oncology solutions

reimagining cancer care™

The Role of the Oncology Nurse Navigator and Integration with Oncology/Hematology Physician Practices

New Jersey Society of Oncology Office Managers

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October 21, 2016

Objectives

- Define and Review Benefits, Goals and Core Competencies of Navigation
- Commission on Cancer, Chapter 3: Continuum of Care
- Institute of Medicine Conceptual Framework and Recommendations
- Value Based Care, Oncology Care Models, and Medical Neighborhoods
- Navigation and Integration with the Oncology Hematology Physician Practices
  - ✓ Best Practices with Standing Order Sets, Physician Profiles, etc.
  - ✓ Appointment Checklist
  - ✓ Decision Aides
- Measuring Success with Metrics
- AONN+ Nurse Navigation Certification

Define & Review Navigator Characteristics

CoC Chapter 3: Continuum of Care

Institute of Medicine Conceptual Framework

ONS Nurse Navigator Core Competencies

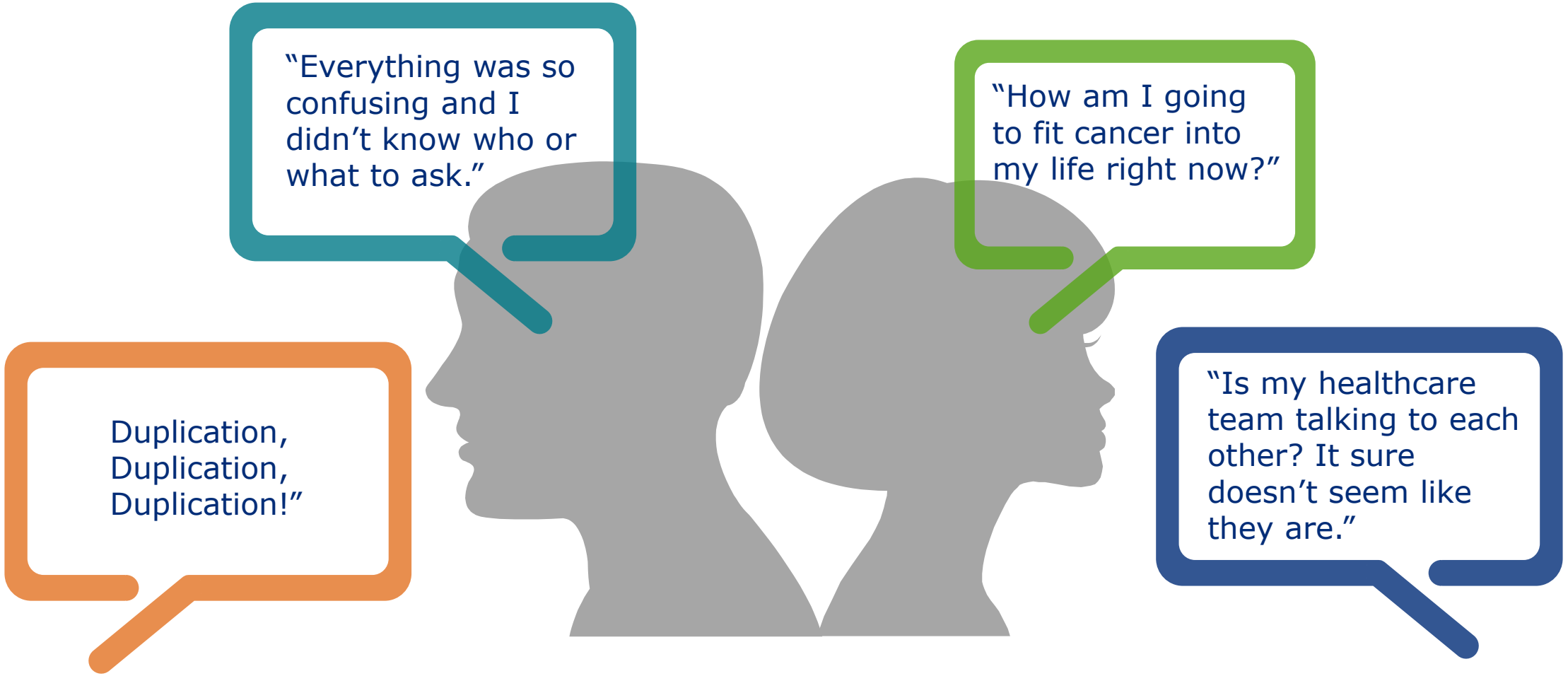
Patient Flow & Managing Transitions

Value-Based Care, Oncology Care Models and Medical Neighborhoods

Reporting Tools & Navigation Metrics

Nurse Navigation Certification

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

Navigation Continuum of Care

- Diet/Exercise
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- Oncology/ Surgery consultation
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- Informed decision making
- **Palliative Care**
- **Pre-habilitation**

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

- Long-term follow up/ surveillance
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Phases of Cancer Care

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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.

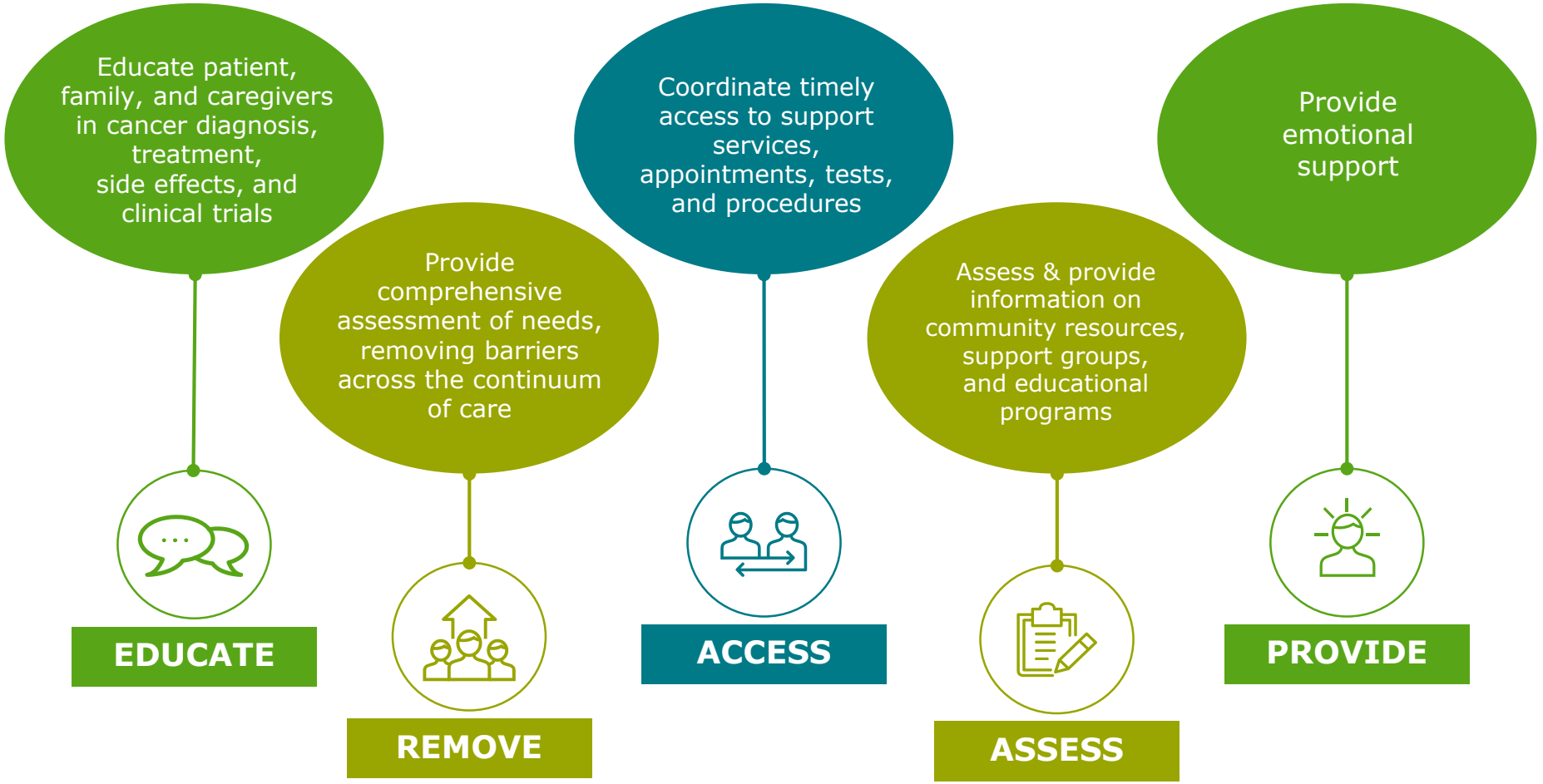
D

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 provide information and support.

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

Navigator Goals



Navigator Characteristics

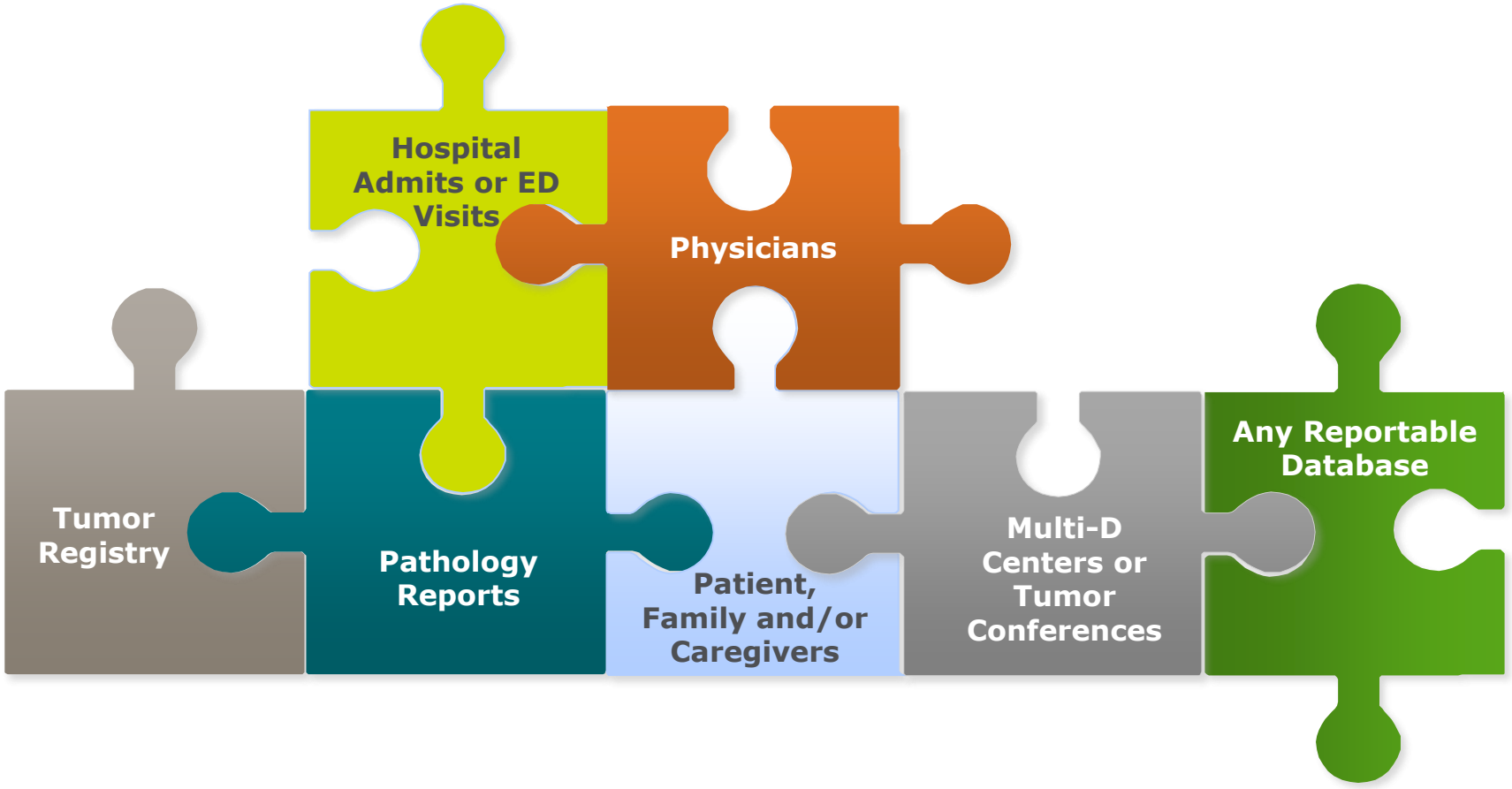
- Oncology clinical experience
- Excellent assessment & education skills
- Compassionate and caring
- Patient advocate
- Superb listening skills
- Flexible & easily adaptable to change
- Supportive, positive attitude
- Ability to multi-task & prioritize
- Knowledge of community resources & support services

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

New as of 2015

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Patient Navigation Process

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Standard 3.3:
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 updated the scope and timing of its standard:

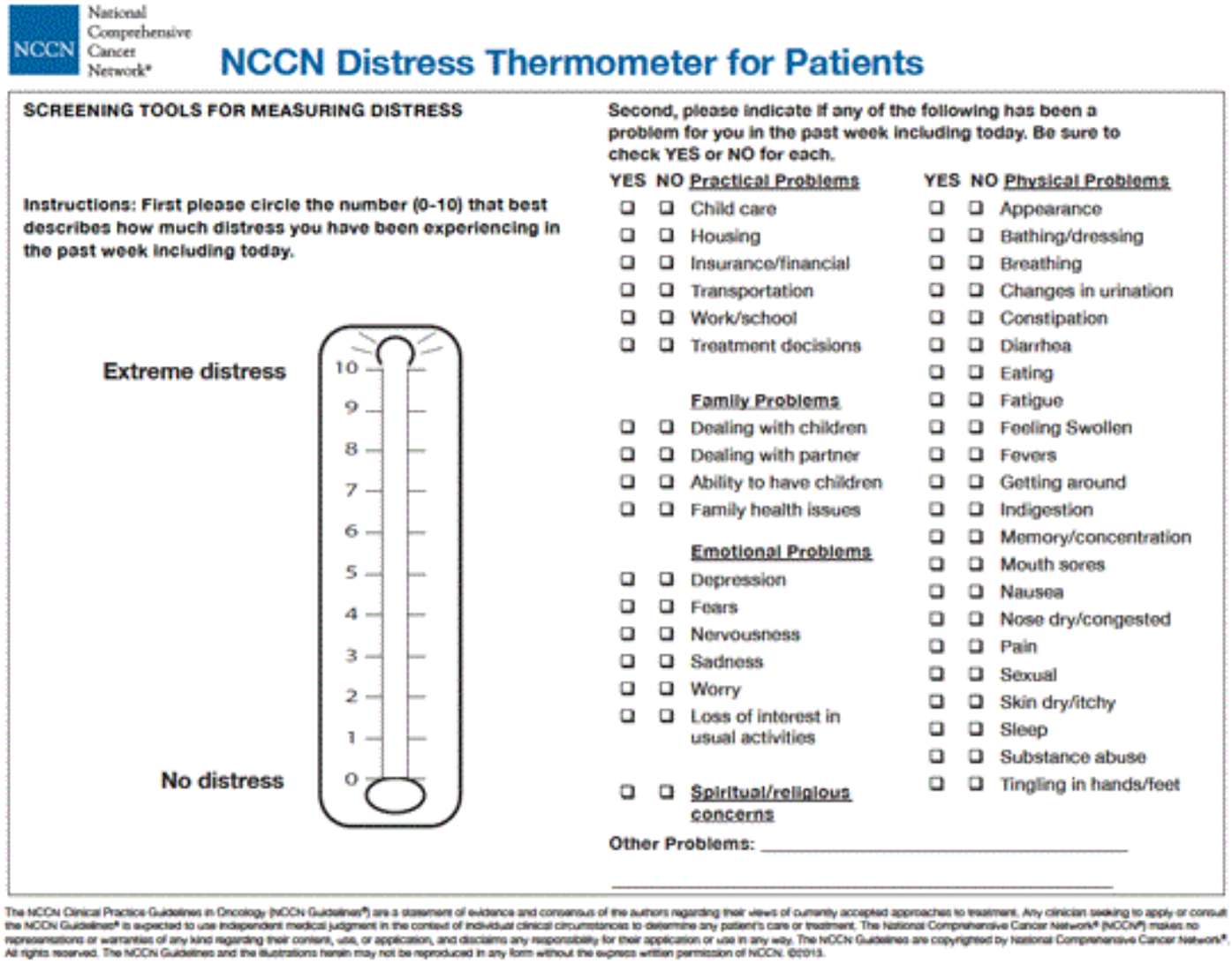
- ✓ Jan. 1, 2016: Provide survivorship care plans to 25% of eligible patients
- ✓ Jan. 1, 2017: Provide survivorship care plans to 50% of eligible patients
- ✓ Jan. 1, 2018: Provide survivorship care plans to 75% of eligible patients
- ✓ Jan. 1, 2019: Provide survivorship care plans to all eligible patients

Who can provide the SCP?

The verbiage in the standard currently states, "A survivorship care plan is prepared by the principal provider(s) who coordinated the oncology treatment for the patient with input from the patient's other care providers."

An overarching goal is to allow each cancer program some flexibility in the formulation and implementation of their own policies and procedures in this regard.

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.

Extreme distress

10 9 8 7 6 5 4 3 2 1 0

No distress

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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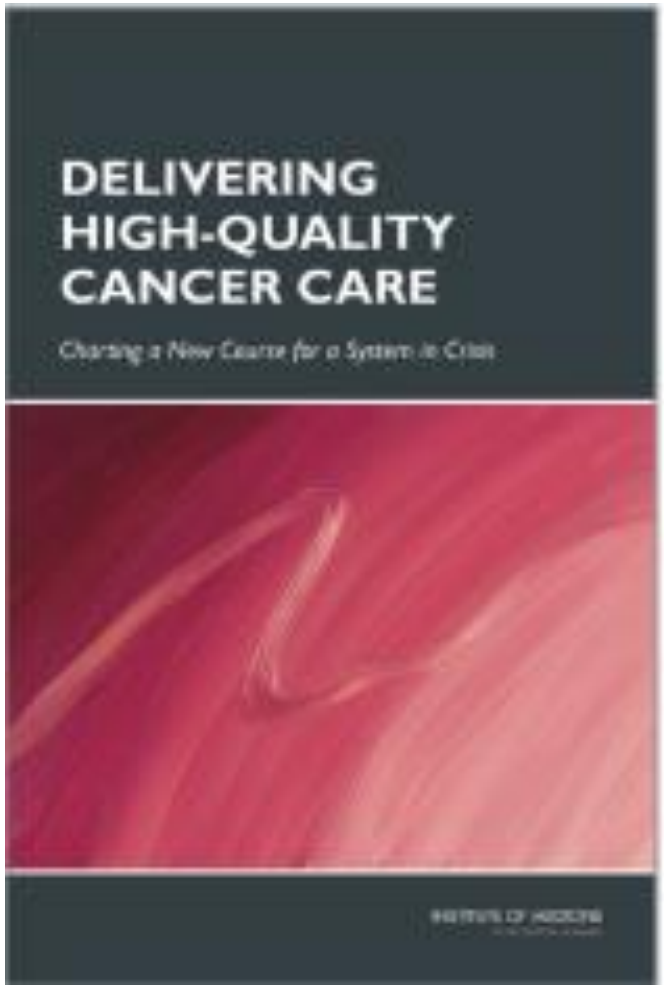
IOM Conceptual Framework



- 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
- End-of-life care consistent with patient's values
- Coordinated, team-based cancer care
- 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
- 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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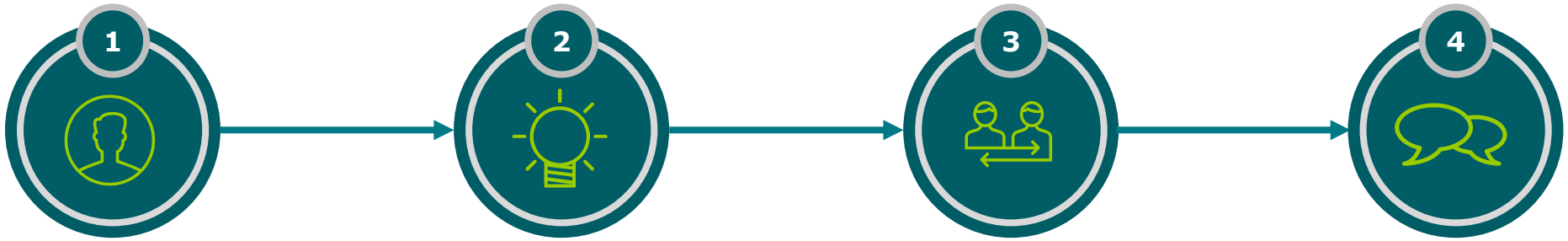
Use the core competencies to create job descriptions, an orientation checklist, annual competencies, and to educate providers.



PROFESSIONAL ROLE

The ONN demonstrates professionalism within both the workplace and community through respectful interactions and effective teamwork. He or she works to promote and advance the role of ONN and takes responsibility to pursue personal professional growth and development.

EDUCATION

ONN provides appropriate and timely education to patients, families, and caregivers to facilitate understanding and support informed decision making.

COORDINATION OF CARE

ONN facilitates the appropriate and efficient delivery of healthcare services, both within and across systems, to promote optimal outcomes while delivering patient-centered care.

COMMUNICATION

ONN demonstrates interpersonal communication skills that enable exchange of ideas and information effectively with patients, families, and colleagues at all levels. This includes writing, speaking, and listening skills.

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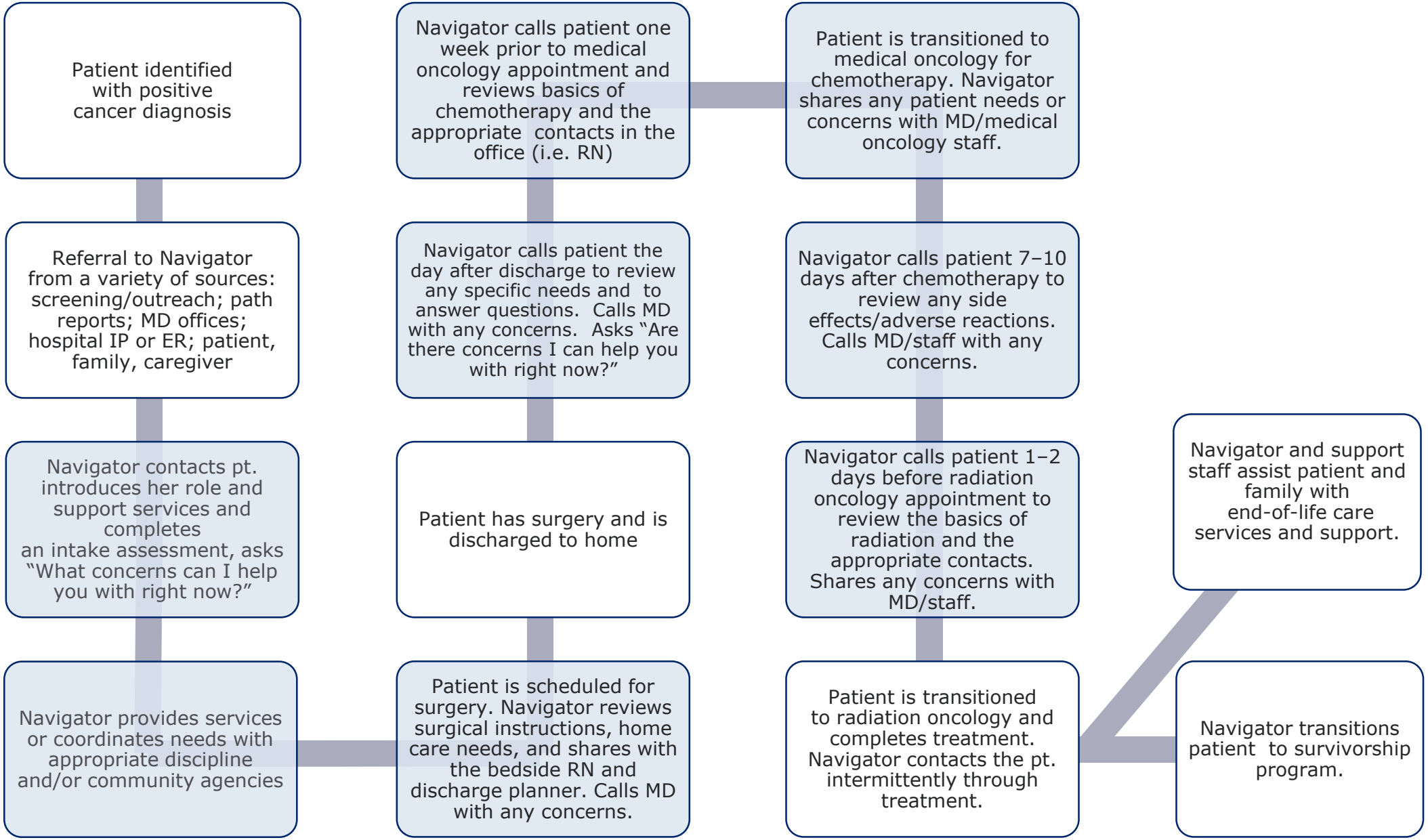
Managing and coordinating the care of the patient, family, and/or caregiver across the continuum sounds simple, but most programs do not share patient information as well as they perceive they do. It is extremely important to communicate the assessments, needs, and barriers of the patient, family, and/or 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
  - *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.*
  - *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
- Commission on Cancer standards—beyond navigation standards
- 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 practice 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
- Seven community oncology practices

What is the 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, 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.

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

Medical Neighborhoods . . . New Buzzword

What are Medical Neighborhoods?

Partnerships with physicians, specialist, skilled nursing facilities, home health care, hospices, and other local organizations to improve success rates in value-based care.

Who initiated Medical Neighborhoods?

Atrius Health is a nonprofit healthcare leader delivering a system of connected care that enables us to know our patients better so that we can serve them well. Across 29 clinical locations, 50 specialties, and 750 physicians, we provide proactive, customized care to more than 675,000 adult and pediatric patients across eastern Massachusetts.

What did they do?

- Targeted opportunities for savings on acute and post acute care
- Integrated local elder resources, ASAPs: Aging Services Access Points
- Collaborated with VNA home health care and social work services
- Provided support for families and caregivers
- Created champions in the community on advance care planning/discussions on care wishes
- Conversations turned from which Skilled Nursing Facility (SNF) to why SNF

Navigation Integration with Oncology Hematology Offices

A perfect fit with Navigation programs!

How?

- Coordination of care for your patients and families across the continuum from pre-diagnosis through survivorship or end-of-life services
- Comprehensive assessments and referrals to appropriate disciplines
- Increase efficiency and timely access to services
- Reinforce patient education and empowerment through decision aids and patient appointment checklist
- Monitoring treatment based on national standards and guidelines
- Create standing order sets, physician profiles, pathways, and guidelines
- Development and coordination of metrics
- Early discussions regarding palliative care and prehabilitation

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

- Community needs assessment
- Intake assessment tool
- 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

Barriers to Care and Interventions

- Financial concerns
- Lack of insurance
- High copays with insurance
- High copays with medication coverage
- No medication coverage
- Inability to pay bills
- Transportation concerns
- Child/elder care
- Homeless or housing concerns
- Interpretation concerns, speaks another language
- Mental health concerns
- Fear and fatalism
- Misconceptions about cancer
- Pain or symptom management
- Lack of knowledge regarding treatment plan
- Mistrust of the healthcare system
- Cultural/spiritual concerns
- Inability to read or write
- Lack of support
- Inability to walk, physical disability
- Substance abuse

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Communicating with the Healthcare Team

- Verbal updates on patient status
- Patient rounds
- Multidisciplinary team meetings
- Tumor conferences
- Electronic medical record/plan of care
- Barriers to care and interventions
- Psychosocial distress screening
- Patient and family education
- Support services
- E-mail
- Patient portal

Navigation and Survivorship Metrics

PATIENT EXPERIENCE

- Measure outcomes/interventions related to barriers to care and distress screening
- Report outreach/navigation of disparate population
- Patient experience survey
- Discharge assessments packets
- Patient education packets for surgery and survivorship
- Caregiver toolkit
- Patient appointment checklist
- Survival toolkits for families
- Telemonitoring program for patients
- Complementary and alternative therapies/outcomes
- Cancer disease-site–specific prehabilitation programs
- Quality of life survey for survivors

CLINICAL OUTCOMES

- NCCCP Matrix Assessment
- MDC care in concordance with NCCN or other national guidelines
- Tumor conference audits, review of recommendations, NCCN guidelines, and stage documentation
- Time of diagnosis to first treatment modality
- Creating standing order sets by cancer disease site for multidisciplinary teams
- Clinical trial education and referrals to cancer research department
- Physician experience survey on navigation
- Disease-site-specific clinical initiatives, i.e., measuring head/neck cancer patient referrals to dentist prior to initiating treatment
- SCP surveillance monitoring

BUSINESS PERFORMANCE

- Decrease emergency room visits and readmissions
- Medication reconciliation review
- Self-pay patients assessed and referred to Medicare or Medicaid
- Medical home for oncology patient
- Length of stay reduction, partner with inpatient oncology unit
- Downstream revenue for imaging, tests, procedures
- Referrals to revenue-generating support services
- Patient retention rates/decrease outmigration
- Care in concordance with NCCN or other national guidelines

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Oncology Nurse Navigator Certification

AONN+ Certification Domains include:

- Professional/Roles & Responsibilities
- Operations Management/Organizational Development/Health Economics
- Patient Advocacy/Patient Empowerment
- Survivorship and End of Life
- Care Coordination/Care Transitions
- Community Outreach/Prevention
- Psychosocial Support/Assessment
- Research/Quality/Performance Improvement

Navigation certification takes place at the annual AONN+ conference.
Details are available on the AONN+ website.

Discussion

Thank you