Timeline Of TRIP Navigation

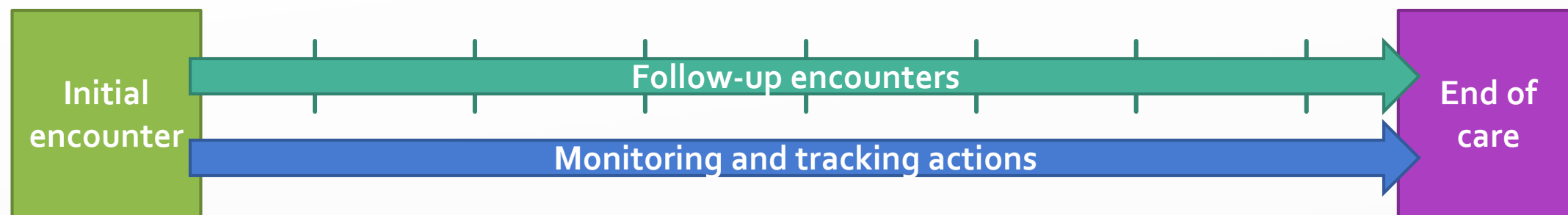| Initial encounter	Follow-up encounters	End of care
	Monitoring and tracking actions	

Initial Encounter Activities

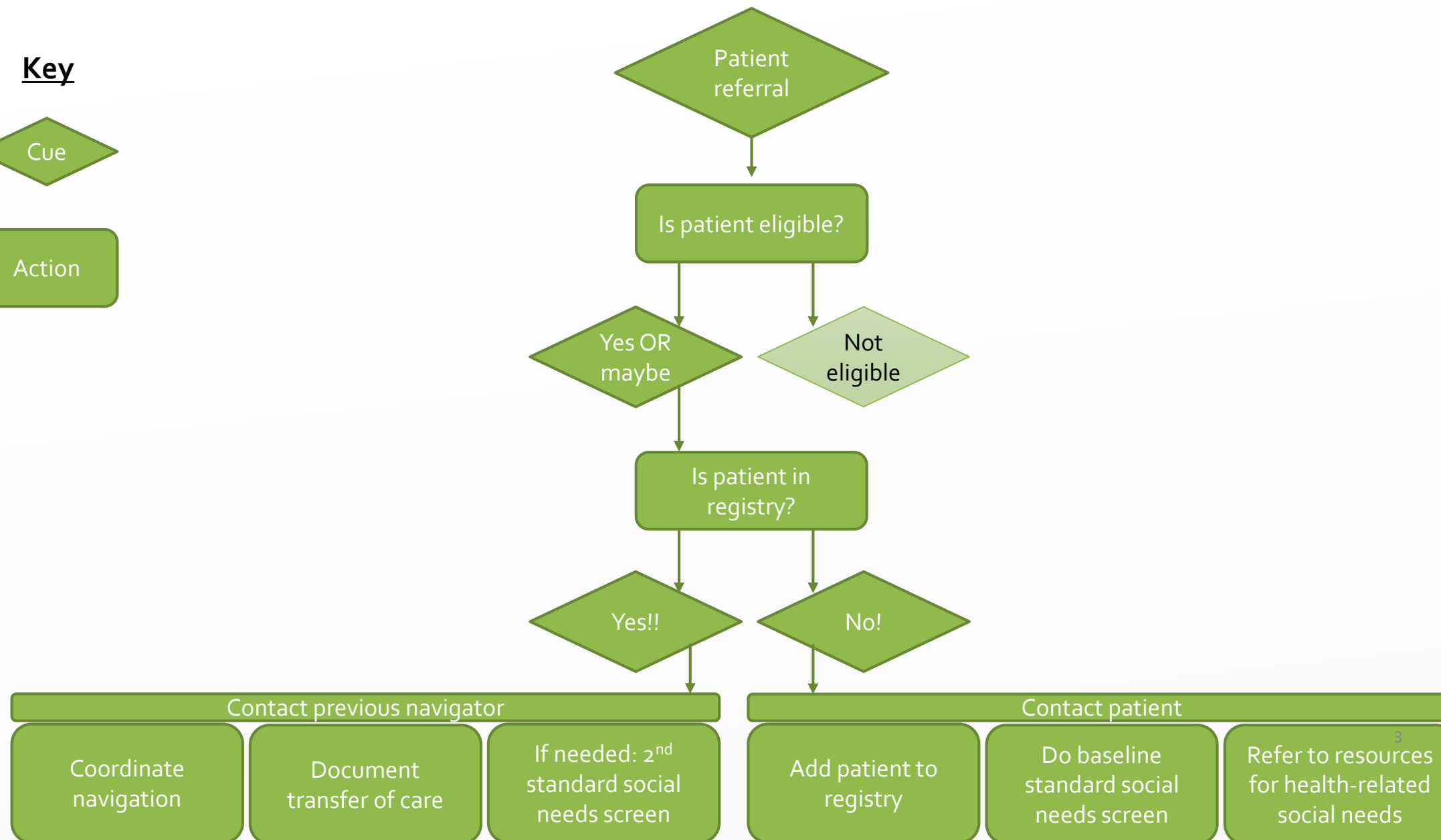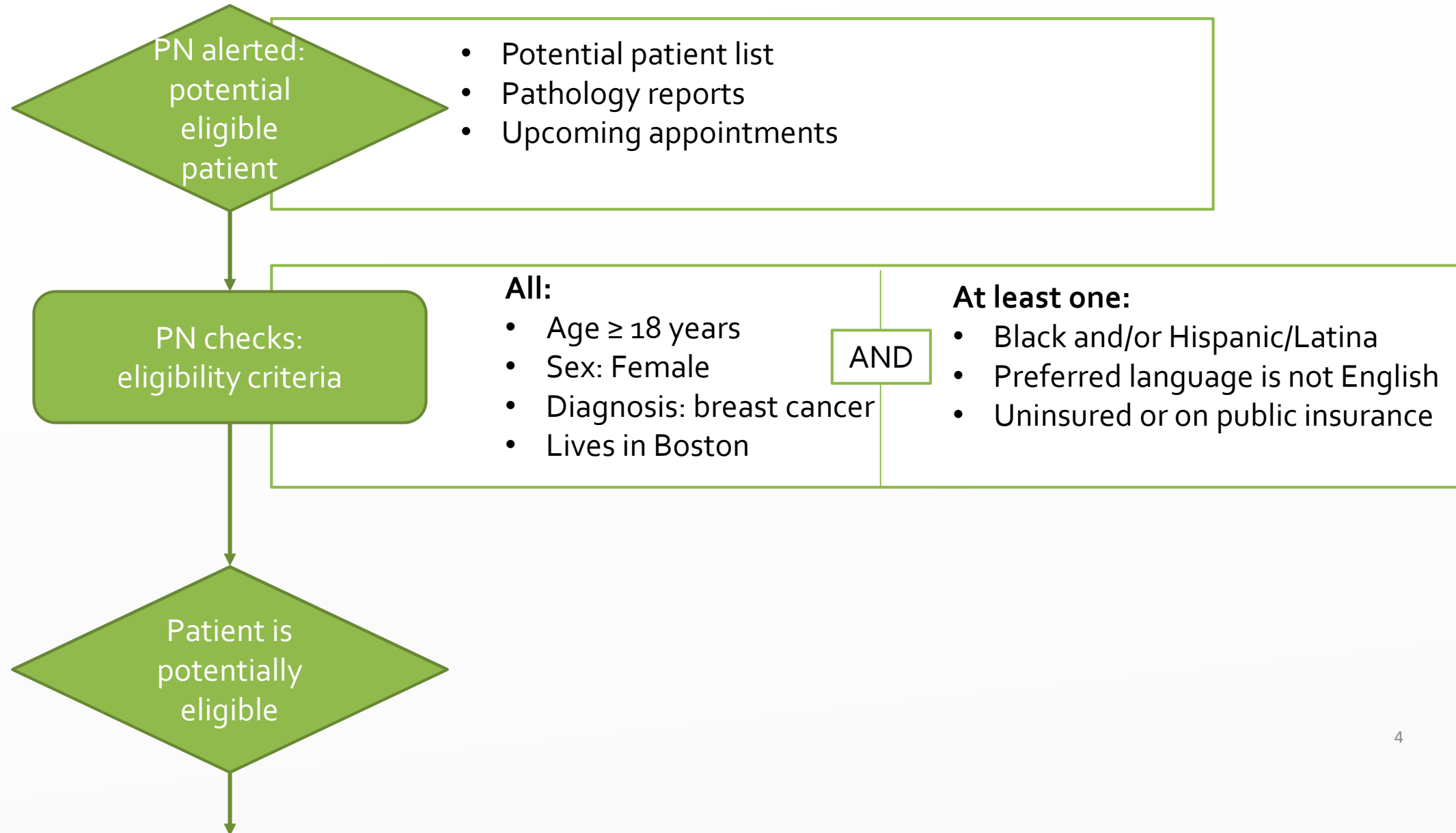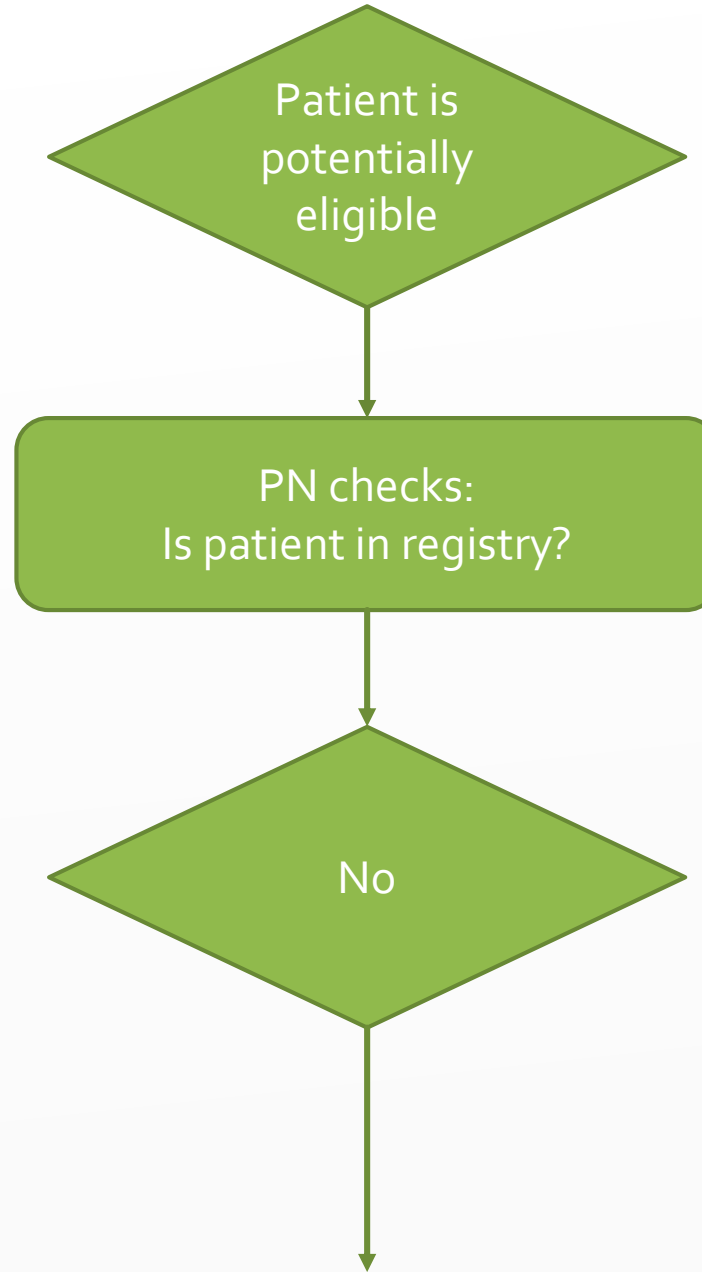| Identifying patients likely to experience delays in care | Including patients in shared registry | Identifying and responding to barriers to care | Navigating patients with care at multiple institutions |

Initial Encounter (Overview)

Key

Cue (diamond shape)

Action (rectangle shape)

Patient referral

↓

Is patient eligible?

├─→ Yes OR maybe
└─→ Not eligible

Yes OR maybe ↓

Is patient in registry?

├─→ Yes!!
└─→ No!

Yes!! → Contact previous navigator

| Coordinate navigation | Document transfer of care | If needed: 2nd standard social needs screen |

No! → Contact patient

| Add patient to registry | Do baseline standard social needs screen | Refer to resources for health-related social needs |

Initial Encounter

PN alerted: potential eligible patient

- Potential patient list
- Pathology reports
- Upcoming appointments

PN checks: eligibility criteria

All:
- Age ≥ 18 years
- Sex: Female
- Diagnosis: breast cancer
- Lives in Boston

AND

At least one:
- Black and/or Hispanic/Latina
- Preferred language is not English
- Uninsured or on public insurance

Patient is potentially eligible

Initial Encounter

Patient is potentially eligible

PN checks:
Is patient in registry?

No

Initial Encounter

Patient is not in registry

Contact patient

Enter patient in registry
- Create registry record
- Enter eligibility information
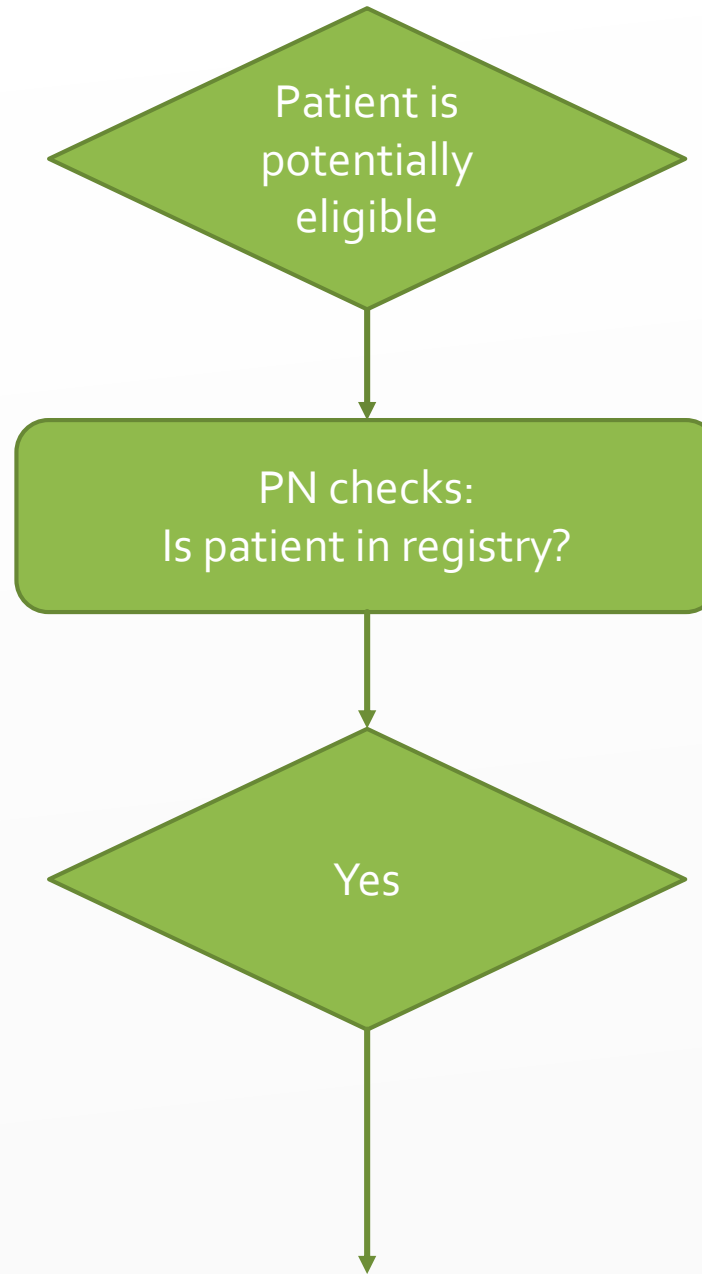- Record baseline systematic social needs assessment

Baseline systematic social needs assessment
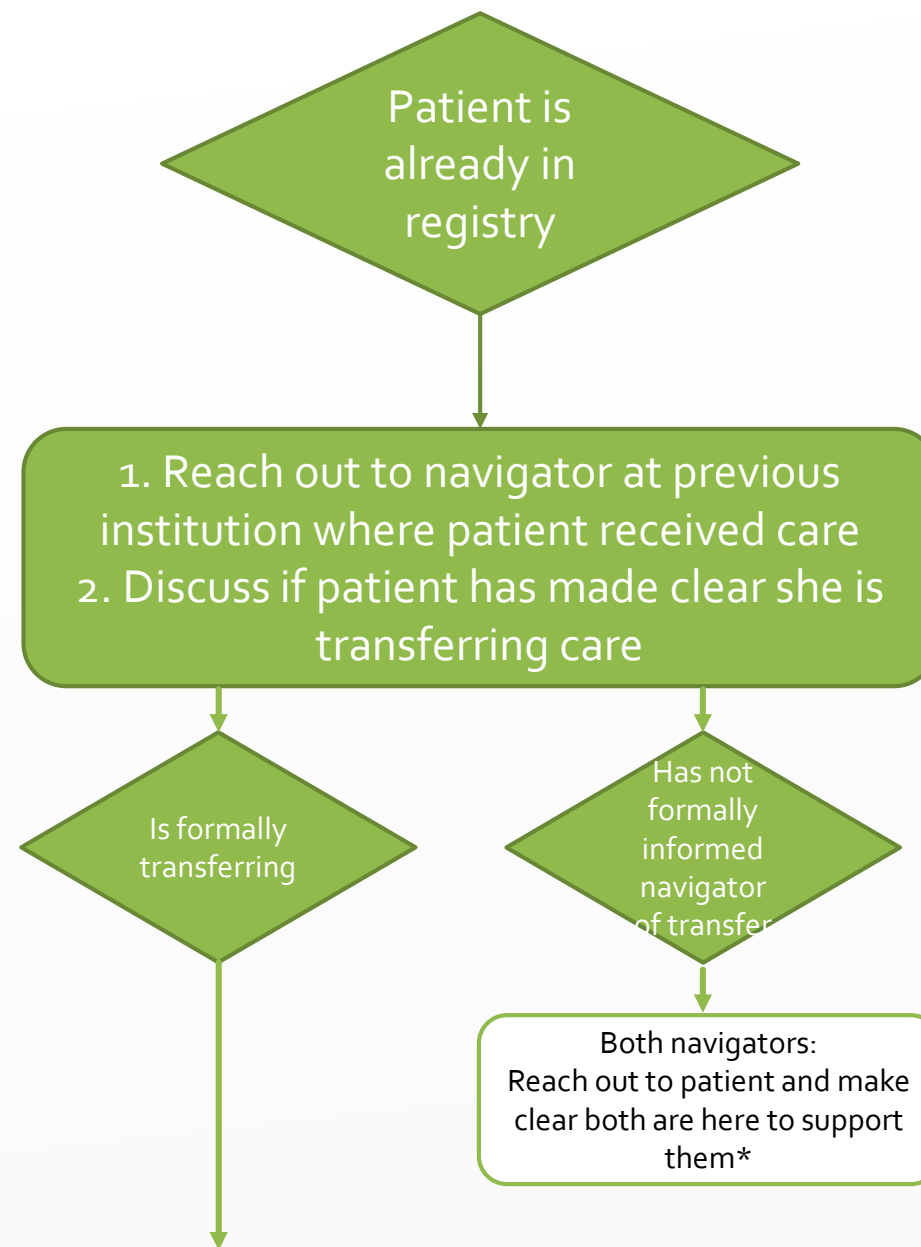- Use a social needs assessment platform to screen patient for needs and barriers to care

Make and document referrals
- Refer patients to resources based on social needs assessment
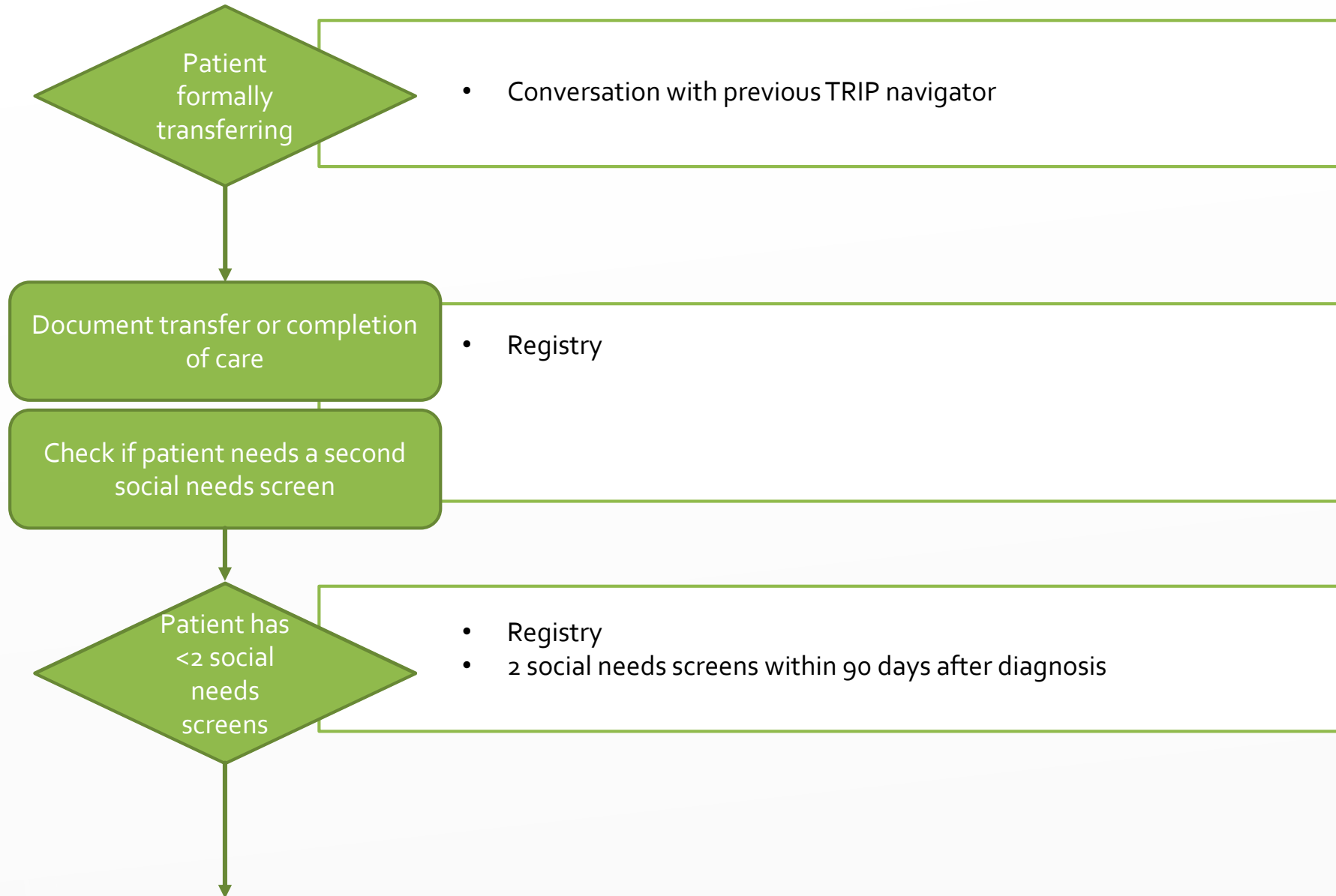- Document referrals in the social needs assessment platform
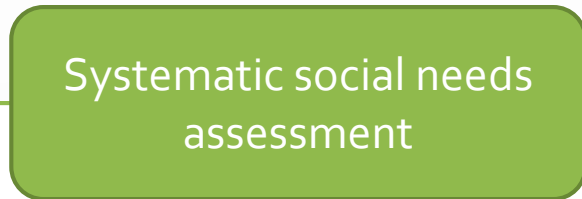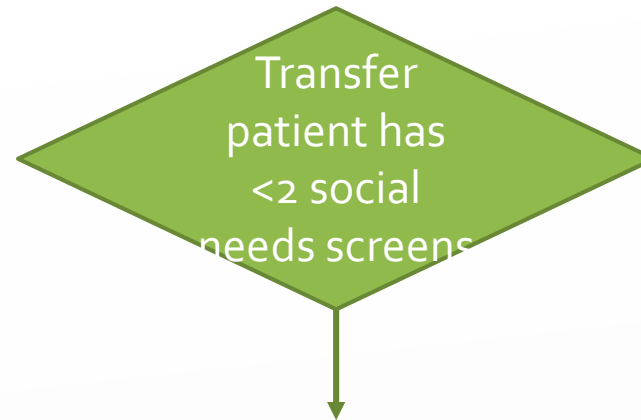
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Initial Encounter

Patient is potentially eligible

PN checks:
Is patient in registry?

Yes

Initial Encounter

Patient is already in registry

1. Reach out to navigator at previous institution where patient received care
2. Discuss if patient has made clear she is transferring care

Is formally transferring

Has not formally informed navigator of transfer

Both navigators:
Reach out to patient and make clear both are here to support them*

*For more information on this process, refer to "Patients at multiple institutions" guide in training binder

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Initial Encounter

```
                    ◇ Patient
                      formally
                      transferring
```

- Conversation with previous TRIP navigator

```
                    ▭ Document transfer or completion
                      of care
```

- Registry

```
                    ▭ Check if patient needs a second
                      social needs screen
```

```
                    ◇ Patient has
                      <2 social
                      needs
                      screens
```

- Registry
- 2 social needs screens within 90 days after diagnosis

Initial Encounter

Transfer patient has <2 social needs screens

Contact patient

Systematic social needs assessment

- Use social needs assessment platform to screen patient for needs and barriers to care

Make and document referrals

- Refer patients to resources based on social needs assessment
- Document referrals in the social needs assessment platform

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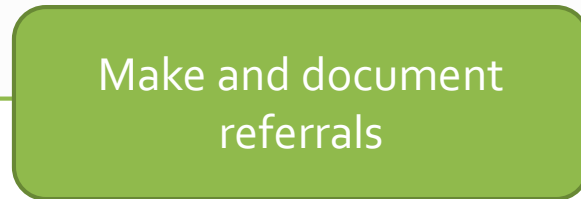
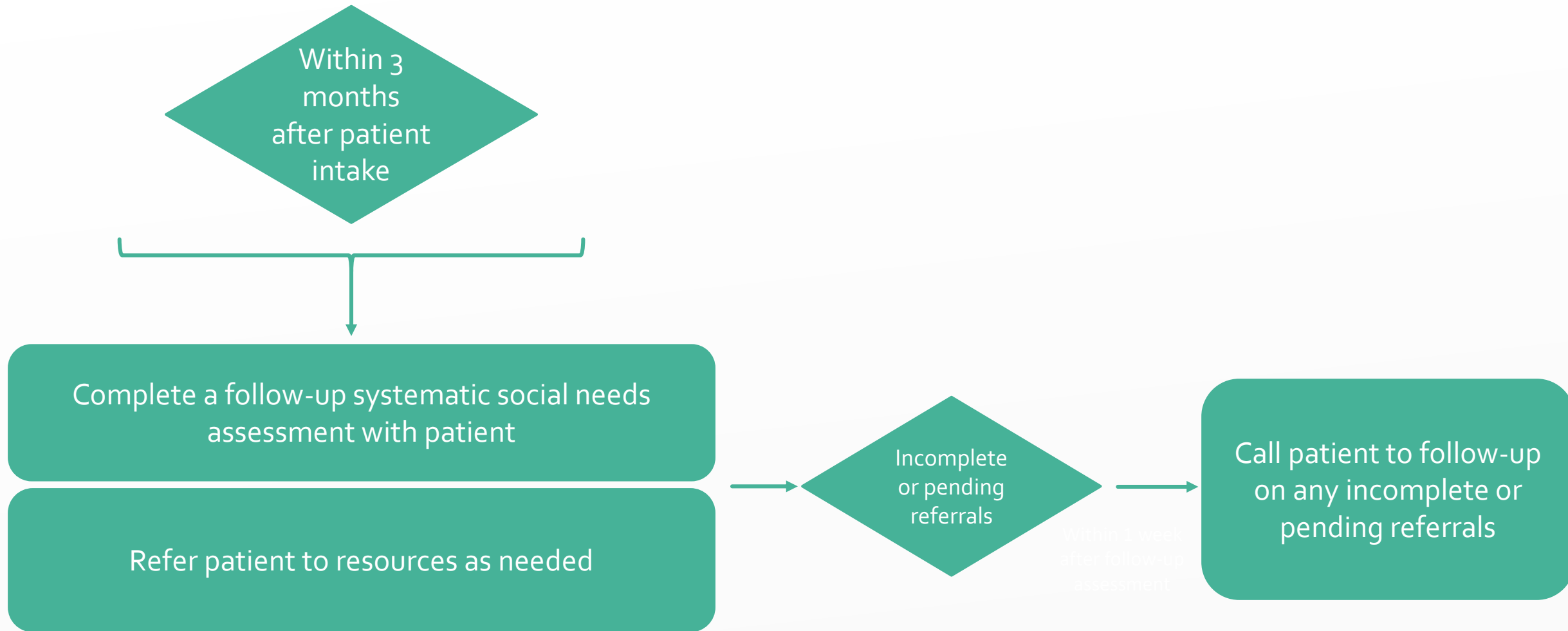# Follow Up Activities

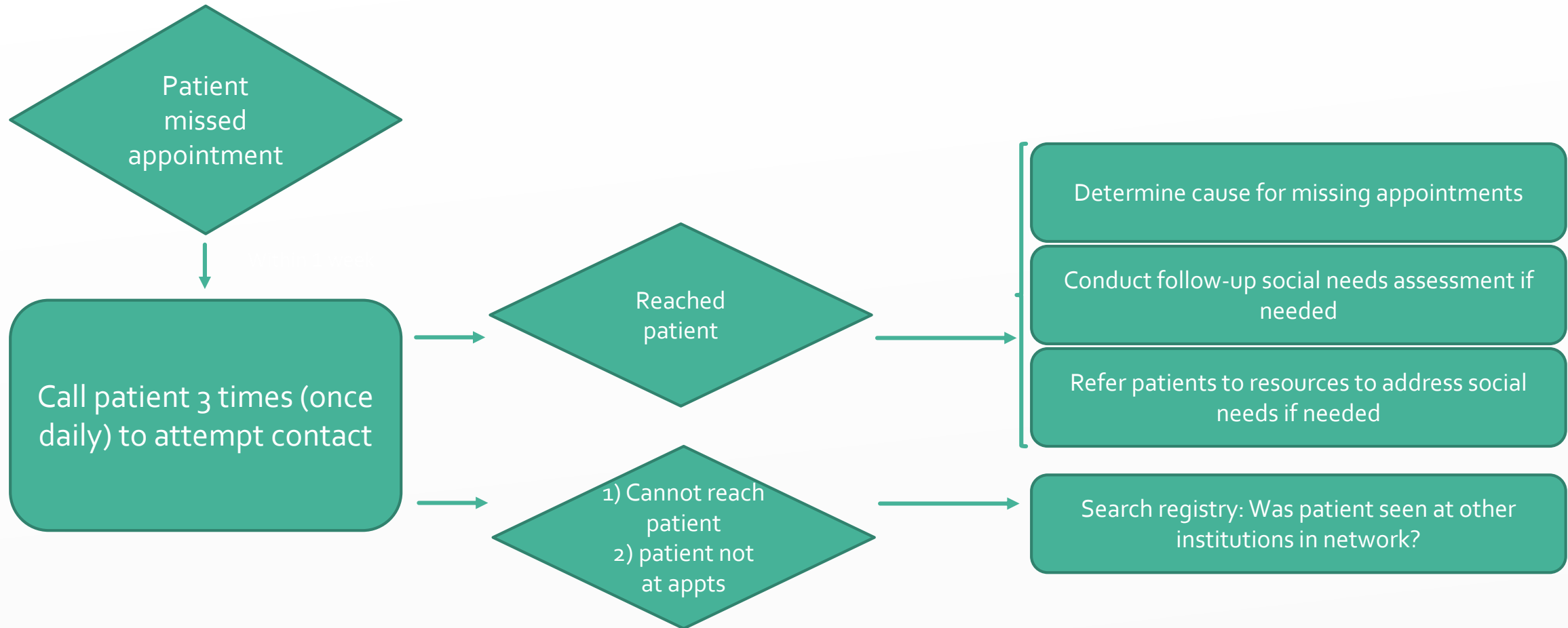| Communication with healthcare team | Identifying and responding to barriers to care | Following up with missed appointments |

Communication With Health Care Team

Identifying And Responding To Barriers To Care

Following Up With Missed Appointments

Monitoring And Tracking

Once a week

View reports to monitor navigation caseload and activities

End Of Care:
Closing Out Navigation