Plotting the Best Course for Patients: Navigators and Their Role at Cancer Centers

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Chief Nursing Officer, Sr. Director of Strategic Planning and Initiatives

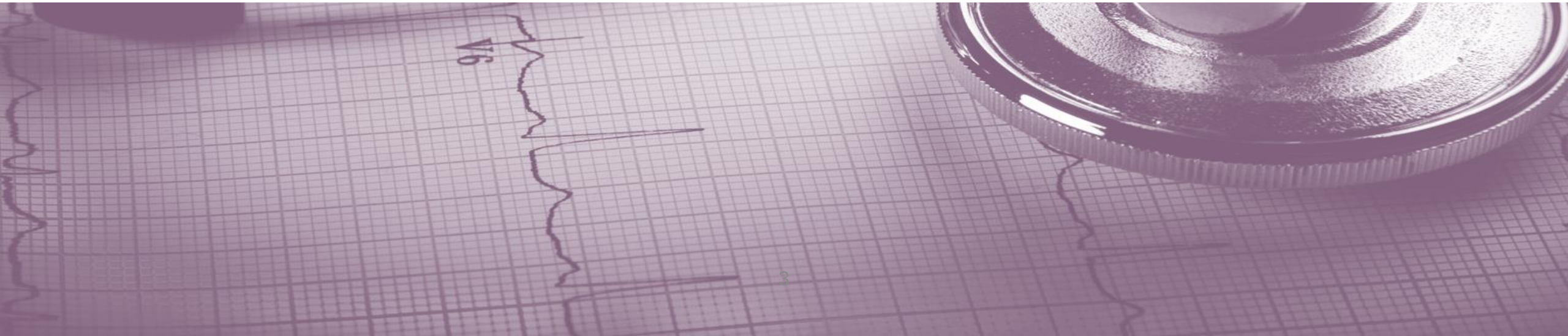
The Lynx Group

Objectives

- Discuss the AONN+ organization mission and vision
- Define navigation across the cancer care continuum
- Define the roles and responsibilities/competencies of the navigator along the continuum of care
- Discuss the “how to” for navigation program implementation
- Discuss the oncology healthcare landscape related to value-based cancer care and outcomes metrics

AONN+ Overview

AONN Academy of Oncology Nurse & Patient Navigators®



Program Director/Co-Founder, AONN+; Fellow of the Commission on Cancer Representing AONN+

University Distinguished Service Professor of Breast Cancer, Departments of Surgery and Oncology

Administrative Director, The Johns Hopkins Breast Center

Director, Cancer Survivorship Programs at the Sidney Kimmel Cancer Center at Johns Hopkins

Professor, JHU School of Medicine, Departments of Surgery, Oncology, Gynecology & Obstetrics, Baltimore, MD

Lillie D. Shockney, RN, BS, MAS, ONN-CG™

AONN+ Mission & Vision

Mission

To advance the role of patient navigation in cancer care and survivorship care planning by providing a network for collaboration and development of best practices for the improvement of patient access to care, evidence-based cancer treatment, and quality of life during and after cancer treatment.

Vision

To increase the role of and access to skilled and experienced oncology nurse and patient navigators so that all cancer patients may benefit from their guidance, insight, and personal advocacy.

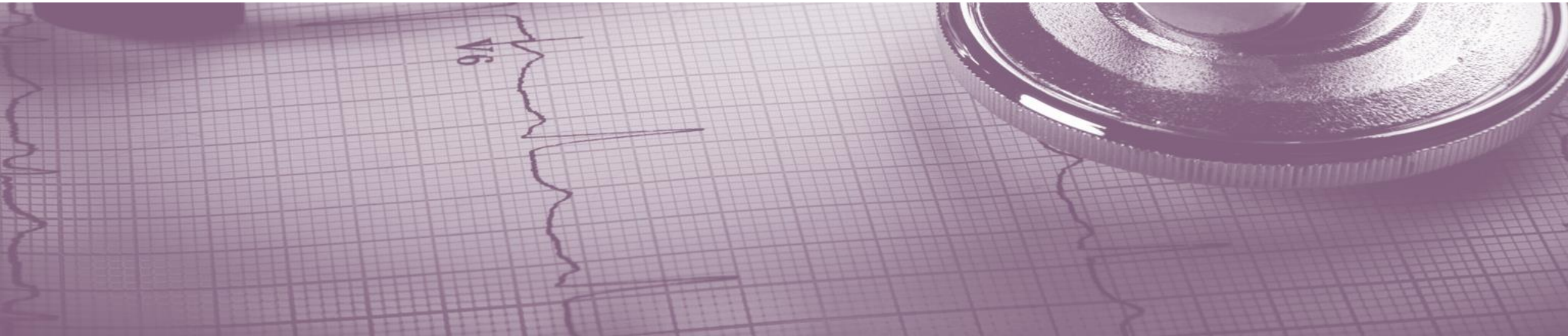
AONN+ Overview

- **Founded in May 2009** to provide a network for all professionals involved and interested in patient navigation and survivorship care services
- **The largest national specialty organization solely dedicated** to improving patient care and quality of life by defining, enhancing, and promoting the role of oncology nurse and patient navigators
- **The only professional association** dedicated to developing and offering national certifications for oncology nurse and patient navigators
- **One of 59 national professional organizations** granted membership into the American College of Surgeons Commission on Cancer (CoC)

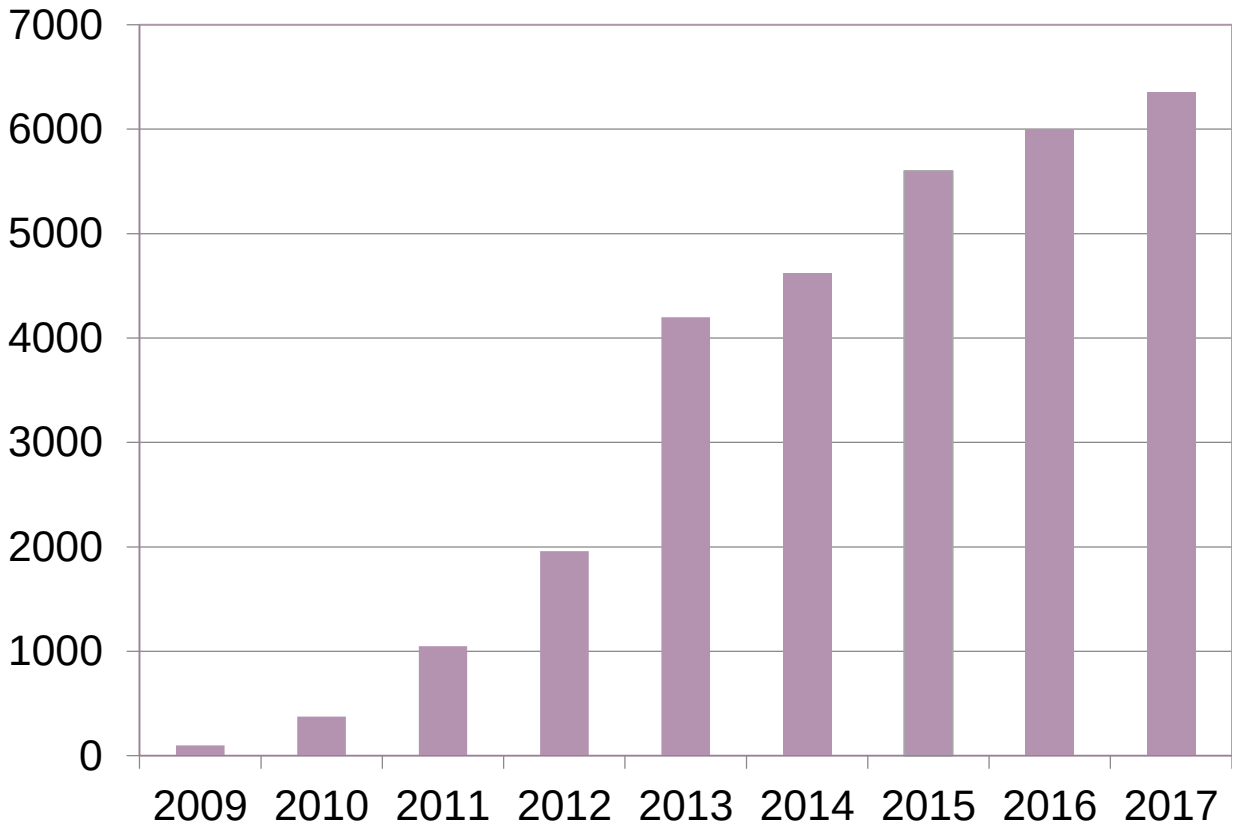
AONN+ Mission-Driven Initiatives and Achievements

Notable Milestones	Year
Granted membership into the American College of Surgeons CoC	**June 2015**
Launched the Oncology Nurse Navigator–Certified Generalist™ (ONN-CG™) and Oncology Patient Navigator–Certified Generalist™ (OPN-CG™) Certification Exams	**November 2016**
35 National Evidence-Based Metrics in the areas of Patient Experience, Clinical Outcomes, and Return on Investment published in the *Journal of Oncology Navigation & Survivorship*®	**February and May 2017**

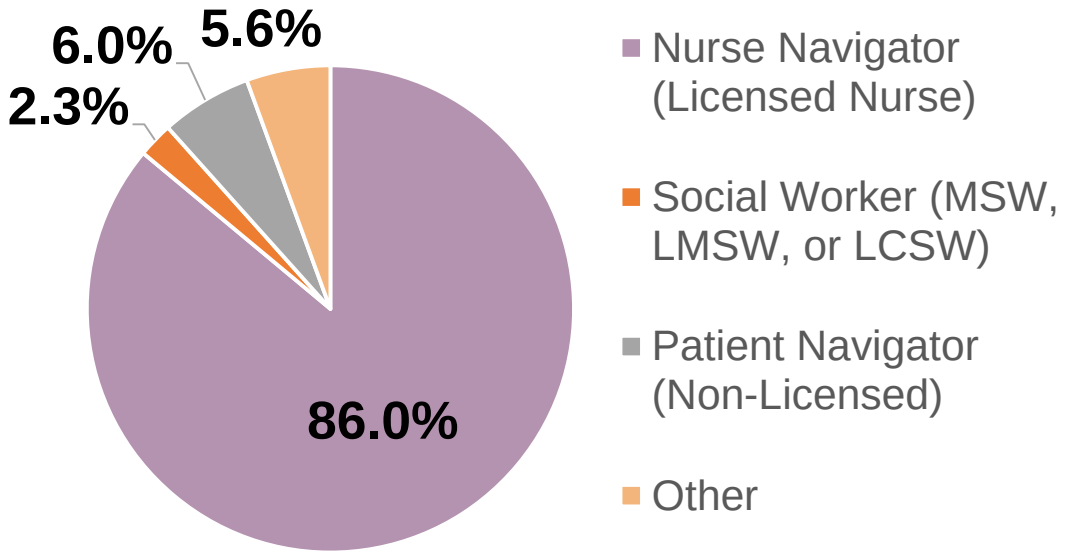
Demographics



More Than 6000 Members and Growing

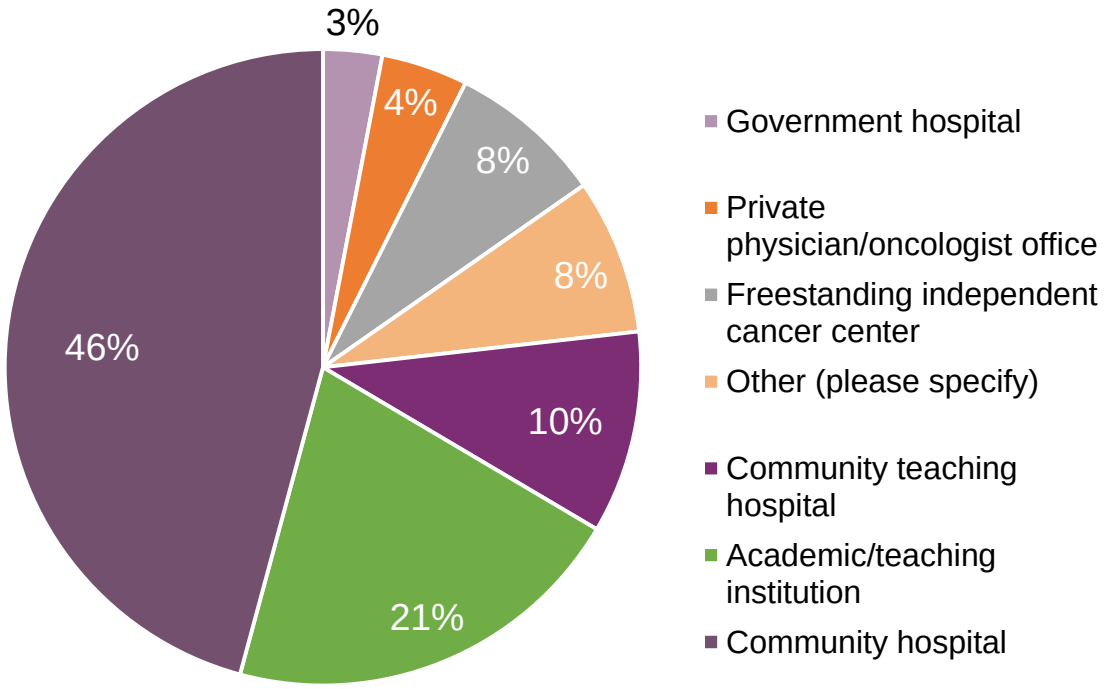


86% of Members Are Nurse Navigators

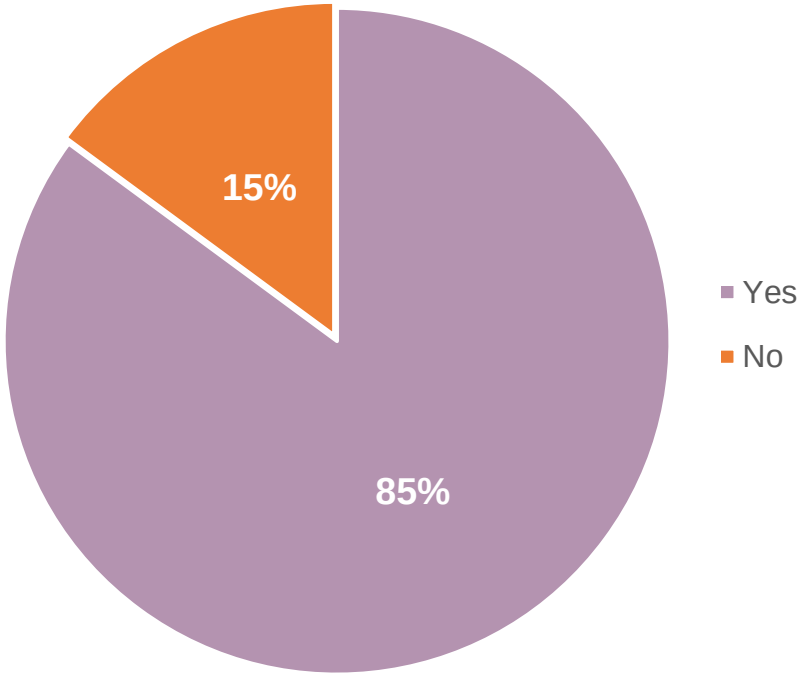


Data on file with the Academy of Oncology Nurse & Patient Navigators (N=215)

Nearly 60% of Nurse Navigators Practice in Community Hospitals



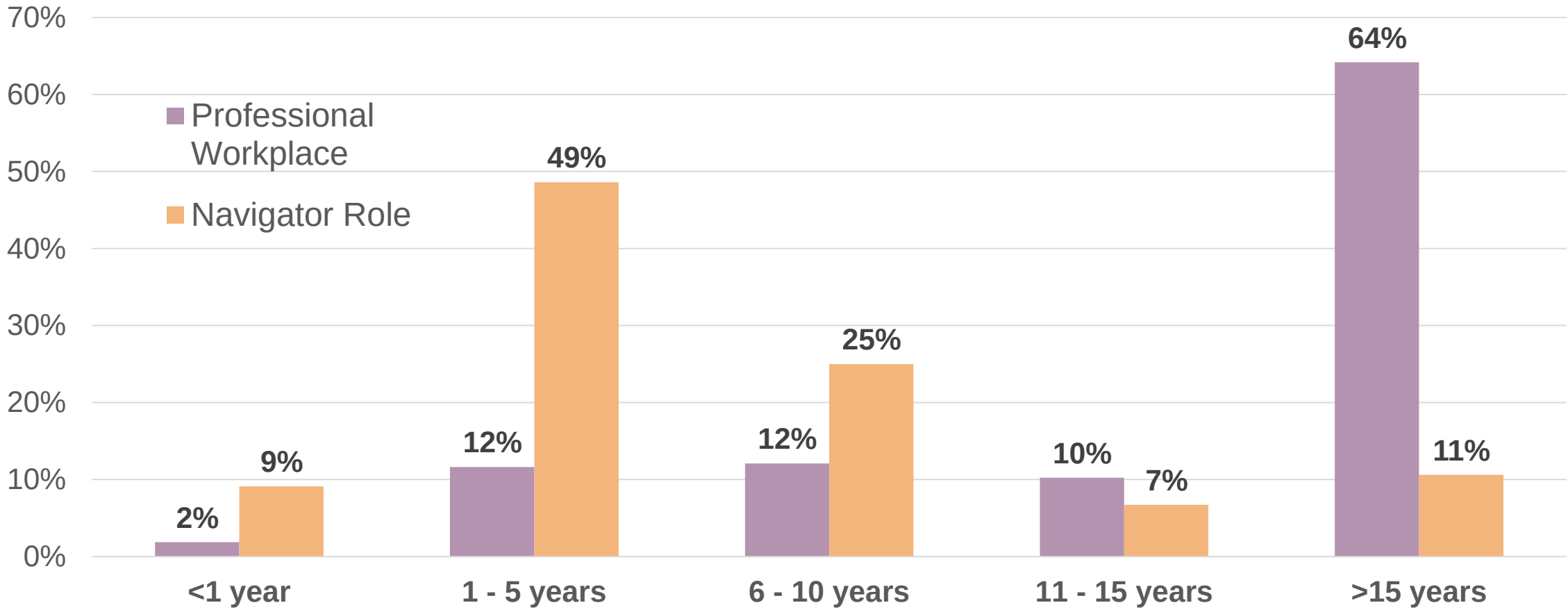
85% of Navigators Participate in Tumor Board Meetings



Data on file with the Academy of Oncology Nurse & Patient Navigators (N=215)

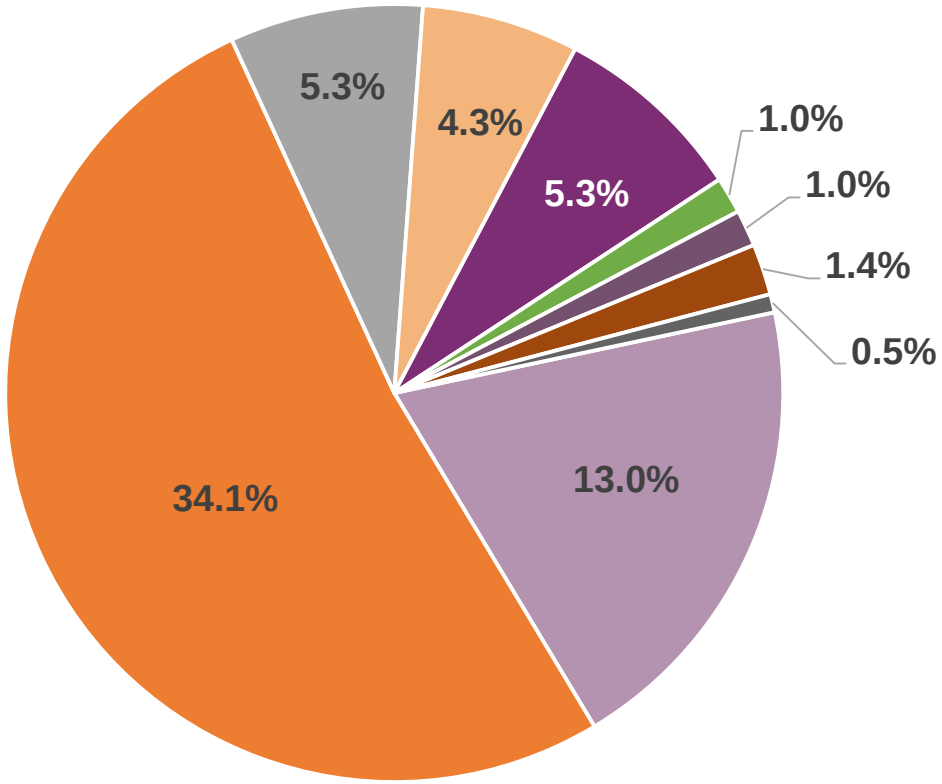
More Than 60% of Members Have >15 Years of Clinical Experience

However, the Majority Have Been Navigators <5 Years



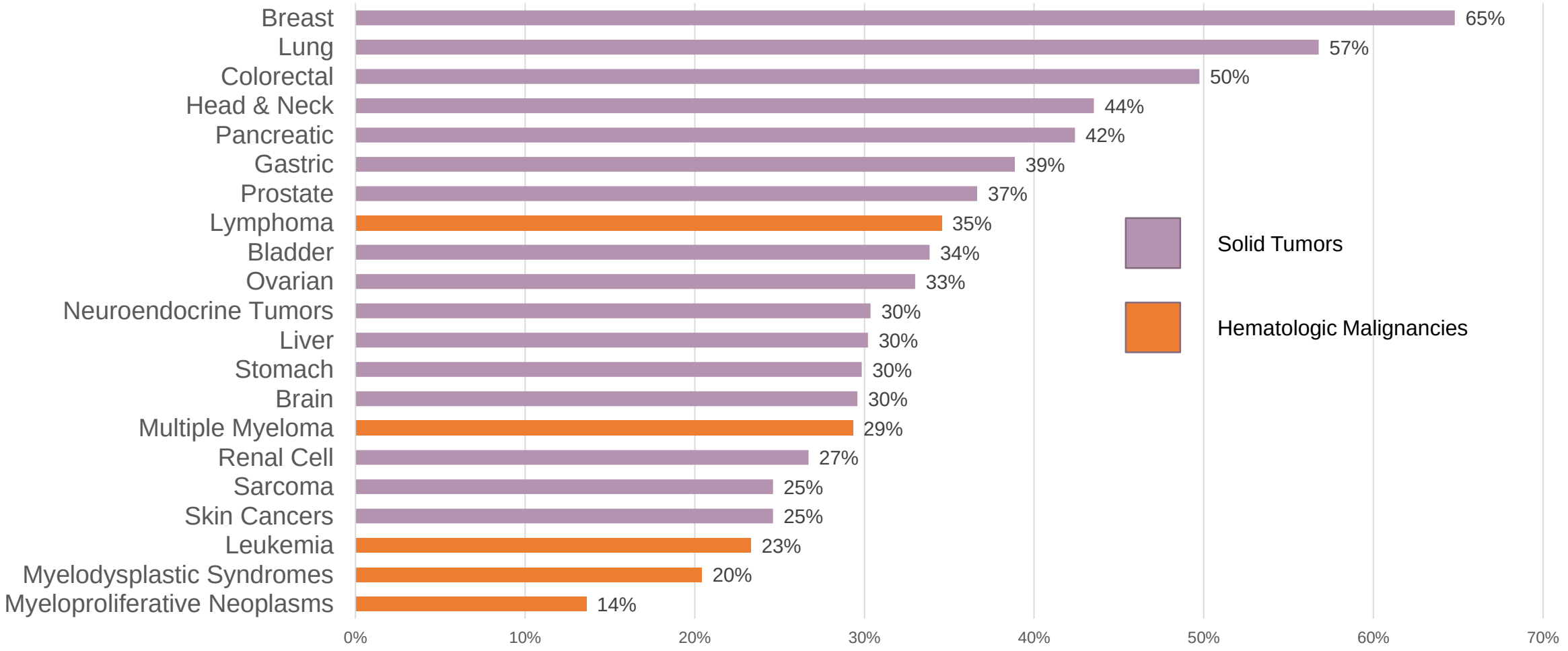
Data on file with the Academy of Oncology Nurse & Patient Navigators (N=215)

Prior to Becoming a Navigator, the Majority Were Clinical Staff and Infusion Nurses



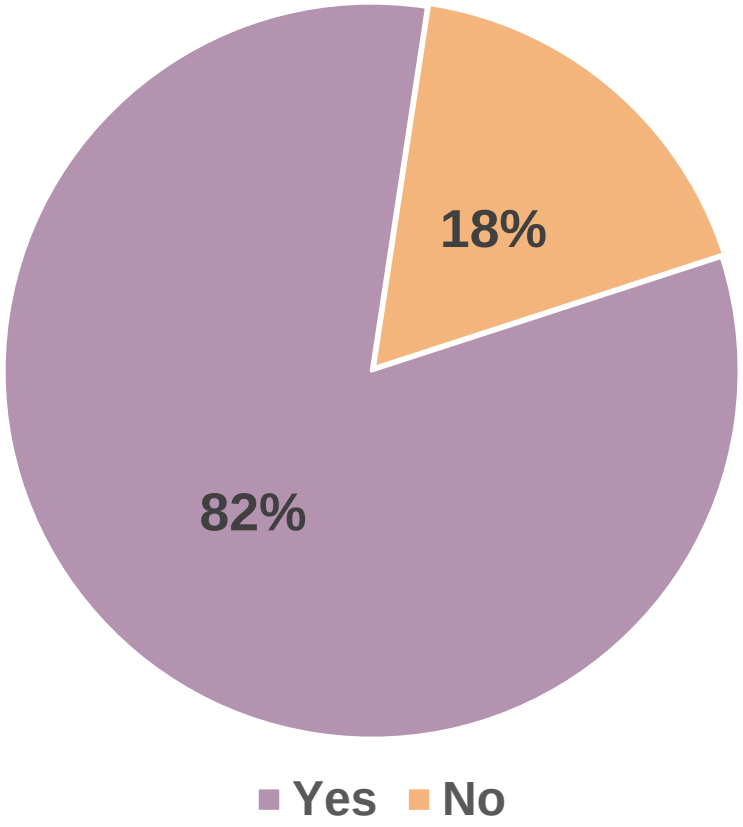
- Infusion Nurse
- Clinical Staff Nurse
- Clinical Research Nurse
- Radiation Nurse
- Surgical Nurse
- Appointment Scheduler
- Medical Assistant (clinical or administrative work)
- Patient Care Technician/ Nursing Assistant
- Volunteer

AONN+ Members Manage Diverse Patient Cases Across Solid Tumors and Hematologic Malignancies

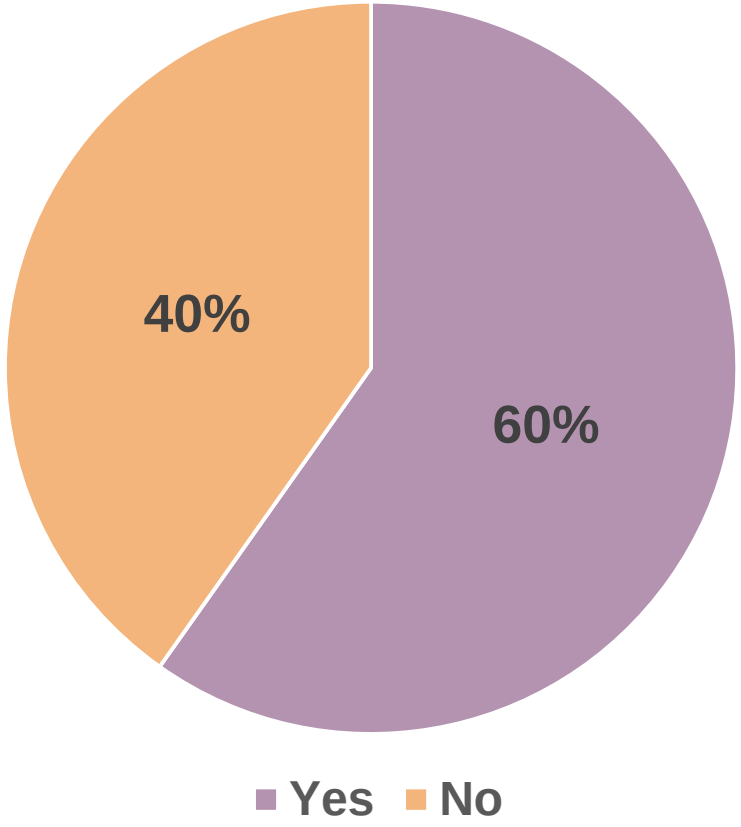


Data on file with the Academy of Oncology Nurse & Patient Navigators (N=215)

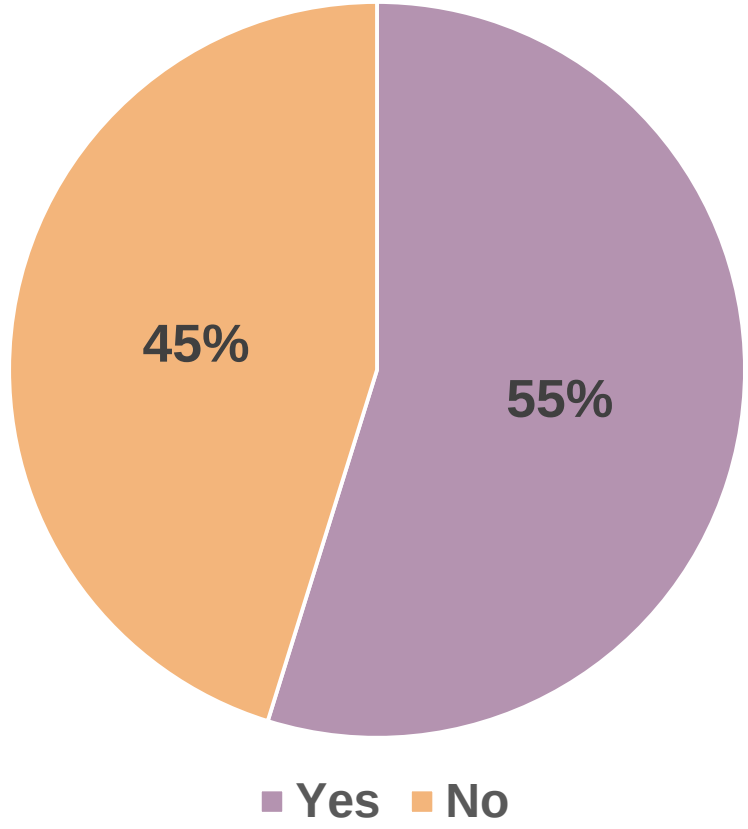
82% Practice in CoC-Accredited Settings



60% Practice in Settings Participating in the Oncology Care Model (OCM) Program

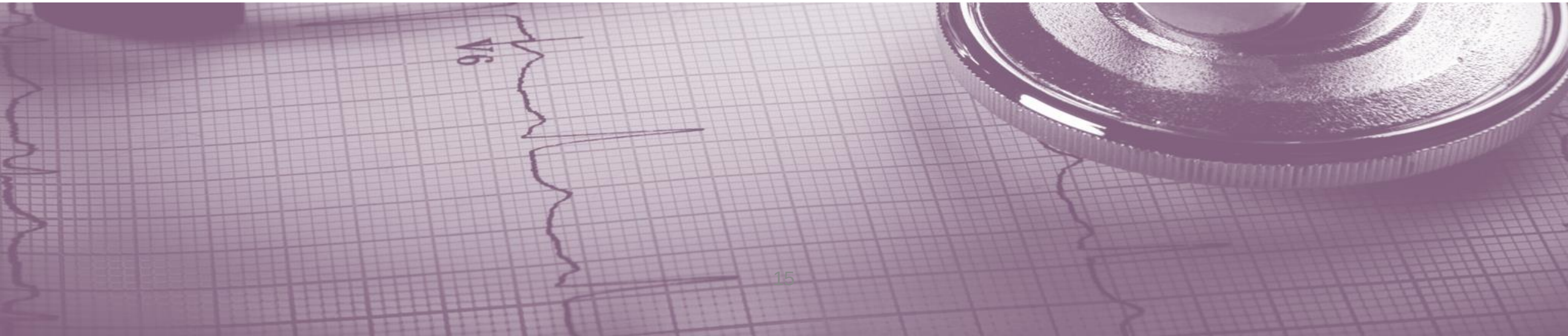


55% Practice in Settings Participating in the Quality Oncology Practice Initiative (QOPI®)

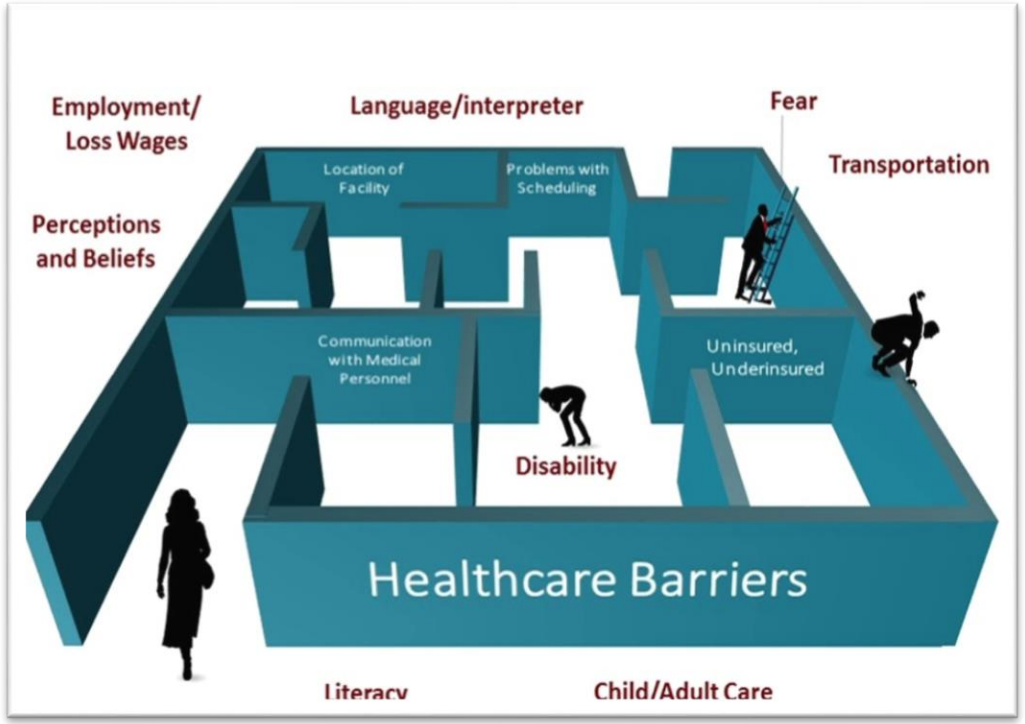


Data on file with the Academy of Oncology Nurse & Patient Navigators (N=215)

History of Navigation



Definition of Navigation



C-Change Definition:

"Individualized assistance offered to patients, families, and caregivers to help **overcome healthcare system barriers** and facilitate **timely access to quality medical and psychosocial care** from pre-diagnosis through all phases of the cancer experience."

C-Change. Cancer patient navigation. www.cancerpatientnavigation.org/resources.html. 2005. Accessed August 12, 2017.

Brief History of Patient Navigation

1970: Utilization Review	**Monitor use & delivery of service**	**Adversarial**	**Inpatient**	**Retrospective chart review**
1980: Utilization Management	Evaluate appropriateness, medical need & efficiency	Adversarial	Inpatient	Concurrent chart review
1990: Case Management	Assess, plan, implement, coordinate, monitor & evaluate	Collaborative	Involved in patient care	Hands-on care
1990: Patient Navigation	Identify, reduce barriers to access to care, diagnose, prescribe	Collaborative	Underserved patients	Community outreach
2000: Patient Navigation	Identify, reduce barriers to access to care, diagnose, prescribe	Clinical collaborative	Across the continuum of care, hands-on	Hands-on care and coordination of care

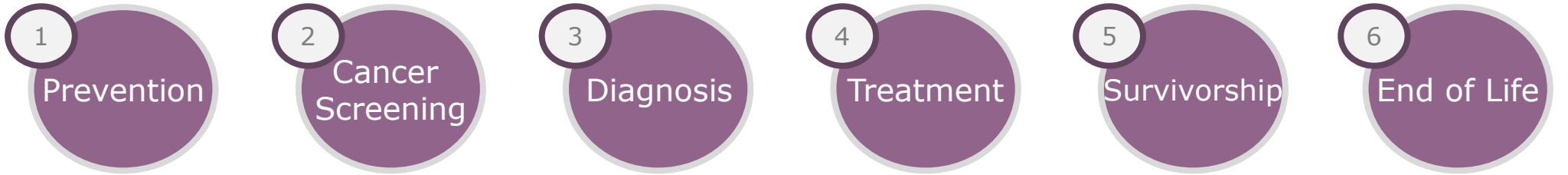
Source: Shockney L. *Becoming a Breast Cancer Nurse Navigator.* 2011.

Oncology Nurse & Patient Navigators Impact Patients' Lives

Navigators are invaluable members of the cancer care team; they:

- Coordinate the care of the patient through the entire cancer care continuum
- Improve patient outcomes through education, support, and performance-improvement monitoring
- Collaborate and facilitate communication between patients, family/caregivers, and the healthcare team
- Coordinate care among healthcare providers
- Provide cancer program and community resources
- Participate in multidisciplinary clinics, tumor conferences, and cancer committee
- Break down barriers to care
- Ensure education and access to clinical trials

Navigation Continuum of Care



- Diet/exercise
- Sun exposure
- Alcohol
- Tobacco control
- Chemo prevention

- Pap test
- Mammogram
- PSA/DRE
- Fecal occult
- Blood test
- Colonoscopy
- Awareness of cancer risk, signs, and symptoms

- Oncology/surgery consultation
- Tumor staging
- Patient counseling and decision-making
- Clinical trials
- Informed decision-making

- **Palliative care**
- **Prehabilitation**
- **Introduction of SCP components**
- **Goals of care**
- **Advance directives**

- Chemotherapy
- Surgery
- Radiation
- Symptom management
- Psychosocial
- Maintenance therapy

- Long-term follow-up/surveillance
- Manage late effects
- Rehabilitation
- Coping
- Health promotion
- Prevention
- Palliative care

- Support patient and family
- Hospice
- Informed decision-making

Phases of Cancer Care

We must initiate critical conversations earlier in the continuum. Your navigator can help.

Adapted from http://cancercontrol.cancer.gov/od/continuum.html.

Navigator Roles, Competencies, & Implementation

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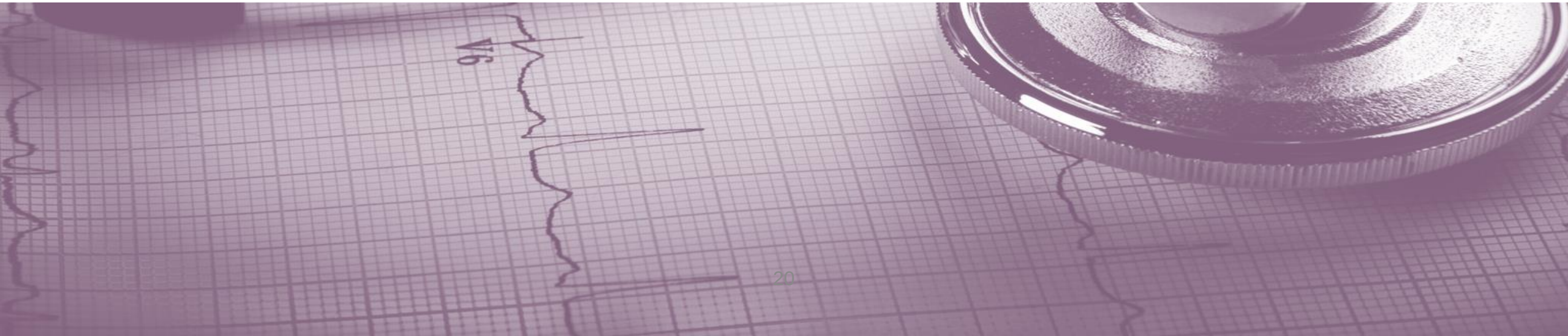

Types of Navigation Roles

Clinical Navigator	Patient Navigator	Social Worker	Other Roles
• A professional registered nurse with oncology-specific knowledge. Using the nursing process, the nurse navigator provides education and resources to facilitate informed decision-making and timely access to quality health and psychosocial care throughout all phases of the cancer continuum	• Through a basic understanding of cancer, healthcare systems, and how patients access care and services across the cancer continuum, the patient navigator facilitates patient-centered care that is compassionate, appropriate, and effective for the treatment of patients with cancer and the promotion of health	• Social worker with oncology-specific clinical knowledge, who offers individualized assistance to patients, families, and caregivers to help overcome healthcare system barriers	• Community health-care worker • Financial navigator

Development of a Framework for Patient Navigation: Delineating Roles Across Navigator Types. www.jons-online.com/issue-archive/2013-issues/december-2013-vol-4-no-6/development-of-a-framework-for-patient-navigation-delineating-roles-across-navigator-types/.

Oncology Nurse & Patient Navigator Competencies

Competencies:

- Oncology Nursing Society Nurse Navigator Core Competencies (2017) www.ons.org/sites/default/files/2017ONNcompetencies.pdf
- George Washington University (GW) Cancer Institute: Core Competencies for Non-Clinically Licensed Patient Navigators (2014) https://smhs.gwu.edu/gwci/sites/gwci/files/PN%20Competencies%20Report.pdf
- AONN+ Functional Knowledge Domains www.aonnonline.org/education/modules

Certification:

- Oncology Nurse Navigator Certification www.aonnonline.org/certification/nurse-navigator-certification
- Oncology Patient Navigator Certification www.aonnonline.org/certification/patient-navigator-certification

Navigation Program Implementation

Navigation Program Action Item List

Task	Responsible Individual	Target Completion Date	Date Completed
Choose navigation model			
Benefits, definition and goals of navigation			
Create job description, roles and responsibilities based on ONS nurse navigator core competencies			
Identify patient flow, develop navigation algorithm			
Review cancer committee and Commission on Cancer (CoC) Standards			
Review Institute of Medicine (IOM): Conceptual Framework			
Utilize NCCCP navigation assessment tool (new and existing programs)			
Educate navigators on NCCN, ASCO and other national guidelines			
Identify referral process to the navigation program			
Identify internal resources, roles and responsibilities: • Social workers • Registered dietitian • Financial assistant • Health Psychologist • Pastoral Care • Genetic counseling			
• Tumor registry • Rehabilitation team • Palliative care team • Hospice team • Other, _____			
Identify community resources, list _____			
Create pt. welcome packet with intake assessment, frequently asked questions (FAQ), cancer program support services/depts. and contact #s.			
Research patient educational materials, i.e. disease site specific information, clinical trials, patient journal, etc.			
Research assessment tools, documentation and reporting needs based on national standards			
Outline communication and managing transitions with the patient, family and/or caregiver (key pivotal medical visits/contacts)			
Outline communication among the healthcare team, internal and external resources and referral process			
Develop patient experience survey and coordinate with appropriate dept.			
Identify performance improvement initiatives: • Patient experience • Clinical outcomes • Business performance			
Identify needed support groups and educational programs (coordinate with community agencies)			
Outline tumor conference responsibilities			
Outline multidisciplinary consults and navigator responsibilities (if applicable)			
Review professional organizations, core competencies and certification • AONN, Academy of Oncology Nurse Navigators			
• ONS, Oncology Nursing Society			
Develop caregiver toolkit and resources			
Meet with marketing dept. to review program, marketing materials, website and roll out of program			
Other, list _____			

Oncology Solutions LLC, Tricia Strusowski, MS, RN

Navigation Orientation Checklist

Name: _____

Start Date: _____ **Preceptor:** _____

Key Components of Role	Preceptor Sign-off / Date
Hospital Specific policies/procedures and mandatory educational programs	
Cancer Program Community Needs Assessment	
Navigation definition and domains of care and competencies of navigation (ONS, AONN+, AOSW/NASW position statement)	
AONN+ Domains of Knowledge • Professional Roles and Responsibilities • Patient Advocacy • Psychosocial Support Assessment • Care Coordination • Community Outreach • Operations Management • Survivorship/End of Life • Research and Quality Performance Improvement	
Benefits and goals of navigation	
Job description, roles and responsibilities	
Cancer Committee and Commission on Cancer Standards (CoC)	
National Accreditation Program for Breast Centers Standards (NAPBC)	
Institute of Medicine Reports	

1

NCCCP navigation matrix	
NCCN, ASCO and other national guidelines	
Referrals to the navigation program; navigation algorithm/pathway	
Internal resources, roles and responsibilities: • Social workers • Registered dietitian • Financial assistant • Clinical Trial research staff • Pastoral Care • Genetic counseling • Tumor registry • Rehabilitation team • Palliative care team • Hospice team • Other, _____	
Community resources, list _____	
Patient educational materials, i.e. disease site specific information, clinical trials, patient journal, etc.	
Caregiver support services/resources	
Patient assessment tools, documentation and reporting (Distress Thermometer, Patient Education)	
Communication and managing transitions with the patient, family and/or caregiver	
Communication among the healthcare team, internal and external resources	

2

AONN+ Navigation Metrics/Monthly reporting Performance improvement models and initiatives: • Patient experience • Clinical outcomes • Business performance	
Support groups and educational programs	
Tumor conference responsibilities ___% attendance required at tumor conferences.	
Multidisciplinary consults and navigator responsibilities	
Professional organizations and certification • AONN+, Academy of Oncology Nurse and Patient Navigators • ONS, Oncology Nursing Society	
Other, list _____	

Table of Content for Navigation Academy Curriculum

Module One: *History of Navigation*

- Navigation: Argument in Brief
- Cancer Institute Mission and Goals
- Cancer Institute Community Needs Assessment
- History of Navigation (ONS, use Table 1-1. Milestones in the Emergence and Evolution of Patient Navigation)
- https://www.ons.org/sites/default/files/publication_pdfs/Oncology%20Nurse%20Navigation%20sample%20chapter.pdf
- Navigation: Continuum of Care
- ONS Navigation Core Competencies https://www.ons.org/sites/default/files/ONNCompetencies
- AOSW Core Competencies https://www.ons.org/advocacy-policy/positions/education/patient-navigation
- Commission on Cancer Standards, Chapter 3, Continuum of Care
- Institute of Medicine (IOM), Delivering High Quality Cancer Care

Module Two: The Navigation Process

- Definition of Navigation
- Benefits and Goals of Navigation
- Characteristics of a Navigator
- Roles/Responsibilities of a Navigator
- Models of Navigation
- Referrals to the Navigation Program
- Communication among the Team, Managing Transitions
- Navigation Algorithm
  - Intake Assessment/Comprehensive Assessment
  - NCCN Psychosocial Distress Screening and Policies

Module Three: Department Orientation to Navigation

- Navigation Dept. orientation chart
- Navigator Assignments by Disease site
- Navigator JD
- Support Staff JD
- Staff Responsibilities
- Screening Tools by Discipline (RD, SW, etc.)
- Patient and Family Educational Materials
  - ACS (Disease Site, Treatment, CTs, etc.)
  - Patient Journal
  - Frequently Asked Questions
  - Navigation P/P

Module Four: Health Literacy and Culturally Competent Communication

- Health Literacy Manual
- Facilitating Communication Skills, Building Rapport, Active Listening
- The Joint Commission Standards for Cultural Competencies
- Communication Among the Team Members (i.e. daily huddles, weekly meetings/updates) and example agenda
- Department Updates/Staff Meetings

Module Five: Utilizing Internal and External Resources and National Evidence Based Guidelines

- Cancer Institute Resources
- Community Resources
- National Evidence Based Guidelines
  - NCCN http://www.nccn.org/professionals/physician_gls/f_guidelines.asp
  - NCI http://www.cancer.gov/
  - ACS http://www.cancer.org/
  - ACCC http://www.accc-cancer.org/
  - CoC https://www.facs.org/quality-programs/cancer
  - Other

Module Six: Reporting and Performance Improvement

- Monthly Reports
  - New Cases, Open Cases, Closed Cases
  - Barriers to Care and Interventions Provided
  - Psychosocial Distress Screening Level/Interventions
- Performance Improvement Initiatives (Steps for PI)
  - Patient Experience Survey
  - Navigation Dashboard
  - Physician Experience Survey

Navigation Resource List

AONN+ Focus Group Results: Administrator Engagement

Highlights

- What are the barriers and challenges to engage program administrators in discussion for navigation program enhancement?
  - Funding
  - Lack of metrics
  - Navigator seen as “Band-Aid to poor process”
  - Knowledge deficit about navigator role

- What are the concerns that are expressed from your administrator that prevent program growth and development?
  - Reimbursement
  - Lack of understanding scope & role of navigator
  - Fear - navigator redirecting referral patterns

Data

- **Do you have navigator job descriptions that incorporate national organizations core competencies and position statements for navigation?**
  - 14/37 have a specific job description = 38%
  - 13/37 have a general job description = 35%
  - 10/37 had no response = 27%
- **Do you have support by clerical assistance so the professional roles on your team (SW, RN, RD, Genetics, NP, etc.) can function at the top of their license?**
  - 8/37 do have clerical support = 22%
  - 19/37 do not have clerical support = 51%
  - 10/37 had no response = 27%
- **Does your program have guidelines for when to open and close a case as well as referral guidelines to the navigation program?**
  - 9/37 utilize referral guidelines = 24%
  - 12/37 utilize guidelines for open cases = 32%
  - 5/37 utilize guidelines for closed cases = 14%
- **Do you have a formal on-boarding process?**
  - 9/37 Yes = 24%
  - 28/37 No = 76%

Business Justification - Navigation

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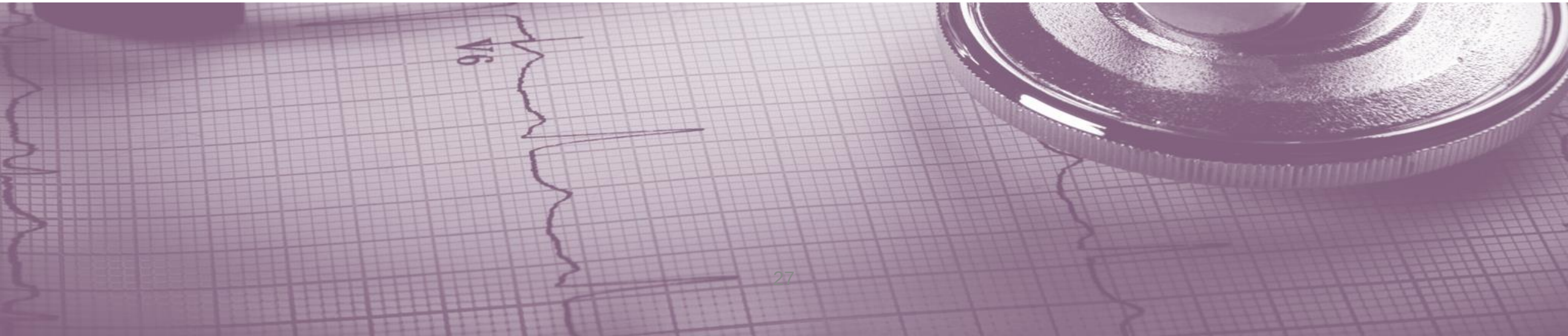


Quotes from Administrators

"What is the return on our investment with our navigation program?"

"How are we going to measure success with our navigation program?"

"How can we better coordinate the care of our patients and families?"

"How can our navigators support value-based care initiatives with our physicians?"

Background

There is a **void in the literature** regarding the key areas that measure the success of navigation programs:

- Patient experience (PE)
- Clinical outcomes (CO)
- Business performance or return on investment (ROI)

The creation of standardized national metrics to measure programmatic success is vital to:

- Coordinating high-quality, team-based care
- Demonstrating the sustainability of navigation programs

Standardized Navigation Metrics Project Results

After completion of an **extensive literature review**, the task force developed 35 standardized metrics that focused on:

- The **AONN+ Certification Domains** for navigation, which concentrated on ROI, PE, and CO
- Putting each metric through **rigorous criteria** to ensure accuracy and soundness

These are baseline metrics that all institutions can use irrespective of the structure of their navigation programs.

AONN+ Navigation Knowledge Domains
Community Outreach and Prevention
Coordination of Care/ Care Transitions
Patient Advocacy/Patient Empowerment
Psychosocial Support Services/Assessment
Survivorship/End of Life
Professional Roles and Responsibilities
Operations Management/Organizational Development/Healthcare Economics
Research/Quality/Performance Improvement

Care Coordination/Care Transitions Metrics

CARE COORDINATION/
CARE TRANSITIONS

01.	**Treatment Compliance** Percentage of navigated patients who adhere to institutional treatment pathways per quarter
02.	**Barriers to Care** Number and list of specific barriers to care identified by navigator per month. *Barriers to care definition*: Obstacles that prevent a patient with cancer from accessing care, services, resources, and/or support
03.	**Interventions** Number of specific referrals/interventions offered to navigated patients per month. *Intervention definition*: The act of intervening, interfering, or interceding with the intent of modifying the outcome
04.	**Clinical Trials Education** Number of patients educated on clinical trials by the navigator per month

Care Coordination/Care Transitions Metrics

CARE COORDINATION/
CARE TRANSITIONS

05.	**Clinical Trial Referrals** Number of navigated patients per month referred to clinical trial department
06.	**Patient Education** Number of patient education encounters by navigator per month
07.	**Diagnosis to Initial Treatment** Number of business days from diagnosis (date pathology resulted) to initial treatment modality (date of first treatment)
08.	**Diagnosis to First Oncology Consult** Number of business days from diagnosis (date pathology resulted) to initial oncology consult (date of first appointment)

Research, Quality, Performance Improvement Metrics

RESEARCH, QUALITY, & PERFORMANCE IMPROVEMENT

09.	**Patient Experience/ Patient Satisfaction with Care** Patient experience or patient satisfaction survey results per month (utilize institutional-specific navigation tool with internal benchmark)
10.	**Navigation Program Validation Based on Community Needs Assessment** Monitor 1 major goal of current navigation program annually as defined by cancer committee *Example*: Population served

Research, Quality, Performance Improvement Metrics

RESEARCH, QUALITY, & PERFORMANCE IMPROVEMENT

11.	**Patient Transitions from Point of Entry** Percentage of navigated analytic cases per month transitioned from institutional point of entry to initial treatment modality. *Care transitions definition*: "The movement patients make between healthcare practitioners and settings as their condition and care needs change during the course of chronic or acute illness" (Coleman, n.d., para 1). *Modality definition*: Chemotherapy, surgery, radiation therapy, endocrine therapy, and biotherapy
12.	**Diagnostic Workup to Diagnosis** Number of business days from date of abnormal finding to pathology report for navigated patients. *Abnormal finding definition*: Number of business days from abnormal finding diagnostic workup (date of workup) to diagnosis (date pathology resulted)

Operations Management Metrics

OPERATIONS MANAGEMENT, ORGANIZATIONAL DEVELOPMENT, & HEALTH ECONOMICS

13.	**30-, 60-, 90-Day Readmission Rates** Number of navigated patients readmitted to the hospital at 30, 60, 90 days; report quarterly
14.	**Navigation Operational Budget** Monthly operating expenses by line item. *Definition*: Operational budget is a combination of known expenses, expected future costs, and forecasted income over the course of a year
15.	**Navigation Caseload** Number of new cases, open cases, and closed cases navigated per month. *Definitions* – *New cases*: New patient cases referred to the navigation program per month. *Open cases*: Patient cases that remain open per month. *Closed cases*: Number of patient cases closed per month; formal closing of a patient case from the navigation program

Operations Management Metrics

OPERATIONS MANAGEMENT, ORGANIZATIONAL DEVELOPMENT, & HEALTH ECONOMICS

16.	**Referrals to Revenue-Generating Services** Number of referrals to revenue-generating services per month by navigator
17.	**No-Show Rate** Number of navigated patients who do not complete a scheduled appointment per month
18.	**Patient Retention through Navigation** Number of analytic cases per month or quarter that remained in your institution due to navigation
19.	**Emergency Department Utilization** Number of navigated patient visits to the emergency department per month
20.	**Emergency Department Admissions per Number of Chemotherapy Patients** Number of navigated patient visits per 1000 chemotherapy patients who had an emergency department visit per month

Community Outreach and Prevention Metrics

21.	**Cancer Screening Follow-Up to Diagnostic Workup** Number of navigated patients per quarter with abnormal screening referred for follow-up diagnostic workup. *Cancer screening definition*: Screening tests can help find cancer at an early stage, before symptoms will appear. When abnormal tissue or cancer is found early, it may be easier to treat or cure. By the time symptoms appear, the cancer may have grown and spread. This can make cancer harder to treat or cure
22.	**Cancer Screening** Number of participants at cancer screening event and/or percentage increase of cancer screening

Community Outreach and Prevention Metrics

23.	**Completion of Diagnostic Workup** Number of navigated individuals with abnormal screening who completed diagnostic workup per month/quarter
24.	**Disparate Population at Screening Event** Number of individuals per quarter at community screening events by Office of Management and Budget standards. *Disparate population definition (from the National Institute on Minority Health and Health Disparities)*: Differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific populations in the United States (racial and ethnic minorities, low socioeconomic status)

Professional Roles and Responsibilities Metrics

PROFESSIONAL ROLES & RESPONSIBILITIES

25.	**Navigation Knowledge at Time of Orientation** Percentage of new hires who have completed institutionally developed navigator core competencies
26.	**Navigator Annual Core Competencies Review** Percentage of staff who have completed institutionally developed navigator core competencies annually to validate core knowledge of oncology navigation

Psychosocial Support Services and Assessment Metrics

PSYCHOSOCIAL ASSESSMENT & SUPPORT SERVICES

27. **Psychosocial Distress Screening**

Number of navigated patients per month who received psychosocial distress screening at a pivotal medical visit with a validated tool. *Pivotal medical visit definition*: Period of high distress for the patient when psychosocial assessment should be completed. *Define various validated tools as examples*: FACT, NCCN Distress Thermometer

28. **Social Support Referrals**

Number of navigated patients referred to support network per month

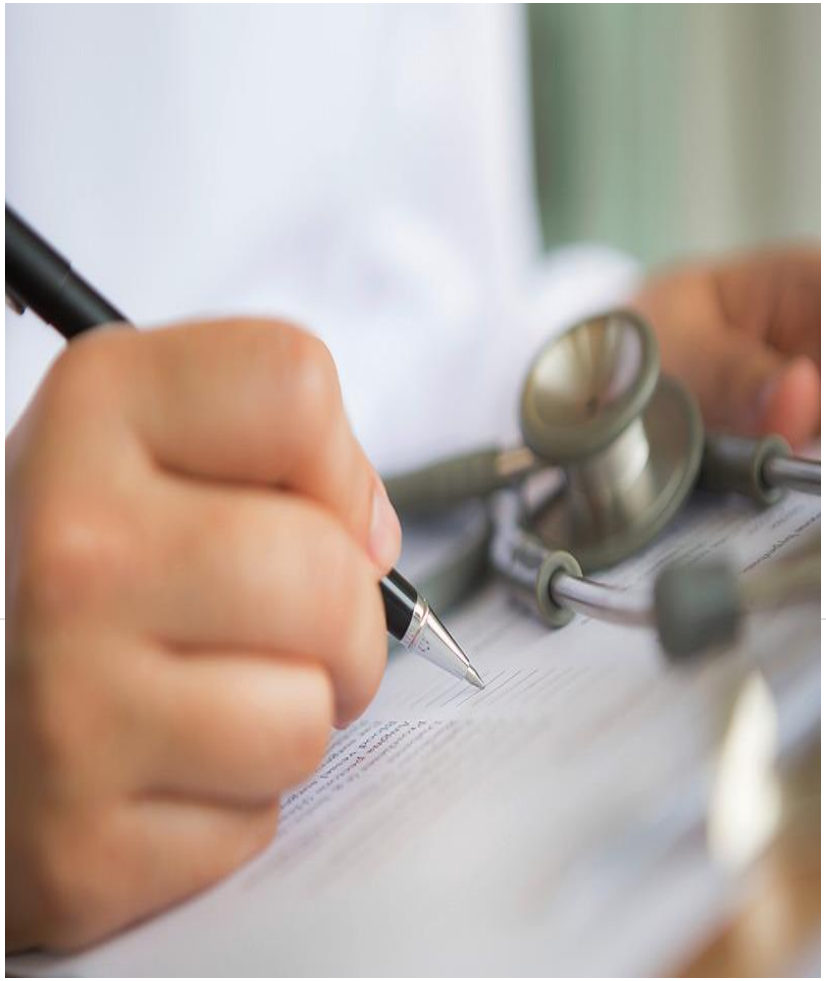
Patient Advocacy/Patient Empowerment Metrics

PATIENT EMPOWERMENT & ADVOCACY

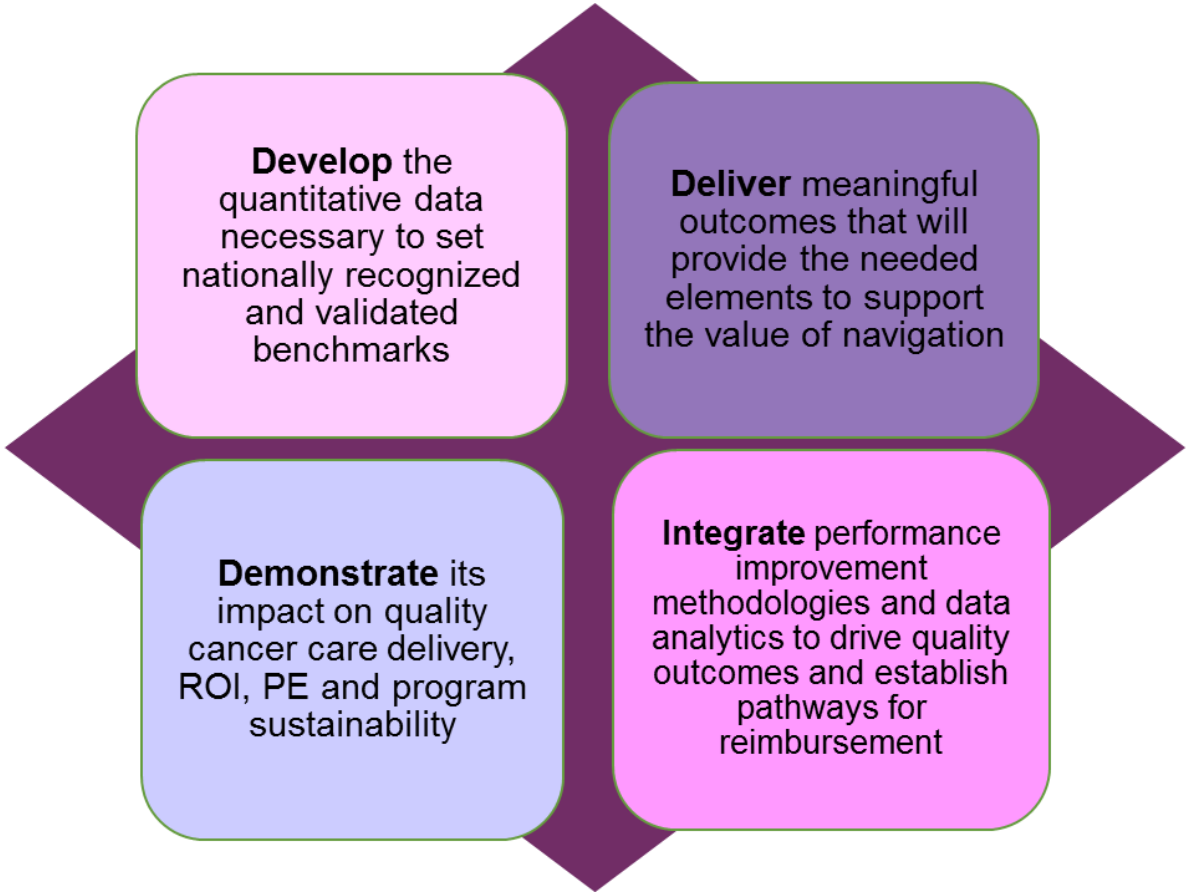
29.	**Patient Goals** Percentage of analytic cases per month that patient goals identified and discussed with the navigator
30.	**Caregiver Support** Number of caregiver needs/preferences discussed with navigator per month
31.	**Identify Learning Style Preference** Number of navigated patients per month whose preferred learning style was discussed during the intake process. *Learning styles*: ▪ Visual/spatial: Using pictures, images, and spatial understanding ▪ Aural (auditory-musical): Using sound and music ▪ Verbal (linguistic): Using words, in speech and writing ▪ Physical (kinesthetic): Using body, hands, and touch ▪ Logical (mathematical): Using logic, reasoning, and systems ▪ Social (interpersonal): Learning in groups or with people ▪ Solitary (intrapersonal): Working alone and using self-study

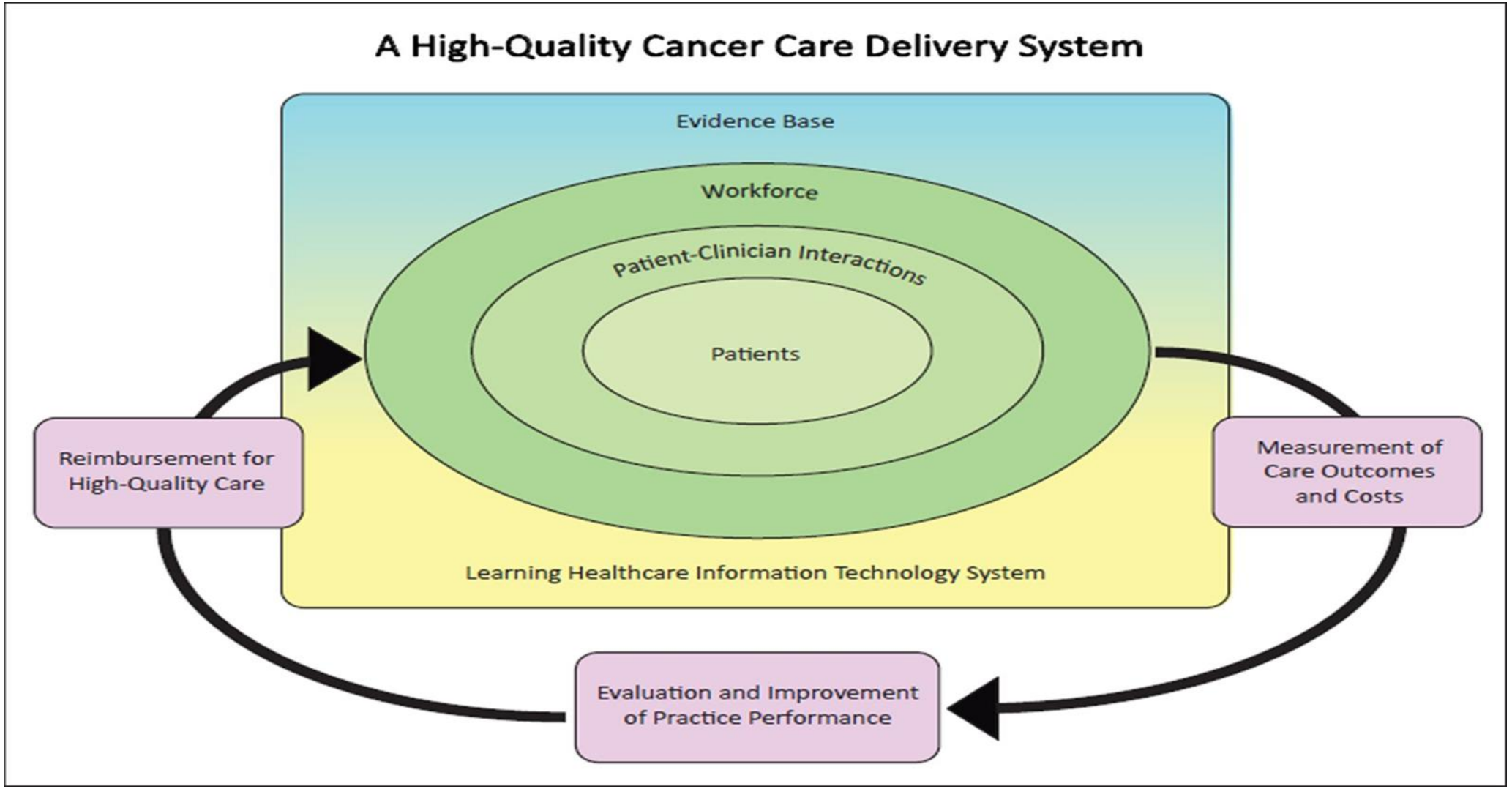
Survivorship/End-of-Life Metrics

32.	**Survivorship Care Plan** Number of navigated patients (patients with curative intent) per month who received a survivorship care plan and treatment summary
33.	**Transition from Treatment to Survivorship** Percentage of navigated analytic cases per month transitioned from completed cancer treatment to survivorship. *Care transitions definition*: The movement patients make between healthcare practitioners and settings as their condition and care needs change during the course of chronic or acute illness
34.	**Referrals to Support Services at Survivorship Visit** Number of navigated patients per month referred to appropriate support service at the survivorship visit
35.	**Palliative Care Referral** Number of navigated patients per month referred for palliative care services



Evidence Guides Practice: Validating AONN+ Standardized Metrics





Institute of Medicine. *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis.* Washington, DC: National Academies Press; 2013.

AONN+ Metrics Crosswalk with National Standards

AONN+ Metrics	Commission on Cancer CoC	NAPBC	QOPI	OCM	MIPS
Psychosocial Support, Assessment					
Psychosocial Distress Screening - Number of navigated patients per month that received psychosocial distress screening at a pivotal medical visit with a validated tool. **Pivotal medical visit definition** - Period of high distress for the patient when psychosocial assessment should be completed **Define various validated tools as examples** - FACT, NCCN Psychosocial Distress Screening Thermometer PE, CO	STANDARD 3.2 Psychosocial Distress Screening Each calendar year, the cancer committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care. We utilize NCCN distress screening tool The following pivotal medical visits: CT simulation in radiation oncology, completion of radiation therapy, and chemo teach OR first infusion in medical oncology. Identified "pivotal medical visits" are subject to revision as improvements to screening protocols are made		Documentation of psychosocial concerns may include: copy of distress, depression, or anxiety screening form in the chart; patient self-report of distress, depression or anxiety; or chart documentation regarding patient coping, adjustment, depression, distress, anxiety, emotional status, family support and caregiving, coping style, cultural background, and socioeconomic status.	OCM-4a: Oncology: Medical and Radiation- Pain Intensity Quantified OCM-5 Preventive Care and Screening: Screening for depression and follow-up plan	Pain Assessment and Follow-Up Measure ID: 131 Screening for Clinical Depression and Follow-Up Plan Measure ID: 134 Functional Outcome Assessment Measure ID: 182 Depression Utilization of the PHQ-9 Tool Measure ID: 371 Depression Screening Measure ID: PPRNET 21 Quality of Life (VR--12 or Promis Global 10) Monitoring Measure ID: OBERD 10

Testimonial

Recognizing the Value of AONN+ Navigation Metrics

"Having the AONN+ navigation metrics has enhanced the nurse navigator job description providing a stronger framework for role description and delineation."

"I have presented the AONN+ navigation metrics to my individual physician teams. Recognizing the importance of care coordination and multidisciplinary care team communication, we now implement team meetings to discuss individual patient cases and their care needs."

Oncology Nurse Navigator, US Oncology Network

(Part of the OCM Initiative)

Implications for Navigation Practice

- Transformative
- Evaluating professional practice and care delivery
- Define oncology navigation practice and outcomes
  - Quality care delivery
  - Health outcomes
  - Overall value throughout the cancer care continuum
- Necessary for the sustainability of navigation

Barnsteiner JH, et al. *Nursing Administration Quarterly.* 2010;34(3):217-225.
Crane-Okada R. *Seminars in Oncology Nursing.* 2013;29(2):128-140.
Guadagnolo BA, et al. *Cancer.* 2011;117(15 suppl):3565-3574.

Navigation Metrics Research Study Goals

- ***Implementation*** of Metrics and ***Reporting*** Outcomes with Data ***Analytics***
- Establish Evidence-Based National Standardized Navigation ***Benchmarks***
- Navigation Research to ***Validate Sustainability and Value of Navigation***
- Identify Navigation ***Best Practices*** and ***Lessons Learned***
- Creation of a Centralized Navigation ***Metrics Database and Repository***

Navigation Integration with Oncology/Hematology Practices

AONN Academy of Oncology Nurse & Patient Navigators®

Navigation Integration with Oncology/Hematology Practices

- Enhances care coordination for patients and families across the continuum from prediagnosis through survivorship or end-of-life services
- Creates partnerships, incorporates performance improvement based on navigation and value-based cancer care metrics
- Increases efficiency and timely access to services by providing comprehensive assessments and referrals to appropriate disciplines
- Reinforces patient education and empowerment through decision aids and patient appointment checklist
- Creates standing order sets, physician profiles, pathways, and guidelines
- Increases support for providers; i.e., early discussions regarding palliative care, goals of care, advance care planning, and prehabilitation
- Increases contacts with “frequently flyers” to decrease emergency department visits and avoidable admissions
- Automates financial counseling referrals at time of diagnosis (generates self-referral reports)

Open Discussion

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Resources

- Academy of Oncology Nurse & Patient Navigators. (2017). www.aonnonline.org/
- Standardized Evidence-Based Oncology Navigation Metrics for All Models: A Powerful Tool in Assessing the Value and Impact of Navigation Programs. www.jons-online.com/issue-archive/2017-issues/may-2017-vol-8-no-5/value-impact-of-navigation-programs
- AONN+ Evidence-Based Oncology Navigation Metrics Source Document. www.aonnonline.org/metrics-source-document
- Association of Community Cancer Centers. (2015). www.accc-cancer.org/resources/PatientNavigation-Tools.asp
- Development of a Framework for Patient Navigation: Delineating Roles Across Navigator Types. www.jons-online.com/issue-archive/2013-issues/december-2013-vol-4-no-6/development-of-a-framework-for-patient-navigation-delineating-roles-across-navigator-types/
- George Washington University Patient Navigation Education and Resources. (2017). https://smhs.gwu.edu/gwci/education
- George Washington University (GW) Cancer Institute: Core Competencies for Non-Clinically Licensed Patient Navigators (2014). https://smhs.gwu.edu/gwci/sites/gwci/files/PN%20Competencies%20Report.pdf
- Harold P. Freeman Patient Navigation Institute. (2017). http://hpfreemanpni.org/
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- Institute of Medicine. (2013). *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis.* Washington, DC: National Academies Press.