The journey of oncology navigation

Nurse navigators help avoid care fragmentation and support shared decision making.

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OVER the past 3 decades, cancer screening services and treatments have improved. However, as complex technologies flood the market, patients and caregivers face data overload and struggle to understand treatment. Patients may meet with each of their oncology providers one at a time, creating a silo effect, or they may have a multidisciplinary consultation where they see several providers at one appointment, which can make it challenging to absorb all the information provided. The patient also may experience a fragmented healthcare system within a single clinical setting or between clinics in different locations. Oncology navigation can address this fragmentation, help explain the maze of information, and enhance shared decision making.

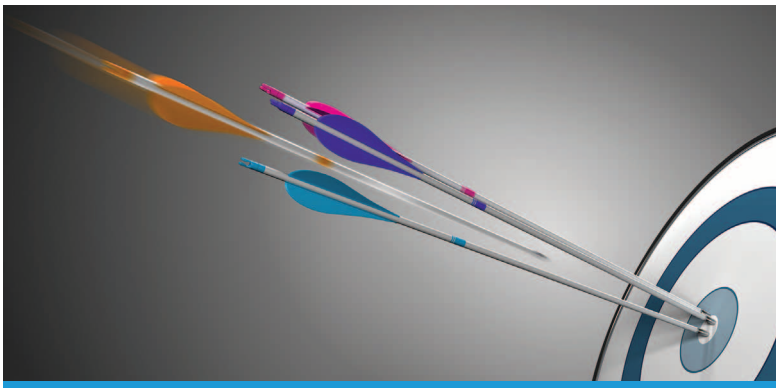
Several organizations—including the Commission on Cancer (CoC), American Cancer Society (ACS), Academy of Oncology Nurse & Patient Navigators (AONN+), and Oncology Nursing Society (ONS)—recognize the importance of the navigation care approach and its role in increasing health equity among patients with cancer. Oncology navigators practice in a variety of settings, including healthcare systems, specialty practices such as urology and gynecology, and community agencies.

Evolution of oncology navigation

The roots of this profession begin with the 1989 findings of the ACS National Hearings on Cancer, which revealed that individuals in lower-income U.S. populations endure greater pain and suffering from cancer than those in higher-income populations. In response to that report, Harold P. Freeman, MD, founded the Harlem Cancer Education and Demonstration Project to develop and pilot a navigation program that included culturally sensitive education for public outreach and access to screening services in his predominantly poor urban Black community. This navigator model used nonclinical licensed staff (patient navigators) who focus on reducing health disparities. The pilot program showed improvements in 5-year breast cancer survival rates from 39% (pre-navigation) to 70% (after introducing navigation).

Oncology navigator programs grew nationwide, with funding from sources such as the National Cancer Institute, ACS, Avon Foundation, Susan G. Komen, and federal government agencies. Most of the funding supported patient navigators who had direct knowledge of the community and its resources. After training provided by the health system employer, the navigators helped patients overcome barriers to ensure prompt diagnosis and treatment, enroll in clinical trials, and explore insurance coverage options.

At the same time, the nurse navigator role evolved as healthcare systems focused on pa-



Common goals

All oncology navigators share these common goals:

- **Needs assessment**—Identify barriers to care (logistical, psychosocial, financial, cultural), individualized resources (local, state, national), and patient goals that can be incorporated into the treatment plan.
- **Care coordination**—Ensure timely access to support services, appointments, tests, and procedures. Encourage active communication among healthcare providers to optimize patient outcomes.
- **Patient and caregiver education**—Promote shared decision-making by providing personalized education on health access, screening, diagnosis, treatment, side effects and their management, clinical trials, and other health needs.
- **Psychosocial support**—Identify patient distress, facilitate coping skill development, and make referrals to psychosocial resources.
- **Patient advocacy**—Ensure that patients' goals, preferences, and voice are heard. Many navigators participate in multidisciplinary clinics or tumor boards, and they help patients prioritize questions and clarify information with the treatment team.

tient-centered care. It advanced through oncology utilization review, utilization management, and case management to the point where nurses experienced in oncology worked with multidisciplinary healthcare teams to improve efficiency and adherence to care by linking patients with hospital or community resources.

In the early 2000s, as most oncology care moved to the outpatient setting, nurse navigation progressed to this setting with emphasis on care and transition coordination using community resource outreach. Breast cancer navigation became a primary patient population focus of nurse navigation when Lillie Shockney, MAS, BS, RN, publicized her success at the Johns Hopkins Hospital in Baltimore, Maryland, where she helped increase appointment completions, improve timeliness of care, and expedite chemotherapy start time by 2 weeks.

Clinical and nonclinical navigators now work as members of multidisciplinary teams throughout a patient's care continuum and are viewed as a central point of contact who acts on behalf of the patient. The navigation process has a bidimensional care concept—patient-centered to ensure continuity of care by promoting patient empowerment and integrated psychosocial care across disciplines and the health system—which focuses on improving access to medical care and decreasing setting fragmentation.

Navigation goals

No single standardized oncology navigation process can meet the needs of diverse populations in distinctive settings across the cancer continuum. Different models of navigation—including those that are care-continuum specific (only community outreach, screening, diagnostics, treatment, or survivorship), longitudinal (from diagnosis through survivorship with the same navigator), disease-specific (solely one disease such as breast, thoracic, or GI), general (all oncology patients), or financial (reduce hardship related to treatment cost)—have been created to meet the needs of unique populations and settings. Roles and activities fulfilled by oncology navigators may vary given their professional background and work environment, but they all share common goals. (See *Common goals.*)

The navigator goals and activities comprise integral components of the Chronic Care Model. They promote productive interactions between educated patients and a proactive practice team for improved outcomes. The basis of this model highlights care coordination within and across three overlapping domains—the entire community, healthcare systems, and provider organizations—in which the navigator promotes shared decision making. The navigator works within and promotes the model's six elements of community resources—healthcare system, patient self-management, decision support, delivery system redesign, and clinical information systems—to facilitate interprofessional collaboration, ensure quality care delivery, promote patient satisfaction, and effectively use resources to promote value-based care.

Role delineation and competencies

As the navigation profession evolved, so did the competencies and role functions used to describe the navigator types within the oncology care team. The patient navigator isn't clinically licensed but is trained to provide indi-

vidualized assistance to patients and families affected by cancer to improve healthcare service access. Programs such as the George Washington Cancer Center's Oncology Patient Navigator Training: The Fundamentals, the Patient Navigation Training Collaborative, and AONN+ are used to prepare these navigators. Clinically licensed navigators, such as nurses and social workers, navigate within the scope of their practice and have training opportunities through ONS and AONN+.

The current patient navigator competencies are reflected in the Patient Navigation Framework published by the George Washington University Cancer Institute team and consists of 12 functional navigation domains: professional roles and responsibilities, community resources, patient empowerment, communication, barriers to care/health disparities, education/prevention and health promotion, ethics and professional conduct, cultural competency, outreach, care coordination, psychosocial support services/assessment, and advocacy. ONS published Oncology Nurse Navigator Core Competencies, which include four functional areas of the professional role: education, coordination of care, communication, and professional role. ONS also defines an expert oncology nurse navigator (ONN) with 12 core competencies.

AONN+ created eight knowledge domains that differ from ONS competencies with an emphasis on community outreach and prevention (focusing on population health, community needs assessment, and risk reduction), operations management (focusing on organizational structure, mission, and vision), development and healthcare economics for patient optimization in healthcare, and quality and performance improvement (promoting metrics that measure and create processes to enhance value in evidence-based navigation practices). (See *Accreditation and certification*.)

Metrics

With the shift to value-based care, the navigation profession moved to promote metrics as an avenue for sustaining the role. Early in the profession's development, published results demonstrated that navigation could increase participation in cancer screening, promote adherence to diagnostic follow-up care, provide health education about cancer across the continuum, increase clinical trial knowledge and participation, address patient barriers to care, and provide psychosocial support to populations most at risk for poor outcomes. The AONN+ Evidence into Practice Metrics Committee created 35 evidenced-based national navigation metrics that

Accreditation and certification

The Oncology Care Model, which is focused on value-based quality care, includes navigation as one of its six fundamental transformation processes. Navigation with patient or clinical navigators supports coordination, communication, and resource facilitation for a patient-centered approach. To promote navigation as a health delivery support strategy, national accreditation programs have recognized the navigation process.

- The National Accreditation Program for Breast Centers was the first organization to include a standard for guiding patients via provided and referred services.
- In 2012, the American College of Surgeons' Commission on Cancer released a new standard that reflects their focus on enhancing patient-centered care standards that required navigation to be implemented by 2015 for all cancer facilities applying for accreditation.

Navigation role clarification and competency development supports the Academy of Oncology Nurse & Patient Navigators' (AONN+'s) vision and membership desire for general navigation certification.

- In 2016, AONN+ launched the oncology nurse navigator–certified generalist certification examination as well as an oncology patient navigator–certified generalist.
- Beginning in 2020, nurse navigators can achieve national accreditation through The ANSI National Accreditation Board via their certification arm, Foundation for Learning, Inc., which offers the only national certification of Oncology Nurse Navigator-Certified Generalist (ONN-CG℠) and the Oncology Patient Navigator-Certified Generalist (OPN-CG℠).
- National recognition from the American College of Surgeons Commission on Cancer confirmed that the ONN-CG℠ demonstrates compliance under Standard 4.2 Oncology Nursing Credentials—"oncology nursing care is provided by nurses with specialized knowledge and skills demonstrated by a cancer-specific certification or continuing education in oncology nursing."

Navigation beyond oncology

Navigators have gained recognition in chronic disease management, including heart disease, respiratory conditions, HIV, and diabetes. The navigator's focus is helping patients manage their care goals by addressing specific needs, and overcoming barriers to care remains a fundamental approach. Navigators don't provide clinical care. Instead, they focus on

- helping patients access, understand, and better use available healthcare resources
- adhering to recommended guidelines
- providing relevant information for specific needs
- educating patients to enhance their chronic disease care.

Many navigators are nurses who worked in the clinical area before becoming a chronic disease navigator, and others are laypeople trained for the role. As the role expands and additional research is published, successful outcomes related to patient experience, clinical outcomes, and return on investment may be achieved.

any program can use in their navigation model. The metrics fall into the categories of patient experience, clinical outcomes, and return on investment. The committee developed a crosswalk by taking the standardized metrics and demonstrating how they align with the national standards and indicators from CoC, the National Accreditation Program for Breast Cancers, OCM, the Quality Oncology Practice Initiative, and the Medicare Access and CHIP Reauthorization Act.

With the support of ACS, a national standardized toolkit for validating measures and demonstrating the impact

of any oncology navigation model was finalized. This how-to guide on metric selection, implementation, reporting, and quality strategy improvements can be applied to daily care in new or mature navigation programs.

Improving outcomes

As members of the oncology interdisciplinary team, navigators help address care fragmentation and promote delivery of a coordinated and seamless patient experience across the care continuum. This role also aids in improving the clinical processes and financial outcomes for the settings where they work. Ongoing evidence supports the navigator's value in oncology and other chronic disease care. (See *Navigation beyond oncology*.) AN

Sharon Gentry is program director for the Academy of Oncology Nurse and Patient Navigators in Cranbury, New Jersey. She has received navigation presentation sponsorship from Pfizer.

References

Academy of Oncology Nurse & Patient Navigators. ANAB awards national accreditation to AONN+ Foundations for Learning, Inc. August 5, 2020. aonnonline.org/press/3068-anab-awards-national-accreditation-to-aonn-foundations-for-learning-inc

Academy of Oncology Nurse & Patient Navigator. Certification. aonnffl.org

Academy of Oncology Nurse & Patient Navigators. Navigation metrics. August 2020. aonnonline.org/navigation-metrics

Gentry S. Breast navigation. In: Mahon S, ed. *Guide to Breast Care For Oncology Nurses*. Pittsburgh, PA: Oncology Nursing Society; 2018.

Kaiser Permanente. The Chronic Care Model. improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

McBrien KA, Ivers N, Barnieh L, et al. Patient navigators for people with chronic disease: A systematic review. *PLoS ONE*. 2018;13(2):e0191980. doi:10.1371/journal.pone.0191980

Oncology Nursing Society. *2017 Oncology Nurse Navigator Core Competencies*. 2017. ons.org/sites/default/files/2017-05/2017_Oncology_Nurse_Navigator_Competencies.pdf

Patel M. The Oncology Care Model: Aligning financial incentives to improve outcomes. *Oncology Practice Management*. 2016;6(12). bit.ly/3qprq68

Pratt-Chapman M, Burhansstipanov L. Navigation training, tools, and resources. In: Shockney L. D. ed. *Team-Based Oncology Care: The Pivotal Role of Oncology Navigation*. Cham, Switzerland: Springer International Publishing; 2018.