entered Aunt Bertha patient record.
    b. Click through to 'Forms' to view all Social Needs Assessments previously completed

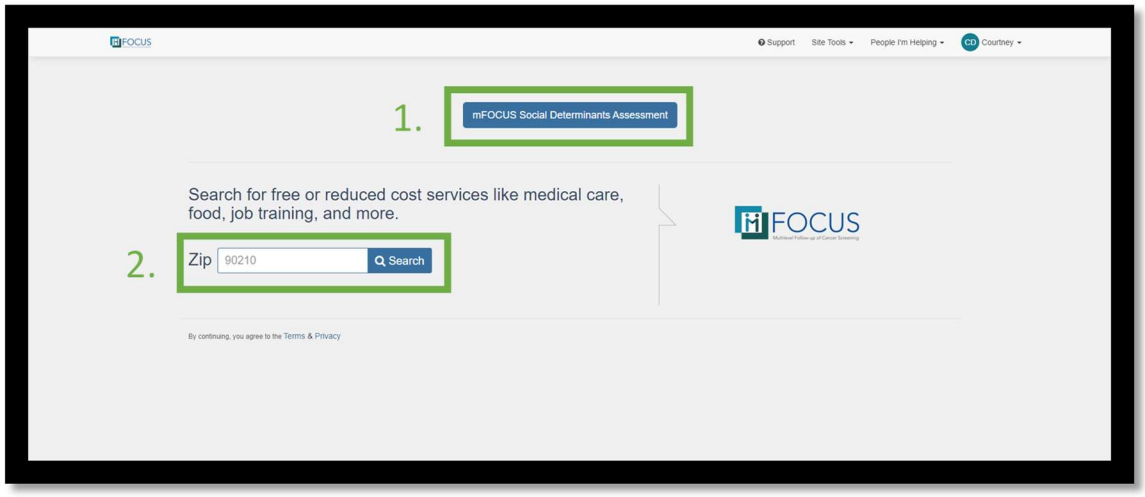
4. **User Options:** Click here to –
    a. Access and manage your 'My Favorites' folder for your favorite referrals
    b. See any referrals made to you under 'Referrals for Me'
    c. Change your username and password under 'Settings'
    Note: You will receive a notification to reset your password every 3 months
    d. View your Activity dashboard under 'Search History' (also available under 'Site Analytics')
    e. Log out of Aunt Bertha



Finding Resources

Once logged in, you will have 2 options on the mFOCUS homepage to find resources to assist your patients with their social barriers to care.

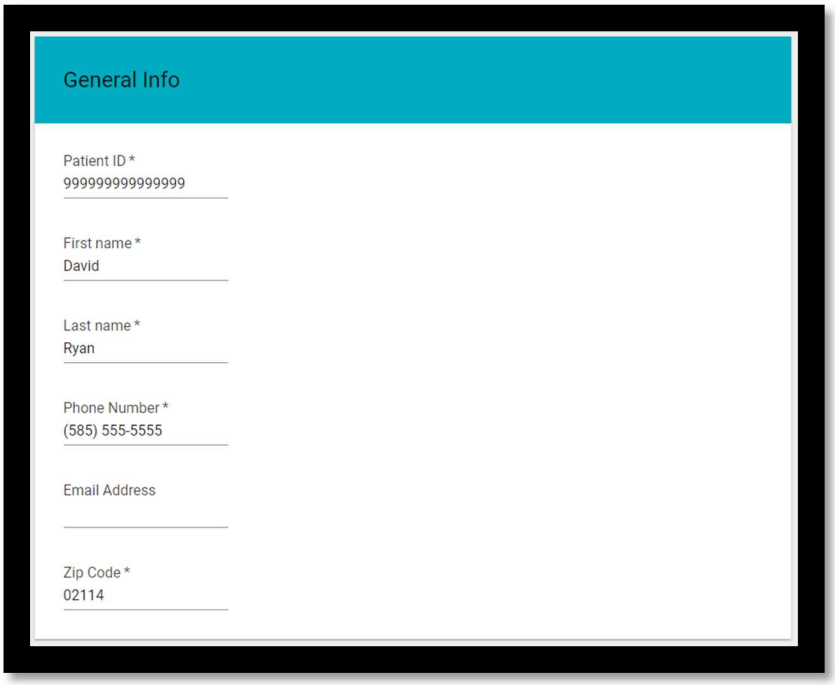
1. The mFOCUS Project Social Needs Assessment – a question form to screen for social barriers to care. Completing this assessment will link to appropriate resources to address domains identified as a problem by a patient when the Patient Navigator reaches out to them over the phone for the first time.
2. Zip code search bar – typing in the patient's zip code (either home or a zip code where it is convenient for a patient to receive services) will allow you access local resources by domain.



For the mFOCUS Project, it is required that the Social Needs Assessment be completed for all arm 4 patients that have not received their follow up test. The zip code search can be utilized as a quick use tool should the patient identify a specific needs between assessments.

Social Needs Assessment

- From the home page, click on 'Social Needs Assessment' to begin.
- Enter the required information – First Name, Last Name, Phone Number, and Zip Code.



- The Aunt Bertha platform uses the patient's zip code to provide a list of nearby resources for assistance. The zip code should be the one identified by the patient as most convenient for them to receive services (home, family member, work, physician's office). If a patient indicates that they do not have a permanent address please ask the patient which they prefer:
    - The zip code of a friend or family member.
    - The zip code of their temporary residence (shelter, group home, address of friends or family).
    - The zip code at the hospital where they are receiving treatment.
- Scroll down to complete the Social Needs Assessment. It is strongly recommended that all 14 questions in the assessment be completed at intake for each patient to ensure that all initial needs are matched with resources to address all barriers.
- If a patient offers additional details or concerns about their needs during the Social Needs Assessment, we suggest that the patient navigator says something like: "*Let's get through the main questions first, and then have a more in-depth discussion of your specific concerns*." Also, the comment fields can be used to store additional details or notes that may be helpful.

Identifying Needs

In the past 12 months, has lack of reliable transportation kept you from medical appointments, work or from getting things needed for daily living?

- ◯ Yes
- ◯ No
- ◯ Refused

Comments

_____

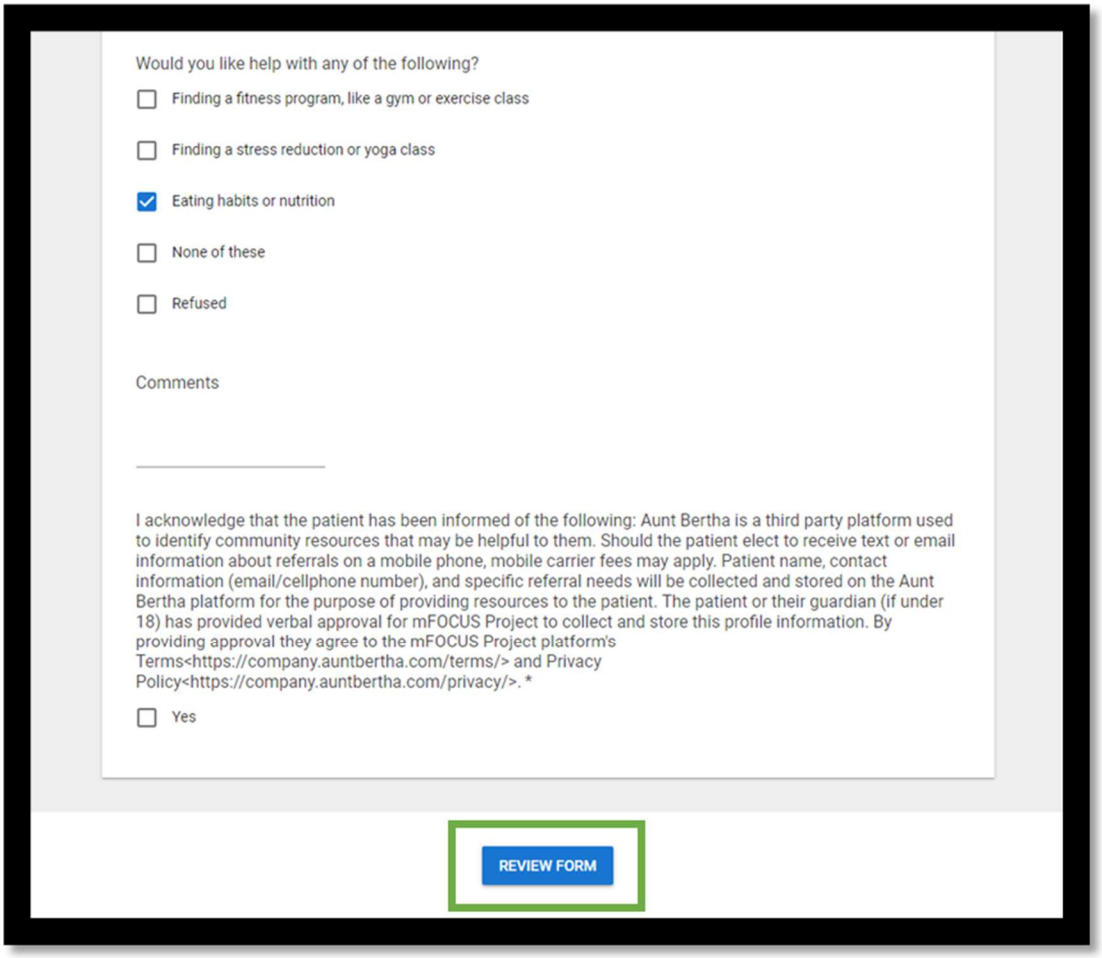
In the last 12 months have you worried that your food would run out before you had the money to buy more?

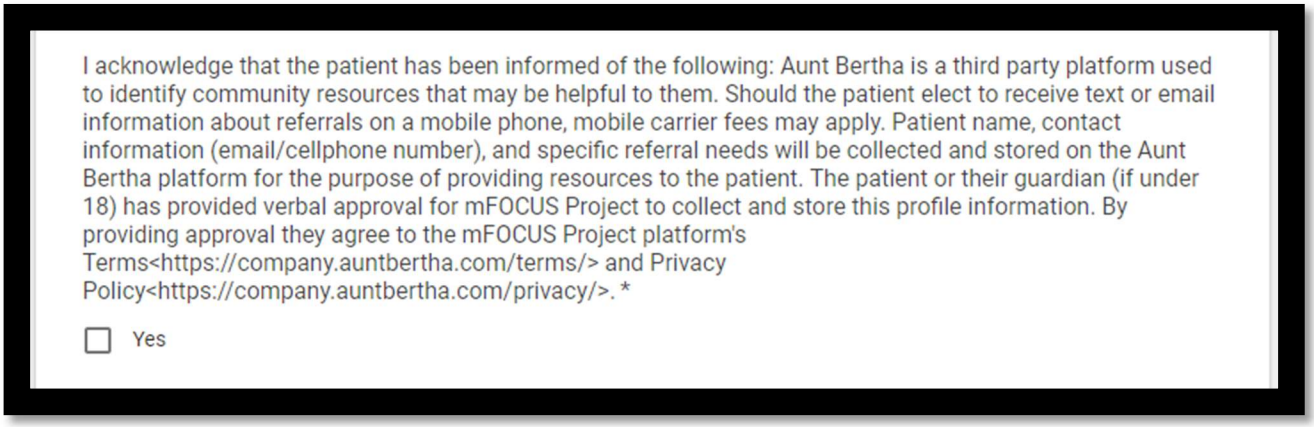
- ◯ Often True
- ◯ Sometimes True
- ◯ Never True
- ◯ Refused

Comments

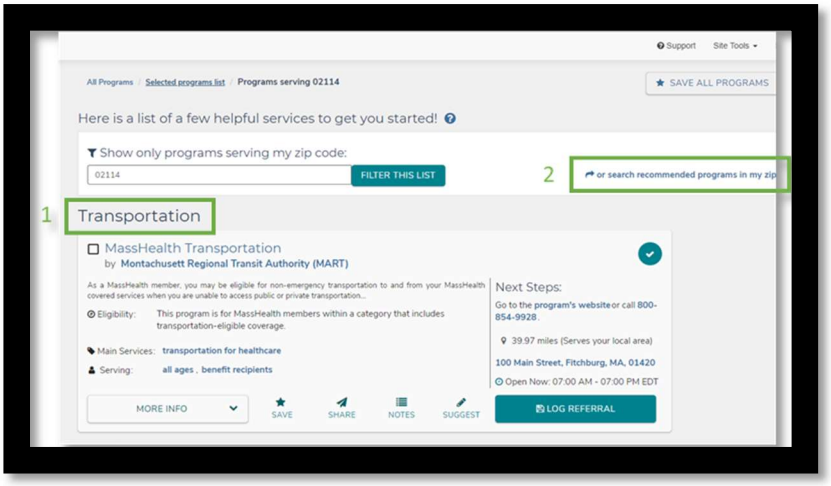
_____

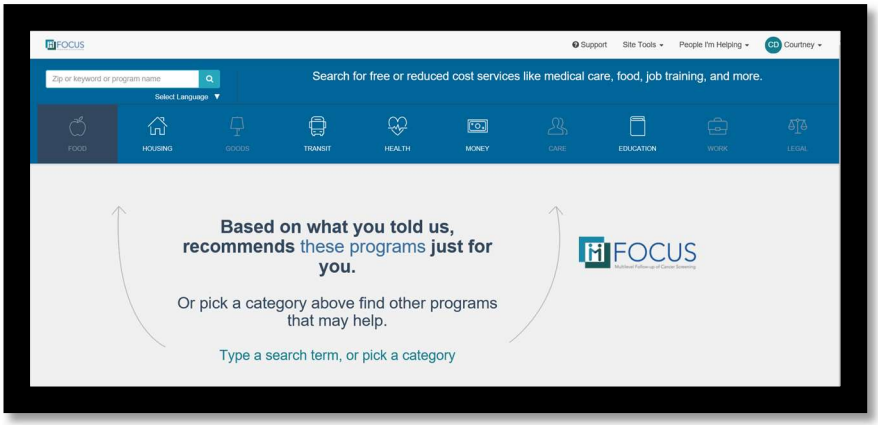
Once you have completed the Social Needs Assessment, confirm with the patient that your recorded responses are accurate. After this, confirm that you have reviewed the 'consent' terms with the patient by clicking the 'Yes' checkbox, and click 'Review Form' at the bottom of the page.





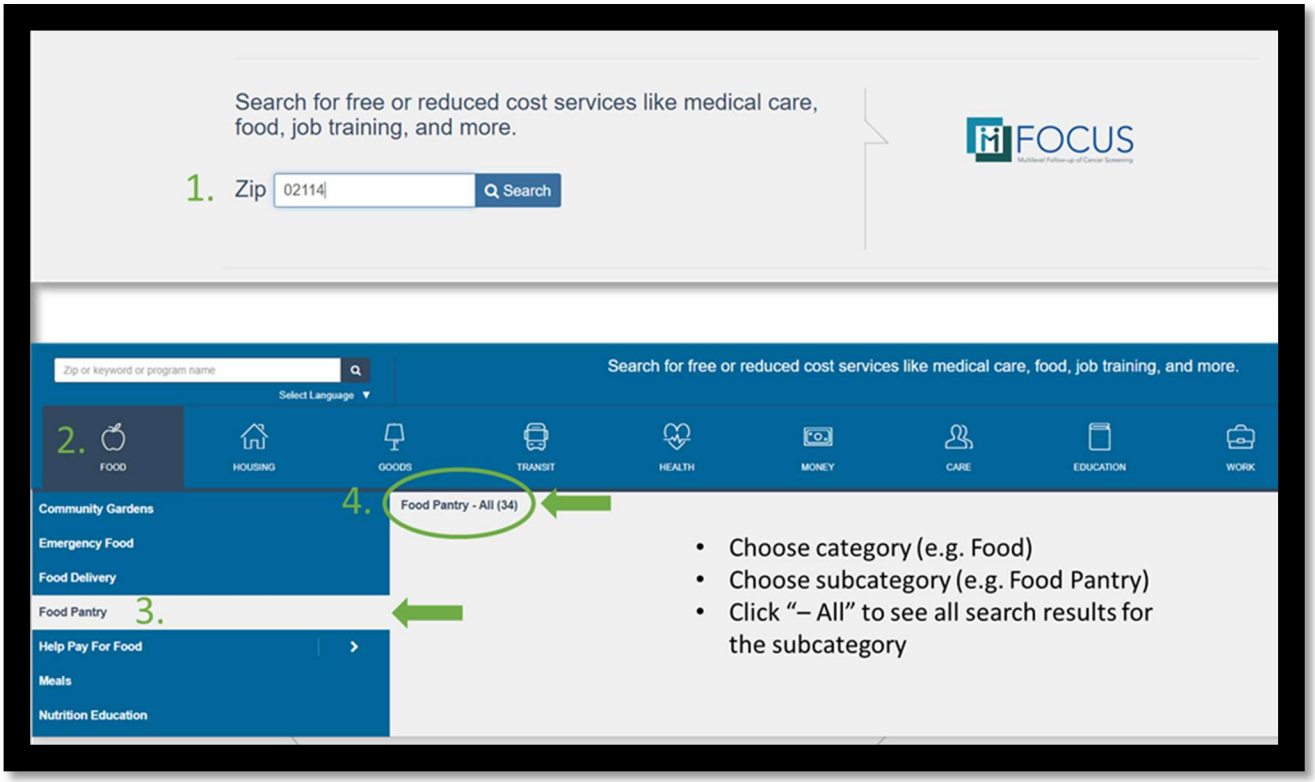
- Note: rather than consenting to mFOCUS, checking this box indicates that the patient has acknowledged they've been informed that Aunt Bertha is a third party platform.
- Once the assessment has been submitted, you will be provided with the resources that address the needs identified during the screening process. The resources are sorted by the domains identified (e.g., transportation resources). Please note that the list of resources under 'Recommended Programs' (1.) will include any resources filed to the shared favorites folders (for information regarding populating the favorites folders please see the 'Favorites Folders' section of this user manual).
    - If you identify a useful resource under 'recommended programs', you can add the resource to the patient's file in Aunt Bertha (for details please see 'Connecting Patients' below).
- If you are looking for a more comprehensive list of local resources, click 'or search recommended programs in your area' (2.)
- If 'or search recommended programs in your area' is selected you will be linked to the complete search page. Only the categories of needs that were identified during the assessment will appear as 'white' in the top taskbar.
- Click the graphic (e.g. the bus for 'transit') to see the relevant sources for this category:





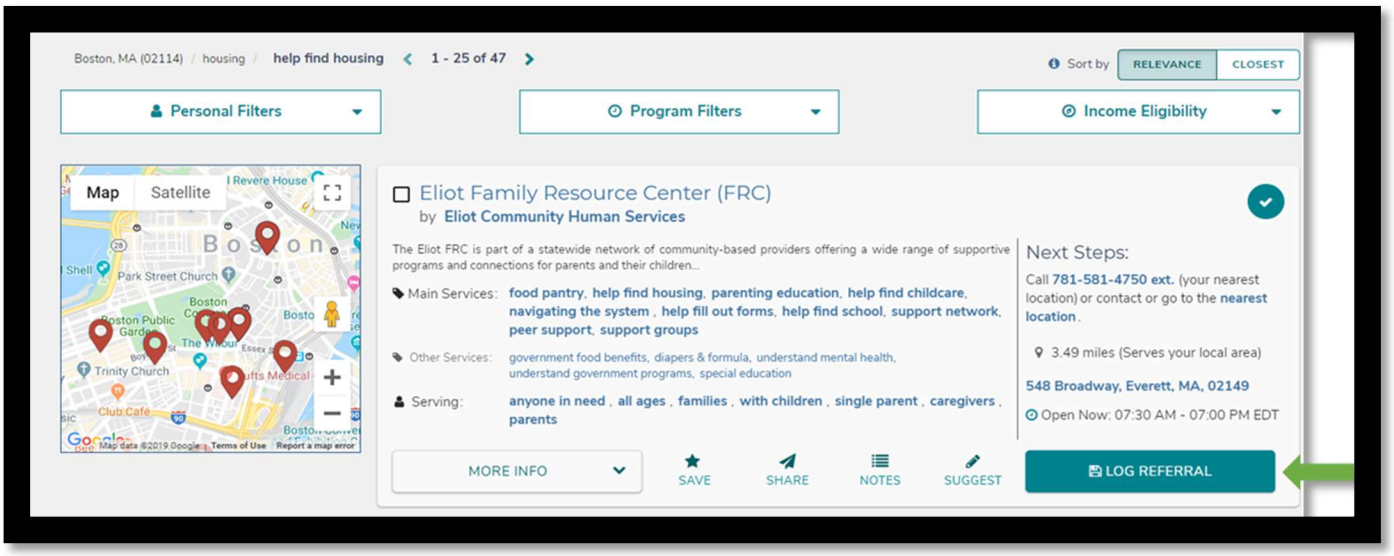
Zip Code Search (For Follow-up Encounters)

- To quickly search for resources by patient zip code:
    1. Enter the patient's zip code into the zip code field on the mFOCUS homepage and click 'Search.'
    2. Hover your mouse over the most applicable category for your patient's current needs.
    3. Hover over the preferred subcategory.
    4. Once you have identified the subcategory for which you want to view search results, click the '-All' button to the right of the subcategory.
- For details regarding how to save zip code resource search results to your patient's individual file, please see 'Connecting Patients' below.



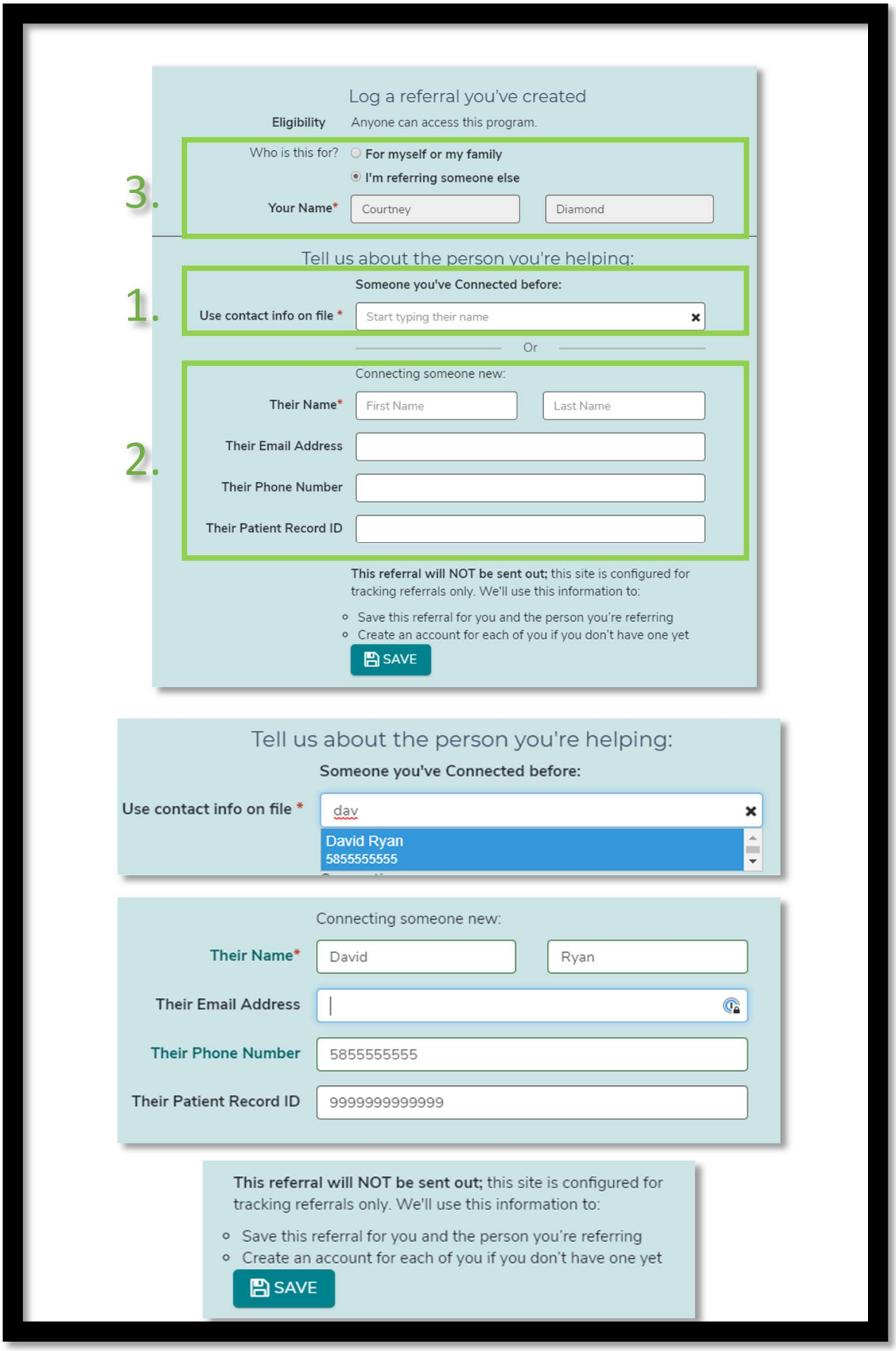
Connecting Patients

- Whether you are identifying resources for your patient through the recommended resources listing or the 'search recommended programs in your area' results page, you will use the 'Log Referral' button to add a resource to your patient's record in Aunt Bertha. **Clicking the Log Referral button is required for you and other navigators to know later what resources have been suggested. Tracking these resources is also very important to the mFOCUS project goals.**



- Once you click Log Referral, there are 3 ways to log information (see pictures on next page):
    1. 'Someone you have connected before' – if the patient has an existing Aunt Bertha record, start typing their name in the 'Use contact info on file' box. When you enter the patient's name, click once on the green background to auto-populate the patient's information and save the referral to their existing file.
    2. 'Connecting Someone New' – if this is the first time you are entering a particular patient's information into the Aunt Bertha system, please use this option by entering their name and email. NOTE: it will be important to ensure that the name and email you enter match the information that you entered for the patient when completing the Social Needs Assessment form in order to ensure that the resources appear with the form in the Aunt Bertha patient record.
    3. Referring yourself – NOT Recommended; this will add the resource to your personal referrals list instead of the Aunt Bertha patient record.

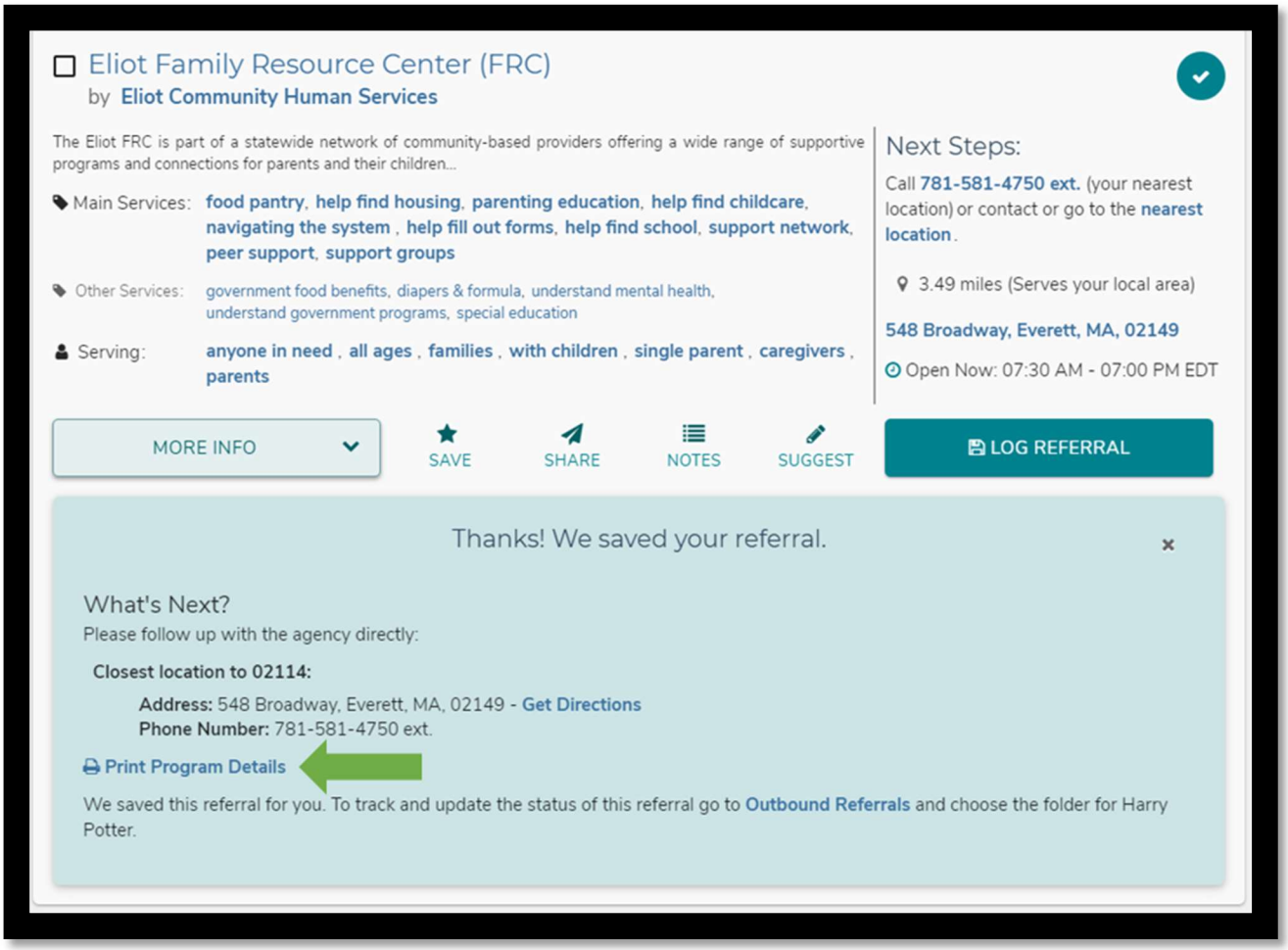
Please note that the 'Log Referral' button WILL NOT send patient referrals out to resource organizations. This will only be used for tracking and organization of each patient's resources within the Aunt Bertha platform.


Log a referral you've created
Eligibility
Anyone can access this program.
3.
Who is this for?
For myself or my family
I'm referring someone else
Your Name*
Courtney
Diamond
Tell us about the person you're helping:
1.
Someone you've Connected before:
Use contact info on file *
Start typing their name
Or
Connecting someone new:
Their Name*
First Name
Last Name
2.
Their Email Address
Their Phone Number
Their Patient Record ID
This referral will NOT be sent out; this site is configured for tracking referrals only. We'll use this information to:
Save this referral for you and the person you're referring
Create an account for each of you if you don't have one yet
SAVE
Tell us about the person you're helping:
Someone you've Connected before:
Use contact info on file *
dav
David Ryan
5855555555
Connecting someone new:
Their Name*
David
Ryan
Their Email Address
Their Phone Number
5855555555
Their Patient Record ID
9999999999999
This referral will NOT be sent out; this site is configured for tracking referrals only. We'll use this information to:
Save this referral for you and the person you're referring
Create an account for each of you if you don't have one yet
SAVE

Providing Your Patient with Referral Information

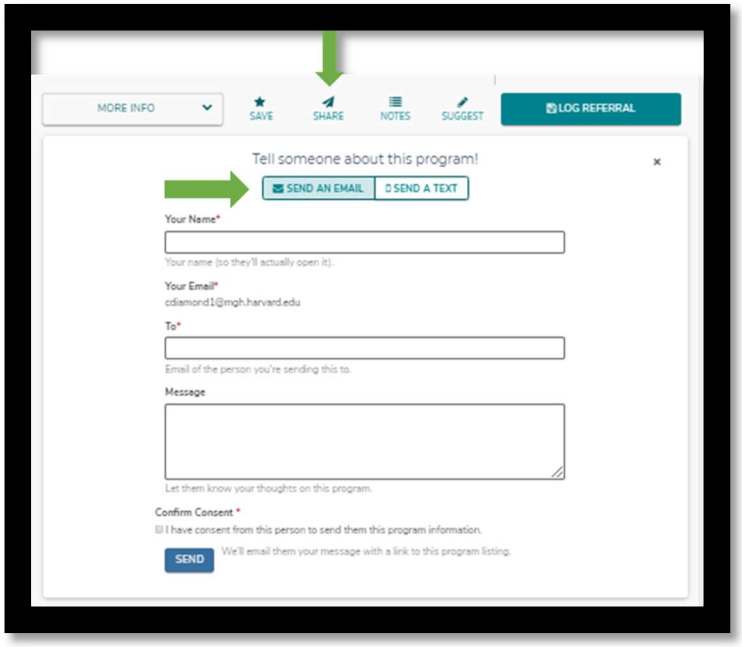
There are two ways to share referral information with your patient:

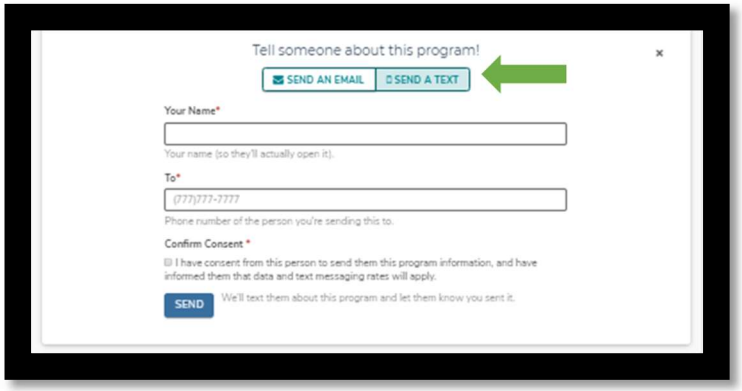
1. To print a hard copy of the referral, select the 'Print this Program' option once you have saved the referral to the patient's file.



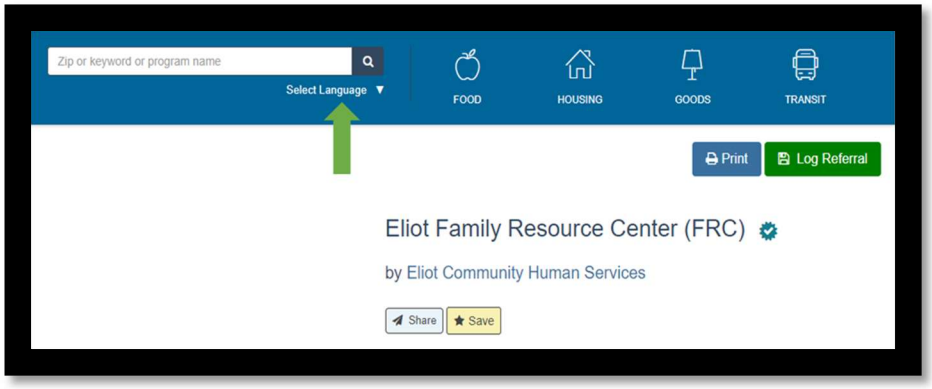
2. Electronically share the referral information by selecting 'SHARE'. This allows you to email or text the referral to your patient. For electronic sharing, you must obtain consent from your patient.
    a. **Email instructions**: Enter your name and email, the email of the patient, and optionally, enter a personalized message to the patient. Select the 'I have consent from this person to send them this program information'. Finally, select 'Send.'

b. **Text instructions:** Enter your name and the patient's phone number. Then, select 'Send'.

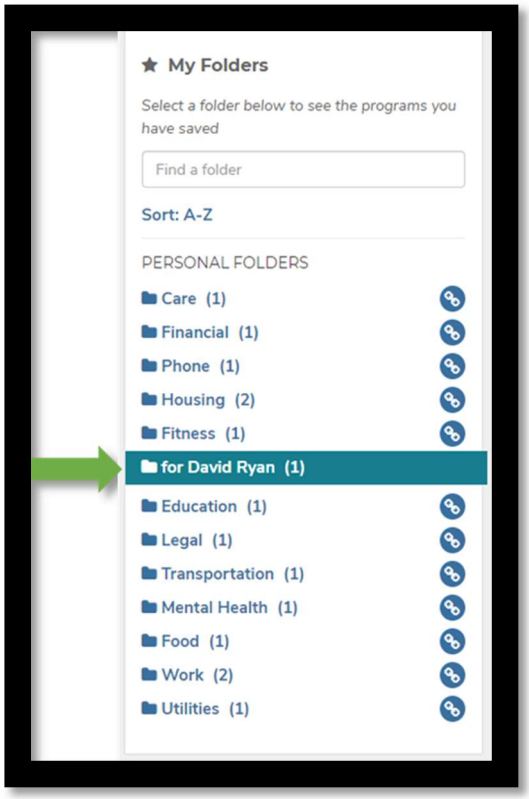




NOTE: Aunt Bertha resources can be provided to patients in various different languages. When a resource is selected, navigate to the upper left corner of the page, and select the language from the drop-down menu. This will NOT change the language of the link sent to a patient; they will need to navigate to the Select Language menu when viewing the link from a referral email.

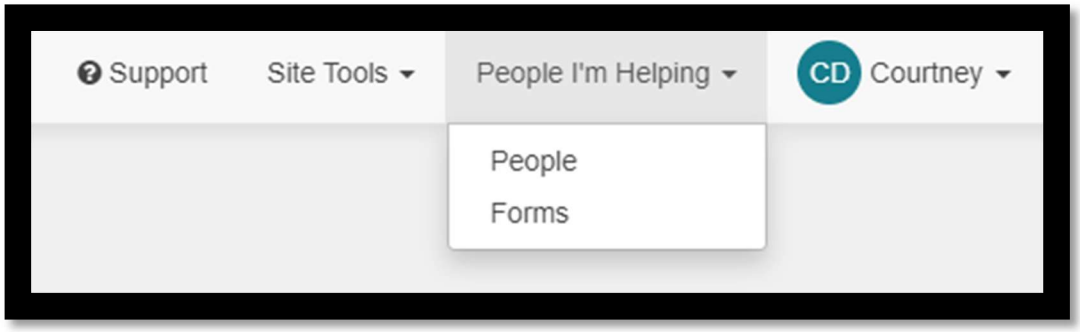


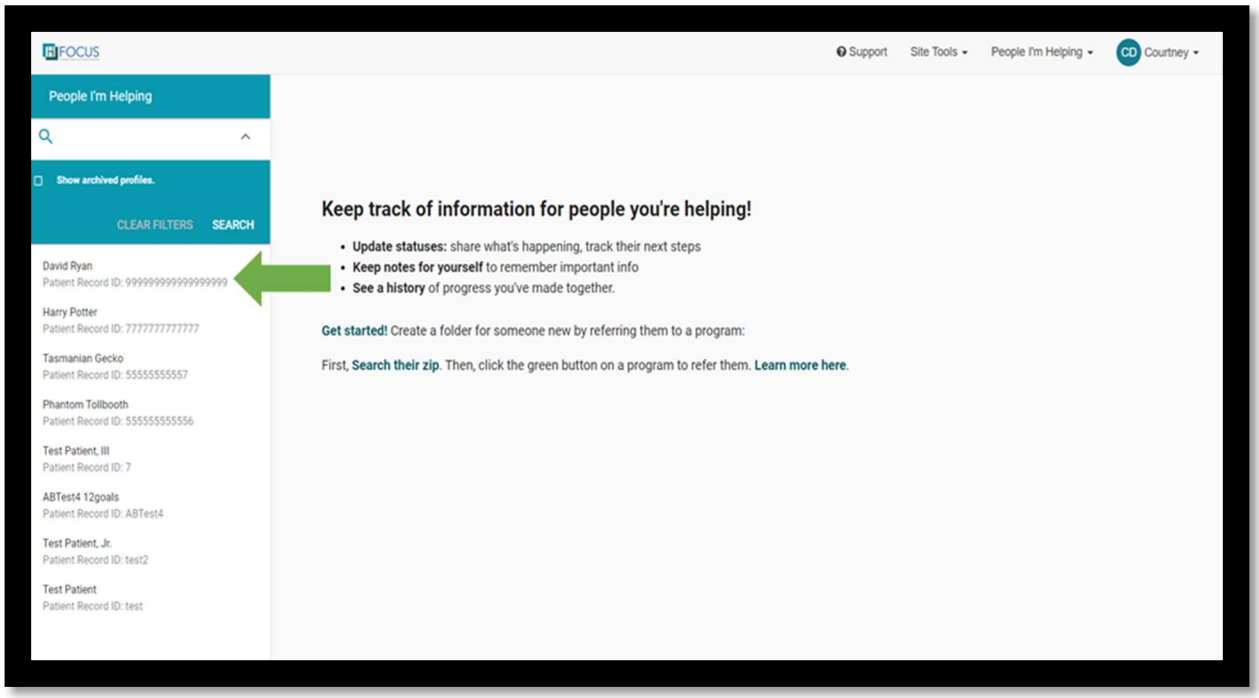
If you are printing more than one resource for a patient, you may want to create a personal folder for a particular patient (see 'Favorites' section for instructions to create folders). After entering this folder, multiple resources can be printed together by clicking on the "Print" button in the upper right-hand corner. NOTE: only you will be able to see these personal folders.



Reviewing Aunt Bertha Patient Records

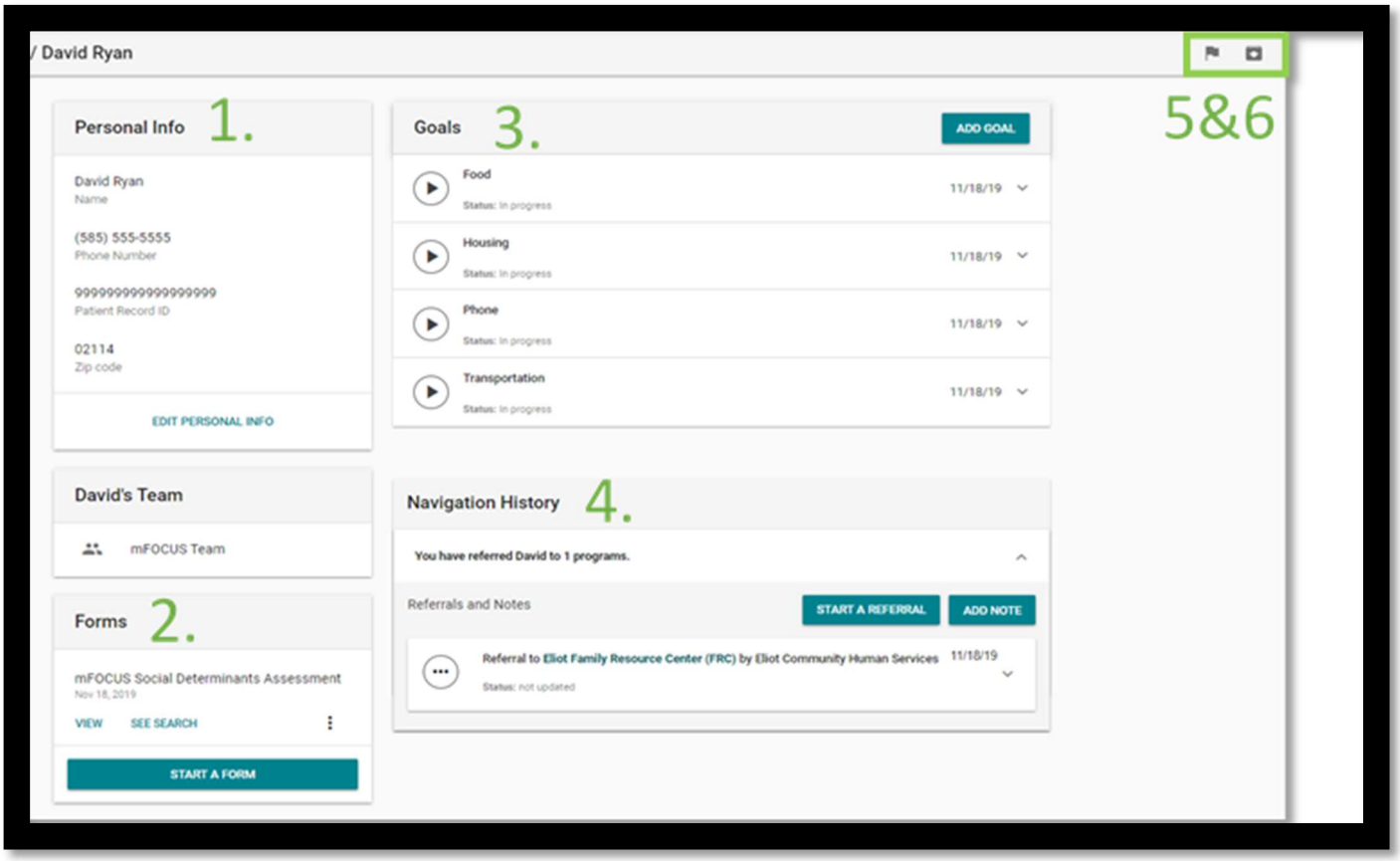
- To view a patient's Aunt Bertha record, navigate to the 'People I'm Helping' page from the homepage top toolbar – this option is found under 'People.'
- Under 'People', search for your patient in the search bar on the left-hand side of the page by name, email or phone number, and click on their name to access their individual referral history.
- Select your patient name to open their individual record.





- Under Aunt Bertha patient record you will see the following information boxes:
    1. **Personal Information** – name, email, phone, patient registry ID number and zip code.
    2. **Forms** – will allow access to any previously completed Social Needs Assessments and related resource recommendations.
    3. **Goals** – displays a patient's progress toward addressing needs identified in their Social Needs Assessment. You may update the status of a goal to *In Progress, On Hold, Done,* or *No Longer a Goal.*

4. **Navigation History** – allows you to see all resources you previously provided to the patient, to input notes about a patient or about individual resources, and to track whether resources were successful for the patient. For more details please see 'Tracking Patient Referral Progress.'



- In the top right corner of the patient's record you will see the following two buttons (pictured above):
  5. The flag button will allow you to flag the patient's record.
  6. The button with a downward arrow inside a box will allow you to archive the patient's record. Please be careful to not accidently archive a patient's record as they will not show up under the 'People I'm Helping' page.

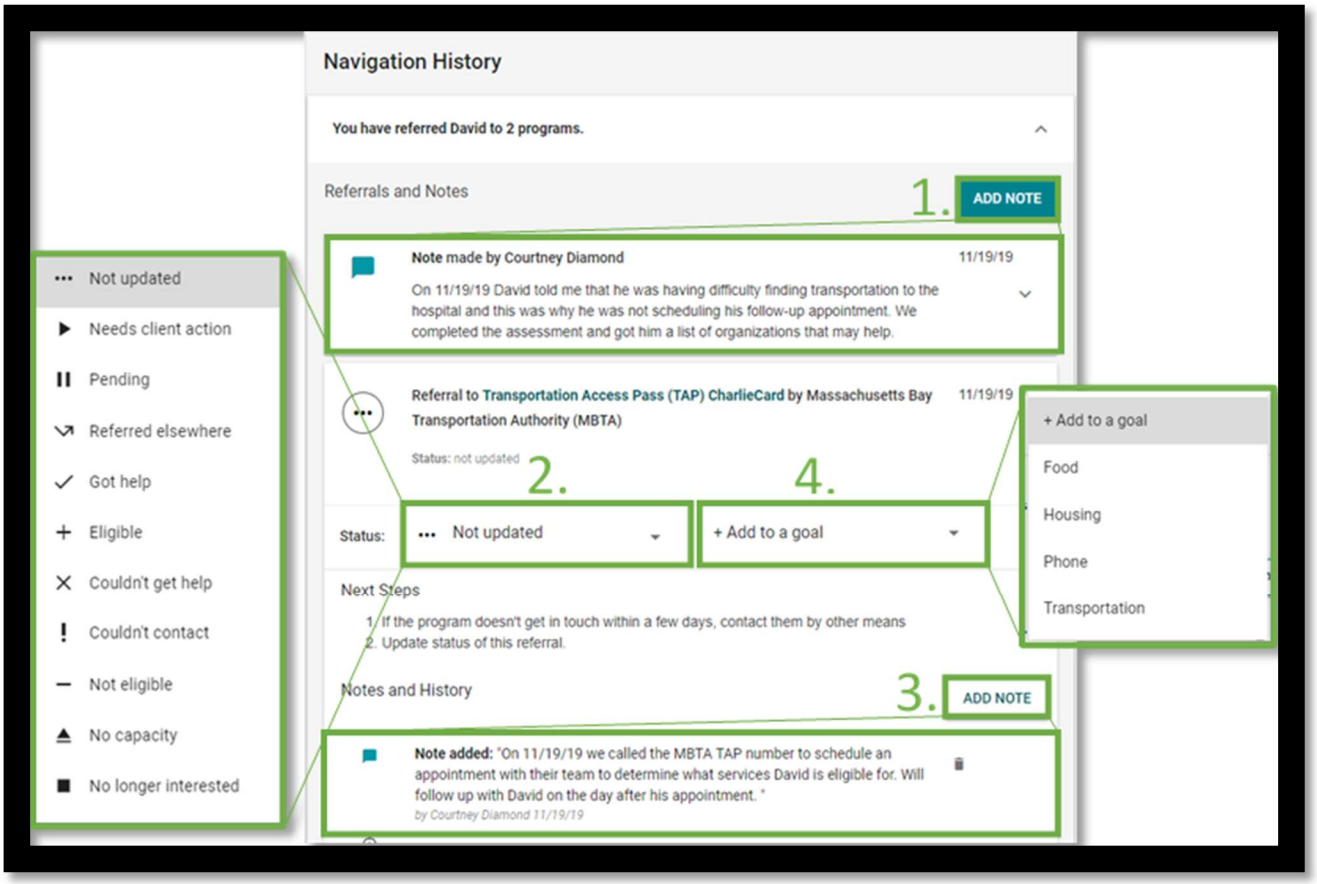
Tracking Patient Referral Progress

- There are 4 ways to add details to a patient's individual record:
  1. To add a 'general' patient related note to the record click the blue box labeled 'ADD NOTE'. Once your note is complete click 'SAVE'
  2. To track the status of a previous referral, click the down arrow on 'status' under an individual referral record and choose the most applicable status

- Updates in referral status will be marked with the name of the patient navigator making the status change and the date of the status change

3. To add a note to an individual referral record click the 'ADD NOTE' button under the individual referral and type your note. Once your note is complete click 'SAVE'
4. To add a referral to a specific goal, click the 'ADD TO A GOAL' button and select the goal. Note: this will move the referral from the "Navigation History" section of the patient patient profile and associate it with the goal in the "Goals" section.

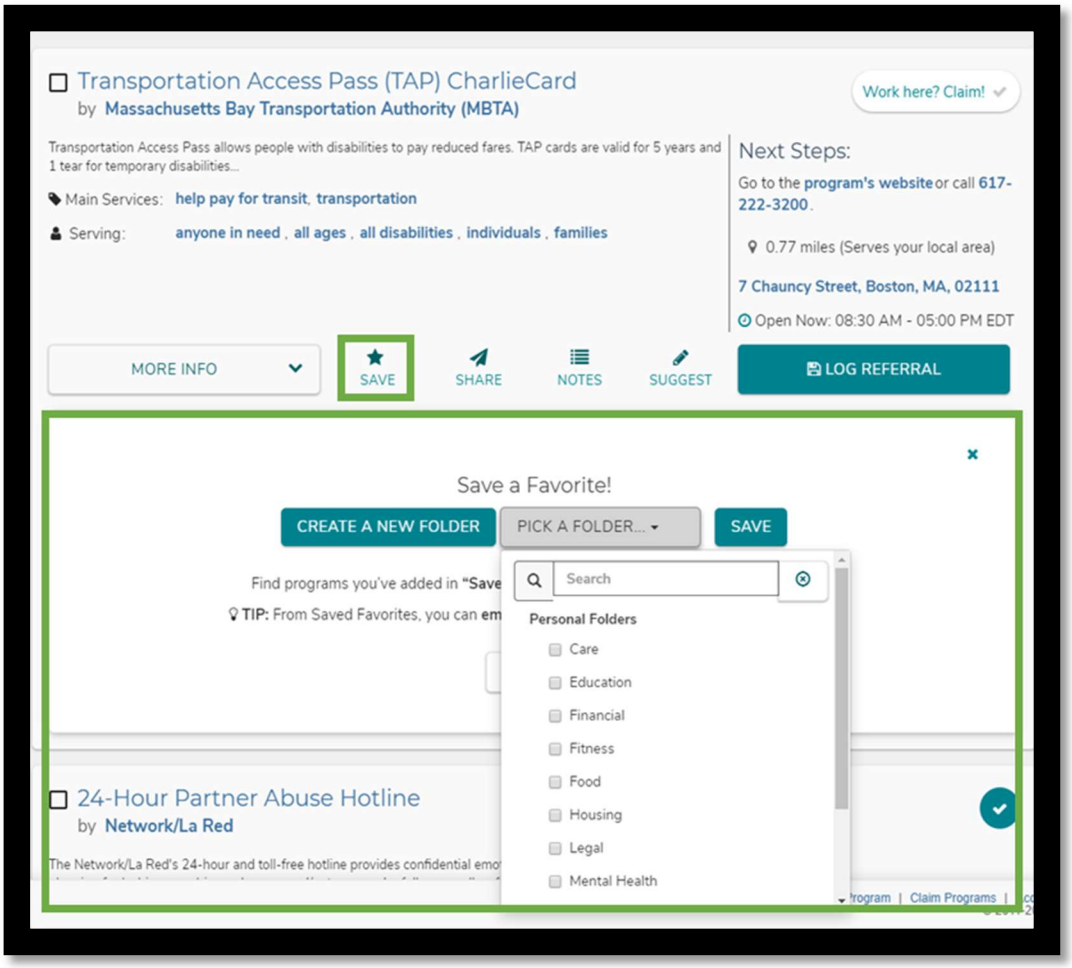
- Note: every patient navigator can see all the referrals that have been made for a patient



Favorites

Adding Resources to Favorites

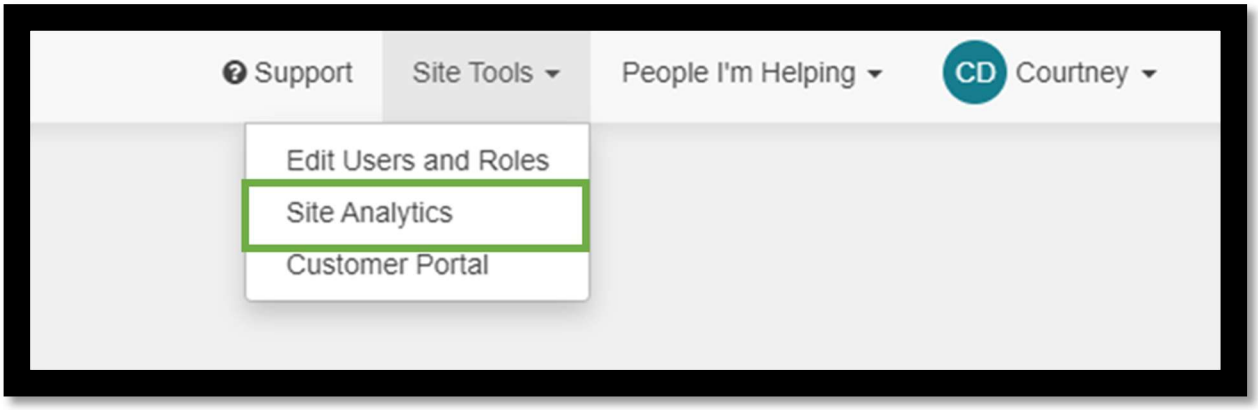
- To add resources to either your personal favorites folders or the 'shared favorites folders' (to be shared with all of the mFOCUS navigators) click on the SAVE button at the bottom of the resource. We have already created shared folders for each of the social barrier domains for you to use based upon your resource recommendations. **A resource can be shared to 1 or more folders depending on how many of the domains they address.**
- Any resources added to the shared favorites will automatically show up as recommended resources when you complete the Social Needs Assessment
- To create a new personal shared folder click the green 'create a new folder' button, give your folder a name and click 'SAVE'
- To add a resource to one or several shared folders click the drop-down menu to the right of 'create new folder' and select all categories that apply; click 'SAVE'



Site Analytics

Reports

- To access Aunt Bertha reports, click on 'Site Tools' in the homepage top tool bar, and then click on 'Site Analytics'.



- You will have access to the following five reports which provide useful information:
    1. **'My Activity Dashboard'** displays the referrals you have searched for by date as well as recently added Aunt Bertha programs in Boston.
    2. **'Search History (Basic)'** displays data regarding the zip codes where you have searched for referrals as well as a pie chart of the different categories of referrals (i.e., transit, food, goods, health, and housing). Additionally, at the bottom of the page is a chart displaying the five most recently added programs to Aunt Bertha nationwide.
    3. **'Program Inventory Suite (Pro)'** displays data regarding the type and number of programs available through Aunt Bertha on a local, state, and national level, with a chart that organizes available resources by the five most searched zip codes.
    4. **'Referral Activity Suite (Pro)'** displays data regarding the number of patient navigators making referrals, the total referrals made, and users referred, as well as shared referrals. Additionally, this report includes the most referred programs as well as the details and status of individual referrals.
    5. **'Detailed Referral Activity Suite (Enterprise)'** displays monthly referrals with a bar graph indicating the status* of that months total referrals. Additionally, a chart displays the most referred programs broken down by referral status* and another chart displays the status* of referrals by patient navigator.

        *Status refers to whether the patient got help from the referral, is yet to receive help, was not able to receive help, or whether the status of the referral is unknown.

Appendix E: Aunt Bertha Questions

1) **In the past 12 months, has lack of reliable transportation kept you from medical appointments, work, or from getting things needed for daily living?**

   Yes

   No

   Refused

2) **In the past 12 months, have you worried that your food would run out before you had the money to buy more?**

   Often True

   Sometimes True

   Never True

   Refused

3) **At any time in the last 12 months, how often did you struggle to make food/groceries last, with the inability to obtain more?**

   Often True

   Sometimes True

   Never True

   Refused

4) **What is your housing situation today?**

   I have a steady place to live

   I have a place to live today but I am worried about losing it in the future

   I do not have a steady place to live (staying with others, in a hotel, in a shelter, in a car, living outside or on the street)

   Refused

5) **How many times have you moved in the past 12 months?**

   Zero (I did not move)

   Once

   Two or more times

   Refused

6) **Think about the place you live. Do you have problems with any of the following?**

Pests such as bugs, mice, rats

Mold

Lead paint or pipes

Oven or stove not working

Leaking or broken pipes, sinks or toilets

Smoke detectors missing or not working

Lack of heat

None of the above

7) **In the past 12 months, has the electric, gas, oil or water company threatened to shut off or shut off services to your home?**

Yes

No

Already shut off

Refused

8) **Do you have trouble paying for your treatment, including medicines, visits or tests?**

Yes

No

Refused

9) **Do you want help finding or keeping work or a job?**

Yes, help finding work

Yes, help keeping work

I do not need or want help

Not applicable/not employed

10) **Are you interested in going to school or getting job training?**

Yes

No

Refused

11) **In the last 12 months, have you missed a health care visit or work because you needed to care for a child, family member or friend?**

Yes

No

Refused

12) **Do you currently have any legal concerns or needs (like to prevent eviction, being fired, or discrimination)?**

Yes

No

Refused

13) **In the past 12 months, has your phone service been shut off or disconnected?**

Yes

No

Already shut off

Refused

14) **Would you like help with any of the following?**

Finding a fitness program, like a gym or exercise class

Finding a stress reduction or yoga class

Eating habits or nutrition

None of these

Refused

15) **It sounds like you may need some assistance in the following areas. Which are the 3 that are most important to you today? We will look for resources related to those things.**

Transportation

Food security

Housing

Paying utility bills

Paying for treatment

Work

Education or training

Child or family care

Legal

Phone

Appendix F: Educational Materials

Educational materials can be found on the U01 Abnormal SFA in the Patient Outreach folder.