ITEM	THEMES	ENTRY [knowledge & comprehension]	INTERMEDIATE [application & analysis]	ADVANCED [synthesis & evaluation]
DEFINITIONS		One to two years or equivalent experience. Starting a new position without experience in navigation and builds on resources for addressing barriers (logistical, economic, cultural & linguistic, communication, and provider centered) and basic Oncology Patient Navigator-Certified Generalist (OPN-CG) principles to guide practice.	Two to three years or equivalent to such effort. Possesses a basic understanding of patient care flow within job boundaries, matching resources to the unique needs of the patient, identifying resources lacking in the community of care, beginning to analyze needs and gaps, and exploring/collaborating with multidisciplinary team members to advocate for resources for unmet needs for community or clinical setting.	Four or more years. Skilled in the ability to perceive patient situations holistically based on past experiences, focusing in on the unique aspects of the patient assessment, and uses critical thinking and decision-making skills pertaining to navigation processes.
I. Domain: Ethical, Cultural, Legal, and Professional Issues – Process (How)				
Competency: Demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to respecting				
		Entry	**Intermediate**	**Advanced**
I.1	Confidentia-lity	Maintain patient confidentiality and privacy when working with clinical and professional staff both within and outside of systems of care and community-based programs.	Demonstrate patient confidentiality and privacy when working with clinical and professional staff both within and outside of systems of care and community-based programs.	Enhance processes to ensure patient confidentiality and privacy when working with clinical and professional staff both within and outside of systems of care and community-based programs.
I.2	Assessment & Record Keeping	Be cognizant of all assessments and record information that contributes to a patient's needs, priorities and preferences.	Use assessment information to follow plans to address health and related patient needs in cooperation with the patient and based on patient priorities. Identify and collect data on key process metrics.	Develop, maintain, and utilize an organizational system to record and update healthcare, cultural relevance, health literacy, and linguistically appropriate resources for patients and their communities.

		Entry	Intermediate	Advanced
I.3	Help & Referral	Recognize when to help and refer the patient navigate to appropriate health care.	Assist the patient in navigating to appropriate health care by assessing and referring patients to appropriate, culturally-relevant experts to assist with ceremonies or special services beyond one's personal level of expertise.	While (and after) the patient is receiving appropriate health care, collect interview or survey data in a culturally-competent manner that complies with the given methodological design of the protocol.
I.4	Cultural Knowledge & Behaviors	Develop, maintain, and utilize an organizational system to record and update healthcare, cultural relevance, health literacy, and linguistically appropriate resources for patients and their communities. Collect data and share with the organization leadership.	Demonstrate culturally-respectful behaviors when assisting patients with ceremonies or special services (that are pertinent to the patients' cultural healthcare values, beliefs, and practices).	Implement cultural knowledge and sensitivity in all aspects of work, including: (1) seeking to understand and acting in accordance with specific cultural norms when appropriate; (2) awareness of potential bias in one's own culture and life experience; and (3) awareness of the influence of diverse beliefs and practices on thinking and behavior across cultures, communities, and organizations.
I.5	Privacy Laws & policies (HIPAA)	Ensure documentation complies with applicable privacy laws and policies (e.g., Health Insurance Portability and Accountability Act [HIPAA]).	Develop documentation that complies with applicable privacy laws and policies (e.g., Health Insurance Portability and Accountability Act [HIPAA]).	Implement policies that ensure documentation complies with applicable privacy laws and policies (e.g., Health Insurance Portability and Accountability Act [HIPAA]).
I.6	Behavior Change	Understand reasons for health behavior change and patient options.	Adapt to behavior changes and patient options in a culturally-sensitive manner and be able to coach a patient through a behavior change.	Utilize motivational interviewing skills to effectively navigate behavior changes from patients in a clturally-sensitive manner.
I.7	Respectful Behavior	Respect patients' privacy and modesty (e.g., during a pap smear, some patients may prefer to maintain wearing a blouse or shirt).	Demonstrate the ability to identify and suggest alternatives that respect patients' privacy and modesty (e.g., during a pap smear, some patients may prefer to maintain wearing a blouse or shirt).	Proactively advocate for varying ways to respect patients' privacy and modesty (e.g., during a pap smear, some patients may prefer to maintain wearing a blouse or shirt).

		Entry	Intermediate	Advanced
I.8	Health Equity	Understand and identify ways that PN roles can increase health equity practices throughout the cancer continuum.	Describe ways PN roles and strategies can promote health equity throughout the cancer continuum.	Demonstrate and implement behaviors that enhance health equity behaviors while interacting with patients throughout the cancer continuum.
II. Domain: Client and Care Team Interaction - Process (How) **Competency: Apply insight and understanding concerning human emotional responses to create and maintain positive interpersonal interactions leading to trust and collaboration between patient/client/family and the healthcare team. Patient safety and satisfaction is a priority.**				
		Entry	Intermediate	Advanced
II.1	PN Role & Function	Understand PN role within team and explain role and function to clinical/research staff, patients, families, and partners (e.g., community based, clinic, research, academia, and other audiences).	Explain role and function of PN to various colleagues and stakeholders and tailor the description based on the audience.	Advocate for PN role sustainability among providers, administrators, stakeholders and funders.
II.2	Traditional Cultural Care	Learn about and respond to specific traditional/cultural care patients may use or prefer.	Integrate specific traditional/cultural care patients may use or prefer and work with health care team to accommodate practices.	Advocate and be proactive in preparing healthcare team to accomodate traditional/cultural care patients may use or prefer to improve the effectiveness of services provided.
II.3	Patient Barriers & Solutions	Participate in health care team discussions about ways to address patient barriers and improve overall patient care.	Participate in health care team discussions and collaborate with collegues and partners about ways to proactively address patient barriers and improve overall patient care.	Participate in health care team discussions and program planning to advocate / proactively address patient barriers and improve overall patient care at the community/system level.
II.4	Identifying Barriers	Assist patients in idenifying and documenting patients' barriers and services needed.	Document barriers and services needed for care coordiantion.	Follow-up with oncology team for resolution of barriers.

		Entry	Intermediate	Advanced
II.5	Forms & Documen-tation	Collaboratively and accurately complete required forms with patients, attaching required documentation, and submit to appropriate programs, staff or organizations (ex. needs assessment, stress-distress surveys).	Collaboratively and accurately complete required forms with patients, attaching required documentation, and submit to appropriate programs, staff or organizations. (note: higher level, advanced forms, e.g., SCPs, efficient use of tools based within technology).	Collaboratively and accurately complete required forms with patients, attaching required documentation, and submit to appropriate programs, staff or organizations. Analyze/interpret survey findings to share trends with the health care team, administrators, stakeholders and funders.
II.6	Resource Access	Identify and share appropriate information, referrals, and other resources to help individuals, families, groups, and organizations meet their respective needs. Help patients complete applications to access support resources and organizations.	Assist patients with follow-up with support programs from supporting organizations.	Build relationships with supporting organizations and maintain a good relationship with all stakeholders and organizations involved in supporting the patient treatment as they walk through survivorship.
II.7	Emotional Support	Provide emotional support regarding healthcare decisions. Recognize when to refer out and identify appropriate community and clinical resources for social, emotional, cultural support and related issues (language).	Demonstrate skill in navigating emotionally-charged or high stake issues with other healthcare professionals, staff, patients and families. Demonstrate skill in linking individuals and families to appropriate community and clinical resources.	Model competence in navigating emotionally-charged or high stake issues. Advocate for patients' healthcare needs and decisions when interacting with healthcare professionals and systems of care.
II.8	Social Determi-nants of Health (SDOH)	Demonstrate an awareness of the social determinants of health and knowledge of referral sources to address social needs.	Identify how the social determinants of health (poverty, transportation, safety, housing, etc.) impact a client's ability to access health care at the individual, family, and community level. Demonstrate knowledge of referral sources to address social needs.	Recommend ways that organizational practices can address the social determinants of health (e.g. food deserts, violence, poor infrastructure) at the individual, family, and community level.

		Entry	Intermediate	Advanced
II.9	Cultural Assets	Learn and identify the cultural assets of patients and community members using a strengths-based perspective.	Integrate and expand understanding of cultural assets of individuals, families and community.	Understand and effectively communicate cultural assets of patients, families, and community with providers, stakeholders and funders.
II.10	Social justice	Identify racism and privilege that influence health disparities.	Identify and combat racism and privilege that influence health disparities. Understand the relationship between public health and social justice.	Work to combat racism and privilege that influence health disparities. Using a public health perspective, understand the role of policy change in health promotion and disease prevention.

III. Domain: Health Knowledge – Content (What)

Competency: Demonstrates breadth of health, the cancer continuum, psychosocial and spiritual knowledge, attitudes and behaviors specific to their PN (clinical/licensed or non-medical) role.

		Entry	Intermediate	Advanced
III.1	Use of Knowledge	Obtain basic knowledge of disease. Identify key providers/caregivers with specialized disease knowledge with whom the navigator will collaborate for patient support. Use standard knowledge of basic health and social indicators.	Based on knowledge of the disease, help the patient identify personal strengths and problem-solving abilities Conduct Stress Distress Scales or Surveys (SDS), symptom/side effects and /or risk assessments and based on results, identify plan of actions, alternatives and solutions to understand and manage health conditions and treatment options. Help patient identify goals, barriers to change, and supports for change, including eliciting personal strengths and problem-solving abilities. Mentor and onboard new navigators and provide education about role to healthcare team members. Discover new things to expand knowledge. Formulates and tests theories.	Implement and evaluate the plan of action to address disease and/or treatment side effects / symptoms. Share knowledge about treatment, side effects and similar findings to other PNs and professions during meetings, conferences, symposia, tumor boards, etc. Provide education, mentor and supervise new navigators and healthcare team members. Seeks knowledge by asking questions with the intent to solve practical problems.

		Entry	Intermediate	Advanced
III.2	Patient / Caregiver Education	Provide culturally sensitive patient education and coaching. Develop listening skills and ask open ended questions. Interpret and summarize information that is being given or handed to the patient by health care providers.	Establish accountability and negotiate responsibilities with the patient and or healthcare team/family to complete plans of actions and fulfill healthcare needs (e.g., wellness care plans, integrative health coaching). Provide and explain credible online and print materials that are culturally-appropriate and at the patients' health literacy levels to facilitate learning.	Identify gaps in patients' knowledge regarding how to self-manage their health conditions. Anticipate and educate patients on the potential physical, psychological, social and spiritual impacts of cancer & treatments.
III.3	Healthcare System Basics	Identify fundamentals of health systems operations & continuum of cancer care. Identify financial burden and how to assist patient regarding healthcare payments, insurance, & financial assistance. Document encounters following HIPPA guidelines. Demonstrate ability to negotiate across health care systems providing care to the patient.	Effectively use coaching techniques (e.g., teach-back, demonstration, motivational interviewing, strength-based statements, role playing, discussing healthcare language) to maximize the patient's learning and skill transfer.	Participate as a member of the multidiciplinary team at meetings, tumor boards, huddles, etc. with a focus on being an advocate for the patient. Assumes leadership roles within and an outside ot the organization, examples include acting as commitee chair, facilitating workgroups, delivering professional presentation, and mentoring upcoming navigators.
III.4	Prevention	Collaboratively and accurately complete required forms with patients, attaching required documentation, and submit to appropriate programs, staff or organizations (needs assessment, stress-distress surveys). Explain the principles of public health and its relevance for helping patients, their families, and the community.	Ability to facilitate educational discussion the navigator must be able to integrate and apply knowledge of cancer pathophysiology, disease process and treatments.	Present pertinent information in a manner that is perceived as culturally and linguistically relevant to patients and their families. Proactively advocate for patient at high risk for cancer or treatment adherance.

		Entry	Intermediate	Advanced
III.5	Empathy	Identify the difference between sympathy vs. empathy. Recognize boundaries with patient and care givers while providing emotional support. Identify appropriate support personal and when to facilitate involvement in the patient care.	Facilitate support groups for patients and/or caregivers. Provide direction of support services to patients and caregivers.	Identify social determinants of health that may impact adherance to healthcare services and provide interventions proactively to support the patient and caregiver.
VI. Domain: Patient Care Coordination – Process and Content (How and What) **Competency: Participates in the development of an evidence-based or promising/best practice patient-centered plan of care, which is inclusive of the client's personal assessment and health provider/system and community resources. The PN acts as liaison among all team members to advocate for patients in order to optimize health and wellness with the overall focus to improve access to services for all patients. PN conducts patient assessments (needs, goals, self-management, behaviors, strategies for improvement) integrating**				
		Entry	Intermediate	Advanced
IV.1	Patient Needs (General)	Assess clinical, emotional, spiritual, psychosocial, financial and other patient needs.	Implement strategies that assist patients in identifying and prioritizing their personal, family, and community needs for new resources.	Develop relationships with relevant agencies and professionals in patients' communities to secure needed care and relevant local, state and federal organizations/ resources to address health needs and inequities.
IV.2	Patient Needs (Insurance)	Obtain and share up-to-date information about health insurance programs and eligibility, public health and social service programs, and additional resources to protect and promote health.	Gather and integrate information from different sources better to understand patients, their families and their communities. Sources may include--but are not limited to--performing interviews and researching community resources and conditions and participating in peer-reviewed publications describing the specific population.	Apply financial assessment that gauges a patient's ability to achieve the best possible outcome with the least possible financial burden is a core component of navigation services.

		Entry	Intermediate	Advanced
IV.3	Patient Advocacy (General)	Advocate on behalf of patients and communities, as appropriate, to assist them and relevant others to attain needed care or resources in a reasonable and timely fashion. Develop a network to support the navigator and patient. Identify barriers to care and support to eliminate barriers.	Provide information and support for patients to advocate for themselves over time and to participate in the provision of improved services.	Lead and/or undertake an active role in community and agency planning to bring needed resources into the community.
IV.4	Patient Advocacy (Self-determina-tion)	Provide support for patients to follow professional caregiver instructions or advice. Provide support, information, and referrals to caregivers.	Advocate for patients' self-determination, personal motivations, and dignity.	Lead efforts to identify gaps in community resources, collaborate with other service providers, and inform policymakers.
IV.5	Medical Appointment s & Follow-Up	Schedule medical appointments on behalf of patients when appropriate. Accompany patient to appointments when appropriate. Guide patients in getting prescriptions fillied and accessing their medications.	Screen patients for issues associated with their emotional wellbeing, distress, stress level, and anxiety, and provide resources as needed to reduce these stressors.	Employ techniques for interacting sensitively and effectively with people from cultures or communities that differ from one's own (e.g., demonstration of cultural humility in instances when cultural competence is not possible).
IV.6	Follow-Up Care	Monitor, follow-up and respond to change of care plan(s).	Employ a formal tool to assess risk/acuity. Re-evaluate and update assessment regularly.	Tailor assessment tools to identify and address unique risks and/or opportunities that consider cultural and linguistic needs and opportunities.
IV.7	Patient Documenta-tion	Collaboratively and accurately complete required forms with patients, attaching required documentation, and submit to appropriate programs, staff or organizations.	Conduct education to ensure patient understands consent or other forms needed to provide quality care.	Inform the development of forms and other documentation that use health literacy best practices to maximize patient understanding

		Entry	Intermediate	Advanced
IV.8	Care Coordina-tion (Internal)	Provide information and support for people in using internal agency and/or institutional services.	Apply information from patient and community assessments to develop and/or better use existing health education resources and/or strategies.	Apply assessment information to create and implement holistic approach to support patients and their families (may include participating in peer-reviewed publications describing successful practices and outcomes).
IV.9	Care Coordina-tion (External)	Provide information and support for patients in using external community services and resources.	Coordinate one's roles with other local programs to prevent duplication of services.	Participate in community coalitions and/or other opportunities to coordinate services and reduce redundancies.
IV.10	Quality Improve-ment	Provide information to agency or institution quality improvement initiatives about patients served, when appropriate	Engage in quality improvement initiatives.	Take leadership in identifying quality improvement opportunities, and designing and evaluating outcomes in patients and caregivers
IV.11	Clinical Trials	Inform patients about clinical trials and share information regarding appropriate clinical trials.	Provide referrals for clinical trials.	Collaborate with clinical trials staff to coordinate patient education and documentation on clinical trials enrollment
IV.12	Culturally Competent Care Coordina-tion	Identify clinical trials resources and/or education within agency and distribute to patients	Regularly inform patients about culturally or linguistically appropriate services and resources in agency.	Advocate for and promote the use of culturally and linguistically-appropriate services and resources within organizations and with diverse colleagues and community partners.

		Entry	Intermediate	Advanced
V. Domain: Practice-Based Learning **Competency: Optimizes navigator practice through continual professional development and the assimilation of scientific evidence to continuously improve patient care, based on individual PN gaps in knowledge, skills, attitudes and abilities.**				
		Entry	**Intermediate**	**Advanced**
V.1	Education & Training	Complete competency based PN education or training. Identify mentor, request opportunity to shadow an experienced navigator. Request to shadow providers/social workers/genetic counselors in clinic and listen in on patient encounters. Pursues personal ongoing continuing education on navigation, community resources and specific oncology education needs.	Document continuing education (webinars, CEUs during PN conferences) to expand navigation skills. Network with other navigators and share best practices. Seek Certifications and more expertise by narrowing down an area of focus.	Obtain certification for navigation skills and other disciplines and specialities. Mentor new navigator, present at conferences, meetings best practices. Work more in the capacity of a consultant haven built expertise over the years.
V.2	Roles	Identify roles appropriate for PNs, including identifying barriers to care and connect to community resources. Communicate PN roles and responsibilities to stakeholders. *[NOTE: Think of language that clearly delineates role of navigator - not house cleaning, market shopping, photocopying, and other extraneous roles that are not appropriate for PN at any level) within community and clinical setting(s)*	Implement and clarify appropriate PN boundaries based on patient case studies and can describe strategies to help patient and members of healthcare team understand what does and does not fit within PN roles, including reviewing and editing job descriptions.	Collaborating with other members of the healthcare team to improve patient care. Evaluate the role of the PN as a member of the healthcare team and evolve to support best evidence-based practice. Write job description and help draft policies the governing role of PNs.

		Entry	Intermediate	Advanced
V.3	Privacy, Respect & Legality	Recognize and understand system policies and procedures around confidentiality and privacy. Complete ethics training and recertification related to maintaining patient confidentiality, privacy, and legality. Understand actions that may be illegal or discriminatory, such as sharing HIPAA protected information.	Obtain training that assists with documentation and follow-up on issues related to abuse, neglect, and criminal activity that may be reportable by law and under regulation according to agency policy and report activities when required.	Intervene when confronted with illegal or inappropriate (e.g., privilege, racism) situations in professional manners
V.5	Patient Goals	Identify and document patient goals and communicate with the provider treatment team.	Assist the patient in developing a strategic plan for attainment of personal goals	Evaluate the process for supporting the patient in attaining personal goals and recommend improvements to the navigation processes
V.6	Quality Improve-ment	Identify what comprises quality improvement for the patient	Engage in quality improvement initiatives.	Analyze existing quality improvement initiatives and create new initiatives

VI. Domain: Systems-Based Practice

Competency: Advocate for quality patient care by acknowledging and monitoring needed (desirable) improvements in systems of care for patients from enhancing community relationships and outreach through end-of-life. This includes Enhancing community relationships, developing skills and knowledge to monitor and evaluate patient care and the effectiveness of the program.

		Entry	Intermediate	Advanced
VI.1	Advocacy	Advocate for care for patients. Define the role of an “advocate”. Utilize Distress Screening tool and NCCN's Problem List.	Provide care coordination, including basic care planning (prepare questions to ask provider, treatment options clarifications) with individuals and families based on engagement and needs assessments, and facilitate care transitions.	Share community assessment results with colleagues and community partners to inform planning and health improvement efforts.

		Entry	Intermediate	Advanced
VI.2	Knowledge of Resources	Knowledge of existing local, state, and national patient advocacy groups. Create and keep updated a list of key providers and contacts in your region that you can refer patients/caregivers	Become a member of community advisory group, task forces, workgroups. Network with mental health professionals and specialists in cancer support in your health system and beyond. Provide case studies describing use of the PONT Standards of Practice, program strategies, and best practices and lessons learned serve as valuable tools to inform sustainability for the PN movement.	Participate on internal and external system-wide cancer committees, including work groups, cancer alliance, and state cancer coaliations.
VI.3	Toolkits & Resources	Identify appropriate toolkits and resources to assist them in their functions as PNs . Create a document with resources that can be updated	Use PN repository of tools that are appropriate to their populations and help augment and expand toolkits related to system-wide care coordination	Have a leadership role in updating and refining toolkits and resources
VI.4	Community Advisory Council	Become a member of the Community Advisory Council and grow membership	Assume roles in Community Advisory Council (e.g., chair of a sub-committee)	Facilitate Community Advisory Council
VI.5	Cultural Compe-tency	Identify what culturally appropriate behavior is for diverse, underserved populations	Shadow and integrate cultural sensitivity in all patient and healthcare team interactions throughout cancer continuum (e.g., Diversity and Inclusion)	Demonstrate cultural knowledge and sensitivity for diverse and underserved patients through supervisor's on-site observation.
VI.6	Documenta-tion	Document PN tasks within the system's database. Document and track information using a database or electronic medical record. Track, document and report both externally and internally-relevant PN activities for internal administration and funders.	Utilize an existing database of the health site and update data quarterly. Use journals, diaries, one-on-one sections, call recording, video interviews /sections. Identify factors that affect health and resources that will benefit community members.	Analyze and report to leadership PN documentation. Ability to collect, document, and report information in compliance with specifications within grant awards. Formulate and test theories. Use both quantitative and qualitative data in developing and evaluating program priorities.

		Entry	Intermediate	Advanced
VI.7	Outreach	Knowledge of community- and clinic-based outreach workers within your health care system. Bring information and services to communities where patients reside, including where they work and spend their time (e.g., grocery stores, parks).	Coordinate with local, regional outreach programs. Use outreach methods to engage individuals and groups in diverse settings including underserved and rural populations.	Implement outreach plans based on individual and community strengths, needs, and resources, all of which are developed in collaboration with other stakeholders. Examples include creation of a webinar and delivery to both communities and patients to create awareness and guidance.
VI.8	Needs Assessment	Assist with local and health care system community needs assessments and review previous years' assessments for content.	Conduct baseline and on-going needs assessments of communities and their members with clearly defined goals and objectives.	Analyze and report community priorities (based on local needs assessment) to leadership PN documentation

VII. Domain: Communication/Interpersonal Skills

Competency: Promote effective communication and interactions with patients in shared decision making based on their needs, goals, strengths, barriers, solutions and resources. Resolution of conflict among patients, family members, community partners and members of the oncology care team is demonstrated in professional and culturally acceptable behaviors.

		Entry	Intermediate	Advanced
VII.1	Health Equity	Demonstrate knowledge of cultural humility, implicit bias, cancer disparities among ethnic/racial and sex gender minorities and and those groups that have been economically/ socially marginalized.	Communicate effectively with patients, families/loved ones from ethnic/racially and culturally diverse groups and those that have been economically/ socially marginalized by applying cultural humility.	Evaluate the health equity communication practices with patients, the healthcare setting, among the oncology team, and with the community to identify gaps and make improvements.
V11. 2	Social Determi-nants of Health (SDOH)	Demonstrate knowledge of the SDOH and their specific impact on ethnic/racial and sex gender minority populations and those groups that have been economically/ socially marginalized.	Identify and resolve key SDOH relevant in the care of patients and their families/loved ones from ethnic/racially and sex gender minority and those that have been economically/ socially marginalized (language access, food insecurity, financial toxicity etc.).	Evaluate outcomes of how heathcare setting is identifying gaps and resolving key SDOH for cancer patients.

		Entry	Intermediate	Advanced
VII.3	Self-Advocacy	Assess patient and family members/loved ones capacity to self-advocate and communicate with their oncology team.	Develop self-advocacy and communication action plan with patient and family members / loved ones to improve interactions with HC team.	Evaluate the processes, self-advocacy and communication plan and its impact on patient satisfaction.
VII.4	Community Resources	Assess patient needs for community resources and services.	Conduct timely searches of resources, reach out to community agencies to ensure appropriate alignment of patient demographics, language, health and technology literacy.	Evaluate processes and outcomes with community agencies to ensure patients are properly referred.
VII.5	Interper-sonal Skills	Demonstrate the ability to effectively communicate with clients patients, families, and loved ones and members of the health care team. Facilitate communication between patients and providers when clinical expertise is needed. Use appropriate technology, such as computers and database systems, for work-based communication in accordance with employer requirements.	Assess effective communication skills with patient and members of the team Apply active listening skills, demonstrate empathy, compassion, nonjudgemental language, respect and solution oriented when communicating with patients, family and loved ones.	Advance the practice of effective interpersonal skills through the practice of evaluation of interactions with patients.
VII.6	Communicat ion Styles	Demonstrate knowledge of different communication styles, non-verbal and verbal, and culturally specific in your patient population.	Asesses patient communication styles and identify sources that can assist in effective communication with the patient, family/loved ones.	Evaluate the delivery of different communication styles with patients and their family/loves ones to identify gaps and improve communication.

		Entry	Intermediate	Advanced
VII.7	Needs Assessment	Elicit disclosure and feedback from patients so that they can communicate their needs to oncology team; conduct assessment of patient needs and goals across their cancer journey	Generate potential interventions based on needs assessment findings.	Analyze needs and share findings and collaborate with oncology team, social workers and other professionals in on-going patient and program needs assessments. Apply longitudinal and cross-sectional approaches to analyze data from a population or a representative subset at a specific points in time.
VII.8	Outreach and Engage-ment	Effectively engage patients and families in on-going assessment efforts. Gather and combine information from different sources to better understand patients, their families and their communities.	Use surveys and other data collection tools to gather information and data to better understand patients and their communities and their families. Use surveys and other data collection tools for on-going assessment.	Share and discuss evidence-based outreach and engagment best practices with other professionals with the intention to solve practical problems.