# Advanced Oncology Certified Nurse Practitioner

**REVIEW COURSE 2024** 

October 10-12, 2024 | Houston, TX

MDAnderson Cancer Center

Making Cancer History\*

# Care Coordination & Patient Navigation

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# Disclosures

Dr. Morgan Nestingen receives compensation from Janssen Biotech, Inc. for consulting services related to the design and implementation of patient support programs.

### **Objectives** (Cancer Continuum – 28%)

At the completion of this session, the learner will be able to:

- 1. Define oncology patient navigation
- 2. Describe common barriers to cancer care
- 3. Give examples of care coordination activities
- 4. Delineate between key roles involved in the coordination of patient care
- 5. Describe collaboration between oncology nurse practitioners and nurse navigators
- 6. List evidence-based outcomes associated with patient navigation

# Oncology Patient Navigation

"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."<sup>1-3</sup>

# A Brief History of Oncology Navigation in the US

**1990:** 1<sup>st</sup> Pilot study in Harlem, NY among underserved breast patients; diagnostics + navigator support to address patient barriers

**2005/6:** National funding from Congress, NCI, ACS, CMS for multi-site Navigation outcomes research<sup>5,6</sup>

NIH

NATIONAL CANCER

INSTITUTE

**2009:** Academy of Oncology Nurse & Patient Navigators (AONN+) formed

**Outcomes:** 28% decrease in late-stage presentation, 31% increase in 5-yr survival<sup>4</sup>

**Outcomes:** Funding for navigation research, improved timeliness of care, adherence, access to care and quality of life, particularly in vulnerable patients<sup>7-9</sup>

Outcomes: Professional society dedicated to oncology navigation, ~9,000 members

# A Brief History of Oncology Navigation in the US

**2017:** National Navigation Roundtable launched

**2020:** ACS/AONN+ Standardized Navigation Metrics Toolkit published

**Outcomes:** Advocacy and expert recommendations for training navigators<sup>10</sup> & measuring outcomes<sup>11</sup>

**Outcomes:** 35 standardized metrics measuring impact of navigation on patient experience, clinical outcomes and return on investment<sup>12</sup>

**2024:** CMS Principal II

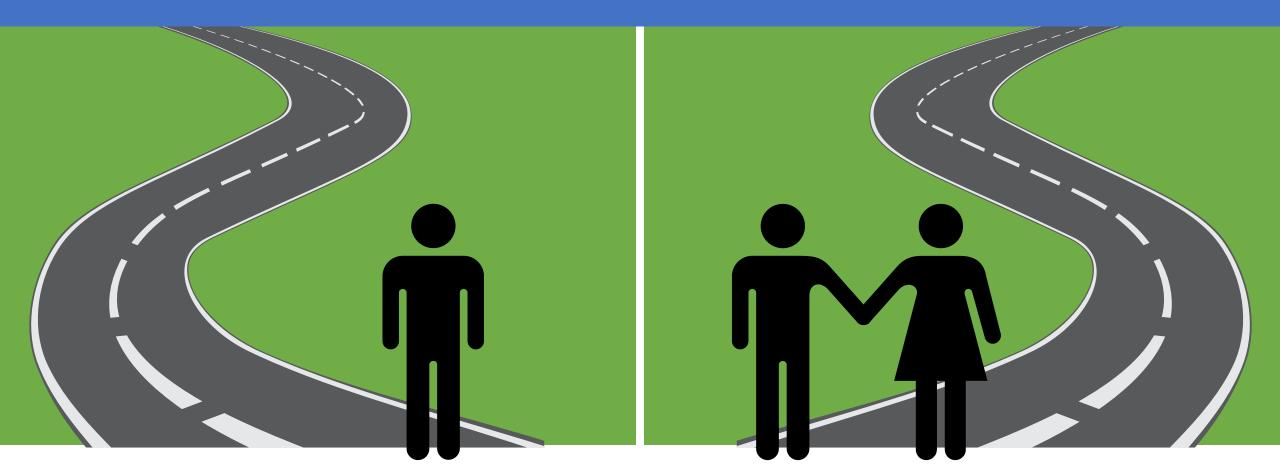
NATIONAL

NAVIGATION ROUNDTABLE

**2024:** CMS approves funding for Principal Illness Navigation

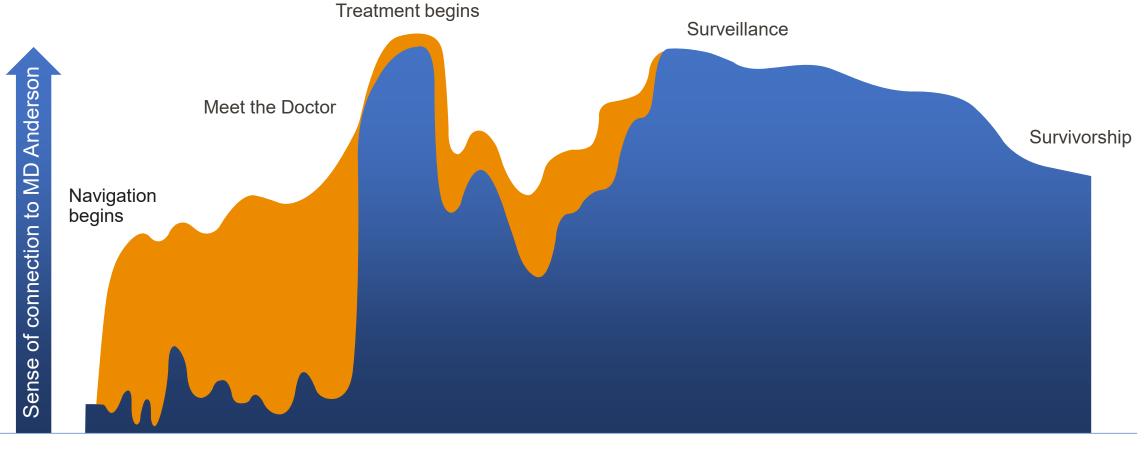
**Outcomes:** ACS LION certification, programs across the US expanding navigation

#### Every patient having a navigator creates EQUALITY.



Navigators individualizing education, care and resources based on patient needs creates EQUITY.

# Filling the White Space with Patient Navigation



1 day 5 days

Individual Barriers to Care<sup>13</sup>

- Physical Concerns
- Emotional Concerns
- Social Concerns
- Practical Concerns
- Spiritual, Religious, or Cultural Concerns



#### Systematic Barriers to Care

Generally, includes access and adequacy of resources:<sup>14</sup>

- Access to care in rural settings
- Limited availability of specialized services
- Health disparities affecting populations of patients

...Requires a team-based, systems solution!



## Care Coordination

"....deliberately organizing patient care activities and sharing information among all participants...to achieve safer and more effective care.

[T]he patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."<sup>15</sup>

# Examples of Care Coordination Activities<sup>15</sup>



Assessing patient needs and goals



Creating a proactive care plan



Monitoring and follow-up



Communicating and sharing knowledge



Supporting patient self-management



Helping with transitions of care



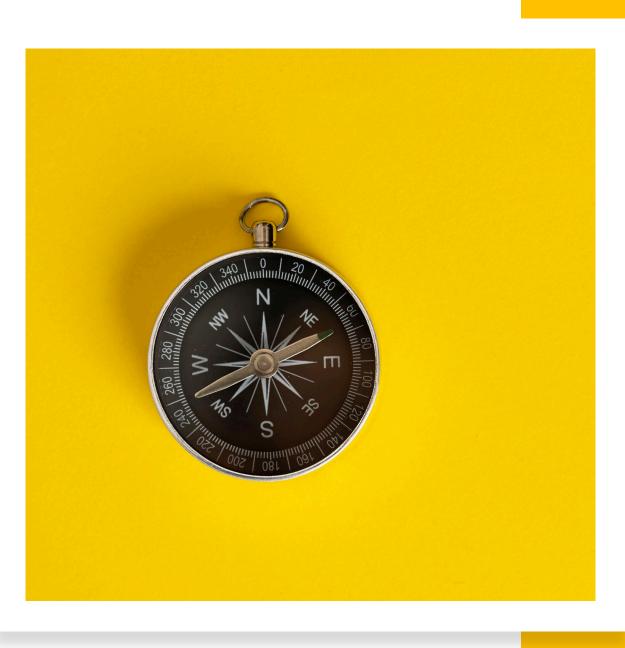
Linking to community resources



Aligning resources with patient needs

The Relationship Between Navigation and Care Coordination<sup>2</sup>

- Care Coordination is the fundamental core competency for nurse navigators
- Communication is #2



## Nurse Navigation Care Plan

- Assessment  $\rightarrow$  Resources, actual/anticipated barriers to care, coping methods
- Diagnosis → Unmet needs
- Planning 

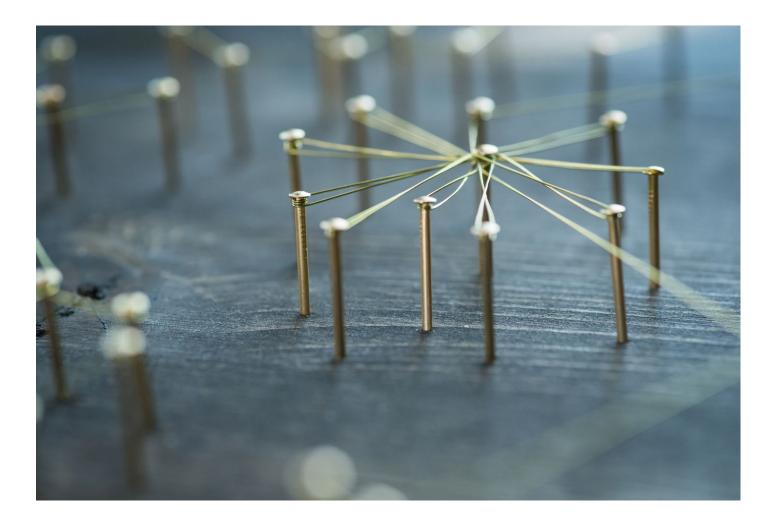
   Coordination of care, reminders, follow ups

#### Comparison of Oncology Navigator Roles

Nurse Navigator	Social Worker	Patient Navigator
<ul> <li>Academy of Oncology Nurse &amp; Patient Navigators</li> <li>American Cancer Society</li> </ul>		
Oncology Nursing Society	<ul> <li>Association of Oncology Social Work</li> <li>National Association of Social Workers</li> </ul>	<ul> <li>George Washington University Patient Navigator Fundamentals</li> <li>Patient Navigation Training Collaborative</li> </ul>
Perform holistic assessments, including clinical factors	Assess mental health concerns	Address practical barriers to care
Deliver patient education	Provide counseling and psychosocial support	Refer patients to credible resources
Triage and prioritize patient needs	Address social justice and financial issues	Specialize in specific populations and communities

...Advanced Practice Registered Nurses, Community Health Workers, Promotores, and many more!

#### Collaboration Between ONPs and ONNs<sup>16</sup>



- Shared goals
- Clear roles
- Mutual trust
- Effective communication
- Measurable processes and outcomes

...ONN is a constant point of contact Outcomes Associated with Patient Navigation<sup>12</sup>

- Clinical Outcomes
  - → Adherence, timeliness of care, access
- Patient Experience
  - → Lower distress, higher quality of life
- Return on Investment
  - → Efficient resource use, 'downstream' revenue-generating services



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# Thank you! Please feel free to contact me with questions.

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