Getting Started with Metrics and Reports for Patient Navigation Programs

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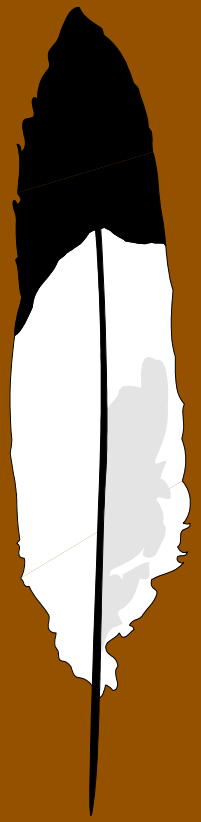
Objectives; By the end of this session, participants will be able to:

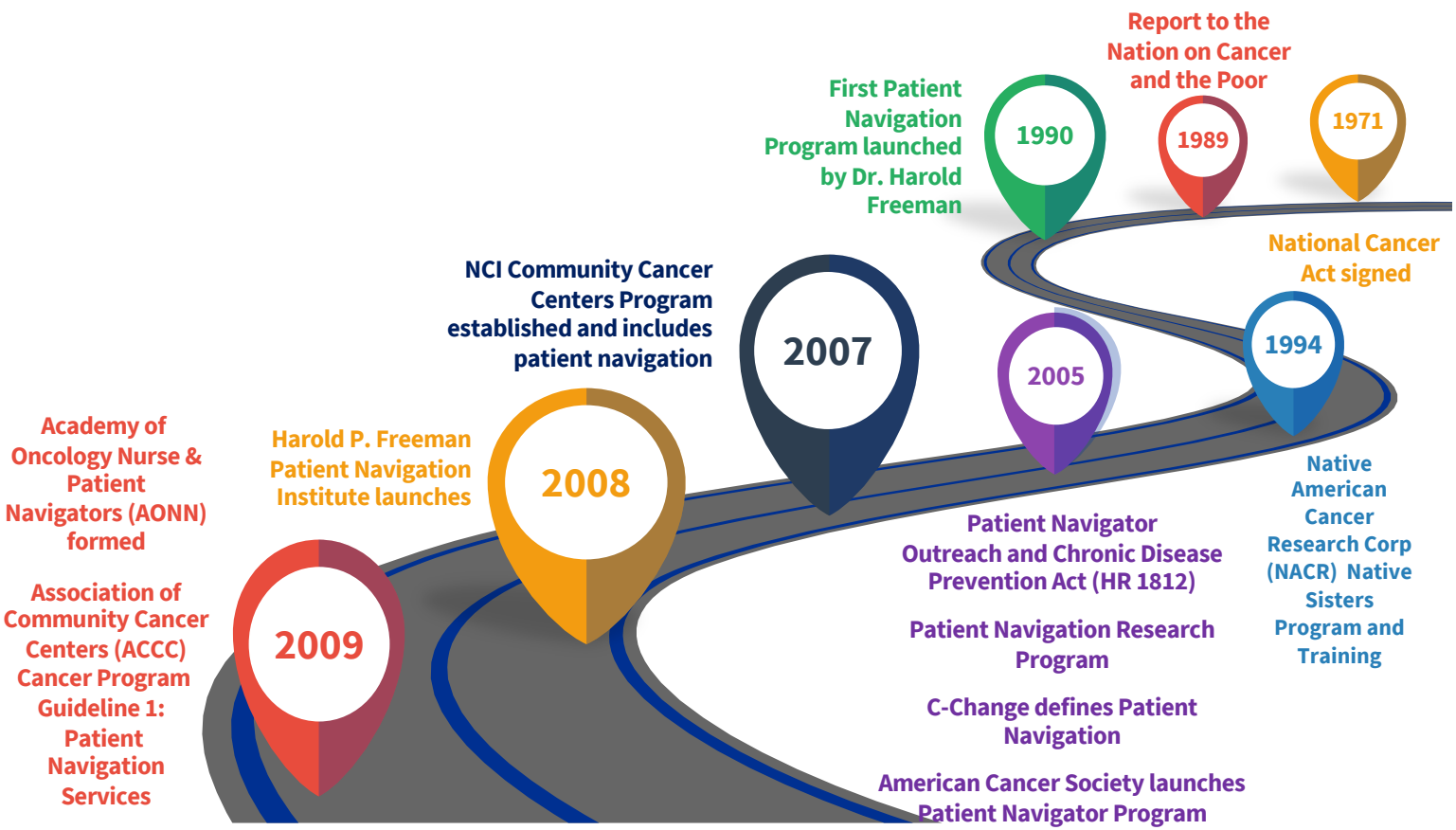
- Explain the evolution of nationally recommended metrics
- Identify what a navigation program needs to have in place to begin collecting, reporting and using nationally recommended metrics
- Examine 3 group-selected metrics from the ~35 nationally recommended metrics

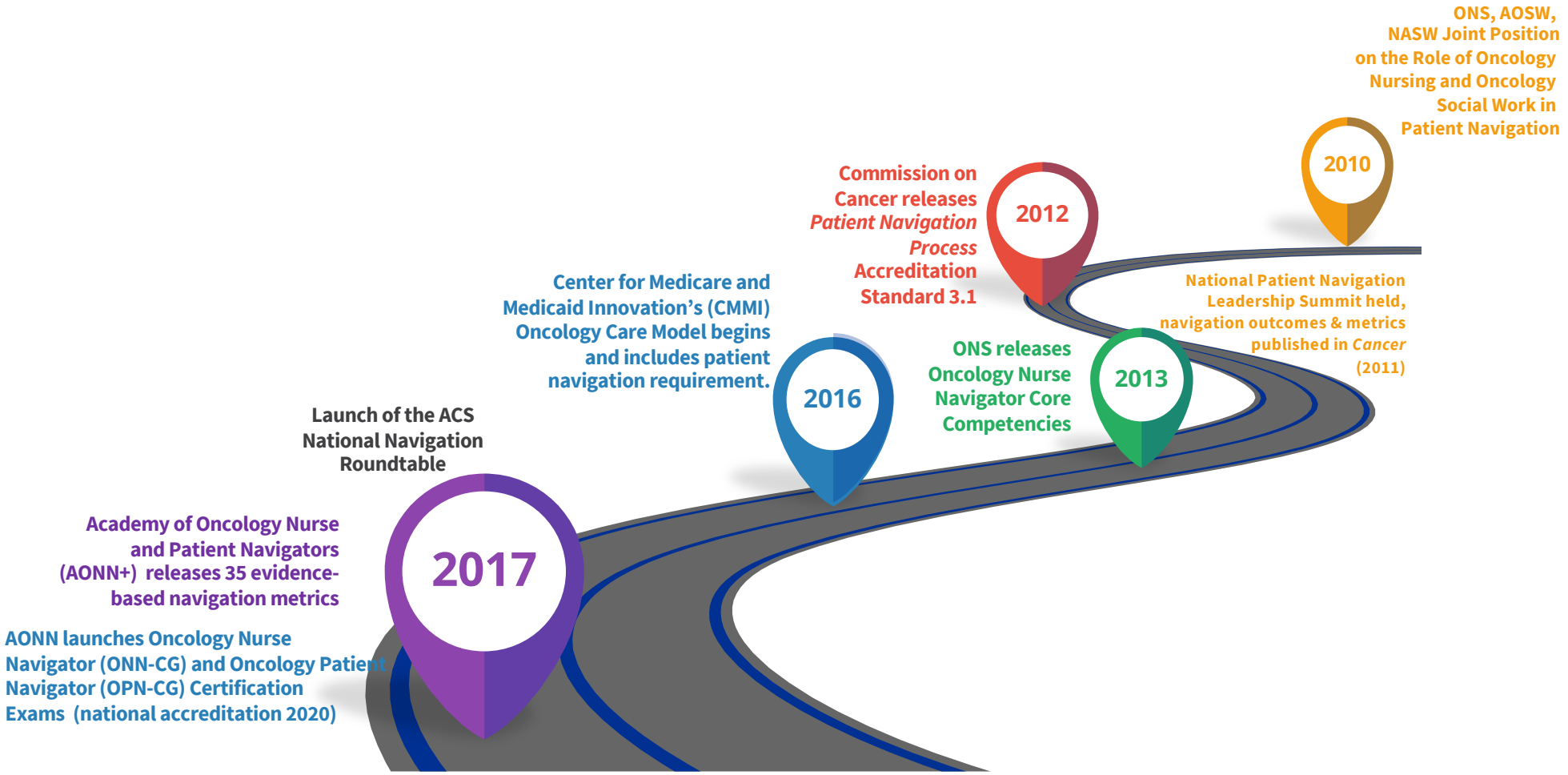
Disclosure: we will be using NACI Care™ to illustrate how to enter data and generate reports for this IPNN session. NACI Care™ is a licensed product for sale (Indigenous programs get significant discount).



Explain the evolution of nationally recommended metrics

Linda Burhansstipanov

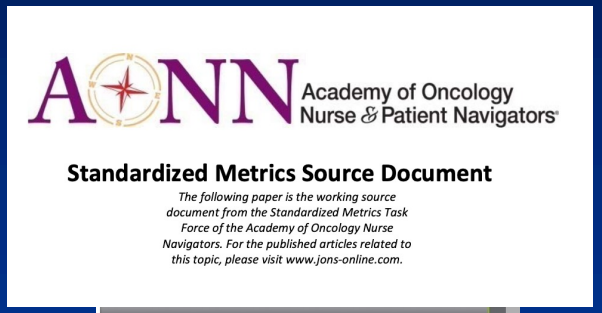

Report to the Nation on Cancer and the Poor
1971
1989
First Patient Navigation Program launched by Dr. Harold Freeman
1990
National Cancer Act signed
1994
NCI Community Cancer Centers Program established and includes patient navigation
2007
2005
Academy of Oncology Nurse & Patient Navigators (AONN) formed
Harold P. Freeman Patient Navigation Institute launches
2008
Native American Cancer Research Corp (NACR) Native Sisters Program and Training
Patient Navigator Outreach and Chronic Disease Prevention Act (HR 1812)
Patient Navigation Research Program
C-Change defines Patient Navigation
American Cancer Society launches Patient Navigator Program
Association of Community Cancer Centers (ACCC) Cancer Program Guideline 1: Patient Navigation Services
2009

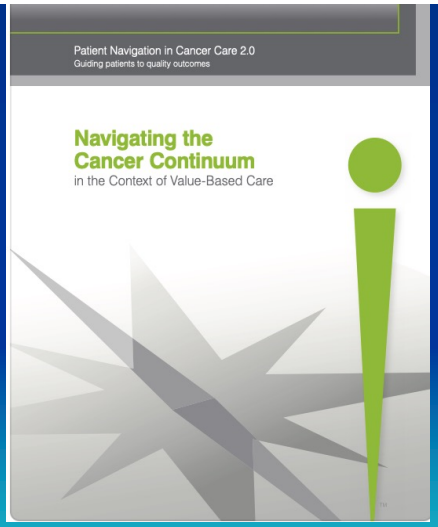

2010
ONS, AOSW, NASW Joint Position on the Role of Oncology Nursing and Oncology Social Work in Patient Navigation
2012
Commission on Cancer releases *Patient Navigation Process* Accreditation Standard 3.1
National Patient Navigation Leadership Summit held, navigation outcomes & metrics published in *Cancer* (2011)
2013
ONS releases Oncology Nurse Navigator Core Competencies
2016
Center for Medicare and Medicaid Innovation's (CMMI) Oncology Care Model begins and includes patient navigation requirement.
Launch of the ACS National Navigation Roundtable
2017
Academy of Oncology Nurse and Patient Navigators (AONN+) releases 35 evidence-based navigation metrics
AONN launches Oncology Nurse Navigator (ONN-CG) and Oncology Patient Navigator (OPN-CG) Certification Exams (national accreditation 2020)

Patient Navigation and refinement of metrics

- Academy of Oncology Nurse and Patient Navigators (AONN+) released Standard metrics (35) in 2017

- Patient Navigation in Cancer Care 2.0: Guiding patients to quality outcomes: Navigating the Cancer Continuum in the Context of Value-Based Care. Pfizer Oncology, PP-IBR-USA-2070-05, November 2018





https://www.patientnavigation.com/

Examples of National Organizations & recommendations for metrics and reports

- Commission on Cancer
- The National Accreditation Program for Breast Centers
- The American Society of Clinical Oncology (ASCO), Quality Oncology Practice Initiative Merit-based Incentive Payment System / Alternative Payment Models
- Center for Medicare and Medicaid, Oncology Care Model
- Academy Of Oncology Nurse & Patient Navigators
- Oncology Nursing Society

NOTE: uniformity in PN data metrics

3 areas of measurement:
- Patient Experience (PE)
- Clinical outcomes (CO)
- Return on investment (ROI)

Navigation Metrics Toolkit (August 2020)

- Collaboration between the American Cancer Society, the Academy of Oncology Nurse and Patient Navigators (AONN+) and the Merck Foundation
- Designed to facilitate patient navigation programs integrate the 35 metrics identified and documented by AONN+ in 2017.
- These metrics were important for all programs ("basic") … so there are many more metrics that individual programs need
  - Not all programs will include all metrics

https://aonnonline.org/images/resources/navigation_tools/2020-AONN-Navigation-Metrics-Toolkit.pdf

2020 Clarified how 10 of the 35 metrics could be measured and evaluated

- Concurrently, process for obtaining national accreditation for PN exam
- American National Standards Institute (ANSI) National Accreditation Board (ANAB)
- National Certification for Oncology Nurse and Patient Navigator Generalists Available in US (August 5, 2020)

https://aonnonline.org/press/3068-anab-awards-national-accreditation-to-aonn-foundations-for-learning-inc

Detailed Study Metrics with Measurement Information

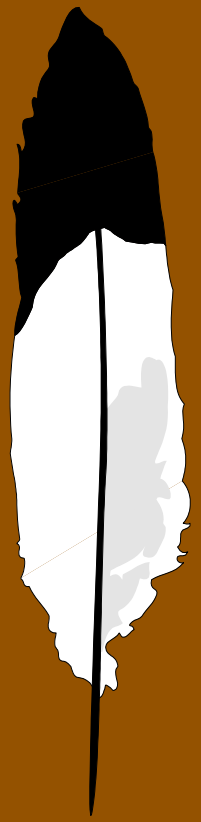
1	BARRIERS TO CARE
Measure description	Number and list of specific barriers to care identified by navigator per month (obstacles that prevent a cancer patient from accessing care, services, resources and/or support)
Initial population	Number of cancer patients, regardless of age, who were receiving navigation services during the 6-month measurement period
Denominator	Total number of barriers identified per patient during the measurement period
Numerator	Number of barriers identified per patient per month
Exclusion and exception	None
Data sources	▪ EHR ▪ NAVmetrics™ ▪ Institutional navigation software
Key terms, data elements, codes	▪ Financial [insurance, transportation, communication, language, knowledge deficits, work/disability, need help at psychological (fear, anxiety, distress)] ▪ Practical [children, etc.] ▪ Physical [pain, anorexia, mobility] ▪ Complex care coordination ▪ Other [home, cultural, spiritual]
Unit of measurement or analysis	Number of barriers
Sampling	Care settings will be compared.
Risk adjustment	None per patient (outer data will be analyzed and omitted if necessary)
Data period	October 15, 2018, through April 15, 2019
Measure results	Monthly metric data will be compared between each study site and an aggregate benchmark for all participating sites; the benchmark will use rolling 12-month data and display 25th, 50th, and 75th percentiles.
Calculation/Measure algorithm	Data will be reported in percentiles.

Coordination of Care / Care Transitions	1. Treatment Compliance: Percentage of navigated patients that adhere to institutional treatment pathways per	quarter	Number Percent
	2. Barriers to care: Number and list of specific barriers to care identify by navigator per month	month	Number
	3. Interventions: Number and specific referrals / interventions offered to navigated patients per month	month	Number
	4. Clinical Trial Education: Number of patients educated on clinical trials by the navigator per month	month	Number
	5. Clinical Trial Referrals: Number of navigated patients per month referred to clinical trial department	month	Number
	6. Patient Education: Number of patient education encounters by navigator per month	month	
	7. Multidisciplinary Communication: number of patients who are referred to revenue generating services (i.e., radiology, rehabilitation, palliative care, tumor site-specific pre/rehab programs)		Number
	8. Diagnosis to initial treatment: Number of business days from diagnosis (date pathology resulted) to iniitial treatment modality (date of first treatment)	Business days	Number
	9. Diagnosis to First Oncology Consult: Number of business days from diagnosis (date pathology received) to initial oncology consult (date of first appointment)	Business days	Number
Research, Quality, Performance Improvement	10. Patient Experience / Patient Satisfiaction with Care: Patient experience or patient satisfaction survey results per month (utilize institutional specific navigation tool with internal benchmark)		
	11. Patient Experience / Patient Satisfaction with Care: Monitor one major goal of current navigation program annually as defined by cancer committee (example:		
	12. Patient Transition from Point of Entry: Percentage of navigated analytic cases per month transitioned from institutional point of entry to initial treatment modality	month	Number Percent
	13. Diagnostic Workup to Diagnosis: Number of business days from date of abnormal finding to pathology report for navigated patients "suspicious findings" for bone cancers, myelomas, lymphomas ... Need to confirm these data are being collected and include in the formula	Business days	
Organizational Develop, conomics	14. 30-, 60-, 90-Day Readmission Rate: Number of navigated patients readmitted to the hospital at 30, 60, 90 days. Report quarterly	quarterly	Number
	15. Navigation Operational Budget: Monthly operating expenses by line item	NA	NA
	16. Navigation Caseload: Number of new cases, open cases, and closed cased navigated		Number
	17. Referrals to Revenue-Generating Services: Number of referrals to revenue-generating services per month by	month	Number
	18. Inpatient Oncology Unit Length of Stay	days	
	19. No show rate. Number of navigated patients who do not complete a scheduled appointment		Number
Operations management, Health E	20. Patient Retention through Navigation: Number of analytic cases per month or quarter that remained in your institution due to navigation. [Part 1 of metric: Reason for outmigration (i.e., insurance, logistics,	month	Number
	21. Emergency Department Utilization: Number of navigated patient visits to the emergency department per month [nausea/vomiting/dehydration, constitpation, symptom management, sepsis, other on for admission]	month	Number
	22. Emergency admissions per Number of Chemotherapy Patients: Number of navigated patient visits per 1000 chemotherapy patients that had an emergency department visit per month	month	Number
Community Outreach, Prevention	23. Cancer Screening Follow-Up to Diagnostic Workup: Number of navigated patients per quarter with abnormal screening referred for follow-up diagnostic workup	quarter	Number
	24. Cancer Screening: Number of participants at cancer screening event and/or percentage increase of cancer screening		Number Percentage
	25. Completion of Diagnostic Workup: Number of navigated individuals with abnormal screening that completed diagnostic workup per month/quarter	month / quarter	Number
	26. Disparate Population at Screening Event: Number of individuals per quarter at community screening events by Office of Management and Budget (OMB) Standards.	quarter	Number
Professional Roles and Responsibilities	27. Navigation Knowledge at the Time of Orientation: Percentage of new hires that have completed institutionally accepted developed navigator core competencies		Number Percent
	28. Oncology Navigator Annual Core Competencies Review: Percentage of staff that have completed institutionally accepted developed navigator core competencies annually to validate core knowledge of oncology navigation	annual	Number Percent
Psychosocial Support, Assessment	29. Psychosocial Distress Screening: Number of navigated patients per month that received psychosocial distress screening at a pivotal medical visit with a validated tool	month	Number
	30. Social Support Referrals: Number of navigated patients referred to support network per month [social worker, psychologist, chaplain, Palliative care, financial counselor]	month	Number
Patient Empowerment, Patient Advocacy	31. Patient goals: Percentage of analytic cases per month that patient goals identified and discussed with the navigator	month	Number Percent
	32. Caregiver Support: Number of caregiver needs / preferences discussed with navigator per month	month	Number
	33. Identify Learning Style Preference: Number of navigated patients per month that preferred learning style was discussed during the intake process	month	Number
nd End of Life	34. Survivorship Care Plan: Number of navigated patients (patients with curative intent) per month that received a survivorship care plan and treatment summary	month	Number
	35. Transition from Treatment to Survivorship: Percentage of navigated analytic cases per month transitioned from completed cancer treatment to survivorship.	month	Number Percent
Survivorship c	36. Referrals to Support Services at the Survivorship Visit: Number of navigated patients per month referred to appropriate support service at the survivorship visit	month	Number
	37. Palliative Care Referral: Number of navigated patients per month referred for palliative care services	month	Number

Handout

Blue font: metrics clarified in 2020 Metrics Document

Green highlight: metrics NACI Care™ refined fall 2023



Identify what a navigation program needs to have in place to begin collecting, reporting and using nationally recommended metrics

Linda Krebs

Needs for metric collection

- Overall navigation program readiness
  - An administration/organization that understands what the navigation program is supposed to do / understands its goals and mission
  - Administrative / organization support to begin collecting and reporting metrics
  - Which metrics are most likely to make an impact?
  - What is the question the navigation program needs answered first?
  - SWOT (strength and weaknesses) analysis

Needs for metric collection

- PN staff readiness
  - Willing to learn about and collect metrics
  - Have a knowledge-base of current recommended metrics
  - Understand navigation program well enough to determine what data are feasible to collect
- Some method to collect the data (desirable to have at least Excel or REDcap)
  - Does not need to be linked to EHR or EMR
- Templates to make data entry and reporting simpler
  - May create a metric and report template library; user can pick and choose which metrics the program needs

Needs for metric collection

- IT session / cheat sheet to assure talking about the same issues (same data fields/common language)
- Knowledge of what do you do with the data once you've got it
  - How validate the data that are being collected
  - How do you assure data contribute to patient well-being
  - How to create benchmarks; is there a central location for benchmarks; which are appropriate for your site / multiple sites?
- Meet with team to review and discuss metrics regularly (frequency defined by your program)
- NACI Care™ or similar data entry program

Desirable for metric collection

- PNs have had competency-based training
- PN has Computer skills
- Have available IT staff
  - Have a good Relationship with IT
- Readiness to present data at Cancer Committee Meetings and Tumor Boards, and through conferences, publications, etc.

Challenges in *Collecting* Data for Metrics

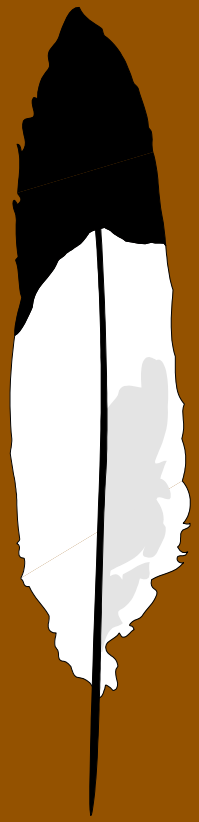
- Multiple systems within same program that don't link
- Ability to collect metrics vary by how the programs/clinics are set up; what challenges (e.g., COVID), staffing issues, staff spread out rather than what navigator may normally be required to so
- Having to double document
- ROI: don't know how to gather data
  - A tool for documentation

Challenges in *Reporting* Metrics and Data

- When generate reports, they are not what they need to be
- Put data in system (e.g., report sheet, EHR, etc.) and not able to get reports
- Uncertain of data validity
  - Discrete versus duplicative reportable fields
  - People document in different fields
  - Items are not indexed the same
- ROI: Converting barriers to dollars

Challenges in *Using* Metrics

- ROI: PNs get patients with the highest barriers. The non-navigated patients may not need PNs and the data look worse for the PNs with high demand patients.
- Managing versus solving / resolving or overcoming barriers
- Admin: how to elevate metric discussion to higher-ups
  - How tie data to dollar amounts for PN programs
- What does the PN or navigation program do when the data identify a problem with patient care, or within the PN program, or HC organization



Examine 3 group-selected metrics from the ~35 nationally recommended metrics

Lisa Harjo

Brief Overview of NACI Care™

- Focuses on cancer care, addressing the entire cancer continuum (outreach to end of life)
- Manages patient care (in and out of clinical settings)
- Expedites gathering, collecting and analyzing patient navigation visit data
- Designed to work with all racial and underserved patient programs (minorities, genders, ages) (i.e., it is not limited to Indigenous populations)
- Facilitates compliance with standardized metrics and accreditation requirements
- Generates tailored pages and reports for:

Brief Overview of NACI Care™

- Generates tailored pages and reports for:
  - Individual or groups of patients
  - Individual or groups of patient navigators (PNs)
  - Navigation program evaluation, research, and benchmarking
- Designed for iPad tablets
- Capable of linking to EPIC electronic health records

Using NACI Care™ Reports as examples

- Metric 2. Barriers to Care
- Metric 3. Referrals to Interventions
- Metric 4. Clinical Trial Referrals
- Metric 8. Diagnosis to initial treatment
- Metric 10. Patient Experience / Satisfaction with Care
- Metric 16. Navigation Caseload
- Metric 23. Cancer Screening Follow-Up Diagnostic Workup
- Metric 24. Cancer Screening
- Metric 29. Psychosocial Distress Screening
- Metric 30: Social Support Referrals

QUESTION: Which metrics are of highest priority to your program?

Coordination of Care / Care Transitions

1. Treatment Compliance
2. Barriers to Care
3. Interventions: Referrals
4. Clinical Trials Education
5. Clinical Trial Referrals
6. Patient education
7. Referrals to revenue-generating services
8. Diagnosis to initial treatment
9. Diagnosis to First Oncology Consult

Research, Quality, Performance Improvement

10. Patient Experience / Patient Satisfaction with Care
11. Patient Experience / Patient Satisfaction with Care *(program goals)*
12. Patient Transition from Point of Entry
13. Diagnostic Workup to Diagnosis

Operations Management, Organizational Development, Health Economics

14. 30-, 60-, 90-Day Readmission Rate
16. Navigation Caseloads
17. Referrals to revenue-generating services by PN
18. Hospital: Inpatient Oncology Unit Length of Stay
19. No show rate
20. Patient Retention through Navigation
21. Emergency Department Utilization
22. Emergency admissions per Number of Chemotherapy Patients

Community Outreach, Prevention

23. Cancer Screening Follow-Up to Diagnostic Workup
24. Cancer Screening
25. Completion of Diagnostic Workup
26. Disparate Population at Screening event

Professional Roles and Responsibilities

27. Navigation Knowledge at Time of Orientation
28. Oncology Navigator Annual Core Competencies Review

Psychosocial Support, Assessment

29. Psychosocial Distress Screening
30. Social Support Referrals

Patient Empowerment, Patient Advocacy

31. Patient goals
32. Caregiver support
33. Identify Learning Style Preference

Survivorship and End of Life

34. Survivorship Care Plan
35. Transition from Treatment to Survivorship
36. Referrals to Support Services at the Survivorship Visit
37. Palliative Care Referral

Thank you for allowing us to share information about patient navigation metrics and reports