Crosswalk of ONS and AONN+ Core Competencies/Knowledge Domains, Metrics, and CoC/NAPBC Standards©			
ONS Coordination of Care AONN+ Community Outreach/Prevention, Care Coordination/Care Transitions/Psychosocial Support Services and Assessment/ Survivorship and End of Life		**Supportive AONN+ Metric/s**	**2020 CoC and 2018 NAPBC Standards That Support Competencies and Metrics**
Oncology Nursing Society (ONS) Core Competencies	**Academy of Oncology Nurse & Patient Navigators (AONN+) Knowledge Domains**		
ONS Assesses patient needs upon initial encounter and periodically throughout navigation, matching unmet needs with appropriate services and referrals and support services, such as palliative care, dietitians, medical providers, social work, pre-/rehabilitation, and legal and financial services	AONN+ Finding community resources; Referrals to psychosocial support/resources	**Psychosocial Distress Screening:** Number of navigated patients per month who received psychosocial distress screening at a pivotal medical visit with a validated tool **Interventions:** Number of specific referrals/interventions offered to navigated patients per month **Social Support Referrals:** Number of navigated patients referred to support services per month **Referrals to Revenue Generating Services:** Number of referrals to revenue-generating services per month by navigator **Referrals to Support Services at the Survivorship Visit:** Number of navigated patients per month referred to appropriate support services at the survivorship visit **Palliative Care Referrals:** Number of navigated patients per month referred for palliative care services	**CoC** 8.2 Cancer Prevention Events 8.3 Cancer Screening Events **NAPBC** 4.1 Education, Prevention, Early Detection
ONS Identifies potential and realized barriers to care (eg, transportation, childcare, elder care, housing, language, culture, literacy, role disparity, psychosocial, employment, financial, insurance) and facilitates referrals as appropriate to mitigate barriers	AONN+ Identification/intervention of barriers to care and remove barriers to care	**Barriers to Care:** Number and list of specific barriers to care identified by the navigator per month **Interventions:** Number of specific referrals/interventions offered to navigated patients per month **Social Support Referrals:** Number of navigated patients referred to support services per month **Referrals to Revenue-Generating Services:** Number of referrals to revenue-generating services per month by navigator **Referrals to Support Services at the Survivorship Visit:** Number of navigated patients per month referred to appropriate support services at the survivorship visit **Palliative Care Referrals:** Number of navigated patients per month referred for palliative care services	**CoC** 8.1 Addressing Barriers to Care **NAPBC** 2.2 Patient Navigation
ONS Develops knowledge of available local, community, or national resources and the quality of services provided; also establishes relationships with the providers of these services	AONN+ Community needs assessment; Community education prevention and screening; Population health; Risk assessment	**Psychosocial Distress Screening:** Number of navigated patients per month who received psychosocial distress screening at a pivotal medical visit with a validated tool **Cancer Screening, Follow-Up to Diagnostic Workup:** Number of navigated patients per month with abnormal screening referred for follow-up diagnostic workup **Cancer Screening:** Number of participants at cancer screening events and/or percentage increase of cancer screening **Completion of Diagnostic Workup:** Number of navigated individuals with abnormal screening that completed diagnostic workup per month/quarter **Disparate Population at Screening Events:** Number of individuals per quarter at community screening events by the Office of Management and Budget standards	

ONS Develops or uses appropriate screening/assessment tools and methods (eg, Distress Thermometer, pain scale, fatigue scale, performance status, motivational interviewing, financial) to promote a consistent, holistic plan of care	AONN+ Distress screening; Strategies for coping: disease, treatment, distress/anxiety	**Psychosocial Distress Screening:** Number of navigated patients per month who received psychosocial distress screening at a pivotal medical visit with a validated tool **Identifying Learning Style Preferences:** Number of navigated patients per month whose preferred learning style was discussed during the intake process **Treatment Compliance:** Percentage of navigated patients who adhere to institutional treatments pathways per quarter	**CoC** 5.2 Psychosocial Distress Screening **NAPBC** 2.2 Patient Navigation
ONS Facilitates timely scheduling of appointments, diagnostic testing, and procedures to expedite the plan of care and to promote continuity of care		**Treatment Compliance:** Percentage of navigated patients who adhere to institutional treatments pathways per quarter **Diagnosis to Initial Treatment:** Number of business days from diagnosis (date pathology resulted) to initial treatment (date of first treatment) **Diagnosis to First Oncology Consult:** Number of business days from diagnosis (date pathology resulted) to initial oncology consults (date of first appointment)	
ONS Participates in coordination of the plan of care with the multidisciplinary team, promoting timely follow-up on treatment and supportive care recommendations (eg, cancer conferences/tumor boards)	AONN+ Multidisciplinary approach to care/tumor boards	**Survivorship Care Plan (although SCP is no longer mandated by CoC):** Number of navigated patients with creative intent per month who received an SCP and treatment summary	**CoC** 7.2 Monitoring Concordance with Evidence-Based Guidelines **NAPBC** 2.1 Multidisciplinary Patient Management
ONS Facilitates individualized care within the context of functional status, cultural consideration, health literacy, psychosocial, reproductive/fertility, and spiritual needs for patients, families, and caregivers	AONN+ Cultural competency; Provide culturally sensitive care and education	**Psychosocial Distress Screening:** Number of navigated patients per month who received psychosocial distress screening at a pivotal medical visit with a validated tool	
ONS Applies knowledge of clinical guidelines (eg, National Comprehensive Cancer Network, American Joint Committee on Cancer) and specialty resources (eg, ONS Putting Evidence into Practice resources) throughout the cancer continuum. Assists in the identification of candidates for molecular testing and/or genetic testing and counseling and facilitates appropriate referrals	AONN+ Genetics/NCCN guidelines (National guidelines)	**Treatment Compliance:** Percentage of navigated patients who adhere to institutional treatments pathways per quarter	**CoC** 4.4 Genetic Counseling and Risk Assessment **NAPBC** 2.16 Genetic Evaluation and Management
ONS Supports a smooth transition of patients from active treatment into survivorship, chronic cancer management, or end-of-life care. Assists patients with cancer with issues related to treatment goals, advance directives, palliative care, and end-of-life concerns using an ethical framework that is nonjudgmental and nondiscriminatory. Ensures documentation of patient encounters and provided services	AONN+ Goal-setting and life goals; Survivorship education: long-term and late effects; Care planning; Palliative care; Hospice	**Survivorship Care Plan (although no longer mandated by CoC):** Number of navigated patients with creative intent per month who received an SCP and treatment summary **Transition from Treatment to Survivorship:** Percentage of navigated analytic cases per month transitioned from completed cancer treatment to survivorship **Referrals to Support Services at the Survivorship Visit:** Number of navigated patients per month referred to appropriate support services at the survivorship visit **Palliative Care Referrals:** Number of navigated patients per month referred for palliative care services	**CoC** 4.8 Survivorship Program **NAPBC** 2.20 Breast Cancer Survivorship Care

ONS Applies knowledge of insurance processes (eg, Medicare, Medicaid, third-party payers) and their impact on staging, referrals, and patient care decisions toward establishing appropriate referrals, as needed	AONN+ Healthcare reform; Healthcare economics		
ONS Communication/AONN+ Patient Advocacy/Patient Empowerment			
ONS Builds therapeutic and trusting relationships with patients, families, and caregivers through effective communication and listening skills	AONN+ Relationship building/trust		
ONS Acts as a liaison among the patients, families, and caregivers and the providers to optimize outcomes	AONN+ Assisting the patient with care team/communication; Counseling: conduit between patient and providers	**Patient Goals:** Percentage of analytic cases per month that patient goals identified and discussed with the navigator	
ONS Advocates for patients to promote patient-centered care that includes shared decision-making and patients' goals of care with optimal outcomes	AONN+ Patient/family center education (screening, diagnosis, treatment, side effects and management, survivorship/end of life); Patient and family center education (assess educational needs)	**Patient Goals:** Percentage of analytic cases per month that patient goals identified and discussed with the navigator **Caregiver Support:** Number of caregiver needs/preferences discussed with the navigator per month	
ONS Provides psychosocial support to and facilitates appropriate referrals for patients, families, and caregivers, especially during periods of high emotional stress and anxiety	AONN+ Referrals to psychosocial support/ resources	**Psychosocial Distress Screening:** Number of navigated patients per month who received psychosocial distress screening at a pivotal medical visit with a validated tool **Interventions:** Number of specific referrals/interventions offered to navigated patients per month **Social Support Referrals:** Number of navigated patients referred to support services per month **Referrals to Revenue-Generating Services:** Number of referrals to revenue-generating services per month by navigator **Referrals to Support Services at the Survivorship Visit:** Number of navigated patients per month referred to appropriate support services at the survivorship visit **Palliative Care Referrals:** Number of navigated patients per month referred for palliative care services	**CoC** 5.2 Psychosocial Distress Screening **NAPBC** 2.2 Patient Navigation
ONS Empowers patients and families to self-advocate and communicate their needs	AONN+ Patient problem-solving	**Patient Goals:** Percentage of analytic cases per month that patient goals identified and discussed with the navigator	
ONS Adheres to established regulations concerning patient information and privacy		**Navigator Knowledge at Time of Orientation:** Percentage of new hires who have completed institutionally developed navigator core competencies **Oncology Navigator Annual Core Competencies:** Percentage of staff that have completed institutionally developed navigator core competencies annually to validate core knowledge of oncology navigation	
ONS Promotes a patient- and family-centered care environment for ethical decision-making and advocacy for patients with cancer	AONN+ Ethics	**Navigator Knowledge at Time of Orientation:** Percentage of new hires who have completed institutionally developed navigator core competencies **Oncology Navigator Annual Core Competencies:** Percentage of staff that have completed institutionally developed navigator core competencies annually to validate core knowledge of oncology navigation	

ONS Ensures that communication is culturally sensitive and appropriate for identified level of health literacy	AONN+ Cultural competency	**Navigator Knowledge at Time of Orientation:** Percentage of new hires who have completed institutionally developed navigator core competencies **Oncology Navigator Annual Core Competencies:** Percentage of staff that have completed institutionally developed navigator core competencies annually to validate core knowledge of oncology navigation	
ONS Facilitates communication among members of the multidisciplinary cancer care team to prevent fragmented or delayed care that could adversely affect patient outcomes	AONN+ Assisting the patient with care team/communication/counseling: conduit between patient and providers; Multidisciplinary approach to care		
ONS Education/AONN+ Patient Advocacy/Patient Empowerment			
ONS Assesses educational needs of patients, families, and caregivers by taking into consideration barriers to care (eg, literacy, language, cultural influences, and comorbidities)	AONN+ Patient/family center education (assess educational needs)	**Patient Education:** Number of patient education encounters by navigator per month	**CoC** 8.1 Addressing Barriers to Care **NAPBC** 2.2 Patient Navigation 2.17 Educational Resources
ONS Provides and reinforces education to patients, families, and caregivers about diagnosis, treatment options, side-effect management, and post-treatment care and survivorship (eg, survivorship care plan, treatment summary)	AONN+ Patient/family center education (screening, diagnosis, treatment, side effects and management, survivorship/end of life)	**Patient Education:** Number of patient education encounters by navigator per month	**CoC** 4.8 Survivorship Program **NAPBC** 2.20 Breast Cancer Survivorship Care
ONS Educates patients, families, and caregivers on the role of the ONN		**Patient Education:** Number of patient education encounters by navigator per month **Caregiver Support:** Number of caregiver needs/preferences discussed with the navigator per month	
ONS Orients and educates patients, families, and caregivers to the cancer healthcare system, multidisciplinary team member roles, and available resources	AONN+ Multidisciplinary team; Utilization of resources	**Patient Education:** Number of patient education encounters by navigator per month **Caregiver Support:** Number of caregiver needs/preferences discussed with the navigator per month	
ONS Promotes autonomous decision-making by patients through the provision of personalized education and support	AONN+ Patient problem-solving; Engagement in decision-making tools	**Patient Education:** Number of patient education encounters by navigator per month	
ONS Educates and reinforces the significance of adherence with the patients, families, and caregivers regarding treatment schedules, protocols, and follow-up		**Patient Education:** Number of patient education encounters by navigator per month **Caregiver Support:** Number of caregiver needs/preferences discussed with the navigator per month	
ONS Assesses and promotes healthy lifestyle choices and self-care strategies through education and referrals to ancillary services	AONN+ Behavior modification	**Patient Education:** Number of patient education encounters by navigator per month	

ONS Provides anticipatory guidance and manages expectations to assist patients in coping with the diagnosis of cancer and its potential or expected outcomes	AONN+ Strategies for coping: disease, treatment, distress/anxiety	**Psychosocial Distress Screening:** Number of navigated patients per month who received psychosocial distress screening at a pivotal medical visit with a validated tool	
ONS Promotes awareness of clinical trials to patients, families, and caregivers		**Clinical Trial Education:** Number of patients educated by the navigator about clinical trials per month **Clinical Trial Referrals:** Number of patients per month referred to the clinical trial department	**CoC** 9.1 Clinical Research Accrual **NAPBC** 3.1 Clinical Trial Information 3.2 Clinical Trial Accrual
ONS Obtains or develops oncology-related education materials for patients, staff, and community members as appropriate	AONN+ Patient/family center education (assess educational needs); Provide culturally sensitive care and education	**Patient Education:** Number of patient education encounters by navigator per month **Caregiver Support:** Number of caregiver needs/preferences discussed with the navigator per month	**NAPBC** 2.17 Educational Resources
ONS Provides education on genomic and molecular testing and the implication of the results	AONN+ Risk assessment; Genetics	**Patient Education:** Number of patient education encounters by navigator per month	**CoC** 4.4 Genetic Counseling and Risk Assessment **NAPBC** 2.16 Genetic Evaluation and Management
ONS Professional Role/AONN+ Professional Role/Quality and Performance Improvement/Operational Management			
ONS Promotes lifelong learning and evidence-based practice to improve the care of patients with a past, current, or potential diagnosis of cancer	AONN+ Value/role of nursing research to validate practice and build evidence-based practices; Research; Quality metrics (selects metrics, develops measure, and creates dashboards) Performance improvement: methodologies-PDSA; SMART goals; Role in identifying quality needs, areas of quality improvement; Role in improving the process	**Navigator Knowledge at Time of Orientation:** Percentage of new hires who have completed institutionally developed navigator core competencies **Oncology Navigator Annual Core Competencies:** Percentage of staff that have completed institutionally developed navigator core competencies annually to validate core knowledge of oncology navigation	**CoC** 7.1 Accountability and Quality Improvement Measures 7.2 Monitoring Concordance with Evidence-Based Guidelines 7.3 Quality Initiatives 9.2 CoC Cancer Special Studies **NAPBC** 6.1 Quality and Outcomes
ONS Demonstrates effective communication with peers, members of the multidisciplinary healthcare team, and community organizations and resources	AONN+ Team-building; Leadership; Workforce shortages; Organizational structure, mission, and vision	**Navigator Knowledge at Time of Orientation:** Percentage of new hires who have completed institutionally developed navigator core competencies **Oncology Navigator Annual Core Competencies:** Percentage of staff that have completed institutionally developed navigator core competencies annually to validate core knowledge of oncology navigation	**CoC** Multidisciplinary Cancer Case Conferences **NAPBC** 1.2 Multidisciplinary Breast Care Conference 2.1 Multidisciplinary Patient Management

ONS Contributes to ONN program and role development, implementation, and evaluation within the healthcare system and community	AONN+ History/evolution of navigation; Definition of navigation and types of navigators (community, lay, clinical navigator-RN/SW)	**Navigator Knowledge at Time of Orientation:** Percentage of new hires who have completed institutionally developed navigator core competencies **Oncology Navigator Annual Core Competencies:** Percentage of staff that have completed institutionally developed navigator core competencies annually to validate core knowledge of oncology navigation	
ONS Participates in the tracking and monitoring of metrics and outcomes, in collaboration with administration, to document and evaluate outcomes of the navigation program and report findings to the cancer committee	AONN+ Quality metrics (selects metrics, develops measure, and creates dashboards)	**Navigator Knowledge at Time of Orientation:** Percentage of new hires who have completed institutionally developed navigator core competencies **Oncology Navigator Annual Core Competencies:** Percentage of staff that have completed institutionally developed navigator core competencies annually to validate core knowledge of oncology navigation	**CoC** 6.4 Rapid Quality Reporting System Participation (RQRS) 7.1 Accountability and Quality Improvement Measures 7.2 Monitoring Concordance with Evidence-Based Guidelines 7.3 Quality Initiatives 9.2 CoC Cancer Special Studies **NAPBC** 1.3 Evaluation and Management Guidelines 6.1 Quality and Outcomes
ONS Collaborates with the cancer committee and administration to perform and evaluate data from the community needs assessment to identify areas of improvement that will affect the patient navigation process and participate in quality improvement based on identified service gaps	AONN+ Community needs assessment	**Navigation Program Validation Based on Community Needs Assessment:** Monitor one major goal of current navigation program annually as defined by the cancer committee	**CoC** 7.1 Accountability and Quality Improvement Measures 7.2 Monitoring Concordance with Evidence-Based Guidelines 7.3 Quality Initiatives 8.1 Barriers to Care **NAPBC** 6.1 Quality and Outcomes
ONS In collaboration with other members of the healthcare team, builds partnerships with local agencies and groups that may assist with cancer patient care, support, or educational needs. Establishes and maintains professional role	AONN+ Finding community resources	**Interventions:** Number of specific referrals/interventions offered to navigated patients per month **Social Support Referrals:** Number of navigated patients referred to support services per month	