

# Implementing COC Standard 3.1: The Navigator's Perspective

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begin shortly.*

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# Implementing COC Standard 3.1

## The Navigator's Perspective

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# Gean Brown, MSN, RN, OCN

Gean Brown is the Clinical Manager of the Cancer Center and Surgical Alliance at Middlesex Hospital in Middletown, CT. Gean received her Masters' of Science in Nursing, Patient Care Administration, from Sacred Heart University in Fairfield, CT. She has been an oncology nurse for 20 years, is an Oncology Certified Nurse, and holds a Chemotherapy/Biotherapy certificate. Gean was instrumental in developing a Lung Cancer Screening program at her organization in 2012, when she was the Lung Nurse Navigator, and has advocated nationally and locally for Lung Cancer Screening reimbursement

Gean has been published in the *Journal of Oncology Navigation and Survivorship*, with an article titled, Assuring Lung Nodule Surveillance: A Navigation Model. She also coauthored Voices of Oncology Nursing Society Members Matter in Advocacy and Decisions Related to U.S. Health Policy in the *Clinical Journal of Oncology Nursing*. Ms. Brown has been a podium presenter at the Academy of Oncology Nurse Navigators national conference, as well as a faculty speaker on the subject of lung cancer navigation and lung screening. Additionally, she was a podium poster presenter at the Association of Community Cancer Centers National Oncology Conference, and a podium presenter at the 40<sup>th</sup> annual

# Amy Thorn, LMSW, CN-BM

Amy Thorn is the Breast Health Patient Navigator within the Center for Breast Health at Conway Medical Center. Ms. Thorn is a Licensed Master Social Worker and Certified Breast Navigator through the National Consortium of Breast Centers. With over 10 years of experience in breast health navigation and breast oncology social work, Ms. Thorn specializes in patient education, supportive counseling, breast cancer screening guidelines and breast program planning. Amy also coordinates the Multidisciplinary Breast Conference, facilitates a Breast Cancer Support Group and is involved in community outreach projects. She was recently integral in her center's achievement of becoming a Certified Quality Breast Center of Excellence through the National Quality Measures for Breast Centers.

# Objectives

- Identify strategies to implement COC Standard 3.1 Navigation Process
- Provide two examples of metrics to demonstrate the value of a navigation program.
- Describe two methods for identifying barriers to care.

In an era of patient-center care, having a process in place for navigating patients through their cancer journey is invaluable.

The Commission on Cancer (CoC) recognized the need, and have implemented Standard 3.1, Patient Navigation Process.



# Standard 3.1

## Patient Navigation Process

- 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.

# Patient Navigation Process Continued

- 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.

American College of Surgeons, Commission on Cancer.  
(2012). Cancer program standards 2012: ensuring patient-centered care.

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# Program Development Considerations

- Identify key stakeholders – medical oncologists, radiation oncologists, administration, oncology nurses and patient support staff.
- Site specific or general navigation
- Point of entry – prevention & screening, first suspicious finding, post diagnosis.

- Navigation can begin prior to a diagnosis or can begin any time through all phases of the cancer experience. And hopefully into survivorship.

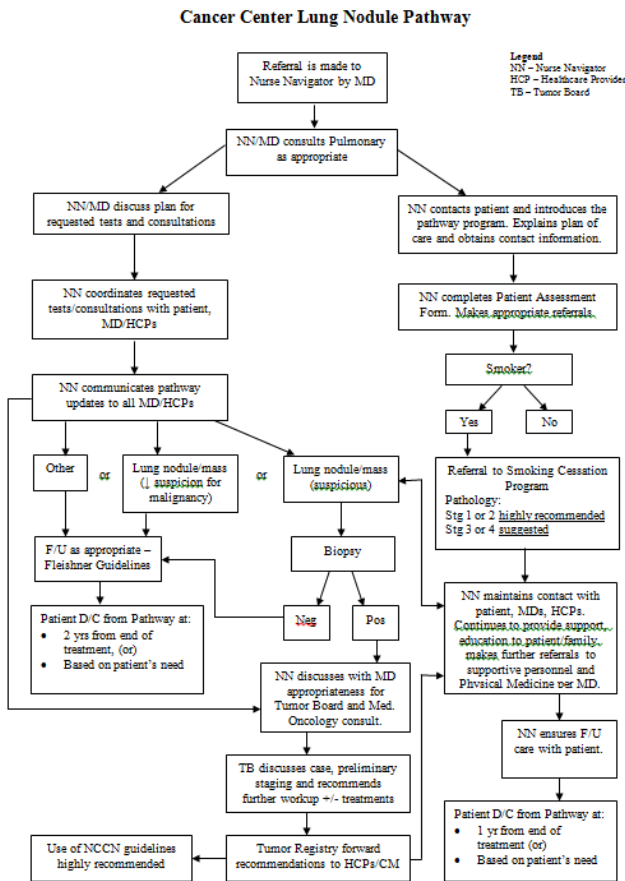
How will you get referrals to the navigator?

This can be challenging at first. Physicians may not remember to refer to the navigator.

Many referrals come from nursing.

Developing a disease site pathway helps to identify the point of entry for navigation and serves as a reminder to include the navigator in the care plan.

# Sample of Lung Nodule Pathway



Pathways are developed for all disease sites.

# Example of Intake/Assessment Form

**MIDDLESEX HOSPITAL** **Cancer Center**  
Urology Pathway  
Assessment Form

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

MR #: \_\_\_\_\_ DOB: \_\_\_\_\_

PREFERRED NAME: \_\_\_\_\_

SIGNIFICANT MED/SURG HISTORY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SIGNIFICANT FAMILY HISTORY: \_\_\_\_\_

\_\_\_\_\_

URINARY ASSESSMENT: No problems voiding: \_\_\_\_\_ Frequency: \_\_\_\_\_

Urgency: \_\_\_\_\_ Incontinence: \_\_\_\_\_ Pads used per day: \_\_\_\_\_ Nocturia: \_\_\_\_\_ x nightly

Precipitating factors: \_\_\_\_\_

Comments: \_\_\_\_\_

PAIN ASSESSMENT: No pain at present: \_\_\_\_\_ Constant / intermittent: \_\_\_\_\_

Location: \_\_\_\_\_

Character: Dull: \_\_\_\_\_ Sharp: \_\_\_\_\_ Achy: \_\_\_\_\_ Soreness: \_\_\_\_\_ Stabbing: \_\_\_\_\_ Throbbing: \_\_\_\_\_

Pain level now: \_\_\_\_\_/10 Pain at its worst: \_\_\_\_\_/10, Aggravating factors: \_\_\_\_\_

Alleviating factors: \_\_\_\_\_ MD treating pain: \_\_\_\_\_

SOCIAL HISTORY: Marital status: \_\_\_\_\_ Lives with: \_\_\_\_\_

Living environment: \_\_\_\_\_ Employment status: \_\_\_\_\_

Alcohol: \_\_\_\_\_ Illicit Drugs: \_\_\_\_\_

Tobacco History-  None Began at age: \_\_\_\_\_ PPD: \_\_\_\_\_

Year quit: \_\_\_\_\_ Continues at present: \_\_\_\_\_

SUPPORT SYSTEM: Is there anyone available to help you at home? \_\_\_\_\_

\_\_\_\_\_

How have your family or other loved ones responded when you have needed help? \_\_\_\_\_

\_\_\_\_\_

Are there any concerns that might keep you from getting to all of your appointments?

Child care  Transportation  Finances  Job responsibilities  Insurance  Caregiver

\_\_\_\_\_

COMMUNITY RESOURCES CURRENTLY UTILIZED:  None  Yes

\_\_\_\_\_

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SPIRITUAL/CULTURAL: Is there anything that comes from your culture or religion that you need to know in caring for you? \_\_\_\_\_

Religious preference: \_\_\_\_\_

FUNCTIONAL LIMITATIONS:  No limitations  Other: \_\_\_\_\_

Other problems: \_\_\_\_\_

\_\_\_\_\_

LEARNING PREFERENCES: In which language(s) do you prefer to learn? \_\_\_\_\_

Which of the following are most helpful in learning something new? (Check all that apply)

Reading  Verbal  Video  Demonstration  Teachback

BARRIERS TO LEARNING: (Check all that apply)

No Barriers  Financial  Written Language  Physical

Vision  Cultural  Cognitive Disability  Emotional

Family Support  Hearing  Language  Other

NUTRITIONAL: Do you have any nutritional concerns at this time? \_\_\_\_\_

\_\_\_\_\_

HT: \_\_\_\_\_ Current WT: \_\_\_\_\_ Usual WT: \_\_\_\_\_

How can we best help you at this time? \_\_\_\_\_

\_\_\_\_\_

## REFERRALS

None at this time  Social Services  Smoking Cessation

Support Groups  Nutrition  Clergy/Spiritual

Palliative Care/Hospice  Distress Management  Educational packet sent

Physical Therapy Referral  Clinical trial

Interpreter/ Assistive Devices Needed

## NOTES

\_\_\_\_\_

\_\_\_\_\_

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Nurse Navigator

Date/Time

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**Oncology**  
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# Who will be your navigator?

- Will you use Oncology Nurse Navigators?
- Social Workers?
- Lay Navigators?



Some organizations don't use the term navigator. Care coordinator, care management, case manager, community resource navigator.

Many organizations use a combination of these.

For COC purposes, it isn't really the title, it's the process. Individualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality medical and psychosocial care.

# Position Description

- The Oncology Nursing Society developed very comprehensive Core Competencies for an ONN.
- The Academy of Oncology Nurse & Patient Navigators is another great source.
- Care Coordinators have similar, if not the same position description, nurse or another specialty.

# Patient Advocacy

- Breakdown barriers
- Guide patient through system.
- Open lines of communication between disciplines.
- Advocate for all patients.
- Assure continuity of care
- Educate patient and family.
- Assure shared decision making.
- Work to eliminate health care disparities.

# Case Load

- This question is most often raised at conferences and navigator networking events, and anytime there is a discussion on navigation.
- The answer I believe is that there is no right answer. It depends on many factors.

# Case Load Factors

- Disease site
- Number of navigators or other support resources.
- Point of entry for the patient.
- End point of navigation.
- On site or other.



# One Size Does Not Fit All

- Middlesex Hospital Cancer Center's navigation program has 4 ONN's navigating 12 disease sites.
- Not all sites are navigated the same.
- Two ONN's have their base in our surgical clinic.
- Two work out of the Cancer Center where most patients are contacted by phone initially

# Factors to Consider

- Navigation is not a revenue generating service by itself, but the downstream generally proves the program's effectiveness.
- Patient satisfaction, seamless transitions, timeliness of care, and provider satisfaction.

# Other Downstream

- Decrease in out-migration.
- Use of other revenue generating services: diagnostic imaging, lab, etc.
- Referral to pre-habilitation, genetic risk counselor, survivorship.

# Community Needs Assessment

- ✦ The COC requires a community needs assessment that must be done every three years.

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The Cancer Committee defines the scope of the community needs assessment and is encouraged to link with the outreach/marketing department or community-based organizations to accomplish this.

The Cancer Committee must be involved in the design and evaluation of the results. The requirement is to identify and address a new barrier each year.

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A Community Health Needs Assessment compiled by the organization along with various community organizations is a start.

This begins the process of identifying the needs of populations served with the objective of improving healthcare disparities and breaking down barriers.

The Navigators are in a position to assist in identifying barriers faced by their patients.



Another way to identify barriers common to cancer patients is to keep track of what patients note on their psychosocial distress screening tool. Whether it be the NCCN Thermometer or another distress screening tool.

Patient surveys may be an avenue to identify gaps in services either real or perceived. Staff surveys may be helpful.

3.1 requires the Cancer Committee not only identify barriers, but that they are addressed and that a new barrier is addressed annually.

- ① The Cancer Committee determines that addressing the barrier is the most important concern for their patients.
- ② The Cancer Committee documents in their minutes that they have put forth significant activity over the year, but that there is an ongoing need to continue to address that particular barrier.
- ③ The current process to address the barrier must be documented in the minutes annually.
- ④ The Cancer Committee decides to work on the barrier until the issue is resolved for a period not to exceed three years between COC program surveys.

# Conclusion

- Whether you have an Oncology Nurse Navigator, lay navigator, or a social worker like the one we will hear from next, the important thing is the navigation process.
- Improving healthcare disparities, removing barriers, ensuring safe high quality patient-centered care with smooth transitions along the care continuum is all of our responsibility.

# References

- American College of Surgeons, Commission on Cancer. (2012). Cancer program standards 2012: ensuring patient-centered care.
- COC Source. (2014). Accreditation Committee Clarifications for Standards 3.1 Patient Navigation Process and 3.2 Psychosocial Distress Screening.
- Raedler, L.A., (2014). Community Needs and Navigation. *Journal of Oncology Navigation & Survivorship*, 5(3).

# A Breast Navigation Model Example from a Small Community Hospital

- Breast Health Navigator/  
Program Coordinator role
- Housed at Outpatient Imaging Center/  
Breast Center (Radiology)



# Needs and Barriers that led to our Navigation Program

- Several organizations provide care
- Patients needed support and a liaison to guide them through the process.
- Patients needed knowledge of local facilities for care
- Process needed to be made more efficient.
- Wanted to trim wait times from step to step

# Point of Entry

- 4 main entry points to navigation
  - At time of abnormal screening mammogram
  - At time of recommendation for breast biopsy
  - At time of symptoms, need for education, distress
  - (In community needing exam)
- Once diagnosed I am still available and transition to navigators in MedOnc

# Abnormal Screening Mammogram

- Navigator is person who calls patient
- Anxiety for patient begins at time of call to return for additional imaging
- Knowing some detail helps to decrease worry or also prepare mentally for visit
- Timeliness- decrease those “sleepless nights”

# Recommended for Breast Biopsy

- On day of abnormal Diagnostic Mammogram & US- pt meets Radiologist and Navigator
- Procedures explained- decreases anxiety
- Written materials provided
- Biopsy or Surgical Consults are scheduled
- Navigator attends majority of breast biopsies
- Advocate timely results back to patient

# Symptoms/Education/Distress

- Calls from community with symptoms
- Educate on benign symptoms/conditions
  - i.e. breast pain, nipple discharge, fibroadenomas, gynecomastia
- Staff refer patients that are anxious, upset, or have a lot of questions
- Meet with high-risk patients to help them understand their screening recommendations

# Benefits to my Hospital

- Patients are happy, more likely to continue seeking care here.
- We're able to market our commitment to quality breast health care & NQMBC certification and attract patients



# Benefits to Area Providers

- Contact for Breast Health questions/concerns
- 2<sup>nd</sup> set of eyes to ensure quality/timely care
- Assistance to get patients moving through the process when they are busy

# Benefits to the Community

- One point of contact for Breast Health needs
- Outreach in the community- Screening and Early Detection
- Referrals to Programs for assistance to get exams or Medicaid if diagnosed
- Quality care emphasizing the patient perspective

# My Road to Becoming a Navigator

- Masters in Social Work
- 5 years- Oncology Social Worker on a Multidisciplinary team at a teaching hospital
  - Shared “navigation” role with Nurse Coordinators
- Hired as Navigator- new position
- Certified Navigator through NCBC as CN-BM

# Benefits of SW as Navigator

- Primary teaching in SW- start where the patient is mentally- support them there
- Communication to all levels of patients is key- “translate”
- Supportive Counseling/ Psychosocial needs
- Knowledge of Resources

# Conclusion

- There are times of distress prior to diagnosis
- Staying tuned-in to the patient perspective is imperative
- With the right knowledge and passion there can be great candidates for Navigators in addition to nurses

Thanks and Good Luck  
with your Navigation Program!

Amy Thorn, LMSW, CN-BM  
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# Questions

- Any questions not addressed here may be emailed to [solutions@oncologymgmt.com](mailto:solutions@oncologymgmt.com)
- OMC Group will compile questions and answers and distribute to webinar registrants

# Thank You!

Sincere thanks to all of you for joining us today. We hope that you will keep OMC Group in mind when consulting needs arise in the future.

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