Title: Relationship-based care in the context of navigation

Authors: **Anthony Levitt,** MD, MBBS, FRCPC; Naomi Algate; Staci Weingust

Abstract:
Relationship-based care (RBC) has emerged as a new concept along the developmental pathway in health care strategies starting with “patient-focused care” and then to “family-focused care” and then to “person- centred care”. RBC expands on person-centred care in that it is focused on three levels of relationship that are relevant to the care of clients: namely, the client's relationship with 1. the service provider; 2 their caregivers and supports; and 3. the system including other health care providers, work/school relationship, legal systems etc. Although RBC has been conceptualized as a powerful tool in delivering direct patient care, this presentation will suggest it has particular value in navigation services, where direct care is recommended and not specifically provided.

The presentation will propose three other important relationships as part of RBC in navigation; namely, 1. the relationship of the navigator with the support systems of the identified client, 2. the relationship of the navigator to the health care system at large, and 3. the relationship of the navigator to themselves and their own needs.

This broader concept of RBC will be explored in the context of the Family Navigation Project in Toronto, an intensive navigation service for youth 13-26 and their families.

Title: Navigation Across the Life Span

Authors: **Heather Beaton**, BSC(OT); **Maya Williams**, Rec Therapist; Tina McPhee, PDt; Lisa Sutherland, PDt; Jill Robison, PT; Gina Hanley, OT; Jennifer MacLennan, SW; Sheila Lane, RN; Kim Rose, RN; Melissa Boland, SW; Erika MacFarland, OT; Cheryl Jeffers-Johnson, Rec Therapist; Cheyenne Smythe-Kelvey, OT; Monique Yazbek, OT; Nancy Snow, SW.

Abstract:

The Community Health Teams (CHTs), a creative partnership between the Nova Scotia Health Authority (NSHA) and the IWK Pediatric Health Centre, are part of Primary Health Care in Nova Scotia. The CHTs work collaboratively with community partners, healthcare, business and government partners to strengthen links and build stronger and healthier communities together. The uniqueness of the partnership between the NSHA and IWK allows for navigation services to occur across the life span. Navigators have the ability to provide support to a whole family living in their community as well as individuals and may include working with children, parents, adults, seniors, grandparents and other caregivers. Adult and Child/Youth Navigators work side by side, sharing expertise and offering a service that addresses health needs. The CHT Wellness Navigators are health professionals that meet with community members to identify and prioritize health needs and use behaviour change strategies to support goal setting. Navigators provide referrals/recommendations, coordinate and advocate for services, provide education and emotional support and are easily accessible throughout the community. Navigation is accessible to all residents of a community within a geographic area and for populations at higher risk due to health inequities. The CHTs have been systematically evaluating the impact of navigation services through community engagement, identification of systemic barriers, client satisfaction and impact data. This innovative model can be replicated provincially and nationally to advance health access across the lifespan. Elements of the model, ways in which navigation and complex needs are being addressed, case examples and key outcomes will be presented.

Title: Multiple Sclerosis Society Knowledge Network

Authors: **Emily Knight,** BPH; **Laura Barry**, MSW

Abstract:

The Multiple Sclerosis Society of Canada created the MS Knowledge Network to address the unique needs of Canadians affected by MS, by providing a one-stop shop for quality information and support, assistance navigating the health and social service systems, and locating programs and services in local communities to improve quality of life.

The Knowledge Network is available bilingually nationwide and is easily accessible through various channels including self-service through the website, or connecting with MS Navigators by phone, email, live web chat or social media. MS Navigators are information and referral provision specialists and are experts in topics including MS research, health systems, drug approvals, MS treatments, community services, crisis management, etc. The individually tailored, patient-centric approach of the Knowledge Network is playing a unique role in addressing the challenges of an overburdened healthcare system to deliver disease-specific, evidence-informed information and personalized support to the MS community.

Since 2016, MS Navigators have responded to over 19,000 inquiries from 12000 individuals across the country, and has seen an increase in volume year over year across all channels. It's allowed the MS Society to provide equal access to information and supports across the country which has increased the reach to individuals living in rural communities and has ensured consistency in the information being delivered. Data collected has given the organization a better understanding of the needs of people affected by MS, which allows for more strategic program and service offerings, government advocacy efforts and research investments in the future.

Through exploration of customer feedback and data, this presentation will expand on Knowledge Network achievements, best practice sharing, and how we are becoming a leader in the health care navigation space to serve as a model for other health charities in the future.

Title: Post Discharge Follow-up and System Navigation after an Inpatient Rehabilitation Stay.

Authors: **Monica McCullagh**, BA, ECPC; **Erin Leneeuw**, BA; Tracey Sanford, BA Recreation and Leisure Studies Hon, inclusive and Therapeutic Recreation, R/TRO, Kelly Tough BScOT, MHM, OT Reg. (Ont)

Abstract:
Introduction/Background: In order to facilitate safe transitions home from inpatient rehabilitation, a live call from the Community Health Navigators (CHNs) or touch-tone activated system telephones the discharged patient/caregiver and asks questions about their transition home, current care/living situation, and health conditions. CHNs then follow up on any reported issues. Providence Healthcare offers the following inpatient programs: Stroke and Neuro Rehab, Orthopaedic and Amputee Rehab, Geriatric and Medical Rehab.

Design: Our aim is to reach as many patients as possible post discharge via either automated and/or live call. A real time multi call automated platform and electronic database is in place. After reviewing Health Equity data, Providence Healthcare added multiple languages: Greek, Cantonese, Italian and French. Phone calls include CHNs making five attempts to reach patients/caregivers, completing follow up questions, and implementing a variety of standardized tools. The automated system identifies patient/caregiver by discharge date confirmation. The 48-hour call explores discharge package, medications, primary care, discharge preparedness and patient mood. The 1 and 4 month calls often include standardized tool implementation, such as; The Patient Health Questionnaire (PHQ-2), Reintegration to Normal Living Index (RNLI), and Caregiver Strain Index (CSI).

Results: CHNs are able to compare standardized testing scores over time. Patient/caregiver reported outcome measures, gauge the successful reintegration of patients into the community and how caregivers are coping. CHNs are able to analyze data and be proactive in understanding the needs of patient/caregiver populations at different intervals post discharge. This has become increasingly important in supporting patients/caregivers throughout the pandemic. High-level data and outcomes will be shared.

Conclusion: The role of CHN has expanded including Health Equity Data, a new electronic referral form, various program supports and resources, promoting system navigation, self-management programs, and empowering patients/caregivers to advocate for themselves with the goal of improved health and quality of life.

Title: Suicide, Care Navigation and Recovery

Authors: Dr. **Gary Jacobson**; **Marika Kontellis**

Abstract:

The Sydney Northern Beaches is home to 252,000 people who enjoy some of the best living conditions and most spectacular geography in Australia. But suicide and its impact does not discriminate, and local region leaders became increasingly alarmed following the deaths of four young people known to each other. These deaths were set in a context of other deaths by suicide and many attempts.

Service providers converged and identified that they needed to work together better. Many agreeing that they were great collaborators and partners and already had good working relationships. Police were calling out for urgent support.

The local Police, Local Council, and CCNB designed and delivered a Care Navigation model of service specifically targeting people following a suicide attempt.

Seven months later, a preliminary independent evaluation is showing that the model is saving lives and supporting people on their recovery journey.

This Care Navigation model supports people to understand and access the health and community care sectors, build their health literacy as well as the capacity of their informal support network.

Presenters will engage the audience and highlight the importance of;

- using data and evidence
- focusing on outcomes – not just activities
- understanding the value of care navigation in a rigid, formal system
- enabling people with lived experience to lead responses
- challenging the current system and processes
- doing rather than waiting for funding

Title: Building pathways for mental health enhances healing for families

Authors: **Jeanne Foot**, ICADC

Abstract:

Navigating mental health care and addiction services can be overwhelming for families trying to find the care they need for their children. It is further complicated by ‘no clear pathway’ to best-matched treatment. In this presentation, I would like to share my experience of supporting my son and how we finally navigated the mental health and addictions system.

Waves of desperation washed over our family while trying to access services for our son. We exhausted traditional routes: family physician, psychiatrist, multiple trips to the hospital, and therapists.

A year later, we had not moved forward.

I recall my moment of clarity, as I realized we needed intervention and wasn’t sure what we needed. But what was more concerning was that the professionals didn’t know either.

I now had a new role as a Navigator to find resources to support my son’s mental health.

There were numerous roadblocks when trying to enter the system. Each attempt led us to another queue to find the door was closed as well. Eligibility criteria of all kinds contributed to the frustration of finding care.

Each call led to the next link in the chain. My research finally led me to a therapeutic placement consultant in the U.S. who was able to offer us hope as she helped guide our child to the appropriate clinical fit with compassion and care. We finally felt understood and supported.

Through this experience, I have learned that 'mental health is health' and compassion is lacking in comparison to physical illness. It is vital we embed this value into the culture of mental wellness service delivery. Models that treat the whole family build capacity and health capital while healing intergenerational trauma for all.

Lived experience is a fast learning curve and the lessons learned from our experience to ensure smoother pathways. Navigation should not be by chance but a necessity for all.

Title: Enhancing Community Health through Patient Navigation, Advocacy ad Social Support

Authors: **Kerry McBrien**, MD, MPH, CCFP; David Campbell, MD, PhD, MSc, FRCPC; Gabriel Fabreau, MD, MPH, FRCPC; Natalie Ludlow, PhD; Jennifer Malkin, MPH
Emily Nunez, MPH; Rachel Clare, MSW, RSW; Stephanie Montesanti, PhD, MA, BA

Abstract:
Background | Patients with multiple chronic conditions are at higher risk of poor health outcomes and may face barriers to care (e.g., language, financial, cultural) that impede access to needed resources. In partnership with Calgary's Mosaic Primary Care Network (PCN), we developed and implemented the ENhancing COMmunity health through Patient navigation, Advocacy and Social Support (ENCOMPASS) study. This study has since expanded to three additional PCNs in Alberta. The objective is to examine the effectiveness of Community Health Navigators (CHNs) in improving outcomes for adult patients with multiple chronic conditions seen in primary care.

Design | The ENCOMPASS research program includes: 1) a pilot single-arm observational study in two clinics; 2) a parallel two-arm pragmatic cluster randomized wait-list controlled trial; and 3) three additional pragmatic implementation studies across additional PCNs. Each study uses a mixed-methods design. CHNs complete a needs assessment to identify barriers to care, work with patients to set goals and provide tailored navigation and assistance. The primary outcome is the rate of acute care use (emergency department visits and hospital admissions). Secondary outcomes include: disease-specific clinical outcomes, medication adherence, and patient-reported outcomes. Interviews with patients, CHNs and health care providers, together with field observations, explore program experience. The RE-AIM framework is used to evaluate implementation.

Results | Anticipated program results include lower acute care use and improvements in patient experience with care, social support, and patient activation. Program evaluation will assist with progressive program refinement.

Conclusions | The ENCOMPASS research program will assess the impact of the CHN program for patients with multiple chronic conditions. This research will inform primary care health navigation programs provincially and in other jurisdictions.

CONCURRENT SESSION ABSTRACTS - NAVIGATION IN RESEARCH

Title: How can we best reduce the structural burden of system navigation on families of older adults?

Authors: **Laura Funk**, PhD

Abstract:

Introduction: How effective are formal navigators in relation to other options, such as disseminating resource information, or addressing root problems, like service fragmentation? And how can public navigator positions be designed in ways that help family caregivers?

Design: A review of research literature on navigator effectiveness is supplemented by findings from qualitative research with family carers of older adults and with formal navigators in Winnipeg, Canada.

Results: This study, alongside several other qualitative Canadian studies, confirms the navigational struggles of family carers of older adults, identifying this as an otherwise-overlooked structural source of caregiver burden, through lost time, stress, and emotional labour. Service navigation challenges complicate equitable access to resources and supports, transitions between care settings or services, and can generate dissatisfaction and undermine support for public systems. Although patient navigator roles have promise, the design and purpose of these positions is often unclear and may have lost some of their original focus; navigators may experience tensions between competing goals and interests, or lack sufficient time to effectively help broker access to services.

Conclusions: Because this is an equity issue, and because the root of the problem lies in system design, navigational work is a public responsibility. Recognition of structural barriers to accessing supports requires both policy-makers and navigators to think beyond providing service information and education, and for public navigators to have dedicated time and ability to help broker and advocate access to services using a family-centric approach.

Title: Sanctum 1.5

Authors: **Shelby Moniuk** BISW, MISW student; **Melissa April** PFA; (Ali) Hubert Tote Alimezelli PhD; Maryam Yasinian M.Ed; Melissa April PFA; Richard Jessop PFA.

Abstract:
Introduction: Saskatchewan has the highest HIV/AIDS diagnosis rate in Canada. The increased HIV prevalence could lead to an increase in child apprehension. Our research is Realist Evaluation (RE) of a program, Sanctum 1.5, that offers residential and navigating healthcare services to pregnant women living with HIV or at risk of contracting HIV and child apprehension. Sanctum 1.5 can accommodate ten women and their infants after delivery. Our goal is to determine how Sanctum staff and peer-mentors assist residents in navigating the program, accessing healthcare, counselling support, and medication management to living independently after program completion.

Methods: A team of Patient Family Advisors (PFAs) and researchers have been conducting a RE to determine what makes Sanctum 1.5 program work (or not work), for whom, in what contexts, why, and how. PFAs and researchers have developed the initial Contexts-Mechanisms-Outcomes (CMO) configurations as part of program theory development as seen in the following six steps: document review, development of initial CMOs, generation of initial program theory, data gathering, data analyses and theory refinement, and validation of program theory. Two main data collection methods will be used: Participant interviews led by PFAs, and Sharing circles facilitated by an Elder.

Results: The goal of this RE is to develop a program theory. The supportive environment at Sanctum that includes the support from staff and peer-mentors may be shown in the program theory to impact the health and wellbeing of mothers and infants through empowerment and navigation support.

Conclusion: Navigation of support and healthcare services is essential for pregnant women living with or at risk of HIV. A realist-driven program theory will enable Sanctum 1.5 and similar programs in Saskatchewan and across Canada to evaluate their support system and create a more robust approach to navigating a healthy lifestyle for both mothers and infants.

Title: A Multisite Project Investigating Navigation Service Advancement for Families in which a Child has a Neurodevelopmental Disability

Authors: **David Nicholas**, PhD, RSW; Lucyna Lach, PhD, MSW; Wendy Mitchell, PhD, R.SLP.

Abstract:

This project has examined and advanced health and disability service access and navigational processes in three Canadian regions (Alberta, British Columbia and the Yukon) for families in which a child has a neurodevelopmental disability (NDD).

We have sought 'Collective Impact' aims, based on tenets of Participatory Action Research (PAR). Regional teams from each province/territory identified key partners in disability and health sectors, who collectively determined system gaps and priorities for proactive change.

To date innovative changes have been implemented to navigation systems based on evidence that has been collected. As an example, based on feedback received from families in Vancouver, navigation support offered to children who have neurologic, psychiatric, and developmental pediatric service needs have been transformed. Preliminary findings indicate families are very satisfied with this change as navigation is focused on supporting social determinants of health such as family overload, monetary issues, travel needs, and community supports that go beyond coordinating numerous appointments for families. In the Yukon, the implementation of a navigator in a remote community has positively influenced family trust and engagement with service providers, heightened cross-ministerial collaboration, and resulted in more timely access to services. In Alberta, greater understanding of multiple service systems/resources has been developed, including gaps and approaches for moving forward.

Based on PAR, regions have collectively developed and shared learnings, with key regional (and cross-regional) relationships being nurtured for both inquiry/learning aims and systems innovation. Backbone support by university partners has facilitated project evaluation, inter-regional communication and project coordination. A person in environment framework illustrates key project elements linking research to action at micro, mezzo and macro system levels.

Title: Exploring the experiences of caregivers of children and youth with complex care needs who have received services from NaviCare/SoinsNavi

Authors: **Alison Luke**, PhD; Shelley Doucet, RN, BN, MScN, PhD; Kerrie Luck, BScOT, MScOT, PhD, OTReg.

Abstract:

BACKGROUND:Children and youth with complex care needs (CCNs) make up only a small sub-set of the pediatric population yet their needs for resources and services from various providers working across disciplines, settings, levels of care, and sectors can be quite extensive. Many families experience barriers to accessing care for their children/youth with CCNs. To address gaps in care, a research-based navigation centre for children/youth with CCNs and their families was launched in New Brunswick in January 2017. NaviCare/SoinsNavi aims to facilitate more convenient and integrated care to support the physical, mental, emotional, social, cultural and spiritual needs of children/youth and their families. The purpose of this study was to explore the overall experiences of caregivers of children/youth with CCNs who have received services from NaviCare/SoinsNavi.

METHODS: This qualitative descriptive study involved semi-structured interviews with 22 caregivers of children/youth with CCNs. Thematic analysis was used to identify, analyze and report patterns across the data. The research questions explored include: 1) What are caregivers' experiences caring for a child/youth with complex care needs? and 2) What are caregivers' experiences and satisfaction as clients of a patient navigation centre for children/youth with complex care needs?

RESULTS: Three main themes emerged from the data: 1) caring for a child/youth with complex care needs, 2) navigating the system, and 3) the value of patient navigation. Findings suggest caregivers caring for a child/youth with complex care needs often feel overwhelmed, fearful, and alone; yet, patient navigation can be an innovative approach to support their needs through facilitating more convenient and integrated care, and improving access to education, supports, and resources.

CONCLUSION: This study demonstrates that patient navigation can have a positive impact on caregiver's experiences when caring for a child/youth with CCNs, including providing support and information; improving access to resources and services; enhancing coordination and integration of care; and improving overall quality of life. These findings can be used to inform policy on how to best improve care coordination, enhance patient experiences, and identify gaps and barriers to care across New Brunswick.

Title: Navigation of Mental Health and Addictions Services Indicator Development

Authors: **Andrea Foebel;** Lynn Buckwell

Abstract:

Introduction: In 2017, federal, provincial, and territorial (FPT) governments endorsed A Common Statement of Principles on Shared Health Priorities that outlined a collective commitment to improve access to mental health and addictions (MHA) services and home and community care. FPT Health Ministers agreed to work collectively with the Canadian Institute of Health Information (CIHI) to develop a focused set of common indicators to measure pan-Canadian progress towards these objectives. As part of this work, CIHI is developing a new pan-Canadian indicator assessing client experiences of navigating MHA services.

Design: CIHI has four stages of indicator development: initiate/evaluate, develop, calculate, and release. A conceptual report and environmental scan were completed in 2019, which included an extensive literature review and interviews with 17 subject matter experts (SMEs). To support the development of this indicator, CIHI is engaging a panel of SMEs from across Canada in an Expert Advisory Group as well as clients and caregivers with lived and living experience in a Client Advisory Group to support the development of this patient reported experience measure that focuses on navigation of MHA services. We have also conducted field testing to ensure the questions resonate with respondents, that they are respectful of the unique experiences of participants and are easy to understand.

Preliminary Findings: This indicator is currently in the develop phase of indicator development and CIHI is targeting public reporting of results by2022. The goal of this session will be to highlight the approach used in defining this indicator and developing the survey questions. We will seek feedback and insights on its ongoing development and potential improvements over time. Please join CIHI in this session to share your perspective on the work to date and considerations for how it will evolve and expand in subsequent years.

Implications: Client navigation of MHA services is a priority across Canada. This indicator is intended to help jurisdictions better understand the barriers and help drive improvements in accessing MHA services.

Title: Developing an Ontario Graduate Certificate in Systems Navigation; Three Lessons Learned

Authors: **Colin MacRae**, RN, Psychotherapist, MA, PGDip(Ed), FHEA

Abstract:

With the many promised outcomes of the role of Systems Navigator and in the context of shifting political landscapes affecting the delivery of health and social care in Ontario, the opportunity exists to respond with quality education fit for career ready citizens. This brief oral presentation aims to highlight a small selection of key learning that emerged from the process of developing an Ontario Graduate Certificate in Systems Navigation.

Drawing from both personal & professional reflective experiences of passing through various stages of post-secondary education development; from need identification to graduation, this ten minute presentation will highlight the top three key learning along with a brief outline of potential ideas for future response and growth.

Title: Living with Mental Illness and the Side Effects of Systems

Authors: **Melanie Lefebvre**

Abstract:
Introduction: I am approaching this from two perspectives: 1) an educator from Cambrian College's Community and Health Services Navigation post-graduate certificate program and the results of a navigational simulation in the virtual classroom setting, and 2) a person with lived experience of the difficulties of navigating a diagnosis and subsequent treatment for OCD (obsessive-compulsive disorder).

Design: I will share some of the struggles from my personal experience in trying to navigate the system to obtain help for my OCD.

This will provide context for the navigation simulation I created with students, which will begin with an opportunity for the audience to experience a small portion of the simulation.

This will be followed by an overview of the simulated activity, including prep, facilitation and debriefing with students and participating faculty.

Lessons Learned: Students reported that the experiential experience resulted in the following: 1) a realization that prior to the simulation, they did not understand what OCD is, 2) an enhanced appreciation for the benefits of having a navigator for support in complex systems, 3) a deepened sense of empathy for people who have to navigate complex systems.

I will then return to the perspective of lived experience with OCD and discuss how I am an advisory member for Ontario Health Quality’s quality standard for OCD, intended to assist patients and their caregivers in navigating this diagnosis.

Implications for Education: I facilitated this simulation for a second time in March 2020 with a new round of Community and Health Services Navigation students. The second simulation was expanded to include students from Cambrian’s Community and Justice Services program for the following reasons: 1) Opportunity for interdisciplinary collaboration with students from each program, and 2) Enhanced realism with intersecting systems embedded into the simulation (legal and mental health systems).

APRIL 15th 2021 - CANADIAN HEALTHCARE NAVIGATION CONFERENCE

CONCURRENT SESSION ABSTRACTS - NAVIGATION IN EDUCATION; NAVIGATION IN RESEARCH; NAVIGATION IN PRACTICE

Title: System Navigation: Connecting People & Creating Linkages

Authors: **Jillian Beaupré**, BSW, RSW; **Krista Schneider**, BA Soc DTATI; Anna Labelle, B.S.W., RSW; Michele Vigneux, B.S.W., RSW.

Abstract:

Behavioural Supports Ontario (BSO) was implemented within Erie St. Clair in 2012 and aims to reduce and stabilize responsive behaviours associated with dementia, complex mental health, substance use and other neurological conditions experienced by older adults. With the following value statement in mind, “I am a unique individual and am worthy of respect, dignity and quality care”, Erie St. Clair recognized the need for a point person to assist clients, care partners and professional service partners. Thus, three System Navigator roles were created to provide navigation support and guidance to BSO clients experiencing responsive behaviours, their care partners and professional service partners throughout various sectors (eg: health, social, justice).

An interdisciplinary and multi-sectoral approach to service delivery is taken by the System Navigator to work through complex cases. A variety of case studies will be utilized to highlight and demonstrate the complexity of referrals and the importance of the System Navigator role as a source of guidance for the client and their care partner, as well as a communication hub for all professional service partners involved in the case.

The System Navigator role has been successful due in large part to the development of processes, identifying gaps within service delivery, knowing and respecting the needs of the client, and the ability to build positive working relationships with professional service partners.

As the role of the System Navigator continues to move forward and evolve, ongoing evaluation of the role and role description continues to occur to ensure the needs of the population served are being met. The evolution of the System Navigator role is highlighted through its partnership with Humber College where the System Navigators were instrumental in the design, development and implementation of the college’s Systems Navigator graduate program.

Title: A National Discussion around Newcomer Navigation

Authors: **Christine Kouri** BScN, MHA; Kimberley deLaunay, BSc, MPH; Julia Kurzawa, BA, MPH; Sahar Zohni, MD, MHA; Seeta Ramdass, PsyD; Adoniran Santos, BA, MA; Lauren Provost; Andrew Tomayer, BHSc., CHIM, MSc; Yvonne Kienast, MPH, MA; Mariah Maddok, MPH.

Abstract:

Background: New Canadians (i.e. refugees and immigrants) face many linguistic and cultural barriers in access to health and social services. In response, organizations have begun investing in health and system navigation for newcomers; yet they often work in silos and with limited funds. This need prompted CHEO to develop the first of its kind, National Newcomer Navigator Network (N4), to facilitate collaboration and improve the collective impact of these programs. N4 will provide eLearning modules and webinars, a structured online program, conferences, a forum for staff to connect with peers, and a database of immigration trends at the local and national level.

Design: To inform the development of the network and ensure that is responsive to the needs of stakeholders, an in person and phone needs assessment was conducted with staff from hospitals, health centers, and settlement agencies. The N4 team met with 401 stakeholders from 125 organizations, including children's hospitals/rehab centres, general hospitals, newcomer clinics, community clinics, and settlement organizations, among others

Results: Most organizations were in the early stages of developing programs and policies to address healthcare navigation needs for newcomer populations. Major themes that emerged were gaps in education, professional development, peer support, communities of practice, and access to resources. The results of this needs assessment informed the development of the N4 project structure (i.e. the online program, forum, database, community of practice).

Conclusion: To our knowledge, this is the first time a comprehensive needs assessment was conducted around the emerging field of newcomer navigation. Results from this needs assessment have advanced knowledge of the current state of healthcare navigation in Canada, as it pertains to a priority population, newcomers. Presentation at this conference will allow for wider dissemination of this information which attendee's can apply to their current practice.

Title: “Peer-to-Peer” Support when caring for a Child with Medical Complexity

Authors: **Teresa MacMillan; Amelie Deslauriers,** Chantal K, Lilian Kitcher

Abstract:

Parents who are caring for a child with medical complexities report experiencing social isolation, among other challenges. The role of a caregiver is all consuming. Parents speak of not being able to turn off the ‘caregiver’ role; they are uncomfortable stepping out of this role which they are very familiar with or can’t participate actively in their community.

The Navigator Program is a 5-year federally funded program to help address critical gaps in supports and connections for parents of children with medical complexities. The program promotes the social and emotional health of families by helping them access peer supports and navigating key services.

This presentation will focus on the peer support component of the program. The two Parent Navigators bring their own personal, lived experiences in caring for a child with complex medical needs. Through their “peer-to-peer” efforts, they promote caring connections to cultivate a community of support for families. This includes:

- Hosting coffee and chat meetings in the community
- Supporting parents during admissions and clinic visits
- Organizing social gatherings
- Hosting workshops based on the needs identified by families (PTSD yoga, tax clinics)
- Leading self-care challenges
- Being present on Social Media
- Delivering “A Day in the Life” Awareness Campaign to CHEO staff and external stakeholders
- Collaborating in the creation of video campaigns

In conclusion, Parent Navigators provide parents with unique and diverse opportunities to connect with other families, and share ideas and learn from other parents “who get it”.

Title: Breaking Barriers: St. Joseph's Health Centre Family Navigation

Authors: **Elly Litvak** PhD; **Shannon O'Neill**, Hon. BA

Abstract:

In 2014 the Toronto Central LHIN called for proposals for family mental health programs. Family Outreach and Response (FOR) viewed this as an opportunity and partnered with Mental Health and Addictions at St. Joseph's Health Centre. It was the belief that families also needed support when a loved one was admitted to hospital due to mental health. The two organizations collaborated on a 1-year charter outlining the goals of the Family Navigation Program. Two goals were to serve 100 families and reduce Emergency Department (ED) visits.

The program was promoted through one-on-one engagement with individual staff, posters and brochures, and presentations by the navigator. The navigator was on site once a week connecting with staff and families at the various mental health services. While a loved one was in hospital the Family Navigator supported the family in understanding the hospital mental health system, liaised between the family and hospital staff, and prepared families for discharge. The support continued post discharge with 1:1 support, groups, psychoeducation, etc.

All goals were achieved within the first year and the program was successful in securing further TC LHIN funding for expansion. Surveys of the program indicate that up to 75% of families who were supported no longer saw hospitals as the only option in a mental health crisis, 78% reported improved self-care, and 70% reported decreased isolation.

FOR, now a program of CMHA Toronto, has developed an e-learning course for hospital staff, Delivering Family Centered Care from a Recovery Framework. This course supports staff in building their capacity to engage and collaborate with families. Evaluation of the course pilot showed that staff improved their assessment and referral skills for families, while also changing the ways they support families.

The long-term vision for our program is to spread the family navigation model to other hospitals in Toronto, through community-hospital partnerships.

Title: Exploration of the feasibility and role of Bilingual Community Navigators for healthcare navigation in general practice in Australian setting

Authors: **Sabuj Kantri Mistry,** MPH, PhD scholar; Elizabeth Harris, PhD; Mark Harris, PhD.

Abstract:
Background: General practitioners (GPs) are often the first point of contact, with a unique role in the prevention of long-term conditions, especially for the culturally and linguistically diverse (CALD) population. Bilingual Community Navigators (BCNs) are a promising way to support GPs, practice nurses and patients to 'bridge the cultural gap' to improve equity of access to prevention and care through support with healthcare navigation. However, there has been little research done on the role of BCNs in Australian primary care. This research aims to explore the implementation and role of BCN's in providing navigation support for patients in general practice settings.

Design: This study involved qualitative in-depth interviews with GPs, nurses and other practice staff in five general practices in Sydney where most patients spoke a language other than English.

Results: All the interview participants were positive about the potential healthcare navigation role of BCNs in their practices, helping to motivate patients, especially those of CALD backgrounds to seek care from GPs, provide cultural support, improve health literacy, and reduce the workload of the general practice staff. Their role can include helping patients in completing the paperwork and provide health information before the appointment. They can help the patient understand the care plan provided by the GP and how to navigate to referral services. The participants felt that BCNs may provide both cultural and health system navigation support before and after the GP appointment. With patient permission, BCN could also be present during the GP consultation to facilitate proper communication between the patient and the GP.

Conclusions: This study suggests that there is a potential role for BCNs in healthcare navigation in general practice, especially for CALD patients. Information from this study will be used to plan their training and supervision and to evaluate their implementation.

Title: Helping older adults and their caregivers navigate Health and Home Care systems in New Brunswick

Authors: **Michelle Lafrance,** PhD; Ms. Ashley Erb,; Dr. Janet Durkee-Lloyd,; Dr. Michelle Greason; Dr. Shelley Doucet; Dr. Alison Luke; Dr. Catherine Bigonnesse,; Ms. Karen Lake; Ms. Erin Jackson.

Abstract:

Introduction: The COVID-19 pandemic has highlighted the urgent need to better attend to the care needs of older adults and their caregivers. While many services exist to support older adults, knowing where and how to find these remains elusive for many and a significant source of stress. In this presentation, we report on an ongoing project to establish an Information Hub to assist older adults and their caregivers navigate Health and Home Care systems in New Brunswick.

Design: The Information Hub is being organized around a series of concerns identified in our team's research that often lead individuals to enter Health and Home Care systems (e.g., the need for home support services, long term care, assistive devices, legal matters, end of life care, etc.). The materials for the Information Hub are being developed from interview data with three groups of stakeholders in New Brunswick: 1) older adults (n=33); 2) informal caregivers of older adults (n =45); and administrators and front-line staff of governmental/non-governmental agencies (n = 22). Preliminary drafts are being pilot tested with older adults and caregivers. Final materials will be presented in a set of accessible and image-rich pamphlets that will be printed and distributed in the province, as well as housed on a website for ease of access by the public, health care providers, and provincial navigation services (e.g., 211, "NB Seniors' Information Line").

Results: We will present an outline of our navigational materials and discuss the results of our pilot tests. We will also explore lessons learned in this process, including the challenges and successes we have encountered in bringing this project to fruition.

Conclusion:By streamlining and coordinating information, and enhancing the quality of existing provincial services, our project aims to help individuals connect to appropriate services and ease the burden of system navigation.

Title: Developing and Implementing a Program Evaluation Framework at the Family Navigation Project: Challenges, Successes, and Outcomes

Authors: **Roula Markoulakis, PhD; Naomi Algate**; Jillian Thistel.

Abstract:

Youth with mental health and/or addictions (MHA) issues and their families face numerous individual, social, and systemic barriers to finding timely and appropriate care. Family Navigation programs are gaining recognition as a resource to support youth and families in connecting with appropriate MHA services. This presentation will share the process of developing and implementing an Evaluation Framework at the Family Navigation Project (FNP). Working group consultations were held over the course of one year with FNP management, staff, youth and caregiver clients, and Family Advisory Council members to define overarching evaluation questions, identify key indicators and outcome measures, and develop an implementation plan.

We will share the process of engaging the working group, our evaluation implementation process, and preliminary findings pertaining to caregiver and youth functioning, health and quality of life, and achievement of goals and satisfaction with the FNP. Analysis of pilot data revealed significantly decreased caregiver strain ($p<.05$), significantly higher youth quality of life ($p<.001$) and caregiver quality of life ($p<.05$), and significantly improved youth symptoms ($p<.001$). High levels of service satisfaction were indicated among respondents, in FNP service overall, FNP's ability to address the barriers to care experienced, availability of FNP staff, emotional support provided by the navigator, the navigator's knowledge of MHA and the MHA system, and with the resource options the FNP staff provided for them.

This presentation will highlight our findings around upholding program evaluation principles and applying evidence-informed measurement of key program processes and outcomes, providing high-quality Navigation programming for youth and families, and ensuring accountability to stakeholders. Plans for utilizing positive and negative findings for navigation service quality improvement and implications for clinical practice will also be shared.

Title: A qualitative study assessing organizational factors associated with the readiness to implement patient navigator programs in Toronto, Canada

Authors: **Kristina Kokorelias**, PhD; Sarah Gould; Tracey DasGupta; Sander L Hitzig, PhD.

Abstract:

Introduction/background: There have been increased efforts by hospitals and community organizations to foster stronger linkages to provide enhanced integration of care. One mechanism growing in popularity for achieving this goal has been the implementation of patient navigator programs. Patient navigators have been shown to be effective of improving outcomes for patients with various chronic conditions, but there is a lack of understanding on the factors influencing the successful implementation of patient navigators.

Design: A qualitative descriptive study is being conducted to explore factors influencing implementation of patient navigator programs within a healthcare institution in Ontario for seniors with complex care needs. Thirty-five semi-structured interviews have been conducted with 33 participants from a large urban hospital (n=19) and community healthcare organizations (n=14), including organizational leaders and acute care and rehabilitation providers.

Results: Preliminary analysis has identified five themes: (1) senior leadership buy-in and department commitment (2) technological infrastructure (3) existing hospital-community partnerships (4) well-established process for referrals (5) general capacity (e.g., adequate staff). The overarching theme of communication has also been identified. No differences in themes based upon profession or organizational setting have emerged.

Conclusion: This study is identifying key factors influencing organizational readiness for successful implementation of a patient navigator program for seniors with complex conditions. The findings will provide a better understanding of hospital and community professionals' needs and challenges when implementing patient navigator programs. Preliminary results suggest that when developing patient navigator programs, there should be concentrated effort to engage all organizational staff through clear communication and to consider existing technological barriers.

Title: Exploring the roles, functions, and background of patient navigators and case managers: A scoping review

Authors: **Katherine J Kelly**, PhD Candidate; Shelley Doucet, RN, BN, MScN, PhD; Alison Luke, PhD

Abstract:

Background: Patient navigators (PNs) and case managers (CMs) are health care workers who aim to provide individualized assistance to patients facing significant health concerns. Although these roles emerged from distinct historical need, the terms are often used interchangeably in the literature and are described to have overlapping functions. Differences in the way that these roles are conceptualized across countries has led to a lack of clarity regarding the exact functions that each offer to patients, caregivers, and the health care system.

Objectives: To differentiate the functions and backgrounds of PNs and CMs across settings and disease contexts.

Design: This review was guided based on the PRISMA extension for scoping reviews using a five-step process: identify the research questions; identify studies; select studies based on a priori criterion; chart the data; and summarize the results.

Results: The search strategy resulted in 10,523 articles. After applying the eligibility criteria, 468 full-text articles were reviewed, resulting in a total of 160 articles. Functions of PNs and CMs were organized into nine categories: (1) advocacy; (2) care coordination; (3) case monitoring and patient needs assessment; (4) community engagement; (5) education; (6) administration and research activities; (7) psychosocial support; (8) navigation of services; and (9) reduction of barriers. The background and knowledge areas of each role were compared and contrasted, and three categories related to the practice context of each role were identified: (1) typical setting and care trajectory; (2) target patient population; and (3) mode of service delivery.

Conclusion: The current study identified important differences in the functions between PNs and CMs. However, there remains significant ambiguity between the functions of these two roles. Standardized definitions detailing scope of practice, and allowing for flexibility across settings, are needed to improve service delivery.

Title: Patient navigation programs for people with dementia, their caregivers and members of the care team: A scoping review

Authors: **Grailing Anthonisien,** MA; Shelley Doucet, RN, BN, MScN, PhD; Alison Luke, PhD; Katherine J Kelly, PhD Candidate.

Abstract:
Background: Dementia is an umbrella term that covers more than a hundred diagnoses characterized by cognitive impairment. Patient navigation may benefit people with dementia because this population frequently faces fragmented and uncoordinated care and has individualized care needs. This scoping review seeks to find out how patient navigation is being implemented for people with dementia and their caregivers.

Design: This project is being conducted according to the Joanna Briggs Institute (JBI) framework for scoping reviews. It examines the characteristics of patient navigation programs to support people with dementia, their caregivers, and/or members of the care team that have been reported in the literature. Our goal is to present and chart existing evidence to build an understanding of how these programs work and their characteristics.

Results: The scoping review is currently underway, examining articles that contain information on programs, including their setting, delivery format, population, team composition, services offered, and the facilitators and barriers to program implementation. Final results will be presented at the conference.

Conclusion: The results of this scoping review will provide useful information to support the development and implementation of patient navigation programs for people with dementia, their caregivers, as well as the care team. This research also has the potential to help to inform researchers, decision-makers, and other stakeholders on the facilitators and barriers to program implementation.

Title: The Story of The Family Navigation Project

Authors: **Doris Jayson,** Family Advisory Council Member, FNP; **Karen Moffat,** Family Advisory Council Member, FNP; Ingrid Lane Family Advisory Council Member, FNP; Jeanne Foote, Family Advisory Council Member, FNP

Abstract:

The objective of this presentation is to tell the story of how The Family Navigation Project came to be. Since 2008, the design and implementation of The Family Navigation Project has been guided by parents who have had first-hand experience in the challenges of getting their children the help they need in a complicated mental health and addiction system. United by the frustrating experience of searching for appropriate treatment for their children, and fueled by the need to maintain hope, these families came together and enlisted the support of a visionary psychiatrist.

A mental health and addiction navigation model was envisioned based on compassionate persistence by a system navigator with expert clinical experience. A business plan was developed, and a family advisory council (FAC) was formed. The FAC attended town hall meetings and conducted interviews with local, provincial and national stakeholders to learn about other navigation models and to determine the needs of families and address the gaps in the system. A navigation service was then created in 2013 by hiring navigators, administrative staff, and later, other specialized positions such as an on-staff Parent with Lived Experience. Currently, the FNP has 9 navigators and 12 other staff and support positions who together have navigated for over 3,000 families. Lived experience has proven to be integral to the inception and continued development of FNP. Embedding the voice of lived experience is crucial to the culture and successful integrity of the project. The FAC lends its voice in an advisory capacity in strategic planning and operations through the lens of lived experience.

Navigation is a valuable tool and is increasingly utilized within Canada's healthcare system, underscoring the need for province-wide programs which serve all ages and demographics. Lived experience-informed models allow programs to be developed that are more responsive and adaptive to client needs.

Title: The Multiple Benefits of Dementia-Specialist System Navigators

Authors: **Daniel Gaetano,** Care Partner, Dementia Advocacy Canada; **Lisa Poole**, Care Partner, Dementia Advocacy Canada.

Abstract:

Dementia-specialist system navigators, assigned upon diagnosis through to end of life, could improve health outcomes, reduce care partner stress and save our healthcare system money.

The Canadian healthcare system is complex and difficult to navigate for people with chronic conditions like dementia. At their greatest time of need, people living with dementia and their families need kind and compassionate care. The burden of understanding the complexities of our fragmented system should not be their responsibility. When people are unable to access appropriate supports and services or are unaware they exist, their default is a visit to the Emergency Department, the most expensive level of care or a premature move to institutional care, the next most expensive level of care.

Based on examples from other countries like Scotland and Australia, an investment in dementia-specialist system navigators who provide a connection to appropriate community health and social supports and guidance with transitions, can mitigate system fragmentation and increase cost effectiveness. Navigators with dementia specialization can help people with a dementia diagnosis retain their independence and remain at home longer, the least expensive level of care and where most people want to be.

Title: Recipe for success: Key ingredients in creating a Patient Navigation Program that works.

Authors: **Rosemary Kohr,** BA, BScN, MScN, PhD, RN.

Abstract:

Patient Navigation has been identified as a powerful tool in supporting smooth transitions, as a way of addressing the gaps in healthcare services that impact patients and families often facing complex health challenges. Many organizations as well as the public, are beginning to want access to Patient Navigation/Navigators. While there is enthusiasm and support for the role, there is also the potential for failure when attempting to insert Patient Navigators into existing systems.

In this presentation, the discussion will focus on the 5 key ingredients required to support success and sustainability of Patient Navigators and programs in the healthcare environment. This recipe is based on the results of examining the current literature, inclusion of the experiences of both providers and patients and outcomes of a review of Patient Navigation practices across the continuum of care.

This presentation will provide a summary of the key elements required for successful outcomes in development and sustaining Patient Navigator roles and programs, and serve as a check-list for those who are in the process of implementing or evaluating Patient Navigation in their setting.

Title: Wheatland & Area Hospice Society (WAHS) Outreach Navigator Program

Authors: **Martina Vergouwen,** BN student; **Joni McNeely,** MD; Diane Cammaert, RN.

Abstract:

Introduction: Improved access to community resources supporting rural palliative care was identified by both caregivers and stakeholders as a priority need in a 2016 WAHS needs assessment. A large geographical area, few palliative volunteers, and limited local awareness of a formal palliative system were identified challenges.

Design: The role of a volunteer Palliative Navigator was created. General palliative training was provided by Alberta Health Services. Policy and procedures mirrored Australia's LaTrobe University Navigator Program. Orientation was provided to community stakeholders (MD's, PCN, Homecare, pharmacies, churches, and community support services) to initiate referrals. Using a client centered model of care the Navigator, client, and caregivers created a network of informal community resources to support home based palliative care. The Palliative Navigator also conducted hospital visits or phone visits.

Results: More than 30 patient cases are completed. Stakeholder participation is encouraging, although missed or refused referrals are not reported. Our Navigator is a retired public health and homecare nurse, which decreased the need for formal training. Motivational interviewing was identified for future education. A recognized challenge was balancing caregiver support (especially anticipatory needs) and formal care plans. Transitions in awareness, consideration of options, and decision-making is often difficult for caregivers with their own stressors and capabilities. A 'coaching' role that is non-threatening to formal systems is a potential improvement in navigation.

Conclusion: WAHS's Navigator provides intimate and flexible support to rural patients during their palliative journey. Patient and caregiver satisfaction is positive, which is a successful component of WAHS's Programming Pillar. Future directions include analyzing the benefits, like prolonged out of hospital stay, afforded by the Palliative Navigator.

Title: Helping Ontario patients navigate the system using digital tools, data governance, and front-line staff: a case study

Authors: **Norah Cuzzocrea, Lynn Buckwell,** CRS, CRS-DC; Gabriele Davey, BA

Abstract:

Introduction: thehealthline.ca is Ontario's provincial online system navigation tool. Launched province-wide in 2012, it has grown to include more than 47,000 health and social services profiles arranged in over 400 categories. It is currently configured to support the 14 Ontario Local Health Integration Networks (LHINs). Much has changed in the past decade in terms of the Internet, health consumer needs and expectations and health system transformation. This presentation will explore the genesis of this digital system navigation tool, reflect the perspectives of system designers, planners and users and discuss the implications for adapting to a changing health care landscape.

Design: This presentation will be an interactive discussion with thehealthline.ca Information Network staff responsible for building and maintaining the tool and Lynn Buckwell CRS, CRS-DC, a Community Resource Specialist with the Hamilton, Niagara Haldimand and Brant LHIN, who will speak to the user perspective. The mechanics of the system will be reviewed: how it was built as well as how data collection, information management data presentation work. The differing needs of users will be discussed, including: self-navigation, assisted navigation and planning and asset mapping.

Results: The lessons learned from almost a decade of provincial deployment will be discussed. This will include a greater understanding of real-world usage, patient and caregiver needs, the requirement for rigour in governance, data stewardship and roles and responsibilities clarity.

Conclusion: The implications from these results will be explored, including the need to more fully reflect patient needs and capabilities (e.g. varying levels of health literacy and patient activation), the requirement for a mobile-first digital solution to align with current user behaviour and the need to align more closely to care pathways, especially for chronic disease.

Title: A Journey with You: Indigenous Peer Navigation in Saskatchewan Cancer Care

Authors: **Shelby Moniuk,** MISW student; Cassie Stefanski, MISW; Tracey Carr, PhD; Gary Groot, MD, PhD.

Abstract:

Introduction: For many Indigenous people in Saskatchewan, Canada, the burden of cancer is amplified by a host of systemic, cultural and personal challenges and barriers. This study pilots an Indigenous Patient Navigator (IPN) program in a Saskatchewan context to gain a deeper understanding of the unique health experiences and barriers facing Indigenous cancer patients and to document the potential benefits of an IPN.

Methods: In this cohort study, we will provide 30 Indigenous patients with individualized navigation as they journey through first diagnosis to journey home. The IPN will assist patients to navigate health system barriers, provide health education about cancer, address patient barriers to cancer care, and provide psychosocial support. Qualitative interviews will be completed with newly diagnosed cancer patients at the beginning and at the end of treatment. Through 30 Indigenous cancer survivor qualitative interviews, we will compare navigated and non-navigated cancer journeys. The IPN will document their interactions with participants using mobile based questionnaires and will complete a checklist about their encounters.

Results: Currently, the IPN is recruiting patients, and three survivor stories have been documented. We anticipate that an IPN will improve patient outcomes by elevating patient trust and reducing anxiety, increasing patient understanding, and advocating for incorporation of the patient’s world view.

Conclusion: The goal of the IPN study is to determine how to best support Indigenous people in Saskatchewan in making optimal, informed, patient-centered health decisions. The IPN role is to identify barriers faced by Indigenous people such as cultural, systemic, and other personal barriers. The proposed study seeks to advance and contribute to knowledge of the effects and effectiveness of the navigator role.

Title: A model for reducing hospital recidivism rates for child and youth mental health; transitions in care from hospitals to community based mental health settings for children and youth

Authors: **David O'Brien,** CYW, CYC B.A., MACP, MBA, RP**; Neeli Grewal;** Chantal Senechal; Karina Gonzalez.

Abstract:

Across the province of Ontario, children and youth are falling through the cracks when transitioning from hospital inpatient and outpatient services to community based mental health centres. As a result, children, youth and their families are required to tell their story several times, information and recommendations often don't make it from the hospitals to the next service provider in the community, and children, youth and families return to the hospital unnecessarily at times because they don't know where to go. Hospital visits for mental health issues concerning children and youth are on the raise with over a 30% increase and some of this percent is a result of limited knowledge about services in the community and barriers to access. In 2018, Yorktown Family Services reallocated funding to create a Care Navigation position to 1.) Provide warm transitions from hospitals to community-based mental health organizations 2.) Carry forward and implement recommendations from hospitals to the community setting 3.) Support with rapid access and reduce barriers to community based mental health services.

The objectives of the presentation will look at;

1. The pathway between hospital and community-based child and youth mental health and the role Care Navigation plays to facilitate this process.
2. The communication infrastructure and documentation between the Care Navigator and hospital staff to ensure a successful transition.
3. Metrics, screeners, and tools used to support the transition and understand the patient experience and needs within the transition.
4. Testimonials from patients, hospital staff and community-based child and youth mental health staff.
5. How this model can apply to local communities and what is required.

APRIL 16th 2021 - CANADIAN HEALTHCARE NAVIGATION CONFERENCE

CONCURRENT SESSION ABSTRACTS - NAVIGATION IN PRACTICE; NAVIGATION IN POLICY/ADMINISTRATION

Title: No strings attached: Care Navigation in Australia

Authors: **Marika Kontellis**, BA, BSW, MA; **Gary Jacobson,** BA Hons, MPH, MA, Doctor of Business

Abstract:

Australia's health and social care systems are shifting. The marketisation of the health and care sectors is promising customer choice and self-determination. The not for profit sector is being rocked by competition and emerging social entrepreneurs are arguing that the digital age will answer every health and social care problem presented. Everyone has a special "deal" for customers in this changing context.

In this entertaining and interactive session the presenters will:

- Provide an overview of the changes in Australian's health and social care landscape.
- Contextualize the rhetoric of choice by linking the findings of the Australian Royal Commission into the Financial Services Industry to the Health and Social Care sector
- Showcase how care navigation is delivering customer protection, choice and good outcomes.

Whilst it is a work in progress, the journey to enabling Australians to understand their entitlements, rights and options continues to be rocky. Rhetoric often masks resistance and consumer choice is often thwarted by bureaucracy, professionalization and the lack of readiness of the "market" in the market to buy and sell health and social care.

Leveraging the lived experience of others can provide a "no strings attached" model of care navigation. Independent and impartial care navigation does not see a person as a cash grab or even as a customer. They see them as needing independent and impartial information, advice and guidance at one of their most vulnerable times in their life. People can get the most out of life. All we need to do is make it easier for them.

Title: The Newcomer Navigation and Support Program at Manitoba Possible- Navigating the Spaces Between

Authors: **Traicy Robertson**, BA

Abstract:

The mission of Manitoba Possible is to continually develop, maintain and deliver relevant services that assist in the development of individual independence and community support for persons with disabilities. Our vision is a community that supports the independence, participation and empowerment of persons of all abilities.

Established in 1997, the Newcomer Navigation and Support Program (NNSP) provides direct cultural services and supports across disability, age, gender and ethnicity. We support newcomers to Canada, living with a disability, who are experiencing a language barrier. We provide intensive first language assistance and support to individuals and families, using a case management approach, connecting them to the complex systems available to support their unique needs.

The Newcomer Navigation and Support Program was developed based on the concept of Cultural Brokering. The programs team utilize their multiple language skills; their ability as interpreters, both literally and culturally; their ability to mediate and manage conflict; and their ability to advocate on behalf of their consumers. They work to bridge the cultural gap of understanding in the disability, social services and health care field. Our ultimate goal is that our clients are ultimately able to make independent, informed decisions on their own care or the care of a family member.

This workshop will discuss the challenges and benefits of cultural brokerage programs, and their essential role for new Canadians in the disability, health and social service sectors.

Title: Closing the Gap through Clinical Navigation: The Transitional Youth Program at Michael Garron Hospital

Authors: **Adina Hauser,** MSW, RSW**;** **Vanessa DaCosta,** MSW, RSW; Amil Riaz, MSW, RSW.

Abstract:

Introduction: Young adults (16-24) accessing mental health supports at MGH often face barriers in transition from the child/adolescent system to the adult system; from the ER to ongoing services, and from inpatient to outpatient/community programs. TYP is designed to fill these gaps by providing service navigation and clinical support to improve continuity of care. A subsequent goal is to build community partnerships and better connect these youth to the community at large.

Design: Surveys from youth/families and service providers during the design phase showed the desire for flexible, mobile, timely, and in-person resource navigation and clinical support. Data collected from participants produced a framework for program goal setting and evaluation. Consultation with hospital/community stakeholders was essential to program design and enhancement.

Results: Early results show a reduction in ER visits for participants of TYP compared to pre-program involvement. The completion of warm-handovers with community agencies has meant successful transitions for young adults. Preliminary qualitative data also suggests that TYP is meeting the needs of service users and providers. Lessons learned thus far highlight the importance of flexibility, mobility and texting for engagement with navigation services. Community partnerships and ongoing communication also contribute greatly to the success and enhancement of such programs.

Conclusion: Young adults experience significant barriers in the mental health system at large, including difficulty with transitions between and within systems and often stop accessing care as a result. TYP has shown promise by removing barriers and supporting youth in finding and sticking with treatment. Clinical navigation support highlights both the significant need and potential contributions to the system at large, youth, caregivers, and providers alike.

APRIL 16th 2021 - CANADIAN HEALTHCARE NAVIGATION CONFERENCE

CONCURRENT SESSION ABSTRACTS - NAVIGATION IN PRACTICE; NAVIGATION IN POLICY/ADMINISTRATION

Title: Improving connectedness-to-care-and-services for children with neurodisability and their families: The Kids Brain Health Network Navigation Project in BC

Authors: **Anton Miller,** MB. ChB, FRCFP

Abstract:

Background: British Columbia is part of a Western Canada initiative aiming to improve connectedness-to-care-and-services for families of children with Neurodisability. These children and families often require an array of services and supports from multiple sectors (medical; early intervention/ (re)habilitation; mental health; education; social services). There is no service system per se that integrates sectors and agencies; instead, there is fragmentation and families struggle to “navigate” the terrain of services and supports.

Details: We adopted a dual population focus: (i) local–aimed at improving the experience for children and families transitioning from specialized diagnostic services at a tertiary centre in BC, to community therapies and supports; (ii) provincial–aimed at working with partners and stakeholders who serve children with ND and families across the province.

Lessons Learned: In the local work, we have learned that families struggle to learn about, and connect to, needed services and supports across clinical programs. Small incremental process changes are being made within the tertiary organization and in collaboration with affiliated agencies.

On the provincial side, we worked with partners and stakeholders to identify shared, actionable priorities. Terminology emerged as a sensitive area, especially ‘navigation’ and ‘navigators.’ We are working to systematically review definitions from academic literature combined with input from practitioners and stakeholders, to achieve consensus around the words and concepts spanning related terms. We are also aiming to bring together agencies that support families to ‘navigate the terrain’, to learn from each other. Establishment of a community of practice has emerged as a possible goal.

This presentation will share insights gleaned from activities to date, including the salience of terminology in navigation, and complexities inherent in collaborative efforts to change systems and to evaluate such efforts.

Title: Navigation and OHTs: Breakthrough Opportunity or Business As Usual?

Authors: **Sugy Kodeeswaran**, BSc, MHSc; **Adair Roberts**

Abstract:

The Family Navigation Project was the brainchild of a group of committed parents who had firsthand experience of the seemingly insurmountable barriers and confusion many families face when trying to get the right mental health or addictions (MHA) care for their youth. However, their experiences were, and are not unique.

In 2019, the (Ontario) Premier's Council reports on Improving Healthcare and Ending Hallway Medicine indicated there is a need to "Improve patients' and providers' ability to navigate the healthcare system." Similarly, jack.org surveyed more than 1,500 youth and found that 74% of those surveyed didn't know when or where to get help; 72% didn't know what types of mental health services were available; and 62% cited that difficulty in navigating the mental health system is a barrier that youth face when trying to get help. Additionally, the 2019 Ontario's Caregivers report found that mental health caregivers feel there are many barriers standing between them and the support they need to provide the best care (including the: inability to find support to care for mental illness (51%); and lack of information on how or where to get support (47%)).

The above reasons, coupled with the recent proliferation of navigation services, highlight the need for a broader discussion and collaborative approach to understanding the critical role which navigation can play within a high-functioning healthcare system. There is a timely opportunity within Ontario's landscape, as the healthcare system is undergoing significant transformation through the Ontario Health Teams (OHTs) and system integration processes. This talk invites the community to help explore how navigation as a care delivery process should be seen as complementary to, and mutually reinforcing of, the system integration objectives and processes of the OHTs and serves as a real opportunity to fundamentally transform how MHA services are accessed within the system.