

Implementing the Commission on Cancer Standard 3.1 Patient Navigation Process

*A Road Map for Comprehensive Cancer Control Professionals and
Cancer Program Administrators*



September 2017

INTRODUCTION

Welcome to *Implementing the Commission on Cancer Standard 3.1: Patient Navigation Process*. We developed this road map to support comprehensive cancer control (CCC) professionals and cancer program administrators from hospitals, treatment centers and other facilities who are responsible for conducting the triennial Community Needs Assessment (CNA) focusing on cancer disparities and barriers to care. The purpose of this road map is to guide the CNA team in designing a patient navigation process that navigates cancer patients through their care and addresses barriers facing patients, caregivers and communities in the cancer program's catchment area.

This road map for *Implementing the Commission on Cancer Standard 3.1: Patient Navigation Process* was developed through examining several existing cancer-specific CNAs and through consultation with the American College of Surgeon's Commission on Cancer (CoC) team members (see "[Cancer-Specific Community Needs Assessment Examples](#)"). The road map may be used directly by the cancer program's CNA team. CCC professionals are instrumental in disseminating this resource to cancer programs who are members of their coalitions, as well as providing input into the CNA process as public health experts with keen understanding of population data and social determinants of health.

Funding for this project was generously provided by the Centers for Disease Control and Prevention (CDC) in response to technical assistance requests by comprehensive cancer control stakeholders to help build capacity to meet CoC Standard 3.1.

HOW TO USE THIS ROAD MAP

If you are a CCC professional, use this road map to:

- Identify CoC cancer programs in your region and disseminate this resource
- Provide technical assistance and training in public health strategy development, research and evaluation
- Connect CoC cancer programs with data sources

If you are a cancer program administrator, use the road map to help you:

- Conduct a cancer-specific CNA
- Identify barriers to care and determine potential solutions to reduce cancer disparities
- Establish a patient navigation process and identify resources available to assist patients in need
- Modify or enhance the patient navigation process
- Work with your CCC partners to address identified gaps in resources

If you need technical assistance or would like more information, please contact us at cancercontrol@gwu.edu.

Viewing this PDF in Google Chrome? Use "Ctrl+Click" on links to open them in a new tab.

ACKNOWLEDGEMENTS AND CONTRIBUTORS

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ABOUT THE INSTITUTE FOR PATIENT-CENTERED INITIATIVES AND HEALTH EQUITY AT THE GW CANCER CENTER

The mission of the Institute for Patient-Centered Initiatives and Health Equity at the GW Cancer Center is to foster healthy communities, prepared patients, responsive health care professionals and supportive health care systems through applied cancer research, education, advocacy and translation of evidence to practice. Our vision is a cancer-free world and health care that is patient-centered, accessible and equitable.

The GW Cancer Center is a collaboration between the GW Hospital, the GW Medical Faculty Associates, and the GW School of Medicine and Health Sciences to expand GW's efforts in the fight against cancer. The GW Cancer Center also partners with the Milken Institute School of Public Health at GW, and incorporates all existing cancer-related activities at GW, serving as a platform for future cancer services and research development.

ABOUT THE COMPREHENSIVE CANCER CONTROL PROJECT

In 2013, the Institute for Patient-Centered Initiatives and Health Equity (formerly the GW Cancer Institute) was awarded a 5-year cooperative agreement to work with CDC to design and implement comprehensive, high-quality training and technical assistance to CCC

programs and their partners to implement cancer control activities. To learn more, visit www.CancerControlTAP.org.

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ROAD MAP FOR IMPLEMENTING COC STANDARD 3.1: PATIENT NAVIGATION PROCESS AN OVERVIEW



STEP 1: CONDUCT A COMMUNITY NEEDS ASSESSMENT (CNA)

Every three years, you must conduct a CNA that describes:

- Your program and facility
- The community or population you serve
- Health disparities and factors that contribute to cancer-related health disparities
- Barriers to cancer care
- Resources available to overcome barriers to care
- Any gaps in the availability of resources to address barriers

STEP 2: ESTABLISH A PATIENT NAVIGATION PROCESS AND IDENTIFY RESOURCES

Design and implement a patient navigation process that helps overcome barriers to care by linking patients, caregivers and families to resources identified in your CNA. Use this process to revisit and update your CNA as needed.

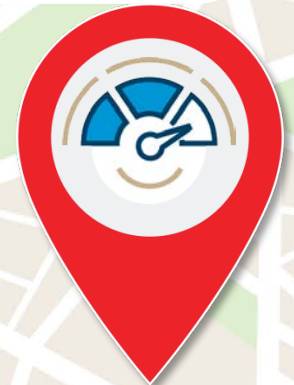


STEP 3: ASSESS BARRIERS TO CARE AND EVALUATE/DOCUMENT THE PATIENT NAVIGATION PROCESS

Every year, you must assess and evaluate your patient navigation process in your cancer committee minutes. At the beginning of each calendar year, review and summarize barriers identified in the CNA and determine whether your navigation process is helping to meet identified needs. Your annual report should provide a list of action steps to address barriers identified in the CNA that still exist.

STEP 4: MODIFY OR ENHANCE THE PATIENT NAVIGATION PROCESS

At the end of each year, use the data from your evaluation and your discussion with the cancer committee to modify or enhance your process. Discuss your action steps with the cancer committee and reach consensus on your new and improved strategies.



ABOUT COMISSION ON CANCER STANDARD

3.1: PATIENT NAVIGATION PROCESS

The CoC Accreditation Committee established standards for hospitals, treatment centers and other facilities seeking accreditation. These standards are aimed at improving the quality of patient care across the cancer continuum by ensuring that cancer programs within these facilities offer their patients a full range of services and access to community-based resources. The CoC Accreditation Committee outlines these standards in [Cancer Program Standards 2016: Ensuring Patient-Centered Care](#).

“A patient navigation process, driven by a triennial Community Needs Assessment, is established to address health care disparities and barriers to cancer care. Resources to address identified barriers may be provided either on-site or by referral.

(CoC, 2016, p. 54)

Documentation

To fulfill the main criteria for CoC accreditation, your program must complete all standard fields in the Survey Application Record. Each year your program must upload:

- “A copy of the results and findings of the triennial Community Needs Assessment
- Documentation of the monitoring, evaluation and findings of the patient navigation process including the health disparity populations served and the barrier(s) that are addressed.”

(CoC, 2016, p. 55)

Compliance

To fulfill the main criteria for CoC accreditation, your program must meet the following compliance criteria:

1. “Conduct a Community Needs Assessment at least **once during the three-year accreditation cycle** to address health care disparities and barriers to cancer care.”
2. “Establish a navigation process and identify resources to address barriers that are provided either on-site or by referral to community-based or national organizations.”
3. Identify and assess barriers to care and evaluate and document the navigation process **each year**. Report the findings to the cancer committee.
4. Modify or enhance the patient navigation process **each year** to address additional barriers identified by the Community Needs Assessment.

(CoC, 2016, p. 55)



Adapted from Mercurio, 2016

STEP 1: CONDUCT A COMMUNITY NEEDS ASSESSMENT (ONCE EVERY THREE YEARS)



Before establishing the patient navigation process, conduct a *cancer-specific* Community Needs Assessment (CNA) of the population(s) served. The CNA is required once **every three years** and will set the stage for identifying needs, disparities, barriers, community resources and gaps in resources.

"The CNA must define/identify:

- The cancer program's community and local population
- Health disparities (numerous factors can contribute to disparities in cancer incidence and death rates such as race, ethnicity, gender, underserved groups and socioeconomic status)
- Barriers to care, which may include patient-centered, provider-centered or health system-centered barriers
- Resources available to overcome barriers on-site or by formal referral
- Gaps in the availability of resources to overcome barriers"

(CoC, 2016, p. 54)

In your CNA, describe your facility and the characteristics of your program's comprehensive cancer care.

Description of facility

- Number of beds
- Specialized, cancer-related programs offered (e.g., transportation, financial assistance)
- Reputation in cancer care
- Number of cancer patients served, cancer case volume
- List of accreditations

Comprehensive cancer care characteristics

- Range of cancer-related clinical services and equipment
- Multidisciplinary team approach, coordinated care
- Clinical trials information and new treatment options
- Prevention and detection programs, including education and support services by partner organizations

PATIENT POPULATION AND HEALTH DISPARITIES

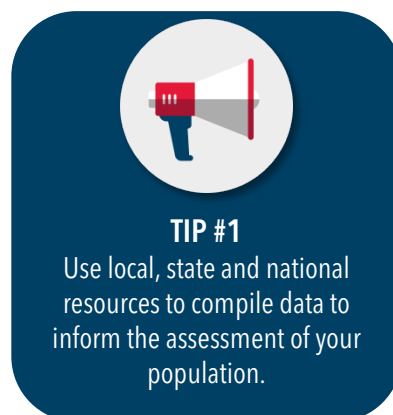
You will also need to describe your patient population, as well as cancer-related health disparities that may exist in the population.

Population(s) served and/or patient characteristics

- Catchment area, including geographic boundaries and characteristics (e.g., urban, suburban, rural)
- Socioeconomic characteristics (e.g., median household income, housing security, health insurance rate, average education level/quality of public schools, food insecurity, languages spoken, immigration status, employment status, poverty level, availability of affordable housing and public transportation, homelessness)
- Race/ethnicity
- Age
- Behavioral and psychosocial health characteristics such as tobacco use rates, alcohol/substance abuse rates and/or mental illness rates
- If available and relevant, include chronic disease incidence or comorbidity rates of obesity, heart disease, diabetes and/or respiratory disease

Cancer burden

- Cancer screening rates
- Cancer survival rates, including 5-year survival rate and/or 10-year survival rate
- Cancer incidence among patient population by diagnosis, age, gender, ethnicity, socioeconomic status or zip code (if data are available)
- Cancer mortality among patient population by diagnosis, age, gender, ethnicity, socioeconomic status or zip code (if data are available)



Do not simply look at facility-based patient data. Compare your cancer program data with national and regional level data as well. Collect data that will allow you to address barriers in the community for patients *not* seeking care. Below are some potential data sources that can help inform your efforts.

Local/Site-Specific Sources	<ul style="list-style-type: none">• Patient navigators• Community outreach coordinators• Breast and Cervical Cancer Early Detection Program coordinators• Cancer program administrators• Hospital and clinic annual reports• Tumor/cancer registries• Cancer committee minutes• Other local resources
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Community or Regional Sources	<ul style="list-style-type: none"> • Community health needs assessments by non-profit hospitals or departments of health • Community health improvement plans by government entities • Susan G. Komen regional needs assessment community profiles
State Sources	<ul style="list-style-type: none"> • State health policy and plan agencies (e.g., Florida's Agency for Healthcare Administration, D.C.'s Department of Health Care Finance) • Division of Vital Records from departments of health • State cancer surveillance data • State demographer websites
National and Multi-Level Sources	<ul style="list-style-type: none"> • CDC Cancer Data and Statistics • National Cancer Institute (NCI) State Cancer Profiles • National Institute of Health (NIH) Surveillance, Epidemiology and End Results (SEER) • American Cancer Society (ACS) Cancer Facts and Figures • American College of Surgeons National Cancer Database • National Academy of Medicine • U.S. Census Bureau • Cancer Control P.L.A.N.E.T. • Robert Wood Johnson 500 Cities Project

Conduct confidential interviews or focus groups with patients and caregivers to identify barriers to care and disparities. Remember that patient surveys alone **do not** provide enough primary data for a complete CNA.

IDENTIFYING BARRIERS TO CARE




Identify barriers to care from the CNA. Barriers may be patient-centered, provider-centered or health system-centered (CoC, 2016). Determine potential solutions to reduce cancer disparities.



The table below provides some examples of identified barriers, as well as actions and solutions that could be used to address them. Please note that this is not an exhaustive list, and could look different from the barriers faced by your organization and patient population.



TIP #2

Consider partnering with a university to design and conduct primary data collection through a research study or student project.

IDENTIFIED BARRIERS	EXAMPLES	POTENTIAL ACTIONS	POTENTIAL SOLUTIONS
Logistical 	<ul style="list-style-type: none"> • Transportation issues • Lack of childcare 	<ul style="list-style-type: none"> • Identify patients who require transportation to medical care or support services within or outside their community • Identify patients who require childcare 	<p><i>Transportation (within community):</i></p> <ul style="list-style-type: none"> • Work with local Medicaid managed care organizations on improvements to transportation vendor availability • Work with ride sharing companies (e.g., Lyft) to pay for rides for patients • Engage local churches or non-profit organizations • Identify local or national resources that provide financial assistance for transportation and create an instructional document for patients on how to access these resources (e.g., American Cancer Society (ACS's) Road to Recovery) <p><i>Transportation (outside of community):</i></p> <ul style="list-style-type: none"> • Utilize ACS's Hope Lodges or Ronald McDonald Houses for children • Develop a hotel partner program • Work with administrators of telemedicine services to provide care
Economic 	<ul style="list-style-type: none"> • Lack of insurance or under-insurance • High co-pays or deductibles • Prescription medication costs • Financial and legal issues 	<ul style="list-style-type: none"> • Assess financial and legal issues faced by patients during and after treatment • Have navigators document barriers 	<ul style="list-style-type: none"> • Develop provider skills in discussing costs/benefits of cancer treatment with patients • Develop support initiatives such as medical-legal partnerships • Provide ACS's National Cancer Information Center (NCIC) with information about resources in your community and refer patients to NCIC • Work with local insurance exchange navigators or safety net insurers to enroll eligible patients • Help patients locate and apply for patient assistance programs • Screen patients for financial assistance eligibility
Cultural and Linguistic 	<ul style="list-style-type: none"> • Lack of culturally or linguistically competent services • Patient mistrust or negative perception of health care providers 	<ul style="list-style-type: none"> • Assess cultural and linguistic competency of services and providers • Understand cultural background(s) of patient population 	<ul style="list-style-type: none"> • Adopt the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care • Ensure access to in-person or telephone medical interpreter services on demand • Conduct culturally sensitive community

			outreach
Communication 	<ul style="list-style-type: none"> • Low health literacy • Lack of knowledge about wellness behaviors • Lack of knowledge about resources or events 	<ul style="list-style-type: none"> • Track and document communication issues 	<ul style="list-style-type: none"> • Collaborate with on-site or community wellness group to offer support groups • Ensure access to patient navigators • Ensure educational materials meet health literacy standards for readability (e.g., reading grade level should be 5th grade or below) • Improve provider education
Provider-Centered 	<ul style="list-style-type: none"> • Perceptions or attitudes, including implicit bias • Time constraints and demand for health care services • Communication issues • Administrative barriers 	<ul style="list-style-type: none"> • Assess providers' perceptions, time constraints and other administrative barriers, like excessive paperwork 	<ul style="list-style-type: none"> • Measure patient satisfaction and identify opportunities to improve patient-provider communication • Use resources from the American Medical Association or other organizations to reduce administrative burden associated with prior authorization programs from insurers • Work directly with managed care organizations to reduce referral burden

IDENTIFYING COMMUNITY RESOURCES AND GAPS TO ADDRESS BARRIERS

Design a patient navigation process that includes initiatives aimed at leveraging community resources to address barriers you have identified. A list of potential local and national [resources](#) is provided at the end of this document.

Consider partnering with local community-based organizations to address identified barriers. For example, you could collaborate with a local community health center to sponsor a cancer screening event or find a local gym that offers American College of Sports Medicine/American Cancer Society (ACS)-certified exercise trainers. You could also refer patients to online support groups or financial assistance resources depending on the results of your assessment of barriers to care.

Revisit the potential actions and solutions you identified and align them with the resources you mapped. Gaps in resources may become apparent during this process. Create an action plan that includes specific, measurable, achievable, realistic and time-bound (SMART) objectives.



TIP #3





Perform internal and external resource mapping to help think through existing resources within your facility or community that may be of assistance as you develop your patient navigation process.


The GW Cancer Center's [Action4PSEChange.org](#) site lists several tools to assist in mapping resources and compiling data.

Prioritize objectives that:

- Promote policy, systems or environmental improvements within your facility
- Implement evidence-based cancer screening or prevention programs
- Focus on the most vulnerable populations in your service or catchment area
- Create continuing education programs for providers
- Promote a holistic view of wellness
- Provide survivorship care plan development and support
- Support accreditation by CoC

Document strategies under each objective including output and outcome metrics. These data will allow you to identify areas of quality improvement and steps for addressing issues.

IDENTIFIED BARRIERS	SMART OBJECTIVE EXAMPLES
Logistical 	<ul style="list-style-type: none"> • Implement program with community partner to provide # of patients with free transportation services for cancer treatment by <u>mm/dd/yyyy</u> • Work with Medicaid or other payer to initiate pilot program for emergency transportation services for outpatient visits in order to reduce visits to emergency department % by <u>mm/dd/yyyy</u>
Economic 	<ul style="list-style-type: none"> • Identify existing in-hospital financial resources and partner with safety net clinics to develop a financial navigation resource guide for patients and caregivers by <u>mm/dd/yyyy</u> • By <u>mm/dd/yyyy</u>, designate a financial navigator to assist patients with financial assistance applications • Catalog co-pay and financial assistance programs from pharmaceutical companies and non-profit agencies to support eligible patients by <u>mm/dd/yyyy</u> • Conduct a fundraising campaign to create patient assistance fund with \$ by <u>mm/dd/yyyy</u>
Cultural and Linguistic 	<ul style="list-style-type: none"> • Sponsor one evening or weekend patient support group for # Spanish-speaking cancer patients for three six-week sessions by <u>mm/dd/yyyy</u> • Provide education to # clinicians on the importance of providing interpretation services for patients whose first language is not English by <u>mm/dd/yyyy</u> • Contract to provide medical interpretation services for oncology patients by <u>mm/dd/yyyy</u> • Hire certified medical interpreters for patients speaking top three languages after English by <u>mm/dd/yyyy</u>
Communication 	<ul style="list-style-type: none"> • Implement e-learning communication training to # primary care providers who have patients who are cancer survivors by <u>mm/dd/yyyy</u> • Contract with communication expert to facilitate workshop for oncologists to enhance patient-provider communication by <u>mm/dd/yyyy</u>

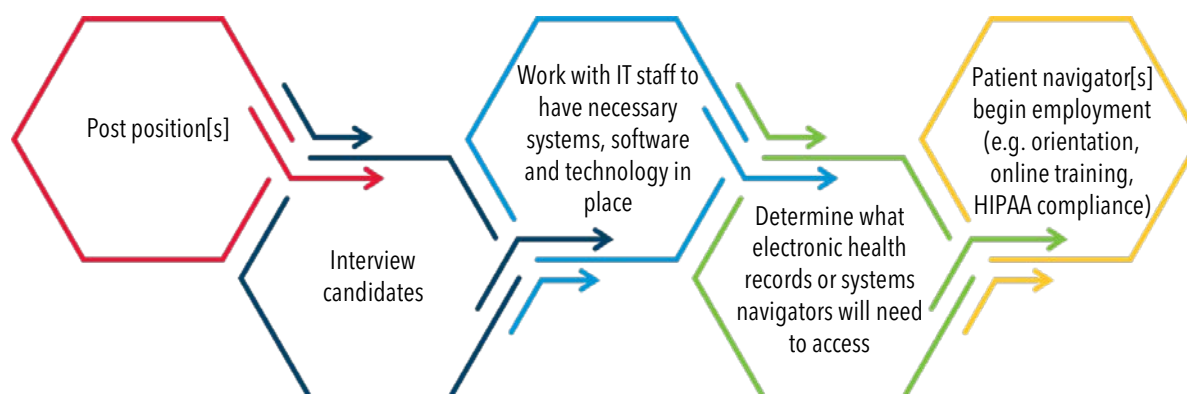
<p>Provider-Centered</p> 	<ul style="list-style-type: none"> • Implement # evidence-based, provider-focused culturally sensitive care workshops for oncologists and navigators to increase their skills in providing culturally sensitive care by <u>mm/dd/yyyy</u> • Extend weekday or weekend hours for radiation oncology and medical oncology clinics by <u>mm/dd/yyyy</u>
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STEP 2: ESTABLISH A PATIENT NAVIGATION PROCESS AND IDENTIFY RESOURCES


Design a patient navigation process that offers individualized assistance to patients, caregivers and families to help them overcome barriers to care. Staff that provide navigation services to patients may be referred to as nurse navigators, social workers, patient navigators, peer navigators, outreach staff, patient representatives, nurses or case managers. These terms are not always fully distinguished, which can create confusion about the roles of different types of navigators (Willis et al., 2016).

Regardless of a navigator's title, your cancer program's navigation process should help patients, caregivers and families overcome barriers by linking them to the resources you have identified. Visit the [resources](#) at the end of this document to understand the competencies and scope of practice for different types of navigators.

While the standard does not require developing a comprehensive patient navigation program, Willis et al. (2016, p. 32) offers steps that could be useful to you as you establish a patient navigation process in your setting:



Once you have designed your patient navigation process, revisit and update the resources you have identified in your CNA. Again, gaps in resources may become apparent during this

TIP #4
Identify key stakeholders and their needs. This helps determine who else could be impacted by your program or process.

process. Implementation of your navigation process should be based on your needs assessment and will be refined through ongoing evaluation (Willis et al., 2016).

“As part of establishing the appropriate patient navigation to address the results of the CNA, the cancer committee will construct a report including, but not limited to, the following:

- Population(s) to be served [as] identified by the CNA
- Health disparities and barriers identified by the CNA
- Description of the navigation process to overcome barriers
- Documentation of activities and outcomes of the navigation process
- Areas for improvement, enhancement, and future directions”

(CoC, 2016, p. 54)

STEP 3: ASSESS BARRIERS TO CARE AND EVALUATE AND DOCUMENT THE NAVIGATION PROCESS (ONCE PER YEAR)

While the CNA is required every three years, CoC accreditation requires assessment of barriers as well as evaluation of the patient navigation process **each year** to be documented in your cancer committee minutes. At the beginning of each calendar year, review and summarize barriers identified in the CNA. Choose at least one barrier to focus on for that year. (See [Step 4](#)).



TIP #5

Use the [American Society for Quality's Impact Effort Matrix](#) to help prioritize barriers and decide which to address.

If the same barrier is chosen two years in a row, update your resources and progress made to address resource gaps and document any changes. When you identify new barrier(s) to address during the next term, create SMART objectives and strategies or modify strategies that have not been successful. Assigning metrics to these strategies will prepare you for the end-of-year evaluation to measure how well your program did to address the barrier. Your program will then choose a new barrier to focus on (or determine the need to continue working on the same barrier) at the first meeting of the next year.

[AONN+ Metrics Initiative](#) provides a tool to measure the success of a navigation process or program's patient experience, clinical outcomes and business performance or return on investment. For more information, visit the [Standardized Evidence-Based Oncology Navigation Metrics for All Models: A Powerful Tool in Assessing the Value and Impact of Navigation Programs](#). Based on your initial evaluation results, redirect resources as needed and document your approach.

You should have previously designed a patient navigation process based on the results of your CNA. As you prepare your report evaluating the program, outline the background and role of any patient navigators at your facility and define roles of staff providing navigation-related services.

Your report should:

- Describe the navigation process – who will address identified barriers and how?
- Evaluate the patient navigation process impacting the current status of the barriers identified in the CNA
- Provide a list of recommendations or action steps to address barriers identified in the CNA that still exist

Finally, discuss your report with the cancer committee and reach consensus regarding the process.

STEP 4: MODIFY OR ENHANCE THE PATIENT NAVIGATION PROCESS (ONCE PER YEAR)

At the end of each year, use the data from your evaluation (process and short-term outcomes) and your discussion with the cancer committee to modify or enhance your process. Some tips for evaluating your patient navigation process include:

- “Assess your program at regular intervals (e.g., quarterly)
- Refer back to your logic model and evaluation plan
- Keep in mind what stakeholders value and if the information you provide to them is aligned with those values (e.g., cost savings, revenue generated, increased patient satisfaction)”
(Willis et al., 2016, p. 33)

Once again, discuss your action steps with the cancer committee and reach consensus on your new and improved strategies.



TIP #6

Determine patient flow and consider conducting an analysis of your program's strengths and weaknesses, as well as external opportunities and threats (SWOT analysis).

TIP #7

Consider using a diagram to illustrate a multidisciplinary team approach to coordinated care.



TIP #8

Disseminate findings through CoC and other channels to improve the field of patient navigation. Use your successes to apply for additional funding to support your patient navigation process.

RESOURCES

Administrative

- [Reducing Administrative Barriers to Care](#): This resource from the American Medical Association helps patients and physicians ease burdens of prior authorizations and other arduous barriers to care.

Commission on Cancer Standard 3.1

- [Cancer Program Standards 2016: Ensuring Patient-Centered Care](#): Developed by CoC, this resource lists quality improvement standards for cancer programs seeking CoC accreditation. These standards require that programs meet performance criteria in program management, clinical services, continuum of care services, patient outcomes and data quality.
- [How Are We Doing? How to Evaluate Your Patient Navigation Program](#): Developed by the Patient Navigator Training Collaborative, this toolkit is designed to help Patient Navigation program managers identify goals, identify what measures can be tracked to help determine if goals are being met, create data collection tools and conduct basic descriptive analysis.
- [Implementing CoC Standard 3.1: The Navigator's Perspective](#): Developed by Oncology Management Consulting Group, this webinar identifies strategies to implement CoC Standard 3.1: Patient Navigation Process, provides two examples of metrics to demonstrate the value of a navigation process and describes two methods for identifying barriers to care.
- [Navigating Standard 3.1](#): Developed by City of Hope Comprehensive Cancer Center, this presentation provides a step-by-step process for implementing CoC Standard 3.1: Patient Navigation Process, including a description of City of Hope Cancer Committee's partnership with El Concilio to address cultural and linguistic barriers impacting Hispanic/Latino patients and families.

Communication and Marketing

- [CancerCare Publications](#): Written by experts, these easy-to-read booklets and fact sheets from CancerCare provide reliable information on cancer-related topics.
- [Cancer Information in Other Languages](#): This resource from the American Cancer Society offers information about cancer including prevention, early detection, treatment and managing side effects in 14 languages in addition to English.
- [Guide to Making Communication Campaigns Evidence-Based](#): This guide from the GW Cancer Center is a companion text to the [Communication Training for Comprehensive Cancer Control Professionals 102](#) course. While it is intended as a

resource on cancer control communication, Lesson 2.1 contains useful information on [Conducting a Systematic Community Assessment](#).

- [National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care](#): The National CLAS Standards from the Office of Minority Health aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities.

Community Needs Assessment (CNA)

This road map was developed through examining several existing cancer-specific CNAs, including:

- [Moffitt Cancer Center Community Health Needs Assessment 2016](#): This cancer-specific community health needs assessment includes data collected from local and national sources, as well as primary data from key informant interviews and focus groups with community residents.
- [St. Joseph Hospital, Humboldt County, OR: A Cancer Care Community Needs Assessment](#): This 2014 cancer-specific CNA has a specific focus on data collected through surveys of primary care providers and cancer patients.
- [University of Vermont Medical Center Cancer Community Needs Assessment Report](#): This 2016 report highlights three specific community needs in cancer care and aligns them with the 2020 Vermont State Cancer Plan goals.

Financial/Legal

- [Cancer Financial Assistance Coalition \(CFAC\)](#): CFAC is a coalition of organizations helping cancer patients manage their financial challenges.
- [National Cancer Information Center \(NCIC\)](#): The National Cancer Information Center from the American Cancer Society provides information and support to those facing cancer. Trained cancer information specialists are available via phone or live chat, and provide accurate, up-to-date cancer information to patients, family members and caregivers and connect them to valuable services and resources in their communities.
- [National Center for Medical-Legal Partnership](#): This project aims to improve the health and well-being of people and communities by leading health, public health and legal sectors in an integrated, upstream approach to combating health-harming social conditions.

Patient Navigation Competencies, Scope of Practice and Program Planning

- [Advancing the Field of Cancer Patient Navigation: A Toolkit for Comprehensive Cancer Control Professionals](#): This toolkit from the GW Cancer Center was developed

to guide states in advancing patient navigation. This resource can be used to educate and train patient navigators, provide technical assistance to members of comprehensive cancer control coalitions, build navigation networks at the state level and identify policy approaches to sustain patient navigation.

- [Core Competencies for Non-Clinically Licensed Patient Navigators](#): These competencies from the GW Cancer Center can be used by health care professionals and institutions considering qualifications for patient navigators.
- [Executive Training on Navigation and Survivorship](#): This interactive online program from the GW Cancer Center teaches the nuts and bolts of patient navigation and clinical survivorship program development and implementation. Target audiences include administrators, comprehensive cancer control practitioners, nurses, physicians, patient navigators, social workers and others. The companion guide, [Executive Training on Navigation and Survivorship: Finding Your Patient Focus - Guide for Program Development](#) can also be used as a standalone resource for creating and sustaining navigation programs.
- [Job Task and Knowledge Area Analysis](#): This form from the National Consortium of Breast Centers helps describe the knowledge areas and job tasks for assisting patients, caregivers and survivors throughout the continuum of care.
- [Navigation Matrix Tool](#): This tool from the National Cancer Institute can be used to assist in building a stronger navigation process. This form can be used to assess an individual tumor site or an entire program or process.
- [Navigator Responsibilities and Core Functions](#): This resource from the Association of Community Cancer Centers provides a sample list of patient navigator responsibilities and job functions designed to be adapted to meet your program's specific resources, community needs and strategic objectives.
- [Oncology Nurse Navigator Core Competencies](#): These role-specific core competencies from the Oncology Nursing Society are designed for a variety of oncology nursing responsibilities. They provide the fundamental knowledge, skills and expertise required for nurses to perform proficiently in their roles.
- [Oncology Patient Navigator Training: The Fundamentals](#): This competency-based training from the GW Cancer Center uses interactive web-based presentations to discuss evidence-based information and case studies to prepare patient navigators to effectively address barriers to care for cancer patients and survivors. The [Guide for Patient Navigators](#) provides a supplement to the Oncology Patient Navigator Training as you move through the course.
- [Patient Navigation Barriers and Outcomes Tool \(PN-BOT™\)](#): This free, Excel-based data entry management and reporting product from the GW Cancer Center is

designed for oncology patient navigation programs. Navigation programs can use the PN-BOT™ to document, track and generate simple reports.

- [Scope of Practice in Oncology Social Work](#): This resource from the Association of Oncology Social Work provides a list of common goals and functions for oncology social workers.
- [Standardized Navigation Metrics](#) and [Standardized Evidence-Based Oncology Navigation Metrics for All Models: A Powerful Tool in Assessing the Value and Impact of Navigation Programs](#): Developed by the Academy of Oncology Nurse and Patient Navigators (AONN+) Standardized Metrics Task Force, this tool includes a set of universal, research-supported metrics to measure the impact of navigation programs. It consists of eight domains in which to measure patient experience, clinical outcome, and business performance or return on investment.

Policy, Systems and Environmental Change

- [Action for PSE Change Tool](#): This no-cost online tool from the GW Cancer Center helps comprehensive cancer control professionals, coalitions and communities with improving health across the cancer continuum. It also features tips on how to use and visualize cancer data for reporting purposes.
- [The Community Guide](#): An independent panel of public health and prevention experts from the Department of Health and Human Services (the Community Preventive Services Task Force) is responsible for collecting these evidence-based interventions to help you select programs to improve health and reduce disease. Search by topic and choose policy development, environmental change or other relevant terms under “strategy.”

Screening Navigation

- [The Mammovan Mobile Mammography Unit](#): The GW Cancer Center’s mobile mammography program can serve as an example to help your program establish a cost-effective mobile screening initiative or program. GW’s Mammovan Mobile Mammography Unit provides breast cancer screening services to underserved communities across the metropolitan Washington, D.C. region.

Survivorship, Rehabilitation and Supportive Care Resources

- [ACS Guidelines for Nutrition and Physical Activity](#): These guidelines from the American Cancer Society cover cancer prevention but may also be useful general guidelines for cancer survivors.
- [Cancer Support Groups](#): These online, telephone and face-to-face support groups from CancerCare can provide support and connection for cancer survivors.

- [Cancer Survivorship E-Learning Series for Primary Care Providers](#): This continuing education program from the GW Cancer Center provides a forum to educate primary care providers who may have patients who are cancer survivors about how to better understand and care for survivors in the primary care setting.
- [Generation and Translation of Evidence \(GATE\)](#): This online community of practice from the GW Cancer Center serves as an engagement and communication mechanism for cancer survivorship and patient navigation. It includes research findings, practice-based insights and lessons learned, and a searchable question and answer database.
- [LIVESTRONG at the YMCA](#): This 12-week physical activity program is designed to get cancer survivors back on their feet.
- [Survivorship Care Guidelines](#): Clinical survivorship care guidelines are available from the American Cancer Society for colorectal cancer, prostate cancer, head and neck cancer and breast cancer (in partnership with the American Society for Clinical Oncology).

Transportation/Lodging

- [Hope Lodge](#): Each Hope Lodge from the American Cancer Society offers cancer patients and their caregivers a free place to stay when their best hope for effective treatment may be in another city.
- [Road to Recovery](#): This program from the American Cancer Society provides transportation to and from treatment for people with cancer who do not have a ride or are unable to drive themselves.
- [Ronald McDonald House](#): These houses provide lodging for families so they can stay close by their hospitalized child at little to no cost.

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