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| **Navigation Activity** | **Ideal Navigation** | **Minimum Recommendation** |
| 1. **Identify Eligible patients**
 | **Identify newly diagnosed** **patients** by reviewing pathology reports or upcoming appointments for initial appointment--------------------------------------When: Weekly (within one week of diagnosis, or scheduling initial appointment) | **Input eligibility criteria** in required REDCap fields to yield eligibility determination--------------------------------------When: At time of initial patient consult or treatment appointment |
| 1. **Initial Contact (after formally informed of diagnosis)**
 | Meet with patient **in-person** to complete intake and social needs assessment--------------------------------------When: Within 1 (one) week of **pathologic diagnosis** or scheduling of initial appointment. | Speak to patient **by phone** to complete intake and social needs assessment--------------------------------------When: Within 1 (one) week of **initial patient consult** or treatment appointment |
| 1. **Communication with Healthcare Team[[1]](#footnote-1)**
 | Communicate with healthcare team by email, phone, or in-person throughout the patient's treatment and discuss social needs, most useful and critical navigation services, and navigator concerns.--------------------------------------When: **Within 48 hours** following initial consultation with any new oncologist. Also, contact patient’s current oncologist within 48 hours of initial surgery, chemo, and/or radiation treatment and at least quarterly through treatment (if a patient is on a course of chemo, radiation, and/or biologic therapy and in active navigation care) | Communicate with healthcare team by email, phone, or in-person throughout the patient's treatment and discuss most critical and useful navigation services, as well as navigator concerns--------------------------------------When: **Within 1 week** following initial consultation with any new oncologist. Also contact patient’s current oncologist within 1 week after initial surgery, chemo, and/or radiation treatment and again halfway through treatment (if patient is on a course of chemo, radiation, and/or biologic therapy) |
| 1. **Tracking Patients Over Time**
 | Meet with patient **in-person** prior to **each** **care transition**--------------------------------------When: 1) within one week of diagnosis2) start of surgery3) from surgery to chemo4) from chemo to radiation, etc. | Speak to patient **by phone** **at least twice** during cancer treatment--------------------------------------When: 1) at initial intake2) within 3 months after diagnosis |
| 1. **# of Contact Attempts to Reach Patient**
 | Attempt to reach patient by preferred contact method, usually by phone at least **3 times**, including **1 in the ‘evening’ hours**, followed by **1 follow-up letter** from hospital--------------------------------------When: Once daily (one attempt/day for 3 different days) | Attempt to reach patient by preferred contact method, usually by phone at least **3 times on 3 different days**--------------------------------------When: Once daily (one attempt/day for 3 different days) |
| 1. **Missed[[2]](#footnote-2) Appointment Follow-up**
 | **Any missed appointments** should result in a navigator phone call and completion of the social needs assessment. If patient has a history of missed appointments navigator should **provide reminder call the day before every scheduled appointment**.--------------------------------------When: **Within 48 hours** of missed appointment | **After first missed appointment**, navigator should call to determine cause and complete social needs assessment if determined necessary--------------------------------------When: **Within 1 (one) week** of missed appointment |
| 1. **Patients Lost to Follow-up**
 | **Message other navigators** within registry to see if the patient has been seen elsewhere, and reach out to the patient’s support contacts. Consider a home visit.--------------------------------------When: After 3 contact attempts and unable to reach patient and not showing for scheduled appointments | **Search registry** to see if patient seen elsewhere --------------------------------------When: After 3 contact attempts and unable to reach patient and not showing for scheduled appointments |
| 1. **Completing the Social Needs Assessment (THRIVE Screener)**
 | Complete assessment **at intake and then at any transitions of care** (e.g. from surgery to chemo therapy) and as needed throughout the course of treatment. Additional, targeted referrals as needed between assessments--------------------------------------When: Every 3 months and/or transition of care.1) within one week of diagnosis2) start of surgery3) from surgery to chemo4) from chemo to radiation, etc. | Complete assessment **at least 2 times** \*additional assessments at navigator’s discretion\*--------------------------------------When: 1) At initial intake and then2) within 3 months post intake |
| 1. **Follow Up Regarding Social Needs Referrals (FindHelp!)**
 | Navigator should **ask patient at each follow-up encounter** if their identified needs have been met and document result in FindHelp! If needs not met, additional referrals should be made--------------------------------------When: At each routine follow up encounter, or encounter for a missed appointment or on request of patient | **Follow up by phone** on any incomplete or pending referrals for identified needs--------------------------------------When: 1 week post assessment |
| 1. **Transition in Care/End of Navigation**
 | Fill out the ‘PN Transfer/Completion’ form in REDCap when patient transfers care to new facility and/or completes hospital-based treatment (i.e., radiation, chemotherapy, biological therapy). If patient transfers care, hand-off the patient to her new navigator. **Follow up 1 year after diagnosis** to determine if treatment complete, if patient’s treatment period is less than 1 year--------------------------------------When: When appropriate, for transfers at 1 year post diagnosis or upon completion of biological therapies | Fill out the ‘PN Transfer/Completion’ form in REDCap when patient transfers care to new facility and/or completes hospital-based treatment (i.e., radiation, chemotherapy, biological therapy). If patient transfers care, hand-off the patient to her new navigator--------------------------------------When: When appropriate, for transfers at 1 year post diagnosis or upon completion of biological therapies |
| 1. **Monitoring Caseload**
 | View a population level report, with evidence of conducting activities for patients as identified (e,g., contact patient for q 3 month screening on social determinants--------------------------------------When: Weekly | View any of the population level reports (\*report = patient search, days since diagnosis, appointments, to-do)--------------------------------------When: Weekly |

1. i.e., oncologists, nurses, social work [↑](#footnote-ref-1)
2. This includes missed diagnostic tests, scans, and office appointments [↑](#footnote-ref-2)