Navigation Program Resource Guide

Best Practices for Patient Navigation Programs

Compiled by the CHI NOSL Patient Navigation Affinity Workgroups
Navigation Program Resource Guide

Goal: To provide evidence-based recommendations for best navigation practices as well as create a consistent approach to navigation across our CHI cancer programs. Navigation workgroup projects are built on the NCCCP (1) navigation work along with input from our programs via the 2011 navigation program survey.

Dedication and Acknowledgement

This work is dedicated to all of the patient navigators across CHI who positively impact the lives of our oncology patients every day!

An expression of deep appreciation goes to our Patient Navigation Affinity Workgroup members (listed below) for the many hours and the level of commitment they have given to this project. This Guide would not have been possible without their dedication, time and expertise!

(1) The National Cancer Institute Community Cancer Centers Program (NCCCP) is a public-private partnership of the National Cancer Institute (NCI) and a network of community hospital-based cancer centers from around the United States. The NCCCP is working to improve the quality of cancer care delivered at community hospitals and to enhance the level of cancer research taking place in the community. CHI facilities who have or are participating in the NCCCP project are Penrose Cancer Center, Colorado Springs, CO; St. Francis Medical Center, Grand Island, NE; Good Samaritan Hospital, Kearney, NE; St. Elizabeth Regional Medical Center, Lincoln, NE; Mercy Medical Center, Des Moines, IA; St. Joseph Medical Center, Towson, MD
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<td>Judy DeGroot Penrose Cancer Center</td>
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<td>Lori Dagostino Penrose Cancer Center</td>
<td>Shannon Becker Mercy – Des Moines</td>
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<td>Tricia Sinek (Lead) Tacoma</td>
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<tr>
<td>Peggy McKinney NOSL</td>
<td>Temera Schneider Jewish-St. Mary’s</td>
<td>Teresa Heckel NOSL</td>
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<td>Dr. Jackie Matar St. Joe’s - Lexington</td>
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2011 - 2012
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Definition of Patient Navigation

In this section is a core definition of patient navigation adapted from the definition developed by the NCI’s Patient Navigation Research Project along with a statement of the scope of navigation services. Included as well are supporting resources and key takeaways related to patient navigation.
CHI Definition for Patient Navigation
(Adapted from the NIH Patient Navigation Research Project)

Patient Navigators are trained, culturally sensitive health care workers who provide support and guidance throughout the cancer care continuum. They help people "navigate" through the maze of doctors' offices, clinics, hospitals, outpatient centers, insurance and payment systems, patient-support organizations, and other components of the health care system. Services are designed to support timely delivery of quality standard cancer care and ensure that patients, survivors, and families are satisfied with their encounters with the cancer care system. Patient Navigator activities designed to achieve these outcomes include:

- Assessing for and mitigating barriers to care. Assisting patients with access concerns (for either screening, diagnosis or treatment) and assisting with paperwork access barriers as indicated.

- Coordinating appointments with providers to ensure timely delivery of diagnostic and treatment services. May include accompanying patients to appointments (particularly if there are multiple barriers to care) and/or providing clarification and literacy-level-appropriate education related to the visit.

- Maintaining communication with patients, survivors, families, and the health care providers to monitor patient satisfaction with the cancer care experience.

- Ensuring that appropriate medical records are available at scheduled appointments as needed.

- Facilitating language translation or interpretation services.

- Facilitating financial support and helping with paperwork as needed.

- Facilitating transportation and/or child/elder care.

- Facilitating linkages to follow-up services.

- Other Navigator activities include community outreach, facilitating access to clinical trials, and building partnerships with local agencies and groups (e.g., referrals to other services and/or cancer survivor support groups)
**Scope of Navigation Services**

GOAL: Navigation services are offered to identified cancer patients based on the capability and structure of each specific navigation program.
Key Takeaways on Maximizing The Value Of Navigation – The Oncology Roundtable
Concepts to keep in mind while considering implementing/enhancing navigation services.

Maximizing the Value of Patient Navigation

Key Takeaways

1. Navigators an Under-Leveraged Resource
   Many cancer programs have hired navigators without clearly defining organizational needs, the navigator role, or what they hope to achieve; as a result, these programs are not realizing the full benefits of their investment.

2. Navigators Often Used to Cover Up Bad Processes
   Increasing patient volumes, treatment complexity and care fragmentation have strained cancer program operations. While navigators have the potential to ameliorate some of the resulting problems, cancer programs would be better served by examining their processes and taking steps to redress the root causes of delays and gaps in care.

3. A Rigorous Needs Assessment is Critical
   After process improvement, cancer program leaders should undertake a rigorous needs assessment to identify any remaining patient and physician needs, gaps in care, operational bottlenecks, and market opportunities; findings from these analyses can then be used to inform navigator role development.

4. Measurement Critical for Justifying Ongoing Investment
   Given that navigation is an uniminsured service, cancer program leaders face increasing pressure to quantify the benefits of this investment; the most promising approaches involve tracking revenues from new or returned patients who were attracted by the program’s navigation services and by tracking navigation-specific patient satisfaction.
Navigation Program Implementation

This section contains tools and resources for planning and implementing navigation services
This key takeaway from Sg2 supports our workgroup’s recommendation for a comprehensive needs assessment prior to implementing a patient navigation program.

**Begin With a Program Needs Assessment**

When starting a navigation program, it is vital to begin with a program needs assessment. All too often, navigators are hired without specifics to their role and their responsibilities can be misinterpreted. Combine this unclear purpose with often fragmented, complex care and an absence of accreditation standards, and it becomes obvious that navigators must work with hospital administration to establish professional performance parameters that make the most sense for the organization. As an overall working definition, the nurse navigator’s primary role is to improve patient preparedness for treatment by providing education and psychosocial support. Nurse navigators also facilitate patient-physician interaction, provide logistical support, secure referrals and assist with financial and insurance issues. A sample nurse navigator job description (in this case, for oncology navigation) is attached in the upper right corner of the online post. Although roles and duties for navigators are highly specific to each hospital and service line, this example defines many of the emerging parameters of the position.

First and foremost, the needs assessment should analyze care delivery as seen through the eyes of the patient. Process mapping, a gap analysis and a SWOT analysis (strengths, weaknesses, opportunities and threats) should follow. In our work at Sg2, this service gap identification is a crucial step toward building a complete, seamless System of CARE (Clinical Alignment and Resource Effectiveness). Defining care transition processes are part of this planning and mapping, clearly establishing policies and procedures for each care site and identifying the right corresponding providers.

Indeed, gaps are most often found in care transitions, through care delays or barriers within the system, as well as in patient education and verbal instruction adherence. Navigation program planners also should examine the reasons for emergency department visits and related admissions, and learn where patients are referred for diagnostic testing. The resulting hospital-based program should focus on high-stress points in the care delivery system with the greatest patient need. These could include navigation assistance between patients’ cancer diagnosis and their first visit with their surgeon, as well as support during presurgery, postsurgery and after follow-up appointments.

The sample Nurse Navigator Job Description can be found in the Appendix.
**Considering Navigation Services – Cancer Program Assessment Tools**

**Feasibility Diagnostic**

Feasibility Diagnostic – Advisory Board

Purpose: To be utilized as a preliminary tool to determine cancer program readiness for implementation of navigation services.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>#1 Do you lack a process/person accountable for ensuring patients have access to the resources they need and answers to their questions?</td>
<td></td>
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<tr>
<td>#2 Have you identified gaps in the patient care continuum from the time of screening/diagnosis to the transition to follow-up care?</td>
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<td>#3 Have you experienced lags in facilitating the care process from point of abnormal finding to treatment for at least one tumor site?</td>
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<td>#4 Have you experienced patient outmigration for one or more tumor sites?</td>
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<td>#5 Do you have the financial resources, either from institution-held capital or grant funds, to finance at least one full-time employee? (Note: investment can vary significantly depending on the clinical background of the navigator)</td>
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Elevating the Patient Experience

Source: Oncology Roundtable interviews and analysis.

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Navigation Program Pre-assessment Tool
(adapted from ACCC and Pfizer example tools)

Purpose: To be used for cancer program assessment related to implementing patient navigation services as well as to facilitate contemplation of navigation program model and program scope.

Goals and Challenges
Goals for navigation program:

Barriers/Challenges to navigation program:
What are your strategies for mitigating barriers?

Organization demographics
Please identify and rank the 5 most commonly diagnosed cancers in your organization (1 = most common; 5 = least common):

____ Blood and lymph  ____ Colon and rectal  ____ Melanoma
____ Brain tumors  ____ Kidney  ____ Ovarian
____ Breast  ____ Liver  ____ Pancreatic
____ Cervical  ____ Lung and bronchus  ____ Prostate
____ Other, please specify: _________________________________

For which cancer type(s) are you considering implementing a patient navigation program? (check all that apply)
Blood and lymph
Colon and rectal
Melanoma
Brain tumors
Kidney
Ovarian
Breast
Liver
Pancreatic
Cervical
Lung and bronchus
Prostate
Other: ________________________________________________

Are you considering other types of navigation focus such as outreach or survivorship?

What model of navigation are you considering?

What percentage of your population has?
Private health insurance _____________________________
Medicare _________________________________
Medicaid or Medicaid-eligible ________________________________
No insurance _________________________________
Underinsured______________________________
Approximate percentage breakdown of cancer patients’ race and ethnicity:

–Ethnicity
  • Hispanic or Latino _____
  • Not Hispanic or Latino _____

–Race (may select more than one)
  • American Indian or Alaska Native _____
  • Asian _____
  • Native Hawaiian or Other Pacific Islander _____
  • Black or African American _____
  • White _____
  • More than one race _____
  • Not reported - patient refused _____
  • Not reported - data not available _____
  • Unknown - patient unsure of race _____

What are the most common barriers/issues your cancer patient population faces in receiving care?
(rank these in order of the most common [1] to least common)
_____ Lack of insurance
_____ Lack of understanding of how to utilize insurance
_____ Missed appointments
_____ Language barriers
_____ Transportation difficulties
_____ Cultural belief system/differences in health care
_____ Fear
_____ Lack of education
_____ Other, please specify:

Provide approximate percentage of patients not returning after screening for reasons such as:
_____ Missed appointments
_____ Financial barriers
_____ Communication/informational barriers
_____ Lack of education
_____ Fear
_____ Other, please specify: ________________________________

Provide approximate percentage of patients not returning after diagnosis for reasons such as:
_____ Missed appointments
_____ Financial barriers
_____ Communication/informational barriers
Lack of education
Fear
Other, please specify:

Provide approximate percentage of patients not receiving treatment for reasons such as:
Missed appointments
Financial barriers
Communication/informational barriers
Lack of education
Fear
Other, please specify:

What do you perceive to be the main reason for missed appointments?
Understanding/completing paperwork for insurance
Financial issues
Transportation issues
Child care issues
Language/communication issues
Other, please specify:

Navigation Program Operations

Anticipated timeline for implementation:

How many patients per year do you anticipate will participate in the navigation program?

How will you identify patients eligible for the program?
Pathology reports
Inpatient referrals (to facilitate thoughts about what process might need to be in place)
Provider referrals
Social workers
Surgical reports
Staff nurses
Other

Where will the navigator(s) be housed?

What other space is allocated for the navigation program:
Patient library/education space
Counseling rooms
Other offices
Other
How will program be funded?
- Grants
- Patient pays
- Insurance
- Other

Which salaries will be supported solely by program budget (navigator, administrative assistant, etc.)?

What else will budget be used for (patient education materials, journals, etc.)?

Do you have an electronic charting system? If yes, how will navigation tracking, reporting and documentation integrate with the EMR?

How will you communicate between navigators and the rest of the cancer care team?

Role of Navigator
Who do you see as the navigator in your program? (Check all that apply based on the model that you’re considering)
- RN
- Social Worker
- Lay person/survivor
- Other

When would you like the navigator to become involved with the patient? (May differ based on navigator focus)
- Prior to entering the healthcare system
- At time of screening
- At time of suspicious finding
- At time of diagnosis
- Other (please specify)

Which health care provider (eg, nurse, social worker, physician) is likely to be the most involved in addressing the following activities with cancer patients and, approximately, for how many hours per day?
- Explaining insurance or financial issues
- Locating local resources
- Tracking missed appointments
- Coordinating care services
- Coordinating patient resources (i.e., transportation, child care, etc.)
- Other, please specify:

What are the primary functions you would like the navigator to fulfill? Please rank them with 1 being the most important.

_____ Community education  _____ Patient education  _____ Care coordinator  _____ Financial counselor
_____ Psychosocial counselor  _____ Attending patient appointments  _____ Mitigating barriers to care
_____ Other (please specify)  __________________________________________________________
What other activities would you like the navigator to be involved in? Please rank them with 1 being the most important.
_____ QI/PI activities _____ Community _____ Educational programs _____ Screenings _____ Staff educational programs _____ Survivorship program _____ Help set up program(s) by disease state(s) _____ Other (please specify)

Resources
What resources do you currently have in place?
- Case managers
- Social workers
- Registered dietitians
- Financial assistants
- Genetic counselors
- Chaplain
- Health psychologists
- PT/OT
- Speech therapy
- Home care services
- Hospice services
- Palliative care services
- Interpreter services
- Multi-disciplinary conferences in place
- Patient advisory committee
- Support groups (specify) ________________________________
- Other (please specify) ________________________________

Do you currently have relationships with community patient support agencies and services?
Examples:
- American Cancer Society
- Transportation services
- Caregiver support services
- Childcare support services
- Food delivery services
- Employment training/placement services
- Exercise facilities
- Other: ________________________________

Do you have program marketing resources in place?

Key Stakeholders
Do you have a physician champion for patient navigation program?
- Can you identify a potential champion?
Do physicians support the program concept? If not, will physicians need convincing of the need for a program?
Strategies for physician engagement

Administration - level of support/commitment or lack of support/commitment?
   Strategies for administrative engagement

Are patients engaged with the navigation concept?
   Strategies for patient engagement
Navigation Program Implementation
Strategies and Processes
Models of Patient Navigation

Existing models of patient navigation are described in detail in this section providing an opportunity to explore which model is most compatible with your cancer program structure and patient population.
Models of Patient Navigation

When developing a patient navigation program, there are two common models for pairing navigators with patients—by tumor site, a more clinically oriented approach, and by point of patient entry, a more logically driven method. The six models listed on this page provide an overview of the most common variations within these two approaches. Notably, dedicating patient navigators to a high-volume, low-acuity tumor site, such as breast cancer, results in the most common approach as this allows for higher patient loads per navigator. Alternately, some designate a navigator to focus on high-acuity, complex patients with the greatest need for services, such as those diagnosed with head and neck cancer.

Over time the traditional navigation model has evolved to encompass a broad range of roles all aimed at expanding access to care and improving the patient experience. Many navigators play a critical role in organizing multidisciplinary conferences and clinics. In addition, it is increasingly common for navigators to focus their time specifically on underserved populations through outreach and the development of awareness programs. Pages 15 and 16 provide detailed cases in brief for each model.

Group I: Navigators Designated by Tumor Site

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Rationale</th>
<th>Site</th>
<th>Concept</th>
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<tbody>
<tr>
<td>I:</td>
<td>Navigator assigned to high-volume, low-acuity tumor site</td>
<td></td>
<td>Breast cancer</td>
<td>Although acuity is low, entire volumes are appropriate given high-acuity case load</td>
</tr>
<tr>
<td>II:</td>
<td>Navigator assigned to low-volume, high-acuity tumor site</td>
<td>Patients with high levels of acuity tend to have a greater need for navigation services</td>
<td>Head and neck, G.I. cancer</td>
<td>Level of frequency, intensity of navigation services likely to benefit high-case load sites</td>
</tr>
<tr>
<td>III:</td>
<td>Navigator assigned to provide coverage for all tumor sites</td>
<td>Provides access to all cancer patients, recognizing universal need, benefit across tumor sites</td>
<td>All cancer types</td>
<td>Varying patient volumes across groups may necessitate assigning several tumor sites per navigator</td>
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Group II: Navigators Designated by Patient Entry Point

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Rationale</th>
<th>Entry</th>
<th>Concept</th>
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</thead>
<tbody>
<tr>
<td>IV:</td>
<td>Navigator assigned to tumor site-specific, comprehensive care</td>
<td>Tumor site case presentations, follow-up coordination</td>
<td>Patient identified by referral, clinic visit</td>
<td>Navigator assigned to tumor site-specific clinic, likely to vary by tumor site</td>
</tr>
<tr>
<td>V:</td>
<td>Navigator assigned to work with several physicians</td>
<td>Provides assistance when needed, reduces opportunity for increased physician efficiency</td>
<td>Patient identified by lead oncology physician</td>
<td>Patient identified in community by navigator</td>
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<td>VI:</td>
<td>Navigator assigned to subset of population experiencing disparities in care</td>
<td>Includes, addresses gaps in access, utilization of cancer services</td>
<td>Physician may request services beyond scope of navigator site</td>
<td>Funding commonly associated with consider grant, foundation funding opportunities</td>
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Employing a Strategic Approach to Implementation

Conducting an assessment based on your specific program needs is essential to successful program implementation. This section contains detailed information on needs assessment options and processes.
Cancer Program Needs Assessment

The Advisory Board’s Oncology Roundtable recommends a rigorous need assessment prior to planning and implementing navigation services. There are three options recommended for assessing program needs: Comprehensive, Targeted and Market-Driven.

Lesson #1: Conduct a Rigorous Needs Assessment

Looking across cancer programs, there is a remarkable range in the type of responsibilities that have been assigned to navigators. Traditionally the role has focused on supporting patients and families by serving as a main point of contact, removing barriers to care, providing patient education and helping to improve timeliness of care. At some organizations, navigators have taken on business development responsibilities such as serving as the point person for referring physicians, leading up community outreach efforts, and even assisting with strategic planning for the organization. Navigators have the potential to be successful in all of these roles; however, in order to maximize the value of this job to the organization, cancer program leaders must be strategic in how they define the position.

Unfortunately, in many cases, cancer programs have hired patient navigators without taking the time to properly assess their patients’ and their organizations’ needs. Without a clear focus, navigators become the “fix it” people for the organization, called upon to address any and every problem that arises. As a result, cancer program leaders struggle to articulate the goals of their navigation program much less measure its impact and justify the ongoing investment.

Interviews Suggest Lack of Rigor in Program Design

Heard in the Research

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>What factors led you to hire a navigator?</td>
<td>We wanted to go for NAPBC accreditation and having a breast navigator is one of the requirements</td>
</tr>
<tr>
<td>How did you determine what the navigator would do?</td>
<td>We looked at what other programs were doing and modeled our approach after theirs</td>
</tr>
<tr>
<td>How do you measure the effectiveness of your navigation program?</td>
<td>We rely on patient feedback. Our patient satisfaction surveys ask how satisfied people are with their experience. Of course, it’s not specific to navigation</td>
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Taking a More Disciplined Approach

Comprehensive Needs Assessment

Lehigh Valley Health Network is an example of an institution that has taken a rigorous approach to identifying unmet patient needs and organizational performance improvement opportunities. In the process, they have laid the groundwork for successful implementation of the navigator role.

The cancer program has employed a navigator in the breast center for many years. Given the success of that role, the cancer center’s leadership wanted to assess the possibility of hiring a second navigator to support other types of patients. Specifically, they were responding to concerns from physicians and staff that some patients were not receiving needed support.

Prior to hiring the second patient navigator, the organization undertook a three-part needs assessment. First, they conducted a value stream mapping exercise in which they used Lean process improvement methodologies to analyze the patient pathway and identify problems. Second, they conducted one-on-one interviews with patients in order to understand their experience at the cancer center and identify additional problem areas. Finally, they conducted interviews with staff and physicians in order to understand their perspective and learn what, if any, problems they may have observed.

Case in Brief: Lehigh Valley Health Network

- Three-hospital health system based in Allentown, Pennsylvania
- Breast program has employed navigator for 12 years
- Success of breast navigator, along with observation that patients in other areas were “falling through the cracks,” led leadership to investigate hiring navigators to support other tumor sites in early 2010

Source: Lehigh Valley Health Network, Allentown, PA; Oncology Bundesen interviews and analysis.
Comprehensive Needs Assessment

Mapping the Patient Experience Step-by-Step

The value stream mapping exercise was led by three of the cancer center’s directors. Their first initiative was to craft a map of all of the steps in the patient care process. To create the map, they scheduled a series of 30 minute meetings with each of the managers from the cancer center’s nine departments over the course of a single morning.

During each meeting, the three directors and department managers wrote down every patient “touch point” on Post-It notes and attached them to the conference room wall in the order in which they occur. They used a color-coded system to flag decision points, possible problem areas, as well as touch points which only applied to a sub-set of patients.

Over the course of this half-day session, it became apparent that each department manager had little visibility into the processes and procedures used in other areas of the cancer center. Consequently just the process of drafting the patient flow map turned out to be a valuable learning experience.

Leveraging Lean Methodologies to Identify Improvement Opportunities

Value Mapping Process

- Manager and one staff member from each department invited for 30-minute session.
- Post-it Notes used to represent each touch point; problem areas flagged in blue.
- Leadership created map of ideal patient flow, compared to actual flow.

Map Creation

Leaders set aside half-day to create initial draft of map on wall of conference room.

Refinement

Leaders asked probing questions to help identify every “patient touch point.”

Ideal State

Over subsequent weeks, all staff invited to review map, make changes as appropriate.

Source: Lehigh Valley Health Network, Allentown, PA

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Comprehensive Needs Assessment

Documenting Each Patient Touch Point

In order to ensure the accuracy of the patient flow map, all of the cancer center’s staff were invited to review it and make changes over the subsequent weeks. The end product was a step-by-step analysis of the patient experience, which then provided a framework for discussions about what the ideal patient flow should look like.

Lehigh Valley’s Patient Experience Map

- Assist with arranging second opinion
- Assess transport, family, social needs
- Spiritual support
- Financial assessment
- Genetics counseling offered
- Make appointment / education
- Specialty referral in plastic
- PDOF

Yes

Second Opinion

Yes

Refer to surgery, rad, med/gyn onc

No

Surgery Med Onc

Financial assessment

Assess transport, family, social needs

Spiritual support
Comprehensive Needs Assessment

Getting the Patient Perspective

The next step in Lehigh Valley’s needs assessment was to speak directly with patients and families about their experiences at the cancer center. The three project leaders met one-on-one with patients while they were waiting for their appointments and posed a series of questions aimed at identifying any problems or delays that patients may have experienced during the course of their care. While all of the leaders used the same set of questions as a starting point for these conversations, often the most important information was gleaned through targeted follow-up questions.

These interviews with patients were followed by similar conversations with the cancer center’s staff and physicians. They were encouraged to relate stories in which patients had encountered difficulties or had not received recommended care.

The Patient Interview Tool can be found in the Appendix.
Comprehensive Needs Assessment

Drilling Down to the Root Cause

Based on their findings from the patient flow mapping exercises and the interviews with patients, staff and physicians, the project leaders identified three core problems. First, there was a lack of awareness among physicians, staff and patients about the cancer center’s services. Second, there was confusion about who was responsible for referring patients to support services. In the absence of clear accountability, staff often assumed mistakenly that another person would make the referral. Finally, there were several processes being repeated unnecessarily across the cancer center’s departments. Given the extent of these issues, they concluded it was essential to address each in turn prior to hiring an additional navigator.

Lehigh Valley’s needs assessment was followed by various initiatives to streamline processes, clarify roles, and increase awareness of the Cancer center’s services and resources. Once complete, the program’s leadership was then able to turn its attention to remaining needs and design the navigator role accordingly.

Needs Analysis Identifies Key Issues

<table>
<thead>
<tr>
<th>Lack of Awareness of Services</th>
<th>Lack of Accountability</th>
<th>Redundant Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>Patients not accessing financial counseling in a timely way or not referred at all</td>
<td>Patients not referred to support services when appropriate</td>
</tr>
<tr>
<td>Root Causes</td>
<td>Patients and staff not aware of all of Cancer center’s services</td>
<td>Staff not aware of support services</td>
</tr>
<tr>
<td></td>
<td>Patients and staff don’t know who to ask for help</td>
<td>Individual staff assume someone else making referrals</td>
</tr>
</tbody>
</table>

Solving Problems, Not Glossing Over Them

“We realized that we did not want our navigators to have to work against the system. We wanted to identify and fix the gaps so that the navigators would be able to navigate patients within a good system.”

Director of Oncology Health Services
Lehigh Valley Health Network

Targeted Needs Assessment

Seeking to Address Timelines of Care

An alternative approach to conducting a needs assessment comes from Self Regional Healthcare in South Carolina. When the cancer program leadership observed some delays in care for breast cancer patients, they set out to determine where the bottlenecks were and whether hiring a navigator would be an appropriate solution.

The cancer program staff had used the Lean value mapping process in the past to improve infusion center operations and had achieved significant efficiency gains as a result. Thus the oncology director knew that the same process could be applied to evaluate timelines of care for their breast patients; however, given the time that a value mapping exercise requires, she first took the idea to her team in order to be sure that everyone was in agreement that it would be a good use of time. Once everyone confirmed their support for the project, they collectively defined their goals: understanding patient flow and pinpointing the causes of delays.

Case in Brief: Self Regional Healthcare

- 411-bed community hospital located in Greenwood, South Carolina
- Leadership observed patterns of increasing delays in care
- Prompted leadership to consider hiring breast navigator to streamline patient flow and improve timelines of care; took idea to the Physician Task Force for consideration
- Prior to defining navigator role, care team mapped patient flow with goal of identifying problem leading to delays in care

Physician Task Force Calls Attention to Problems with Patient Flow

- Physician Task Force
- Problems Observed
  - Delays in scheduling diagnostic tests
  - Delays in scheduling surgical consults

Source: Self Regional Healthcare, Greenwood, SC
Oncology Boardroom interviews and analysis.
Targeted Needs Assessment

Mapping Patient Flow Reveals Disconnect between Perception and Reality

In order to create the patient flow map, the team held a series of three meetings to brainstorm the steps in patient care. At the end of each meeting, the team had a list of questions about what actually happened; one individual was assigned to research the questions and bring the findings to the next meeting. Just like at Lehigh Valley, the process of mapping patient flow turned out to be a learning experience for everyone involved, as no one person was familiar with all of the steps.

Once an initial draft of patient flow had been completed, each team member was asked to estimate the time required to complete each step. Their estimates were then compared to actual data collected for six patients. The discrepancy between the team’s estimates and the actual time required was striking. Each person believed that patients were moving from one step to the next in one or two days, whereas in reality, it often took weeks. While this was sobering news, the exercise yielded critical information about shortcomings in their current processes as well as the actions needed to achieve optimal patient flow.

Value Mapping Process

- Set goals
  - Hold initial meeting with entire team of ten people
  - Reached consensus about need for value mapping
  - Set goals for project

- Map flow
  - Over course of three 60-90 minute meetings brainstormed steps in patient care
  - At end of each session compiled list of questions to research and answer before next meeting

- Analyze time per step
  - Once map completed, each team member estimated time required for each step in patient care process
  - Gathered data on actual time required for each step for six patients and compared estimates to actual times

- Ideal map
  - Held additional meeting to map ideal patient flow, taking into account resource constraints

Significant Difference Between Expectation and Reality

“Each area involved felt they were getting the patient in within 24-48 hours, which should result in a two week process overall. The reality was some patients were experiencing a six week process.”

Administrative Director, Oncology Services
Self Regional Hospital

Source: Self Regional Healthcare, Greenwood, SC
Oncology. Identifiable measures and analysis.
Targeted Needs Assessment

Analysis Provides Foundation for Navigator Role

After completing the process mapping exercise, the oncology director took the team's findings to the cancer program's physician task force. The physicians were bowled over by the data and agreed that a breast navigator would be instrumental in redesigning processes to improve timeliness of care. With the backing of the task force, the oncology director was then able to use the results of the patient flow mapping exercise to determine the navigator's responsibilities. For example, the team had discovered that referring physicians frequently contributed to delays in care because they were not reading and responding to patients' biopsy results in a timely way. Consequently, one of the navigator's responsibilities is to work with referring physicians to determine how they would like to receive pathology results, expedite the process, and follow up in the event that a physician is non-responsive.

Turning Skeptics into Believers

Team Presented Findings to Physician Task Force

Physicians who had been skeptical of need for navigator were won over by timeliness of care data

Navigator Responsibilities

- Serve as a main point of contact for referring physicians
- Coordinate patient testing
- Accompany patients to biopsy
- Ensure early referral to financial counselor
- Provide updates to referring physicians on a regular basis

Source: St. Regional Institute, Greenwood, SC. Oncology Roundtable Interviews and written.
Market-Driven Needs Assessment

Seeking a Market Advantage through Improved Support and Care Coordination

Whereas Lehigh Valley and Self Regional used process improvement methodologies to identify needs and define their navigators’ roles, Percy Hospital (a pseudonym) took a more market-driven approach. After recruiting a surgeon specializing in robotic prostatectomies away from one of their competitors, they set the goal of developing a formal program. To that end, they hired an advanced practice nurse (APN) to help design the program, grow their volumes, and serve as the care coordinator.

In order to better understand prostate cancer patients’ needs and preferences, one of the first things the APN did was conduct a focus group with patients who had been treated by the surgeon at the competitor institution.

The focus groups, which included both former prostate cancer patients and their spouses, yielded valuable information. Patients complained that they did not know what to expect on the day of surgery.

- Follow-up care was “sketchy”
- Lack of access to care team after business hours
- Nurse phone line was a “dead-end”

Competitor’s Shortcomings Drive Navigator Role

Navigator Role

- Conducting pre-op classes
- Checking in with patients by phone pre- and post-op
- Checking in with patients on the day of their surgery
- Visiting patients in hospital on day after surgery to review post-op instructions
- Available by phone as resource on an ongoing basis

Case in Brief: Percy Hospital

- 154-bed hospital located in the Midwest
- Recruited surgeon specializing in robotic prostatectomies from competitor, set goal of growing prostate program volumes
- Held focus groups with patients treated at surgeon’s former hospital to assist with program design

Source: Oncology Roundtable interviews and analysis.
Strategies for Physician Engagement

Physician understanding of and engagement with the navigation process is essential to successful program implementation. This section provides ways in which to engage physicians in the program planning and implementation process.
A Physician Champion is Essential to Program Success

One nurse navigator I met went to her cancer committee, asking for help to start a cancer survivorship program. Most of the physicians she spoke with were not particularly supportive of her idea, with the exception of the hospital's radiation oncologist. So she began working with his patients and soon other physicians in the organization took notice of her positive impact on care delivery.

Although navigation programs require a multidisciplinary team, an initial clinical champion is key for gaining momentum for a full-scale navigation program. This champion should understand the benefits of patient navigation and should have the visibility and credibility to help achieve the buy-in of other physicians within the organization. As one nurse navigator pointed out, “success is the ability to network,” sharing the benefits of the navigation program with all stakeholders.
**Physician Engagement Strategies**

- Identify and involve key physician(s) up front in navigation program planning and implementation
  - Participation in Cancer Program Needs Assessment
  - Assist with defining the Navigator Role
  - Involvement in screening Candidates for Navigator Position
    - Oncology Roundtable: “Physician involvement from the get-go ensures physicians feel engaged, valued”

- Engage physicians in pre-implementation assessments, planning and role development (physician engagement strategies located in Appendix)

- Identify physician(s) champion/advocate
  - Opportunities for peer to peer “marketing”
  - Assist with program planning, implementation and growth
    - Involvement in ongoing program assessment and improvement (CoC Std. 3.1)

- Establish physician/navigator collaboration opportunities
  - MDC
    - Case studies/navigation program outcome reporting by navigator(s)
    - Share “physician scorecards” related to number of referrals to navigation – creates friendly competition among physicians
    - Engage physicians in identifying program metrics and quality measures
  - Navigator cultivation of strong relationships with physician office nurses and staff
    - Regular visits to office creates presence and builds relationships
  - Navigator involvement/presence in cancer program steering committees, physician section meetings, Cancer Committee, etc.
  - Navigator exhibits knowledge of and respect for physician referral patterns
Physician Engagement Strategies (con’t)

- Navigator asks physicians for “permission” to navigate patients – facilitates trust and collaboration; opportunity for navigator to interact with physician

- Navigator creates “preference cards” for each physician so she/he is aware of specific physician preferences for their patients

- Navigator creates patient update letters for PCPs at key points in the cancer journey and sends a copy to referring physician as well in order to facilitate communication and interaction with physicians

- **Physician education opportunities**
  - Office visits by navigator (education, relationship-building, presence)
  - Navigator provides “Section” meeting presentations related to navigation program, outcome metrics, etc.
  - Cancer Committee meetings/MDC presentations
    - Annual navigation program reporting requirement by CoC Std. 3.1
  - Educate and involve physicians in definition of navigator role and responsibilities
  - Informational navigation fliers and contact information in key areas such as physician dictation stations
  - Reach out to physicians who are particularly resistant to patient navigation to learn what the barriers might be and collaborate on ways to resolve them

- **Demonstrate program value/ROI**
  - Ensures physician awareness of program outcome metrics and value
  - Engages physicians in defining quality and outcome metrics

- **Navigation Program “Track Record”**
  - Timely navigation of referred patients
  - Quality of communication between navigator and referring physician
  - Improved patient care/timeliness/coordination/satisfaction
  - Patients share their (positive) perspective on navigation experience with physicians
Physician Engagement Strategies

- Physician satisfaction survey (located on page 60)
  - Physician feedback
  - Identify opportunities for improvement/to address issues or barriers to patient referrals for navigation services
  - Identify physician education opportunities
  - Provide physician sense of involvement
Navigation Program Marketing Strategies and Tools

This section provides strategies for developing a successful marketing plan at the time of program implementation along with a long-term plan for program marketing.
Navigation Program Marketing Strategies

**Target Audiences for Marketing Efforts**

**Community Physicians/Practitioners** – Include those who not only might be potential referral sources but also those who will be interacting with the navigator, such as PCPs, those who are potential program advocates, and don’t forget to include advance practice nurses and PAs. For example:
- Surgery (all specialties)
- Gyn
- GI
- Thoracic
- Ortho
- Dermatology

**Internal Practitioners** – Include those who typically might be interacting with oncology patients throughout the cancer continuum, for example:
- Radiologists
- Pathologists
- ED
- Hospitalists

**Oncology Practitioners and Staff** – These are key people to have engaged in and educated about navigation services

**Oncology Patients/Families** – Addressing facility-specific patient populations and needs can help focus marketing efforts. Emphasize how navigation works and the benefits of navigation along with navigation program contact information and referral process

**General Population** – Educating the community about navigation services can facilitate referrals when a cancer diagnosis occurs

**Key Stakeholders**

Administrative and cancer program leadership engagement, support and advocacy is essential for developing and launching a successful marketing campaign. This will drive support for funding and facilitate strong marketing efforts.

A strong partnership with the marketing team will facilitate a commitment to navigation program marketing efforts.
**Navigation Program Marketing Strategies (con't)**

Marketing development team

Establish short- and long-term marketing plans based on specific cancer program and patient population needs and strengths

Explore funding opportunities for marketing

Is there a navigation program marketing budget?
Are there grant funding opportunities?

Develop marketing sub-teams with specific foci:

Marketing tool development:

Navigation program brochure – consider using actual photos of program staff, navigators, patients; patient and physician quotes. Outline specific navigator roles, benefits of navigation. Stress that navigation services are FREE. Include navigation program contact information and referral process

Business cards – consider listing all navigators and contact information

Website – establish a strong website presence; consider using actual navigator and patient photos with patient quotes to provide a personal touch; consider using quotes from physician advocates

Navigator visibility – facilitate navigator presence at screenings and community events; explore opportunities for community education

Utilization of existing oncology marketing opportunities to include navigation – for example, commercials, brochures, cancer program physician resource guide, etc.
Navigation Program Marketing Strategies (con't)

Other tools to be considered if feasible:
- Print ads – consider color ads again including photos and quotes
- Radio ads
- Billboards – consider a branded slogan
- Commercials – consider a branded theme

Physician Liaison Team
- Visit physician offices
  - Provide navigation education and resources for providers and staff
  - Base physician marketing campaign on specific physician feedback
  - Focus on ease of referrals and referral process
- Provide educational presentations at established provider meetings (i.e., section meetings, etc)
Navigation Program Operations

This section provides tools and resources for navigation program operations.
Utilizing the Harold P. Freeman model for patient navigation, we see that the cancer continuum starts with community outreach (prevention, screening and early detection) and goes through the end of active cancer treatment into the survivorship phase and/or the palliative care/hospice phase. Key patient entry points into navigation can occur at or during any of these phases of the cancer continuum and specific navigation program structure can determine the optimal entry points for your patient population.
Key Patient Contact Points Along the Cancer Continuum

Expanding on the Harold P. Freeman model, below you see the key points at which navigation contact and intervention can impact a patient’s flow through the cancer continuum. Again, adapting this model to your specific program, patient population, available resources and focus provides an opportunity for customization.

Outreach
• Education/Prevention
• Early Detection/Access to Care

Diagnosis/Tx
• Time of abn finding
• Time of diagnosis
• Barriers, concerns, issues arise
• Beginning of tx
• Treatment transitions
• Change in status
• End of tx

Survivorship
• Summary/Care Plan
• QOL
• Rehab
• Pall care/hospice/EOL
Establish Patient Entry and Exit Points

As patient advocates, nurse navigators strive to improve patients' preparedness for all stages of care, as well as their hopeful eventual self-sufficiency. To make the timeline and the process clear, navigators need to discuss and establish entry and exit points for their services with patients—and each program will make its own determinations. I met navigators who hand patients off after diagnosis and others who follow patients for as long as 5 years after treatment. Setting explicit exit and entry points for navigation services can make caseloads more manageable and give navigators more time with patients. Additionally, it is important to set boundaries with both staff and patients on how and when patients should contact the navigator. Navigators should not duplicate any other staff member’s job functions and should work within the boundaries of their own licenses. Appropriate points of initial patient contact might include time of abnormal screening, initial diagnosis, end of active treatment, point of recurrence or any point of exceptional anxiety along the care continuum.
Navigation Program Tracking, Documentation and Reporting

Recommendations For Tracking, Documentation and Reporting Tools

Our CHI Navigation Tracking and Documentation workgroup developed a list of navigation software user requirements based on our comprehensive CHI navigation program survey along with a review of the existing literature around navigation software products. These requirements can be found in the Appendix.
Navigation Program Metric Selection

The following guidelines were used in determining metric selection to demonstrating navigation program value and return on investment:

**Metric Selection**

- **Meaningful**
  - Does senior administration consider the metric important?

- **Reliable**
  - Do managers and clinicians trust the data for decision making?

- **Collection Feasibility**
  - Can staff collect and report on data within a reasonable time frame?

- **Communicability**
  - Is the metric easily understood by stakeholders?

- **Evidenced based**
  - Is the metric derived from clinical guidelines or published standard?
Key Navigation Program Metrics for Demonstrating Program Value, Return on Investment and Navigator Productivity

Metrics for Navigation Programs

- **Goal:** To improve patient care coordination, quality and timeliness of care as well as demonstrate navigation program value and return on investment.
- **While all of these metrics can be tracked, recommendations for core navigation program metrics are highlighted in yellow**
  - **Disease site/staging at time of diagnosis** (target is to increase early stage diagnosis)
  - **Referral source** (provider, self, etc.)
  - **Timeliness to care** (determined by specific navigator focus and facility benchmarks)
    - National timeliness data/benchmarks (can be used as a reference):
      - Breast
      - Lung
      - CRC
      - Head and Neck
    - For those patients who fall outside of timeliness benchmarks, a review is indicated.
      - If delay in care is outside of the control of the facility (i.e., patient request such as travel or life event, patient illness, any extenuating circumstances, etc), these patients should be excluded from the timeliness data
      - For a delay related to care coordination, an opportunity exists for process evaluation and improvement
  - **Navigator productivity indicators**
    - **Patient volumes** – can be further broken down into:
      - “Initial” – when enrolled in navigation services
      - “Ongoing” – any time after initial enrollment until completion of treatment
      - “Surveillance/Survivorship”- up to 6 month follow-up after completion of active treatment
    - **Number of barriers to care/needs identified**
    - **Number of referral needs for barrier mitigation**
      - Time spent making referrals
    - **Number, type of encounters with patient/family**
      - Time spent with patient/family
    - **Encounters with providers/services (scheduling/coordination of care)**
- **Patient acuity level**
  - Additional navigator daily activities (i.e., multi-d conference, community outreach, etc. along with prep time for such activities) – determined by navigator role
- **Patient satisfaction** (identified using patient satisfaction survey)
  - Patient perspective on timeliness
  - Patient perspective on barrier mitigation and referrals
- **Patient retention (decrease outmigration) and subsequent revenue (including downstream)**
  - Patient perspective on seamless transitions and coordination of care
  - Navigator impact on distress
  - Navigator impact on treatment adherence (can indicate revenue capture)
  - Patient perspective on navigation program value
- **Physician satisfaction**
  - Elements reflective of outcome metrics
    - Timeliness to Care
    - Coordination/Continuity of Care
  - Other elements:
    - Program gaps/needs
    - Collaboration with navigator/quality of communication
    - Ease of referrals
    - Understanding of navigation role/program
    - Navigator knowledge of resources/quality of pt education
    - Responsiveness
    - Collaboration with addressing patient concerns
- **Referral to services** (can demonstrate downstream revenue)
- **Patient race/ethnicity** (indicates service to disparate populations)
- **Navigator Impact on Patient Readmissions/ED visits**
  - If pre-navigation services data is available on specific patient populations related to unplanned admissions and ED visits, a comparison can be made post-navigation services implementation to evaluate navigator impact
  - If a trend related to unplanned admissions/ED visits is identified for a specific patient or for patient populations, there may be an opportunity for pro-active phone calls and/or scheduling of appointments with a provider in order to avoid unplanned admissions and ED visits
    - Identifying high risk patients can assist with determining which patients to follow more closely
  - **24/7** navigator on-call services may impact the number of ED visits/unplanned admissions
For further discussion on navigation program metrics, see 

The following pages contain recommendations from the Oncology Roundtable on Navigation Program on metric selection and ways in which to demonstrate program value and return on investment.

**Lesson #7: Select Navigator-Specific Performance Metrics**

Perhaps one of the most challenging aspects of managing a navigation program is devising a method for measuring the impact of navigation services. Starting with well-defined goals and a measure of baseline performance on key metrics can make the process significantly easier.

The metrics most commonly used to monitor navigation include the number of patients receiving navigation services, overall patient satisfaction scores and timeliness of care indicators. While each of these measures is potentially useful, none speaks to the unique value that navigators add, rather all of them measure multiple aspects of patient care.

**Most Commonly Used Navigation Metrics Lack Specificity**

- **Sample Indicators**
  - Number of Patients Navigated
  - Patient Satisfaction Scores
  - Number of Patient Interventions
  - Physician, Staff Satisfaction Scores
  - Patient Retention Rates
  - Timeliness of Care Indicators

*Source: Oncology Roundtable interviews and analysis*
A More Targeted Approach to Measuring Navigators' Contributions

Survey Explicitly Evaluates Navigators' Performance

Navigator-Specific Patient Satisfaction Survey

Please rate your level of agreement with the following statements:

- My cancer care was provided in a timely fashion
- My care navigator helped me develop my unique treatment plan
- My care navigator was important in ensuring seamless care between different areas of the clinic
- My care navigator coordinated my care to meet my unique needs
- My navigator answered my questions in a manner I could easily understand

Case in Brief: Billings Clinic

- 215-bed community hospital based in Billings, Montana
- Conduct navigator-specific patient satisfaction surveys via phone

Deltor Hospital takes a more market-oriented approach to measuring the impact of navigation, focusing on the potential for navigators to influence patient volume. Several years ago, the cancer program director observed that many breast cancer patients initiated their care at other institutions than switched to Deltor because of the breast navigator. She began tracking these patients and observed that the numbers grew each year. Thus, the navigator was having a major impact on program revenues.

The popularity of the navigator ultimately led to the development of a marketing campaign featuring women who switched to Deltor for their breast cancer treatment, and it has become a powerful market differentiator for the cancer program.

**Switched Patients Featured In Marketing Campaign**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of Patients Who Switched</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>7%</td>
</tr>
<tr>
<td>Year 2</td>
<td>10%</td>
</tr>
<tr>
<td>Year 3</td>
<td>16%</td>
</tr>
</tbody>
</table>

**Case In Brief: Deltor Hospital**

- 159-bed general medical and surgical hospital located in Geneva, Illinois
- Started tracking “switched” breast cancer patients (i.e. patients that left their original cancer care provider for Deltor due to the navigation program) three years ago
- Observed that number of switched patients grew each year, used findings as basis for “Switched” advertising campaign featuring patients who changed providers
Realizing the Promise of Navigation

Perhaps the most rigorous approach to measuring the return on investment associated with navigation comes from Forsyth Regional Cancer Center at Novant Health. Forsyth started its navigation program in 2001, when one of the radiation oncologists called attention to the high level of anxiety she observed among breast cancer patients. At the time, the oncology administrator was able to secure a Komen Foundation grant which covered half of a breast navigator's salary for two years. The breast navigator was so popular that over the years the cancer center added positions for thoracic, gynecological, geriatric, neurological, and complex cancer patients. It is a major investment, but one that is justified by the impact on patient satisfaction and program revenues.

Milestones In Navigator Program Development

- Radiation oncologist notices breast cancer patients experiencing high levels of anxiety
- Breast navigator role evolves to support tumor board, clinical research, genetic counseling
- Over subsequent years added navigators for thoracic, GI, GI, and neuro
- Employ total of eight navigators

2001

Case in Brief: Derrick L. Davis Forsyth Regional Cancer Center

- 981-bed health system based in Winston-Salem, North Carolina
- Navigators follow patients from diagnosis through treatment, and in the case of breast, one-year post-treatment
- Navigators' responsibilities include:
  - Helping patients understand/interpret what their doctors tell them
  - Educating patients about disease process
  - Referring patients for support services, e.g. chaplain, nutrition, lymphedema care
  - Scheduling patients to be presented at Tumor Board
  - Being available to patients for questions or concerns 24/7
- Navigators do not have administrative responsibilities, e.g. scheduling patients' appointments
- Patients are referred to the navigator through pathology reports, physicians, and other patients; before contacting patients, navigator will first speak with the physicians to learn what the patient has been told about his/her diagnosis

Source: Derrick L. Davis. Forsyth Regional Cancer Center, Winston-Salem, NC. Oncologic Nursing interviews and analysis.
Option #2: Document Revenues from Returned Patients

Documenting Their Value

Each month Forsyth’s navigators complete a productivity report covering all their patients’ activities, including outmigration for second opinions. If patients leave Forsyth and later return, this is recorded. If the patient proactively shares their reason for returning to the navigator, then those patient names are flagged and any subsequent revenues associated with their care are documented. These dollars are credited to the navigator program as they would have been lost otherwise. Obviously, because this approach relies on patients volunteering information about the reason for their return to Forsyth, it likely undercounts the actual number of patients who return due to the navigators.

Developing a System for Tracking Financial Value of Navigators

Nurse Navigator Input + Monthly Productivity Report + Accounting

Nurse navigator completes monthly productivity report; one composed of which is patient outmigration.

Data points include:
- Patient name and DOB
- Outmigration source
- Reason for outmigration
- Reason for return
- Medical record number

Patients listing nurse navigators as reason for return forwarded to accounting; revenue associated with service utilization compiled.

Note: Brach L. Evans Breast Surgery Cancer Center, Rochester, MN; Destiny Endocrine/Obstetrics and Gynecology.
Quantifying ROI on the Nurse Navigator Investment

In an average year, 30 to 45 patients leave the system to seek a second opinion and report that they returned to Forsyth for their care because of the navigator. In one year, the services billed for these patients translated into over $600,000 in revenues. This return more than justifies the navigator program, particularly when coupled with the impact on physician and patient satisfaction.

Both Forsyth and Dalton Hospital have used their navigators as a means of improving the patient experience and differentiating themselves from competitor institutions. An obvious question is whether, as navigators become more common, this market advantage will disappear. However, findings from this research indicate that cancer programs that deploy navigators effectively will continue to attract more patients, whereas those who hire navigators without the proper analysis and planning will continue to lose out.

It's Not If You Have Navigators, It's How You Use Them

As more cancer programs hire navigators, simply having navigators on staff will no longer be sufficient to confer a market advantage. In order for a cancer program to use navigation to differentiate itself, it must deploy navigators more effectively than its competition.

Source: Daniel J. Dory, Forsyth Regional Cancer Center, Winston-Salem, NC.
Oncology Recruitment: overcome and succeed.
Metrics Matter, but Patient Time Matters More

In an age of accountability for tracking metrics, navigators—and those who support navigation programs—must understand that there is a trade-off between tracking metrics and supporting patients. Focusing on too many program measurements can dilute the focus of the program itself. However, metrics are vital to program survival. At the conference, the Association of Community Cancer Centers stated: "As a nonrevenue producing program, patient navigation programs must provide robust outcomes metrics that can be tracked and trended to ensure continued support and resource allocation." New navigation programs should initially track 4 basic measurements to prove their impact:

- Timeliness of care
- Referrals to ancillary services
- Retained patients
- Patient satisfaction

Although there are no established benchmarks for nurse navigation outcome measures, research has demonstrated a significant positive impact. For example, a 2012 study in the Clinical Journal of Oncology Nursing evaluated the impact of a nurse navigator on improving the timeliness of lung cancer care at the Connecticut Veterans Affairs Healthcare System. The system hired an advanced practice nurse as a navigator in 2007 to help reduce delays between diagnosis and treatment for lung cancer patients. Based on the navigator’s recorded data detailing timeliness and tumor stage at diagnosis for lung cancer patients, the health care system created and improved several efficiency and quality processes. As proof of the navigator’s value, the time from a suspicion of cancer to treatment was 55 days in 2010, compared to 136 days in 2003.

How Nurse Navigators Help

<table>
<thead>
<tr>
<th>Patient Benefits</th>
<th>Physician Benefits</th>
<th>Hospital Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistent point of hospital contact</td>
<td>Better interdisciplinary team communication</td>
<td>Shorter lengths of stay</td>
</tr>
<tr>
<td>Help coordinating appointments</td>
<td>More informed patient preparation for clinician visits</td>
<td>Increased downstream revenue</td>
</tr>
<tr>
<td>Streamlined care from diagnosis to treatment</td>
<td>Dependable referral pathways to specialists</td>
<td>Referrals to ancillary services</td>
</tr>
<tr>
<td>Decreased anxiety</td>
<td>Improved patient satisfaction</td>
<td>Improved physician and staff satisfaction</td>
</tr>
<tr>
<td></td>
<td>Reduced outmigration, leading to increased revenue</td>
<td>Increased use of multidisciplinary teams</td>
</tr>
</tbody>
</table>
Satisfaction Tools and Processes

This section contains patient and physician satisfaction surveys along with processes for distributing these tools. Satisfaction data can demonstrate program value, assist with gathering outcome metric data and provide insight into program gaps and improvement opportunities.
Physician Satisfaction

This survey was developed based on tools recommended by national navigation program leaders and organizations and is intended to provide valuable feedback on program value from the physician’s perspective as well as opportunities to address program barriers and gaps.

Navigation Program
Physician Satisfaction Survey

Please rate our Patient Navigation services on a 1 – 5 scale, 1 being least satisfied, 5 being most satisfied.

<table>
<thead>
<tr>
<th>Physician Survey</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall rating of our navigation program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall experience with the navigator(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Navigator’s timeliness in coordination of care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration in addressing patient concerns/quality of communication between physician and navigator/navigator responsiveness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician understanding of navigation role/program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ease of referrals to navigation program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Navigator knowledge of resources/quality of pt education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Navigator follows evidence-based guidelines for patient care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Navigator relationship with office staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall, I value the navigation service to my practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would recommend this service to other patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please identify any gaps in our navigation services:

Suggestions or comments:

Name (optional):
**Navigation Program**

**Physician Satisfaction Survey Distribution Process**

- Each facility must determine who is responsible for collecting, analyzing and reporting physician satisfaction data
- A electronic version of the survey (ex – Vovici) maximizes return rate
- Timing of survey distribution:
  - Within 1st year of navigation services being implemented – twice
  - 2nd year on – annually
  - Consider coinciding survey distribution with annual navigation program report to the Cancer Committee
- Market the survey prior to distribution - explanation about the survey with an emphasis on the need for and value of physicians’ feedback on the navigation program
  - Announcements at meetings (i.e., Cancer Committee)
  - Conversations with physicians
  - Physician champion support with marketing
  - Make it fun and exciting!
    - Facilitate a friendly competition among physicians
- Report results back to physicians, addressing any concerns they may have (particularly those who refer rarely or not at all)
Patient Satisfaction

Our workgroup has developed patient satisfaction surveys for both patients mid-way through treatment and for patients who have completed active cancer treatment. Two mid-way surveys are offered, one of which is a survey developed by the Patient Navigation Research Program and is specific to the interpersonal relationship between the patient and the navigator. Information gathered through these surveys can provide outcome metric data as well as identify opportunities for program improvement.
Navigation Services
Patient Satisfaction Survey (Midway in Treatment Continuum)

Timeliness to Care
- Where in your cancer journey did your navigator first meet with you? (Please circle)
  - When I had an abnormal test (for example, a mammogram)
  - Right after I found out I had cancer
  - Before surgery
  - Before chemotherapy
  - Before radiation therapy
  - Before hormonal therapy
  - Other (please describe)______________________________

- My navigator has helped get my appointments scheduled in a timely manner
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A

- My navigator responds to me and/or returns my calls within an acceptable time frame
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A

- Comments: ______________________________________________________

Barriers and Referrals
- My navigator identifies and helps resolve any barriers, such as transportation, child care, financial concerns, to my receiving cancer care
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A

- Support services referrals (such as help with transportation or child care, social worker, rehab, etc) are made by my navigator
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A

- These referrals are helpful and met my needs
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A

- Please list any barriers to care that you have or are experiencing during your cancer journey:
  ___________________________________________________________________

- Comments: ____________________________________________________________________
Coordination/Continuity of Care
- My care navigator is important in ensuring seamless care among all of the cancer care departments, facilities and providers
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A
- Comments: ________________________________________________________________

Distress
- The support from my navigator helps decrease my stress and anxiety
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A
- Comments: ________________________________________________________________

Navigator Impact on Treatment Adherence
- My navigator helps me to understand my cancer treatment plan
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A
- My navigator helps me stay on track with my treatment schedule
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A
- Comments: ________________________________________________________________

Other
- I value working with the navigator
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A
- I would recommend this service to others with a cancer diagnosis
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A
- Comments: ________________________________________________________________

Patient Name (optional): __________________________________________________________
Navigation Patient Satisfaction Tool
Midway (PNRP Generated PSN-I Tool)

Purpose: Provides feedback on satisfaction with interpersonal relationship with navigator

- My navigator is easy to talk to
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A
- My navigator listens to my problems
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A
- My navigator is dependable
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A
- My navigator is easy for me to reach
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A
- My navigator cares about me personally
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A
- My navigator is courteous and respectful to me
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A
- My navigator gives me enough time
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A
- My navigator figures out the important issues in my health care
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A
- My navigator makes me feel comfortable
  1 (Strongly Agree) 2 3 4 5 (Strongly Disagree) N/A
Navigation Services
Patient Satisfaction Survey (post-treatment)

Timeliness to Care

- Tell us about how quickly your appointments were scheduled:
  o Time between your call to schedule an appointment for diagnostic testing and your appointment date ______ (business days)
  o Time from abnormal test result to diagnosis ______ (business days)
  o Time to appointment with surgeon, oncologist or radiation oncologist ______ (business days)
  o Time to appointment with other physician(s) ______ (business days)
  o Time from diagnosis to start of treatment ______ (business days)
  Comments about timeliness in your experience?_________________

- Where in this process did your navigator first meet with you? (Please circle)
  o When I had an abnormal test (for example, a mammogram)
  o Right after I found out I had cancer
  o Before surgery
  o Before chemotherapy
  o Before radiation therapy
  o Before hormonal therapy
  o Other (please describe)________________________________________

- My navigator helped get my appointments scheduled in a timely manner (1 – 5 scale)
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A

- My navigator responded to me and/or returned my calls within an acceptable time frame
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A

Comments:___________________________________________________________________________

Barrier Assessment and Mitigation/ Referral to services

My navigator identified and helped resolve any barriers, such as transportation, child care, financial concerns, to my receiving cancer care

1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A

- Support services referrals (such as help with transportation or child care, social worker, rehab, etc) were made by my navigator
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A

- These referrals were helpful and met my needs
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A
- Please list any barriers to care that you experienced during your cancer journey:
  
  Comments: 

**Patient Retention**
- I came to this facility because I knew a navigation program was in place __Yes__ No__ N/A
- I stayed with this facility because a navigation program is in place __Yes__ No__ N/A

  Comments: 

**Coordination/Continuity of Care**
- My navigator was important in ensuring seamless care among all of the cancer care departments, facilities and providers
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A
- The navigator coordinated my care to meet my unique needs
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A

  Comments: 

**Distress**
- The support from my navigator helped decrease my stress and anxiety
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A

  Comments: 

**Navigator Impact on Treatment Adherence**
- My navigator helped me to understand my cancer treatment plan
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A
- My navigator helped me stay on track with my treatment schedule
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A
- My navigator contributed to my successfully completing my cancer treatment
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A

  Comments: 

**Other**
- I valued working with the navigator
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A
• I would recommend this service to others with a cancer diagnosis
  1 (Strongly Agree)  2  3  4  5 (Strongly Disagree)  N/A
• Was there any additional information or education that would have been helpful for you?
  _____________________________________________________________
• Do you have any comments about how we can improve the navigator program?
  _____________________________________________________________
• Were there any exceptionally good experiences that you’d like to share?
  _____________________________________________________________

Patient Name (optional):  _____________________________________________________________
Navigation Services
Patient Satisfaction Survey Distribution Process

- Each facility needs to determine who is responsible for collecting, analyzing and reporting patient satisfaction data
- To maximize response rate, the navigator hand-delivers the survey to the patient with an explanation about the survey with an emphasis on the need for and value of the patient’s feedback on the navigation program.
  - The patient is encouraged to complete the survey before leaving the cancer center, is given a private place to complete it and a drop box is made available for ease of submitting the survey
  - If the patient is unable to complete the survey before leaving, a SASE is provided so that it can be returned by mail
  - If applicable, the navigator may ask a family member or caregiver to assist with the survey completion
  - Each facility may want to consider a way to incentivize patients to complete and return the surveys
- Timing of survey distribution
  - Programs have an opportunity to distribute a survey midway through a patient’s cancer journey to garner feedback about navigation during cancer treatment. There are 2 options for this survey (or both may be utilized):
    - An abbreviated version of the final Navigation Patient Satisfaction Survey
    - PSN-I tool, which assesses the interpersonal relationship between the patient and the navigator
  - At the end of treatment, either the survivorship navigator or the disease-specific navigator distributes the survey to the patient as described above
**Quality Improvement Projects**

We recognize that as a result of program metric tracking, opportunities may emerge for quality improvement projects. This section describes processes for identifying potential projects.
Process for Identifying PI Projects that Emerge as a Result of Metric Tracking

Recommendation: 3 quarters of outcome metric data collection to effectively evaluate trending

Performance Standards and Potential PI Projects

- **Timeliness to care**
  - Data collection considerations:
    - Head and Neck cancers – potential goal may be 14 days from diagnosis to treatment
    - Breast cancer
      - Days from abnormal findings to diagnostic mammogram
      - Days from diagnostic mammogram to biopsy
      - Days from diagnosis to surgery
      - Days from diagnosis to treatment
      - RT within 1 year when indicated
    - Colorectal – 30 days from diagnosis to treatment (NCCN benchmark)
    - Thoracic – Abnormal finding to treatment national average is 40 – 60 days; a potential goal for navigation programs might be 20 days
  - Recommendation: Take to Multidisciplinary Conference or to key physicians/program leaders for further discussion and institution-specific targets

- **Disease site**
  - Navigation services meeting patient population needs?
  - Appropriate navigator staffing related to patient volumes?

- **Navigator Productivity**
  - Assessment of barrier and needs/patient referrals
    - Assessment tools and processes
    - Cancer program gaps and needs
    - Service to disparate populations
  - Patient acuity
    - Assessment tools and processes
    - Frequency of acuity assessment

- **Impact on patient re-admissions and ED visits**
  - Process for evaluation of unplanned admission/ED visit cause
  - Development of processes to reduce unplanned admissions/ED visits
    - Identification of high-risk patients
    - Pro-active contacts to decrease incidence of visits/admissions
• **Patient Satisfaction**
  - Patient retention
    - Marketing of navigation services to patients and physicians
  - Coordination of patient care
    - Care coordination processes
  - Distress assessment
    - Distress assessment processes
    - Distress management processes
  - Treatment adherence
    - Best practices for navigators to provide support during treatment
  - Program value
    - Patient education re: navigation services

• **Physician Satisfaction**
  - Identification of and processes for addressing program gaps and needs from physician perspective
  - Physician involvement and collaboration in development and evaluation of navigation program quality metrics

• **Race and ethnicity**
  - Services offered to disparate populations
  - Identification of gaps in services

• **Process Improvement Process**
  - Once opportunities for PI projects are identified, programs may utilize facility-specific process for managing improvements
    - Examples - LEAN, PDCA, FMEA, RCA, Rapid-Decision, etc.

• The **NCCCP Navigation Program Assessment Tool** may assist in evaluating current navigation program state and opportunities for improvement projects. This document may be found in the Appendix.

This article, which appeared in the July/August 2012 issue of *Oncology Issues*, provides guidance for using the assessment matrix:  
Growing a Navigation Program
Determining Optimal Navigator Caseloads

The most recent research from the Advisory Board’s Oncology Roundtable indicates that determining patient acuity is the best way to identify optimal patient caseloads for navigators. Those navigators who have patients with a higher acuity level would ideally have a lesser volume of patients being navigated at one time. In this section you will find tools and resources for determining patient acuity levels.
The use of patient acuity scales is determined by specific navigation program needs. Options for the purpose of capturing patient acuity data are:

- A means to identifying optimal patient caseload for navigators based on patient acuity (for example, patient needs may be higher for a head and neck cancer patient as opposed to a breast cancer patient and measuring acuity may help to identify optimal caseload)
- Determining number of navigators needed for a navigation program and/or providing justification for additional navigation FTEs (navigators, lay navigators, admin support, etc)
- A means of measuring navigator productivity (time spent with patients; number of patient needs/barriers; number of referrals needed)
- Assessing patient needs to identify potential gaps in cancer program services

Recommended patient acuity tools (see Appendix for tools):

- Billings Clinic tool
- Franciscan tool

These tools can be modified to meet specific navigation program needs.

Patient acuity should reflect:

- Number of barriers/needs
- Number of referrals for services needed
- Time navigator spends with patient or on patient needs/referrals

**Frequency for Assessing Patient Acuity**

- Acuity can be assessed along with Distress Screening at “pivotal medical visits” related to times within the cancer continuum (i.e., time of diagnosis, start of treatment, treatment transitions, end of treatment, etc) at which the patient is most at risk for distress (CoC Std. 3.2)
- The frequency of acuity assessment can also be determined by the navigator based on the specific patient population being navigated
Below are the Oncology Roundtable’s recommendations for assessing patient acuity as well as for increasing navigator efficiency.

Imperative #1: Account for Patient Acuity

Recognizing the imbalance, Billings created a workload equation to estimate actual patient need for services according to tumor site and cancer stage. Next, they developed a list of acuity definitions, reflecting not only the degree of need for services but also the duration of follow-up from the time of diagnosis. Finally, based on the previous year’s new case loads, they assigned acuity levels by patient type, which were then multiplied by the number of patients in the respective category. This new workload estimation allowed Billings to restructure patient population assignments across navigators, decreasing the potential for one navigator to be overburdened relative to another.

Source: Billings Clinic, Billings, MT: Oncology Roundtable interviews and analysis

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Imperative #2: Leverage Existing Resources to Increase Navigator Efficiency

Given that resource constraints prevent many programs from hiring additional navigators, it is essential to maximize navigator effectiveness by leveraging existing support staff. Reassigning "non-navigator" tasks to other staff members enables navigators to spend more time performing "high value" tasks, as evidenced by a navigator workload study conducted by Anne Arundel Medical Center. The main findings revealed an overlap in existing service delivery due to lack of sufficient role definition, which was further exacerbated by a recent increase in service offerings and patient volumes. Through the redefinition of roles and redistribution of navigator and "non-navigator" tasks, Anne Arundel reduced multiple workload inefficiencies, increasing the center's ability to handle existing and growing demand for services.

Finding the Right Balance
Breast Center Workload Study at Anne Arundel

<table>
<thead>
<tr>
<th>Measures</th>
<th>Findings</th>
<th>Improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly patient volumes</td>
<td>Navigator lacking sufficient role definition, many tasks outside of scope</td>
<td>1) Clearly defined navigator role</td>
</tr>
<tr>
<td>Phone reports with volumes, frequency of calls to navigator</td>
<td>Reallocated non-navigation tasks to staff</td>
<td>2) Reallocated non-navigation tasks to staff</td>
</tr>
<tr>
<td>Direct observation of patient flow</td>
<td>High volume of patient calls missed when navigator unavailable, patient satisfaction at risk</td>
<td>3) Hired additional navigator based on increased phone, clinic volumes</td>
</tr>
<tr>
<td>Clinic schedules with staff mix, time utilized by type of patient visit</td>
<td>Clinic scheduling template inconsistent with trends; led to delays, frustrated staff</td>
<td>4) Reevaluated scheduling template</td>
</tr>
<tr>
<td>Interviews with staff</td>
<td></td>
<td>5) Addressed additional process inefficiencies</td>
</tr>
</tbody>
</table>

Case in Brief
Anne Arundel Medical Center

- A 280-bed community hospital located in Annapolis, Maryland
- Breast center noted increase in volumes, led to concerns regarding navigator workload, staff coordination, process inefficiencies
- Center director requested an analysis evaluating staffing setup, process flow
- Study led to staff responsibility reassignments, notably affecting nurse navigator despite role restructuring, overall increase in volumes, service offerings justified need for additional navigator

Source: Anne Arundel Medical Center, Annapolis, MD; Oncology Roundtable interviews and analysis.
Leveraging Staff to Provide Relief
Support Staff Candidates

Volunteer
- Provides resource guidance for cancer center staff, patients
- Reduces time navigator spends searching for cancer-related information
- Creates new role

Administrative Staff
- Allocates nonclinical responsibilities to support staff
- Tasks may include pulling charts, clinic room setup, etc.
- Utilizes existing role

Social Worker
- Navigator identifies, refers patients with mental health needs
- Navigator able to focus on other care gaps while ensuring patient access
- Utilizes existing role

As shown at left, there are numerous staff well-positioned to assist navigators. Volunteers can work in the cancer resource center and library to assist patients and staff in accessing cancer-related materials. Alternatively, depending on staff availability, administrative staff can assist with nonclinical tasks and a social worker can take responsibility for connecting patients to psychosocial evaluations and manage follow-up as needed. The document at the bottom of the page provides a sample volunteer patient navigator job description.
Volunteer Patient Navigator Job Description

Volunteer Summary:
The Patient Navigator is the contact person to those who have made an inquiry to the leadership of your faith-based organization or who has been diagnosed with cancer and reaching out to someone who is able and qualified to guide them through their cancer journey. The Patient Navigator ensures that the person's needs are met through their initial contact and provides additional support and information regarding community resources, programs, and services, basic cancer information. The Patient Navigator is not to address the medical needs of the patient, rather to be a resource to guide them to the proper referral source. No medical advice is given to the patient and/or their caregiver. Hours are flexible. Time commitment: 1 year. Ability to attend quarterly update meetings.

Responsibilities:
• Maintains the strict confidentiality of the patient
• Provides general information about cancer and its treatment
• Provides referral to local community and national resources
• Promotes programs and services
• Assists patients/caregivers on Internet use, websites and support information
• Maintains accurate records for continued follow up

Qualifications:
• Demonstrates knowledge and commitment to the Patient Navigator program
• Knowledge about the core programs and services
• Strong communication skills
• Willingness to follow up with patients/caregivers
• Recognizes importance of maintaining the strictest of confidentiality and record keeping
• Appreciates diversity
• Ability to handle difficult or emotional situations and has the knowledge base to make appropriate referrals, with the patient's permission
• Ability to locate and appropriate information utilizing available resources
• Demonstrates computer skills or willingness to learn desirable, training may be offered
• Able to respond to direction and recommendations

Source: Morristown Memorial Hospital, Morristown, NJ. Uncology Roundtable interviews and analysis.
Other Considerations for Determining Navigator Caseload

Ideally, all cancer patients should have the opportunity to be navigated. However, in taking a realistic look at resources and navigator capacity, it may be necessary to narrow the focus for patients needing navigation. The following considerations may assist with determining those patients most in need of navigation services:

- Identification of those medically underserved and disparate populations specific to your specific community
- Identification of where there are gaps related to timeliness or care coordination in your specific cancer program
- Identification of those patients with a higher number of barriers and/or needs using a navigation intake assessment tool and assigning an acuity level based on the number of barriers and/or needs

Navigators may then focus their time and energy in supporting those patients who have a higher level of need for navigation. On the following page are recommendations from the Advisory Board which support this consideration.
Lesson #10: Focus Limited Resources on Patients with Greatest Needs

Not all cancer programs are able to make the same level of investment in navigation as Foosyth Cancer Center. Advocate Good Samaritan employs a Cancer Care Liaison, who has multiple responsibilities including patient navigation. She spends approximately 70% of her time on navigation responsibilities, but is unable to support every patient. In order to ensure that patients are receiving the help they need, she has recruited and trained several volunteers.

The volunteers work in the radiation therapy center one morning or afternoon each week, introducing themselves to patients and asking if they can be of assistance. Using an acuity scale, they rate each patient as either requiring no assistance, requiring some questions the volunteer could address, or having more complex needs requiring the attention of the navigator. In total, the navigator works with approximately 10 percent of patients with the most complex needs. It is a thoughtful and principled approach that ensures those patients who stand to benefit the most from navigation are able to access the service.

Volunteers Handle Less Acute Cases

<table>
<thead>
<tr>
<th>Volunteers</th>
<th>Acuity Scale</th>
<th>Navigator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly-trained volunteers introduce themselves to patients in waiting rooms, assess needs, and provide information.</td>
<td>Volunteers rate patients’ needs on scale: 1 indicates patient was contacted but does not need assistance. 2 indicates patient had simple questions which were answered by the volunteer. 3 indicates patient had significant need and was referred to the nurse navigator.</td>
<td>Focuses attention on patients with greatest need.</td>
</tr>
</tbody>
</table>

Case in Brief: Advocate Good Samaritan Hospital

- 540-bed community hospital in Downers Grove, Illinois
- Cancer program employs clinical navigator called Cancer Care Liaison who spends approximately 70% of time on navigation and 30% of time on community outreach activities
- In 2009, began using volunteers to assist navigator with connecting patients to resources
- Volunteers screened by hospital’s Volunteer Department; they receive training from hospital and the American Cancer Society
- Navigator created acuity scale to assist volunteers in triaging patients appropriately; high acuity patients, approximately ten percent of cases, referred to navigator.
Navigation Program Policies and Procedures

Our Program Implementation Workgroup modeled these navigation program policies and procedures using the navigator responsibilities as defined by the NCI’s Patient Navigation Research Project.
**CHI Navigation Policy and Procedures**

**POLICY:**

It is the policy of CHI/____________________ to provide continuity of care for cancer patients utilizing the resources identified and provided by the oncology nurse navigator. The intent is to enable oncology patients to receive timely, appropriate and equitable access to care.

**DEFINITION:**

Patient Navigators are trained, culturally sensitive health care workers who provide support and guidance throughout the cancer care continuum. They help people "navigate" through the maze of doctors' offices, clinics, hospitals, outpatient centers, insurance and payment systems, patient-support organizations, and other components of the health care system. Services are designed to support timely delivery of quality standard cancer care and ensure that patients, survivors, and families are satisfied with their encounters with the cancer care system.

**PROCEDURE: Referrals**

- **Provides Access to Resources (internal and external) and Assesses Patients’ Current and Future Needs, Facilitates Distress Screenings, Coordinates Financial Assessment and Referrals**
  - Makes referrals for services based on patient/family needs – education, finances, psychosocial, survivorship, transportation, child care, lodging
  - Assesses for and assist with patient/family resources
  - Facilitates access to physicians and services
  - Assesses for and mitigate barriers to care. Assists patients with access concerns (for screening, diagnosis or treatment) and assists with paperwork and addressing access barriers as indicated.
  - Facilitates appropriate medical record availability at scheduled appointments as needed.
  - Facilitates language translation or interpretation services.
  - Facilitates financial assessment and referrals as well as helping with paperwork as needed.
  - Facilitates transportation, lodging and/or child/elder care and addresses any other practical needs
  - Facilitates linkages to follow-up services.
  - Facilitates access to clinical trials
  - Builds partnerships with local agencies and groups (e.g., referrals to other services and/or cancer survivor support groups)
  - Facilitates distress screening and appropriate referrals
    - Assesses for emotional well-being and makes appropriate referrals as needed
PROCEDURE: Coordination of Patient Care

- Coordination of Patient Care (coordinating/facilitating appts, accompanying patients to appts as needed)
  - Coordinate patient care from diagnosis through survivorship or palliative care/hospice
  - Assist with coordinating appointments
  - Meet with patient by phone or in person “within designated time” following “designated event” and follow patient per navigator- or facility-specific guidelines
  - Facilitate timely coordination of services between diagnosis and treatment
  - Provide telephone triage services (e.g., symptom management, emotional support, education, resource referral) for patients/families
  - Coordinate appointments for diagnostic testing, services and with providers to ensure timely delivery of diagnostic and treatment services. May include accompanying patients to appointments (particularly if there are multiple barriers to care) and/or providing clarification and literacy-level-appropriate education related to the visit

PROCEDURE: Collaboration

- Develops Physician/Cancer Care Team Relationships
  - Communicate and collaborate with involved physicians and staff members to facilitate individualized, holistic patient care plan
  - Facilitate communication between cancer care disciplines
  - Maintain communication with patients, survivors, families, and the health care providers to monitor patient satisfaction with the cancer care experience
  - Ensure that navigator functions are meeting physician expectations and that navigator activities remain within scope of defined role
- Assists With Preparing MDC Conference Materials and Providing Follow-up
  - Assists with coordination of Multi-D Conference(s)
  - Assists with patient follow-up as needed

PROCEDURE: Tracking and Documentation

- Tracks Metrics, Quality Indicators; Documents Patient Interactions, Progression
  - Ensure timely documentation of all patient interactions into navigation tracking and documentation system(s)
  - Assist with tracking, documentation and outcome reporting for navigation services
  - Assist with ongoing navigation program assessment and identification of process improvement opportunities
• Assist with annual CoC Std. 3.1 activities related to community needs assessment and resulting program modifications related to needs; assist with program reporting to Cancer Committee

PROCEDURE: Education

• **Provides Patient Education, Provides Symptom Management Support**
  • Discuss physician visits with patients and families and answer questions
  • Provide and reinforce education re: treatment, care plan, symptom management and survivorship concerns
  • Empower patients with education and knowledge to help improve patient outcomes and satisfaction

• **Community Outreach**
  • Conduct health promotion and awareness programs in community as appropriate
  • Attend community health fairs and screenings; provides community education presentations as appropriate

• **Other**
  • Facilitate/attend support groups as appropriate
Patient Intake and Assessment Tools

Four types of patient intake/assessment tools have been developed:

- Basic – identifies key areas of needs and barriers to care
- NCCN – utilizes the problem list identified by the NCCN Distress Tool to determine patient needs and barriers. The NCCN Distress Tool can be used as an assessment tool itself and should be self-administered by the patient in a paper format. Permission from the NCCN is required for use of this tool.
- 2 types of complex tools which expand on both the basic and NCCN tools and provide a more comprehensive patient assessment of needs and barriers to care

The assessment tool items can be found in the Appendix.
Ongoing Navigation Program Evaluation and Improvement Tools and Processes

This section provides resources and tools for continuous navigation program evaluation and improvement, including tools for ensuring compliance with the new CoC Standard 3.1 related to patient navigation.
The following pages contain recommendations from the Oncology Roundtable for navigation program evaluation and improvement.

**Establishing a Process for Continuous Improvement**

Beyond the initial needs assessment, the APN wanted to create a mechanism that would enable her to identify opportunities for improving the program on an ongoing basis. To that end, she developed a survey to measure the extent to which patients’ needs were being met. Approximately one year after the program was launched, she mailed the first set of surveys to the program’s former patients.

Overall, the majority of respondents reported that they were completely satisfied with their care. While only 10% of patients were “adequately satisfied” or “dissatisfied,” the APN wanted to understand how their experience could have been improved. Analysis of the survey data revealed two problem areas: first, patients felt they had insufficient information regarding recovery of continence and sexual functioning; second, they expressed concern about the next steps in their care.

These findings highlighted the necessary steps to achieve even higher patient satisfaction. Perhaps more importantly, the survey is an instrument for alerting program leaders to changes in patients’ needs over time.

**Patient Satisfaction Surveys Guide Program Development**

- 200 surveys mailed; 142 returned
- Surveys mailed to patients three months after their surgery
- Questions addressed satisfaction with care team communication, treatment, outcomes

Surveys revealed 10 percent of patients rated two areas as less than excellent:
1. Amount of focus and support regarding recovery of continence and sexual functioning
2. Confidence in understanding next steps of care

---

1 Numbers do not sum to 100 percent because 1 percent of patients answered “not applicable.”

Source: Oncology Roundtable interviews and analysis.
Lesson #2: Streamline Cancer Program Processes

In order to help member institutions conduct their own needs assessments and translate their findings into a navigable job description, the Oncology Roundtable has developed two implementation tools. The first, called the Process Mapping Tool, provides guidance for creating a step-by-step map of the patient experience, and in the process, identify problem areas and opportunities for improvement.

Patient Experience Mapping Tool
Step-by-Step Instructions To Diagram Patient Flow

Step One: Form a Team
Make a list of stakeholders to invite to the mapping session and issue invitations. You want the team to include representatives from every department or functional area in the cancer program. Smaller cancer programs may want to invite all staff to participate. Ideally, the team would include no more than 15 people in order to keep the group manageable.

Step Two: Establish Realistic Goals
In order to ensure that the exercise is ultimately productive, define what you hope to accomplish as a result of the mapping session. Goals should be specific and achievable. For example, “Preventing the causes of delays in the diagnostic process,” “Understanding current processes for connecting patients to supportive care,” or “Identifying opportunities to improve patient intake.”

The Oncology Roundtable’s Patient Experience Mapping Tool is available in the Appendix on page 53.

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Patient Experience Mapping Tool

Overview: The purpose of the Patient Experience Mapping Tool is to diagram each step in the patient experience so that cancer program staff can better understand the patient perspective, identify operational problems and pinpoint opportunities for improvement. This tool provides a step-by-step process for creating the patient experience map. The resulting map can then be compared with the "ideal" patient experience with the ultimate goal of identifying process improvement needs as well as areas requiring staff intervention.

Involving staff from across the cancer program in the mapping process will help to ensure that all perspectives are represented, increase the accuracy of the map, and provide a foundation for building support for any initiatives resulting from the exercise.

Time required: Varies, depends on size of cancer program as larger programs will require time for review by staff members who are not on the mapping team.

Materials needed: Markers, post-it notes and blank wall space, or whiteboard and flipchart.

Step One: Form a Team

Make a list of stakeholders to invite to the mapping session and issue invitations. You want the team to include representatives from every department or functional area in the cancer program. Smaller cancer programs may want to invite all staff to participate. Ideally the team would include no more than 15 people in order to keep the group manageable.

Step Two: Establish Realistic Goals

In order to ensure that the exercise is ultimately productive, define what you hope to accomplish as a result of the mapping exercise. Goals should be specific and achievable. For example, “Pinpointing the causes of delays in the diagnostic process,” “Understanding current processes for connecting patients to supportive care,” or “Identifying opportunities to improve patient intake.”
Patient Experience Mapping Tool

Your Goals:
1. 
2. 
3. 
4. 
5. 

Step Three: Develop a Case Statement
Draft a case statement explaining the need to conduct the Patient Experience Mapping exercise. While you may want to cite specific issues to be addressed, ensure that your description does not include assumptions about the causality of those problems. Refer to this case statement when inviting people to participate in the exercise.

Sample Case Statement:
The Patient Experience Mapping exercise will help us to isolate gaps in the care and services we provide to our patients. By identifying the discrete steps in the patient experience, we will develop a shared understanding of the processes currently in use across the cancer center, pinpoint process breakdowns, and identify opportunities for improvement.

Your Case Statement:

Step Four: Determine Your Approach
Prior to drafting the patient experience map, determine what approach you will take. There are two options that have been shown to work well:
Patient Experience Mapping Tool

Option #1: Schedule representatives from all areas of the cancer program to meet for 30 minute intervals over the course of one day. For example, the schedule might look like:
- 9:00 – Resident center manager
- 9:10 – Medical oncologist clinic manager
- 10:00 – Social worker
- 10:30 – Radiation therapy manager etc.

During each 30 minute meeting, ask the representative to describe exactly what happens as patients move through his/her area of the cancer center.

Option #2: Assemble the entire team in a conference room. Ask team members to think through each step in the patient care process, starting with screening all the way through to the end of their care (e.g. survivorship or end-of-life care).

Regardless of which approach you choose, budget four to eight hours to create the initial map.

Step Four: Draft the Patient Experience Map

Record each patient touch in the order in which it occurs. Use different colors to indicate decision points or “triggers” that lead to the next step (e.g. treatment decision, referral, etc.) and potential problems in the process.

If there are questions about what actually happens, make a note of them. At the end of the meeting(s), review the list of questions and assign individual team members to find answers and report back.

See page 22 for a sample Patient Experience Map.
Patient Experience Mapping Tool

Step Six: Map Verification

In order to improve the accuracy of the map, invite staff and physicians from throughout the cancer program to review it and suggest changes. You may want to post the map in a common area (e.g. conference room) or create an electronic version that can be circulated to all stakeholders. Ask people to submit their edits and additions in writing.

Step Seven: Revise the Map

Revise the Patient Experience Map based on feedback from stakeholders. In addition, incorporate findings from the investigations conducted in response to questions arising from the initial mapping exercise.

Step Eight: Create “Ideal” Process Map

Reassemble the original Patient Experience Mapping team. Follow the same process as before, but this time capture what would ideally happen as patients move across the care continuum. Keep in mind resource constraints and other practical limitations so that the resulting map reflects a process that could actually be implemented.
Lesson #3: Map Needs to Navigator Responsibilities

The second tool, the Navigator Pick List, is designed to assist member institutions in mapping their programmatic needs to specific navigator responsibilities. To that end, it provides a list of common patient and programmatic needs and then identifies the corresponding responsibilities that a navigator might assume to address that need.

**Navigator Pick List**

### NEEDS: Improved Care Coordination

- Serve as main point of contact for patients and families
- Collect patients' medical records and test results from other providers, as needed
- Schedule patient appointments (e.g., physician office visits, tests, procedures)
- Ensure referrals to supportive care and support services are made in a timely way; facilitate scheduling and monitor patients to ensure follow-through
- Round on patients (inpatient and outpatient) to provide support, identify unmet needs
- Track patient progress and keep other care team members apprised, as needed
- Serve as main point of contact for referring physicians and their staff
- Work with referring physicians to understand their preferences for communication about patients’ test results, treatment progress and manage those communications
- Prepare letters for referring physicians summarizing treatment recommendations from treatment planning conference
- Help eligible patients access appropriate clinical trials
- Collaborate with local individuals, agencies, and organizations to facilitate access to community-based cancer care services

### NEEDS: More Timely Care

- Work with referring physicians to understand their preferences for communication about patients’ test results, treatment progress and manage those communications
- Inform patients of test results
- Schedule patient appointments (e.g., physician office visits, tests, procedures)
- Track individual patient’s progress along care continuum; identify potential bottlenecks and perform appropriate interventions
- Work with radiation oncologist to identify any treatment or care actions to be performed or monitored
- Prepare monthly report of performance on treatment of care metrics (e.g., time from mammogram to biopsy or time from biopsy to surgical consult)
- Identify bottlenecks in the patient pathway and gaps in care; propose process improvement measures to address them

The Oncology Roundtable’s Navigator Pick List is available in the Appendix on page 58.
Navigator Pick List

Overview: The Navigator Pick List is a list of responsibilities commonly assigned to cancer program navigators. The responsibilities are categorized according to the specific institutional need or problem that they are intended to address. The goal is to provide a starting point for developing a navigator job description and to help ensure that cancer programs make the most of their investment in navigation.

Prior to using this tool, cancer program leaders should complete a rigorous assessment to identify and prioritize institutional needs. We recommend starting with the Patient Experience Mapping Tool to identify gaps and delays in care. This step should be followed by interviews with patients, staff, and physicians to surface other issues related to the patient experience. (See Lehigh Valley’s Navigator Needs Assessment for sample questions to ask patients). Both exercises will help cancer program leaders hone in on areas in need of process improvement and/or navigator support.

Once the organization’s needs have been identified, cancer program leaders can use the Navigator Pick List to generate a list of potential navigator job responsibilities.

Directions for use:
1. Start by reviewing the categories of responsibilities included in this tool (e.g., improved care coordination, more timely care). Note which categories correspond to your organization’s needs and rank them according to level of priority.
2. Consider the responsibilities that correspond to your organization’s most pressing need (i.e., the category that you ranked as your first priority).
3. Next consider the responsibilities that correspond to the category that you ranked as your second priority. Within this category, tick off responsibilities that would be relevant to your organization. Cross off responsibilities that are not relevant. Note that some responsibilities are repeated between categories. These responsibilities have been marked with an asterisk.
4. Continue this process, working through all of the relevant categories in order of priority. The result will be a list of responsibilities to consider for inclusion in your navigator’s job description.

Note: Cancer program leaders should be aware of the tradeoff between the level of service that navigators can provide and the number of patients that they can support. Navigators who provide a higher level of service will not be able to work with as many patients as those providing a more cursory level of support.

In addition, program leaders should consider the types of skills required to perform each responsibility. Some responsibilities (e.g., patient education, serving as a main point of contact for referring physicians) may require a clinical background, whereas others (e.g., designing and implementing community outreach programs) may be more suitable for someone with a business background. This depth and breadth of skills required will have a direct impact on how difficult it will be to fill the position.
### Navigator Pick List

#### NEED: Improved Care Coordination

- "Serve as main point of contact for patients and families" [ ]
- "Collect patients’ medical records and test results from other providers, as needed" [ ]
- "Schedule patient appointments (e.g. physician office visits, tests, procedures)" [ ]
- "Ensure referrals to supportive care and supportive services are made in a timely way, facilitate scheduling and monitor patients to ensure follow-through" [ ]
- "Recruit patients (inpatient and outpatient) to provide support, identify unmet needs" [ ]
- "Track patient progress and keep other care team members apprised, as needed" [ ]
- "Serve as main point of contact for referring physicians and their staffs" [ ]
- "Work with referring physicians to understand their preferences for communication about patients’ test results, treatment progress and manage these communications" [ ]
- "Prepare letters for referring physicians summarizing treatment recommendations from treatment planning conference" [ ]
- "Help eligible patients access appropriate clinical trials" [ ]
- "Collaborate with local individuals, agencies, and organizations to facilitate access to community-based cancer care services" [ ]

#### NEED: More Timely Care

- "Work with referring physicians to understand their preferences for communication about patients’ test results, treatment progress and manage these communications" [ ]
- "Inform patients of test results" [ ]
- "Schedule patient appointments (e.g. physician office visits, tests, procedures)" [ ]
- "Track individual patient's progress along care continuum; identify potential bottlenecks and perform appropriate interventions" [ ]
- "Work with oncology administrators to identify key timeliness of care metrics for performance monitoring" [ ]
- "Prepare monthly report of performance on timeliness of care metrics (e.g. time from mammogram to biopsy, time from biopsy to surgical consult)" [ ]
- "Identify bottlenecks in the patient pathway and gaps in care; propose process improvement measures to address them" [ ]

#### NEED: Multidisciplinary Clinic Support

- "Help determine which patients are good candidates for the multidisciplinary clinic" [ ]
- "Educate patients about the purpose of the clinic and what to expect on the day of their visit" [ ]
- "Collect patients’ medical records, test results and any other documentation required for the clinic" [ ]
- "Manage clinic logistics, including scheduling of patients and consultants; set up of IV equipment, note taking during treatment planning conferences" [ ]
- "Greet patients on day of clinic and provide them with personalized schedule" [ ]
- "Conduct patient assessments on day of clinic" [ ]
- "Prepare letters for referring physicians summarizing recommendations from treatment planning conference" [ ]
- "Help to explain treatment recommendations to patients and families, answer questions" [ ]
- "Schedule patient appointments (e.g. physician office visits, tests, procedures)" [ ]

* Responsibilities that are required between categories

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# Navigator Pick List

## NEED: Business Development/Increased Patient Volumes

- Serve as main point of contact for referring physicians and their staff
- Work with referring physicians to understand their preferences for communication about patients’ test results, treatment progress and manage those communications
- Prepare letters for referring physicians summarizing treatment recommendations from treatment planning conferences
- Actively solicit and record feedback from referring physicians and their staff, develop recommendations for improving clinic operations to better meet their needs
- Meet with physicians who have the potential to become referral sources for the cancer program to provide information about the cancer program’s offerings
- Prepare monthly report on patients who come to the cancer program for care or return to the cancer program for treatment because of the navigation program
- Collaborate with marketing and public relations departments to develop and design materials for entire customer base, from Physicians to consumers
- Develop collaborative relationships with local industries, agencies and organizations that provide cancer education and support for cancer patients
- Design and implement community outreach programs designed to increase public awareness of cancer, cancer prevention and the importance of regular screenings
- Manage community cancer screening events

## NEED: Improved Patient Education and Empowerment

- Serve as the main point of contact for patients and their families
- Identify and document individual patient’s barriers to learning
- Help patients prepare a lot of questions and concerns to review with their physicians prior to office visits
- Accompany patients to physician office visits, review information covered with patient afterwards
- Educate patients and families about disease process, treatment options, potential side effects
- Assist patients with treatment decision-making, develop and use decision aids as appropriate
- Provide pre- and post-operative education
- Educate patients about survivorship, set expectations for the post-treatment transition, remain available to patients and families for questions after the completion of treatment
- Assist patients with end-of-life care decisions
- Educate patients and families about diet, exercise, smoking cessation and other wellness and cancer prevention strategies
- Develop programming focused on promoting cancer awareness, prevention, screening

## NEED: Improved Psychosocial Support

- Serve as main point of contact for patients and families
- Administer psychosocial screening at patient’s first visit, repeat screening at regular intervals or as needed
- Make referrals to social worker, financial counselor, chaplain, mental health services, as needed; facilitate scheduling and monitor patients to ensure follow-up
- Manage support groups for patients and caregivers
- Accompany patients to key physician office visits, tests, procedures
- Check in with patients via phone or in person prior to surgery and/or treatment start; ensure patients know exactly what to expect before, during and after procedure
- Educate patients about survivorship; set expectations for the post-treatment transition and remain available to patients and families for questions after the completion of treatment
**Strategies for Ongoing Navigation Program Assessment and Improvement**

The following strategies have been developed by the Program Implementation workgroup:

- Solicit patient feedback to identify program needs and gaps
  - Satisfaction Surveys
  - Focus or Advisory Groups

- Annual Community Needs Assessment (CoC Std. 3.1) will provide insight into needs, gaps and opportunities for program improvement (see next section on CoC Std 3.1 compliance)
  - Program review annually with Cancer Committee along with CoC Std 3.1 requirements

- Solicit physician feedback on program successes and challenges
  - Satisfaction Surveys
  - Physician input on navigation program quality metrics/outcomes

- Identifying PI projects that emerge as a result of evaluation of outcome metric trending (see section on Outcome Metrics)

- The Navigation Assessment tool, developed by the NCCCP Navigation Workgroups, can be used to identify both your navigation program strengths as well as opportunities for growth and enhancement.
CoC Standard 3.1: Patient Navigation Process

The following sections provide guidance for navigation program assessment and enhancement in order to meet the new CoC Standard 3.1. This information has been provided by:

Linda W. Ferris, PhD,
Centura Health,
Chair, Accreditation Committee, Commission on Cancer.

Patient Navigation – Phase-in in 2015

Standard 3.1: “A patient navigation process, driven by a community needs assessment, is established to address health care disparities and barriers to care for patients. Resources to address identified barriers may be provided either on-site or by referral to community-based or national organizations. 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.”

Components of the Standard

- Community assessment results and navigation process reported annually to the cancer committee.
- The report includes the following:
  1. Identified health care disparities and/or barriers addressed by the navigation process.
  2. Description of established navigation process.
  3. Identification of community served (who and how many).
  4. Documentation of activities and metrics.
  6. Assessment can be used to guide initiatives to comply with community outreach and/or psychosocial services/distress screening.
  7. Assessment does not represent “study of quality”
- Community assessment
  1. Serves as the building blocks for the navigation process
     - Identify needs of the population
     - Define gaps or disparities in resources or services
     - Develop opportunities to improve
     - Evaluate results of process
  2. Cancer committee defines community to be evaluated
  3. Assessment performed at least once during 3 year accreditation cycle
  4. Assessment may be delegated
     - Individual
     - Subcommittee
     - Department
CoC Standard 3.1: Patient Navigation Process

Goals of the Needs Assessment

1. What are the needs of the patient population?
2. What barriers to care exist?
3. Are available services adequate for patient needs?
4. What additional services are needed?
5. Are the services used? (Under use vs. over use)
6. Are services easy to access?
7. Are there enough staff to provide adequate services?

Components of a Needs Assessment

- What is the need in your cancer program? Among your patients?
- What are the outcomes you expect to achieve? What are your goals and objectives for the program? Why are you creating this program?
- Who are your stakeholders? Who will benefit from the program?
- What currently exists and where are the gaps in service?
- What are the barriers and limitations to your program?
- What funding is available? Other resources (staffing)?
- What is the feasibility and readiness for the program in your system?
- What are reliable sources of data (primary and secondary sources)?
- The goal is to: Understand what you find, turn data into information that is relevant and useful to meet the needs of your patient population

Requirements of the Standard

- Develop and implement the navigation process:
  - Identify population that will be reached;
  - Develop program to address one or more barriers;
  - Define metrics to measure success; and
  - Implement the navigation process:
  - Who
  - What
  - Where
  - When
  - How
CoC Standard 3.1: Patient Navigation Process

Compliance with the Standard

• Community assessment results and navigation process reported annually to cancer committee.
• Report includes:
  – Identified health care disparities and/or barriers addressed by the navigation process.
  – Description of established navigation process.
  – Identification of community served (who and how many).
  – Documentation of activities and metrics.
  – Options for future directions:
    • Quality improvement
    • Enhancements

Documenting Compliance

• Results of community needs assessment.
• Report on the navigation process.
• Respond to questions in Survey Application Record
• Navigation process discussed during cancer program survey
  – CoC surveyor
  – Cancer committee member
  – Patient navigators

Compliance with the Standard

• All criteria fulfilled:
  – Conducted community needs assessment to identify health care disparities once during accreditation cycle.
  – Each year:
    • Establish/review navigation process and resources to address barriers.
    • Provide services on site or by referral to community-based or national organizations.
    • Assess navigation process and report to cancer committee.
    • Modify or enhance process to address additional disparities or barriers.
Outcomes of Patient Navigation

• Improved rates of screening and follow-up.
• Lower clinical stage of presentation.
• Improvements in completion of treatments and reported levels of increased psychosocial support.
• Higher patient satisfaction.
• The clinic’s ability to engage, track, and support patients.
• The clinic’s ability to develop communication and trust between clinics and disadvantaged populations.
• Increased enrollment and retention into clinical trials.
Strategies for Navigation Program Sustainability
Navigation Program Sustainability

In most cases, navigation services are not reimbursable. Although grant funding opportunities may be beneficial in starting up navigation services, planning for program sustainability from the beginning is critical to the success of the program. Tracking the following metrics provides the ability to demonstrate navigation program value and return on investment.

- **Timeliness to care**
  - Supports the ability to meet national benchmarks
- **Care coordination**
  - Evidenced by patient and provider perception
- **Number of barriers to care/needs identified**
  - Indicates service to disparate populations
- **Referral to services**
  - Can demonstrate downstream revenue
- **Patient retention (decreased outmigration) and subsequent revenue (including downstream)**
  - Evidenced by patient perception – chose facility because of navigation services
- **Patient satisfaction**
- **Physician satisfaction**
- **Navigator impact on distress**
  - Evidenced by patient perception
- **Navigator impact on treatment adherence**
  - Can indicate revenue capture
  - Evidenced by patient perception
- **Navigator Impact on Patient Readmissions/ED visits**
  - If pre-navigation services data is available on specific patient populations related to unplanned admissions and ED visits, a comparison can be made post-navigation services implementation to evaluate navigator impact
  - If a trend related to unplanned admissions/ED visits is identified for a specific patient or for patient populations, there may be an opportunity for pro-active phone calls and/or scheduling of appointments with a provider in order to avoid unplanned admissions and ED visits
    - Identifying high risk patients can assist with determining which patients to follow more closely
    - 24/7 navigator on-call services may impact the number of ED visits/unplanned admissions

The addition of CoC Standard 3.1, which requires a patient navigation process to be in place for cancer program accreditation, also supports the need for navigation services. This standard goes live in 2015.
Opportunities for Reimbursement for Navigation Services

Key Takeaway From Sg2 – November 2012, Tina Shah, Sg2 Senior Analyst

New Navigator Funding
As a resounding acknowledgement of these benefits, Medicare has created a new rule, effective January 1, 2013, that will pay nurses for services that help successfully transition hospital patients to post-acute care and other settings. Two new payment codes have been created for transitional care management (TCM), one for TCM services requiring moderately complex medical decision making and one for TCM requiring highly complex medical decision making. Both are in place to prevent complications and conditions that result in hospital readmissions. The new payments will go to nurse practitioners, clinical nurse specialists, certified nurse midwives and other primary care professionals, for TCM services provided within 30 days of a Medicare patient's discharge from a hospital or similar acute care facility.

In spite of this encouraging support, one of the larger remaining challenges for nurse navigation is its similarity and potential overlap with other care coordination roles—specifically transitional care coordinators, community-based case managers and health plan case managers. As health systems strive to better link inpatient, discharge and ongoing care coordination efforts, particularly for chronically ill patients, these roles are still being defined and reworked.
Navigation Role Clarity

This section addresses role clarity for nurse navigation, medical professional navigation and lay navigation. It also speaks to navigator training and orientation along with optimal navigator interaction with the clinical trials team in order to maximize patient accrual as well as provide access for disparate populations to clinical research.
## Nurse Navigator
### Role Requirements

<table>
<thead>
<tr>
<th>Education</th>
<th>Experience</th>
<th>License and Certifications</th>
<th>Skills</th>
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<tbody>
<tr>
<td>BSN preferred</td>
<td>2 yrs. clinical practice in oncology</td>
<td>Current RN license</td>
<td>Computer skills</td>
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<tr>
<td>Knowledge base regarding cancer care and specialty area of navigation with education to support that knowledge base to include community and cancer program assessment, resolution of system barriers, the cancer continuum, health disparities and cultural sensitivity</td>
<td>OCN preferred or OCN within 1.5 years of hire</td>
<td>Professional communication skills</td>
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<td>Specialty certifications as designated by facility (i.e., Harold P. Freeman, NCBC, Educare Breast Navigator Certification,</td>
<td>Organizational skills</td>
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<tr>
<td>Self-directed</td>
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<tr>
<td>Ability to develop collaborative relationships both internally and externally</td>
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<tr>
<td>Customer service skills</td>
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<tr>
<td>Education or experience with outcome analysis, project mgmt, case or utilization mgmt</td>
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<td>Leadership skills</td>
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<td>Cultural sensitivity/language skills</td>
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<td>Patient triage skills</td>
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<td>Nursing theory and practice knowledge and skills</td>
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<tr>
<td>Problem-solving skills</td>
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<td>Advocacy skills</td>
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Additional requirements (adapted from Billings Clinic requirements):

- Ability to define and implement an evolving role of patient centered care delivered in a complex integrated health care system which includes setting common goals, merging resources, providing education, and cross training of roles.
- Must be able to work with a variety of diverse and complex patients, families, and both internal and external health care providers.
Nurse Navigator Roles and Responsibilities

The 2010 Oncology Nursing Society’s Oncology Nurse Navigator Role Delineation Study published the following top tasks, knowledge areas and skills as identified by nurse navigator study respondents:

**Tasks**
- Provide emotional and educational support for patients.
- Practice according to professional and legal standards.
- Advocate on behalf of the patient.
- Demonstrate ethical principles in practice.
- Orient patients to the cancer care system.
- Receive and respond to new patient referrals.
- Pursue continuing education opportunities related to oncology and navigation.
- Collaborate with physicians and other healthcare providers.
- Empower patients to self-advocate.
- Assist patients to make informed decisions.
- Provide education or referrals for coping with the diagnosis.
- Identify patients with a new diagnosis of cancer.

**Knowledge Areas**
- Confidentiality and informed consent
- Advocacy
- Symptom management
- Ethical principles
- Quality of life
- Goal of treatment
- Therapeutic options
- Evidence-based practice guidelines
- Professional scope of practice
- Legal and professional guidelines

**Skills**
- Communication
- Problem solving
- Critical thinking
- Multitasking
- Collaboration
- Time management
- Advocacy

FIGURE 1. The Top Tasks, Knowledge Areas, and Skills as Rated by Respondents

Clinical Journal of Oncology Nursing, December 2012 • Volume 16, Number 6 • Oncology Nurse Navigator Role Delineation
Nurse Navigator Responsibilities

(Adapted from the NIH Patient Navigation Research Project Definition of Navigation)

- Provides Access to Resources (internal and external) and Assesses Patients’ Current and Future Needs, Facilitates Distress Screenings, Coordinates Financial Assessment and Referrals (Core)
  - Make referrals for services based on patient/family needs – education, finances, psychosocial, survivorship, transportation, child care, lodging
  - Assess for and assist with patient/family resources
  - Facilitate access to physicians and services
  - Assess for and mitigate barriers to care. Assist patients with access concerns (for screening, diagnosis or treatment) and assist with paperwork and addressing access barriers as indicated.
  - Facilitate appropriate medical record availability at scheduled appointments as needed.
  - Facilitate language translation or interpretation services.
  - Facilitate financial assessment and referrals as well as helping with paperwork as needed.
  - Facilitate transportation, lodging and/or child/elder care and addresses any other practical needs
  - Facilitate linkages to follow-up services.
  - Facilitate access to clinical trials
  - Build partnerships with local agencies and groups (e.g., referrals to other services and/or cancer survivor support groups)
  - Facilitate distress screening and appropriate referrals
    - Assess for emotional well-being and make appropriate referrals as needed

- Develops Physician Relationships (Core)
  - Communicate and collaborate with involved physicians and staff members to facilitate individualized, holistic patient care plans
  - Facilitate communication between cancer care disciplines
  - Maintain communication with patients, survivors, families, and the health care providers to monitor patient satisfaction with the cancer care experience
  - Ensure that navigator functions are meeting physician expectations and that navigator activities remain within scope of defined role
• **Provides Patient Education, Provides Symptom Management Support (Core)**
  - Discuss physician visits with patients and families and answer questions
  - Provide and reinforce education re: treatment, care plan, symptom management and survivorship concerns
  - Empower patients with education and knowledge to help improve patient outcomes and satisfaction

• **Coordination of Patient Care (coordinating/facilitating appts, accompanying patients to appts as needed) (Core)**
  - Coordinate patient care from diagnosis through survivorship or palliative care/hospice
  - Assist with coordinating appointments
  - Meet with patient by phone or in person “within designated time” following “designated event” and follow patient per navigator- or facility-specific guidelines
  - Facilitate timely coordination of services between diagnosis and treatment
  - Provide telephone triage services (e.g., symptom management, emotional support, education, resource referral) for patients/families
  - Coordinate appointments for diagnostic testing, services and with providers to ensure timely delivery of diagnostic and treatment services. May include accompanying patients to appointments (particularly if there are multiple barriers to care) and/or providing clarification and literacy-level-appropriate education related to the visit

• **Tracks Metrics, Quality Indicators; Documents Patient Interactions, Progression (Core)**
  - Assist with tracking, documentation and outcome reporting for navigation services
  - Assist with ongoing navigation program assessment and identification of process improvement opportunities
  - Assist with annual CoC Std. 3.1 activities related to community needs assessment and resulting program modifications related to needs; assist with program reporting to Cancer Committee

• **Assists With Preparing MDC Conference Materials and Providing Follow-up (Core)**
  - Assists with coordination of Multi-D Conference(s)
  - Assists with patient follow-up as needed

• **Community Outreach (Additional)**
  - Conduct health promotion and awareness programs in community
  - Attend community health fairs and screenings; provides community education presentations

• **Other (Additional)**
  - Facilitate/attend support groups
Nurse Navigator
Competencies

• Provides Access to Resources (internal and external) and Assesses Patients’ Current and Future Needs, Facilitates Distress Screenings, Coordinates Financial Assessment and Referrals
• Coordination of Patient Care (coordinating/facilitating appts, accompanying patients to appts as needed)
  • Competencies
    • Facilitates the coordination of patient care services to assure excellence in patient care and patient flow
      1. Follows patient through the care continuum/experience, eliminating operational (such as scheduling, test results, etc.) barriers as well as other barriers to cancer services
      2. Works closely with other healthcare disciplines to ensure timely appointments, result reporting, financial need and other referrals, communication, patient care and follow-up
  • Verification Methods – to be specified by each facility – examples:
    1. Peer review from social worker, financial counselor or others as determined by navigation program leader(s)
    2. Evidence by daily work – i.e., review of 5 cases from tracking tool for evidence of timeliness
    3. Case presentation to navigator team and program leaders
  • Demonstrates patient service excellence
    4. Demonstrates excellence in communication skills and patient interactions
    5. Demonstrates ability to work as a team member intra- and inter-departmentally
    6. Adheres to facility behavior expectations (i.e., RICE)
  • Verification Methods – to be specified by each facility – examples:
    1. Peer review by other team members (both intra- and inter-departmentally)
    2. Patient satisfaction scores

• Develops Physician/Cancer Care Team Relationships
• Assists With Preparing MDC Conference Materials and Providing Follow-up
  • Competencies
    • Collaborates with the cancer care team to ensure optimal clinical outcomes for patients
      1. Works with the care team to assure direct care needs are met, assisting as needed
      2. Facilitates follow-up on identified patient clinical and non-clinical care, facilitating communication and compliance to care plans (follow-up on trigger points, patient care conferences as needed)
3. Develops strategies for relationship-building with physicians in order to facilitate patient referrals to navigation services

- **Verification Methods – to be specified by each facility – examples:**
  1. Review of patient care documentation
  2. Physician satisfaction related to referrals for navigation services

- **Works as an active team member and effective communicator**
  1. Demonstrates effective internal and external communication strategies, written and verbal, to assure a collaborative environment
  2. Ensures appropriate documentation in EMR and databases
  3. Demonstrates a productive work ethic
  4. Works consistently as an active team player, intra- and inter-departmentally

- **Verification Methods – to be specified by each facility – examples:**
  1. Observation of daily work – i.e., print and submit 5 navigation notes for review by navigation program leader(s)
  2. Peer and supervisor review

- **Provides Patient Education, Provides Symptom Management Support**

- **Community Outreach**
  - **Competencies**
    - **Demonstrates expertise in education and resourcing services**
      1. Demonstrates oncology patient care competency
      2. Collaborates with cancer care team in developing, implementing and evaluating educational materials and resources for patients and families
      3. Facilitates consistency of patient education among cancer care team members

- **Verification Methods – to be specified by each facility – examples:**
  1. Observation of daily work
  2. OCN certification (within 1.5 years of hire)
  3. Peer review
  4. Presentation at educational event – community, patient, professional or MDC

- **Tracks Metrics, Quality Indicators; Documents Patient Interactions, Progression**
  - **Competencies**
    - **Contributes to an environment of quality and process improvement**
      1. Ensures accurate and timely data collection and entry into navigation patient database
2. Participates in identified quality assessment and improvement activities to ensure quality patient services are provided

3. Ensures navigation patient care activities are monitored through program reporting and audits and reported to cancer committee at least annually

• **Verification Methods – to be specified by each facility - examples**
  1. Supervisor and peer review
  2. Observation of daily work – timely data collection and entry per documentation
  3. Participation in PI projects
  4. Physician satisfaction

Competencies for nurse navigators have been developed by the National Coalition for Oncology Nurse Navigators and can be accessed at the [NCONN website](http://www.nconn.org).
Medical Professional Navigator

There are medical professionals from diverse backgrounds filling the role of patient navigator across CHI, including Social Workers, Mammographers and Medical Assistants. In this section, we’ve provided role requirements and job description recommendations for these types of roles.
# Medical Professional Navigator

## Role Requirements

### Breast Imaging Navigator (Mammography Technologist)

<table>
<thead>
<tr>
<th>Education</th>
<th>Experience</th>
<th>License and Certifications</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduation from an accredited school of Radiologic Technology/ARRT</td>
<td>5 years experience as a mammography technologist</td>
<td>ARRT (R) (M)</td>
<td>Professional communication skills</td>
</tr>
<tr>
<td>Knowledge base regarding cancer care and specialty area of navigation with education to support that knowledge base to include community and cancer program assessment, resolution of system barriers, the cancer continuum, health disparities and cultural competence</td>
<td>Knowledge and understanding of diagnostic patient navigation</td>
<td>Specialty certification as designated by facility (i.e., CBPN through NCBC, etc)</td>
<td>Organizational skills</td>
</tr>
</tbody>
</table>

- Self-directed
- Ability to develop collaborative relationships both internally and externally
- Customer service skills
- Leadership skills
- Cultural sensitivity/language skills
- Patient triage skills
- Problem-solving skills
- Advocacy skills
- Computer skills
<table>
<thead>
<tr>
<th>Education</th>
<th>Experience</th>
<th>License and Certifications</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school diploma or GED</td>
<td>Two years experience in specialty area</td>
<td>Medical Assistant cert.</td>
<td>Computer skills</td>
</tr>
<tr>
<td>Knowledge base regarding cancer care and specialty area of navigation with education to support that knowledge base to include community and cancer program assessment, resolution of system barriers, the cancer continuum, health disparities and cultural competence</td>
<td>Knowledge and application of P/P and regulatory requirements</td>
<td>Specialty certification as designated by the facility</td>
<td>Professional communication skills</td>
</tr>
<tr>
<td>Knowledge of insurance and medical terminology/abbreviations</td>
<td></td>
<td></td>
<td>Organizational skills</td>
</tr>
<tr>
<td>Knowledge and understanding of patient navigation within their specialty</td>
<td></td>
<td></td>
<td>Self-directed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ability to develop collaborative relationships both internally and externally</td>
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<td></td>
<td></td>
<td></td>
<td>Customer service skills</td>
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<tr>
<td></td>
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<td></td>
<td>Cultural sensitivity/language skills</td>
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<td></td>
<td></td>
<td></td>
<td>Patient triage skills</td>
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<td></td>
<td></td>
<td></td>
<td>Problem-solving skills</td>
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<td></td>
<td></td>
<td></td>
<td>Advocacy skills</td>
</tr>
</tbody>
</table>
**Social Worker Navigator**

The ONS/AOSW joint position statement on patient navigation can be found in the Appendix.

<table>
<thead>
<tr>
<th>Education</th>
<th>Experience</th>
<th>License and Certifications</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor’s degree in healthcare field or actively pursuing same preferred</td>
<td>Two years experience in oncology</td>
<td>MSW</td>
<td>Computer skills</td>
</tr>
<tr>
<td>Knowledge base regarding cancer care and specialty area of navigation with education to support that knowledge base to include community and cancer program assessment, resolution of system barriers, the cancer continuum, health disparities and cultural competence</td>
<td>Specialty certification as designated by the facility (i.e., CBPN by NCBC, Harold P. Freeman certification, etc.)</td>
<td></td>
<td>Professional communication skills</td>
</tr>
</tbody>
</table>

| | | | Organizational skills |
| | | | Self-directed |
| | | | Ability to develop collaborative relationships both internally and externally |
| | | | Customer service skills |
| | | | Cultural sensitivity/language skills |
| | | | Patient triage skills |
| | | | Problem-solving skills |
| | | | Advocacy skills |
Medical Professional Navigators

Additional requirements for all navigators:

- Ability to define and implement an evolving role of patient centered care delivered in a complex integrated health care system which includes setting common goals, merging resources, providing education, and cross training of roles.
- Must be able to work with a variety of diverse and complex patients, families, and both internal and external health care providers.
Nurse and Medical Professional Navigator
Training and Orientation

This section contains an Introduction to Navigation tool, which includes the various aspects of the navigator role along with a Navigator Orientation to the Cancer Program Checklist, designed to familiarize the new navigator with the various aspects of the cancer program. These documents can be edited to include specifics for each cancer program. Also included in this section are options for navigator certification, requirements for which can be determined by each facility based on their program structure and needs. In the Appendix is an example of a navigator self-assessment tool which can be utilized to help the new navigator determine training and orientation focus.
### Introduction to Navigator Role

#### Orientation Checklist

<table>
<thead>
<tr>
<th>Task</th>
<th>Date completed</th>
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</thead>
<tbody>
<tr>
<td>Introduction to Job Description</td>
<td></td>
</tr>
<tr>
<td>Navigator Role</td>
<td></td>
</tr>
<tr>
<td>Navigator Responsibilities</td>
<td></td>
</tr>
<tr>
<td>Navigation mentor</td>
<td></td>
</tr>
<tr>
<td>Contact information</td>
<td></td>
</tr>
<tr>
<td>Self-assessment checklist/assessment tool</td>
<td></td>
</tr>
<tr>
<td>Areas of focus:</td>
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</tr>
<tr>
<td>Orientation to Cancer Program</td>
<td></td>
</tr>
<tr>
<td>Checklist</td>
<td></td>
</tr>
<tr>
<td>Patient Assessment tool</td>
<td></td>
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<tr>
<td>Distress assessment tool</td>
<td></td>
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<tr>
<td>Patient acuity assessment</td>
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<tr>
<td>Patient Resources</td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
</tr>
<tr>
<td>Patient scheduling processes/systems</td>
<td></td>
</tr>
<tr>
<td>Tracking, documentation and reporting software and processes</td>
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<tr>
<td>Multi-d Conference/Tumor Boards</td>
<td></td>
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<tr>
<td>Cancer Committee</td>
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<tr>
<td>Patient education materials</td>
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</tbody>
</table>
### Navigator Orientation to Cancer Program

<table>
<thead>
<tr>
<th>Department</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Medical Oncology Physician Practice</td>
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<tr>
<td>Contact person:</td>
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<tr>
<td>Infusion Center</td>
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<tr>
<td>Contact person:</td>
<td></td>
</tr>
<tr>
<td>Inpatient oncology unit</td>
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<tr>
<td>Contact person:</td>
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<tr>
<td>Radiation Oncology</td>
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<tr>
<td>Contact person:</td>
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</tr>
<tr>
<td>Social Work</td>
<td></td>
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<tr>
<td>Contact person:</td>
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</tr>
<tr>
<td>Dietitian</td>
<td></td>
</tr>
<tr>
<td>Contact person:</td>
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</tr>
<tr>
<td>Surgical Physician Practice(s)</td>
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<tr>
<td>Contact person:</td>
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<tr>
<td>Surgery Department</td>
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<tr>
<td>Contact person:</td>
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<tr>
<td>Genetic Counseling</td>
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<tr>
<td>Contact person:</td>
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<tr>
<td>Clinical Trials</td>
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<tr>
<td>Contact person:</td>
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<tr>
<td>Spiritual Care</td>
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<tr>
<td>Contact person:</td>
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<tr>
<td>Physical Therapy</td>
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<tr>
<td>Lymphedema</td>
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<tr>
<td>Cancer Rehab</td>
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<td>Contact person:</td>
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<tr>
<td>Financial Counseling/ Patient Billing</td>
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<tr>
<td>Financial Resources</td>
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<td>Drug programs</td>
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<td>Contact person:</td>
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<tr>
<td>Specialty areas related to navigation population:</td>
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<tr>
<td>Breast imaging center/imaging technology and processes</td>
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<tr>
<td>ENT practice</td>
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<td>GI lab</td>
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<td>Contact person:</td>
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<tr>
<td>Cancer Registry</td>
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<td>Contact person:</td>
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<tr>
<td>Learning Resource Center</td>
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<td>Contact person:</td>
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<tr>
<td>Palliative care and hospice</td>
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<tr>
<td>Referral processes</td>
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<tr>
<td>Contact person:</td>
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</tbody>
</table>
Navigator Training and Orientation

The following pages provide training recommendations by the Advisory Board’s Oncology Roundtable along with a list of certification opportunities for navigators.
Lesson #5: Provide Navigators with Experiential Learning Opportunities

Once a navigator has been hired, the next step is to provide him or her with the training needed to succeed. Familiarizing the new navigator with the organization, its staff, and standard operating procedures is critical. Consequently, many cancer programs have new navigators shadow patients and staff, attend tumor boards, and spend time observing physicians.

The Fox Chase Cancer Center’s affiliate network has taken this idea one step further by developing a formal navigator preceptorship program. New navigators staff by taking a knowledge assessment to determine their current level of knowledge about the navigator role and to identify training needs. They then complete a preceptorship, shadowing one of the navigators at Fox Chase, observing firsthand the scope of her responsibilities as well as how she interacts with patients, staff, and physicians.

Recognizing that not all institutions are like Fox Chase, new navigators complete a second preceptorship at an institution that more closely resembles their own. At the end of the experience, they take the same knowledge assessment again to gauge how their knowledge has grown and identify further training needs.

New Hires Shadow Seasoned Navigators

Preceptorship Program

- Knowledge Assessment
  - New navigator completes questionnaire to assess current level of knowledge and training needs
- AMC Preceptorship
  - Navigator completes preceptorship at Fox Chase shadowing clinical navigator
- Like-Institution Preceptorship
  - Navigator completes preceptorship at institution similar to own organization with seasoned navigator
- Knowledge Assessment
  - Navigator completes original questionnaire again to identify further training needs

Case in Brief: Fox Chase Cancer Center
- 100-bed teaching comprehensive cancer center with community hospital affiliates located in Pennsylvania and New Jersey
- Identified need among community hospital affiliates to create training and development opportunities for navigators
- Holds quarterly meetings for navigators to discuss role development, education, common issues, troubleshooting problems, and share best practices
- Leverages forum to collaborate on projects, including development of standardized navigator orientation manual and new hire training

Fox Chase’s Navigator Knowledge Assessment tool is available in the Appendix on page 61.

Source: Fox Chase Cancer Center, Philadelphia, PA; Oncology Researcher interviews and analysis.
Certification and Training Programs for Patient Navigators

As part of our 2010 research on patient navigation, our Advisory Board Oncology Roundtable research team assembled a list of certification and training programs for navigators. We’ve included the prerequisites for participation, a summary of the curriculum and certification process, credentials earned, and cost as of May 2011.

<table>
<thead>
<tr>
<th>Harold P. Freeman Patient Navigation Institute</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.hpfreemanpni.org/">http://www.hpfreemanpni.org/</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prerequisites</th>
<th>• None specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certification Process</td>
<td>• 2.5 in-person training or online</td>
</tr>
</tbody>
</table>
| Curriculum | • Features five modules, case studies, and a patient interaction practicum  
| | • Topics covered include:  
| | o Increased retention, diagnostic, and treatment resolution rates  
| | o Improved organizational efficiencies by preventing lost revenue and providing revenue to the facility |
| Credential Earned | • Certificate of Completion |
| Re-certification | • Not specified |
| Cost | • $1500/student  
| | • Group/Corporate discounts and scholarships available for programs that serve an underserved population |
Colorado Patient Navigator Training

http://patientnavigatortraining.org/index.htm

| Prerequisites                  | • Level 1: May be a lay healthcare worker or may have some college
|                               | • Level 2: May be a nurse or social worker with a bachelor's or master's degree; or, very experienced patient navigator |
| Certification Process          | • Level 1: Four days of three in-person courses
|                               | • Level 2: Online courses, requiring four to six hours per week for six to eight weeks
|                               | • Self-paced online tutorials |
| Curriculum                    | • Level 1 courses cover:
|                               |   o Patient navigator basic skills and patient resources
|                               |   o Basic health promotion
|                               |   o Patient navigator professional conduct
|                               | • Level 2 courses cover:
|                               |   o Physical aspects of disease
|                               |   o Emotional and social aspects of disease
|                               |   o Advanced care coordination
|                               |   o Advanced professional conduct
|                               | • Self-paced tutorials cover:
|                               |   o Patient navigator overview
|                               |   o Impact of chronic disease and risk factors |
| Credential Earned             | • Certificate for each course completed
<p>|                               | • Certificate for completion of the Navigator Fundamentals program (four courses) |</p>
<table>
<thead>
<tr>
<th><strong>Re-certification</strong></th>
<th>• Not specified</th>
</tr>
</thead>
</table>
| **Cost**             | • Level 1: $400 for all 3 courses; $250/day fee for out-of-state residents  
• Level 1: $400/course |

**EduCare**


| **Prerequisites** | • RNs and NPs working in breast health centers, hospitals, or physician offices  
• Management and staff of hospitals and breast centers only |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Certification Process</strong></td>
<td>• 4-day, 40-hour RN training in breast health education</td>
</tr>
</tbody>
</table>

**Curriculum**

• Topics covered include:
  - Role of breast health navigator
  - Anatomy and physiology of the breast and breast diseases
  - Diagnostic evaluation of breast diseases
  - Hormones and breast disease
  - Understanding breast cancer
  - Breast cancer treatments
  - Post-operative nursing care
| Prerequisites               | • RN, MD, PA, DO, DC, MSW (medical), PT, OT, ST, PharmD, or other medically-trained personnel  
|                           | • Applicant must have at least four years of post-licensure experience, including two years of inpatient and two years of outpatient experience |

| Credential Earned          | • Certificate of Completion |

| Re-certification          | • Not specified |

| Cost                      | Per institution:  
|                           | • $2,195 for first attendee  
|                           | • $1,895 for each additional attendee |
| Certification Process | • Applicant must complete the introductory workshop "Becoming a Healthcare Advocate: 11 Steps to a New Career in Healthcare"
|---|---
| | • 1-Year Program: For aspiring independent advocates
| | • 9-Month Program: For advocates seeking employment/staff position
| | • Certification groups have maximum of six participants who meet via video and web-conference once a month
| | • Students complete written and oral assignments with a written and oral exam at end of program
| Curriculum | • Topics covered include:
| |   o Communication strategies
| |   o Insurance
| |   o Discharge planning
| |   o Ethics
| |   o Assisting families
| |   o Age-specific approaches
| |   o Cultural sensitivity
| |   o Placement issues
| |   o End of life decision making
| | • 1-Year Program includes business plan development coaching
| Credential Earned | • Certified Healthcare Advocate
| Re-certification | • Not specified
| Cost | • 1-Year Program: $3,000
| | • 9-Month Program: $2,500
**National Consortium of Breast Centers (NCBC) Breast Patient Navigation Certification Program**

**http://www.bpnc.org/**

<table>
<thead>
<tr>
<th><strong>Prerequisites</strong></th>
<th>To sit for the certification exam must:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Be a licensed medical professional with valid license as a physician, nurse, radiologic technologist, or social worker; or, certified medical professional with valid certification as physician assistant, radiologic technologist, radiology practitioner assistant, social worker, or advanced practice nurse; or, master-level prepared in health-related field</td>
</tr>
<tr>
<td></td>
<td>• Navigate breast patients at least 50 percent of work time</td>
</tr>
<tr>
<td></td>
<td>• Recommended that candidate has minimum two years of experience</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Certification Process</strong></th>
<th>Two-part exam:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Part I: Breast Imaging Navigator Certification Exam, must attain 80 percent proficiency for Breast Imaging Patient Navigator Certification (CBPN-I)</td>
</tr>
<tr>
<td></td>
<td>• Part II: Breast Cancer Navigator Certification Exam, must attain 80 percent proficiency for Breast Cancer Patient Navigator Certification (CBPN-C)</td>
</tr>
<tr>
<td></td>
<td>• Earning 80 percent on Parts I and II leads to CBPN-IC</td>
</tr>
</tbody>
</table>

| **Curriculum** | • Optional certification program open to individual regardless of whether eligible to sit for certification exam |

| **Credential Earned** | • CBPN-I: designates an individual as a Certified Breast Patient Navigator in Imaging Navigation |
|                      | • CBPN-C: designates an individual as a Certified Breast Patient Navigator in Breast Cancer Navigation |
|                      | • CBPN-IC: designates individual as a Certified Breast Patient Navigator in Breast Imaging and Breast Cancer Navigation |

| **Re-certification** | • Certification must be renewed annually and meet the following requirements: |
|                      | o CEU: eight breast health specific units, of which four are breast patient navigation specific |
Individuals with less than two years of breast navigation experience (as defined in the NCBC Breast Patient Navigation Matrix) must have served at least 1,000 hours as a breast patient navigator.

Individuals with two or more years of breast patient navigation experience must have served as a navigator utilizing the Breast Patient Navigation Matrix for at least 500 hours.

- Collection and submission of performance data
  - If renewal requirements not met, certification revoked and individual must take certification exam(s) again.

| Cost               | • Certification program and exam fee: $295 for NCBC members; $395 for non-members
|                   | • Re-Certification: $95 for NCBC members; $190 for non-members

**Smith Farm Center for Healing and the Arts**

[http://www.smithfarm.com/patNav.html](http://www.smithfarm.com/patNav.html)

| Prerequisites | • New or experienced cancer navigator
| Certification Process | • Five-day program, taught by experts in oncology care, the healing arts, cancer survivorship, palliative care, nutrition, and stress reduction
| Curriculum | • Topics covered include:
  - Psychosocial support for individuals and their caregivers
  - Facilitating access to health care and integrative therapies
  - Reducing the stress of living with cancer
  - Engaging patients in taking ownership of their health and well-being
  - Empowering patients to enhance their treatment experience and
improve their quality of life

- Facilitating the physical, emotional, and spiritual healing of patients
- Integrative mind-body therapies

<table>
<thead>
<tr>
<th>Credential Earned</th>
<th>Certificate of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-certification</td>
<td>Not specified</td>
</tr>
<tr>
<td>Cost</td>
<td>Not available</td>
</tr>
</tbody>
</table>

**Other Training Opportunities:**

**The GW Cancer Institute: Center for the Advancement of Cancer Survivorship, Navigation and Policy (caSNP)**

Education and Training: caSNP has a multi-disciplinary, multi-tiered approach to educating entire systems of care to support navigation and survivorship efforts in a policy-savvy context. Trainings will inform practice across disciplines and around the country as participants return to their home institutions. The center is proud to guide the ever-growing population of new lay and clinical health care professionals who are providing navigation and survivorship services within hospitals and clinics throughout the US as well as the executives who sustain these programs: [caSNP Training](#)

**Current Education and Training Programs:**

- Executive Training on Navigation and Survivorship
- Patient Navigation Training

The Integrative Medical Clinic Foundation and Sonoma State University in California offer a Patient Navigator Certificate Program with an Integrative Health specialty

The Health Resources and Services Administration (HRSA), AHRQ’s sister agency, has released a new video discussing how culture, language, and health literacy are important to effective health communication. The video also describes HRSA’s free online course, "Effective Communication Tools for Health Care Professionals." This program is highly recommended for anyone in a navigator role. [Training Module](#)
The Advisory Board’s Oncology Roundtable recommends that, along with training and orientation, the new navigator is provided with time for relationship building with cancer care team members and physicians.
Lay Navigation

This section provides current models for lay navigation which can assist in determining which model may work best for your program’s structure and patient population. Also included are lay navigator core role/responsibilities and training and orientation recommendations.
<table>
<thead>
<tr>
<th>Model</th>
<th>Experience</th>
<th>Education</th>
<th>Certification</th>
<th>Skills</th>
<th>Role</th>
<th>Potential Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culturally-based (serving disparate</td>
<td>Non-clinical</td>
<td>Determined by role/</td>
<td>TBD by role/</td>
<td>Language</td>
<td>Community outreach</td>
<td>Barrier driven: Translation, Transportation, Registration into community program,</td>
</tr>
<tr>
<td>populations)</td>
<td></td>
<td>facility</td>
<td>facility</td>
<td>Knowledge of cultural and family beliefs</td>
<td>education and screening</td>
<td>charity care, Financial support (food stamps, utilities, etc), EOL resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Knowledge of community resources</td>
<td></td>
<td>Immigration</td>
</tr>
<tr>
<td>General lay navigator (Similar to TAVs</td>
<td>Medical industry</td>
<td>Determined by role/</td>
<td>TBD by role/</td>
<td>Knowledge of cultural and family beliefs</td>
<td>Eliminating barriers</td>
<td>Provision of resources for patients/families, Financial Travel,</td>
</tr>
<tr>
<td>Population Health Specialist)</td>
<td>background</td>
<td>facility</td>
<td>facility</td>
<td>Knowledge of community resources</td>
<td>from time of dx to end of tx</td>
<td>Lodging</td>
</tr>
</tbody>
</table>

- Other community resources
- Orient new patients to cancer center
- Follow up on no-shows
<table>
<thead>
<tr>
<th>Model</th>
<th>Experience</th>
<th>Education</th>
<th>Certification</th>
<th>Skills</th>
<th>Role</th>
<th>Potential Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical educator (Similar to funded ACS navigator role, which is grant funded)</td>
<td>One to two years experience/knowledge in community health setting/services; patient education experience desired</td>
<td>Bachelors of Science in Human and Health Services, Social work or Public Health required. MBA Preferred</td>
<td>CHES</td>
<td>Strong communication skills, Interpersonal skills, Cultural diversity, Familiarity with hospital processes, structure, functions, Solid computer skills, especially Excel reporting function, Bi-lingual language skills desired</td>
<td>Complements nurse navigator role by providing non-clinical support</td>
<td>1. Facilitates the coordination of patient care services to assure excellence in patient care and patient flow by: a) following the patient through the care continuum/experience, eliminating operational (i.e. scheduling, test results, etc) barriers to service; b) working closely with other health care disciplines to ensure timely appointments, results reporting, financial need referrals, communication, patient care and follow-up. 2. Interfaces with other healthcare teams for appropriate referrals/services. 3. Initiates and provides education resources to the patient, family and significant others.</td>
</tr>
<tr>
<td>Model</td>
<td>Experience</td>
<td>Education</td>
<td>Certification</td>
<td>Skills</td>
<td>Role</td>
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</tr>
<tr>
<td>Volunteer patient</td>
<td>Many times are cancer survivors or caregivers</td>
<td>TBD by role/facility</td>
<td>Strong oral and written communication skills</td>
<td>To provide patients and families with information and resources</td>
<td>May man the Patient Resource Center Provide educational materials and resources for patients/families Provide community resource assistance (i.e., transportation, wigs, prostheses, LGFB, etc.)</td>
<td></td>
</tr>
</tbody>
</table>

Potential Responsibilities

Based on assessment of needs, direction of nurse, including responding to patient request for information regarding the disease process, expected side effects of treatment and community resources.

4. Assists with annual CoC Standard 3.1 activities related to the annual community needs assessments and resulting programs modifications.
<table>
<thead>
<tr>
<th>Model</th>
<th>Experience</th>
<th>Education</th>
<th>Certification</th>
<th>Skills</th>
<th>Role</th>
<th>Potential Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial counselor</td>
<td>Financial/billing/insurance background</td>
<td>Determined by role/facility</td>
<td></td>
<td>Knowledge of financial support resources</td>
<td>Provide financial counseling and resources</td>
<td>Meets with patients face to face to discuss financial aspects of cancer treatment</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Reviews insurance and financial resources in order to provide patients with a cost estimate</td>
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<td></td>
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<td></td>
<td></td>
<td>Connects patients with financial support services</td>
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<td></td>
<td>Assists with completing insurance forms and with claims</td>
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<td></td>
<td>Collaborates with navigators/pharmacy in identifying patients eligible for drug assistance/reimbursement programs and assists with completing forms</td>
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<td>Makes prompt referrals for enrolling patients in governmental support programs (i.e., disability, Medicaid, etc)</td>
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<td></td>
<td></td>
<td></td>
<td>Tracks revenue</td>
</tr>
<tr>
<td>Model</td>
<td>Experience</td>
<td>Education</td>
<td>Certification</td>
<td>Skills</td>
<td>Role</td>
<td>Potential Responsibilities</td>
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<td>captured by financial counseling activities</td>
</tr>
</tbody>
</table>
Lay Navigator
Role and Responsibilities

Lay navigation focus: Identification and mitigation of barriers to care

Patient Assignments: Ideally, a patient’s needs are matched with an individual lay navigator’s skills and experience. Whenever possible, navigators can be culturally and linguistically matched to patients to facilitate development of a supportive relationship that can be maintained throughout the patient’s treatment course. Examples of criteria for matching patients with navigators are language, racial/ethnic background, navigator’s experience with patient’s type of cancer and navigation in general, navigator’s personality and interpersonal style.

Main Responsibilities:
The lay navigator’s primary function is guiding cancer patients through the healthcare system by assisting with access issues, developing relationships with service providers, and tracking interventions and outcomes.

Lay Navigator Activities:
- Develop relationships with cancer care staff and providers as well as other patient navigators
- Initiate communication with patients referred to navigation services as directed by professional staff
- Use interventions and strategies that are appropriate to the individual and population, taking into account culture, language, age and gender
- Provide support to patients through active, empathetic listening
- Identify each patient’s unique needs and barriers to care and coordinate with professional staff to develop effective solutions
- Guide patients through the healthcare system; assist patients with arriving at scheduled appointments on time and prepared
- Connect patients to facility, community, financial and support resources
- Facilitate interaction and communication with healthcare staff and providers
- Provide health education resources as needed
- Assist patients with using the Patient Resource Center and with access to language-specific materials
- Assist with arranging transportation and lodging as needed
- Document and track patient encounters and outcomes
- Attend scheduled navigation meetings and inservices
## Lay Navigation

### Training and Orientation

<table>
<thead>
<tr>
<th>Training Element</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility volunteer training (if applicable)</td>
<td></td>
</tr>
<tr>
<td>ACS volunteer navigator training (if applicable)</td>
<td></td>
</tr>
<tr>
<td>Facility employee orientation (if applicable)</td>
<td></td>
</tr>
</tbody>
</table>

**Navigation program orientation**

- Cancer program goals and structure
- Introduction to existing community barriers to care
- Introduction to existing patient resources
  - Transportation
  - Lodging
  - Financial Resources
  - Community Resources
  - Educational Resources
  - Interpreter services
  - Others:

- Navigator/patient relationship
  - Initiating contact
  - Offering services
  - Empowering the patient

- Recordkeeping
  - Charting
  - Data collection and reporting

**Cancer 101**

- Biology of cancer
- Common types of cancer
- Cancer treatment
- Introduction to clinical trials
  - Benefits of patient participation
  - Barriers to participation
  - Informed consent
  - ENAACT training

**Caring for people with cancer**

- Emotional challenges of patients and families
  - Fears and uncertainties
  - Facilitative communication skills
  - Building rapport
  - Active listening
<table>
<thead>
<tr>
<th>Patient Confidentiality</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIPAA</td>
</tr>
</tbody>
</table>

**Cancer Program Orientation**

- **Medical Oncology Physician Practice**
  - Contact person: 

- **Infusion Center**
  - Contact person: 

- **Inpatient oncology unit**
  - Contact person: 

- **Radiation Oncology**
  - Contact person: 

- **Social Work**
  - Contact person: 

- **Dietitian**
  - Contact person: 

- **Surgical Physician Practice(s)**
  - Contact person: 

- **Financial Counseling/Patient Billing**
  - Financial Resources
  - Drug programs
  - Contact person: 

- **Genetic Counseling**
  - Contact person: 

- **Clinical Trials**
  - Contact person: 

- **Spiritual Care**
  - Contact person: 

- **Learning Resource Center/Patient Education materials**
  - Contact person: 

- **Ongoing mentoring by clinical staff/regularly scheduled inservices and educational offerings to enhance navigator knowledge and provide structured time for discussing cases and navigation logistics. Besides providing continuing education, these meetings offer navigators support and networking opportunities.**
Navigator Interaction With
Clinical Trials Team

Navigators are in the unique position to introduce opportunities for participation in clinical trials to oncology patients and they have the ability to ensure that disparate populations are introduced to, and have access to, clinical trials. In this section are recommendations for navigator interaction with the clinical trials team.
**Recommendations for Navigator Interaction with Clinical Trials**

- Navigator serves as liaison between physicians’ offices and Clinical Trials team
- Navigator works collaboratively and communicates regularly with Clinical Trials team in recruiting and supporting clinical trials patients
- Navigator collaborates with Multi-D team, clinical trials staff and physicians as patients are evaluated for trials
- Navigator assists with identifying opportunities for patients to participate in trials
  - Knowledge of current trials
  - Identification of opportunities for disparate populations to participate in trials
  - Provides basic patient education related to clinical trials (i.e., explanation of what a clinical trial is, etc.)
- Navigator serves as an advocate for clinical trials
- Navigator assists with coordination of care related to trials
  - Communicates language barriers and facilitates language translation as needed
  - Assists with health literacy barriers to facilitate patient understanding of clinical trials education and consent
  - Assists with logistics related to lodging, transportation, etc.
  - May attend clinical trials/physician office visits related to trials with patient to assist with patient understanding of trials and to provide support for patient
Integrating Navigation With Multi-Disciplinary Care
Navigation and Multi-Disciplinary Care

Navigators have the opportunity to positively impact coordination of care through active participation in multi-disciplinary conferences as well as clinics. Based on the recommendations of the NCI’s Patient Navigation Research Project, here are ways navigation can be integrated into multi-disciplinary care.

1. The navigator actively participates in Multi-disciplinary Conference, assisting with preparing conference materials and providing patient follow-up as needed (This has been defined as a core responsibility for navigators)
   a. Responsibilities
      i. Actively participates in MDC patient presentation and care planning
      ii. Assists with coordination of Multi-D Conference(s) as needed
      iii. Using oncology nursing knowledge base, experience and expertise, assists with patient follow-up as needed

The following recommendations for the navigator role in MDC have been established by the CHI MDC workgroup and are based on work that has been done through the NCCCP Disparities Group.

Key qualifications:

– Experienced nurse navigator
– Skilled at developing relationships with other stakeholders
– Involved with community resources
– Excellent communication and organizational skills

Standard role for navigator:

– Assess for barriers to care and make referrals as needed
– Help guide the patient and family through the health-care system
– Act as the central contact for patients and families
– Ensure that the patient and a family understand the diagnosis and treatment plan
– Assist patients with scheduling tests and consultation
Patient and Family Education

This section contains recommendations for materials for the Patient Resource Center and materials for newly diagnosed patients along with written and online support and education resources. Also included are education resources for healthcare providers. Our workgroup collaborated with the Cancer Patient Education Network in developing these recommendations.
### Patient Education and Support Resources

<table>
<thead>
<tr>
<th>Resource Center Materials</th>
<th>New Patient Resources</th>
<th>General Education/Support Resources</th>
<th>HCP Education Resources</th>
</tr>
</thead>
</table>
| NCI Publications**  
  Health Information Translations [www.healthinfotranslations.org](http://www.healthinfotranslations.org)  
  This takes you to a page where you can choose foreign language |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Breast Cancer Online</strong></td>
<td><strong>Hematologic Cancers</strong></td>
<td><strong>Ovarian Cancer</strong></td>
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</tr>
<tr>
<td>BreastCancer.org</td>
<td>CML-focused website</td>
<td>National Ovarian Cancer Coalition</td>
<td></td>
</tr>
<tr>
<td>CancerInformation.com</td>
<td>Others:</td>
<td><a href="http://guide2chemo.com/">http://guide2chemo.com/</a></td>
<td></td>
</tr>
<tr>
<td>Inflammatory Breast Cancer Research Foundation</td>
<td>The Leukemia &amp; Lymphoma Society</td>
<td>CURE’s Illustrated Guide to Cancer</td>
<td></td>
</tr>
<tr>
<td>Living Beyond Breast Cancer</td>
<td>Leukemia Research Foundation</td>
<td><a href="http://www.curetoday.com/index.cfm/fuseaction/page.show/id/405">http://www.curetoday.com/index.cfm/fuseaction/page.show/id/405</a></td>
<td></td>
</tr>
<tr>
<td>MAMM: Women, Cancer, and Community</td>
<td>Lymphoma Research Foundation</td>
<td>(May be available at no cost through Genentech)</td>
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</tr>
<tr>
<td>National Breast Cancer Coalition</td>
<td>National Children’s Leukemia Foundation</td>
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<tr>
<td>Program on Breast Cancer and Environmental Risk Factors (BCERF)</td>
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<tr>
<td>SHARE: Self-Help for Women With Breast or Ovarian Cancer</td>
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<tr>
<td>Sisters Network, Inc</td>
<td></td>
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<tr>
<td>Susan G. Komen for the Cure</td>
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<tr>
<td>Women’s Information Network Against Breast Cancer (WIN ABC)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>**Cancercare **</th>
<th><strong>Cancercare.org</strong></th>
<th><strong>NCCN Guidelines Translations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Websites</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------------------------------------------</td>
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<tr>
<td></td>
<td>Oncolink website <a href="http://www.oncolink.org/index_ie.cfm">http://www.oncolink.org/index_ie.cfm</a></td>
<td></td>
</tr>
</tbody>
</table>
|                   | Websites: American Lung Association [CancerInformation.com](http://CancerInformation.com)  
|                   | Lung Cancer Alliance [Lung Cancer Online](http://Lung Cancer Online)  
|                   | LungCancer.org |
| Prostate Cancer   | Cancer.net (ASCO) – support and education resources and mobile app [http://www.cancer.net/](http://www.cancer.net/) |
|                   | Websites: American Prostate Society [CancerInformation.com](http://CancerInformation.com)  
|                   | The Education Center for Prostate Cancer Patients (ECP)  
|                   | Prostate Cancer Foundation [Prostate Cancer Institute](http://Prostate Cancer Institute)  
|                   | Prostate Cancer Research Institute [Prostate Conditions Education Council (PCEC)](http://Prostate Conditions Education Council (PCEC))  
|                   | PSA Rising [UrologyHealth.org](http://UrologyHealth.org)  
|                   | Us TOO [ZERO: The Project to End Prostate Cancer](http://ZERO: The Project to End Prostate Cancer) |
| Gastric Cancer    | NCCN.com (patient/family focused) [http://nccn.com/](http://nccn.com/) |
|                   | Websites: CancerInformation.com  
<p>|                   | CORE (Digestive Disorders Foundation) |
|                   | ACS easy reading resources/materials for patients and caregivers with low health literacy and/or limited English proficiency |</p>
<table>
<thead>
<tr>
<th><strong>Gastric Breast Cancer Network Center (GBCNC)</strong></th>
<th><strong>Gastro Esophageal Cancer Foundation Incorporated</strong></th>
<th>Mayo Clinic: Stomach Cancer</th>
<th>MedlinePlus Health Topics: Stomach Cancer</th>
<th>National Cancer Institute (NCI): What You Need to Know About Stomach Cancer</th>
</tr>
</thead>
</table>

**Head and Neck Cancer**

- American Head & Neck Society
- CancerInformation.com
- Head and Neck Cancer Alliance
- Support for People with Oral and Head and Neck Cancer

**Colorectal Cancer**

- CancerInformation.com
- Colon Cancer Alliance
- Colorectal Cancer Coalition

**Patient Resource website**

http://www.patientresource.com/

**Cancer Support Community**


**Oncolink website**

http://www.oncolink.org/index_ie.cfm

**Colorectal Cancer**

- CancerLegalResourceCenter
- http://www.patientresource.com/

**American Institute for Cancer Research – nutrition research and support**

http://www.aicr.org/

**Cancer Legal Resource Center**

https://www.disabilityrightslegalcenter.org/about/cancerlegalresource.cfm

**LiveStrong Professional Tools and Training**

http://livestrong.org/What-We-Do/Our-Actions/Professional-Tools-Training

**My Cancer Advisor – cancer information and opinions from leading experts**

http://www.patientresource.com/
<table>
<thead>
<tr>
<th><strong>Cancer Support Community</strong>&lt;br&gt;<a href="http://www.cancersupportcommunity.org/main_menu/about-cancer.aspx">http://www.cancersupportcommunity.org/main_menu/about-cancer.aspx</a></th>
<th><strong>Cancer Quest website – support and education resources in multiple languages</strong>&lt;br&gt;<a href="http://www.cancerquest.org/">http://www.cancerquest.org/</a></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>AYA Resources</strong>&lt;br&gt;LiveStrong Young Adult Alliance&lt;br&gt;<a href="http://livestrong.org/Get-Help/Find-More-Resources#/r/40">http://livestrong.org/Get-Help/Find-More-Resources#/r/40</a></td>
<td><strong>NCI AYA Resources</strong>&lt;br&gt;<a href="http://www.cancer.gov/cancer-topics/aya">http://www.cancer.gov/cancer-topics/aya</a></td>
</tr>
<tr>
<td></td>
<td><strong>Fight Conquer Cure</strong>&lt;br&gt;<a href="http://fightconquercure.com/programs/resources">http://fightconquercure.com/programs/resources</a></td>
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<tr>
<td>Caregiver Support and Education Resources</td>
<td>Caregiver Support and Education Resources</td>
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<tr>
<td>My Cancer Circle – support community for caregivers</td>
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<tr>
<td>CDC Caregiver Resources</td>
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<tr>
<td><a href="http://www.cdc.gov/cancer/survivorship/caregivers/resources.htm">http://www.cdc.gov/cancer/survivorship/caregivers/resources.htm</a></td>
<td>CDC Caregiver Resources</td>
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<td></td>
<td><a href="http://www.cdc.gov/cancer/survivorship/caregivers/resources.htm">http://www.cdc.gov/cancer/survivorship/caregivers/resources.htm</a></td>
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</tr>
</tbody>
</table>

**Indicates cost for materials as of 2012**
Survivorship

Although most of our cancer programs are using manual processes to generate treatment summaries and care plans, ideally, these documents can be populated through integration with the oncology EHR. In this section are recommendations for survivorship summaries/care plans that can be used in the interim while anticipating EHR implementation along with the recommended process for distribution to patients and care providers. Also in this section are survivorship support and education resources.
Survivorship Care Plan

Survivorship care plans have received increasing attention since the release of the Institute of Medicine report *From Cancer Patient to Cancer Survivor: Lost in Transition*. The report strongly recommends that at completion of cancer treatment, clinicians provide patients with a summary of treatment delivered and a detailed plan of ongoing care, including follow-up schedules for visits and testing, as well as recommendations for early detection and management of treatment-related effects and other health problems.

**What Is a Survivorship Care Plan?**

A survivorship care plan is the record of a patient's cancer history and recommendations for follow-up care. The plan should define responsibilities of cancer-related, non-cancer-related, and psychosocial providers. Clear designation of who is responsible for the various aspects of care can optimize care coordination, avoid unnecessary use of resources, and ensure that care does not “fall through the cracks.” Patients should be encouraged to provide a copy of the care plan to their primary care providers and other healthcare providers throughout life.

**Elements of a Survivorship Care Plan**

**Treatment Summary**

- Details of the cancer diagnosis
  - Diagnosis date
  - Type of cancer
  - Location
  - Stage
  - Histology
- Names and contact information of the providers and treatment facilities
- Treatments administered
  - Chemotherapy/biotherapy — regimen, drug, dose, cycles; clinical trial information
  - Radiation — type, dose, site
  - Surgery — procedure

**Follow-up Plan**

- Specific recommendations for ongoing care
  - Schedule of visits with oncology specialist
  - Surveillance testing for recurrence
  - Identify and manage long-term and late effects
- Health promotional strategies
  - Smoking cessation
- Alcohol and dietary modifications
- Regular weight-bearing exercise

Questions To Be Considered When Implementing Care Plans

- How will the treatment data be collected and from where?
- Who will be responsible for collecting and entering the data?
- What resources will be needed?
- What the services will be included in the follow-up care?
- What guidelines will be followed for surveillance?
- What patient groups will be included?
- When is the most appropriate time to review the survivorship care plan with patients — at the end of treatment or sometime later?
- Should there be a formal transition visit?
- Who will receive the care plan?
- Will the care plan be stored electronically?
- Will the care plan be periodically updated?

(Adapted from Memorial Sloan Kettering Cancer Center recommendations)
Resources for Survivorship Care Plans/Treatment Summaries

Healthcare Provider Resources

- IOM – Lost in Transition
  IOM Lost in Transition
- NCCN Treatment Follow-up Guidelines
  NCCN Treatment Follow-up Guidelines
- AYA Survivorship Guidelines
  AYA Survivorship Guidelines
- Sg2 resources (PDF)
- LiveStrong Survivorship Essentials
  LiveStrong Survivorship Care Plans

Patient Resources

- Patient Survivorship Resources List (see next section)
- ASCO Survivorship booklet
  ASCO Survivorship Publication
- What’s Next: Life After Cancer Treatment (American Cancer Society/Minnesota Cancer Alliance)
  What’s Next: Life After Cancer Treatment

Care Plan and Treatment Summary Templates

- ASCO
  ASCO Cancer Treatment Summaries
- Journey Forward (based on ASCO)
  Journey Forward Care Plan Builder
- LiveStrong (patients can build their own plan; OncoLink)
  LiveStrong Care Plans
- Prescription for Living
  Prescription for Living
- Memorial Sloan Kettering templates can be found on the collaborative site at:
  MSKCC Care Plan Template
Survivorship Summaries and Care Plans
Distribution process/timing to patients, referring providers and PCPs

- Timing
  - To patients - distribute within 6 – 12 weeks of completion of treatment
  - To PCPs/providers – distribute any time after patient has completed treatment
- Process
  - Patients – Summary and care plan are presented to and discussed with the patient (and family if indicated) by their oncology provider(s) and/or Survivorship Navigator
  - PCPs/Providers – delivered electronically or printed out and mailed to provider
Emerging Trends in Navigation

Emerging Market Trends

• Focus on clinical standardization
• Increased role of consumer in decision-making
• Personalized Medicine
• Integration of palliative care for patients with advanced cancer

How can navigation support these trends?

Patient navigation services are positioned to support and positively impact these emerging market trends in cancer care.
Patient navigation is aligned with and able to support the IOM aims as described.
A new paradigm for cancer care: how can patient navigation support and impact the Six Imperatives for Driving Value in Cancer Care as identified by the Advisory Board’s Oncology Roundtable?
APPENDIX
### Patient Needs Assessment Tool

#### Navigation Needs Assessment Survey

<table>
<thead>
<tr>
<th>Date</th>
<th>Interviewer</th>
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**Dept:** MPA MPS RT-CC RT-LVHM HOA LVSO LVGO

1. Have you had any difficulty with the following:
   - Getting appointments
   - Getting results
   - Knowing what to do should symptoms occur
   - If yes, what was the problem?

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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</table>

2. Did anyone discuss resources available to you outside of this department, such as nutrition, financial, or support counseling?

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<th></th>
<th>Yes</th>
<th>No</th>
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3. How would you rate the coordination between your many physicians?
   - Outstanding
   - Very Good
   - Fair
   - Poor
   - Non-existent

4. Did someone review your treatment plan with you?

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<th></th>
<th>Yes</th>
<th>No</th>
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5. Did you receive a written plan of care?

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<th></th>
<th>Yes</th>
<th>No</th>
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6. Has anyone from the cancer care team checked in on you without you calling?

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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   Would this be something you would like?

   |      | Yes | No |

Do you feel you have received enough information and enough time to discuss it with those providing it?

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<th></th>
<th>Yes</th>
<th>No</th>
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163
Navigation Needs Assessment Survey

8. Do you have any unanswered questions?  
   □ Yes  □ No
   If yes, what are they?

9. Do you have any unmet needs?  
   □ Yes  □ No
   If yes, what are they?

10. Where could you have used more help during your cancer journey?
    □ At diagnosis
    □ During treatment planning
    □ During treatment
    □ With financial needs
    □ Support for family
    □ Coordinating with physicians
    □ Other ____________________________

11. Type of Cancer being treated ____________________________

12. Type(s) of treatment patient received:
    □ Surgery
    □ Radiation
    □ Chemotherapy
Physician Engagement Strategies

Lesson #4: Engage Physicians in Role Development

Physician skepticism about the need for navigation services is common. Often physicians feel that they and their staff are already providing patients with sufficient support, and they are concerned that the addition of a navigator will only increase the likelihood of patients becoming confused or receiving conflicting information. This is problematic, as lack of physician support can limit navigator effectiveness; patients are less likely to be referred and physicians are less likely to communicate with the navigator about their patients’ status and treatment plan.

In order to secure physician support for the navigator, physicians should be involved in the planning and role development process. Ideally, they would participate in the needs assessment, providing their insights into where patients need more support and what opportunities exist for improvement. However, if physicians are unable to participate, cancer program leaders should at a minimum, share the findings of their needs assessment and solicit input on the navigator job description. Some organizations even use physicians to help screen and interview candidates for the role.

Numerous Opportunities to Secure Engagement

- Needs Assessment
  - Solicit physician input on need for navigator
  - Present data illustrating need, e.g. timeliness of care metrics

- Defining the Role
  - Physicians help set goals for the position
  - Review and provide feedback on job description
  - Review and provide feedback on policies and standard operating procedures

- Screening Candidates
  - Involve physicians in reviewing resumes
  - Invite physicians to help interview candidates

Source: Oncology Boardroom interviews and analysis.
### Patient Acuity Scales

**Billings Clinic Acuity Scale (2011)**

<table>
<thead>
<tr>
<th>Acuity Scale</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>No navigation</td>
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<tr>
<td>0.5</td>
<td>Meet patient if referral received; Initial guidance/education/coordination as needed; Typically no follow-up required</td>
</tr>
<tr>
<td>1</td>
<td>Meet patients upon diagnosis; Initial guidance/education/coordination; Typically no follow-up required</td>
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<tr>
<td>1.5</td>
<td>Meet patient upon diagnosis; Coordination of multi-modality treatment; Typically ongoing guidance/education for 3-4 months;</td>
</tr>
<tr>
<td>2</td>
<td>Meet patients upon diagnosis; Coordination of multi-modality treatment; Moderate intensity of needs; Typically ongoing guidance/education for 5-6 months or more</td>
</tr>
<tr>
<td>2.5</td>
<td>Meet patients upon diagnosis; Coordination of multi-modality treatment; High intensity of needs, often inpatient hospitalizations associated with care; Typically ongoing guidance/education for 6-12 months or more</td>
</tr>
<tr>
<td>4</td>
<td>Meets patient upon diagnosis; Coordination of multi-modality treatment; High intensity of needs, often associated with care coordination outside of facility; Typically ongoing guidance/education for 6-12 months or more</td>
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</table>
**Breast Cancer Navigator Program**

**Patient Acuity Scale**

<table>
<thead>
<tr>
<th>Acuity Level</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>Breast cancer patient/caregiver, initial contact answer questions, advocate needs, typically no follow up</td>
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<tr>
<td>1</td>
<td>Meet patient upon diagnosis or referral Education, guidance, coordination of care Ongoing follow up for 2 months</td>
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<tr>
<td>2</td>
<td>Meet patient upon diagnosis or referral Education, guidance, coordination of care Assessment of patient needs Typical ongoing follow up for 3 – 4 months</td>
</tr>
<tr>
<td>3</td>
<td>Meet patient upon diagnosis or referral Education, guidance, coordination of care Assessment of patient needs Typical ongoing follow up for 5 – 6 months</td>
</tr>
<tr>
<td>4</td>
<td>Meet patient upon diagnosis or referral Education, guidance, coordination of care Assessment of patient needs Typical ongoing follow up for 7 – 12 months</td>
</tr>
</tbody>
</table>
# Navigator Knowledge Assessment Tool

## Breast Care Coordinator Orientation Manual

Please rate your confidence level in discussing each of the following topics. 4 = EXTREMELY COMFORTABLE, 3 = SOMEWHAT COMFORTABLE, 2 = COMFORTABLE, 1 = NOT COMFORTABLE

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<td>Criteria for BCC job description</td>
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<td>Criteria for Medical Director multidisciplinary breast care program</td>
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<td>Criteria for physician participation in breast program</td>
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<td>Process flow for multidisciplinary breast clinic</td>
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<td>BCC reporting template</td>
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<td>Orientation for patients newly diagnosed</td>
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# Navigator Knowledge Assessment Tool

## Breast Care Coordinator Orientation Manual

Please rate your confidence level in discussing each of the following topics:

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<td>Breast biopsy techniques</td>
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<td>Prognostic indicators</td>
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### Navigator Knowledge Assessment Tool

**Breast Care Coordinator Orientation Manual**

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<td>Surgical Interventions</td>
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<td>Breast reconstruction</td>
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<td>Targeted therapies</td>
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<td>Clinical trials</td>
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<td>High risk programs</td>
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<td>Quality of life issues along the continuum of care</td>
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<td>Decision making</td>
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<td>Psychosocial issues</td>
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<td>Emotional responses to biopsy and diagnosis</td>
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<td>Active treatment</td>
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<td>Advanced, metastatic and recurrent disease</td>
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<td>Complementary therapies</td>
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<td>Family issues</td>
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<td>Long-term survivorship issues</td>
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Navigation Professional Organizations

Academy of Oncology Nurse Navigators (AONN)
http://aonnonline.org/

National Coalition of Oncology Nurse Navigators (NCONN)
http://www.nconn.org/
Title: Nurse Navigator—Oncology
Location: Cancer Center, 333 Main Street
Supervisor: Susanne Service Line Lead
Job Code: 1234
Effective Date: 1/1/2012
Status: Approved

Purpose: To navigate patient and family members through a cancer diagnosis, cancer treatment and follow-up care. Nurse navigators focus on high-quality, timely, integrated and coordinated care that is patient-centered. The mission of the Oncology Nurse Navigator (CNN) is to improve patient preparedness for treatment by providing education and psychosocial support, facilitate interaction across a multidisciplinary team of providers including logistical support during diagnosis and treatment planning phases (ie, referrals to specialists, appointment scheduling and coordination, insurance and financial counseling and test results); and serve as an advocate to ensure customer satisfaction, appropriate follow-up care for up to 3 years post-diagnosis, and assurance that all patient needs and concerns are addressed.

Accountabilities and Job Activities:
- The CNN participates in direct patient care to promote positive clinical outcomes and documents care in the electronic medical record (EMR) per department standards. (Time allocation = 40%)  
  - Assesses, plans, implements and evaluates care of women and men with cancer-related health concerns
  - Interviews and assesses new patients for physicians; completes a nursing assessment of individual needs and recommends patients for clinical trials under physician supervision
  - Assists physicians per department standards with clinic visits and procedures if needed
  - Assists patients and staff in the appointment process to expedite timely appointments
  - Provides patients with appropriate education related to prevention, diagnosis, tests, surgery, chemotherapy and radiation therapy, survivorship and palliative care. Works with discharge planning as appropriate
  - Teaches patients about the importance of screenings (eg, mammograms, colonoscopies)
  - Coordinates testing and expedites results reporting for services across the care continuum
  - Utilizes the EMR per department standards
  - Provides emotional support to patients, their families and other caregivers, especially during high-stress phases of diagnosis and treatment
  - Assures continuity of care by interfacing with physicians, day surgery, inpatient units and outpatient facilities
  - Facilitates patient flow through the continuum of care in partnership with the physician and other members of the health care team
  - Works collaboratively with a multidisciplinary care team to design and update the care plan
- The CNN participates in indirect patient care to promote patient satisfaction, associate engagement and physician satisfaction. (Time allocation = 40%)  
  - Follows up with physicians on all abnormal testing in a timely fashion and documents activities in the EMR per department standards; identifies any barriers to next steps in diagnosis and treatment plans and works to remove those barriers
  - Documents all education, assessments and care given in the EMR, according to department standards
Sg2 Sample Job Description

- Identifies and collects appropriate quality improvement (QI) data; participates in QI projects
- Follows up with patients following appointments and treatments in a timely and professional manner and documents activities in the EMR, per department standards
- Acts as a hospital resource in promoting cancer awareness, education and screening tools
- Acts as a resource for patients and other hospital employees
- Uses effective listening and questioning techniques in a professional and empathetic manner, demonstrating sensitivity to patients and families; develops relationships with patients and their families
- Selects or develops educational tools for patients and families including the various cancer navigation kits (by tumor type)
- Participates in identifying program goals and metrics including outcomes data and registry data; delivers a quarterly report card to demonstrate performance

- The ONN participates in community education to promote growth. (Time allocation = 10%)  
  - Identifies, develops and participates in all hospital and community programs related to cancer screening, diagnosis and cancer-related health issues  
  - Develops education programs for cancer awareness; works with hospital marketing on campaigns  
  - Participates in cancer center committee activities  
  - Under the direction of cancer center leadership, works with all hospital departments to provide seamless care for patients diagnosed with cancer  
  - Teaches other hospital departments and employees about the importance of patient navigation through the cancer care continuum  
  - Develops educational programs for the public around common cancers, screenings, treatments and the role of the care team, including nurse navigators  
  - Works with wellness providers in the community to support their efforts as they relate to cancer and cancer patients and links patients to these resources as appropriate  
  - Leads and facilitates support groups for cancer patients and their families

- The ONN engages in professional activities to stay abreast of industry innovations and standards in order to assist the cancer center with new programming to fund the future of cancer care. (Time allocation = 10%)  
  - Has responsibility for continued self-growth and education in areas related to changes in cancer detection, education and treatment options  
  - Presents a professional image and courteous manner representing the cancer center to the public  
  - Participates in nursing unit and hospital activities to promote service excellence  
  - Promotes team behavior and acts as a role model for others; adheres to productivity benchmarks

Licensure, Registration and/or Certification Required

Registered Nurse license issued by the state; oncology nurse certification and basic life support licensure (BLS) issued by the American Heart Association.

Education Required

Requires 5 years of experience in oncology nursing, including: performing assessments; developing care plans; educating patients and families; possessing a working knowledge of insurance, referrals and non-hospital-based cancer care providers in the community.

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CHI Navigation Software User Requirements

Patient population to be navigated
- Disease-site specific vs general navigation functionality
- Survivorship
- Outreach/screening

Patient Information
- Demographics
- Insurance status
- Race/Ethnicity
- Diagnosis details/Treatment details/Treatment summary functionality
- Referral source (provider, self, etc)
- Care team members

Patient Assessments
- Distress
- Barriers to care/problem list

Tracking Tools
- Patient encounters – type/time spent
- Patient barriers and referrals
- Navigator productivity
  - Patient acuity – tools for determining
  - Number of barrier/problems – number of referrals needed; level of distress
  - Time spent with patient
  - Time spent managing problems/referrals
  - Daily activities
- Timeliness to care

Navigator Workflow
- Task list
- Reminders
- Integration with MDC
- Interface with EMR – medical records, lab, path
- Documentation tools
- Tools for communicating with patient

Reporting
- Patient volumes (race/ethnicity; disease site, etc)
- Navigator productivity
- Referral sources
- Timeliness to care
- Barriers/referrals
- Patient acuity
Patient Portal
- Education
- Communication
- Reminders
- Schedule appointments
- Download forms
- Assessments
- Useful links
- FAQs
<table>
<thead>
<tr>
<th>Category</th>
<th>Issues</th>
</tr>
</thead>
</table>
| Health Insurance | no insurance  
|               | underinsured  
|               | high co-pay |
| Financial     | not employed  
|               | problems with mortgage payments  
|               | problems with health care payments  
|               | problems with other payments |
| Safety        | unsanitary living conditions  
|               | unsafe living conditions |
| Support       | lacks family/friend support  
|               | concern about appearance  
|               | needs assistance in daily function  
|               | needs assistance with child care  
|               | Transportation |
| Personal      | english not first language  
|               | poor reading ability  
|               | poor health literacy  
|               | family health issues |
| Treatment     | unsure of proper treatment path  
|               | wants second opinion  
|               | issues with ability to have children  
<p>|               | treatment related anxiety |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Issues/Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial</td>
<td>anxiety/depression, spiritual/religious concern, hostile patient, hopelessness</td>
</tr>
<tr>
<td>Nutrition</td>
<td>overweight, food allergies, poor eating habits, special dietary considerations</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>smoking, alcohol consumption, unhealthy lifestyle</td>
</tr>
</tbody>
</table>
**Patient Assessment #2**

Health decision making
- Difficulty with decision making specific to treatment
- Difficulty with decision making specific to overall care planning
- Need to understand implications of advanced directives
- Wants 2nd opinion
- Poor health literacy
- English not first language
- Poor reading ability

Home life
- Abusive relationship
- Non-supportive/limited support relationship
- Insufficient child care support during treatment
- Inadequate housing
- Lack of food
- Unhealthy eating habits
- Unsanitary living conditions
- Needs assistance with daily living
- Transportation needs

Financial
- Medication costs
- Medical bills
- Unaffordable co-pay
- Transport costs
- Legal costs
- School costs

Relationships
- Dealing with children
- Dealing with partner
- Dealing with other loved ones
- Dealing with friends/ co-workers
- Ability to have children
- Loved one’s illness
- Loved one’s distress
- Lacks family/friend support

Emotional
- Lack of Control
- Mood Swings
- Depression
Fears
Nervousness
Sadness
Worry
Hopelessness
Hostility
Loss of Interest in usual activities
Spiritual/Religious concerns
Body image
Concern about appearance

Lifestyle
Smoking
Alcohol addiction
Drug Addiction
cultural integration needs

Medical
Falls/ unsteady gait
Breathing
Changes in urination
Vision
Hearing
Weakness
Palpitations
Constipation
Diarrhea
Weight loss
Weight gain
Eating/ Swallowing
Fatigue
Feeling Swollen
Fever
Getting around
Indigestion
Memory/Concentration
Mouth sores
Nausea/ vomiting
Nose dry/congested
Myalgias
Pain
Sexual
Skin dry/itchy
Sleep
Snoring
Tingling in hands/feet
Speech
overweight
food allergies
### Patient Assessment #3

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>home life</strong></td>
<td>housing, child care, nutrition, spousal abuse, living conditions</td>
</tr>
<tr>
<td><strong>work life</strong></td>
<td>job demands, school demands</td>
</tr>
<tr>
<td><strong>treatment life</strong></td>
<td>decision making, understanding implications of treatment, transportation, fertility</td>
</tr>
<tr>
<td><strong>financial/insurance</strong></td>
<td>under insured, no insurance, high co-pay, no job, cannot afford to make payments</td>
</tr>
<tr>
<td><strong>support</strong></td>
<td>limited emotional support, limited home support, limited work support, spiritual needs, language barriers</td>
</tr>
<tr>
<td><strong>emotional</strong></td>
<td>depression, anxiety, worry, sadness, appearance, body image</td>
</tr>
<tr>
<td><strong>medical</strong></td>
<td>medical issues that need intervention or are affecting daily QOL.</td>
</tr>
</tbody>
</table>
**Patient Assessment #4**

**Practical Problems**
- child care
- housing
- insurance/financial
- transportation
- work/school
- treatment decisions

**Family Problems**
- dealing with children
- dealing with partner
- ability to have children
- family health issues

**Emotional problems**
- depression
- fears
- nervousness
- sadness
- worry
- loss of interest in usual activities

**Spiritual/Religious concerns**

**Physical problems**
- Spiritual/Religious concerns
- 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
- tingling in hands/feet
Oncology Nursing Society, the Association of Oncology Social Work, and the National Association of Social Workers Joint Position on the Role of Oncology Nursing and Oncology Social Work in Patient Navigation

Building on the work of C-Change (2009), patient navigation in the cancer care setting is defined by the Oncology Nursing Society (ONS), the Association of Oncology Social Work (AOSW), and the National Association of Social Workers (NASW) as individualized assistance offered to patients, families, and caregivers to help overcome healthcare system barriers and facilitate timely access to quality health and psychosocial care from prediagnosis through all phases of the cancer experience. This definition is modified from the original C-Change definition by using the term “quality health” instead of “quality medical.” Patient navigation services provided by trained lay navigators were introduced in the early 1990s to ensure access to cancer screening, increase efficacy, and reduce delays of cancer diagnoses that particularly affect poor and underserved populations (C-Change, 2009; Newman-Horn, 2005).

More than 200 patient navigation programs exist in the United States (Institute for Alternative Futures, 2007). Patient navigation programs are created to address cancer health disparities identified in the communities in which patients with cancer live and in which health care is being provided (Heide, 2006). Navigation programs incorporate processes that involve collaboration with community-based resources. Models encompassing navigation processes and services should reflect the strengths and desired results, as well as address the challenges of the community, system, and facility in which navigation programs reside.

In practice, barrier-focused patient navigation addresses specific challenges of access to care. The services provided by navigators depend on the barriers identified and the strategies adopted to eliminate or reduce those barriers. Service-focused patient navigation addresses the provision of services to patients and families, such as coordinating patient care and education (Dohan & Schrag, 2005).

Navigation processes are fundamental in nursing and social work. Nurses and social workers enhance their professional knowledge and competencies with preparation in patient navigation processes (AOSW, 2001; NASW, 2005; ONS, 2004b). Based on existing and emerging research findings and experiential reports, optimal outcomes of navigation services are most likely to occur when navigators’ knowledge base and skill sets extend beyond basic professional education and oncology experience to include the ability to conduct community assessments and the identification and crafting of interventions to resolve systems barriers that interfere with timely access to needed care and services.

As patient navigation services evolve and expand, nurses and social workers in oncology have roles in educating patients, survivors, families, healthcare teams and systems, and the public about patient navigation. Challenges revolve around measuring and ensuring desired and optimal outcomes for patients, families, survivors, and individuals in patient navigator roles and processes to address sustainability of navigation programs and services (Wells et al., 2008).
It is the Position of ONS, AOSW, and NASW That

- Patient navigation processes, whether provided on-site 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 perform navigator roles do so based on the scope of practice for each discipline. Educational preparation and professional certification play roles in regulating the practice of both disciplines. Nationally recognized standards of practice specific to the discipline and specialty also define safe and effective practice.
- Nurses and social workers in oncology who perform navigator services should have education and knowledge in community assessment, cancer program assessment, resolution of system barriers, the cancer continuum, cancer health disparities, cultural competence, and the individualized provision of assistance to patients with cancer, their families, caregivers, and survivors at risk.
- Additional research to explore, confirm, and advance patient navigation processes, roles, and identification of appropriate evidence-based outcomes measures must be supported.
- Ongoing collaboration to identify and/or derive metrics that can be used to clarify the role, function, and desired outcomes of navigators must be supported and promoted.

- Navigation services can be delegated to trained nonprofessionals and/or volunteers and should be supervised by nurses or social workers.

Approved by the ONS Board of Directors, 3/2010.
Approved by the AOSW Board of Directors, 3/2010.
Approved by the NASW Board of Directors, 3/2010.

References


NCCCP Navigation Assessment Tool

As all navigation programs are built uniquely, we encourage you to rate your program as you feel appropriate. The purpose of this form is not to gauge one program against another, but to assist you in building a stronger navigation program. This form can be used to assess an individual tumor site or the entire program.

Definitions:
Key Stakeholders: Those people that you feel are essential to making a program work. Include Administration, Navigators, Staff, Physicians (both employed and private practice). Specialty areas include medical, surgical and radiation oncology, rehab, palliative care and hospice.
Community Partnerships: Those entities that exists within and outside of your program that you need the support of or are a referral source for patient use and contribute to the support of the patient along the continuum of their care.
Acuity System: Ability to determine appropriate level of care/intervention based on patient need and disease process.
Risk Factors: Variable associations with increase risk of complications with disease and treatment of cancer.
Metrics/Reporting Measures: Measuring activities and performance
Percentage of Patients Navigated: Cancer Patients inclusive of Analytic cases, new diagnosed primaries, reoccurrences, advanced diseases, metastatic of defined cancer site(s) within your program setting.
Continuum of navigation: Navigation functional areas includes: Outreach/Screening, Abnormal finding to Diagnosis, Treatment, Outpatient &/or Inpatient, Survivorship and end of life care. Navigation can occur along any of or all of these. One single person may do all of these, or you may have one person designated to cover one area of the continuum. They may be disease specific navigators, or cover all diseases within that category. The sign of a level five site is that navigation is continuous across the cancer care continuum.
Disparity: Is any under-represented group that your program is able to focus on. Providing outreach and effort in this population is a hallmark of Navigation according to its original conception and should be continued as part of a navigation program.
Tools for Reporting Navigator Statistics: Documents to help evaluate and measure a navigation program.
MDC Involvement: Multidisciplinary team approach to care including physicians (med onc, rad onc, and surgeon) and other healthcare providers to create plan of care for patient; patient may not always be present to be considered an MDC.

Items with an asterisk (*) are further explained under the definition section at the beginning of the Assessment Tool. Navigation Assessment Tool Version 1.0 was created by the National Cancer Institute Community Cancer Centers Program (NCCCP) and approved by the NCCCP Executive Subcommittee on 7/14/2011. This tool has not been validated.
**NCCCP Navigation Assessment Tool**

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<thead>
<tr>
<th></th>
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<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Quality Improvement Measures</em></td>
<td>None in place.</td>
<td>Brainstorming and discussion regarding metrics and reporting within the multi-disciplinary team or cancer committee.</td>
<td>One Quality Improvement (QI) initiative in place measured and reported to all stakeholders on hardcopy file annually.</td>
<td>QI initiatives developed in collaboration with Patient Feedback and/or Patient Satisfaction Surveys reported to Administration.</td>
<td>Multiple QI initiatives in place monitored to demonstrate program improvement and financial contribution and cost savings services of Navigation (i.e. compliance to POC).</td>
</tr>
<tr>
<td>Marketing of the Navigation program</td>
<td>Occurs by word of mouth.</td>
<td>Includes level 1 as well as some basic written material i.e. Pamphlet.</td>
<td>Plus, Navigator participation at health fairs, cancer screening events as a means of marketing cancer program.</td>
<td>Plus, effort made to promote navigation in some media form.</td>
<td>Plus, multiple sources of media used to support navigation (video, print, audio, web, etc).</td>
</tr>
<tr>
<td>Percentage of patients offered navigation</td>
<td>0-20% of defined tumor site.</td>
<td>21-40%</td>
<td>41-60%</td>
<td>61-80%</td>
<td>&gt;80%</td>
</tr>
<tr>
<td><em>Continuum of Navigation</em></td>
<td>One functional area within the cancer navigation continuum.</td>
<td>Two functional areas navigated within the continuum.</td>
<td>Three functional areas navigated within the continuum.</td>
<td>Four functional areas navigated within the continuum.</td>
<td>Navigation across all functional levels of the continuum.</td>
</tr>
<tr>
<td>Support Services available and used by the Navigation Team</td>
<td>No Resources available.</td>
<td>Hospital resources (SW and/or case manager) are available to assist with cases.</td>
<td>Outpatient Social Services available within Cancer Program.</td>
<td>Level three plus a minimum of two additional out patient oncology specific services available.</td>
<td>All services available or can be accessed within the community or organization (Dietitian, Social Work, psychologist,...)</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>*Tools for reporting navigator statistics</th>
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<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No reports or tools. Paper record (Pt Chart) narrative of services provided for patient and their family</td>
<td>Basic Home grown access file/word, excel Basic info tracked, i.e. number of pts, disease site, supportive services provided</td>
<td>High level home grown access database created, by hospital IT dept. Collects stats and support services provided for pt/family</td>
<td>Formal hospital system EMR database utilized to collect support services and stats. Not a database specific for Navigation.</td>
<td>Reporting of all support services provided to the patient via EMR specific for Navigation including outcome information. Document all support services.</td>
<td></td>
</tr>
</tbody>
</table>

| Financial assessment | No Financial assessment performed | Financial assessment and assistance only available in the inpatient setting | Plus, financial assessment and assistance available for out-patients within Cancer Program | Plus, proactive Financial assessment completed for all oncology patients | Plus, data collection completed on types of services provided and number of patients assisted on a regular basis |

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<tr>
<th>Focus on Disparities</th>
<th>Level 1</th>
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<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Focus on Disparities</em></td>
<td>None defined</td>
<td>Underserved population Defined</td>
<td>At least one culturally sensitive activity devoted to reaching underserved population provided annually</td>
<td>Patient service mechanism defined to integrate underserved patients into the program</td>
<td>Cultural sensitivity assessment completed on cancer center staff with cultural objectives created on at least an annual basis</td>
</tr>
</tbody>
</table>

| Navigator Responsibilities | Navigator is unaligned with any physician and responsible only for support of the Patient | Plus, Navigator coordinates care between multiple disciplines with in the cancer program | Plus, Navigator participation in Support Groups, Family/Patient center programs, | Plus, Navigator maintains an Active role in disease specific MDC/Tumor Conferences | Plus, Navigator is an integral part of Quality Improvement, audits, and strategic planning |

| Patient Identification process | No formal patient identification. Path reports, daily schedule, radiology reports used to identify patients. | | | | Primary Care Provider and/or specialist (GI, Pulmonary, Interventional Radiology) refers at the time of abnormal finding |

| Navigator Training | No formal training in place | Core Competencies of Navigation defined | Local/in-house training curriculum developed specific to navigator core competency and development of Navigator role | Local/in-house training program completed by all navigators -- Or are certified in Oncology in their respective disciplines | Navigators formally trained by nationally recognized training program and certified |

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<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement with Clinical Trials</td>
<td>Navigator shares basic understanding of clinical trials in cancer</td>
<td>Navigator has greater depth understanding of Clinical trials, has completed specific training (NCI, ONS, etc)</td>
<td>Navigator shares information regarding the availability of clinical trials in their community cancer center with patients</td>
<td>Navigator engages with research team in providing general referrals</td>
<td>Navigator engages with research team, assists with specific trial referrals for underserved populations</td>
</tr>
<tr>
<td>*Multi-disciplinary Care/Conference Involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Commission On Cancer requirements met. Including discussion of NCCN guidelines or other National Oncology Standards</td>
<td>Navigator attends tumor conference but doesn’t participate, documents physician discussion of plan of care in narrative note but not formal part of patient record</td>
<td>Navigator assists with Case finding for MDC presentations. No treatment plan documented, Dictation completed by MD re; plan of care.</td>
<td>Navigator provides formal review of discussion of MDC with patient after case presentation.</td>
<td>Patient informed of presentation at MDC with full formal report on treatment planned discussion shared with patient referring MD and primary care, formal audits completed.</td>
<td></td>
</tr>
</tbody>
</table>

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