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@NNRTnews



September 19, 2024

# Sustaining & Evolving your PN Workforce: Getting back to the Basics

[navigationroundtable.org](https://navigationroundtable.org)

*The American Cancer Society National Navigation Roundtable (ACS NNRT) was established in 2017. The ACS NNRT is a national coalition of 80 member organizations to advance navigation efforts that eliminate barriers to quality care, reduce disparities, and foster ongoing health equity across the cancer continuum. The American Cancer Society provides organizational leadership and expert staff support to the ACS NNRT.*

# Facilitators



Arti Patel Varanasi, PhD, MPH, CPH  
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Sharon Gentry, MSN, RN,  
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Academy of Oncology  
Nurse & Patient Navigators  
(AONN+)

The objectives of this session are to:

1

- Developing & implementing organizational tools, process and policies to sustain a patient navigation program.

2

- Identifying effective tools for the PN to sustain a patient navigation program.

3

- Support alignment with Oncology Navigation Professional Standards of Practice.

# Speakers (aka Story Tellers)



Katrina Steiling, MD,  
Boston Medical  
Center



Julie McMahon, MPH,  
Susan G. Komen

# Foundational Building Blocks

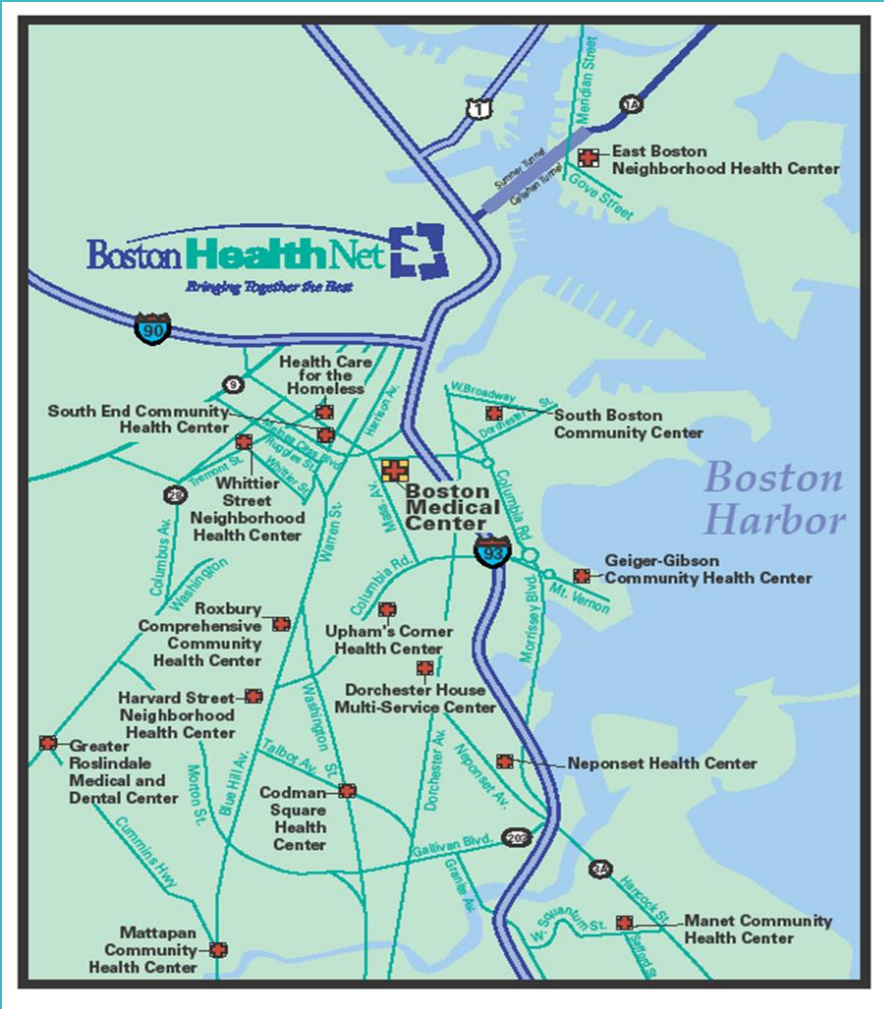
## Patient Navigation Sustainability Assessment Tool PNSAT



Staples ES and Dwyer AJ. (2023). Patient Navigation Sustainability Assessment Tool – Short Version. Colorado School of Public Health and University of Colorado Cancer Center, Aurora, CO.

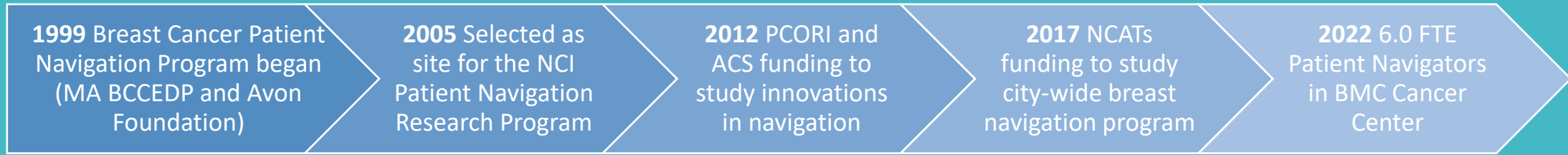
PNSAT Domains	Definition
<b>Engaged Staff &amp; Leadership</b>	Having frontline staff & management within the organization who are supportive of the PN practice
<b>Organizational Context &amp; Capacity</b>	The PN practice has the internal support & resources needed to effectively navigate patients/clients
<b>Funding Stability</b>	The PN practice has established a consistent financial base
<b>Engaged Community</b>	The PN practice has external support & engagement (beyond the clinical navigation team)
<b>Communication, Planning, &amp; Implementation</b>	Using processes that guide the direction, goals, & strategies of the PN practice
<b>Workflow Integration</b>	Designing the PN practice to fit into existing processes, policies, & technologies
<b>Monitoring &amp; Evaluation</b>	Assessing the PN practice to inform planning & document results
<b>Outcomes &amp; Effectiveness</b>	Understanding & measuring practice outcomes and impact of the practice

# Boston Medical Center (BMC)



- Primary teaching hospital of Boston University
- 1<sup>st</sup> public hospital in the US, affiliated with 11 FQHC
- Largest safety-net institution in New England. In FY22:
  - 1,045,677 annual visits
  - 70% racial/ethnic minority
  - >50% uninsured or Medicaid
  - 32% non-English speaking
- Commission on Cancer (CoC) accredited Cancer Center with ~1,500 new cancer patients annually
- Long-standing history of commitment to health equity, emphasis on community-based care and consistently accessible health services

# Patient Navigation at BMC



Current State	Ideal State
Patients referred to navigators post-diagnosis	Navigation begins at diagnosis
Variable Social Needs assessment	THRIVE screener in Epic at diagnosis
Care teams not always engaged in navigation process	Everyone engaged and supports navigation process
No clear navigation policy or protocols	Cancer Center Navigation Policy
Data not real time or shared with care teams	Metrics shared with care teams
Distress Tolerance (DT) screener initiated at patients 1 <sup>st</sup> infusion treatment	DT Screener completed at earlier visit

# BMC's Oncology Equity Alliance

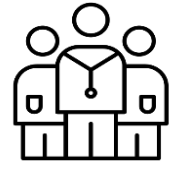
**Overall goal:** to improve equitable, patient-centered cancer care at Boston Medical Center, New England's largest safety net medical center, and **overcome barriers to widespread implementation of evidence-based patient navigation** to coordinate across primary care services and medical, surgical, and radiation oncology—all while bridging care into the community

## Key Intervention Strategies



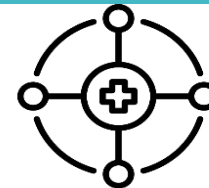
### Individual / Patient Level

Integrate systematic screening and referral system to address patient SDOH and psychosocial barriers to care at time of diagnosis



### Provider / Care Team Level

Disease-specific care team engagement, with an emphasis on team member roles & responsibilities; increase institutional awareness of navigation



### Health Systems Level

Enhanced monitoring of PN Key Performance Indicators (KPIs) & integration of workflow policy to standardize and streamline navigation

# Stakeholder Engagement





# Key progress towards improved implementation

PNSAT Domain	Progress
<u>Engaged leadership and staff</u>	<b>Stakeholder groups:</b> OEA Administrative Team, Disease-specific Navigator Groups, External Advisory Council (n=5) Standardized <b>PN onboarding and training protocols</b>
Organizational capacity and content	Well-established oncology patient navigation program Disease-specific Navigator Groups
Funding stability	Operational funding for additional intake PN positions for social needs assessment screening
Engaged community	Patient Advisory Group (n=12) Patient surveys to understand patient experiences
<u>Communication, planning, implementation</u>	<b>Workflow Assessment interviews</b> in Breast, GI, Lung, Head/Neck (n=38) Shared <b>Workflow Assessment reports</b> with disease-specific care teams for input/feedback and to co-create policy and protocols <b>PN Awareness Campaign</b> including PN Info Cards
<u>Workflow integration</u>	Co-created <b>Cancer Center Navigation Protocol</b> and policies; developed visual flow chart THRIVE <b>Social Needs Assessment</b> Training (including referrals to community-based organizations) <b>Care Team</b> communication plans
<u>Monitoring and evaluation</u>	<b>Data system</b> design for <b>PN data reports</b>
Outcomes and effectiveness	Analysis of quantitative data, qualitative data, survey data

# Ongoing work and the future



## 1 Continued stakeholder groups

- OEA leadership team
- Cancer Center & THRIVE teams
- Patient Advisory Group (n=12)
- Advisory Council (n=5)

## 2 Navigation Protocol and Policy

- Continue integration
- Standardized workflows
- Onboarding of 2 new operationally funded patient navigators to perform social needs assessments

## 3 THRIVE Social Needs Assessment Implementation

- Roll out across selected disease areas
- Roll out across Cancer Center
- THRIVE training sessions

## 4 Refine monitoring reports

- THRIVE Dashboard
- Navigation key performance indicator reports

## 5 Evaluate patient experience

- Surveys to understand patient experiences with navigation
- Qualitative assessments

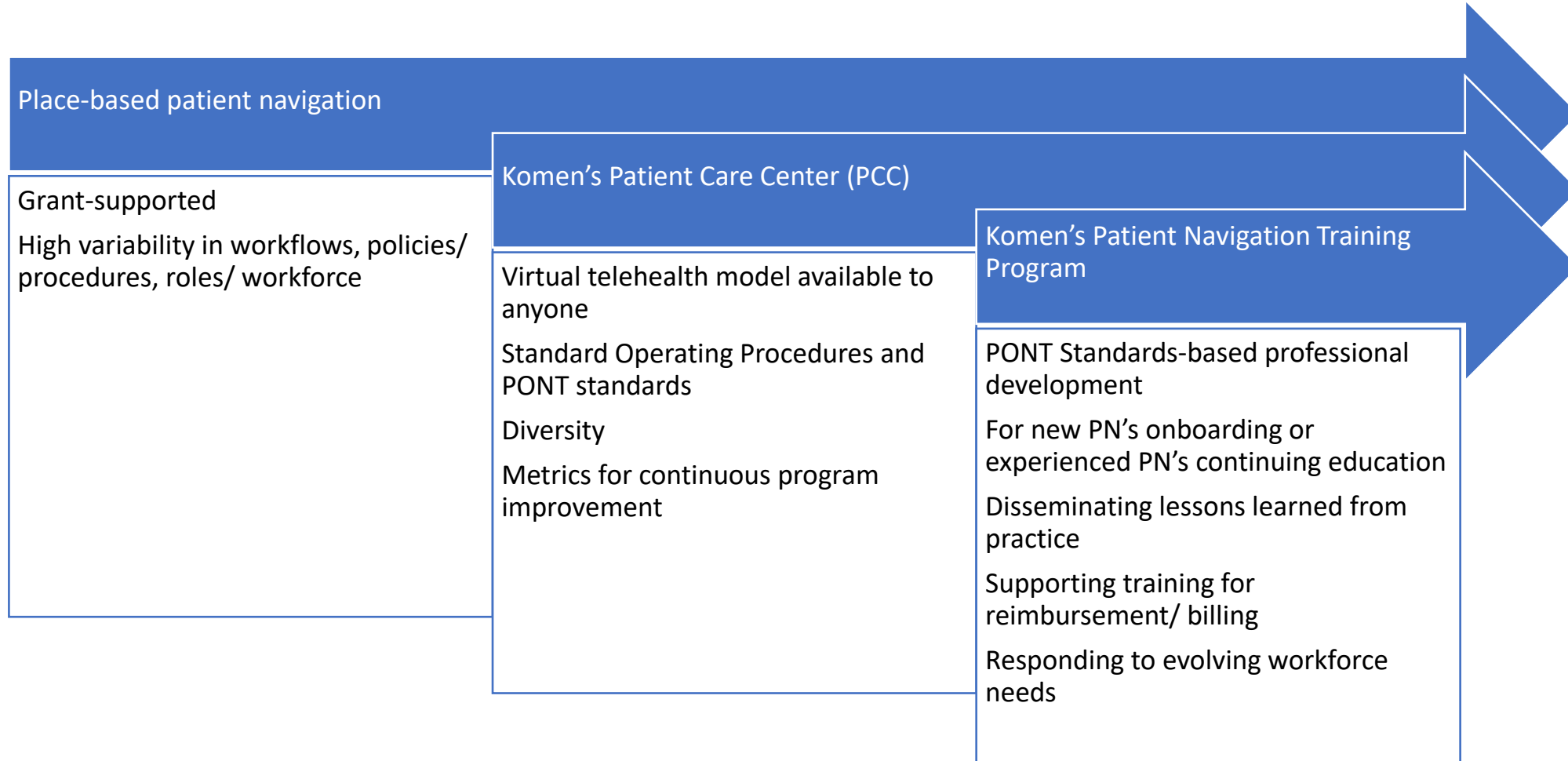
## 6 Patient navigation awareness campaign

- Patient navigation Info Cards
- Coordination with Cancer Center

## 7 Dissemination

- Community engagement activities
- Conferences
- ACS learning communities

# Evolution of Susan G. Komen Patient Navigation



# Building and Sustaining Komen's PCC

## Key Policies and Procedures

### Workflow Integration

- **Care Plan Templates:** a "playbook" for barriers
- **SOAP Notes:** Standardized documentation
- **Distress Screening**

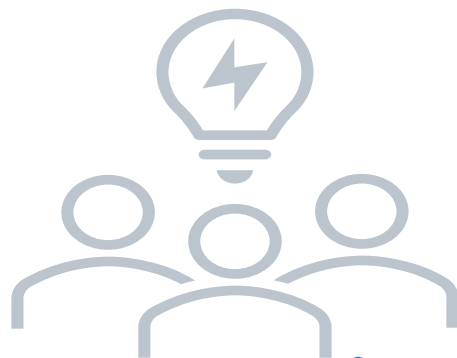
### Communication/ Implementation, Organizational Context, Monitoring/ Evaluation

- **Standard Operating Procedures (SOPs)** with team input
- **Navigator Scope & Role**
- Plan for **Continuing Education**
- **Coaching and Adherence**

### Engaged Staff and Leadership

- **PONT Standards-Based Interview Matrix**
- Diversity
- **Onboarding Process**
- **Streamlined Onboarding**

# Lessons from Practice



Peer mentoring for  
coordination



SOPs for distress screening  
and complex case escalation



Professional quality of life  
SOPs to prevent burnout

• <https://proqol.org/>

# OPEN DISCUSSION

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# LIGHTENING ROUND

*Lessons Learned*





# Thank You