oncology solutions

reimagining cancer care™

The Role of the Oncology Patient Navigator

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January 28th, 2018

Objectives

To Review:

- Definition, History, Goals & Models of Navigation
- CoC Chapter 3: Continuum of Care
- Institute of Medicine Conceptual Framework
- AONN+ Mission & Vision/ONS and AOSW Position Statement on Navigation
- Patient Flow & Managing Transitions
- Value-Based Care & Oncology Care Model
- Reporting Tools & Navigation Metrics

Definition, History, Goals, & Models of Navigation

CoC Chapter 3: Continuum of Care

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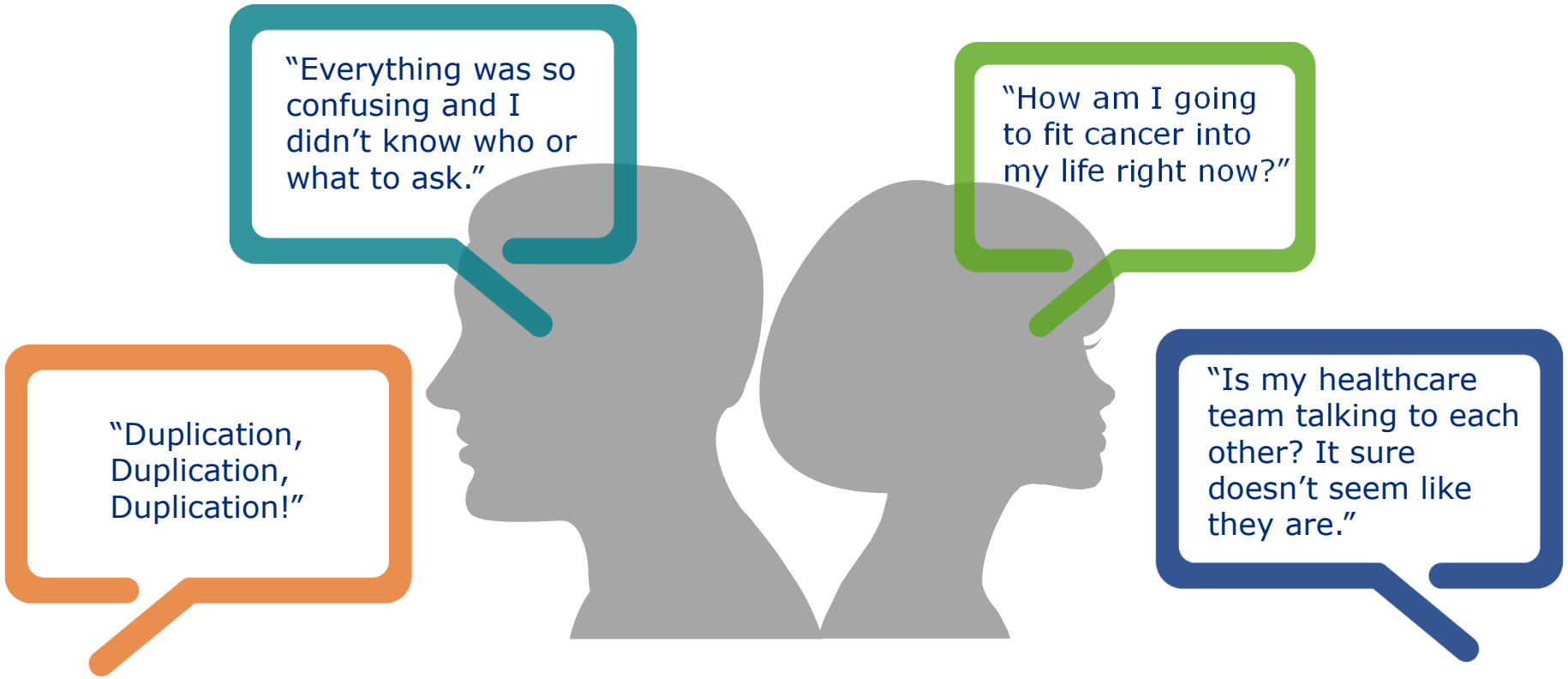
Reporting Tools & Navigation Metrics

Quotes from Patients & Families



Quotes from Patients & Families

"I felt like I was in a dark hallway. Then I met my navigator; all of a sudden I was given a flashlight."

Anna F., Cancer Survivor

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."

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

Navigation Continuum of Care

1 Prevention

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

2 Cancer Screening

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

3 Diagnosis

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

4 Treatment

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

5 Survivorship

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

6 End of Life

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

Phases of Cancer Care

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

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- Oncology/ Surgery consultation
- Tumor staging
- Patient counseling and decision making
- Clinical trials
- Informed decision making
- **Palliative Care**
- **Pre-habilitation**
- **Goals of Care**
- **Advance Care Planning**
- **Intro to SCP concept**

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

- Long-term follow up/ surveillance
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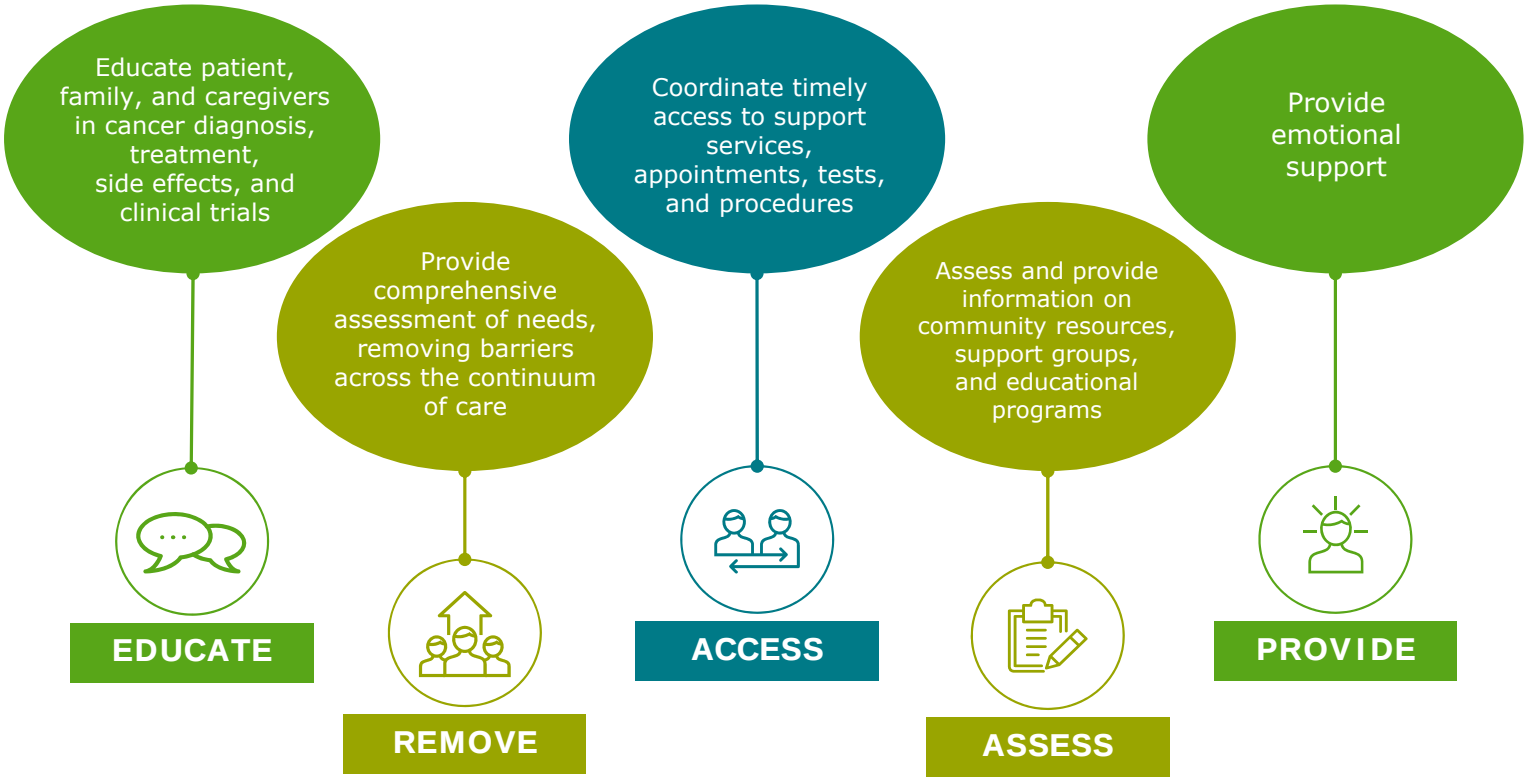
Navigator Goals



Navigation Models

Choose the navigation model that works best for your patients, community, and cancer program.

A

NURSE NAVIGATOR

A professional registered nurse with oncology-specific clinical knowledge who offers individualized assistance to patients, families, and caregivers to help overcome healthcare system barriers. 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.

B

SOCIAL WORK NAVIGATOR

Social worker with oncology-specific clinical knowledge, who offers individualized assistance to patients, families, and caregivers to help overcome healthcare system barriers.

C

PATIENT OR NONCLINICAL LICENSED NAVIGATOR

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.

D

OTHER

American Cancer Society Patient Resource Navigator Program connects patients with a patient navigator at cancer treatment centers. Patients can talk one-on-one with a patient navigator about their situation and receive information and support.

Source: AONN+, Academy of Oncology Nurse Navigators and Patient Navigators

Navigator Characteristics

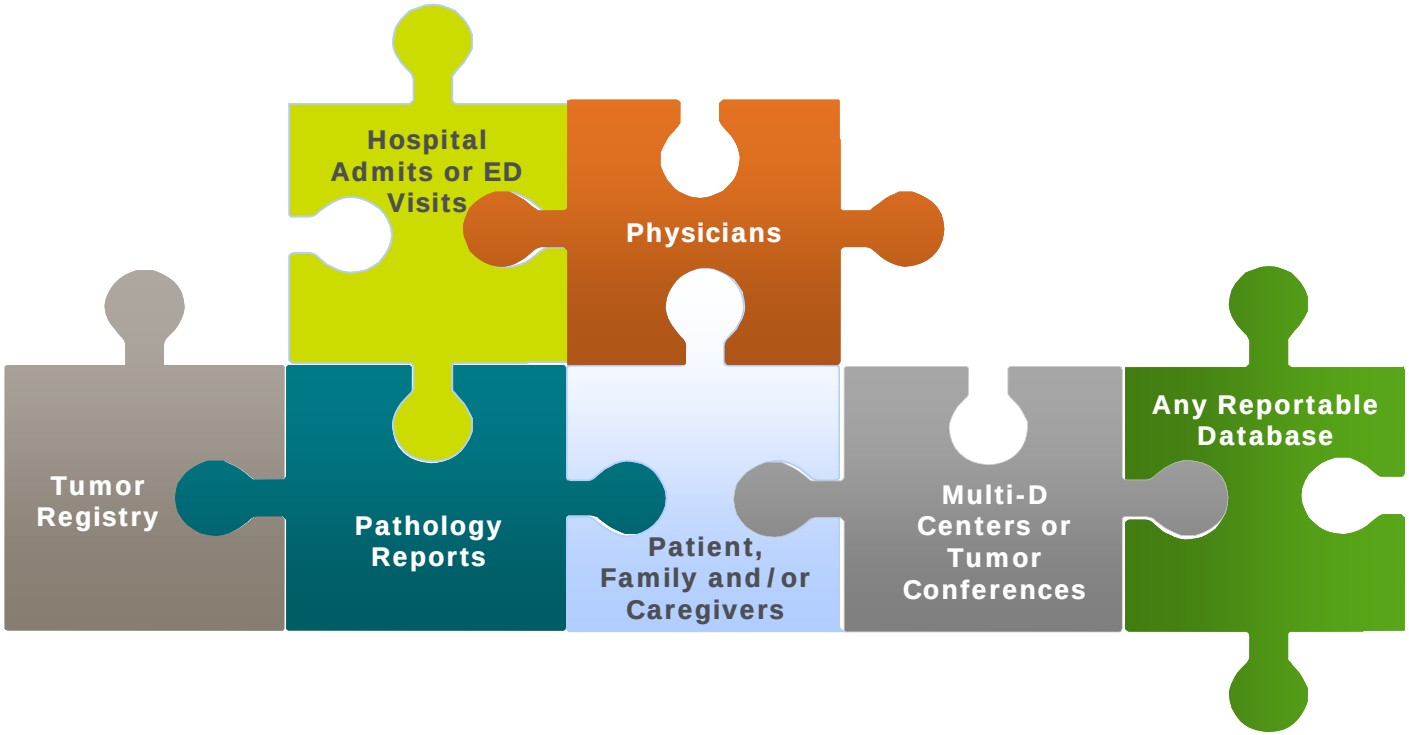
- Oncology clinical experience
- Excellent assessment and education skills
- Compassionate and caring
- Patient advocate
- Superb listening skills
- Flexible and easily adaptable to change
- Supportive, positive attitude
- Ability to multitask and prioritize
- Knowledge of community resources and support services

Navigator Roles & Responsibilities

- Coordinate the care of the patient and family from prediagnosis through survivorship or end-of-life services
- Improve patient outcomes through education, support, and performance improvement monitoring
- Collaborate and facilitate communication between patients, family/caregivers, and healthcare team
- Coordinate care among healthcare providers
- Ensure education and access to clinical trials
- Provide cancer program and community resources
- Participate in multidisciplinary centers, tumor conferences, and cancer committee

Navigation Referrals

Patients enrolled in your navigation program should be under active treatment.



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Commission on Cancer Standards

In today's healthcare environment, the CoC:

- Establishes standards to ensure quality
- Conducts surveys to assess compliance with those standards
- Collects standardized high-quality data from CoC-accredited healthcare settings
- Uses data to measure cancer care quality and to monitor treatment patterns and outcomes
- Supports and enhances cancer control
- Monitors clinical surveillance activities
- Develops education interventions to improve cancer prevention, early detection, care delivery, and outcomes in healthcare settings

Commission on Cancer

https://www.facs.org/quality-programs/cancer/coc/standards

Continuum of Care

New as of 2015

Standard 3.1:
Patient Navigation Process

Standard 3.2:
Psychosocial Distress Screening

Standard 3.3:
Survivorship Care Plan

A patient navigation process, ***driven by a community needs assessment, is established to address healthcare disparities and barriers to care for patients.*** *Resources to address identified barriers may be provided either onsite or by referral to community-based or national organization.* ***The navigation process is evaluated, documented, and reported to the cancer committee annually.*** *The patient navigation process is modified or enhanced each year to address additional barriers identified by the community needs assessment.*

COMMUNITY NEEDS ASSESSMENT

Prior to establishing the navigation process, the cancer committee conducts a community needs assessment ***at least once during the three-year survey cycle to identify the needs of the population served, potential to improve cancer health disparities, and gaps in resources.***

Continuum of Care

New as of 2015

Standard 3.1:
Patient Navigation Process

Standard 3.2:
Psychosocial Distress Screening

Standard 3.3:
Survivorship Care Plan

- *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.*

- ***Requirements:*** *Patients with cancer are offered screening for distress a minimum of one time per patient at a pivotal medical visit.*

Preferred time for administration is during a time of high distress, i.e., diagnosis, first medical oncology/chemotherapy, radiation oncology

Continuum of Care

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Survivorship Care Plan

Standard 3.3 targets only patients receiving curative treatment

The CoC supports the Institute of Medicine, National Coalition for Cancer Survivorship, and the NCI Office of Cancer Survivorship in the idea that "an individual is considered a cancer survivor from the time of cancer diagnosis through the balance of his or her life."

However, it clarifies that its standard is intended to cover those patients who have completed "active therapy (other than long-term hormonal treatment)." Patients should receive a plan, regardless of their disease site, but patients with metastatic disease are not targeted by the standard.

Survivorship Care Plan CoC Updates

Patients excluded (ineligible) from Standard 3.3 requirement include:

- Patients with Stage 0 or IV or metastatic disease, though survivors by varying definitions are not required to receive an SCP
- Patients who are pathologically diagnosed but never treated or seen for follow up by the accredited program are not required to receive an SCP from the facility providing diagnosis

Implementation of the standard and required percentage of SCPs provided must follow the schedule as outlined:

- End of 2017: Provide SCPs to ≥ 50 percent of eligible patients who have completed treatment
- End of 2018 and on: Provide SCPs to ≥ 75 percent of eligible patients who have completed treatment

Who can provide the SCP?

- *Physicians*
- *Registered nurses*
- *Advanced practice nurses*
- *Nurse practitioners*
- *Physician assistants*
- *Credentialed clinical navigators (does not include lay navigator)*

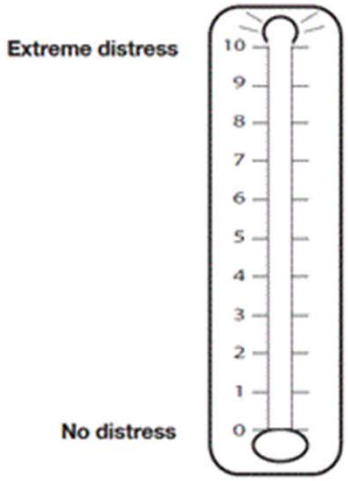
Standard 3.2: Distress Screening

National Comprehensive Cancer Network®

NCCN Distress Thermometer for Patients

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions

YES	NO	Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues

YES	NO	Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	Spiritual/religious concerns

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance abuse
❑	❑	Tingling in hands/feet

Other Problems: _____

What are your guidelines?

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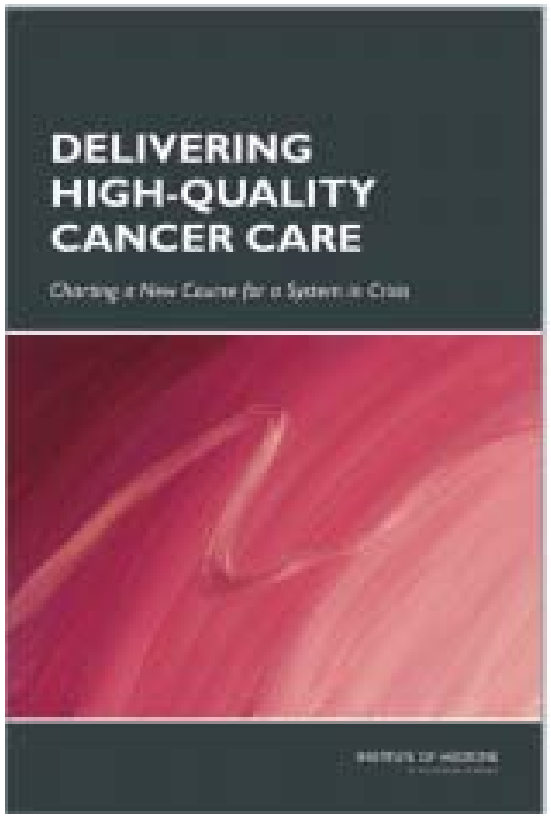
IOM Conceptual Framework



- Engaged patients
- Adequately staffed, trained, and coordinated workforce
- Evidence-based cancer care
- A learning healthcare IT system for cancer
- Translation of evidence into clinical practice, quality measurement, and performance improvement
- Accessible, affordable cancer care

Source: https://www.nationalacademies.org/hmd/Reports/2013/Delivering-High-Quality-Cancer-Care-Charting-a-New-Course-for-a-System-in-Crisis.aspx

IOM Goals of the Recommendations

- Provide clinical and cost information to patients
- Provide end-of-life care consistent with patient's values
- Develop coordinated, team-based cancer care
- Develop core competencies for the workforce
- Expand breadth of cancer research data
- Expand depth of cancer research data
- Develop a learning healthcare IT system for cancer
- Develop a national quality reporting program for cancer care
- Reduce disparities in access to cancer care
- Improve the affordability of cancer care

Source: https://www.nationalacademies.org/hmd/Reports/2013/Delivering-High-Quality-Cancer-Care-Charting-a-New-Course-for-a-System-in-Crisis.aspx

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AONN+ Mission and Vision

Mission: The mission of AONN+ is 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.

Cancer survivorship begins at the time of cancer diagnosis. One-on-one patient navigation should occur simultaneously with diagnosis and be proactive in minimizing the impact treatment can have on quality of life. Additionally, navigation should encompass community outreach to raise awareness targeted toward prevention and early diagnosis, and must encompass short-term survivorship care, including transitioning survivors efficiently and effectively under the care of their community providers.

Vision: The vision of AONN+ is 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.

Source: AONN+ https://www.aonnonline.org/about/mission-and-vision/

AOSW, NASW, and ONS Position Statement on Navigation

- Patient navigation processes, whether provided onsite or in coordination with local agencies or facilities, are essential components of cancer care services
- Patient outcomes are optimal when a social worker, nurse, and lay navigator (defined as a trained nonprofessional or volunteer) function as a multidisciplinary team
- Patient navigation programs in cancer care must address underserved populations in the community
- Patient navigation programs must lay the groundwork for their sustainability
- Nurses and social workers in oncology who function in patient navigator roles do so based on the scope of practice for each discipline

Source: http://www.socialworkers.org/pressroom/2010/Position%20on%20Patient%20Navigation%20BW.pdf

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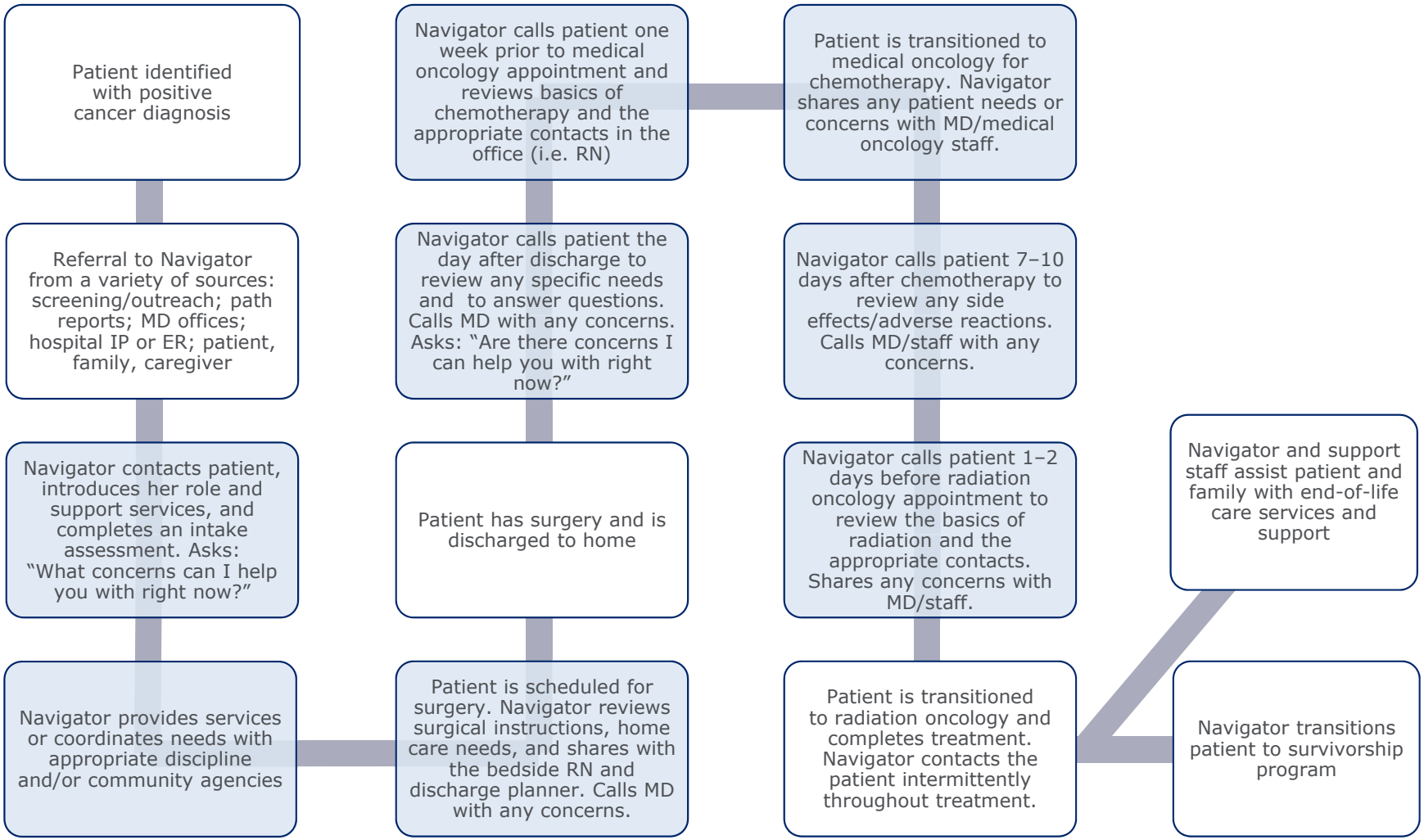
Patient Flow & Managing Transitions

Managing and coordinating the care of the patient, family, and/or caregiver across the continuum sounds simple but most programs do not share patient information as well as they perceive they do. It is extremely important to communicate the assessments, needs, and barriers of the patient, family, and/or caregiver with all appropriate departments, support staff, and MD offices.

- **Great activity: Create disease site–specific process maps**
- **Goal: Increase communication among the healthcare team and decrease duplication for the patient**

SAMPLE Patient Navigation Algorithm



Managing Transitions

DO

- ✓ Create morning meetings to share information across the continuum; invite navigators, social workers, discharge planners, dietitian, pastoral care, etc.
- ✓ Invite your internal and external resources to attend your meetings to provide updates, i.e., finance department, pastoral care, community agencies, etc.
- ✓ Cross train the navigation staff to cover for vacation, time out of the office, and emergencies
- ✓ Create navigation toolkits by disease site for cross training
- ✓ Assign the navigator by disease site and complexity of needs
- ✓ Review the complexity of the disease site for navigation; the higher the complexity, the lower the caseload

DON'T

- ☒ Do not create silos by assigning navigators to a specific department or office setting, i.e., radiation therapy
  - o *A consistent navigator assigned by disease site across the continuum will pick up on little changes/ concerns that can be addressed in a timely manner. These small changes that can be addressed immediately with the patient, family, and/or caregiver will prevent bigger issues from developing later.*
  - o *The navigator functions as a safety net to ensure there are no breaks in treatment and that appropriate referrals are being coordinated with the support staff or other members of the healthcare team.*
- ☒ Be careful not to assign all poorer prognosis late-stage patients to a particular navigator; this will cause potential burnout and assignment fatigue

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Value-Based Cancer Care

- Federal healthcare reform and reimbursement
- The Centers for Medicare & Medicaid Services (CMS) quality measures
- Affordable care organizations (ACOs), oncology medical homes, and bundled payments
- NCI Community Oncology Research Program (NCORP) research related to: symptom and treatment-related toxicities, post-treatment surveillance, over- and under-diagnosing, social factors, financing systems, organizational structure, health technologies, and individual behaviors
- Future reimbursement models for medical care based on quality measures rather than fee for service
- Patient-Reported Outcomes Measurement Information System (PROMIS), which standardizes health-related patient-reported, patient-centered measures
- And so much more . . .

Pilot Projects Driving OCM

OPCMH Oncology Patient Centered Medical Home®

- *Began in 1997*
- *Nine physician oncology practices in PA*
- *29% increase in patient volume since 2009—with the same number of physicians and a decrease in office staff*
- *51% drop in emergency room visits*
- *68% drop in in-patient admissions*
- *95% adherence to NCCN Guidelines for first line therapy*

COME HOME
$20M CMS Innovation grant award in 2012
Community oncology medical home
7 community oncology practices

What is OCM?

The Center for Medicare & Medicaid Innovation (CMS Innovation Center) is developing new payment and delivery models designed to improve the effectiveness and efficiency of specialty care. Among these specialty models is the Oncology Care Model (OCM), which aims to provide higher-quality, more highly coordinated oncology care at the same or lower cost to Medicare.

Goals of the Oncology Care Model

Cancer diagnoses comprise some of the most common and devastating diseases in the United States; more than 1.6 million people are diagnosed with cancer each year in this country. Through OCM, the CMS Innovation Center has the opportunity to achieve three goals in the care of this medically complex population: better care, smarter spending, and healthier people.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
Oncology Care Model

Oncology Care Model Practice Redesign

The practices participating in OCM have committed to providing enhanced services to Medicare beneficiaries, such as care coordination, navigation, and national treatment guidelines for care.

Participating practices must commit to implementing the six practice redesign activities, which are integral to OCM participation:

- 24/7 clinician availability with real-time access to patients' medical records
- Certified EHR Technology
- Use of data for continuous quality improvement
- Patient navigation
- Individualized care plans with the 13 components in the Institute of Medicine Care Management Plan
- Therapies compliant with nationally recognized clinical guidelines

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Create data definitions for your reports to ensure continuity among the staff

- Community needs assessment
- Psychosocial distress screening
- Barriers to care and interventions provided
- Caseloads/Volumes (new cases, open cases, and closed cases)
- Tracking support services provided
- Patient experience survey
- Navigation metrics for patient experience, clinical outcomes, and return on investment

Care Coordination/Care Transitions

Metric	Definition	Patient Experience (PE), Clinical Outcomes (CO), Return on Investment (ROI)
Treatment Compliance	Percentage of navigated patients that adhere to institutional treatment pathways per quarter	ROI, CO
Barriers to Care	Number and list of specific barriers to care identified by navigator per month Barriers to care definition: Obstacles that prevents a cancer patient from accessing care, services, resources and/or support.	PE, CO
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	PE, CO
Clinical Trial Education	Number of patients educated on clinical trials by the navigator per month	PE, CO
Clinical Trial Referrals	Number of navigated patients per month referred to clinical trial department	PE, CO
Patient Education	Number of patient education encounters by navigator per month	PE, CO, ROI
Diagnosis to Initial Treatment	Number of business days from diagnosis (date pathology resulted) to initial treatment modality (date of 1st treatment)	PE, CO
Diagnosis to 1st Oncology Consult	Number of business days from diagnosis (date pathology resulted) to initial oncology consult (date of 1st appointment)	PE, CO

Research, Quality, Performance Improvement

Metric	Definition	Patient Experience (PE), Clinical Outcomes (CO), Return on Investment (ROI)
Patient Experience/ Patient Satisfaction with Care	Patient experience or patient satisfaction survey results per month (utilize institutional specific navigation tool with internal benchmark)	PE
Navigation Program Validation Based on Community Needs Assessment	Monitor one major goal of current navigation program annually as defined by cancer committee Example: Population Served	PE, CO, ROI
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). Define modality: Chemotherapy, surgery, radiation therapy, endocrine therapy, and biotherapy	PE, CO
Diagnostic Workup to Diagnosis	Number of business days from date of abnormal finding to pathology report for navigated patients Definition for abnormal finding: Number of business days from abnormal finding diagnostic work up (date of work up) to diagnosis (date pathology resulted)	CO

Operations Management, Organizational Development, Health Economics

Metric	Definition	Patient Experience, Clinical Outcomes, Return on Investment
30, 60, 90 day readmission rate	Number of navigated patients readmitted to the hospital at 30, 60, 90 days. Report quarterly.	ROI
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.	ROI
Navigation Caseload	Number of new cases, open cases, and closed cases navigated per month Definitions • New cases: New patient case referred to the navigation program per month • Open cases: Patient case that remains open/month • Closed cases: Number of patient cases closed per month. Formal closing of a patient case from the navigation program.	ROI
Referrals to Revenue Generating Services	Number of referrals to revenue-generating services per month by navigator	ROI
No Show Rate	Number of navigated patients who do not complete a scheduled appointment per month	ROI
Patient Retention through Navigation	Number of analytic cases per month or quarter that remained in your institution due to navigation	ROI
Emergency Room Utilization	Number of navigated patients' visits to the emergency room per month	ROI
Emergency Admissions Per Number of Chemotherapy Patients	Number of navigated patient visits per 1,000 chemotherapy patients who had an emergency room visit per month	ROI

Community Outreach, Prevention

Metric	Definition	Patient Experience (PE), Clinical Outcomes (CO), Return on Investment (ROI)
Cancer Screening Follow Up to Diagnostic Work Up	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.	PE, CO, ROI
Cancer Screening	Number of participants at cancer screening event and/or percentage increase of cancer screening	PE, CO
Completion of Diagnostic Work Up	Number of navigated individuals with abnormal screening that completed diagnostic work up per month/quarter	CO, ROI
Disparate Population at Screening Event	Number of individuals per quarter at community screening events by OMB Standards Disparate population definition: The National Institute on Minority Health and Health Disparities definition is 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) OMB definition: Office of Management and Budget	PE, CO

Professional Roles and Responsibilities

Metric	Definition	Patient Experience (PE), Clinical Outcomes (CO), Return on Investment (ROI)
Navigation Knowledge at Time of Orientation	Percentage of new hires who have completed institutionally developed navigator core competencies	CO
Oncology Navigator Annual Core Competencies Review	Percentage of staff who have completed institutionally developed navigator core competencies annually to validate core knowledge of oncology navigation	CO

Psychosocial Support, Assessment

Metric	Definition	Patient Experience (PE), Clinical Outcomes (CO), Return on Investment (ROI)
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 Psychosocial Distress Screening Thermometer	PE, CO
Social Support Referrals	Number of navigated patients referred to support network per month	PE, CO, ROI

Patient Empowerment, Patient Advocacy

Metric	Definition	Patient Experience (PE), Clinical Outcomes (CO), Return on Investment (ROI)
Patient Goals	Percentage of analytic cases per month that patient goals identified and discussed with the navigator	PE, CO, ROI
Caregiver Support	Number of caregiver needs/preferences discussed with navigator per month	CO
Identify Learning Style Preference	Number of navigated patients per month that preferred learning style was discussed during the intake process Learning styles: • Visual (spatial): You prefer using pictures, images, and spatial understanding • Aural (auditory-musical): You prefer using sound and music • Verbal (linguistic): You prefer using words, both in speech and writing • Physical (kinesthetic): You prefer using your body, hands, and sense of touch • Logical (mathematical): You prefer using logic, reasoning, and systems • Social (interpersonal): You prefer to learn in groups or with other people • Solitary (intrapersonal): You prefer to work alone and use self study	PE, CO

Survivorship and End of Life

Metric	Definition	Patient Experience (PE), Clinical Outcomes (CO), Return on Investment (ROI)
Survivorship Care Plan	Number of navigated patients (patients with curative intent) per month who received a survivorship care plan and treatment summary	PE, CO
Transition from Treatment to Survivorship	Percentage of navigated analytic cases per month transitioned from completed cancer treatment to survivorship Define care transitions: "the movement patients make between healthcare practitioners and settings as their condition and care needs change during the course of chronic or acute illness"	PE, CO
Referrals to support services at the survivorship visit	Number of navigated patients per month referred to appropriate support service at the survivorship visit	PE, CO, ROI
Palliative Care Referral	Number of navigated patients per month referred for palliative care services	PE, CO, ROI

Communicating with the Healthcare Team

- Verbal updates on patient status
- Patient rounds
- Multidisciplinary team meetings
- Tumor conferences
- Tumor site teams
- Electronic medical record/plan of care
- E-mail
- Patient portal
- All communication is good!

Discussion

Patients First

Thank you