IMPLEMENTATION GUIDE
Kukui Ahi (Light the Way): Patient Navigation

Using an Evidence-Based Program to develop
a process model for program delivery in the practice setting

Note: Refer to "Putting Public Health Evidence in Action". Review the appropriate Modules and the handouts provided in each, in order to modify and evaluate this program to meet the needs of your organization and audience.

"Putting Public Health Evidence in Action" is available online at:
http://cpcrn.org/pub/evidence-in-action/

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I. PROGRAM ADMINISTRATION

Kukui Ahi staff included two full-time lay navigators and a supervisor. The supervisor was full-time because of her responsibility to implement the RCT research protocol, as well as to supervise the lay navigators. In the absence of research, the supervisor could be part-time.

A. Navigator Position Description

Job Summary**:** Cancer Patient Navigator is responsible to the supervisor, will recruit participants and receive referrals to the program, and will facilitate and expedite the cancer screening process.

Responsibilities

1. Responsible to a supervisor, usually a registered nurse, social worker, or public health graduate.
2. Collaborates and assists client care team to support the coordination of care and internal/external resources to ensure that care is provided in a supportive, seamless, and superior customer approach at all times.

Primary Duties and Responsibilities

1. Assists client in completing intake forms. Gathers client clinical and financial information.
2. Assesses client barriers to timely screening and treatment.
3. Collaborates with care team in setting and implementing the plan for the patient to effectively access needed services at clinical and community sites.
4. Provides ongoing data to patient care team.
5. Assists with scheduling patient's diagnostic tests and procedures.
6. Assists in scheduling initial and follow-up appointments with patient's primary care and specialty physicians; and ensures that patients arrive to appointments prepared and on time.
7. Assists clients to obtain lodging, travel, and ground transportation if needed.
8. Assists clients with acquiring insurance and financial support/aid for healthcare if needed.
9. Assists in providing health education, especially on cancer screening and healthy lifestyle. Gathers relevant health education materials for patients.
10. Assists in connecting clients and their families/caregivers with information and linkages to external health and social support services.
11. Identifies and develops relationships with organizations and community agencies involved in preventative health education and promotion.
12. Builds relationships with other navigators and providers to collaborate on plan of care.
13. Assists with grant writing, special program projects, and professional correspondence.
14. Participates in all meetings designated by administration.

15. Attends required trainings and in-services.
16. Assists with quality assurance monitoring as directed.
17. Completes data entry of client information into navigator database.
18. Assists with preparation of statistics and reports.
19. Manages the maintenance of medical records and files in an organized confidential manner.
20. Assists with the development and review of departmental policies and procedures.
21. Knows and understands the rules and laws governing HIPAA.
22. Maintains and protects client confidentiality.
23. Assists with orientation of new personnel when designated.
24. Supports the philosophy and objectives of the company and assigned department and demonstrates a commitment to overall organization success.
25. Observes all safety and health regulations and works in accordance with safe work procedures and policies of Molokaʻi General Hospital. Ensures compliance with The Joint Commission and accrediting agencies. Reports unsafe acts/conditions and injuries/incidents to the Supervisor promptly.
26. Know and understand the laws and regulations that apply to your specific area of responsibility.
27. Ensure your personal performance measures up legally and professionally to the standards established by your company.
28. Report to management any situations that appear to violate the law, government regulations or company policies.
29. Performs other related duties and accepts responsibility as assigned.

Core Values/Professional Standards

1. Demonstrates the organization's core values and fosters superior customer service.
2. Complies with all organization policies and procedures, applicable laws and regulatory requirements.

Typical Physical Demands

1. Essential: Seeing, hearing, speaking, sitting, walking, stooping/bending, lifting weight up to 25 pounds, pushing/pulling and carrying items, reaching items, reaching above, at and below shoulder level, finger dexterity.
2. Occasional: Sitting, kneeling, climbing stairs, walking on uneven ground, squatting.
3. Operates computer, printer, telephone, and fax.

Typical Working/Environmental Conditions

1. Both inside and outside environmental conditions; noise and/or vibration; hazardous physical conditions; and atmospheric conditions which affect the respiratory system or the skin.

Performance Requirements

1. Ability to speak, read, write and understand English.
2. Ability to speak, read, write, and/or understand languages other than English, with

preference to Filipino languages.

3. Knowledge and ability to network effectively in the community.
4. Ability to establish supportive and effective relationships with patients and their families.
5. Knowledge and ability to plan and coordinate interdisciplinary care and services efficiently and effectively.
6. Knowledge and ability to work with multicultural and underserved populations.
7. Knowledge and ability to problem solve, anticipate issues and concerns, and address and/or resolve them in an effective manner.
8. Knowledge and ability to communicate effectively, both orally and in writing.
9. Knowledge of regulatory requirements pertaining to duties and responsibilities.
10. Excellent interpersonal skills. Ability to establish, communicate, and sustain effective positive working relationships with staff, departments, and other internal and external contacts.
11. Ability to gather patient's clinical and financial information, and provide ongoing data to the clinical staff.
12. Ability to use computer applications as related to job duties.
13. Ability to problem solve, prioritize, and complete tasks in appropriate time frame.
14. Ability to be flexible and to perform multiple tasks in a stressful quick paced environment.

Minimum Qualifications

Education/Certification and Licensure

1. High School diploma or the equivalent.
2. Graduate of an accredited nursing assistant program preferred.
3. Current CPR (Basic Life Support for Healthcare Provider) certification required.

Experience

1. Two (2) years of experience in health care demonstrating an understanding of hospital processes, preferably in a case management assistant type role in a comparable facility preferred.
2. Prior experience in health care billing and insurance preferred.
3. Prior experience in working with the underserved population desirable.

B. Supervisor Position Description

Job Summary: The Supervisor will hire, train, and oversee the work of the Cancer Patient Navigators.

Responsibilities

1. Responsible to the Rural Health Clinic Director
2. Organizes and administers the services provided under the Cancer Navigator Program to support the coordination of care and internal/external resources to ensure that care is provided in a supportive, seamless, and superior customer approach at all times.

Primary Duties and Responsibilities

1. Establishes objectives for the services provided by the Cancer Navigator Program and the community navigators.
2. Prepares and administers the budget for the program including ongoing evaluation of the allocations of fiscal resources.
3. Formulates and ensures review of program policies and procedures with appropriate input from administration and other professional staff.
4. Coordinates activities of all services to maintain effective communication and relationships between community navigators, ancillary staff, program participants, and the public.
5. Develops and implements in-service plans for staff training/orientation and continuous quality improvement programs.
6. Maintains work environment that provides maximum safety and health and encourages safety awareness among staff and participants in accordance with OSHA, DOH, and JCAHO regulations. Will report unsafe conditions and injuries/incidents in a timely and appropriate manner.
7. Responsible for staff in areas assigned, including recruitment and retention efforts, schedules and staffing, training, performance evaluations and personnel actions such as selection, promotion, discipline, up to including discharge with guidelines of The Equal Employment Opportunity Agencies and other hospital and federal policies.
8. Assists in creating contracts and job descriptions of hired personnel.
9. Participates in all meetings as designated by the Administration that pertains to the Cancer Navigation Program.
10. Participates in evaluation and selection of both clinical and non-clinical health care technology to optimize the efficient utilization of clinic services including information management system.
11. Participates in appropriate community organizations, task forces, committees, etc., to identify community cancer health care needs and perceptions and facilitate the program's involvement in meeting the appropriate needs with an emphasis on Medicare patients and eliminating on-island cancer disparities.
12. Seeks ways to update and improve clinical services in the development of efficient, patient centered, pathways of care, which utilizes current theory.
13. Responsible for the maintenance and protection of all participant consents, program forms, and records in the area specified.
14. Assures that all appropriate information is obtained for Medicare billing purposes.

15. Establishes priorities in cases of an emergency or disaster.
16. Actively supports the goals and participates in major projects undertaken by the Cancer Navigator Program.
17. Maintains confidentiality at all times.
18. Knows and understands the laws and regulations that apply to your specific area of responsibility.
19. Ensures your personal performance measures up legally and professionally to the standards established by the hospital and federal government.
20. Reports to management any situations that appear to violate law, government regulations or company policies.
21. Performs and submits progress reports as required.
22. Performs other related duties as assigned.

Core Values/Professional Standards

1. Demonstrates the organization's core values.
2. Fosters superior customer service.
3. Complies with all organization policies and procedures, applicable laws and regulatory requirements.

Typical Physical Demands

1. Essential: Standing, finger dexterity, seeing, hearing, speaking, lifting weight of 45 to 60 pounds.
2. Continuous: Standing, seeing, hearing, speaking, stooping/bending, twisting body. Operates computer, fax, copier, and printer.

Typical Working/Environment Conditions

1. Both inside and outside environmental conditions, noise and/or vibration, hazardous physical condition, atmospheric conditions which affect respiratory.
2. Other and/or specific physical demands, machines, tools, equipment, working conditions, etc., required in area of assignment, noted on job analysis form.

Performance Requirements

1. Ability to speak, read, write and understand English.
2. Knowledge and ability to network effectively in the community.
3. Knowledge and ability to work with multicultural and underserved populations.
4. Knowledge and ability to communicate effectively both orally and in writing.
5. Excellent interpersonal skills. Ability to establish, communicate, and sustain effective positive working relationships with staff, departments, and other internal and external contracts.
6. Knowledge and ability to problem solve, anticipate issues and concerns, and address and/or resolve them in an effective manner.
7. Knowledge of regulatory requirements pertaining to duties and responsibilities.
8. Ability to use computer applications as related to job duties.
9. Ability to evaluate statistical data and make computations relating to departmental operations and budget.

10. Ability to be flexible and to perform multiple tasks in a stressful quick paced environment.

Minimum Qualifications

Education/Certification and Licensure

1. Graduate from an accredited college with a degree preferably Masters in Nursing, Social Work, or Public Health and have managerial experience.
2. Current Hawaii Registered Professional Nurse's license.
3. Current CPR (Basic Life Support for Healthcare Provider) certification required.

Experience

1. Five – ten years nursing, social work, or public health experience, including two years managerial experience.
2. Prior experience in health care preferred.
3. Prior experience in working with the underserved population desirable.

II. PROGRAM DELIVERY

A. Program Materials *(All listed materials can be viewed and/or downloaded from the RTIPs Products Page)*:

Navigator Training Material

1. Sample agenda for 48-hour training
2. Facility tour worksheet
3. Addressing barriers worksheet
4. Role play observation checklist
5. Navigation training evaluations
6. Navigation training certificate

Navigator Program Materials:

1. Intake form
2. Appointment reminder card
3. Addressing barriers worksheet
4. Sample database for client tracking

B. PROGRAM IMPLEMENTATION

Step 1: Set Up Model of Navigation

The model consists of lay navigators at a hospital on a rural island with a mostly minority population. The name, Kukui Ahi, is Hawaiian for "light the way." This name was selected because of its meaningfulness to the local population, which is predominantly Native Hawaiian.

The program aims to increase screening and early detection for four targeted cancers—breast, cervical, colorectal, and prostate—and to improve cancer-related outcomes and client satisfaction with care by employing a culturally appropriate navigation protocol to facilitate the best results at all points along the cancer care continuum.

Generally, lay navigators are responsible to:

- Cultivate relationships and networks in the community.
- Provide community and client outreach.
- Educate clients and their families about cancer screening and healthy lifestyle.
- Assess clients' cancer screening history and need.
- Assess clients' supports and barriers to screening.
- Assist clients by scheduling appointment, arranging transportation, managing referrals, and linking them to supports provided by other agencies and programs.
- Help families re-negotiate roles to assist the client with screening-related needs.

Outreach, education, and access services will involve families as well as patients, as families are important in support of and follow-through of cancer prevention and control decisions.

Navigators do not make medical decisions, take the place of family members, solve domestic disputes, or pay for housing, food, transport, childcare, or medical care.

This model was established upon receipt of funding from the Centers for Medicare and Medicaid Services (CMS) to test screening navigation through a randomized control trial (RCT). The RCT was designed and led by RTI International, a consulting firm contracted by CMS. In the RCT, eligible Medicare recipients on Molokaʻi were randomized to receive the intervention or to receive nutrition education. This project was designed to show that the lay navigator model can positively reduce cancer health disparities in minority populations.

Step 2: Recruit and Train Navigators

Kukui Ahi navigators were recruited from the community. A medical background was not required. The most important attributes were that they were members of the community and they were sensitive to and trusted by the community. The job descriptions for navigators and supervisor are in Section 1.

The navigators completed a 48-hour training called *Hoʻokele i ke Ola*, which means Navigating to Health. This training differs from those offered on the US continent in four ways. First, there were three versions of the training to accommodate the diverse needs of community-based trainees living on the different Hawaiian islands: 1) 6 days of training and tours in urban Honolulu; 2) 4 days of training on a neighbor island, with 2 days of tours in Honolulu; and 3) a 3-credit community college independent study course. Second, the training maximized opportunities to build relationships between lay navigators and hospital-based providers by inviting both to the training. For example, navigators from the Molokaʻi-based CMS navigator program (Kukui Ahi) and from the Queen's Medical Center in Honolulu participated in the first 6-day training in Honolulu, helping to build relationships between navigators at the two locations. Community-based cancer providers (e.g., from local hospitals and the American Cancer Society) served as faculty for the training. The bonds created among the trainees and with cancer providers ultimately increased continuity of care for cancer patients. Third, graduates of the first navigator training became co-teachers of subsequent training offered on their own islands. This helped build their capacity in cancer care as they identified potential trainees, faculty, and tour sites on their islands, and participated as lecturers.

The curriculum was organized around 14 learning objectives (Table 1), and materials were transmitted through lecture and active learning activities. The latter included experiential exercises, role playing, video viewing, tours, demonstrations, short writing assignments, case studies, story-telling, discussion, and networking opportunities. These active strategies responded to community demand and are recommended by adult learning theory to accommodate variations in learning style. For example, to cover the learning objective about identifying the unique diagnostic tests, treatments, and impacts of nine types of cancer, students received lectures from providers (or viewed PowerPoint lectures or videos on WebCT), toured relevant cancer diagnostic and treatment facilities, "talked story" with cancer patients and families, and completed worksheets on specific cancers. One module focused on compiling and organizing a cancer navigation resource binder. Students collected education materials, relevant social service agency information, and listed resource people that could help them with future cancer navigation questions and referrals. For the community college independent study course, the binder was their final graded activity. All students demonstrated their

ability to help patients by working through mock cancer cases to identify barriers, informational needs, and appropriate resources. These case plans could be completed individually and discussed or role played by small groups.

Table 1. Cancer Navigation Curriculum Learning Objectives and Teaching Methods

Learning Objective	Teaching Methods	
1. Describe the role of a Cancer Patient Navigator	L CA W CA	• Attend lecture on cancer patient navigation: definition and role • Talk story with a patient navigator • Write about new knowledge/skills and how they can be applied in your work (after each day) • Give examples of how knowledge/skills have been applied
2. Explain the importance of confidentiality.	L L CA	• Attend lecture on confidentiality and HIPAA • Attend lecture on culture and communication • Discuss personal culture and communication styles
3. Describe barriers to cancer care and ways to overcome them.	L CA W	• Attend lecture on cancer patient navigation: definition and role • Discuss beliefs that can limit help seeking • Write about how to overcome specific barriers
4. Identify unique tests and treatments of cancer (focus on 8 types).	L L T CA W RB	• Attend lecture on cancer 101 • Receive information on specific cancers from providers during facility tours • Tour cancer diagnostic and treatment facilities, including treatment rooms and equipment • Talk story with cancer patients and their families • Complete worksheets on specific cancers, including sections on medical, social, and psychological issues for patient cases • Add information to resource binder
5. Identify related physical, psycho-logical and social issues likely to face people with cancer and their families	L CA W RB CA	• Attend lecture on psychological issues for patients, families, and navigators • Talk story with cancer patients and their families • Search Web and complete worksheet on side-effects and nutritional issues of treatment • Add information resource binder • Use “Questions to Ask When Someone You Love has Cancer” booklet to identify questions the patient should ask
6. Demonstrate the ability to gather data and put it into a “Patient Record”.	L CA RB	• Attend lecture on types of information a patient should keep • Review a model of a record collection folder the patient may want to keep • Find and review free resources for patient record keeping • Add information to resource binder
7. Find reliable cancer info from agencies and on the Web.	CA W NL RB	• Explore the website for the Cancer Information Services (CIS) • Find the answers to these cancer questions online and by phone • Lunch with CIS and American Cancer Society (ACS) staff. • Add information to resource binder

Table 1. Cancer Navigation Curriculum Learning Objectives and Teaching Methods		
Learning Objective	Teaching Methods	
8. Describe cancer-related services available in your community.	T L NL W RB	• Tour of cancer diagnostic and treatment facilities • Attend lecture on financial services, including pharmaceutical assistance programs • Lunch with CIS, ACS, and other providers of cancer care • Develop resource list for a specific cancer patient case • Add information to resource binder
9. List advantages of participating in clinical trials and barriers to participation.	L T CA NL RB	• Attend lecture on clinical trials: advantages and barriers • Tours of facilities and agencies connected with clinical trials • Talk story with patient who benefitted from clinical trial • Lunch with clinical trials network • Add information to resource binder
10. Define palliative care and hospice care.	L T NL RB	• Attend lecture on palliative care and hospice • Tour of facilities that provide hospice and/or palliative care • Lunch with palliative care network staff • Add information to resource binder
11. Complete an advance directive.	L W CA	• Attend lecture on advance directives and end of life issues • Complete an advance directive for oneself • Discuss feelings associated with talking about the end of life
12. Demonstrate the ability to work through "mock" cancer cases.	L CA W	• Attend lecture on case management • Work through cancer cases to practice identifying barriers and information/resource needs; these can be completed individually or discussed and/or role played by small groups
13. Organize a resource binder	RB	• The "resource binder" exercise is introduced on the first day of class and information is added throughout the training. A completed binder is due on the last day. Students take this binder to the worksite to use.
14. Describe ways to care for yourself	L CA	• Attend lecture on burnout and grief • Participate in relaxation exercises

L=lecture, CA=class activities, T=tours, NL=networking lunches, W=writing, RB=resource binder

Since its initially offering in 2007, more than 250 individuals in Hawai'i have completed the *Ho'okele I Ke Ola* training.

Materials provided for the training include:

1. Sample Agenda for 48-hour Training – Training agendas should be adjusted for program needs. For navigators focused on cancer screening, speakers must provide information on cancer in general (and cancer health disparities related to the target group), the specific cancers of interest, diagnostic tests (and, to a lesser extent, cancer staging and treatment), and support services (related to transportation, insurance, appointment reminders, and so forth). Navigators who will also help clients diagnosed with cancer should also learn about treatment and treatment side-effects, clinical trials, medication assistance programs, support

groups, survivorship, and so forth. As much as possible, cancer content should be delivered by cancer providers so that navigators can get to know the cancer care network and who to call for assistance with which services. All navigators should learn and practice motivational interviewing, assessment, barrier identification and resolution, and team communication skills.

2. Facility Tour Worksheet. An important aspect of the training is to take trainees on tours of the facilities where care is provided. Because much of the cancer testing and treatment services in Hawai‘i are located in Honolulu and other city centers, clients from other islands (like Moloka‘i) and from rural areas may have to travel to unfamiliar facilities for care. Having a navigator that has been to the facility and knows staff there is helpful in reassuring clients. Also, prior to training, lay navigators may not know what a mammography unit looks like or where and how a colonoscopy is performed. Facility tours provide them with visuals they can draw on to explain tests to clients. This facilities tour worksheet provides a guide to navigators on what to look for (and a place to take notes) while on tour.

3. Addressing Barriers Worksheet. This worksheet is used in training and also used in the program for identifying barriers to care and tracking actions taken to overcome them. More detail on this is provided in Step 4.

4. Role Play Observation Checklist. The training should provide multiple opportunities for navigators to practice their interviewing and assessment skills. This training tool is used during role playing sessions by a third person (usually another trainee) to check navigators' skills. The checklist prompts attention to, and feedback on a navigator's skills at greeting and welcoming the client, assessing client and family needs, developing a plan, providing referrals as appropriate, encouraging clients and their families to participate and take responsibly for care independently or with assistance, communicating in a respectful and understandable manner, and documenting the encounter and plan (e.g., on the Addressing Barriers Worksheet).

5. Navigation Training Evaluation. This evaluation tool can be used at the end of each day of the training or at the end of the entire training. It provides the trainers with feedback on how to improve the training. It also asks trainees if the training helped with their knowledge about cancer screening, treatments, and services, and how to help clients access health insurance, financial assistance, and other services. It also asks trainees to report how confident they now feel to talk to clients about cancer and cancer screening and about some of the challenges they may face. It asks if they are able to explain their role as a navigator, maintain client confidentially, and help clients communicate with family and providers. This evaluation tool can and should be modified to fit the specifics of the training.

6. Navigation Training Certificate. This sample certificate can and should be modified to reflect your training and institution.

Step 3: Set Up Outreach and Referral Processes

Outreach is important to build community awareness about cancer and the life-saving role played by screening and early detection. Flyers introducing cancer navigation were created and distributed to community leaders and posted in grocery stores, banks, clinics, churches, and other community meeting places. The Kukui Ahi project also sought to establish volunteer participant recruiters through community organizations. These volunteers were charged with identifying people who were eligible for services. Physicians, nurses, and other providers at MGH and community clinics also received flyers and phone calls about the service and were encouraged to refer clients.

Step 4: Screen and Assist Patients

Community navigators administered a cancer screening assessment (CSA) tool to all participants (control and intervention groups) at the beginning and at the end of the project. This tool was provided by CMS. After the CMS-sponsored RCT was completed, a simpler patient intake tool was developed, and it is included in this Implementation Guide. The simplified version prompts navigators to collect data on client and family contact information, ethnicity, language, educational status, income, employment, caregiver support, medical team, insurance status, personal and family history of cancer, and comorbidities. The intake tool also includes questions related to cancer treatment and referral to clinical trials, hospice, and survivorship programs; for programs that focus only on cancer screening navigation, this sections can be deleted from the form.

Most importantly, the intake form prompts the collection of information on the cancer screenings needed by the patient and the barriers to getting this screening. Barriers may include system barriers, personal barriers, and family barriers, as shown in Table 2.

Table 2. Systems, Personal, and Family Barriers to Cancer Screening, as Displayed on the Intake Form

System barriers	**Personal barriers**	**Family barriers**
☐ No established primary care ☐ Transportation (on-island) ☐ Location of health care (off-island) ☐ Housing during off-island care ☐ System problems scheduling care ☐ System problems coordinating care ☐ Lack of access to a specialist ☐ System culture and practices ☐ Staff beliefs and attitudes	☐ Financial difficulties ☐ Difficult access to appropriate food ☐ Disability/comorbidity ☐ Treatment side effects ☐ Unable to care for self at home ☐ Costs: health care ☐ Costs: medication/equipment ☐ Employment issues ☐ Internal psychology (anxiety) ☐ Habitual unhealthy lifestyle ☐ External psychosocial (isolated) ☐ Health literacy/lack of information ☐ Language ☐ Cultural/personal beliefs and attitudes	☐ Childcare/family care issues ☐ Housing ☐ Other barrier: Specify:_____)

The navigator then works to help the patient overcome the identified barriers and obtain needed screening. Barriers and actions to overcome them are tracked on the Intake Form or on the Barriers Worksheet . This Barriers Worksheet is the primary charting tool of navigator. It can be used in a paper-and-pencil version, with data from it later entered into the navigator database, or programs may choose to provide navigators with hand-held devices with screen-based programs for data capture.

BARRIERS WORKSHEET

Client Name:					**ID:**			
Client Contact Info								
Date barrier identified	Barrier category	Details about barrier	Date of action	Action category	Details about action	# of minutes spent	Nav initials	Date barrier resolved

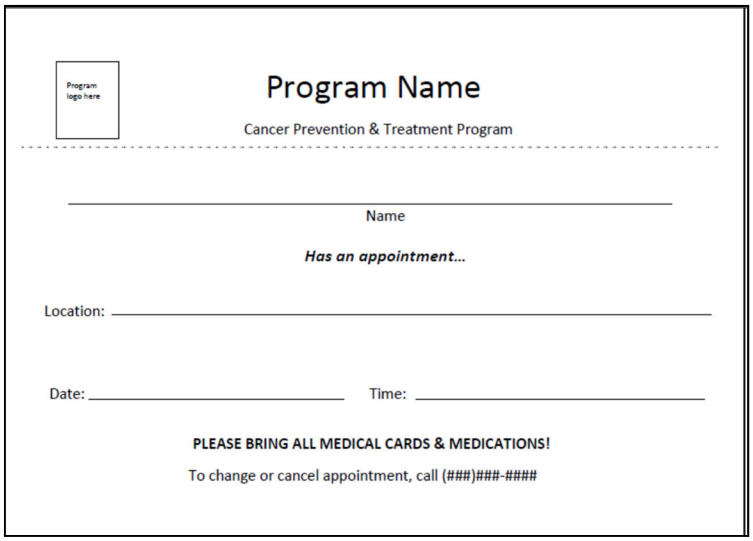
Barrier Categories	Action Categories
System barriers 1. No established primary care 2. Transportation (on-island) 3. Location of health care (off-island) 4. Housing during treatment 5. System problems scheduling care 6. System problems coordinating care 7. Lack of access to a specialist 8. System culture and practices 9. Staff beliefs and attitudes **Personal barriers** 10. Financial Difficulties 11. Difficult access to appropriate food 12. Disability/comorbidity 13. Treatment side effects 14. Unable to care for self at home 15. Costs: health care 16. Costs: medication/equipment 17. Employment issues 18. Internal psychology (anxiety) 19. Habitual unhealthy lifestyle 20. External psychosocial (isolated) 21. Health literacy/lack of information 22. Language 23. Cultural/personal beliefs and attitudes **Family barriers** 24. Childcare/family care issues 25. Housing 26. Other barrier (specify) _____	A. Assessed patient needs B. Introduced Navigation Services C. Coordinated health care appointment logistics (including screening and treatment) D. Discussed diagnosed disease and its treatment E. Coordinated education F. Educated patient G. Confirmed and/or assisted with health care insurance coverage H. Assisted with filling prescriptions or medical equipment request I. Coordinated with social services (e.g., for social support, behavioral health) J. Linked to community organization (e.g., for transportation, housing, childcare) K. Clinical trials notification L. Confirmed patient status and maintained relationship

For participants with positive screening results, the navigators inform the client's PCP of the abnormal test results and schedule an appointment with the PCP to review abnormal screening results. If the navigators are tasked to do so by their supervisor, they may also be asked to schedule additional diagnostic testing for the client, as needed.

If cancer is detected and there is no other assistance available to the client, the cancer navigator may continue to help the client with approval of the supervisor. This help might include following-up with the client and PCP to make sure the client understands the diagnosis and the plan of care. The navigator may then assist the client in identifying and overcoming barriers to receiving timely and appropriate cancer care, working with client, client's family, PCP, and oncologists to assure that the plan of care is completed.

The Implementation Guide includes a sample appointment reminder card, which should be tailored to your program. Appointment reminder cards are sent twice, one month and again one week prior to a screening appointment. Appointment reminder cards also may be used to remind patients with positive screening results about follow up tests and appointments. Some clients may also require the provider's telephone reminder.

Appointment Reminder Card sample



Step 5: Track Clients

The navigators endeavor to maintain a tickler file for clients with and without cancer to remind them of their future screening appointments. Reminder cards are sent one month and one week prior to a screening appointment. These may be followed by phone calls.

The navigators also enter all data into an Access® Database that is formatted to match the Intake Form. This allows navigators with hand-held devices containing the database to enter data directly as they conduct an intake/assessment and as they identify and address barriers. However, data may be collected on paper and entered later.

It should be noted that Dr. Linda Burhansstipinov has a grant from SBIR to develop an electronic database for use by cancer patient navigators (A Tool to Improve Evaluation of Patient Navigation Services in Underserved Populations, PI: Burhansstipanov, 1R43 MD011350-01). Once finished, this product would be an excellent choice for navigator programs, as it will allow for easy report writing, as well as data entry.

III. PROGRAM EVALUATION

Patient Satisfaction

Patient feedback is an important part of evaluating your patient navigation process. To ascertain satisfaction with patient navigation specifically and in enough detail to be meaningful, you may wish to incorporate a survey specifically to patients eligible for navigation services. Your organization will need to determine what questions to ask. You also will need to determine how and at which point to distribute the survey. Findings can help justify your program and identify ways to improve it.

Navigation Performance

You will need to report on who is doing navigation work, and metrics associated with the number of patients navigated, the barriers encountered and addressed, and what impact navigation services had on care delivered to cancer health disparities populations. Incorporating the metrics for navigation performance into the navigation data tracking tool will streamline this part of the evaluation process.

The laptop application being developed by Dr. Linda Burhansstipinov should be able to help you track navigation encounters and evaluate navigation performance (A Tool to Improve Evaluation of Patient Navigation Services in Underserved Populations, PI: Burhansstipanov, 1R43 MD011350-01).

Provider Satisfaction

You may also want to periodically conduct a survey of providers, asking what they think about the patient navigation services. Do they find them helpful? Do they have suggestions to improve your navigation process to better support your cancer patients in need? Your organization will need to determine the frequency of survey, and the scope of providers to survey.

For additional information on planning and adapting an evaluation, review the appropriate Modules for program implementation and evaluation from "Putting Public Health Evidence in Action".
http://cpcrn.org/pub/evidence-in-action/

For further assistance in designing and conducting an evaluation, consider communicating with members of NCI's Research to Reality (R2R) Community of Practice who may be able to help you with your research efforts. Following is a link to start an online discussion with the R2R community of practice, after completing registration on the R2R site:
https://researchtoreality.cancer.gov/discussions**.**