Improving Cancer Prevention and Early Detection among People Experiencing Homelessness in Europe: Co-designing the Health Navigator Model

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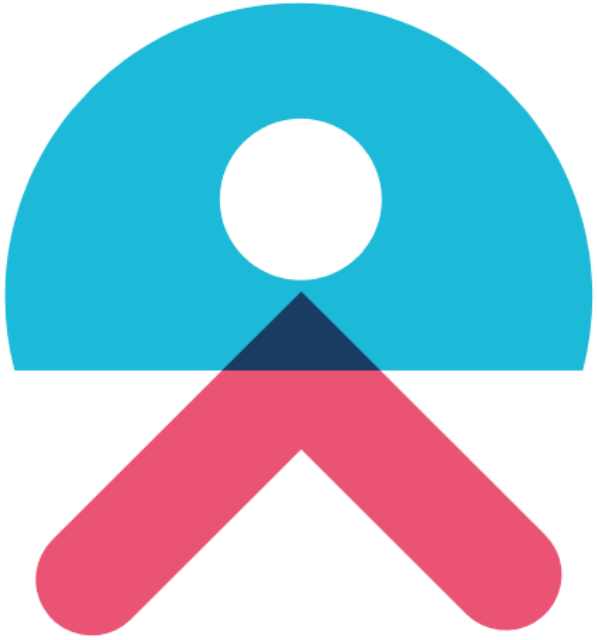

cancerless

Cancer prevention and early detection among the **homeless** population in Europe: Co-adapting and implementing the Health Navigator model

Who?

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Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator model

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Tus ideas son nuestros proyectos

WP 6

PRAKSIS

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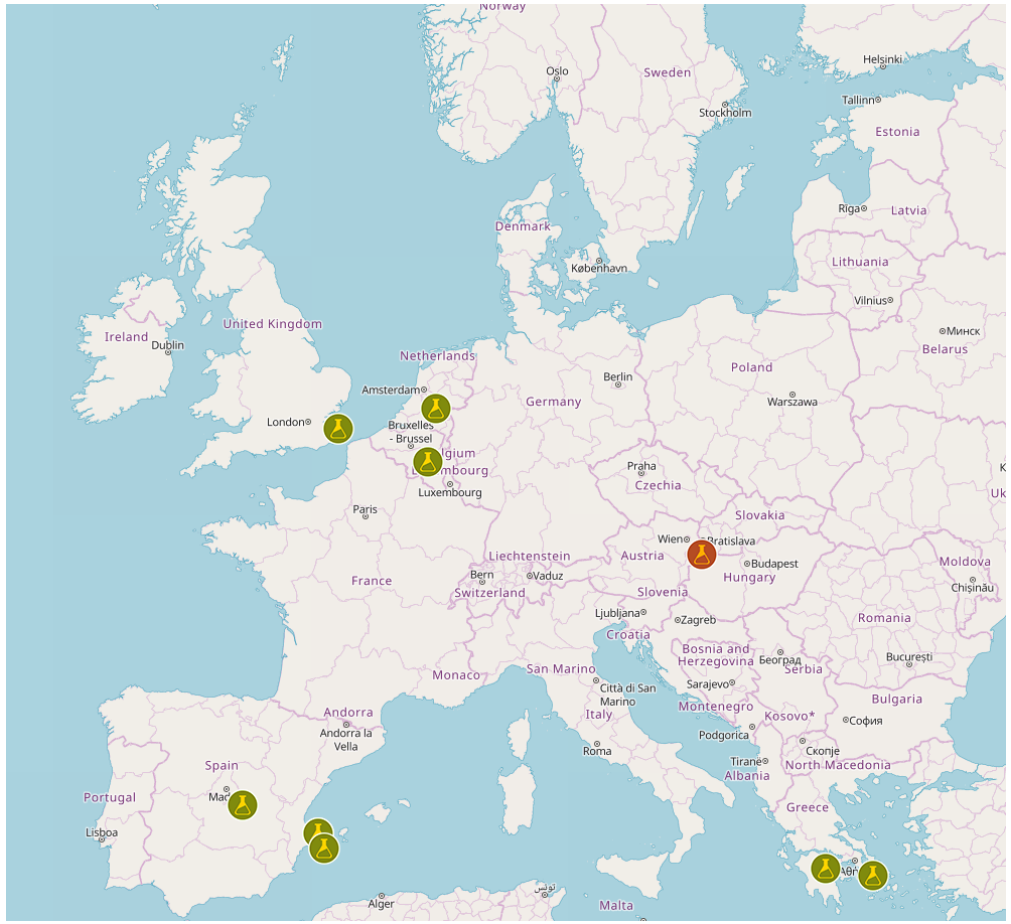

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Disparities in mortality in PEH

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Cancer is the second leading cause of death among people experiencing homelessness (PEH).

(Aldridge, 2019)

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Systemic barriers faced by PEH

- PEH **have trouble accessing** primary and secondary prevention or community health services

- Most service utilization within **acute health care settings**

- Barriers contribute to **treatable medical conditions causing premature mortality** among PEH

  → **this includes cancer**

- This problem could be addressed through **early and effective health care services** tailored for PEH

(Field et al., 2019; Hwang et al., 2013; Lebrun-Harris et al., 2013)

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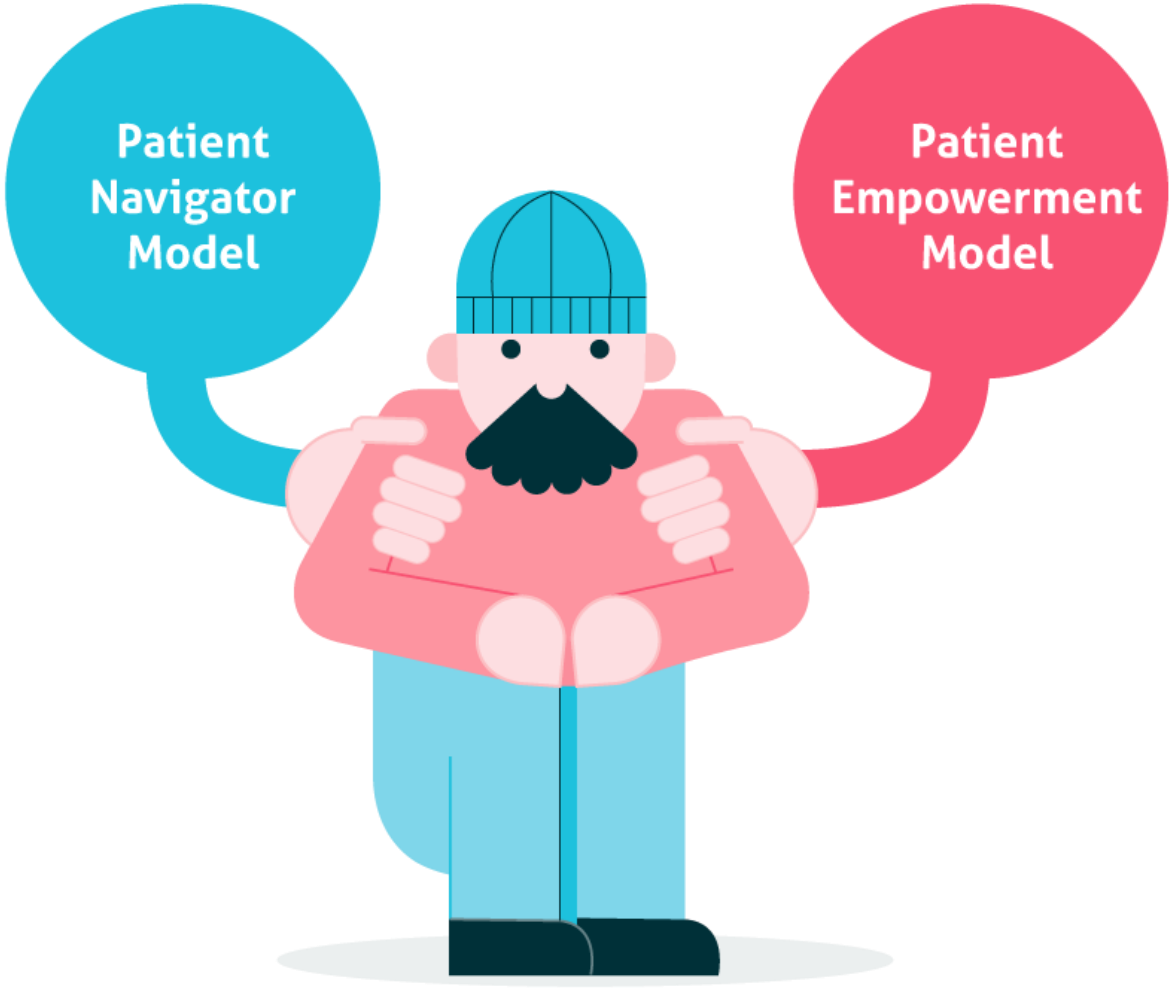
Health Navigator Model



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Health Navigator Model

Community-based
Service provision
Access promotion
Removal of barriers

Patient Navigation Model

Control of action
Decision-making
Health literacy
Higher engagement

Patient Empowerment Model

HEALTH NAVIGATOR MODEL

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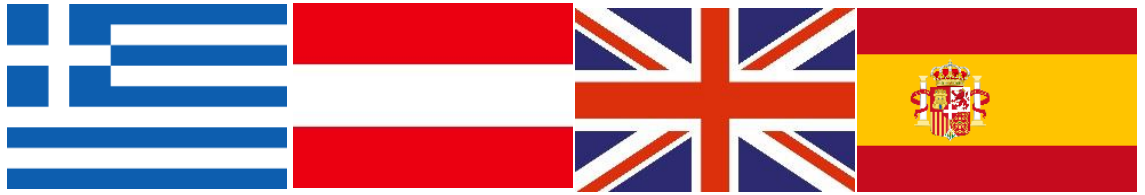
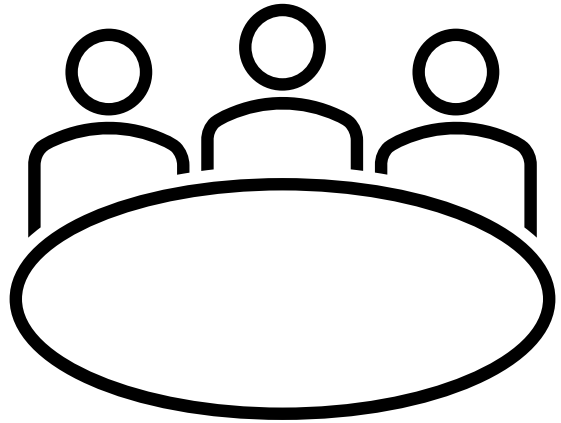
Methods



- **Qualitative cross-national co-design focus groups** during December 2021 and January 2022
- **7 focus group** discussions with a total of **56 participants**
  - **41 professional stakeholders**
    - Managers
    - Representatives of health and social care providers
    - Non-governmental organisations
    - Local government departments and patient organisations
    - Peer support/social workers with prior experience of homelessness
  - **15 persons currently experiencing homelessness**



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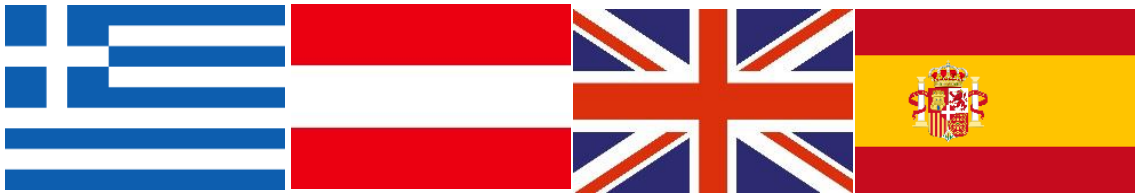
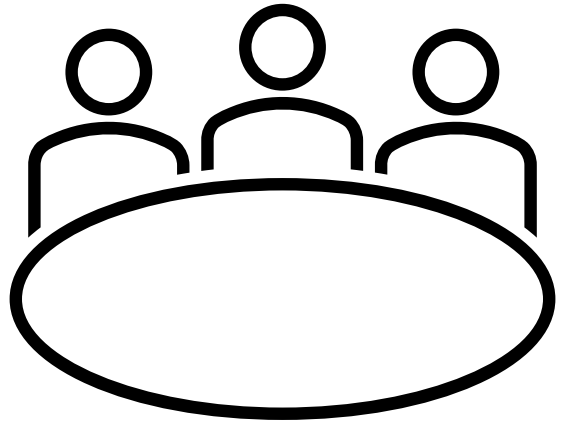
Methods



- Held either in a **field setting** or **online**
- **Structured topic schedule** used to guide the discussion and to ensure consistency between countries
  - Topic schedule based on **10 core components of navigation interventions** outlined by DeGroff et al. (2014)
- **Participatory exercises**
  - Mind-mapping
  - Diamond nine ranking (see Clark, 2012)
- **Inductive thematic analysis** according to Saldaña (2021) organised into the **pre-determined thematic framework** by DeGroff et al. (2014)



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Core components of the Health Navigator Model I

Programme goals	• Deliver a **person-centred intervention**, responsive to user needs. • Improve and build **trusting relationships** between users and health and social care providers, and between health and social care providers. • **Promote awareness and understanding** of cancer (primary prevention). • **Increase rates and timeliness** of cancer screening among homeless users (secondary prevention). • **Improve levels of self-care and overall wellbeing** among homeless users.
Community characteristics	• **Make intervention accessible** to people experiencing and/or at risk of all forms of homelessness as defined by the ETHOS typology (FEANTSA, 2017). • **Prioritise those at most high risk** of cancer, those not currently engaged with healthcare services and those with complex support needs.
Point of intervention	• Build **trusting relationships** and become embedded within the user population as the starting point for intervention. • **Implement intervention preventively**, with continued care and follow-up for users where required.

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Core components of the Health Navigator Model II

Setting	• Deliver main navigation activities in settings **familiar and accessible to homeless users**, and through mobile outreach. • Facilitate access to **formal clinical settings** for full cancer screening and follow-up.
Navigator background	• **Select social or support worker**, ideally experienced with user population and with local/community knowledge, to act as navigator. • **Establish and utilise local stakeholders** (service managers, clinical professionals, and peers) to support implementation and delivery.
Communication channels	• **Deliver navigation activities** through in-person meetings, with optional phone 'check ins'. • Maintain a presence within spaces **familiar and accessible to homeless users**. • **Ensure navigator-user meetings** take place at regular intervals, with exact frequency and timing to be decided by users.

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Core components of the Health Navigator Model III

Training	• Develop and deliver a **comprehensive package of training** with input from local stakeholders, covering:
	  • **Population-specific knowledge**;
	  • **Communication and interpersonal skills**;
	  • **Cancer education**;
	  • **Local context and resources**.

Supervision	• Provide the navigator(s) with **administrative and clinical supervision** from appropriate professionals, either external or internal. • Utilise a **combination of formal observations, peer coaching and informal 'check-ins'**.
Evaluation measures	• Evaluate intervention using a combination of **qualitative and quantitative measures**, and include **direct feedback** from users, navigators, and service providers. • Collect pre- and post- data on **cancer screening rates**; level of **user engagement** with the intervention; user **health and quality of life**; and the **quality of relationships** between users and health and social care providers, and between different health and social care providers.

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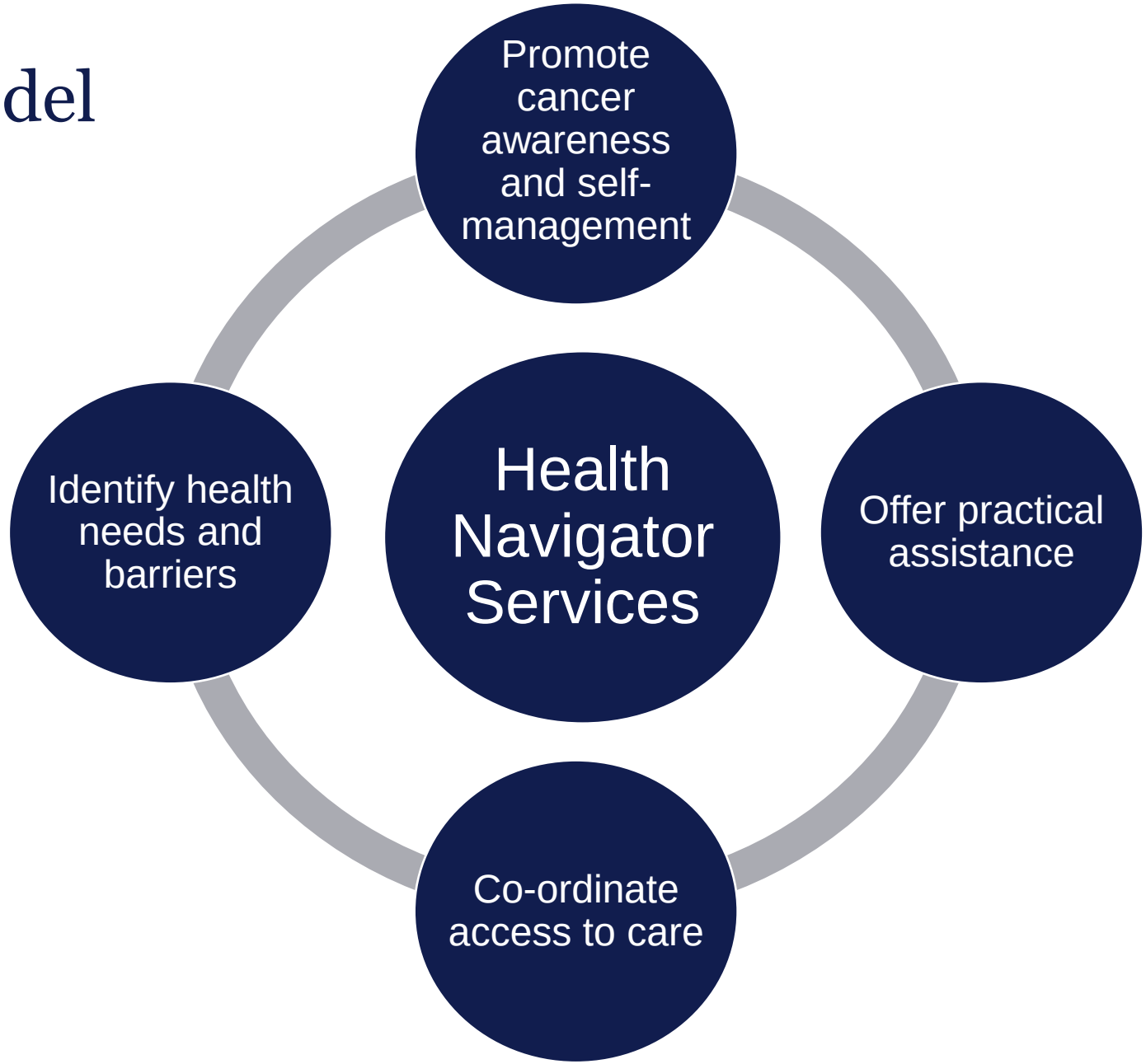
Health Navigator Model

- **Longitudinal, person-centred** and **community-based** intervention
- **Increasing participation** in both primary and secondary cancer prevention services
- **Reducing wider barriers** to health care access



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