The Role of the Nurse Navigator in Quality Outcomes & Measurements

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Objectives

- List best practices for using metrics within a navigation program to improve nursing performance and quality of care for cancer patients.

- Define strategies used to measure the intensity of nursing care required by individual patients.

- Describe processes and procedures for actively tracking the use and success of those strategies.

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Disclosure

- BTG International, Nursing Advisory panel

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WHY Navigation Matters…

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Nursing Role in Quality Cancer Care

- Past: Institute of Medicine (IOM) Report: *Future of Nursing: Leading Change, Advancing Health*

- Present: Commission on Cancer
  - Standard 3.1 Patient Navigation Process
- Future: CMS introduction of the Oncology Care Model (OCM)

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Reviewing the Literature

- Patient Navigation Research Program (2006-2009)
  - 10,000 individuals with abnormal cancer screenings randomized to navigation vs usual care
  - Disparities existed in population served
  - Outcome: Diagnostic resolution higher in navigation group vs control
    (84 % vs 79 %; p<0.001)
  - Added cost $275/patient
- Case (2010)- review of 18 primary nursing research studies specific to validating the nurse navigator role in continuity of care.
  - Synergy Model framework- primary outcome is to “provide safe passage” for patients and families through the healthcare system.
  - Outcomes data varied – patient satisfaction, timeliness to care, coordination of care

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Reviewing the Literature

- Crane-Okada (2013) – summary of 9 systematic review articles with patient navigation outcomes reported with additional 14 studies of Patient Navigation by an Oncology Nurse (PNON)
  - Community Needs Assessment- ID Barriers/Needs of population served
  - Evaluation Measures “descriptive- processes”
  - Outcome Measures “short or long term”

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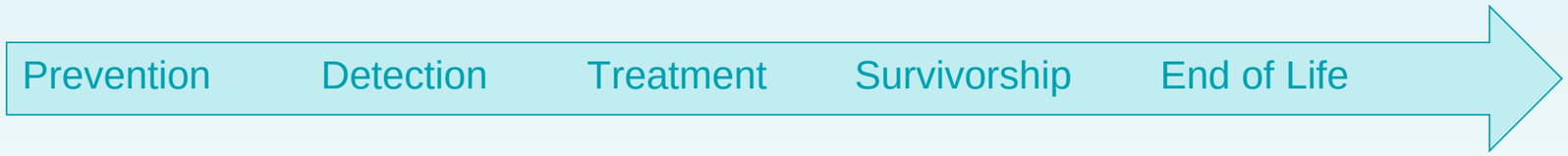
Gaps in Research

- Lack of evidenced based metrics to decrease mortality /long term outcomes

- Lack of proven economic impact

- Specific outcomes measures along the care continuum
  - Research in screening – limited in other phases



- Research in Lay vs PNON model- Is there a difference?

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Navigation Program Outcomes Reported

- Patient Volumes
- Referral Sources to Navigation
- Timeliness to care- Diagnosis and Treatment
- Number of Barriers to Care
- Overall Patient satisfaction/Retention/Outmigration
- Provider Satisfaction-Gaps/Needs identified/engagement Screening/Prevention/Outreach
- Care Coordination/ Transitions of care throughout the continuum
- Education/Advocacy/ Literacy/Learning style
- Referrals to clinical trials, supportive therapies, psychosocial support

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Classification of Outcome Metrics

- Patient reported
  - Experience
  - During Transitions
- Clinical Outcomes
  - Evidenced based practices to Improve outcomes
  - Education/Timeliness/Compliance/NCCN Guidelines
- Business/ Return on Investment (ROI)
  - Downstream Revenue, Cost savings

AONN Standardized Metrics 2017

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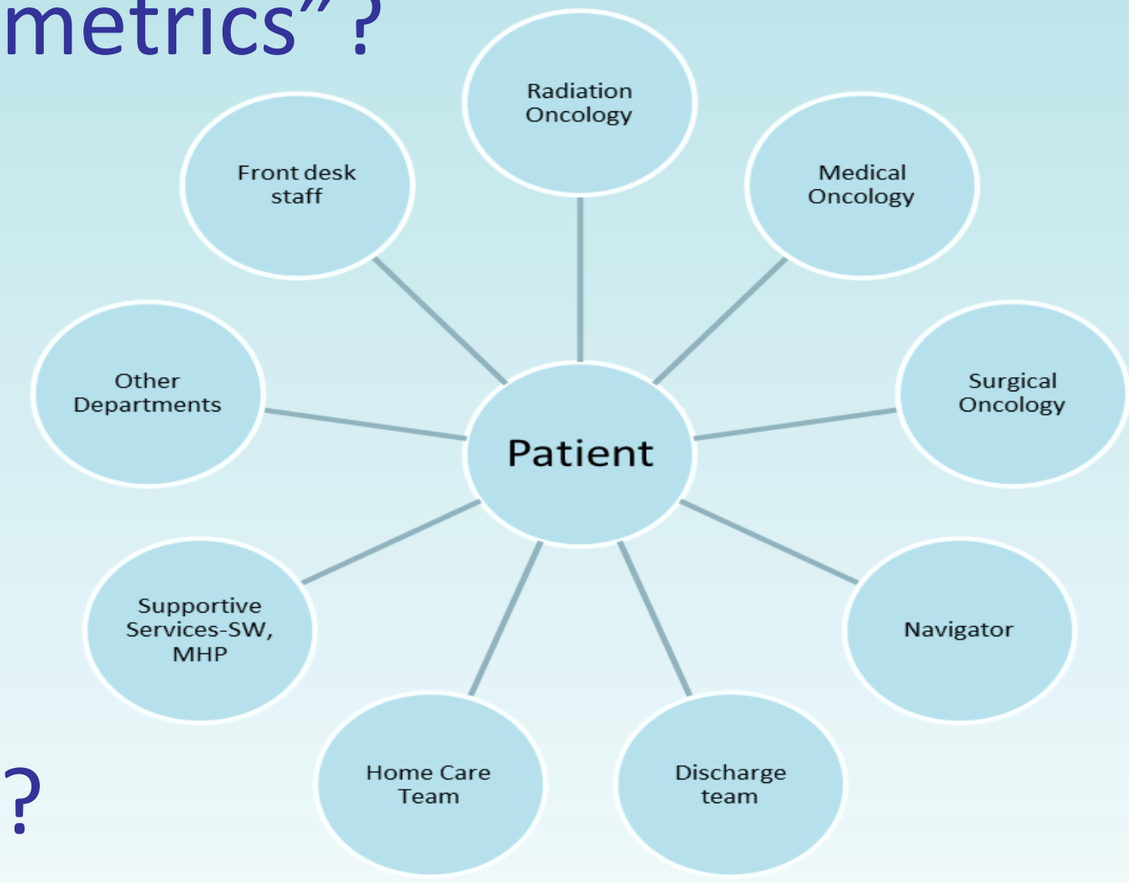
Decisions to Make

- How do you choose the “right metrics”?
- How many?
- How long do you track?
- How easy is it to collect?
- Who collaborates with you?
- What are your stakeholders and administrators asking for?



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Our Choices: 2014 Performance Metrics

Performance Metrics	
Outcome	**Measure of Success**
Time from diagnosis to treatment	Multidisciplinary team data collection
Accruals to clinical trials	Clinical Trials Officedata
Increase in patient volumes	Navigator data collection
Increase in early stage disease	A - Registry decrease in late stage cancer diagnosis B -Decrease in cancer mortality
Improved patient access / elimination of barriers	Decrease in avoidable ED and hospital admits
Provide culturally competent care	Increase in referrals to support programs
Survivorship	Increase in referrals to support programs
Patient Satisfaction	HCAHPS Scores, Admin surveys 2X per year
Physician Satisfaction	Admin surveys 2X per year
Increased patient retention	Navigator to track data
Decrease out-migration	Marketing surveys
Increase in patient recruitment / direct referrals	Navigator to track data
Std. 3.1 - ACOS COC Accreditation	Compliant by 2015
Increase in patients screened	Cancer Services Outreach tracking
Decrease in psychosocial distress screening scores (PDS)	A - Navigation vs those without navigation - chart audits B - Initial PDS vs PDS at D/C

Tracking specific metrics with clear measures of success

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Our Choices: 2016 Outcome Measures

- Increase in patient volumes/coordinated care
- Care closer to home
- Patient Satisfaction
- Physician Satisfaction
- Increase in Patient recruitment/retention/direct referrals
- Decrease in ED visits and readmissions

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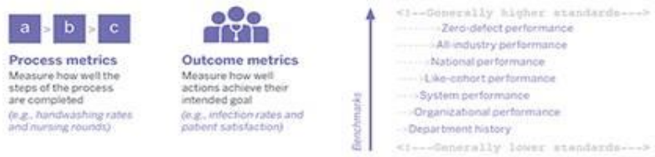
HOW TO BE Data-Driven

Data is everywhere, but it can be challenging to harness it to improve your performance. Use these **five principles** to better incorporate data into your everyday work life.

Data lets you see the world more clearly

"Be data-literate"

Understand what you're measuring and make it meaningful. First, decide what type of metric you're using, and **give that data context** by establishing benchmarks with varying frames of reference. Then, **compare your subject to similar targets**. How these items relate to each other greatly enhances your understanding.



Data tells you what works—and what doesn't

"Be curious"

SET UP TESTS (whenever possible)
Using analytic tools to build tests and experiments is great.

USE THE TOOLS (the ones you have)
The basic resources of today's electronic office are enough to start evaluating data.

SIMPLIFY (if you can)
Strive to reorganize your data so comparisons are more direct and data makes more sense.

ASK YOURSELF

WHAT'S MOST? & WHAT'S LEAST?

HOW MANY? & HOW MUCH?

<#=>
<$=>

Data keeps you focused on your goals

"Be action-oriented"

Think beyond descriptive, contextualized, and insightful analysis. The best way to ensure that you are being action-oriented is to push your observations past "what happened?" to "so what?" and **"what do we do about it?"**

Descriptive	Contextualized	Insightful	Action-oriented
"The readmission rate was 3.0% this month."	"The readmission rate was 3.0% this month, up from last quarter's average of 2.5%."	"The readmission rate was 3.0% this month, up from last quarter's average of 2.5%; the patients most likely to be readmitted are the ones who didn't take the pre-op course."	"We need to make the pre-op course mandatory! The readmission rate was 3.0% this month, up from last quarter's average of 2.5%; the patients most likely to be readmitted are the ones who didn't take the pre-op course."

Data helps you prove your point

"Be communicative"

It's easy to feel constrained by existing management structures and information flows, but **you can achieve data-driven progress with less formal efforts.** Informally sharing data-driven insights in person, or proactively reporting on metrics individually, can be very powerful.

Send a timely one-off email about what you've learned—and what ought to happen as a result

Informally share your data-driven insight at a meeting

Make a regular data report update and email it to your stakeholders

Create a presentation of your insights

Set a goal based on a metric you can both track and inflect, and report on progress

Teach others to find insights in data as well

Data helps you prove your value

"Be skeptical"

If you are refining your own data-driven conclusions or looking at the conclusions of others, **ask these essential questions:** Does the data track the right metrics? Has it been collected and categorized accurately? Is the analysis sound? Is the data presented clearly?

IMPORTANT QUESTIONS

Have I drawn the right conclusions?
- Is this data shown objectively?
- Is the metric better represented as a percentage as opposed to an absolute number (or vice versa)?

Am I looking at these results correctly?
- Is the difference we've observed as big as it looks?
- Is the difference statistically significant?
- Have we accounted for a margin of error?

Are these good goals and benchmarks?
- Are our goals sufficiently ambitious?
- Are our goals sufficiently realistic?
- Are we comparing ourselves to the right peers?

Do I have the right metrics?
- Are we focused on the right outcomes?
- Does what we're measuring reflect those outcomes?
- Does what we're measuring help us understand the success of our tactics?

Is this data accurate?
- Is this data timely?
- Is this data reported honestly?
- Has this data been collected accurately?

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- Develop Metrics
- Perform Some Tests
- Take Action with Your Insights
- Let Management Know
- Continuous Improvement

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Defining Data Collection & Tracking

- Moonshot Data- are we ready?
- MS Access database
- Manual forms/ Excel spreadsheet
- Web based Software products
- Tool embedded in Electronic Medical record
- Innovative technology needed
  - Patient portals (My chart)
  - Patient Relationship Management(PRM)

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Case study- Best Practice for Improvement

- Volumes of data collected

- Streamlined

- GOAL- Benchmark – accurate data easy to report and analyze and align with outcomes

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Vidant Cancer Care Acuity Tool

0	Navigation services not needed
1	Low: Up to 10 minutes • Uncomplicated guidance/education coordination • Brief follow up call • Refill • Appointment assistance • Form or letter completions
2	Moderate: Greater than 11 minutes, less than 45 minutes • Multimodality treatment coordination and education including arrange/transfer care • Language barrier - but has family member to translate and interpreter available at appointments • Lives alone but has support • Symptom management required over phone • Difficulty coping of patient and/or caregiver • Distress > 6 on scale • Coordination of care issues: Incarcerated – complex appointments • Missed appointments/treatment noncompliance • Second opinion/Transplant eval/Transfer care uncomplicated
3	High: Greater than 46 minutes, MORE complicated coordination of care • Multimodality treatment coordination & education with complex issues such as lack of insurance, lack of support, low health literacy, language barrier (living alone without family member to translate) • Lives alone or homeless without support and has poor performance status and/or co morbidities • Symptom management - requiring visits to MD with complex coordination and possible admissions • Maladaptive coping with addiction issues, history of mental health issues • Missed greater than 2 appointments • Second opinion/Transfer care/Transplant evaluation - more complicated

Navigation Intervention Form in EPIC

6/18/2015 visit with Koutlas, Judy, RN for Navigator

Resize

Images | Questionnaires | Admin | Benefits Inquiry | References | Scans | Dictations | Open Orders | Care Teams | Print AVS | Preview AVS | Pt Declined AVS | More

Charting
- Contacts
- Chief Complaint
- Care Teams
- Home Medications
- Distress Screening
- **Intervention Form**
- Progress Notes
- History

MyChart
- MyChart Sign-up
- Pt Reminder

Orders
- **BestPractice**
- SmartSets
- Visit Diagnoses
- Meds & Orders
- Dx and Orders
- Enter Results

Discharge
- Follow-up
- Charge Capture
- Close Encounter

Intervention Form - Oncology Navigator Intervention Form

Time taken: 1320 6/23/2015 Show: All Choices

Values By

Intake

Location of Visit	Inpatient	Clinic/Office	Telephone	Email	Outpatient infusion	Outside provider office	Other
Visit Diagnosis	Brain	Breast- malignant	Breast- non malignant	Diagnosis pending	GI- malignant	
	GI- non malignant	GU	GYN	Head/Neck - malignant	Head/Neck - non mali...	
	Heme - malignant	Heme - non malignant	Melanoma/Skin	Sarcoma	Thoracic - malignant	
	Thoracic - non malign...	Other				
Home situation	Lives alone	Lives with other who is able to assist	Lives with other who is unable to ass...			
	Lives in own house	Lives in apartment	Lives in Assisted Living Facility			
	Lives in Nursing Home	Home Care is involved	Additional information			
Patient needs and barriers to care	Cultural needs	Coordination of Care	Distance for care	Knowledge deficit	Emotional issues/Fear/Anxiety	End of life concerns
	Financial concerns/disability	Low health literacy	Medication assistance	Practical needs/family problems (housing/living alone)		
	Symptom management	Transportation	Housing (living alone, homeless, incarcerated)	No barriers identified		
Referral Source	Health Professional	Inpatient	Outpatient	Outside provider	Referral Coordinator	Toll Free number	Website	EHR referral
	Self/Caregiver	Other				

Interventions

General Interventions/Referrals	Advanced directives/HCPOA	Assistance program	Cancer prevention/screening	Care closer to home	Clinical Trials	
	Counseling/Emotional support	Education (include prescription assistance)	Established care due to Navigator	Financial counselors		
	Genetic counselors	Home care/Hospice/Pallative care	Lodging	MDC coordination	Navigator	Outpatient appointment
	Prevention of ED visit	Primary Care provider/clinic	Prevention of hospitalization	Return from second opinion	Second opinion	
	Smoking cessation/Alcohol/Substance abuse program	Social worker/Case manager/Public Health	Support/Survivorship program			
	Supportive therapies	Transfer/Establish care	Transplant	Transportation assistance		

Continuum of Care

Continuum of Care	Detection up to Diagnosis	Diagnosis/Active Treatment	Surveillance	Non-cancer	End of life

Restore | Close F9 | Cancer | Previous F7 | Next F8

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Time taken: 1457 | 3/30/2016 | Show: All Choices

Values By

Intake

Type of Visit	Initial Evaluation; Recheck; Record Review; Advice Only
Location of Visit	Inpatient; Clinic/Office; Telephone; Email; Outpatient infusion; Outside provider office; Other (specifiy in comments)
Referral Source	Health Professional - Inpatient; Health Professional - Outpatient; ide provider; Referral Coordinator; Toll Free number; Website; EHR referral; Self/Caregiver; Other
Visit Diagnosis	Brain; Breast- malignant; Breast- non malignant; Diagnosis pending; GI- malignant; GI- non malignant; GU; GYN; Head/Neck - malignant; Head/Neck - non malignant; Heme - malignant; Heme - non malignant; Melanoma/Skin; Sarcoma; Thoracic - malignant; Thoracic - non malignant; Other (specify in comments)
Home situation	Lives alone; Lives with other who is able to assist; Lives with other who is unable to assist; Lives in Assisted Living Facility; Lives in Nursing Home; Home Care is involved; Other (specifiy in comments)
Patient needs and barriers to care	Cultural needs; Coordination of Care; Distance for care; Knowledge deficit; Emotional issues/Fear/Anxiety; End of life concerns; Financial concerns/[illegible]ility; Low health literacy; Medication assistance; Caregiver/Family issues; Symptom management; Transportation; Incarcerated; No barriers identified

Interventions

General Interventions/Referrals	Advanced directives/HCPOA; Assistance program; Cancer prevention/screening; Care closer to home; Clinical Trials; Counseling/Emotional support; Education (include prescription assistance); Established care due to Navigator; Financial counselors; Genetic counselors; Home care/Hospice/Pallative care; Lodging; MDC coordination; Navigator; Outpatient appointment; Prevention of ED visit; [illegible]are provider/clinic; Prevention of hospitalization; Return from second opinion; Second opinion; Smoking cessation/Alcoho[illegible]nce abuse program; Social worker/Case manager/Public Health; Support/Survivorship program; Supportive therapies; Transfer Care; Transplant; Transportation assistance
Transfer Care	Vidant Facility; Other (specify in comments)
Supportive Therapies	PT; OT; Dietician; Mental Health; Speech; Lymphedema; Fertility; Ostomy; Chaplain; Prosthetic Device / Fittings; Other (specify in comments)

Acuity Scale

Acuity Scale	0; 1; 2; 3

Continuum of Care

Continuum of Care	Outreach/Screening; Abnormal Finding to Diagnosis; Diagnosis to Treatment; Survivorship; End of life

Restore | Close F9 | Cancel | Previous F7 | Next F8

Navigation Data

Auto-Populated

- Name
- MRN
- Gender
- Age
- Race
- County
- Insurance
- Navigator

Navigator Selected

- Type of Visit
- Location of Visit
- Referral Source
- Diagnosis
- Barriers/Needs
- Interventions/Referrals
- Home Situation
- Acuity Scale
- Continuum of Care

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Scorecard Development
Observed to Expected (O-E)

VMC Navigation O-E Scorecard

December 2015

Timely Access to Care (% Patients seen < 7		
	December	YTD
% < 7 Days		
Chart Reviews	92	1851

New by Navigator - December						
Chelsea	Deb	Janet	Judy	Kim	Teresa	**Totals**
17	16	4	3	16	14	**70**

Disease Site Encounters - December												
Brain	Breast	Dx Pending	GI	GYN	GU	Head/Neck	Heme	Melanoma	Other	Sarcoma	Thoracic	**TOTAL**
9	138	63	138	3	14	28	137	28	9	5	83	**655**

Summary of Encounters - December							
New	Returning	Refer/Advice Only	**Total**	YTD New	YTD Returing	YTD Refer/Advice Only	**YTD Totals**
70	444	70	**584**	743	5874	626	**7243**

Assistance Program Referral		
	MTD	YTD
	37	443

Patient Recruitment & Retention - December					
	MTD	YTD		**MTD**	YTD
Established care due to Nav	1	22	Second Opinion - Duke	0	10
Self Referral	0	21	Second Opinion - UNC	0	11
			Second Opinion - Outside Facility	0	6
			Second Opinion - VMC	0	9
			Second Opinion	3	7
			Return from Second Opinion	4	14
			TOTALS	**7**	**57**
Transfer Care - Out or at Other VH Site	0				
Transfer Care - Here	0				
Transfer/Establish Care	8				

Care Closer to Home - Nov		
	MTD	YTD
	46	502

Prevention of ED Visit - Nov		
	MTD	**YTD**
	8	53

Average Vidant ED cost for cancer dx (per visit) $61,670 x 42 “avoided” =$2,590,140 YTD savings

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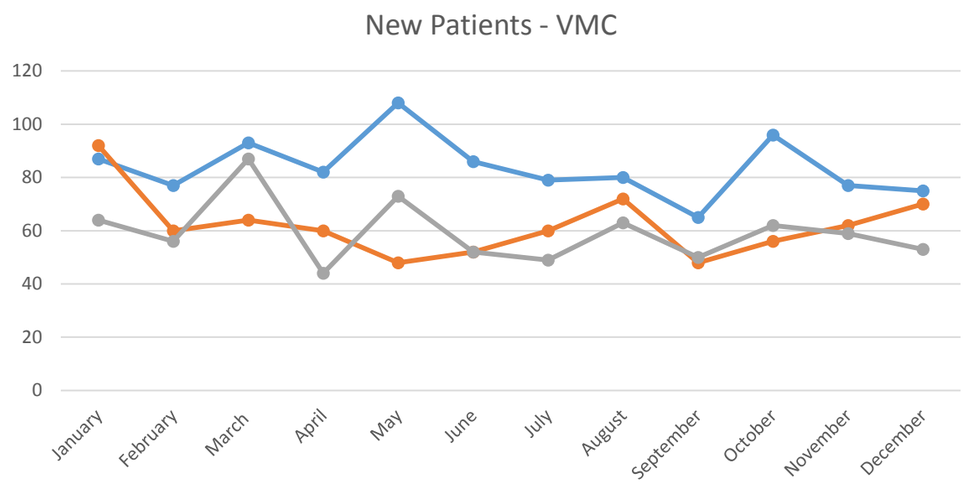
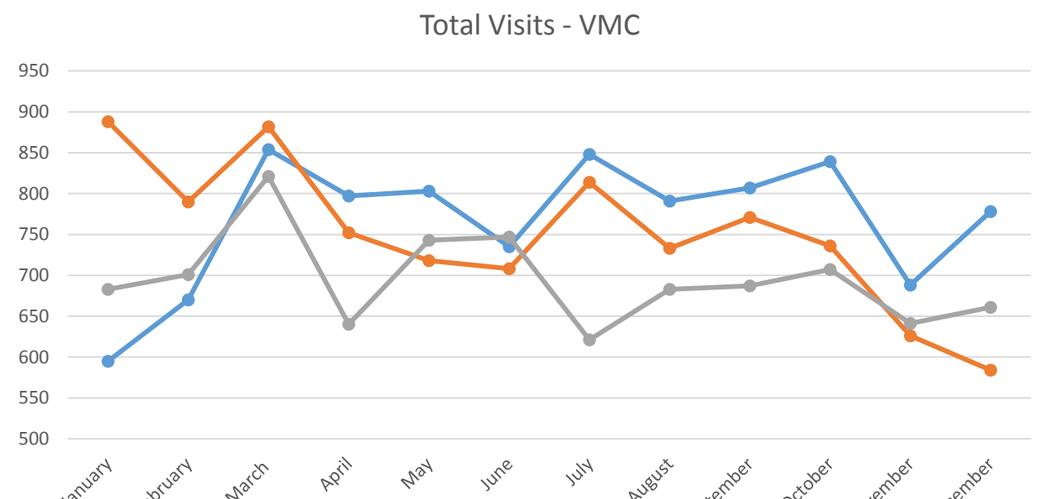
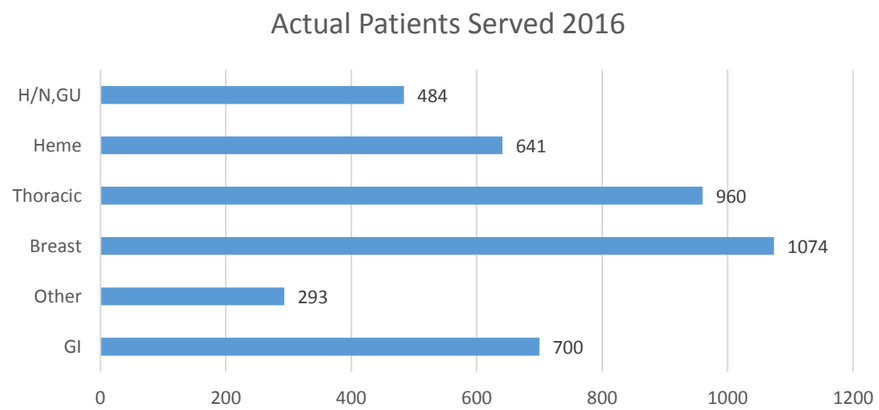
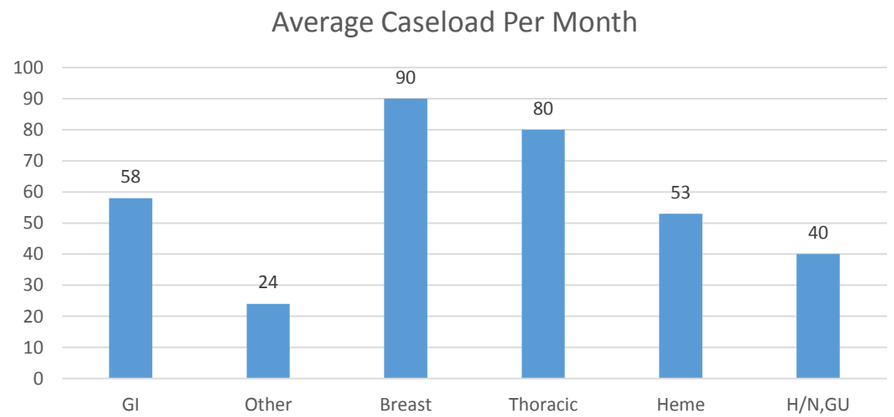
Vidant Cancer Care Navigation

VMC comparisons 2014-16









Mid 2015-early 2016: Data collection methods changed that may have resulted in inefficiencies/loss of reporting. Delay in IT summary and timely analysis noted.

Moving Forward with Outcomes

- Ability to analyze specific data within multidisciplinary teams across the healthcare system
- Standardization of data collection nationally within any EH
- Research opportunities with a national database
- Utilization of outcome measures to show ROI and for program expansions

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Standardization of Metrics – Is it Possible?

Yes

Evidence needed to establish that patient navigation improves outcomes and ensures high quality cancer care.

Align metrics with goals of program – institutional & national benchmarks and collect data to evaluate and measure.

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Vidant Cancer Tower- Opening March 2018
Serving 29 counties in Eastern NC

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Thank You

“We make a living by what we get, we make a life by what we give.”

– Winston Churchill