



## The Emergence of Patient and Nurse Navigation

Sharon Francz, BHA, Executive Director, President and Co-founder NCONN

The most recent innovative development in oncology care is patient navigation. Many “definitions” of this role range from volunteer survivors who walk patients from point A to point B in the hospital, to the oncology nurse navigator whose role is to coordinate, advocate for, educate and support the cancer patient and family throughout their journey and often into survivorship or end of life. There is much iteration across the spectrum of patient navigation that is all well intentioned and helpful in many ways. However, the organization and understanding of patient navigation is so variable that it becomes difficult to see the commonalities and advantages of the navigator role as a vital service for anyone diagnosed with cancer. Because of increasing exposure in the media, hospitals and cancer centers are hiring patient navigators and the movement is beginning to grow nationally. Today, there are patient navigators in hundreds, perhaps thousands, of health care facilities nationwide.

### History

Harold P Freeman, M.D. is widely known and respected as the father of patient navigation. “In 1990, Dr. Freeman initiated and developed the first patient navigation program in Harlem, New York. The purpose of the program was to

reduce disparities in access to diagnosis and treatment of cancer particularly among the poor and uninsured.” As a direct result of Dr. Freeman’s work, in 2005 President Bush signed the Patient Navigation Act. The purpose of the act is to target the poor and under-served that might fall through the cracks in needing cancer care and die needlessly.

Alongside these highly visible and pioneering programs, mainstream America has been experiencing a grassroots movement to bring navigation services to cancer patients and families in communities across the U.S. The groundswell for this movement is rapidly gaining speed and such programs are being created in more hospitals and cancer centers every day.

### Patient, Clinical and Nurse Navigation

Today patient navigation has spread to clinical navigation with the emerging role of the **Oncology Nurse Navigator (ONN)**. The ONN position is being implemented in hospitals, oncology office and cancer centers across the U.S. This is good news for new oncology patients. The value that they receive with the guidance and compassionate care from an ONN makes the journey more tolerable. Patients who have

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“Hospitals and cancer centers are hiring patient navigators and the movement is beginning to grow nationally.”

## How to Simplify Dashboard Measurements for Oncology Leaders

Teri U. Guidi, MBA, FAAMA, President & CEO, The Oncology Management Consulting Group  
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Managing a hospital-based cancer center or large physician practice is a complex task. As most of us know, it is all too easy to lose sight of the larger responsibility of maintaining an efficient and financially viable service line or practice and to become consumed with the daily emergencies. A dashboard can be an invaluable tool in ensuring that the bigger picture and long term trends are not neglected or overlooked.

Like the dashboard in a car, the purpose of the oncology dashboard is to provide important information on a regular basis in a manner that can be quickly digested and that allows for appropriate action. A dashboard should not be cluttered with “interesting” information that does not provide useful knowledge or opportunities for action. In other words, don’t measure something just because it is measurable.

In running a cancer program or private practice, two major categories of information should be reviewed periodically: **operational information** and **strategic information**. Each category may have one or more key indicators, and the indicators can change over time based on changes in the environment, i.e. competition, new physicians, new services, payer or reimbursement changes, etc. These indicators may be **volume-oriented** or they may be **financially oriented**. In either case, the most important reason to use a dashboard is to track performance over time and thus identify important changes and/or trends in order to react appropriately. It is also useful to compare dashboard results to any available national or regional benchmarks.

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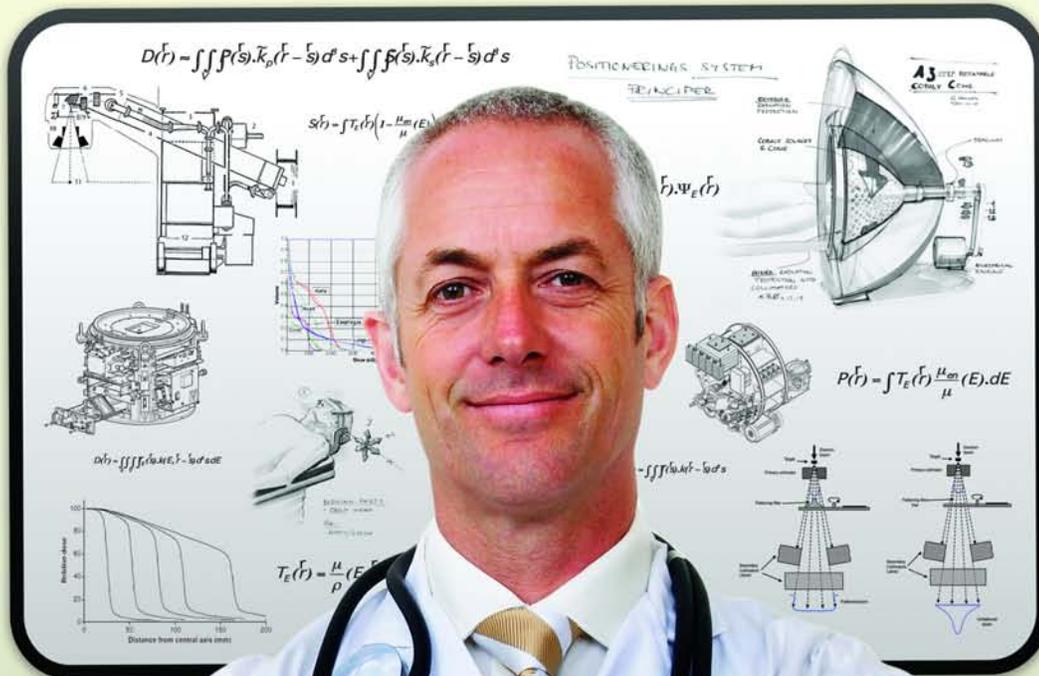
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## Dashboard Measurements for Oncology Leaders

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### Building the Dashboard

Begin by answering two primary questions:

- 1) What do I need to measure to ensure that we are not losing ground?
- 2) What do I need to know to be sure that we are making progress towards our goals?

For each question, determine the measurable indicators. For example, if you define “losing ground” decreasing revenues, then revenue becomes your indicator. Volume indicators are also useful: number of new cancer registry cases, number of consults, number of new starts (chemo or radiation), number of billed procedures, etc. If you are launching a disease-specific program or a new clinical service you may wish to be more specific (e.g. number of new breast cancer consults). If your goals are numeric, put those on the dashboard (e.g. increased clinical trial enrollment, decreased negative biopsies). If your goals relate to progress of a non-numeric project (e.g. strategic initiatives such as developing multi-disciplinary clinics or starting a survivorship clinic), devise a milestone schedule and track your progress. See Table 1 at right for examples of volume indicators and Table 2 for sample financial indicators.

Generally, you should check your dashboard either monthly or quarterly to allow enough time between reviews to see the early results of any recent actions you have taken, and to formulate possible interventions and review trends. More frequent dashboard review is generally not advised as it can place too much importance on small fluctuations. Some indicators, like tracking progress on strategic plan initiatives, may need only quarterly, semi-annual or even annual review.

To the maximum extent possible, a dashboard should be populated by data that is electronically available rather than requiring hand counts, and ideally the dashboard should automatically update itself through IT systems. Remember that a useful dashboard will show you, in a quick table or graph, exactly where you stand on the things that matter most to your center’s or practice’s ultimate success. ■

**“A useful dashboard will show you, in a quick table or graph, exactly where you stand on the things that matter most.”**

### TABLE 1: COMMON VOLUME INDICATORS

- New patient visits for medical oncology – benign and malignant as well as new chemo starts. Also, you may want to measure new patients by tumor type – monthly or quarterly.
- Number of new tumor registry cases (look at Class 0, Class 1 and Class 2 for migration patterns), by major site of disease if you are developing/running a site-specific clinic or program. Registry data should be reviewed no more than quarterly.
- New patient visits for radiation – include new treatment starts and track new patients vs. re-treats as well as % of IMRT patients – quarterly or monthly. Again, you may want to track tumor types.
- Patients accrued to clinical trials (separated for cooperative groups and commercial studies) – quarterly (monthly for very large programs). Track by physician accrual as well.
- New patients to any specialized service/program like an employed physician or a multidisciplinary lung clinic – monthly until well established then quarterly.
- Number of patients referred to departments/services/ programs, segmented by referring physician – monthly for new services/programs, quarterly until well established, then semi-annually. This will allow you to trend volume by referring physician in order to follow up on decreasing trends.
- Clinical/quality measures such as percent of negative breast biopsies, turn-around times for pathology results, adherence to guidelines, etc. – monthly or quarterly depending on the level of concern.
- Volume of social worker, dietician and navigator intervention/new patient contact.

### TABLE 2: COMMON FINANCIAL INDICATORS

- Paid overtime hours by staff category – monthly or quarterly
- Billed charges for each department – monthly
- Expenses for each department, segmented by expense category – monthly
- Claims denied/appealed (number and dollars), segmented by payer – monthly or quarterly
- Accounts receivable (dollars and days) in each department – monthly
- Amount of drug charges recouped from drug assistance programs if uninsured or underinsured patient population warrants
- Staff turnover ratio

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had access to an ONN often express the opinion that they do not know “what I would have done without my nurse navigator.” The ONN truly has the ability to change the face of cancer care.

So where do you find an Oncology Nurse Navigator? ONN's have predominantly come from imaging and breast cancer centers, working with breast cancer patients, as this seems to be the population that many hospitals and clinics target first for implementing navigation services. However, more and more providers are seeing the value that the ONN brings to the patient, family and healthcare team and are creating these positions for other cancer diagnoses too – such as lung, colorectal, prostate and gyn. However, ONN's feel that every cancer patient should have an ONN to guide them through the process. While this is true, it is also the opinion of many ONN's that there is no real structure or framework around their role. In fact, they will often say that they were hired without a relevant job description, without a budget and/or without clear administrative support. This makes the job even more challenging as the nurse must first “create” the job and then, or at the same time, work with patients.

To date there are two organizations that support the nurse navigator, the National Coalition of Oncology Nurse Navigators (NCONN) formed in 2008, and the Academy of Oncology Nurse Navigators (AONN) in 2009. Both asso-

ciations are dedicated to the support of the ONN. Nurses are often the leaders in solving problems and creating solutions that improve patient care and outcomes, and nurses are taking a leadership role in this arena as well.

Dr. Harold P. Freeman, Founder of the Patient Navigation Institute and Medical Director of the Ralph Lauren Center for Cancer Care in New York, acknowledges the critical importance of the “nurse oncologist” to lead a system that ideally also utilizes *lay navigators* to help patients overcome barriers to care, *nurse navigators* to address clinical education and support needs, and *social work navigators* to address psychosocial needs. The lay patient navigator may be a community outreach worker, a financial navigator, or a resource manager. Social work navigation is a critical component as well, since cancer is a disease that affects the family dynamic as well as the patient's mental, emotional and spiritual wellbeing.

Patient navigation is growing in importance and in its ability to affect patient outcomes. When a woman is guided through the maze of issues surrounding access to breast health care and is guided by the hand of an ONN when a cancer diagnosis is made, she is more likely to be diagnosed in an earlier stage of her cancer and realize a better chance for cure. Likewise, the underserved or uninsured population that the outreach navigator encounters in the community will be guided through the process of obtaining breast, gyn, prostate, colon or lung cancer screening and are guided so that they will actually show up for their appointment and follow up with the findings.

**Patients say**  
**“I do not know what I would have done without my nurse navigator.”**

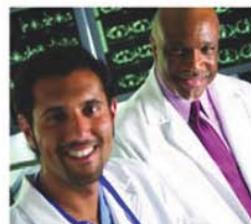
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\* Sg2 forecast

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Patient navigation using the ONN, the lay navigator, and the social work navigator, all working as a team with the surgeons, pathologists, radiologists, medical and radiation oncologists is a service that can and should be available for all cancer patients regardless of income. Everyone with a new cancer diagnosis deserves the same guidance.

The future of the ONN as a leader in patient care is bright and wide open for growth. ONN's may be working under many different titles, but will recognize themselves as a ONN if they are interacting with a patient from the beginning of diagnosis and remaining their navigator throughout the cancer care journey. ONN's can have an active voice in the future of this specialty by coming together and working with their professional association to define and refine their work. There are opportunities to network with one another, to share patient resources and educational information that will benefit the patient and family. When ONN job descriptions, standards of practice, core competencies, orientations and certifications are developed and in place, the role will be acknowledged and respected for the value it brings to oncology care. The ONN will be instrumental in the development of these resources as it expands and becomes recognized by patients and professionals as a must have option in cancer care treatment. ■

**Reference**

1 *Welcome - The Harold P. Freeman Institute for Patient Navigation.* (n.d). Retrieved June 20, 2011, from <http://www.hpfreemanpnri.org/>

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**President's Message**



*William Laffey  
System Director, Cancer Services  
Aurora Health Care*

I am trying to think of a way to tie this issue's message into the joy of being a Boston sports fan (since that was my hometown). Boston is the only city to have had championships in the four major professional sports in a seven year span, most recently the Stanley Cup. Lots of success in those seven years. So too with ACE! In the last few years we've expanded our membership significantly, have begun a list serve for members, begun our Hot Topic Conference Call series, initiated Oncology 101 and conducted a terrific conference on Cancer Center Building Blocks. All in addition to our exceptional Annual Meetings.

One of our priorities this time of year is membership. Please consider this as a reminder to submit your dues and maintain your ACE membership active. We've tried to keep ACE dues as low as possible while still maintaining our financial viability and high level of service. Once you've renewed, think about your coworkers who could also benefit from ACE

membership. Our **Membership Committee** is seeking cancer facility administrators, registry managers, and others who hold leadership positions within oncology programs and who may not be familiar with ACE. There are most likely several people in your organization who could benefit from ACE membership and our educational offerings. Please refer them to us and urge them to join. As an added incentive, we've renewed our **"ACE Member – Get a Member"** campaign where qualified referrals may receive an unlimited number of American Express \$25 gift cards to reward your efforts.

As an update to our **Credentialing work group**, we expect to have a recommendation on that topic presented during our Board meeting in September. We'll certainly keep you informed and thanks to those who responded to the survey that was sent out by that work group. Finally, thanks to our **Member Services Committee** for a valuable Hot Topic phone conference recently. If you missed it, there will be others!

If you haven't yet joined a committee in which you have a special interest, there is still time to participate during this cycle of activity. We look forward to another winning year and I hope to see you in Savannah in January 2012! ■



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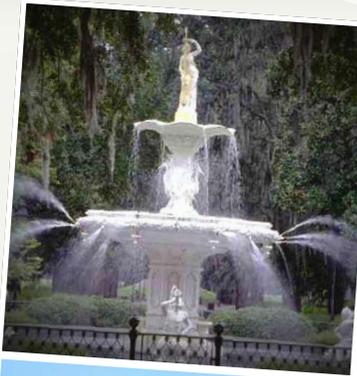
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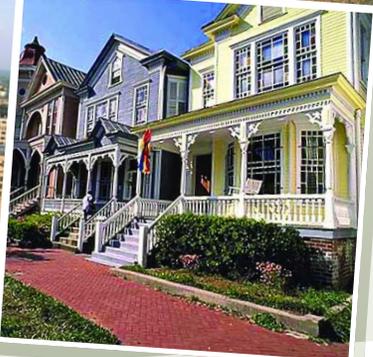
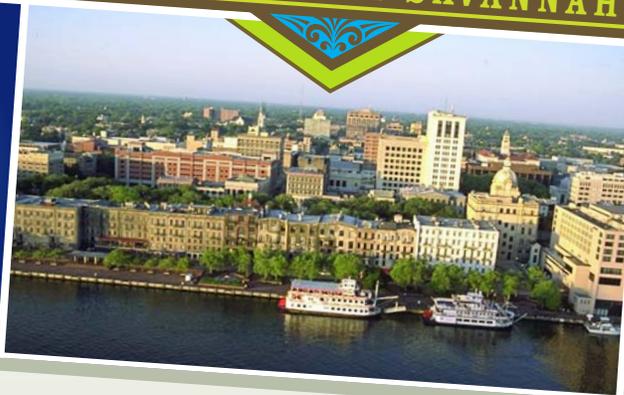
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