Standard Operating Procedure for COMMUNITY SERVICE NAVIGATION

**Owner:** AHCM Director & Navigation Program Manager

**Version:** 1.0

**Issue date:** TBD

**Revisions** (date, version, description): N/A

**Participants:** Community Navigators, Navigation Program Manager, Community Leads and AHCM Director

**Author:** Amy Gallagher, Laura Warner, Lynn Borup, Matt Teague, Megan Geraets, Sarah Robinson, Marnell Bradfield, Katryn Jantz, David Mok-Lamme

**PURPOSE**

This SOP describes the policies and procedures for Community Navigation, including how navigation-eligible Members will be contacted, what occurs during the first meeting, and procedures for follow-up meeting. Information regarding documentation and data collection is also included. Process improvement methods, as well as, program oversight and disciplinary procedures are addressed. Refer to the Appendix for copies of specific documents used by Community Navigators and navigation sites.

**INTENDED AUDIENCE**

- Navigation Program Manager will use the SOP to provide guidance on the implementation of community navigation.
- SOP will provide navigators with an overview the navigation program and their responsibilities within the program.
- SOP will provide CMMI a clear overview of the community navigation program for review and suggestions for improvement.
• To provide clinical providers a summary of the role, responsibility and function of community navigation within the AHCM.

**DEFINITIONS**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCM</td>
<td>Accountable Health Communities Model: RMHP’s specific model that covers 21 counties in Western Colorado</td>
</tr>
<tr>
<td>AHCM DN (also referred to as community navigator)</td>
<td>AHCM Designated Navigators are individuals embedded within communities who support navigation-eligible Members. Navigators must demonstrate core competencies to receive an AHCM designation.</td>
</tr>
<tr>
<td>Action Plan</td>
<td>A document developed by Community Navigator in response to navigation-eligible Member’s stated needs consisting of Specific, Measurable, Achievable, Relevant and Time-bound (SMART) goals that address specific barriers to health.</td>
</tr>
<tr>
<td>Assessment Interview</td>
<td>The patient/client-centered conversation that community navigators conduct during their first meeting to assess needs and create goals with Members.</td>
</tr>
<tr>
<td>Clinical Site</td>
<td>Primary care, behavioral health, hospital emergency department, labor &amp; delivery, or psychiatric unit.</td>
</tr>
<tr>
<td>Community Service Providers</td>
<td>Organizations partnering with the bridge organization to support the health service related needs of Members (excludes clinical delivery sites).</td>
</tr>
<tr>
<td>Community Leads</td>
<td>Regional leaders responsible for helping to organize and implement our model.</td>
</tr>
<tr>
<td></td>
<td>Ken Davis, Northwest Colorado Community Health Partnership</td>
</tr>
<tr>
<td></td>
<td>Cristina Gair, West Mountain Regional Health Alliance</td>
</tr>
<tr>
<td></td>
<td>Sarah Robinson, Mesa County Public Health</td>
</tr>
<tr>
<td></td>
<td>Rasa Kaunelis, Tri County Health Network</td>
</tr>
<tr>
<td></td>
<td>Laura Warner, Director of Health Promotion Services</td>
</tr>
<tr>
<td></td>
<td>Rusty Connor, Southwest Area Health Education Center</td>
</tr>
<tr>
<td>CommunityCare</td>
<td>The care coordination platform that will be provided to all navigators by RMHP.</td>
</tr>
<tr>
<td>CRN</td>
<td>Community Resource Network is the combination of our Health Information Exchange and Social Information Exchange operated by QHN.</td>
</tr>
<tr>
<td>Navigation-Eligible Member</td>
<td>Medicaid and/or Medicare with an identified social need and demonstrated two or more ER visits within the previous 12-months. For the purposes of AHCM, individuals who will be offered community navigation services are those who are high-risk beneficiaries.</td>
</tr>
<tr>
<td>Navigation Network Sites</td>
<td>Community-based organizations where Community Navigators are housed.</td>
</tr>
</tbody>
</table>
Navigation Program Manager

Individual responsible for coordinating the activities, ongoing training, and efforts of the Community Navigators working across the 21-county AHCM region.

Member

Proper noun describing individuals (Medicaid, Medicare-Medicaid, and Medicare Enrollees) served by the Accountable Health Communities Model.

QHN

Quality Health Network – Current Health Information Exchange vendor and entity responsible for administration the Community Resource Network that will serve as the technology backbone of our model.

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A. Developing an AHCM Navigation Network

1. Description: This section describes the process by which RMHP will identify and organize a broad network of Community Navigators through partnership and contracting with community partners.

2. Process:
Any interested navigator or organization that hires navigators may apply for Accountable Health Community Model Designated Navigation (AHCM DN) status on the condition that navigators meet core competencies. AHCM DNs will be hired by RMHP, clinical sites, and/or community service providers. AHCM DN core competencies include:

- Using Motivational Interviewing to support Members in the development of a SMART Action Plan to address un-met health related social needs.
- Working knowledge of community resources
- Meeting Members in their homes or the community location of the Member’s choosing
- Transporting Members to appointments
- Participating in AHCM DN collaborative learning process
- Use of a care navigation platform to send and receive data from Community Resource Network (CRN)
  - RMHP will provide CommunityCare and a CRN Interface to all potential AHCM DNs
  - Sites may use their own care platforms as long as the platform meets data interpretability and connectivity standards necessary to connect to QHN
- Willingness to access the CRN database to receive client referrals and other key information

To support non-RMHP hired navigators, RMHP will provide three levels of funding for community organizations:

1. Incentive Payments: Small payments to organizations that meet or are close to meeting the core competencies. Payments are made to encourage reporting and program fidelity.
2. “Bridge” Funding: A fixed payment to enhance the competencies of a navigator to meet the core competencies. For instance the funding of a vehicle lease for an organization that meets all core competencies except being able to transport Members to appointments.
3. “FTE Funding”: Funding provided to organizations to hire NEW navigator(s) who meet the core competencies. FTE funding will be limited to those areas that are underserved by existing navigation staff.

The AHCM Program Manager will work with Community Leads to identify potential navigators or navigator host cites. Potential individuals/sites will be encouraged to apply for the three funding opportunities outlined above (although all organizations may apply). Selected organizations will sign MOUs or contracts as appropriate to facilitate appropriate provision of navigation services to Members. Note: RMHP navigators will meet the core requirements and
receive the AMCM Designation, but will NOT receive funding from the AHCM grant for their work.

Quality Health Network will create an algorithm that assigns AHCM DN to Members based on geographic location. Automated referrals will be made by QHN for navigation-eligible Members to the appropriate navigation site. This functionality pre-exists in QHN through their “subscription alerts” functioning.

3. Required resources:
   - Quality Health Networks’ CRN
   - Existing care navigators
   - Funding (see three tiers above)
   - Care Management software (CommunityCare and CRN user interface)

4. Anticipated challenges and mitigation strategies.

<table>
<thead>
<tr>
<th>Challenge (example)</th>
<th>Description (example)</th>
<th>Mitigation Strategy (example)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing shortage</td>
<td>Availability of qualified staff to initiate activity</td>
<td>Implement a three-graded funding strategy to leverage existing navigation staff, improve the competency of navigators and provide staff to underserved communities</td>
</tr>
<tr>
<td>Navigators have difficulty meeting core competencies required for AHCM Designation</td>
<td>Many navigators who might otherwise with to participate may find data reporting or transportation requirements prohibitive</td>
<td>Funding will be provided to support navigators that have to change their set of services/competencies; CommunityCare will be provided to navigators free of charge</td>
</tr>
</tbody>
</table>

5. Responsible party: The Navigation Program Manager and AHCM Director will be responsible for recruiting, partnering, and contracting with AHCM DNs.

B. Contacting Navigation-eligibles Individuals

1. Description: The following describes the steps involved in connecting an eligible, high-risk Member who has accepted the offer of community service navigation support with the assigned Community Navigator. It also details the steps the AHCM DN will follow in order to connect with a navigation-eligible Member. This includes scheduling an in-person meeting in the event it is not possible to do so during time of screening.

• Step 1: During the screening, navigation-eligible Members are asked if they can be contacted by an AHCM DN to learn more about navigation services.

If the clinical site offers navigation services on site:
• Step 2 Option A: The same staff member will introduce the navigation-eligible Member to the AHCM DN in the clinic via a warm hand-off.
• Step 2 Option B: The clinic will support the navigation-eligible Member in setting-up an appointment with the AHCM DN.

In the event that a clinical site works with an off-site organization to provide community navigation, or the AHCM DN is unavailable, the following steps will be taken:
• Step 1: The staff member (or designee) who has been working with the navigation-eligible Member at the clinical site will help schedule an appointment with the AHCM DN before s/he leaves the office through a process unique to each community.
• Step 2: Whether or not an appointment is scheduled, the staff member who has been working with the Member will provide the Member with the name and contact information of the assigned AHCM DN on a tailored referral document. The template for this document is included as an appendix in the SOP for Screening and Navigation as well as in the Appendix of this SOP (attachment 1).

If the community navigation assessment interview cannot be scheduled while the navigation-eligible is in the office:
• Step 1: The AHCM DN will make three attempts to contact the navigation-eligible Member by phone within 48 business hours of the visit.
• Step 2: If those attempts are not successful, the AHCM DN will make an attempt to reach the navigation-eligible Member through flexible contact strategies. These may include email, text or, in some cases, a home visit, or letter.

3. Required resources:
* Cell phone - to contact navigation-eligible Members
* Laptop/tablet supported by care navigation software - for documentation
* Access to WI-FI/internet
* Fleet vehicle for home visits
* Access to office supplies (e.g. scanner/printer, paper/letterhead, envelopes, stamps, etc.)
* Funding for AHCM DN

4. Anticipated challenges and mitigation strategies.

<table>
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<tr>
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<tbody>
<tr>
<td>Staffing shortage</td>
<td>Availability of qualified staff to initiate activity</td>
<td>Implement a three-tiered funding strategy to leverage existing navigation staff, improve the competency of navigators and provide staff to underserved communities</td>
</tr>
</tbody>
</table>
Lack of Member interest | Members not wanting to participate in navigation services | When possible AHCM DN will be located within practices for warm handoffs; AHCM DN will offer to meet Members in their homes or in the community location of their choosing; Practice Transformation resources provided to clinical sites to facilitate proactive provider championing of navigation; Staff training to include Motivational Interviewing (MI) and other engagement techniques

Contact difficulties | Community navigator unable to contact navigation-eligible Members | AHCM DN will provide services in the community; Original communication will occur in the clinical setting where contact with the Member is already made

5. **Responsible party:** The Community Navigators will be responsible for executing this policy. The Navigation Program Manager and AHCM Director will be responsible for monitoring the success.

6. **Timing/frequency:** The initial interview will take place within two business days.

**C. Conducting the first meeting**

1. **Description:** The following describes the approach AHCM DN will use in the first meeting with the navigation-eligible, including conducting the assessment interview and developing the Action Plan.

2. **Process:**

   - Step 1: The Community Navigator schedule a first meeting with the eligible Member (see section B above).
   - Step 2: If possible, the Community Navigator drives to navigation-eligible Member’s home or other location of the Member’s choosing.
   - Step 3: Upon arrival, the Community Navigator will introduce himself/herself, find a place to sit and talk that is comfortable for the navigation-eligible, and start building rapport.
   - Step 4: While talking with the Member, the Community Navigator will make use of motivational interview techniques, keep boundaries and ethics in mind, and meet the individual where s/he is at (e.g. provide as much information as individual is able to consume).
     - A strengths-based approached to interviewing will be utilized (e.g. asking about strengths, supports, past successes, etc.).
     - Some individuals may be ready to start working together, while others may need ample time for rapport-building.
   - Step 5: Over the course of the meeting, which will typically last approximately one hour, the AHCM DN will engage the Member in a patient/client-centered interview and review the results of the Screening Tool. The review of the Screening Tool will drive the conversation toward discussions about Action Plan goals.
• Step 6: The Community Navigator will work with the Member to develop an Action Plan to address health related social needs
  o The Community Navigator will discuss positive results on the Screening Tool.
  o The Community Navigator will ask the navigation-eligible Member what goals they would like to set. The Community Navigator will support the Member in the development of SMART (specific, measureable, achievable, relevant, and time-limited). Barriers-to-completion, and steps for overcoming such, will also be discussed.
  o This process will be informed by, but no limited to, those health-related social needs flagged by the AHCM survey.
• Step 7: The goals of the first meeting are to:
  o Build positive report between a Community Navigator and Member.
  o Reviewed the Screening Tool through the use of a strengths-based interview.
  o Created an Action Plan with SMART goals.
  o Set up a second meeting, either in-person or telephonically, to check-in about Action Plan goals and/or to partner on the completion of those goals. Ideally, this meeting would take place within two weeks of the first in-person meeting.
  o Discuss communication preferences with the navigation-eligible Members in order to understand what method of communication will work best. If telehealth is an appropriate option for the navigation-eligible, the Community Navigator will make use of the EasyCare platform, helping the Member install the application on his/her phone or tablet.
• Step 8: Documentation: The patient/client-centered Action Plan will be entered into the Care Navigation platform and submitted to CRN.

3. Required resources:
   * WI-FI-enabled laptop/tablet for Community Navigator
   * CRN compatible care navigation platform
   * Vehicles for travel to Member’s home

4. Anticipated challenges and mitigation strategies.

<table>
<thead>
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<tbody>
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<td>Staffing shortage</td>
<td>Availability of qualified staff to initiate activity</td>
<td>Implement a three-tiered funding strategy to leverage existing navigation staff, improve the competency of navigators and provide staff to underserved communities</td>
</tr>
<tr>
<td>WI-FI access</td>
<td>WI-FI may not exist in places where Community Navigator meets with individuals, especially in some rural areas</td>
<td>Encourage WI-FI enabled meeting spots. Ensure Navigators are able to capture notes and action plan information while off-line.</td>
</tr>
<tr>
<td>Individuals without access to technology</td>
<td>Individuals who do not own a cell phone or other communication platform (email)</td>
<td>Distribution of technology via a broad campaign to ensure individuals eligible for lifeline phones receive them.</td>
</tr>
<tr>
<td>Individuals not familiar with technology</td>
<td>Individuals who have never owned or cell phone or laptop/tablet may be uncomfortable with telehealth options</td>
<td>Encourage trying new tech via MI techniques; provide technology to individuals</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Lost contact with navigation-eligible</td>
<td>This can be a population who is transient and not trusting of agencies</td>
<td>Using flexible contact strategies; MI training for staff; self-care training for staff</td>
</tr>
<tr>
<td>Navigation-eligible terminates relationship</td>
<td>Due to a variety of factors, Members may not want to continue working together with the Community Navigator</td>
<td>MI training for staff; self-care training for staff</td>
</tr>
</tbody>
</table>

5. **Responsible party:** The Community Navigators will be responsible for executing this policy. The Navigation Program Manager and AHCM Director will be responsible for monitoring the success.

6. **Timing/frequency:** Community Navigators will conduct first meetings within two-weeks of contacting navigation-eligible Members for navigation services. First meetings will take place over the course of about one hours. Follow-up meeting will occur within two weeks of the first meeting, either in-person, or telephonically.

D. **conducting follow-up meetings**

1. **Description:** This section details expectations of Community Navigators for following-up with Members on their Action Plans.

2. **Process:**
   - **Step 1:** Setting Expectations for Follow-Up: As part of the first meeting with Members, the Community Navigator will discuss the Member’s needs and develop with the Member a follow-up plan. Community Navigators may follow-up with navigation eligible Members for a minimum of once per month to a maximum of once per business day, depending on need and level of support requested by the Member. It is expected that navigation services will last between 3 and 12 months.
   - **Step 2:** Arranging Follow-Up Meetings: Community Navigators will discuss with the Member how they would like to schedule subsequent meetings. Follow-up meetings include checking in, reviewing goal attainment status, and providing assistance or support in order to accomplish the Action Plan tasks. For example, the Community Navigator might accompany Member to a low-income housing facility in order to submit an application or help the navigation-eligible learn how to shop for healthy food on a budget. To the maximum extent possible, a Community Navigator should always have a follow-up meeting scheduled with each navigation-eligible. Additional meetings may be scheduled before the already-scheduled meeting based upon navigation-eligible need.
   - **Step 3:** Goal Attainment - When the Member has achieved their stated goals, or in the event that the Member and Community Navigator determine that no further progress can be achieved through working together, the Community Navigator will arrange for a small celebration for the
Member’s “graduation” providing an acknowledgement of successes and positively terminate the relationship.

3. **Required resources:**
   - Graduation certificates
   - Petty cash for coffee or other graduation treat

4. **Anticipated challenges and mitigation strategies.**

<table>
<thead>
<tr>
<th>Challenge (example)</th>
<th>Description (example)</th>
<th>Mitigation Strategy (example)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost contact</td>
<td>Community Navigator loses contact with individual</td>
<td>MI to encourage engagement; self-care for staff</td>
</tr>
<tr>
<td>Difficulties graduating individuals</td>
<td>CN may feel attached to individual and/or continuously responds to crises of the week</td>
<td>Training about boundaries and guidelines for discharge provided</td>
</tr>
</tbody>
</table>

5. **Responsible party:** The Community Navigators will be responsible for executing this policy. The Navigation Program Manager and AHCM Director will be responsible for monitoring the success.

6. **Timing/frequency:** Navigation-eligible Members and Community Navigators will decide upon frequency together. It is assumed that navigation services will occur over three to twelve months at a frequency between once a month and one a business day.

E. **Collecting and Submitting Data**

1. **Description:** This section describes how and when Community Navigators will enter data into specific databases and what data needs to be available for the community navigation manager, AHCM Director, AHCM Steering Committee and Bridge Organization review on a regular basis.

2. **Process:**
   1. Provide care navigation platforms for AHCM DN to track action plans and record of contact
      a. Provide CommunityCare to navigators free of charge
      b. Provide a user interface for data entry through CRN (contracted through Quality Health Network)
      c. Work with navigators seeking to use their own navigation system to meet interpretability and connectivity standards for QHN
   2. Quality Health Network will create a centralized database of AHCM DN records that will be exported to RMHP to be submitted CMS on a quarterly basis.
3. **Required resources:**
   * Quality Health Network Databases
   * CommunityCare
   * Community Resource Network
   * Data Analysts

4. **Anticipated challenges and mitigation strategies.** Describe challenges likely to be encountered in this phase. This can be presented as a table or text.

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Description</th>
<th>Mitigation Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navigators don’t submit data</td>
<td>Navigators find the data reporting process and technology adoption onerous</td>
<td>Provide multiple options for data submission and work to leverage data infrastructure solutions that navigators have already adopted to intend to adopt (outside of the AHCM) to integrate AHCM data reporting requirements into other existing/planned workflows.</td>
</tr>
<tr>
<td>Challenges merging data</td>
<td>Allowing multiple modalities for data submission creates challenges for merging data and ensuring that data is compliant for CMS data submission</td>
<td>RMHP will work with QHN a leader in identifying and merging data across multiple data input sources. RMHP will also hire a AHCM Data Strategy and Analytics Lead to oversee the data management strategy.</td>
</tr>
</tbody>
</table>

5. **Responsible party:** The Data Strategy and Analytics Lead for AHCM will be responsible along with QHN to create data reporting systems and submitting data to CMS.

6. **Timing/frequency:** Ongoing starting May 1, 2018.

**F. PROCESS IMPROVEMENT**

1. **Description:** This section details how Community Navigators, Navigation Program Manager, navigation, and Community-Based Organizations will participate in continual process improvement for each of the Community Navigation components.

2. **Process:**

Data Used to Facilitate Process Improvement

- Step 1: Input from navigation sites – Quarterly, each site will:
  - Meet with the Navigation Program Manager, either in-person or telephonically
    - Provide examples of success stories
    - Provide examples of challenges
    - Provide suggestions for improvement
  - Complete a site survey (could have above info)
• Step 2: Input from Community Navigators – Monthly, every Community Navigator will:
  o Meet telephonically with Navigation Program Manager or on-site navigation supervisor
    ▪ Provide examples of success stories
    ▪ Provide examples of challenges
    ▪ Discuss ethical challenges

• Step 3: Input from Community Leads - During regularly scheduled meetings, Regional Community Leads will ask all local partners (e.g. Community-Based Organizations) about process implementation, improvement, and evolution.

• Step 4: Input from Community-Based Organizations - To evaluate the experience and outcomes of navigation services, community-based organizations will:
  o Participate in designing survey about community navigation. Survey questions will focus on community navigation process, satisfaction, outcomes, and overall experience.
  o Bi-annually, community-based organizations will answer survey, anonymously.

• Step 5: Input from Navigation-Eligible Members - To evaluate the experience and outcomes of navigation services, Members will:
  o Participate in designing a survey about community navigation. Survey questions will focus on satisfaction with navigation services, outcomes, experience of working with the Community Navigator, and whether the life changes are sustainable
  o Upon graduation, Members will answer survey, anonymously.

• Step 6: Quantitative measures (by county and navigation site) created quarterly:
  o Navigation penetration rate
    ▪ Numerator: Number of unduplicated Members provided with navigation.
    ▪ Denominator: Number of enrolled Members
  o Percent of Members with navigation needs
    ▪ Numerator: Number of unduplicated Members eligible for navigation services
    ▪ Denominator: Number of Members
  o Close loop navigation rate
    ▪ Numerator: Number of Members who are eligible for navigation and received navigation
    ▪ Denominator: Number of Members who are eligible for navigation

Quality Improvement Process:
Quarterly the data above will be aggregated into a single report and reviewed by the Navigation Program Manager, AHCM Program Manager, Community Leads, and Consortium to identify opportunities for growth in the navigation component of the ACHM. Clear action plans will be created to facilitate quality improvement and all action plans will have clearly defined and measurable outcomes. The Data Strategy and Analytics Lead for AHCM will help to identify and track outcomes of the quality improvement process.

3. Required resources:

* Information to build surveys
4. Anticipated challenges and mitigation strategies.

<table>
<thead>
<tr>
<th>Challenge (example)</th>
<th>Description (example)</th>
<th>Mitigation Strategy (example)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competition of surveys</td>
<td>Members or practices may not be interested in completing surveys.</td>
<td>Community Navigators will build report with Members and Practice Transformation team will building working relationships with practices to improve survey completion fidelity</td>
</tr>
</tbody>
</table>

5. Responsible party: The Navigation Program Manager is responsible for ensuring that regularly scheduled meetings with Community Navigators and navigation sites occur. Under guidance from the Navigation Program Manager and AHCM Director, Community-Based Organizations and navigation-eligible Members will be contacted to assist with survey development. Community-Based Organizations and Members are responsible for completing distributed surveys. The Data Strategy and Analytics Lead for AHCM is responsible for calculating quantitative measures.

6. Timing/frequency: Monthly requirements include Community Navigators meeting telephonically with the Navigation Program Manager. Quarterly requirements include navigation sites meeting telephonically with the Navigation Program Manager. Bi-annual requirements include Community-Based Organizations completing surveys.

**G. PROGRAM OVERSIGHT AND DISCIPLINARY PROCEDURES**

1. Description: This section details oversight and disciplinary procedures for Community Navigators regarding the following foci: interview, action plan, follow-up, data and reporting, ethics, performance, and overall professional conduct.

2. Process:

   Part A – Personnel Oversight
   - Step 1: Each navigation site will designate a supervisor responsible for navigation program development and execution.
   - Step 2: The AHCM Director and Navigation Program Manager will review at least 10 navigation charts each quarter. These will be randomly generated.
   - Step 3: The AHCM Director and Navigation Program Manager will discuss concerns or discrepancies. Blinded examples of strong charts may be used for training purposes.
• Step 4: In the event that a major issue is identified within a chart, the Navigation Program Manager will have a collaborative conversation about the issue, with the Community Navigator. Additional training will be provided and an informal resolution plan will be developed.
• Step 5: If the problems persist, through consultation with the Navigation Program Director, the AHCM Project Lead will write a formal corrective action plan and ask that the navigation site work with the Community Navigator to correct the issue.
• Step 6: If the corrective action plan is not successful, the Navigation Program Manager will work with the AHCM Steering Committee to determine next steps.

Part B – Navigation Oversight

• Step 1: The Navigation Program Manager will conduct monthly telephone calls (e.g. group supervision) with the Community Navigators to address the following:
  o Success stories
  o Challenges
  o Ethical situations
  o Documentation
  o Resources
  o Self-care
  It should be noted that the number of Community Navigators will dictate the number of group supervision calls (e.g. each call should have no more than 6-8 participants to be effective).
• Step 2: The Navigation Program Manager will conduct individual, monthly telephone calls with the Community Navigators to address the above.
• Step 3: The Navigation Program Manager and designated personnel at the navigation sites will have open-door communication in order to address questions, concerns, or challenges in execution the navigation program.

3. Required resources:
   * Navigation Program Manager and AHCM Director will need scheduled time to review charts
   * Navigation Program Manager needs correct contact information for each Community Navigator
   * For fidelity purposes, a standard review tool for charts is necessary

4. Anticipated challenges and mitigation strategies.

<table>
<thead>
<tr>
<th>Challenge (example)</th>
<th>Description (example)</th>
<th>Mitigation Strategy (example)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charts not consistent</td>
<td>Due to multiple Community Navigators across multiple agencies,</td>
<td>Increased training around documentation; use strong examples of charts as models; Hire Navigation manager to provide consistency across navigation staff</td>
</tr>
</tbody>
</table>
5. **Responsible party:** The AHCM Director and the Navigation Program Manager are responsible for conducting chart audits and intervening with Community Navigators demonstrating minor discrepancies. In the event of a major issue, the AHCM Steering Committee may provide suggestions. The navigation sites may also provide corrective support.

6. **Timing/frequency:** At least 10 charts will be audited each quarter. Disciplinary actions, as described above, will occur as necessary.
APPENDICES

Include additional documents/templates (for example, forms, samples, outlines, etc.) when applicable/relevant. Provide a list of items included below and include those items within the subsequent pages.

1. Template for Referral to Community Service Navigation
2. Action Plan Template

Example Template for Referral to Community Service Navigation

Date:
Patient Name:

You are able to get help from a Community Navigator to help you with your needs. This is part of something many groups are doing called the Accountable Health Communities Model.

Your Community Navigator can help you set goals, make plans, and find different resources for you.

Here is the contact information for your Community Navigator:
Name:
City, State
Phone Number
Email Address

If today is not a good day to meet your Community Navigator, s/he will try to contact you within two business days. You are welcome to call the Community Navigator.

If you and your Community Navigator have trouble contacting each other, please let us know! We can help!
Contact Information for site designee.
2. Example Action Plan Template

<table>
<thead>
<tr>
<th>Name: ______________________________</th>
<th>Date: ____________</th>
</tr>
</thead>
</table>

**Goal #1:**
S
M
A
R
T

**Things that could get in the way of meeting my goal:**

**Things I can do to solve the problems:**

**Goal #2:**
S
M
A
R
T

**Things that could get in the way of meeting my goal:**

**Things I can do to solve the problems:**

**Goal #3:**
S
M
A
R
T

**Things that could get in the way of meeting my goal:**

**Things I can do to solve the problems:**

**Next appointment date:** ______________________

Circle: Phone Face-to-Face Meeting Space: ______________