Core Competency	Overview of Competency
Communication	Share knowledge among participants in a patient's care. Communication may occur through a wide variety of channels. **Four overarching themes:** **Frequent communication:** Frequent communication helps to build relationships through the familiarity that grows from repeated interaction. **Timely communication:** Communication can be frequent and still be of poor quality. For one thing, it can lack timeliness. In coordinating highly interdependent work, timing can be critical. **Accurate communication:** The effective coordination of work depends not only on frequent and timely communication, but also on accurate communication. **Problem solving communication:** Task interdependencies often result in problems that require joint problem solving. Hence, effective coordination requires that participants engage in problem solving. Making sure communication takes place in a way that meets the patients information and decision making needs.
Interpersonal Communication	The give-and-take of ideas, preferences, goals, and experiences through personal interactions. Examples include face-to-face interactions, telephone conversations, email, and letters.
Information Transfer	The flow of information, such as medical history, medication lists, test results, and other data, from one participant in a patient's care to another.
Facilitate Transitions	Facilitate specific transitions, which occur when information about or accountability for some aspect of a patient's care is transferred between two or more care entities or is maintained over time by one entity. Facilitation may be achieved through activities designed to ensure timely and complete transmission of information or accountability.
Assess Needs	Determine the patient's needs for care and for coordination, including physical, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations, including prescribed medications; and need for support services
Create a Proactive Plan of Care, a personalised care and support plan	Establish and maintain a plan of care, jointly created and managed by the patient/family and health care team, which outlines the things that matter to the patient, their current and longstanding needs and goals for care and/or identifies coordination gaps. The plan is designed to fill gaps in coordination, establish patient goals that focus on what the patient wants to change or achieve in relation to their needs and, in some cases, set goals for the patient's providers. Ideally, the care plan anticipates routine needs and tracks current progress toward patient goals.

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Monitor, Follow Up, and Respond to Change	Jointly with the patient/family, assess progress toward care and coordination goals outlined in the PCSP. Monitor for successes and failures in care and coordination. Refine thepersonalised care and support plan as needed to accommodate new information or circumstances and to address any failures. Provide necessary follow up care to patients.
Support Self-Management Goals	Tailor education and support to align with patients' capacity for and preferences about involvement in their own care. Education and support include information, training, or coaching provided to patients or their informal caregivers to promote patient understanding of and ability to carry out self-care tasks, including support for navigating their care transitions, self-efficacy, and behavior change.
Link to Community Resources	Provide information on the availability of and, if necessary, coordinate services with additional resources available in the community that may help support patients' health and wellness or meet their care goals. Community resources are any service or program outside the care system that may support a patient's health and wellness.
Enabling and signposting to digital health and wellbeing	Provide information on the availability of and, if necessary, coordinate services with additional resources available in the community that may help support patients' health and wellness or meet their care goals. Community resources are any service or program outside the care system that may support a patient's health and wellness.
Align Resources with Patient and Population Needs	Within the care setting, assess the needs of patients and populations and allocate health care resources according to those needs. At the population level, this includes developing system-level approaches to meet the needs of particular patient populations. At the patient level, it includes assessing the needs of individual patients to determine whether they might benefit from the system-level approach.
Teamwork focused on Coordination	Integration among separate care entities participating in a particular patient's care (whether health care professionals, care teams, or other care organizations) into a cohesive and functioning whole capable of addressing patient needs.
Digital Health IT-enabled Coordination	Using tools, such as electronic medical records, patient portals, or databases, to communicate information about patients and their care between health care entities (health care professionals, care teams, or health care organizations) or to maintain information over time.
Building and sustaining professional relationships	Relationships underpin effective inter-boundary working and are skills people in navigation roles need to develop. The ability to engage and sustain key working relationships is fundamental to work with patients, their family and with multidisciplinary team members.
Personalised Care	Personalised care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs and demands. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcomes. Personalised care is about considering what matters to people their values, family situations, social circumstances and lifestyles; seeing the person as an individual, and working together to develop appropriate solutions. Key Components • Comprehend that effective personalised care and support planning requires several discussions

	• Taking into account what matters to people's as well as their expressed needs • Emotional support involving family and friends. • Provide care that is timely, appropriate, and effective for treating health problems
Continuous Learning	The ability to demonstrate reflective practice, based on the best available evidence and to assess and continually improve the services delivered as an individual provider and as a member of an interprofessional team. • Participate in practice-based learning and improvement activities that involve investigation and evaluation of patient experiences, evidence, and resources. • Apply new technical and information/knowledge to practical use on the job • Regularly engage in interdisciplinary training for staff. • Regularly engage in continuing professional development. • Implement and routinely monitor patient safety standards. • Identify evidence to inform practice and integrated care. People who are in care navigation roles learn significantly through experience and working within local contexts – therefore reflection on practice, for the individual and as teams are of core importance to personal as well as service development
Professionalism	These are rooted in the ethical, moral and legal aspects of care and support, grounded in the principles of patient-centered care. Commitment to develop expertise, self-awareness, limitations of scope of practice and working with integrity are some important features
Establish Accountability or Negotiate Responsibility	Make clear the responsibility of participants in a patient's care for a particular aspect of that care. The accountable entity (whether a health care professional, care team, or social care organisation) will be expected to answer for failures in the aspect(s) of care for which it is accountable. Specify who is primarily responsible for key care and coordination activities, the extent of that responsibility, and when that responsibility will be transferred to other care participants.
Handling data and information	Accurate and accessible information and data underpins effective care navigation. Failures in communication between organisations, sectors and patients/carers can lead to disjointed and poor care. Individuals who work to provide effective care navigation need to be able to appropriately use relevant electronic records, databases to access, input, store and retrieve information. Data is also important for service evaluation improvement.