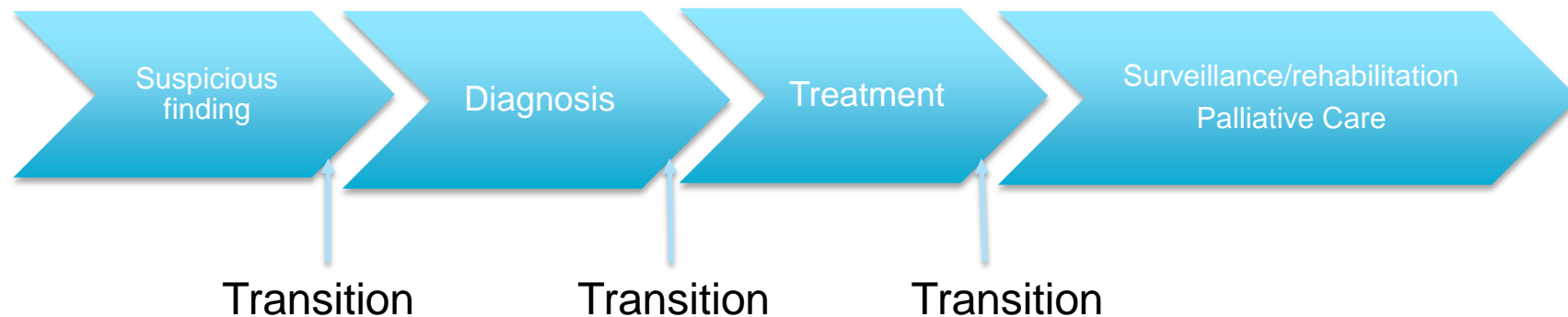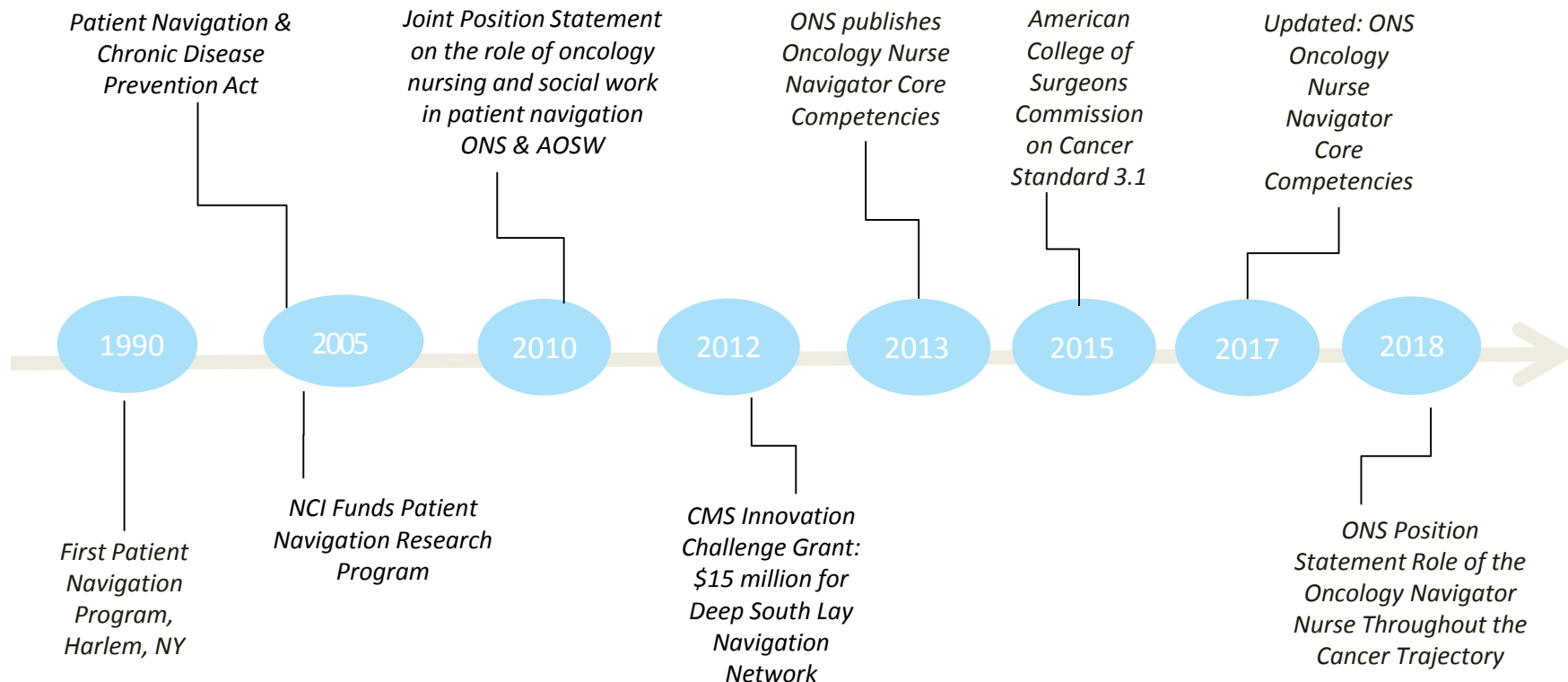# Objectives

- Identify key components of the role of oncology navigator/care coordinator across the cancer care continuum using examples from established, best practice programs

- Describe at least three actionable program planning strategies for new navigation programs and new navigators

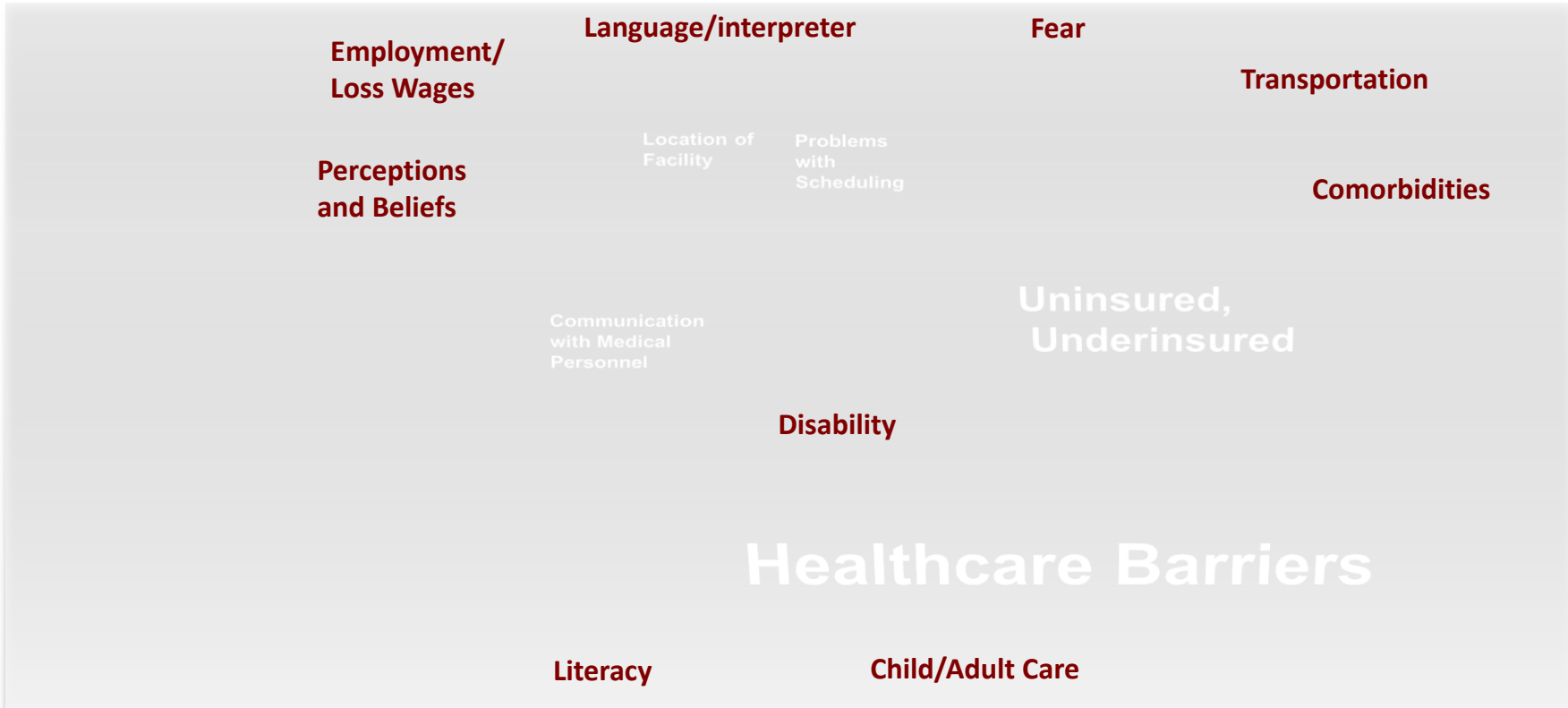# Patient Navigation Is Part of the Cancer Care Continuum

Survivorship

| Suspicious finding | Diagnosis | Treatment | Surveillance/rehabilitation Palliative Care |

Transition   Transition   Transition

Evolution of Patient Navigation

Patient Navigation & Chronic Disease Prevention Act

Joint Position Statement on the role of oncology nursing and social work in patient navigation ONS & AOSW

ONS publishes Oncology Nurse Navigator Core Competencies

American College of Surgeons Commission on Cancer Standard 3.1

Updated: ONS Oncology Nurse Navigator Core Competencies

1990 — 2005 — 2010 — 2012 — 2013 — 2015 — 2017 — 2018

First Patient Navigation Program, Harlem, NY

NCI Funds Patient Navigation Research Program

CMS Innovation Challenge Grant: $15 million for Deep South Lay Navigation Network

ONS Position Statement Role of the Oncology Navigator Nurse Throughout the Cancer Trajectory

State of Cancer Care in America: 2016

Cancer Progress vs Cancer Delivery

- Inconsistent health insurance coverage
- Rising financial burden
- Inadequate cancer workforce
- Access to care

Standard 3.1: Patient Navigation Process

- *Driven by a triennial Community Needs Assessment*
- *Is established to address health care disparities and barriers to cancer care*
- *Resources to address identified barriers may be provided either on-site or by referral*

Source: American College of Surgeons Commission on Cancer

Navigation Program Development

Community Cancer Needs Assessment
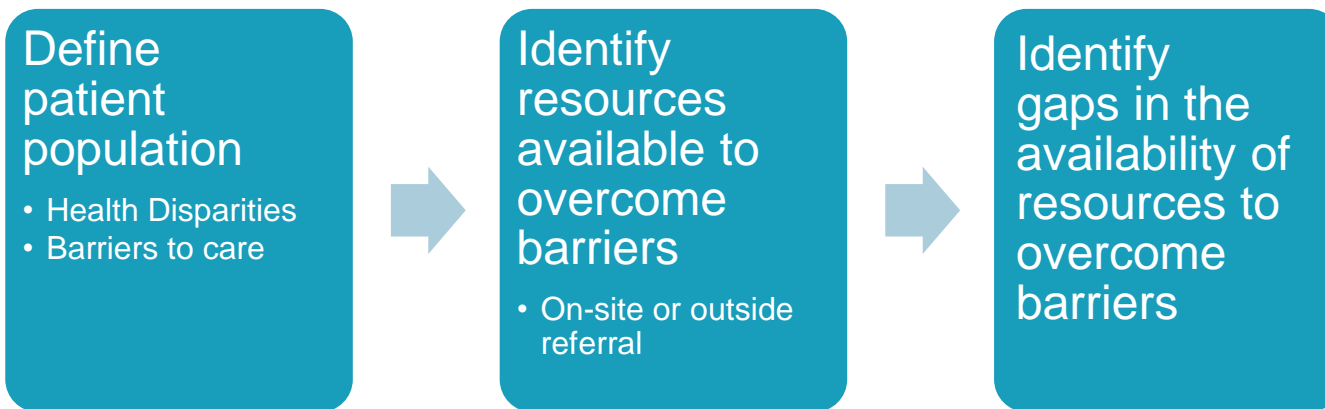
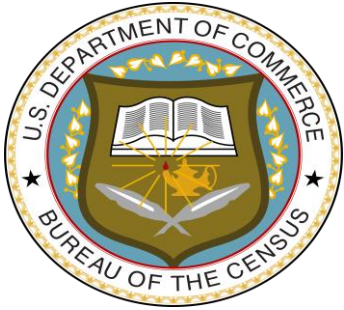Stakeholder Engagement

Determine Appropriate Model/Outcomes

Define Roles/Responsibilities/Competencies

Recruitment/Orientation/Retention

Tracking & Measuring Outcomes

Community Cancer Needs Assessment

Define patient population

- Health Disparities
- Barriers to care

→

Identify resources available to overcome barriers

- On-site or outside referral

→

Identify gaps in the availability of resources to overcome barriers

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Centers for Disease
Control and Prevention
National Center for
Health Statistics

CDC

NATIONAL CANCER INSTITUTE
NIH
Division of Cancer Control & Population Sciences

Assessing the Need for Navigation

- System issues and gap analysis
    - Current practice
    - Cancer tumor registry volume
    - Patient & Community needs - focus groups
    - Stakeholder perspective and concerns
    - Surveys
    - Town Hall Meetings

Stakeholder Engagement

Providers; Nurses	Administrators
Physician Leadership	Social Workers
Financial Counselors	Pastoral Care
Case Managers	Health Educator
Librarian	Survivors/Caregivers

Models of Navigation

Academic Center
Community Cancer Center
Community Outreach

Oncology Nurse Navigator/ Social Worker
Lay Patient Navigator
Community Health Worker

Prevention & Early Detection
Treatment
Survivorship

High Risk Navigation
AYA
Geriatrics
ED
Palliative Care
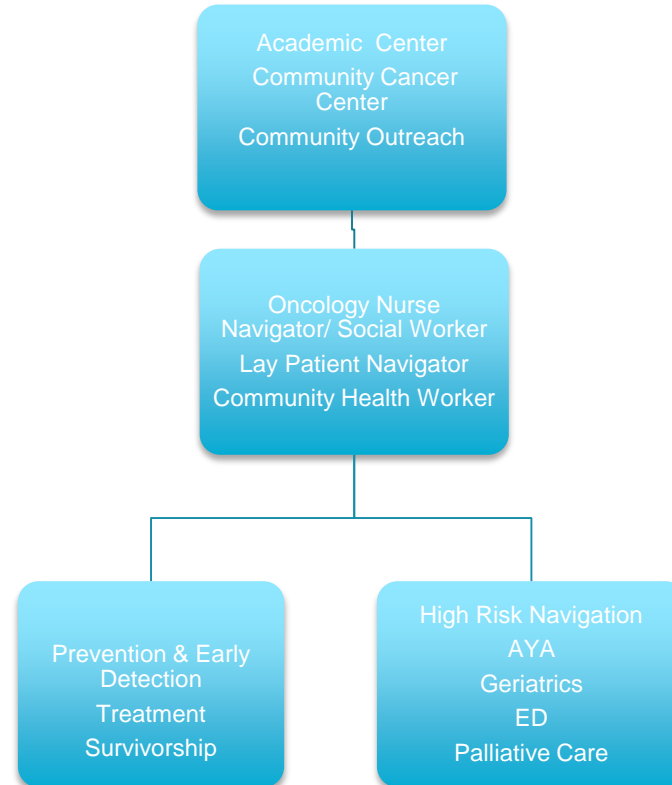
Professional vs Non-Professional Role

ONN, MSW, RN

- Clinical Knowledge
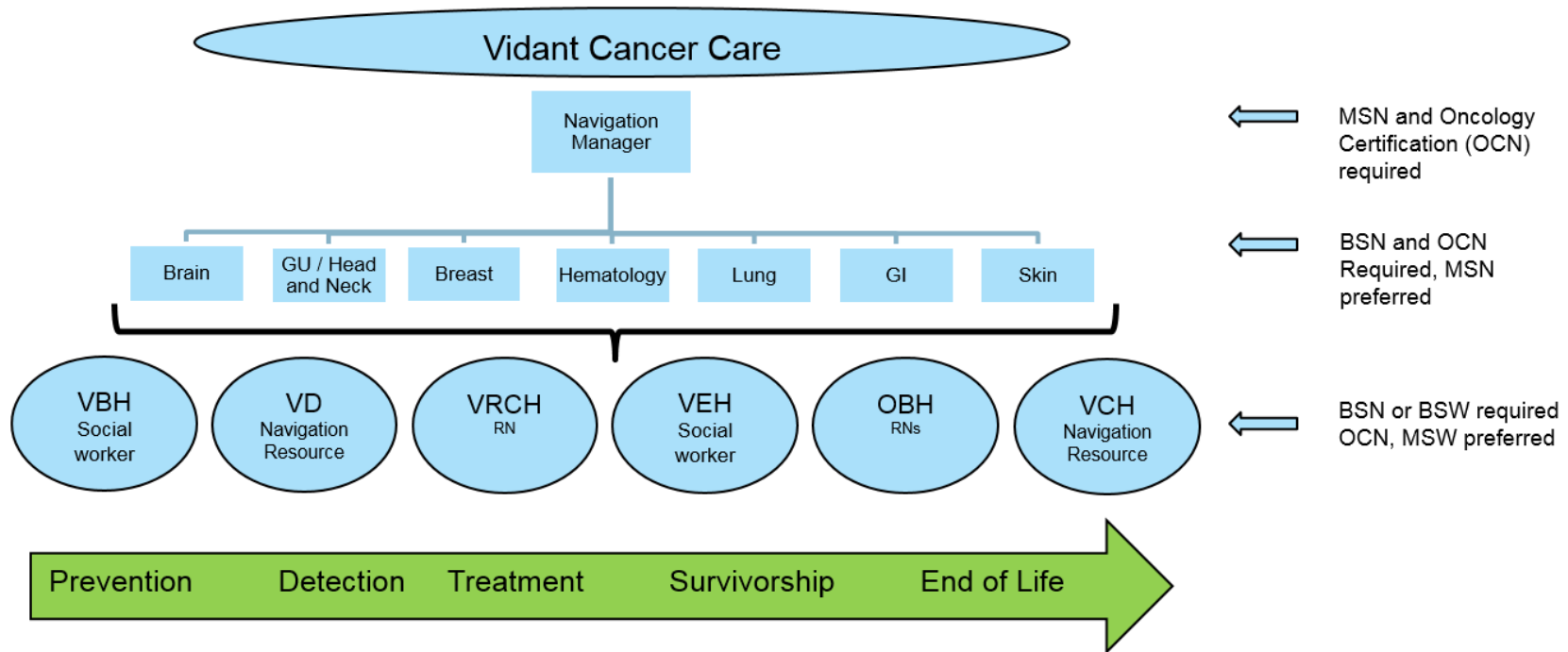- Symptom Management
- Disease Management
- Psychosocial Assessment

Lay Navigators, CHW

- General knowledge of non-clinical barriers to care
- Transportation
- Financial Burden
- Fear
- Resources

Vidant Cancer Care Navigation Model

Disease specific – Top 7 sites at VMC with linkage to regional sites

Program Development

- ## Job Description/Recruitment
    - educational background
    - defined role/responsibilities
    - reporting relationships

Who Are Oncology Nurse Navigators?

ONS is committed to quality care coordination and the role that oncology nurse navigators play in the treatment of patients with cancer.

57% of nurse navigators have been on the job for **1–5 years.**

50% reported their highest educational attainment was a bachelor's degree in nursing.

More than **one-fourth** of nurse navigators have **20+** years of nursing experience.

More than **60%** of nurse navigators reported working in suburban communities

13% reported working in rural communities

25% reported working in urban communities.

Of those who responded, **42%** reported being between the ages of 55 and 64 **31%** reported being between the ages of 45 and 54.

53% of respondents reported holding an **OCN®** OR **CBCN®** certification.

This information is based on ONS's forthcoming 2016 Nurse Navigator Role Delineation Study results, which examines the important work of care coordination in oncology nursing. This full report will be published in an upcoming issue of the Clinical Journal of Oncology Nursing.

ONS Oncology Nursing Society

Program Marketing

- Internal
  - Referral/consult process
  - Define who receives navigation services
  - Educate MDs and Staff

- External

Facing cancer,
side by side

Vidant Health has a team of Cancer Care Navigators dedicated to helping patients with cancer find answers and feel supported. Your navigator will be with you as long as you are a patient at Vidant Health.

Meet our navigators at VidantHealth.com/navigator.

Orientation & Training Resources

ONS Nurse Navigator

Core Competencies

Adapt for Social Workers

Developed in 2013

Useful for Competency based staff orientation

GW Cancer Institute

Core Competencies for Non-Clinically Licensed Patient Navigators

Developed in 2014

Free online program available

GW Cancer Center

Oncology Patient Navigator Training: *The Fundamentals*

ONS®
Where Oncology Nurses Connect

Retention Strategies

- Reassessment of role gaps
- Staff engagement
- Stay interviews
- Educational opportunities

| Assess Program | Identify Solutions | Implement Changes | Evaluate |

Consider use of Advisory Board Company- Patient Navigation Assessment Toolkit

Data Tracking and Streamlining Collection

- Develop tracking and documentation tools to provide standardized, quantifiable data

- Manual vs Electronic

- Eliciting ongoing feedback from patients and physicians through a customer satisfaction tool

Vidant Navigation Intervention Form in Epic

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

Current Challenges

- Variety of role definitions/confusion

- Navigation software vs EMR based

- What to measure

- How to analyze your data

- Limited organizational resources

- Increasing acuity and caseload
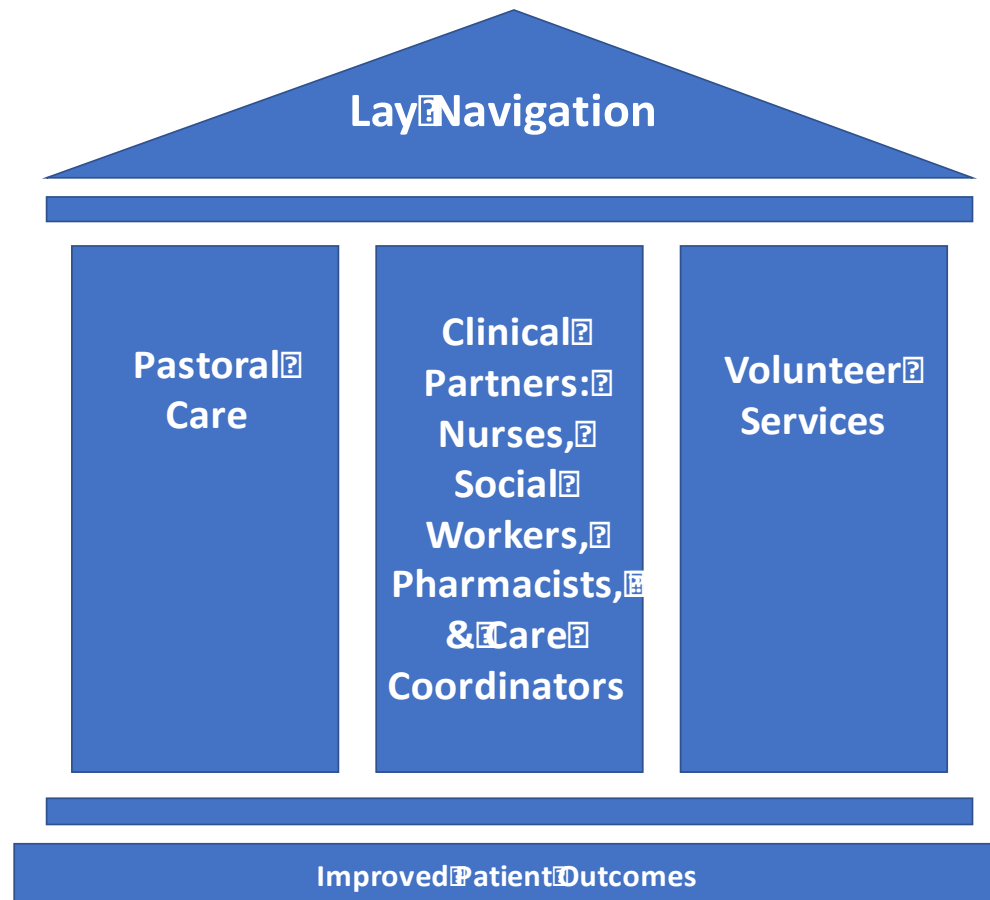
Feasibility of a Lay Cancer Patient Navigation Program To Meet The Needs of Cancer Patients

NCI CCC® A Comprehensive Cancer Center Designated by the National Cancer Institute

William A. Wood, Jean B. Sellers, Thomas C. Shea, Deborah K. Mayer

Background

In North Carolina, more patients are dying with cancer than heart disease. The uninsured and aging represent a large population that face uncertainty about where to turn for information and help for psychosocial support, financial burden and identifying appropriate resources that have important impacts upon health outcomes.

In 2009, UNC Cancer Network developed a lay cancer patient navigators (LCPN) model of navigation in a rural community to decrease barriers to care; improve resource utilization; integrate LCPN in clinics as extenders of the team; improve health outcomes.

In a 2013 patient survey, we found 82% reported feeling alone and isolated during treatment and 55% reported lack of awareness about available patient resources.

Based on the LCPN model and patient survey, we developed a similar model in an Academic Medical Center in Chapel Hill. We are reporting on the first year outcomes of this program.

Methodology

Partnering with UNC Volunteer Services, Pastoral Care and UNC Cancer Care, we identified volunteers to recruit, train, orient and integrate into patient care within the NC Cancer Hospital.

The LCPN would review the patient list with the nurse navigator prior to clinic to ensure identified patients were visited.

An encounter form was developed to capture identified barriers to care, resources provided and confidence of the lay navigator in providing this support in patient encounters.

Training LCPN

UNC volunteers completed a screening process and then participated in an intensive 6 hour training that focused on the following:

- History of patient navigation
- Cancer 101 Facts & Myths
- Compassionate communication
- Boundary setting
- Barriers to Care
- Finding Resources
- Spiritual Support
- Data Collection

Upon successful completion, the lay navigators allocated 21 hours (3 hour shifts) shadowing oncology nurses and physicians in the various clinics. The purpose was to understand the clinic flow, available resources and patients served.

Results

30 volunteers were trained between Jan 2015- June 2016 and 14 were integrated into the following clinics working one 3-4 hour shift per week:
- Breast
- BMT Inpatient
- Thoracic
- GI
- GYN-ONC.
- GU
- Head & Neck;

There have been 1,034 patient encounters; 484 (47%) were with new patients and 550 (53%) were with repeat patients.

Referrals were provided to the following resources:

- Patient and family resource center (74%);
- Community resources (30%);
- Financial counseling (27%); and
- Social work (25%).

LCPN reported feeling adequately trained to meet the needs of cancer patients during these visits.

Funding

Research supported in part by the University Cancer Research Fund

Conclusion

LCPN routinely met with new patients and identified non-clinical barriers to care including informational, logistical, financial, social, emotional and spiritual aspects of care.

In this implementation, the navigator/nurse interaction is critical as the navigator is working in a team concept with the goal of helping patients identify their barrier to care and then to provide assistance with the resolution. Also important to note is the additional support and educational needs of the LCPN. Monthly support meetings facilitated by the oncology nurse and chaplain proved to be critical for the LCPN.

The model is cost effective and requires few internal resources other than training and ongoing supervision.

Research Opportunities

•Future steps will include dissemination throughout NC
•Understanding which barriers to care are addressed by the presence of LCPN.
•Understanding what additional support is necessary to to ensure volunteer retention.
•Identifying specific metrics to reflect the return on the investment.

Duke Endowment Grant to Award $600,000 for Lay Patient Navigation Across North Carolina

Goals of UNC Lay Patient Navigation Program

Improve patients' access to care
Optimize clinical outcomes (including quality of life)
Enhance overall satisfaction with cancer patients' healthcare experience
Link to appropriate cancer resources (community, state, national)

UNC Model of Lay Patient Navigation

Physicians/ Advanced Practice Nurses

Oncology Nurse Navigator/ Nurses

Lay Patient Navigator

Patient

Pharmacists

Social Worker

Pastoral Care

High Risk Disease Groups

Thoracic

Leukemia/Lymphoma/ Multiple Myeloma

Advanced/Metastatic Disease

Pancreatic

Ovarian

Head/Neck

Rocque, G., et al JAMA Onc. 2017

Risk Factors: High Risk Patients

|	
Demographic (age)	> 70 years
ECOG status	> 2 comorbidities
NCCN Distress Score	Low health literacy
Recent hospital discharge	Uninsured
Multiple ED visits	Language barriers
> 4 medication	Lack of social support
	Distance to travel
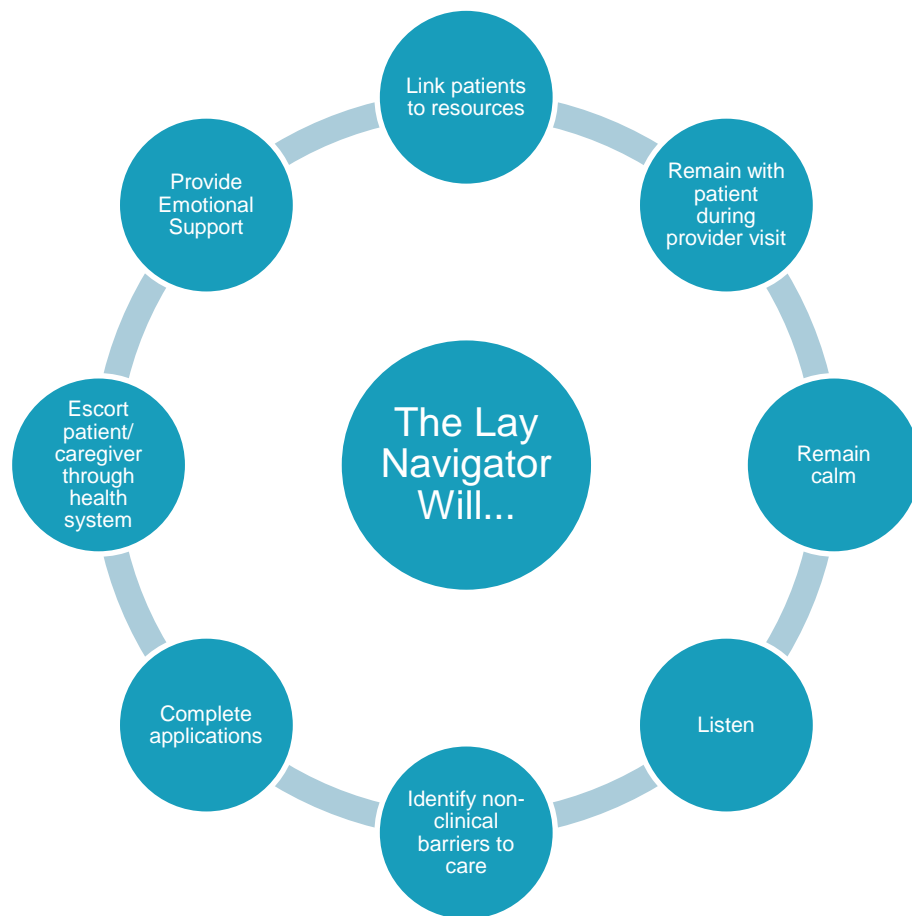
Lessons Learned- Success Strategies

- Volume ALONE does not measure success
- This is a culture change
- Engage stakeholders early
- Be visible; predict there will be problems
- Share data
- Link benefits/experience matters!
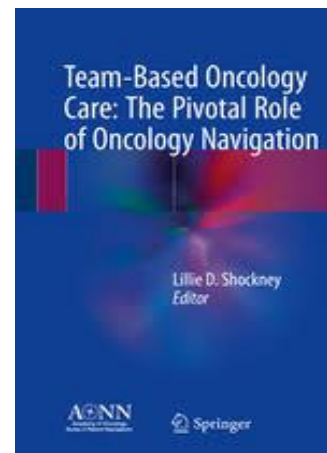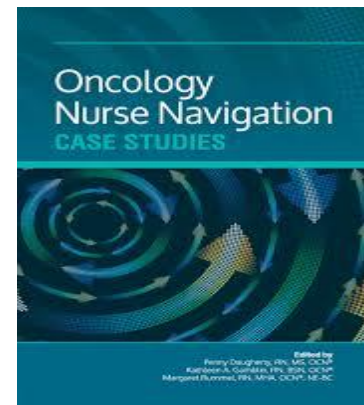- Start small/Pilot/Identify growth opportunity/ROI

TOOLS & RESOURCES
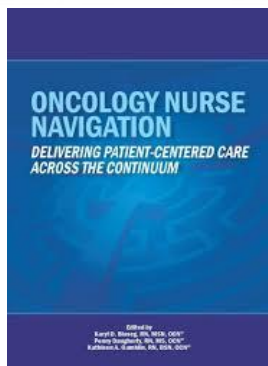
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QUESTIONS ???

ONCOLOGY NURSING