# Appendix Summary and Planning Forms

☞ **This is an example from ARC program. Please adapt it for your setting**

ARC
Access to Resources in the Community
Accès aux ressources communautaires

## Patient Summary and Planning Forms

***Complete the forms Section 1-8 during the first encounter with the patient***

**Patient's name: _____**

**Study ID number: _____**

**Date of first meeting: _____**

**Patient's postal code: _____**

### 1. Patient Needs Identified on the Referral Form

a) Start the conversation by using the active offer *Bonjour /Hi*

b) Ask the patient if they received a copy of the Referral Form. Review the form with them.

c) Ask the patient to share with you their understanding of their health and/or social needs and associated resources (when applicable) that were identified on the form.

d) In the table below, list the needs discussed by the patient and their primary care provider [PCP].

e) Ask the patient: *Have you used any community resources before? How can I help you make use of services available in your community?"*

f) If more than one need is listed on the referral form, help the patient identify their priorities by asking them to attribute importance on a scale of 1-10 for each need.

### 2. Priorities

| **Patient Needs** | **Priority: Importance 1-10**<br>1=not important<br>10=very important |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |

List patient's questions about their needs and how these will be addressed (i.e., potential community resources)

_____

_____

_____

_____

_____

_____

### 3. Patient preferences/ expectations for CR

*Ask the patient the language, time, and area in which they would prefer the service(s) to be offered, whether the cost of a service would prevent them from being able to use it, and whether they have funding assistance.*

Language: ☐ French ☐ English ☐ Other_____

Availability: ☐ AM ☐ PM ☐ Evenings ☐ Weekends ☐ Other _____

Location/area: _____

Free/low cost/other: _____

Funding assistance: ☐ Ontario Disability Support Program (ODSP) ☐ Personal health insurance

☐ Other_____

Did they express interest in a specific program/class? *(Describe).*

_____

_____

_____

_____

### 4. Barriers to access potential [CR]:

Ask the patient: *"What concerns might keep you from getting to a community resource?"*
Refer to list of possible barriers below to help patient identify their concerns.

| Barriers[1] | Needs |
|---|---|
| ☐ Financial issues | |
| ☐ Confusing paperwork (e.g., application for accessible transportation) | |
| ☐ Appointment scheduling | |
| ☐ Transportation problems (e.g., winter weather, need for accessible transportation/ volunteer driver) | |
| ☐ Caregiver needs (e.g., childcare, elder care) | |
| ☐ Primary language other than French or English | |
| ☐ Finding a resource in French or in language of choice | |
| ☐ Literacy: difficulty understanding health information | |
| ☐ Cultural preferences (e.g., effect on health choices) | |
| ☐ Social support | |
| ☐ Motivation (readiness to access) | |
| ☐ Not comfortable with accessing community resources | |
| ☐ Knowledge (e.g. does not know where to go in the community for resources/services) | |
| Other: | |

[1] Adapted from:

- Kansas Cancer Partnership. (2009). Cancer patient navigation program toolkit. http://www.cancerkansas.org/
- Mead et al. (2015). Lay navigator model for impacting cancer health disparities. *Journal of Cancer Education, 29*(3), 449-457. Natale-Pereira, A. et al. (2011). The role of patient navigators in eliminating health disparities. *Cancer, 117,* 3543–3552.

### *5.* Motivation to Access potential Community Resources

In the table below, list potential [CR] to address patient needs.

a) Ask the patient: *"On a scale of 1-10, with 1=not motivated and 10=very motivated, how motivated are you to access the community resource?"* List their response under: **Motivation to Access.**

b) In the final column, identify if the patient agrees to pursue a community resource identified by the navigator.

| **Potential [CR] to address patient needs** | **Motivation to Access**<br>1-10<br>1=not motivated<br>10=very motivated | **Patient agrees to pursue a [CR]**<br>Y=yes<br>N=no |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |

**Personal Motivation**

Ask the patient: *"What are some of the factors that would help to increase your motivation?"* Prompts: confidence, support from others, ability to accomplish your goal.

_____

_____

## 6. Preparation for Action Plan

The action plan should identify the navigation activities required to access [CR]. The plan should identify what the patient and what the navigator commits to doing.

☐ Patient requires additional information on the health issues related to the need(s) identified on the referral form. ***Inform PCP and refer patient to PCP.***

☐ Provide Ontario 211 promotional material (e.g., business card, bookmark, etc.)

| Navigator Activities to Address Patient Barriers | Identified needs |
|---|---|
| ☐ Emotional support: express care or concern, reassurance, encouragement | |
| ☐ Instrumental support: provide guidance to assist patient in accessing community resource (e.g., accompaniment) | |
| ☐ Arrange transportation | |
| ☐ Communicate with [CR] staff | |
| ☐ Make appointment(s) | |
| ☐ Provide/organize translation | |
| ☐ Research new [CR] | |
| ☐ Provide administrative support (e.g., complete forms) | |
| ☐ Help patient access funding | |
| ☐ Provide information on [CR] | |
| ☐ Link to financial resources | |
| ☐ Identify culturally appropriate [CR] | |
| ☐ Arrange caregiver service (e.g., child-care, elder-care) | |
| ☐ Accompany patient to [CR] | |
| ☐ Advocate (e.g., to a community program to provide French Language resources) | |
| ☐ Empower patient | |
| ☐ Other | |

## 7. Patient Activities

List what actions the patient will take to access the community resource(s) (e.g. contact caregiver to arrange childcare, discuss resource options with family, obtain funding forms for navigator to complete).

| Patient Activities | **Timeline** |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

## 8. Set – up Follow-Up

Clarify that you will be contacting the patient to discuss their progress and ability to access and use the community resource(s). Set up the next contact with the patient (telephone, in person, email, date).

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