Advisory Board | Oncology Roundtable

The Cancer Care Transformation Playbook

Opportunities to Reduce Unwarranted Care Variation in Oncology

ROAD MAP

1 At the Top of Executives' Agenda

2 Reducing Costs and Improving Quality in Cancer Care

3 Q&A

Market Pressures Creating New Urgency

Reducing Care Variation Key to Executing on System Imperatives

Major Market Forces

- Mounting margin pressure
- Continuing transition to risk
- Continuing consolidation across the industry
- Emerging health care consumerism

Health System Strategic Imperatives

Reliability
Standardize the care delivery model to ensure that clinical quality and service meet and exceed customer expectations

Affordability
Streamline the fixed cost structure to reduce cost per case and total care costs

Accessibility
Diversify access options to meet patients when, where, and how they want

Necessary Lever for Success

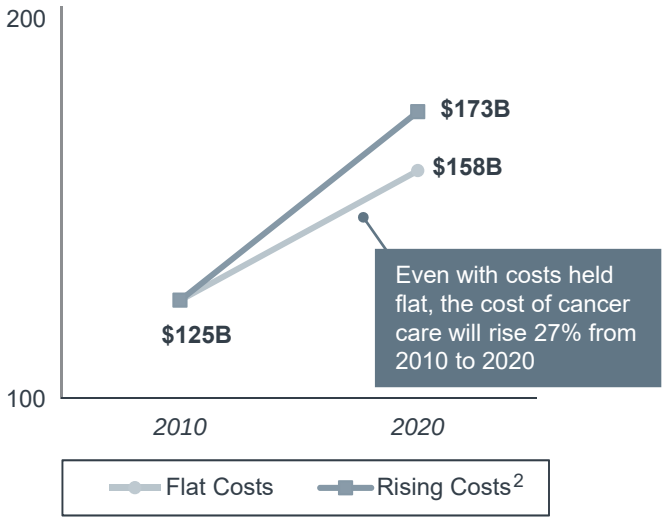
Care Variation Reduction
The primary lever for health systems to provide reliable, affordable care

Source: Oncology Roundtable interviews and analysis.

A Spending Problem in Cancer Care

Reducing Care Variation Critical to Decrease Costs, Improve Outcomes

Annual Spending on Cancer Care[1]



The Oncology Care Model as a Way to Reduce Care Variation

"There is tremendous variation in practice quality across the United States, but **almost all practices can become higher quality and more patient focused**. The [Oncology Care Model] will increase patient-centered care and quality through its practice redesign requirements and its performance-based payments."

Office of Communications, Centers for Medicare and Medicaid Services

1) In 2010 dollars.
2) Assumes a 2% increase in costs in initial and last year phases of treatment.

Source: Riley SA, "The Oncology Care Model: Interview with the Center for Medicare & Medicaid Innovation," *Oncology Practice Management*, 6, no. 8 (2016): http://oncpracticemanagement.com/issue-archive/2016/august-2016-vol-6-no-8/the-oncology-care-model-interview-with-the-center-for-medicare-medicaid-innovation/; Oncology Roundtable interviews and analysis.

Making Big Investments in Support Services

Aim to Improve Quality of Care, Reduce Costs

Palliative Care

90%

Of cancer programs have developed or are currently developing palliative care programs

Symptom Management Phone Triage

61%

Of cancer programs have developed or are currently developing phone-led symptom management triage centers

Navigation

95%

Of cancer programs have developed or are currently developing navigation programs

Source: 2017 Trending Now in Cancer Care Survey; Oncology Roundtable analysis.

The Cancer Care Transformation Playbook

Three Goals for Reducing Costs and Improving Quality

1

Integrate Palliative Care into Oncology Practice

1. Integrate palliative care early
2. Empower patients to start the conversation
3. Give the care team the right tools

2

Reduce Avoidable ED and Hospital Use

4. Encourage patients to report symptoms
5. Dedicate resources to urgent symptom management

3

Maximize the Return on Navigation

6. Perform data-driven analysis to understand navigator activities
7. Update navigation to meet current goals
8. Target navigation to high-risk patients
9. Standardize navigation touchpoints

Source: Oncology Roundtable interviews and analysis.

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Integrate Palliative Care into Oncology Practice

GOAL 1

The Next Wonder Drug?

Landmark Study Makes a Big Splash in 2010

Palliative Care for the Treatment of Advanced NSCLC

2.7	$600	221,000
Months median survival benefit	Approximate cost per treatment course[1]	Patients diagnosed with advanced NSCLC annually

1) Based on billing Medicare for five established patient level E-office visits

Source: Temel J et al,. "Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer," *New England Journal of Medicine*, 2010, 363: 733-742; National Cancer Institute, available at: http://www.cancer.gov/cancertopics/types/lung, accessed September 8, 2011; Oncology Roundtable interviews and analysis.

Palliative Care Models

Models for Providing Palliative Care in Oncology

1

Inpatient Consult Service

- Physicians refer patients to inpatient consult as needed
- Team provides consults to patients throughout hospital

2

Inpatient Palliative Care Unit

- Dedicated palliative staff treat patients in designated wing
- Bed number can remain fixed or be flexible

3

Embedded Specialist

- Dedicated palliative RN or AP with focused responsibilities
- Directs resources to most pressing patient needs

4

Outpatient Palliative Care Unit

- Palliative care team located within the cancer clinic
- Services are provided to patients while visiting center

5

Home-Based Palliative Care

- Palliative AP visits patients in homes regularly
- Addresses needs of complex, "ED frequent flyer" patients

Related Resource

Integrating Palliative Care Into Oncology Practice

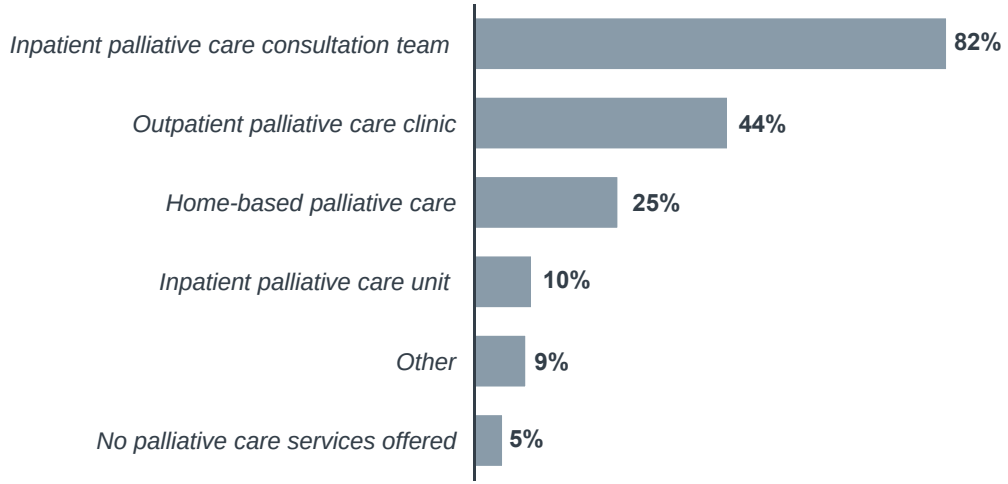
Source: Oncology Roundtable, *Integrating Palliative Care into Oncology Practice*, Washington, DC: The Advisory Board Company, 2011; Kapoor M, "Delivering Palliative Care in Patients' Homes," Oncology Rounds, January 4, 2013, http://www.advisory.com/research/oncology-roundtable/oncology-rounds/2013/01/delivering-palliative-care-in-patients-homes; Oncology Roundtable interviews and analysis.

Organizations Making the Investment

Palliative Care Services Offered by Oncology Roundtable Members

Percentage of Respondents, 2016

n=153



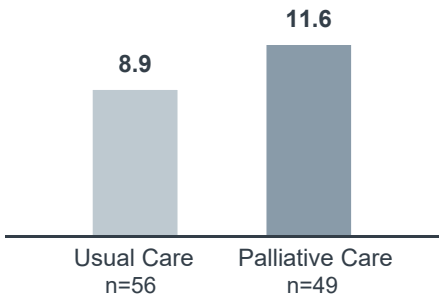
Source: Oncology Roundtable Support Services Volumes, Staffing, and Operations Benchmark Generator; Oncology Roundtable interviews and analysis.

Missing a Big Opportunity

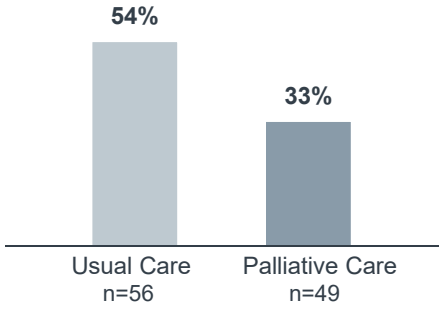
Despite Known Benefits, Many Patients Still Don't Receive It

Patients' Median Survival

In months



Percent of Cancer Patients Receiving Aggressive[1] End-of-Life Care



95%

Of Oncology Roundtable member organizations have a palliative care service[2]

19%

Of cancer patients at Oncology Roundtable member organizations receive palliative care, on average

1) Aggressive care considered as having chemotherapy within 14 days before death, no hospice care, or admission to hospice 3 days or less before death,.

2) Most common services provided are dedicated inpatient consult team (82%) and outpatient clinic (44%).

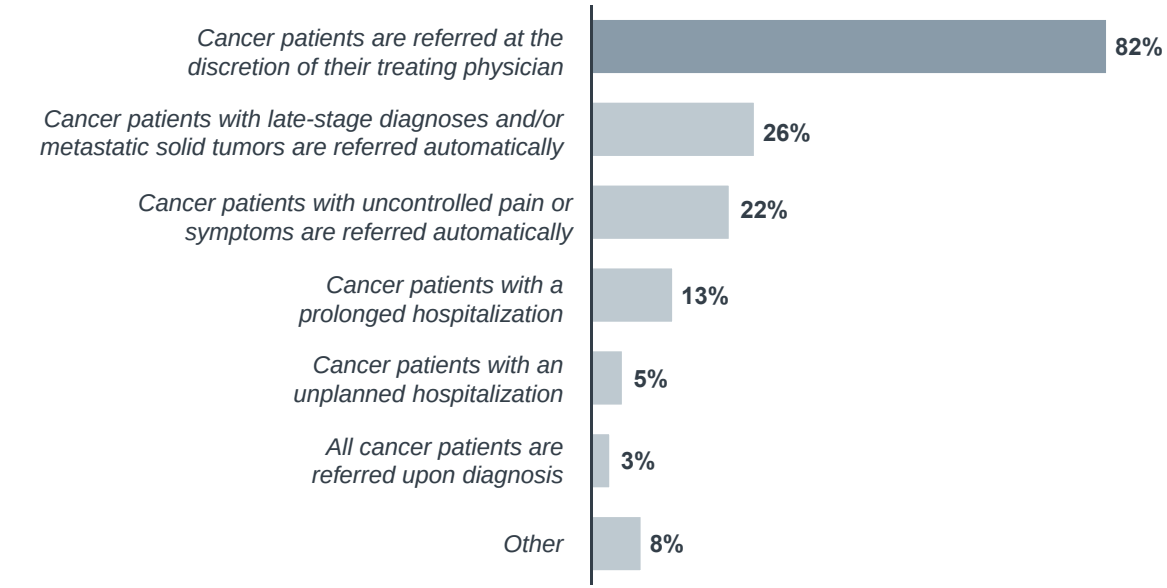
Source: Temel J, et al,. "Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer," *New England Journal of Medicine*, 363: 733-742 (2010); Oncology Roundtable Support Services Volumes, Staffing, and Operations Benchmark Generator; Oncology Roundtable interviews and analysis.

Relying on Physicians to Make the Referral

Palliative Care Referral Points for Cancer Patients

Percentage of Respondents, 2016

n=144



Source: Oncology Roundtable Support Services Volumes, Staffing, and Operations Survey; Oncology Roundtable interviews and analysis.

Hardwiring Referrals to Palliative Care

Mount Sinai Standardizes Palliative Care Criteria, Sees Dramatic Results

Criteria for Palliative Care Consult

- [x] Advanced solid tumor
- [ ] Active symptoms
- [ ] Hospitalization in the past 30 days
- [x] Prolonged hospitalization[1]

Oncology Roundtable Related Resource

Five Steps for Developing Palliative Care Consult Triggers

105%	85%	48%	60%
Increase in palliative care referrals	Increase in hospice use	Decrease in hospital readmissions[2]	Decrease in chemotherapy after discharge

1) More than seven days.
2) Within 30 days of discharge.

Source: Adelson K, et al., "Standardized Criteria for Palliative Care Consultation on a Solid Tumor Oncology Service Reduces Downstream Health Care Use." *Journal of Oncology Practice*, https://www.ncbi.nlm.nih.gov/pubmed/28306372;Oncology Roundtable interviews and analysis.

Hardwiring Referrals to Palliative Care (cont.)

Case in Brief: Mount Sinai Hospital

- 905-bed academic medical center located in New York, New York
- Developed a systematized palliative care referral system in which admitted patients meeting one of four critera are automatically referred to palliative care
- After implementing triggers, researchers at the Icahn School of Medicine at Mount Sinai, Yale University School of Medicine, and Brigham and Women's Hospital observed an increase in palliative care referrals, hospice use, and utilization of support services; hospital readmissions and receipt of chemotherapy after discharge decreased

Source: Adelson K, et al., "Standardized Criteria for Palliative Care Consultation on a Solid Tumor Oncology Service Reduces Downstream Health Care Use." *Journal of Oncology Practice*, https://www.ncbi.nlm.nih.gov/pubmed/28306372;Oncology Roundtable interviews and analysis.

Creating a Comprehensive Palliative Care Plan

City of Hope Uses Quality of Life Assessments to Prioritize Support

Components of City of Hope's Palliative Care Planning Intervention

Nurse conducts comprehensive quality of life assessment for lung patients

Nurse provides education on quality of life domains,[1] creates action steps for patients and caregivers, and schedules referrals

Quality of Life Assessment → **Interdisciplinary Case Discussion** → **Follow-Up**

Medical, nursing, palliative, and supportive care professionals discuss cases, prioritize patient needs, and formulate care plan

Related Resources

City of Hope Pain & Palliative Care Resource Center

1) Quality of life domains are: physical, psychological, social, and spiritual well-being.

Source: Ferrell B, et al., "Interdisciplinary Palliative Care for Patients With Lung Cancer," *Journal of Pain and Symptom Management,* 50.6 (2015); City of Hope National Medical Center, Duarte, CA; Funded by NCI PO1 CA136396, B. Ferrell PI; Oncology Roundtable interviews and analysis.

Creating a Comprehensive Palliative… (cont.)

Case in Brief: City of Hope Medical Center

- 217-bed NCI-designated Comprehensive Cancer Center located in Duarte, California
- NCI-funded five-year "Palliative Care for Quality of Life and Symptom Concerns in Lung Cancer" study to integrate palliative care for lung cancer patients and their caregivers
- Intervention includes three components:
  - Comprehensive assessment of patient's quality of life, synthesis of results into summary report
  - Interdisciplinary team planning meeting to discuss patient needs and support plan
  - Patient and caregiver education about physical, psychological, social, and spiritual well-being quality of life domains
- Planning meetings most helpful for triaging limited palliative care resources to highest need patients and issues, disseminating palliative care strategies to participating clinicians
- Intervention resulted in increased survival, quality of life improvements for patients and caregivers, increased use of advance care directives, reduced hospital admissions, and reduced urgent care visits; early-stage patients derived the most benefit
- NINR[1] funding to implement the intervention in the community setting through partnership with Kaiser systems in Riverside, Fontana, and Anaheim, California

1) National Institute of Nursing Research.

Source: Ferrell B, et al., "Interdisciplinary Palliative Care for Patients With Lung Cancer," *Journal of Pain and Symptom Management,* 50.6 (2015); City of Hope National Medical Center, Duarte, CA; Funded by NCI PO1 CA136396, B. Ferrell PI; Oncology Roundtable interviews and analysis.

Dramatic Results Through Coordinated Support

Palliative Care Important for Both Early- and Late-Stage Patients

Select Results from City of Hope's Intervention

Lung Cancer Patients

- Increased survival
- Reduced symptom burden
- Improved symptom management
- Increased QOL
- Reduced distress

Caregivers

- Reduced burden
- Increased QOL
- Increased preparedness

Institution

- Reduced hospital admissions
- Reduced urgent care visits
- Increased use of advanced care directives
- Increased communication about preferences
- Increased support care referrals

6 month

Increase in survival among patients receiving palliative care intervention[1]

28%

Increase in average FACT-L[2] score

75%

Decrease in NCCN Distress Thermometer scores

1) Among patients who died.
2) Functional Assessment of Cancer Treatment—Lung Cancer.

Source: Ferrell B, et al., "Interdisciplinary Palliative Care for Patients With Lung Cancer," *Journal of Pain and Symptom Management,* 50.6 (2015); City of Hope National Medical Center, Duarte, CA; Funded by NCI PO1 CA136396, B. Ferrell PI; Oncology Roundtable interviews and analysis.

Moving the Model to a Community Setting

Nurse Time Constraints Necessitate Prioritization of Tools

City of Hope's Adaptations of Palliative Care Program for the Community Setting

Different Circumstances Faced at Kaiser

- Less physician focus on research
- Limited staff and resources
- Different patient demographics, including socioeconomic status

Modifications to Palliative Care Program

- Prioritized patient assessment tools, reducing number of tools from nine to six
- Instituted brief morning huddles to replace formal team meetings to discuss patients and designate appropriate referrals

Source: Ferrell B, et al., "Interdisciplinary Palliative Care for Patients With Lung Cancer," *Journal of Pain and Symptom Management,* 50.6 (2015); City of Hope National Medical Center, Duarte, CA; Funded by NCI PO1 CA136396, B. Ferrell PI; Oncology Roundtable interviews and analysis.

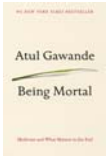
Starting to Have Meaningful Discussions

The New York Times

"One Man's Quest to Change the Way We Die"

NETFLIX

"Oscar-Nominated 'Extremis' Faces End-of-Life Decisions"



"Being Mortal"

#1 *New York Times* Bestseller

The Boston Globe

"Cancer Patients Keep Getting Aggressive End-of-Life Treatment, Despite Lack of Benefit"

The Economist

"How Life Ends: Death Is Inevitable, A Bad Death Is Not"

npr

"Doctor Takes Death Education to High School Classrooms"

Source: Oncology Roundtable interviews and analysis.

Patients Not Getting What They Want

Americans Say They Want End-of-Life Conversations and Care at Home

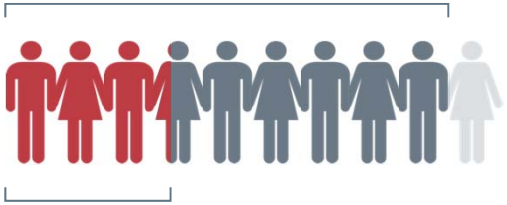
Attitudes About Having End-of-Life Discussions with Physicians

87% of American seniors[1] believe physicians should discuss end-of-life issues with their patients

27% of American seniors actually discuss end-of-life issues with their physicians

Preferred Location for End-of-Life Care

90% of American seniors prefer to receive end-of-life care in their home



33% of Medicare beneficiaries actually die in their homes

1) Adults over 65.

Source: Kaiser Family Foundation Health Tracking Poll 2015. Teno et al, "Change in End-of-Life Care for Medicare Beneficiaries," JAMA, 309, no.5 (2013); Oncology Roundtable interviews and analysis.

A Conversation Starter

UPMC[1] Coaches Patients to Talk to Their Care Team

Components of Social Worker-Patient Meetings

Introduction

- Social worker meets with advanced cancer patient and caregivers
- Introduces question prompt list with suggested end-of-life conversation topics

Prioritization

- Works with patient to identify topics patient is most concerned about
- Prioritizes two to three topics for patients to discuss with care team

Coaching

- Coaches patient on how to ask questions
- Provides guidance on how to raise concerns during oncology appointments

Next Steps

- Provides summary notes
- Outlines follow-up steps with patient for subsequent oncologist visit

1) University of Pittsburgh Medical Canter.

Source: Rodenbach RA, et al., "Promoting End-of-Life Discussions in Advanced Cancer: Effects of Patient Coaching and Question Prompt Lists," *Journal of Clinical Oncology*, 35, no. 8 (2017): 842-851; Oncology Roundtable interviews and analysis.

A Conversation Starter (cont.)

Case in Brief: University of Pittsburgh Medical Center

- Twenty-hospital health system based in Pittsburgh, Pennsylvania
- Developed randomized control trial with 24 participating oncology practices in which advanced solid tumor cancer patients in the intervention group received a one-hour coaching session with a social worker
- In session, social worker introduces a question prompt list that contains end-of-life conversation starters, helps patients prioritize concerns, and coaches them on how to voice concerns with physicians
- Compared with patients in the control group, those that met with the social worker were twice as likely to bring up questions at their next oncologist visit

Source: Rodenbach RA, et al., "Promoting End-of-Life Discussions in Advanced Cancer: Effects of Patient Coaching and Question Prompt Lists," *Journal of Clinical Oncology*, 35, no. 8 (2017): 842-851; Oncology Roundtable interviews and analysis.

Letting Patients Guide the Conversation

UPMC Demonstrates Significant Improvements

2x

More likely patients will ask end-of-life questions at next oncology visit after meeting with social worker

Oncology Roundtable Related Resource

UPMC Question Prompt List

Topics Most Commonly Raised by Patients

1. **Cancer Treatment**
   - How will I know if the treatments are working?
   - What are the pros and cons of further treating my cancer?
2. **Current Cancer State**
   - What is currently happening with my cancer?
3. **Concerns About Care at the End of Life**
   - I don't know what to tell my family
   - I worry that I'm going to suffer
   - I am afraid of dying

Source: Rodenbach RA, et al., "Promoting End-of-Life Discussions in Advanced Cancer: Effects of Patient Coaching and Question Prompt Lists," *Journal of Clinical Oncology*, 35, no. 8 (2017): 842-851; Oncology Roundtable interviews and analysis.

Providers Unprepared for the Conversation

Programs Should Find Innovative Ways to Support Them

Not a Focus for Training

2% Of board certification exam for oncologists is focused on end-of-life care

"Physicians and other health professionals—even those with substantial experience caring for the seriously ill—**commonly lack skills in eliciting the goals, preferences, and values of their patients** and in effectively tuning their care to align with those aims."

Atul Gawande, MD, MPH
"Being Mortal"

Three Strategies to Help the Care Team

1 Identify High-Risk Patients

2 Embed Decision-Support Tools

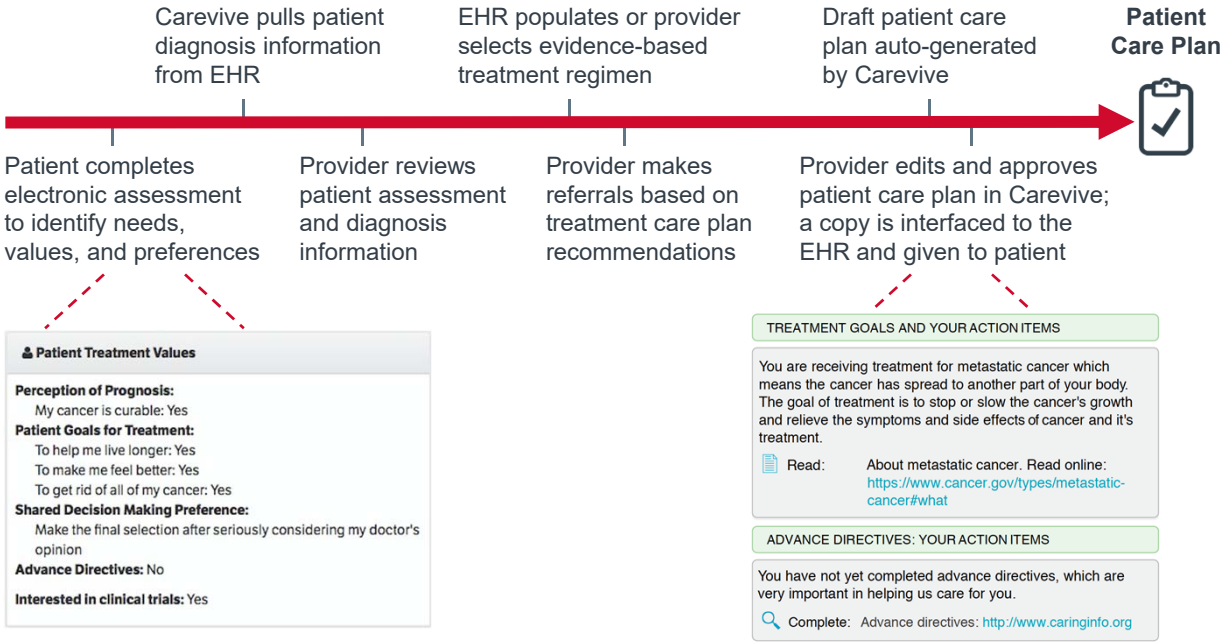
3 Leverage the Full Care Team

Source: "Doctors Are Poorly Trained in End-of-Life Care, but That Can Change," *Scientific American*, https://www.scientificamerican.com/article/doctors-are-poorly-trained-in-end-of-life-care-but-that-can-change/; Gawande, A, "Quantity and Quality of Life: Duties of Care in Life-Limiting Illness," *JAMA*, 315, *no. 3* (2016); Oncology Roundtable interviews and analysis.

Make Advance Care Planning a Critical Component

Embed into Physician Workflow and Patient Care Plan Creation

How UAB, AtlantiCare and USA Mitchell Use Carevive to Support Comprehensive Patient-Centered Treatment Decision Making and Care Planning



Source: UAB Medicine, Birmingham, AL; USA Mitchell Cancer Institute, Mobile, AL; AtlantiCare Cancer Institute, Egg Harbor Township, NJ; Carevive Systems, Philadelphia, PA; Oncology Roundtable interviews and analysis.

Make Advance Care Planning a Critical… (cont.)

Case in Brief: UAB Medicine

- NCI-designated Comprehensive Cancer Center based in Birmingham, Alabama
- Partnered with USA Mitchell Cancer Institute (Mobile, Alabama) and AtlantiCare Cancer Institute (Egg Harbor Township, New Jersey) to conduct a study with Carevive Systems
- Uses Carevive's patient care planning platform to provide physicians with a tool that auto-generates a patient care plan and triggers appropriate referrals across the cancer continuum based on clinical data, patient-reported outcomes, and evidence-based guidelines
- Physician adherence to QOPI[1] metrics improved significantly for those physicians using Carevive across all three sites

1) Quality Oncology Practice Initiative.

Source: UAB Medicine, Birmingham, AL; USA Mitchell Cancer Institute, Mobile, AL; AtlantiCare Cancer Institute, Egg Harbor Township, NJ; Carevive Systems, Philadelphia, PA; Oncology Roundtable interviews and analysis.

Make Advance Care Planning a Critical… (cont.)

Technology in Brief: Carevive Systems

- IT company co-located in Philadelphia, Pennsylvania, and Miami, Florida
- Leverages state-of-the-art technology and world-class oncology researchers to deliver a proprietary cancer patient care planning system to provider organizations
- Software platform collects patient-reported and clinical data and evidence-based guidelines to auto-generate comprehensive patient care plans (provides personalized guidance to patients on treatment, symptom management, and survivorship care)
- The real-world experiences of cancer patients collected in the system are evaluated continuously to refine the offering

Source: Carevive Systems, Philadelphia, PA; Oncology Roundtable interviews and analysis.

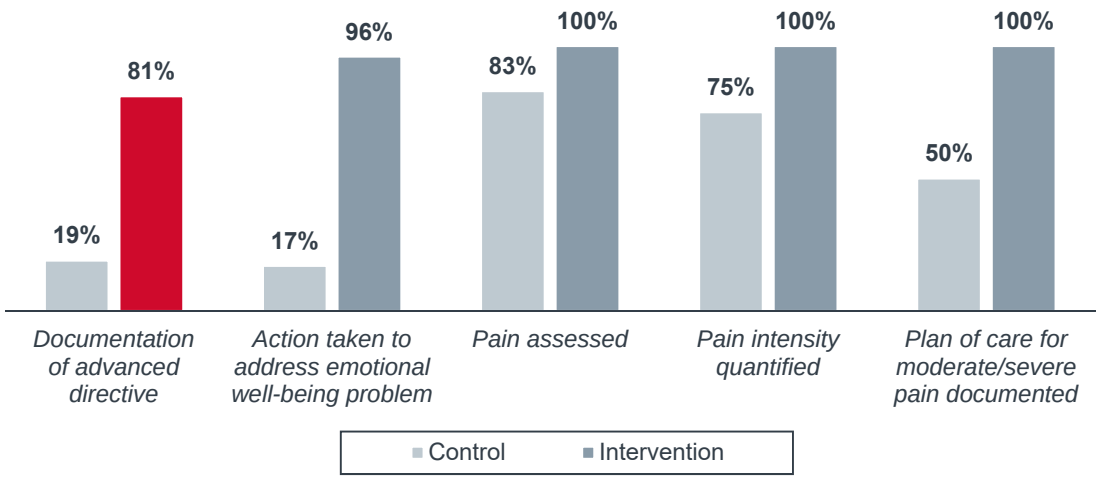
Seeing the Benefits

Use of Carevive Improves Physician Adherence to QOPI[1] Metrics

Adherence to QOPI Metrics for Breast Cancer Patients

At UAB, AtlantiCare, and USA Mitchell Cancer Institute

n=82 physicians in control group; n=72 physicians in intervention group



1) Quality Oncology Practice Initiative.

Source: UAB Medicine, Birmingham, AL; USA Mitchell Cancer Institute, Mobile, AL; AtlantiCare Cancer Institute, Egg Harbor Township, NJ; Carevive Systems, Philadelphia, PA; Oncology Roundtable interviews and analysis.

Building an Integrated Program

Six Hallmarks

1. Physicians trust the palliative care team
2. Palliative care team is scrupulous about care coordination
3. Advance care planning is routine for all cancer patients
4. Palliative care team is highly visible in the cancer center
5. Clinicians share responsibility for initiating palliative care consults
6. Oncology clinicians are trained to provide palliative care

Reduce Avoidable ED and Hospital Use

GOAL 2

A Big Problem

ED Visits and Hospitalizations Contribute Greatly to Avoidable Costs

Emergency Department Visits

ED

Prevalence

56%

Of Medicare patients receiving chemotherapy visit the ED each year

Cost

$800

Average cost for a chemotherapy-related ED visit

Hospital Admissions

Prevalence

63%

Of ED visits by Medicare patients receiving chemotherapy result in a hospitalization

Cost

$22K

Average cost for chemotherapy-related hospitalizations

Source: Fitch K, Pyenson B, "Cancer Patients Receiving Chemotherapy: Opportunity for Better Management," March 30, 2010, http://us.milliman.com/uploadedFiles/insight/research/health-rr/cancer-patients-receiving-chemotherapy.pdf; Advisory Board, Data and Analytics Group analysis; Oncology Roundtable interviews and analysis.

A New Target for CMS

Measure Aims to Reduce Preventable ED Visits and Hospitalizations

OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy

- Tracks cancer patients[1] having an ED visit or inpatient admission for one of ten conditions within 30 days of receiving chemotherapy
- Consists of two scores—one for inpatient admission rates and one for ED visit rates
- Impacts hospitals' outpatient Medicare payments beginning in 2020
- First cancer-specific measure in Outpatient Quality Reporting program

Oncology Roundtable Related Resources for Symptom Management and Urgent Care

- Integrating Palliative Care into Oncology Practice
- Urgent Care for Cancer Patients

Ten Conditions Included

- Anemia
- Nausea
- Dehydration
- Neutropenia
- Diarrhea
- Pain
- Emesis
- Pneumonia
- Fever
- Sepsis

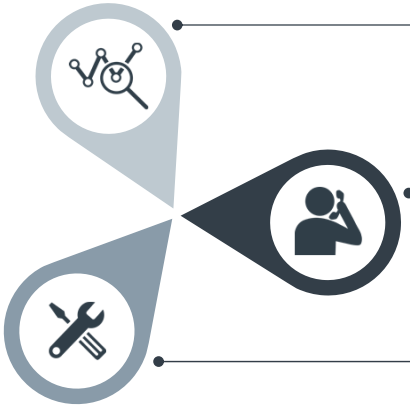
1) Excludes leukemia patients.

Source: CY 2017 Hospital Outpatient Prospective Payment System Final Rule, CMS; Oncology Roundtable interviews and analysis.

Tackling the Problem

Keeping Patients Out of the ED and Hospital

Three Tactics to Reduce Avoidable ED and Hospital Use



Tactic 4

Identify Drivers of Avoidable Utilization

Tactic 5

Encourage Patients to Report Symptoms

Tactic 6

Dedicate Resources to Urgent Symptom Management

Source: Oncology Roundtable interviews and analysis.

Patients Hesitant to Report Symptoms

Making It Difficult for Programs to Proactively Address Needs

Barriers to Patients Reporting Symptoms to the Cancer Care Team

- Unaware of symptoms or don't know which ones are worth reporting
- Assume the care team will anticipate and reach out to them about symptoms
- Don't believe care team is available to help
- Afraid to bother their care team
- Not sure who to call

38%
Of active cancer patients do not report symptoms because they do not want to bother their doctor

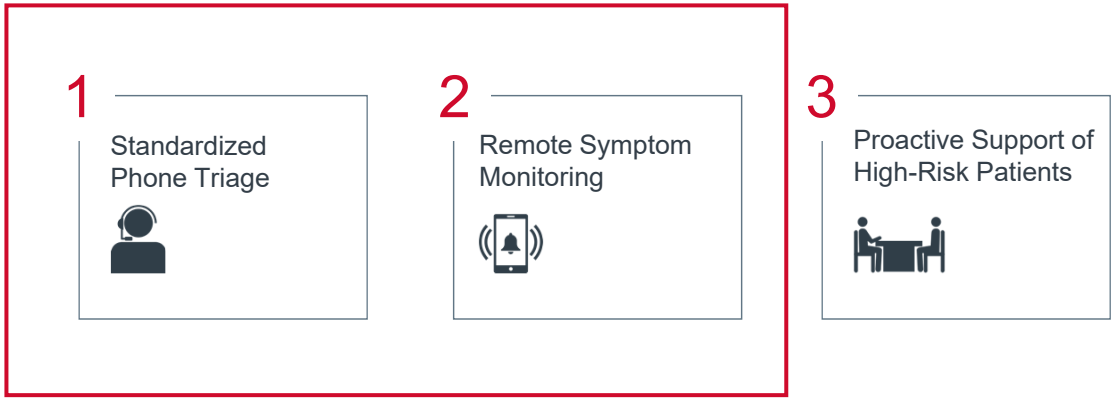
10%
Of symptoms identified by systematic assessment are voluntarily reported to the care team by cancer patients

Source: "2016 Cancer*Care* Patient Access and Engagement Report," Cancer*Care*, http://www.cancercare.org/accessengagementreport; Shoemaker LK, et al., "Symptom Management: An Important Part of Cancer Care," *Cleveland Clinic Journal of Medicine*, 78, no. 1 (2011): 25-34; Oncology Roundtable interviews and analysis.

Make Symptom Reporting Easier

Put the Right Infrastructure in Place

Three Strategies for Cancer Programs

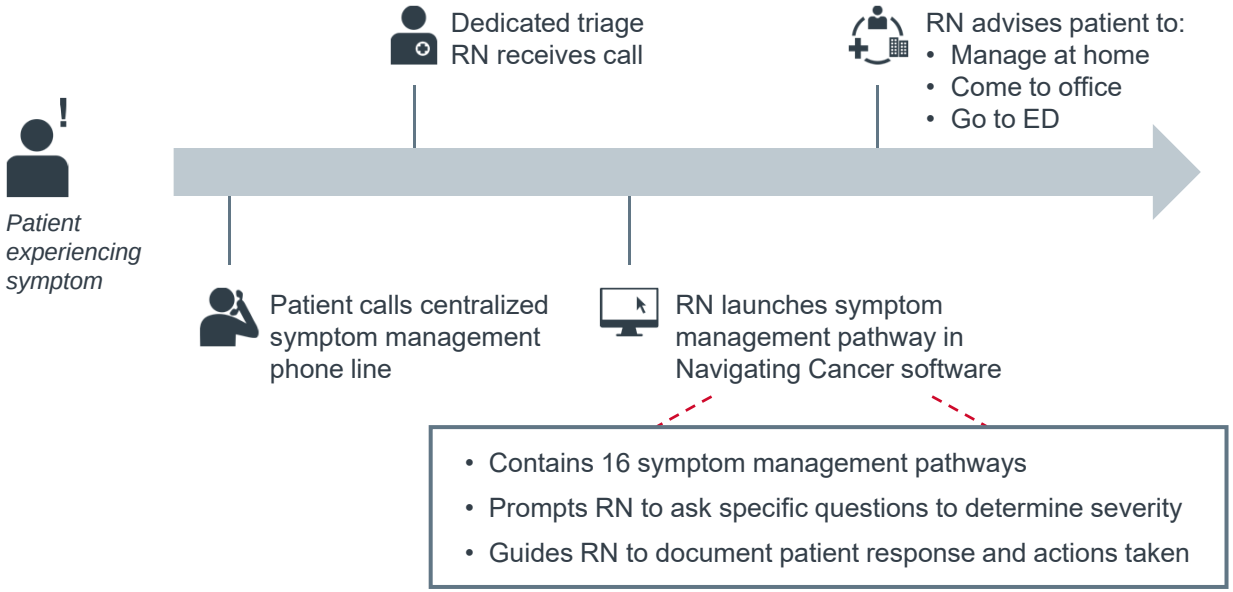


Source: Oncology Roundtable interviews and analysis.

Hardwire Support for Patients

The Center for Cancer and Blood Disorders Maximizes Phone Triage

Phone Triage at The Center for Cancer and Blood Disorders



Source: The Center for Cancer and Blood Disorders, Fort Worth, TX; Navigating Cancer, Seattle, WA; Oncology Roundtable interviews and analysis.

Hardwire Support for Patients (cont.)

Case in Brief: The Center for Cancer and Blood Disorders

- Community oncology practice with nine locations and 18 oncologists based in Fort Worth, Texas
- Restructured phone triage system to better manage urgent symptoms and keep cancer patients out of the ED
- Two RNs dedicated to phone triage, use standardized pathways to manage 16 common symptoms[1]
- Partnered with Navigating Cancer to integrate triage pathways into patient relationship management software platform
- Measured phone triage line call volume, speed of symptom management, and estimated cost savings from same-day appointments scheduled as a result of call; estimated that new phone triage system saved them more than $400,000 in one month

1) Body aches, chest pain, constipation, cycle one follow-up, diarrhea, emergency services, fatigue, fever and chills, follow-up, nausea and vomiting, nosebleed, oral problems, pain, respiratory changes, sinus and cold symptoms, transitional care management.

Source: The Center for Cancer and Blood Disorders, Fort Worth, TX; Navigating Cancer, Seattle, WA; Oncology Roundtable interviews and analysis.

Hardwire Support for Patients (cont.)

Technology in Brief: Navigating Cancer

- Patient relationship management software developed by Navigating Cancer, Inc. headquartered in Seattle, Washington
- Comprised of three components: Care Management (mobile health care tracker, distress assessments, depression screening and follow-up, pain assessment and care plan), Population Care (customizable population segmentation, patient use reporting, OCM reporting, time tracking, insights), and Patient Link (patient education, appointment schedule, intake and registration, patient portal, meaningful use reporting)
- Symptom management pathways in care management component use branching logic to provide clinical decision support for triage RNs; institution-specific standing orders at the end of each pathway empower RNs to work more independently at top of license

Related Resource

For publicly available symptom triage pathways, see COSTaRS' Remote Symptom Practice Guides for Adults on Cancer Treatments

Oncology Roundtable Related Resource

Urgent Care for Cancer Patients

Source: Stacey D, et al., "Remote Symptom Practice Guides for Adults on Cancer Treatments," Ottawa Hospital Research Institute and University of Ottawa, https://ktcanada.ohri.ca/costars/COSTaRS_Practice_Guides_ENGLISH_March2016.pdf; Oncology Roundtable interviews and analysis.

A Measurable Impact

The Center for Cancer and Blood Disorder's Phone Triage Dashboard

One Month of Data	
Number of RNs dedicated to phone triage	2
Number of oncologists in practice	18
Number of phone calls managed	1,216
Number of symptom management calls	317
Number of calls managed immediately	307 (97%)
Number of calls managed without physician intervention	152 (48%)
Number of calls where same-day appointment scheduled	54

$432,000

Estimated savings per month from preventing ED visits and subsequent hospitalizations[1]

1) Assumed an average cost of $8,000 per ED visit and potential subsequent hospital charges.

Source: The Center for Cancer and Blood Disorders, Fort Worth, TX; Navigating Cancer, Seattle, WA; Oncology Roundtable interviews and analysis.

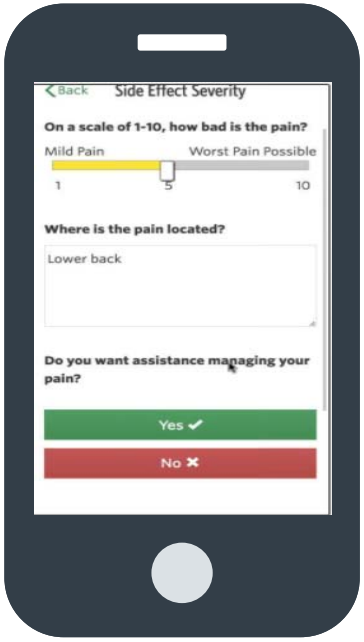
Put It in Patients' Hands

CCBD[1] Uses an App to Engage Patients in Symptom Monitoring

Health Tracker App

Patient regularly prompted to input information on:

- Medication compliance
- Symptoms
- Service utilization outside of treating institution since last appointment



Triage nurse sees:

- Dashboard with compiled patient-reported data
- Prioritized list of patients to follow up with based on symptom severity
- Links to relevant symptom management pathway for each patient

1) The Center for Cancer and Blood Disorders.

Source: The Center for Cancer and Blood Disorders, Fort Worth, TX; Navigating Cancer, Seattle, WA; Oncology Roundtable interviews and analysis.

Put It in Patients' Hands (cont.)

Case in Brief: The Center for Cancer and Blood Disorders

- Community oncology practice with 9 locations and 18 oncologists based in Fort Worth, Texas
- Partnered with Navigating Cancer to use their patient-facing Patient Link platform component and Health Tracker mobile app for remote monitoring
- Patients receive regular text messages prompting them to complete brief survey on side effects and oral medication adherence; patients who indicate side effects are asked follow-up questions to assess severity and whether they would like help from the care team
- Patients with an upcoming appointment are also asked if they have received medical care for their cancer or other cancer-related issues at another facility, urgent care center, or hospital since their last appointment in an effort to improve care coordination
- Navigating Cancer software compiles patient-reported data prioritized based on symptom severity into a dashboard for triage nurses; triage nurses can click on individual patients to view survey responses and launch the relevant symptom management pathway
- Currently in the process of measuring impact of the Health Tracker app for remote symptom monitoring

Source: The Center for Cancer and Blood Disorders, Fort Worth, TX; Navigating Cancer, Seattle, WA; Oncology Roundtable interviews and analysis.

Put It in Patients' Hands (cont.)

Technology in Brief: Navigating Cancer

- Patient relationship management software developed by Navigating Cancer, Inc. headquartered in Seattle, Washington
- Remote monitoring system allows institutions to customize scheduling of symptom reporting and oral medication reminders to match any patient's treatment regimen
- Places certain patients in elevated alert status to trigger more sensitive alerts to the care team, prompting timely follow-up

Source: The Center for Cancer and Blood Disorders, Fort Worth, TX; Navigating Cancer, Seattle, WA; Oncology Roundtable interviews and analysis.

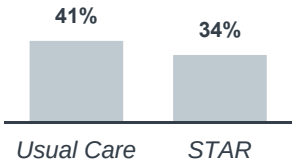
Successfully Decreasing Utilization

Memorial Sloan Kettering Documents Impact of Remote Monitoring

Study Design: Advanced solid tumor patients receiving chemotherapy were randomized to regularly report 12 common symptoms using the web-based Symptom Tracking and Reporting (STAR) platform or to receive usual care consisting of symptom management at the discretion of clinicians

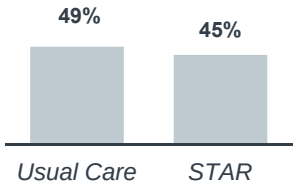
STAR Intervention Results

Percentage of Cancer Patients Visiting the ED Across One Year



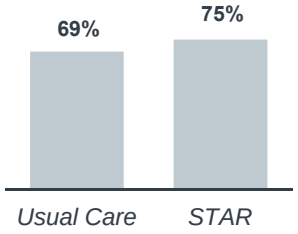
17%
Decrease

Percentage of Cancer Patients Hospitalized Across One Year



8%
Decrease

Percentage of Cancer Patients Alive at One Year



9%
Increase

Source: Basch E, et al., "Symptom Monitoring with Patient-Reported Outcomes During Routine Cancer Treatment," *Journal of Clinical Oncology*, 34, no. 6 (2016): 557-565; Oncology Roundtable interviews and analysis.

Successfully Decreasing Utilization (cont.)

Study in Brief: Symptom Monitoring with Patient-Reported Outcomes

- Randomized control trial of patients receiving routine outpatient chemotherapy for advanced solid tumors at Memorial Sloan Kettering Cancer Center
- Compared remote patient self-reporting of 12 common symptoms using web-based STAR platform to usual care consisting of symptom management at discretion of clinicians; intervention group received weekly email prompts to report symptoms
- Nurses received email alerts when STAR group patients reported severe or worsening symptoms; physicians received symptom printouts at visits
- Observed 17% decrease in ED visits at one year, 8% decrease in hospitalizations at one year, 9% increase in survival at one year, 89% greater increase in health-related quality of life at six months, and 1.9-month increase in time on chemotherapy for STAR participants compared to usual care group

Source: Basch E, et al., "Symptom Monitoring with Patient-Reported Outcomes During Routine Cancer Treatment," *Journal of Clinical Oncology*, 34, no. 6 (2016): 557-565; Oncology Roundtable interviews and analysis.

Symptom Reporting Only Half the Battle

Cancer Programs Need Dedicated Resources to Manage Urgent Issues

Traditional Cancer Center Management of Urgent Symptoms

Patient reports symptom

Care team determines patient needs to be seen immediately

Care team is unable to see patient that day because:

- No time in providers' schedules
- No space in clinic
- Clinic is closed

ED

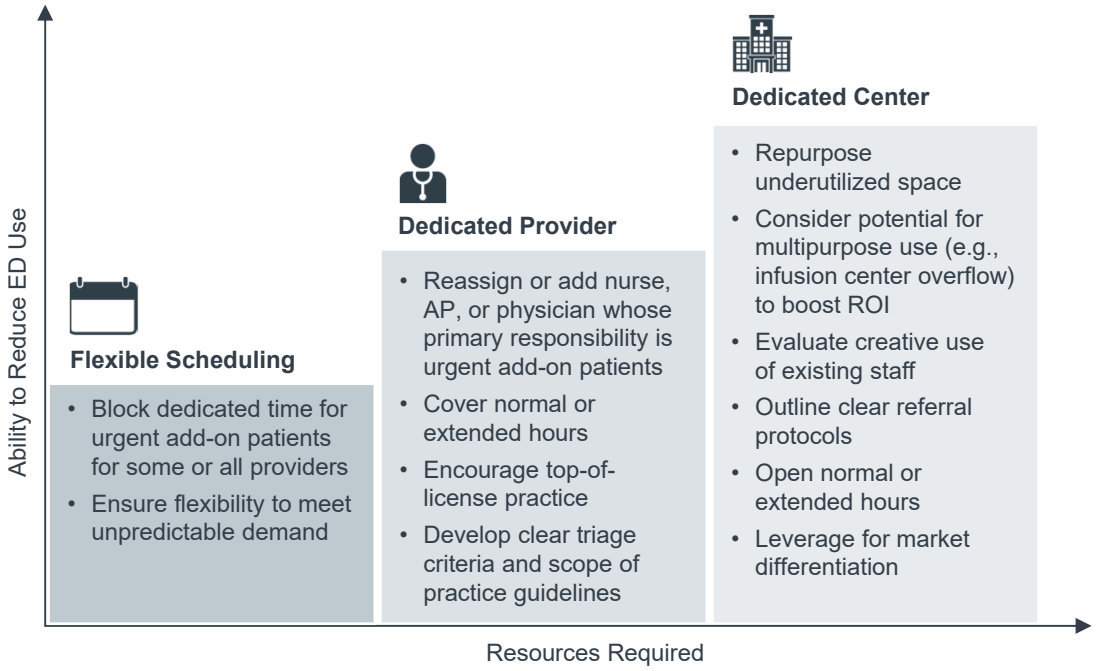
Patient is sent to the emergency department

Source: Oncology Roundtable interviews and analysis.

Keeping It in the Cancer Center

Balance Patient Need with Resources Required

Three Models of Urgent Symptom Support



Source: Oncology Roundtable interviews and analysis.

Identifying a Bigger Problem

Froedtert Leverages ED Data to Understand Scope

Froedtert's Analysis of Cancer Patient ED Use

182

Cancer patients visited the ED in August 2016

55%

Of cancer patients seen in the ED were admitted to the hospital

Common Reasons for ED Visits

- Fever
- Nausea or vomiting
- Mild shortness of breath
- Pain control
- Bleeding
- Cold or flu-like symptoms
- Dehydration
- Diarrhea
- Fatigue
- Home infusion pump concerns
- Rash

Source: Froedtert and the Medical College of Wisconsin Froedtert Hospital, Milwaukee, WI; Oncology Roundtable interviews and analysis.

Identifying a Bigger Problem (cont.)

Case in Brief: Froedtert and the Medical College of Wisconsin Froedtert Hospital

- 561-bed academic medical center located in Milwaukee, Wisconsin
- Found that many cancer patients were going to the ED and receiving additional services (e.g., imaging, labs, EKGs) for non-emergent symptom management because the cancer center did not have capacity for add-on patients or was closed in the evenings and overnight
- Piloted four-infusion chair, referral-based 24-Hour Cancer Clinic next to inpatient hematology unit to treat cancer patients with urgent needs; opened clinic to medical oncology patients first, but recently expanded to accommodate radiation and surgical oncology patients
- Staffed by either two RNs, or one RN and one MA or CNA, at any given time with one of the two staff members floating across inpatient and outpatient oncology when not needed in 24-Hour Cancer Clinic; AP working in hematology-oncology unit overnight provides supervision for clinic until outpatient oncology attending team returns the next morning
- Encourage patient referrals by: training answering service staff to remind on-call oncologists to direct patients to 24-Hour Cancer Clinic when appropriate; creating oncologist badge tags with key logistics about the 24-Hour Cancer Clinic (e.g., phone number, symptoms managed); developing triage algorithms for ED staff to identify patients who can be diverted from the ED to the 24-Hour Cancer Clinic on intake; and creating patient education information
- Observed steady increase in clinic volumes since opening in November 2016 and no increase in the total number of ED visits per month despite growing cancer center volumes overall; found lower hospital admission rate from and fewer services used in 24-Hour Cancer Clinic than ED

Source: Froedtert and the Medical College of Wisconsin Froedtert Hospital, Milwaukee, WI; Oncology Roundtable interviews and analysis.

Dedicating the Staff and Space for Urgent Needs

Froedtert Launches Urgent Care Pilot

Staffing

- Two RNs or one RN and one technician (MA[1] or CNA[2]) per shift
- One RN flexes between outpatient and inpatient oncology if not needed in 24-Hour Cancer Clinic
- Pull from oncology float pool of 8-9 RNs and 3-4 technicians

Operations

- Housed in inpatient hematology-oncology unit
- Four infusion chairs
- Open 24/7
- Supervision provided by outpatient team and AP nocturnist in hematology-oncology unit

Sample Services Provided

- Supportive care (e.g., fluids, electrolytes, antibiotics, blood products, IV medications)
- Basic diagnostics (e.g., EKG, imaging)
- Urgent labs
- Home infusion pump concerns

Patients Seen by Referral

- Hematologic oncology
- Medical oncology
- Radiation oncology
- Surgical oncology

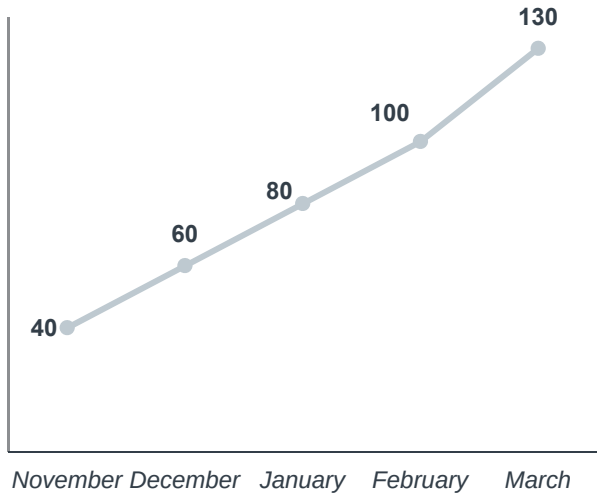
1) Medical assistant.
2) Certified nursing assistant.

Source: Froedtert and the Medical College of Wisconsin Froedtert Hospital, Milwaukee, WI; Oncology Roundtable interviews and analysis.

Getting Patients in the Door

Monthly Patient Volumes in 24-Hour Cancer Clinic

November 2016 to March 2017



Strategies to Drive Referrals to the 24-Hour Cancer Clinic

- Create easy-to-access information for oncologists
- Provide education and referral criteria to answering service staff
- Create patient education handouts and flyers
- Develop triage algorithms for ED staff and clinicians

Source: Froedtert and the Medical College of Wisconsin Froedtert Hospital, Milwaukee, WI; Oncology Roundtable interviews and analysis.

Already Seeing an Impact

Setting Froedtert Up for Success in the Oncology Care Model

ED and Hospital Use

11%

Decrease in the percentage of patients on active treatment who visited the ED since 24-Hour Cancer Clinic opened in November 2016

60%

Fewer hospital admissions from the 24-Hour Cancer Clinic than the ED

Cost

$2,269

Decrease in patient diagnostic charge[1] per 24-Hour Cancer Clinic admission compared to ED admission

$1,554

Decrease in patient diagnostic charge[1] per 24-Hour Cancer Clinic discharge compared to ED discharge

Patient Satisfaction

92%

Patient satisfaction for overall rating of care[2]

> "This is way better than having to go to the ER or an urgent care [center]. You know exactly what I need and know what to do and you get it done."
>
> *Cancer Patient, Froedtert Hospital*

1) Median total charge for lab, imaging, and EKG testing prior to disposition.
2) 99th percentile.

Source: Froedtert and the Medical College of Wisconsin Froedtert Hospital, Milwaukee, WI; Oncology Roundtable interviews and analysis.

Next Steps: Reduce Avoidable ED and Hospital Use

Resources to Guide Your Strategy

Action Items

Pinpoint the reasons for ED and hospital use

- ❑ Engage key stakeholders across departments to compile data sources, such as ACO or ED data
- ❑ Identify utilization trends and develop targeted upstream and downstream interventions

Empower patients to report symptoms

- ❑ Standardize internal processes for triaging symptom management calls
- ❑ Evaluate technology solutions that make it easier for patients to report and clinicians to manage symptoms
- ❑ Develop a risk-stratification system to identify and proactively manage high ED and hospital utilizers

Develop the infrastructure to manage urgent symptoms in the cancer center

- ❑ Assess models based on existing resources, additional resources needed, potential volumes, and potential to reduce ED and hospital use

Select Oncology Roundtable Resources

- Urgent Care for Cancer Patients
- Coordinating Seamless Transitions Across Care Settings
- Oncology Distress Screening and Management
- Avoidable ED Utilization Assessment
- Delivering on the Promise of Patient-Centered Care
- Redesigning Cancer Care for the Era of Accountability

Source: Oncology Roundtable interviews and analysis.

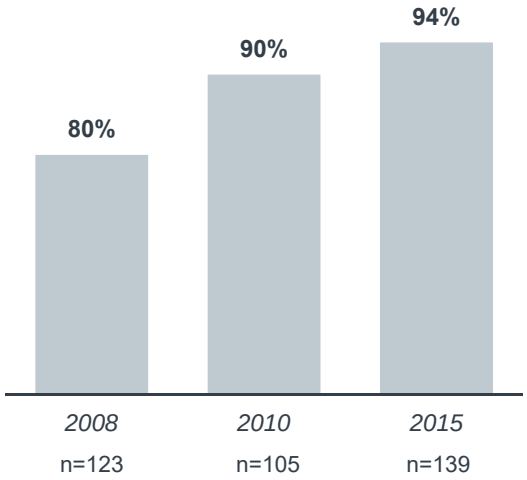
Maximizing the Return on Navigation

A Longstanding Priority

Cancer Programs Have Invested Significant Resources in Navigation

Percentage of Cancer Programs Employing at Least One Navigator

Oncology Roundtable Member Surveys



$1.2B

Direct cost of navigators to Oncology Roundtable members since 2008

Assumptions in Brief

- On average, 90% of Oncology Roundtable members have employed navigators since 2008[1]
- Each program employs an average of two navigators
- Average navigator salary is $65,000 per year

1) The Oncology Roundtable has approximately 1,300 cancer program members.

Source: Oncology Roundtable interviews and analysis.

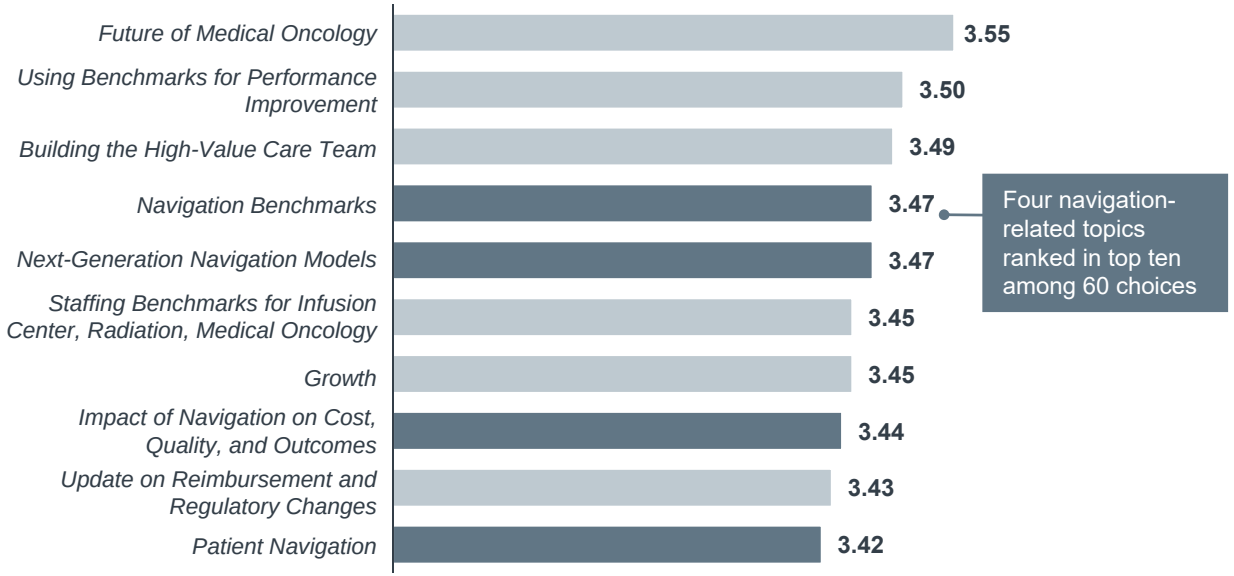
Holding Ourselves to a Higher Standard

Cancer Program Leaders Seek Resources to Optimize Navigation

Results from Oncology Roundtable 2016 Agenda Setting Topic Poll

Average GPA for Proposed Topics and Subtopics

n=313



Source: 2016 Oncology Roundtable Agenda Setting Topic Poll; Oncology Roundtable interviews and analysis.

Cancer Programs Need to Ask Tough Questions

Top Five Questions to Advance Navigation

1. How do I make sure navigators are adding value to the cancer program?
2. How do I help navigators succeed in their role?
3. How do I integrate navigators into the broader care team?
4. How do I make sure the patients who would benefit the most from navigation receive it?
5. How do I measure the value of navigators?

Source: Oncology Roundtable interviews and analysis.

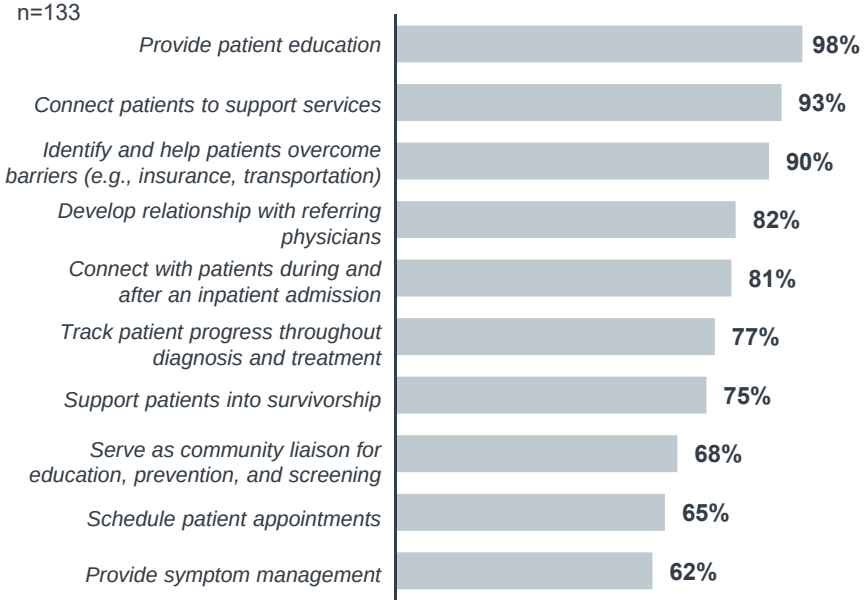
Across the Nation, Putting a Lot on Their Plate

Nurse Navigators Have Many Non-Clinical and Clinical Responsibilities

Top Ten Clinical Navigator Responsibilities

Percentage of Respondents Indicating that Clinical Navigators Regularly Perform Each Responsibility [1]

n=133



1) Respondents were asked to select from a list of 17 tasks all which are regularly performed by their clinical navigators.

77%

Percentage of cancer programs indicating that their clinical navigators have ten or more responsibilities

Source: 2015 Cancer Support Services Survey; Oncology Roundtable interviews and analysis.

An Objective Evaluation of the Role

Time Study Helps Evaluate Use of Nurse Navigators

Nurse Navigator Time Study

Data Collection

Total time cancer center process improvement team shadowed nurse navigators

8
Hours in the clinic

4
Hours in the office

Analysis

Process improvement team divided nurse navigators' activities into three categories

1 Provider-oriented

2 Administrative

3 Navigation[1]

Findings

Nurse navigator time largely spent on administrative and provider-oriented tasks

Scheduling
Paperwork
Test orders

VS

Care coordination
Patient education
Symptom management

1) As outlined by the Oncology Nursing Society.

Source: UNC Health Care, Chapel Hill, NC; Oncology Roundtable interviews and analysis.

Time Studies a Good Way to Assess Navigator Work

Six Steps for Running a Time Study

1

Decide Goals

Clearly articulate the goals of the time study to stakeholders

2

Define Elements

Decide when and how long activities will be tracked

3

Choose Tracking Method

Identify data collection method, such as manual collection or online tools (e.g., Toggl)

4

Assign Responsibility

Determine who is responsible for tracking and reporting data

5

Analyze Results

Categorize activities and analyze time spent on each compared to ideal allocation

6

Create Interventions

Implement necessary changes and communicate changes to all internal stakeholders

Source: Oncology Roundtable interviews and analysis

Redefining the Navigator Role

Program Leaders Use Time Study Data to Educate Physicians

Administrators Use Time Study Results to Reinforce Navigator Role for Physicians

- Cancer program leaders present time study results to physicians to demonstrate inappropriate use of navigators
- Reiterate responsibilities of nurse navigators
- Secure executive support to reinforce message

Tips to Encourage Appropriate Use of Navigators

- Ask physicians to help set goals for navigation program
- Solicit physician input to develop scoped role of navigators
- Involve physicians in navigator resume review and hiring process
- Find regular opportunities to communicate the goals of navigation and navigators' responsibilities

Working Together to Change Physician Behavior

"Leadership and providers are collaborating to define the role and responsibilities of navigators."

Michele Busshart, Nurse Manager of Nurse Navigation

Source: UNC Health Care, Chapel Hill, NC; Oncology Roundtable interviews and analysis.

Award Jumpstarts Patient Navigation Program

CMMI[1] Looking for Innovations to Cut Costs and Create Jobs

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

'UAB Cancer Center Grant Aims to Lower Cost of Cancer Care'

Aims of Health Care Innovation Challenge Grant Award

- Create jobs for people without clinical training
- Find ways to decrease costs of care for Medicare patients

UAB's Goals for Patient Care Connect

1 

Reduce unnecessary utilization

2 

Improve quality of care in community

3 

Foster unity across UAB network

1) Centers for Medicare and Medicaid Innovations.

Source: UAB Medicine, Birmingham, AL; Thannickal, B, "UAB Cancer Center grant aims to lower cost of cancer care," UAB News (2012); Gabrielle B. Rocque et al., "The Patient Care Connect Program: Transforming Health Care Through Lay Navigation," *Journal of Oncology Practice,* (2016), doi: 10.1200/JOP.2015.00896; Oncology Roundtable interviews and analysis.

Shifting from Reactive to Proactive Navigation

Aiming to Empower Patients to Take an Active Role in Their Care

Old Model

Reactive
Serve as a Band-Aid when failures occur

Passive
Wait for patient or clinician to express an issue or barrier

Program Focus
Help patients overcome logistical barriers, e.g. transportation, lodging, scheduling

New Model

Proactive
Use distress screening to identify potential issues and barriers to care

Anticipatory
Predict common barriers and create processes to address

Program Focus
Empower patients to take ownership of their health and engage in their care

Source: UAB Medicine, Birmingham, AL; Gabrielle B. Rocque et al., "The Patient Care Connect Program: Transforming Health Care Through Lay Navigation," *Journal of Oncology Practice,* (2016), doi: 10.1200/JOP.2015.00896; Oncology Roundtable interviews and analysis.

Defining Navigators' Focus at Each Step

Activities Align with Program Goals

Navigator Support Across the Care Continuum

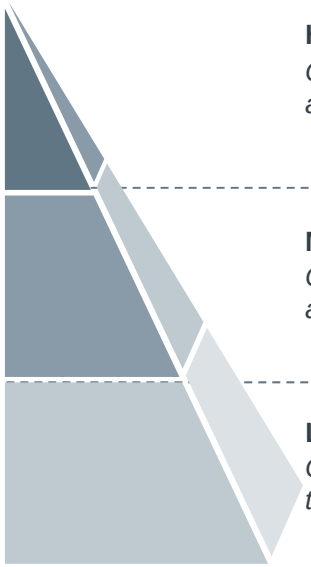
	Evaluation & Treatment Planning	Active Treatment	Post Treatment Follow Up	Survivorship & Surveillance	Palliative & Hospice
Navigator Focus	• Early evaluation • Correct diagnosis • Treatment plan development	• Treatment adherence • Medication adherence	• Medication adherence • Comorbidity management	• Regular surveillance • Physical activity, healthy diet	• Advanced disease management and planning
Potential Savings	• Improving adherence to evidence-based care	• Reducing avoidable ED visits and hospital stays	• Reducing avoidable ED visits and hospital stays	• Reducing avoidable ED visits and hospital stays • Improving compliance with appropriate follow-up care and screenings	• Reducing costs for advanced disease and end-of-life care

Source: UAB Medicine, Birmingham, AL; Gabrielle B. Rocque et al., "The Patient Care Connect Program: Transforming Health Care Through Lay Navigation," *Journal of Oncology Practice,* (2016), doi: 10.1200/JOP.2015.00896; Oncology Roundtable interviews and analysis.

Target Navigation to Patients Who Will Benefit

High-Need Patients at UAB Receive More Frequent and Intense Support

Characteristics of Navigated Patients at UAB



High-Risk Patients
Contacted at least once a week by navigator

- Comorbidities
- Poor prognosis
- Specific medications
- High distress
- Lack of support
- Advanced or complex disease

Medium-Risk Patients
Contacted at least once a month by navigator

- Accepted navigation
- Active treatment
- Distress indicated
- Socioeconomic need

Low-Risk Patients
Contacted at least every three months by navigator

- Refused navigation
- Robust social support
- No or low distress
- Completed treatment

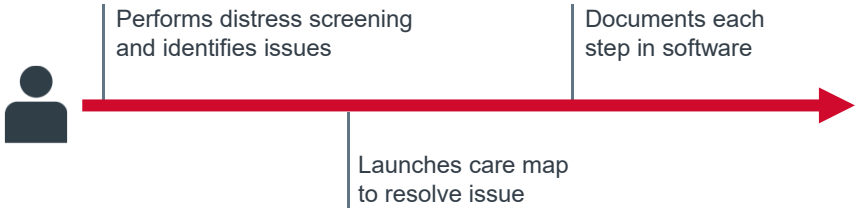
Navigator performs distress screening during outreach to identify and resolve patient issues

Source: UAB Medicine, Birmingham, AL; Rocque GB, et al., "The Patient Care Connect Program: Transforming Health Care Through Lay Navigation," *Journal of Oncology Practice*, 12, no. 6 (2016): e633-e642; Oncology Roundtable interviews and analysis.

Regular Distress Screening Is Linchpin

Identify Issues and Follow Care Maps to Ensure Patient Needs Are Met

Overview of Navigator Activities



Related Resource

Oncology Distress Screening and Management

Care Maps for Navigators

- Professor at School of Nursing developed care maps for multiple events and patient needs using literature and clinician input
- Distress screening using modified NCCN[1] Distress Thermometer is the foundation for identifying needs and launching next steps
- Care maps developed to guide patient-navigator interactions and resolve identified issues and barriers to care
- Sample care maps include: patients undergoing chemotherapy, patients discharged from the hospital, and patients with a knowledge deficit or treatment side effect

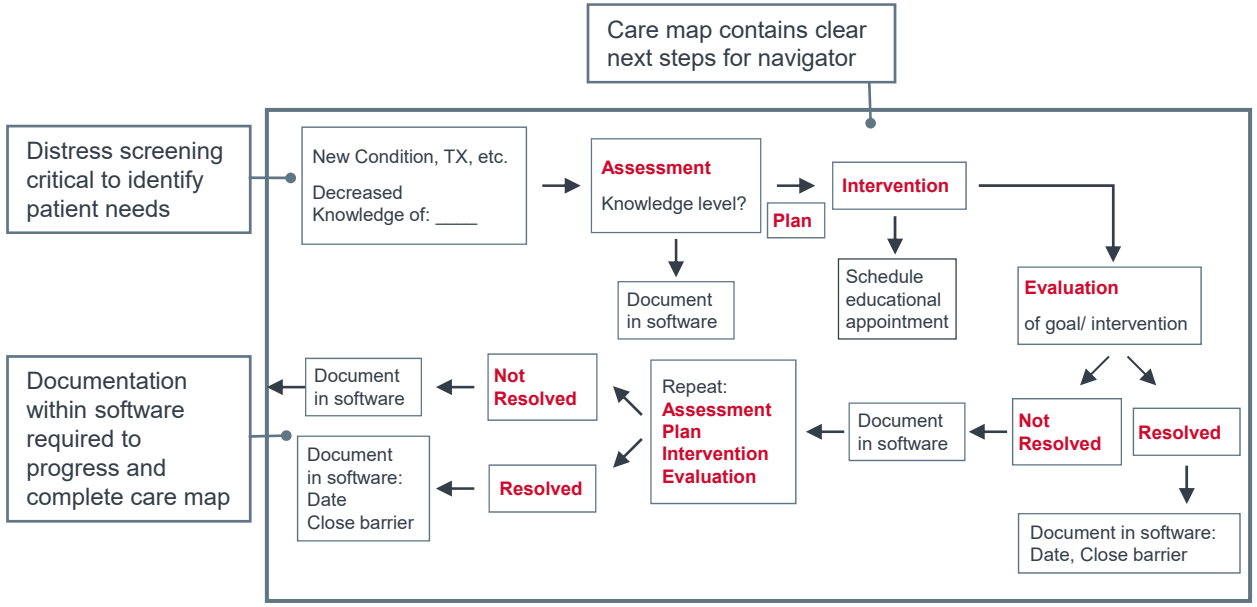
1) National Comprehensive Cancer Network.

Source: UAB Medicine, Birmingham, AL; Gabrielle B. Rocque et al., "The Patient Care Connect Program: Transforming Health Care Through Lay Navigation," *Journal of Oncology Practice*, (2016), doi: 10.1200/JOP.2015.00896; Oncology Roundtable interviews and analysis.

A Road Map for Navigation

Care Maps Guide Patient Navigators Through the Process

Sample Distress Management Care Map[1] to Address a Knowledge Deficit



1) Care map recreated by Oncology Roundtable, not exact copy of UAB care map.

Source: UAB Medicine, Birmingham, AL; Gabrielle B. Rocque et al., "The Patient Care Connect Program: Transforming Health Care Through Lay Navigation," *Journal of Oncology Practice,* (2016), doi: 10.1200/JOP.2015.00896; Oncology Roundtable interviews and analysis.

Worth the Investment

UAB Demonstrated Significant Decrease in Utilization from Navigation

RESOURCE UTILIZATION

6%

Additional decrease in **ED visits** per quarter for navigated patients[1]

8%

Additional decrease in **hospitalizations** per quarter for navigated patients[1]

11%

Additional decrease in **ICU admissions** per quarter for navigated patients[1]

COST SAVINGS

$781

Additional reduction in **total costs of care for each navigated patient**[1] per quarter[2]

$19M

Approximate **total savings** for all navigated patients across the network in one year

1) Compared to non-navigated patients.
2) Excludes Part D claims.

Source: UAB Medicine, Birmingham, AL; Rocque GB, et al., "Resource Use and Medicare Costs During Lay Navigation for Geriatric Patients with Cancer," *JAMA Oncology,* January 26, 2017, https://www.ncbi.nlm.nih.gov/pubmed/28125760; Oncology Roundtable interviews and analysis.

Making Navigation the Backbone

OhioHealth's Longstanding Process to Ensure Quality Care

Process to Standardize Navigation

- Goal to decrease days to cancer diagnosis and remove barriers to care by navigating patient from point of abnormality detection
- Relevant stakeholders met to map out the patient pathway
- Identified key touch points where patients would benefit from contact with the care team
- Interactions hardwired into the patient pathway as nurse care standards

Timeline of Development of Navigation Care Standards

1999-2001 Breast cancer standards developed over two years by a multidisciplinary team

Multidisciplinary team included:

- Medical oncologists, radiologists, surgeons, radiation oncologists, pathologist
- Front line staff and managers from imaging, surgery, in-patient nursing, ambulatory care, labs, and scheduling
- Breast cancer patients and survivors

2006 Navigation program grows to include additional complex cancers at one hospital site

2009 Navigation expands to multiple hospitals

2015 Navigation implemented at all OhioHealth hospitals

2016 Breast Cancer Survivorship Clinic Program established

2017 Ongoing initiative to provide earlier navigation (at time of abnormality)

Source: OhioHealth, Columbus, OH; Oncology Roundtable interviews and analysis.

Making Navigation the Backbone (cont.)

Case in Brief: OhioHealth

- Multi-hospital, not-for-profit system serving 44 counties based in Columbus, Ohio
- Standardized navigation touchpoints in 1999 to ensure that all breast cancer patients are supported from detection of abnormality through survivorship
- To develop standards, stakeholders mapped patient pathway together and identified barriers to care and points where the patient would benefit from contact with the navigator
- Before diagnosis, a diagnostic breast health navigator meets with patients to provide education and assist with scheduling; once diagnosed, patients are assigned to a treatment breast health nurse who provides outreach, education, and guidance across the patient's journey
- Currently expanding navigation to additional care sites, evaluating the potential for earlier navigation, and standardizing the navigation process across the system

Source: OhioHealth, Columbus, OH; Oncology Roundtable interviews and analysis.

Defining Touchpoints at Every Step of Care

Standardized Navigation Touchpoints for Breast Cancer Patients

Breast Health Nurse

Treatment Breast Health Nurse

Diagnosis	Surgery	Chemotherapy	Radiation	Survivorship
• Notifies patient of recommendation for further imaging • Meets patient at diagnostic imaging appointment • Communicates with PCP and surgeon • Schedules follow-up appointments	• Meets patient and family before surgery to reinforce education and evaluate patient needs for discharge • Provides teaching prior to discharge • Contacts patient one to two days after surgery and determines frequency of navigation follow-up	• Contacts patient after first consult • Calls patient two to three days after first chemotherapy • Assesses patient for side effects and provides support	• Contacts patient after first consult • Contacts patient mid-cycle to check-in and assess patient side effects	• Calls patients within six months of treatment to identify patient needs • Completes, reviews, and mails survivorship care plan and treatment summary to patient and providers

Navigators complete assessments and provide education, support, and resources at each intervention.

Source: OhioHealth, Columbus, OH; Oncology Roundtable interviews and analysis.

Cancer Patient Navigation Toolkit

Six Steps to (Re)Design Your Program

Full Toolkit and Resources Available at advisory.com/or/navigation

1 Define the program
- Sample community needs assessments
- Best practices for process mapping

2 Clarify the navigator role
- Navigator responsibility picklist
- Sample job descriptions

3 Secure support
- Tactics for engaging physicians
- Sample business cases and calculator to determine the ROI of a lay navigator

4 Integrate navigators with the care team
- Care team responsibilities audit
- Discussion guides and strategies to improve patient transitions

5 Track performance
- Navigation metric selection tool
- Best practices for measuring the impact of navigators on cost and quality

6 Optimize the role
- Staffing and volumes benchmarks
- Sample acuity scales and training materials

Source: Oncology Roundtable interviews and analysis.

ROAD MAP

1 At the Top of Executives' Agenda

2 Reducing Costs and Improving Quality in Cancer Care

3 Q&A

Thank you!

Please reach out with any questions:

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