

Title: Behavioural Supports Clinical Navigation: Improving Care from a Systems to Referral Level

Authors: **Adrienne Lee, OT; Peter Marczyk, SW; and Varsha Jayaraman, OT.**

Abstract:

Introduction: Toronto Central (TC) Region's Behavioural Supports Ontario (BSO) programs have expanded in response to a growing need for behavioural supports for clients living with dementia. Formed in 2020, the Behavioural Supports Coordinating Office set out to meet the growing demand by centralizing system level flow and triage, and optimizing continuity of care and transitions between sectors. Staffed by Clinical Navigators and Administrative staff, the Office has expanded due to its success and impact.

Design: Grounded in the BSO's three foundational pillars of: system coordination, integration, and capacity building, the Office started with a system navigation Hotline to support families and healthcare providers. The Office quickly grew to become the centralized intake service for all TC Region BSO programs in Community, Acute Care, and LTC (including Geriatric Addictions, and LTC Caregiver Specialist), as well as the triager for the Virtual Behavioural Medicine program (a unique initiative that supports responsive behaviours virtually throughout Ontario). Seeing the complexity of referrals sent to the Office, a further expansion took place to include a Complex Case Resolution Table (CCRT), which facilitates consultations with healthcare providers on complex cases. The Office also expanded to support Acute Care collaboratives and ALC tables to support transitions.

Results: In the last reporting fiscal year alone, the Office processed 1803 referrals for all BSO programs, and addressed 383 BSO Hotline contacts requesting information and guidance in clinical system navigation (in all sectors). Within the 2022 calendar year, the Office has coordinated and led 15 CCRTs in LTC and Community in support of resolving complex clinical cases.

Conclusion: Starting as a system navigation Hotline in 2020, the Behaviour Supports Coordinating Office has become a central resource to provide wrap-around behavioural support and triage in the TC Region, as well as supportive resources for behavioural system navigation beyond the TC Region.

Title: Cross-Sector Collaboration through SCOPE to Support Navigation in Mental Health and Addictions

Authors: **Kittie Pang, MHA (CC); Solmaz Dehghan;** Sugy Kodeeswaran; Amy Wakelin; Kitty Liu.

Abstract:

Introduction: Primary care providers (PCPs) play a key role in an individual's health and well-being, as they are the entry point into the health system. PCPs connect patients to needed services but can face barriers in a confusing system. Seamless Care Optimizing Patient Experience (SCOPE) is a virtual interprofessional team connecting PCPs to specialists and other resources to address the needs of their patients. In North Toronto (NT), PCPs need additional supports in Mental Health and Addictions (MH&A), as patient needs increased during the pandemic. This presentation will highlight the journey of the North Toronto Ontario Health Team (NT OHT) and how its cross-sector collaboration is supporting integrated care by addressing the MH&A navigation needs in primary care.

Design: Sunnybrook Health Sciences Centre is a member of the NT OHT and lead for SCOPE in NT. SCOPE expanded its offerings by working with cross-sectoral partners. The partnership includes: 1) LOFT, a community MH&A service provider, to provide a dedicated staff as the SCOPE MH&A Navigator; 2) Family Navigation Project, a program that provides navigation of the MH&A system for youth and their families, to provide navigation supports, resources and share best practices with the SCOPE MH&A Navigator; and 3) Department of Psychiatry at Sunnybrook, to provide dedicated time to PCPs for just-in-time advice or focused patient consultation for urgent cases.

Results: The SCOPE MH&A collaboration is in its early stages of implementation, but preliminary results show the collaboration has significant potential in improving access to MH&A services, PCP experience and communication between PCPs, community-based providers, and the MH&A system. This collaboration is also contributing to the development of infrastructure for a more integrated health care system via OHTs and building partnerships that addresses the unmet needs of coordination and facilitation of MH&A services.

Conclusion: Further evaluation is needed to examine the effectiveness of this program. Cross-sector collaboration is proving to be an effective model and approach to improving access to appropriate health care services and is well aligned with the current goals of OHTs throughout Ontario, creating further opportunities for expansion and growth.

Title: System Navigation at a Community Mental Health Hub: Coordinating Clients' Care Plans

Authors: Janet Stewart, R. Psych; **Laura Camacho; and Simron Sidhu.**

Abstract:

Introduction: As a response to client experience feedback, two long-standing mental health services expanded to provide targeted health and social system navigation. East side Community Mental Health Services (ECMHS) developed an innovative service delivery model to address the fragmentation of Calgary's social and health services. Presenters will share the following: transforming a mental health hub by adding system navigation services, our definition of system navigation, and the potential of this service to tackle inequities in the health care system.

Design: For 30 years, ECMHS have been providing referrals and resources to clients over the phone, and in person as part of crisis visits or therapy sessions. While clients reported high satisfaction for these services, feedback included the need for personal connections to resources provided rather than a "cold" referral. ECMHS' journey over the past 2 years to create a new service delivery framework integrating the long-standing program principles of immediate, barrier free mental health support and the identification of social determinants of health will be presented.

Results: Presenters will share data related to client satisfaction and outcomes. Qualitative data will include team experiences with warm transfers, in-the-moment system navigation sessions, collaborations with health and community-based partners and strategies to foster an integrated ethno-cultural team at a mental health hub.

Conclusion: Clients have told us that inaccessibility is one of their major reasons for not getting the care they need at the right time in the right place by the right team. We see system navigation to meet these individuals' needs. ECMHS clients whose coping skills have been overwhelmed by a variety of intersectional dimensions of vulnerability have had an enhanced experience due to a service that ensures they receive the care that they deserve. Presenters will highlight how other mental health hubs can integrate system navigation into their current service delivery.

Title: Pillars of Support - The Ontario Provincial Acquired Brain Injury (ABI) System Navigator

Authors: **Julie Osbelt, B.A. in TR (Hons); and Cathy Halovanic, BPHE, M.Sc.**

Abstract:

Introduction: This presentation will introduce and educate on the diverse role of the Province of Ontario's 14 ABI System Navigators, including their involvement in complex case coordination, their voice with the Ministry, and community education. Presentation to highlight how Navigators can broaden awareness of ABI supports and services, both within the ABI setting as well as to external agents.

Design: The role of the ABI System Navigator enables a system level view between the Ministry of Health and front-line programs and services. Navigators are assigned to geographical regions across the province to address healthcare needs specific to their area. While their general role is to help survivors, caregivers and service providers access the various ABI services in their area, they are also involved in educating various social service agencies on ABI, including how to screen for history of injury. Through these efforts as well as involvement with various Committees, they have been able to develop and promote better collaborations between different service sectors such as mental health, addictions, justice, and housing.

Results: Navigators play a role in addressing inequalities and highlighting the need for integrated care. This may include raising awareness to provincial funders, including Ontario Health Teams and Ministry representatives, about the needs of complex individuals. They are also integral in providing support for the Neurotrauma Care Pathways Project. While not providing direct support or case management, they are a valuable asset in terms of system navigation and capacity building, and work alongside members of the Provincial ABI Network.

Conclusion: Navigators provide a navigational link between the healthcare system and the individual with an ABI by focusing on education, resource navigation, complex case coordination and by identifying system gaps.

Title: Two Navigation Toolkits for Service Providers Working With Afghan and Ukrainian Arrivals

Authors: **Cat Goodfellow, PhD.**

Abstract:

Introduction: This presentation reports on the development of two intersectoral toolkits aimed at professionals serving newcomers to Canada. Created using an innovative working group model, the toolkits focus on the unique cultural, social, health and settlement needs of Afghan and Ukrainian arrivals to Canada. We present links to the toolkits, and outline a roadmap to designing, populating, and evaluating these two toolkits which may be useful to others working on the complex intersectoral issues facing newcomers.

Design: Between September 2021 and March 2022, N4 leveraged its Community of Practice intersectoral working groups to address our stakeholders' requests for information about Afghan new arrivals. N4 provided administrative, project management, research and writing support. During the process of developing the Afghan toolkit, the situation in Ukraine became critical and Canada prepared to welcome Ukrainians. In response, the working group rapidly began to work on a Ukraine toolkit.

Results: Both toolkits were launched in the spring of 2022. The addition of settlement and social service participants in this work complemented the healthcare perspective to consider all the culturally specific information newcomer-serving professionals might need to support Afghan and Ukrainian arrivals. Administrative support from N4 facilitated efficient use of participants' time.

Conclusion: While the healthcare and settlement sectors frequently work closely together at the individual patient level, their funding streams and supporting policy is often siloed. The intersectoral working group model allowed providers to come together and understand how they can best support navigation between health and settlement, to contribute to positive health and a strong integration immigrant and refugee experience in Canada. This model could inform the rapid development of other toolkits to meet the specific needs of emergent waves of migration to Canada.

Title: Advancing an Integrated Navigation Approach for Children with Neurodevelopmental Disabilities

Authors: **David B. Nicholas, PhD, RSW, FCAHS**; Samantha B. Sutherland, Research Coordinator; and **Melissa Dobson, PhD.**

Abstract:

Introduction: Children with neurodevelopmental disabilities (NDD) have extensive needs for support. Yet, they experience substantial gaps in, and fragmentation of, resources across various sectors of disability-related services, reflecting a lack of coordination the continuum of care. To address these deep service access challenges, this partnership involves key players needed to advance a novel approach across Alberta, resulting in a NDD navigation system via & across linked community partners.

Design: Based on the preliminary work of this team and further developmental work over several years, we have formulated a navigational approach, entitled the “Integrated Navigational Services System” (INSS) to be trialed and evaluated. INSS is a systematic approach to advance seamless and timely access to services via streamlined navigational support. Our work to date in navigation in NDD (and non-NDD) populations indicates important personal, service and relationship factors, fostering collaboration between the client (family) and the navigator. It further reflects a tiered approach, where families access navigation support that is commensurate with need and level of support desired.

Results: Preliminary findings to date indicate positive impacts of this approach including a critical role of parent-to-parent peer supports. Further evaluation is anticipated and will be reported.

Conclusion: The current gaps in navigational service access for families directly impacted by NDD is (and will be) addressed by this partnership, with collective action and evaluation based on strong partnership with academic and non-academic partners. In building this partnership, it is anticipated that we will incrementally increase mutual understanding and capacity such as innovative methods to improve navigational services.

Title: A collaborative approach to seamless integrated inter-establishment care pathways in Montreal

Authors: **Kelly Thorstad, Nurse Executive;** Stephanie Gould; Camille Brosseau; Julie Letendre; Chantal Damas; Annie Pinet; Caroline Marie Fidalgo; Matthew Bergamin; Aurélie Vigné; The Integrated Working Group; The My Way study team; and Marie Beauséjour.

Abstract:

Introduction: In Montreal, children with musculoskeletal disorders requiring complex care benefit from 3 pediatric hospitals providing high quality healthcare. However, this multi-faceted care makes navigation difficult. Recognizing the need for integrated care, an inter-establishment inter-disciplinary workgroup set out in the context of MUSCO - a privately funded collaborative Initiative - to investigate challenges and design solutions to facilitate these families' care pathways.

Design: Knowing integrated care cannot emerge from fragmented processes, key stakeholders were brought together in an integrated group: professionals, managers, patient-partners and researchers from the 3 centres, a social design agency, and the MUSCO team as facilitators. This exemplifies a learning health system where knowledge generation processes are integrated into practices to improve services. The first step was building a shared understanding of current pathways and continuity challenges in inter-establishment transfers. Fostering neutrality, data collection was conducted, and families and professionals interviewed, by the research team and social design agency about their experiences and practices. Workshops are being held to develop healthcare resources and tools to improve navigation.

Results: As an adjunct, an inter-establishment navigator position was created to support the group's work in the field, bridging the gaps between each center's existing navigators. The discussions have already resulted in clear mapping of inter-establishment pathways and implementation of quick navigation solutions - such as admission criteria clarifications, information exchange tools and pre-operative procedures harmonization. Future macro solutions will be proposed to the hospitals' upper management.

Conclusion: This approach is one of continuous improvement. It has already permitted developing integrated processes, and has allowed mutual understanding and knowledge-sharing between clinical, research and managerial areas, to support an overall community of practice with and for patients.

Title: The UNITE Toolkit: Improving Transitions from Youth Mental Health Care

Authors: **Emma McCann, BSc**; Kristin Cleverley, RN, PhD, CPMHN; and **Julia Davies, RN, PhD Candidate**.

Abstract:

Introduction: Though continuity of care (CoC) is associated with improved functioning, reduced health care costs, decreased mortality, and improved quality of life, there is a paucity of research on the implementation and evaluation of interventions to improve CoC for youth transitioning out of child and adolescent mental health services. Consequently, clinicians, researchers, and policy makers continue to demand greater understanding of the care transition process and evidence-based resources to support the development and implementation of transition interventions. The current project will develop a transition toolkit to guide interventions to improve CoC for young people during this crucial period.

Design: The UNITE Toolkit builds on previous research led by the project team, including a Delphi study conducted with youth, caregivers, and clinicians and administrators across Canada to identify core components of successful mental health transitions. Based on the core components, this CIHR-funded project engages community partners, including youth and caregivers, in the co-design, testing, and dissemination of an implementation toolkit for youth mental health care settings. This presentation will overview the four-phased development process of the final resource: (1) Confirm Pilot Toolkit; (2) Lead Community Consultations; (3) Revise Toolkit; (4) Launch Final Toolkit.

Results: The final UNITE toolkit will include an open access, plain-language downloadable youth mental health transition toolkit and workshop co-developed with community partners to support the integration of core components of successful transitions from CAMHS to AMHS. Dissemination of the toolkit will be supported by a pan-Canadian dissemination strategy in 2023.

Conclusion: The evidence-informed co-design of tools to support CoC during youth mental health transitions is critical to address this pressing service gap. The UNITE project builds on both research and community evidence in order to disseminate best practice, strengthen national communities of practice, and respond to decision-maker demands for better tools to support youth mental health transitions.

Title: The impact of a Youth Engagement Strategy on service providers perceptions of youth engagement

Authors: **Deewa Anwarzi, BA**; Anthony Levitt, MD, FRCPC; Sugy Kodeeswaran, MHSc; and Roula Markoulakis, PhD.

Abstract:

Introduction: An important critique of the current youth mental health and addiction (MHA) system is that youth can be treated as passive recipients of care. This may result in negative effects on how service providers work with youth in the care process and how youth view themselves in their care. One way of shifting perceptions of care providers and enhancing youth experiences are through organizational strategies. Specifically, strategies that promote youth engagement (YE) have been found to improve organizational practices and empower youth within the care process.

Over the last year, the Family Navigation Project, a GTA-based youth MHA navigation service, has developed and implemented its own Youth Engagement Strategy (YES). This study aims to explore the impact of the strategy on front-line staff perspectives of YE and of their work with youth. Specifically, we examine changes in attitudes toward youth, confidence in working with youth, and organizational commitment to YE. Using a within-subject pre-post survey design, we predict that front-line staff will report greater confidence and attitudes toward youth and greater organizational commitment to YE at the one-year follow-up.

Design: This study includes a single 23-item survey administered to front-line staff (n=11) twice: once at the start of strategy implementation (January 2022) and once after a year of implementation (January 2023). Data will be analyzed via repeated measures t-tests and ANOVAs.

Results: Follow-up survey administration is in progress. Anticipated results will indicate improvements in navigator confidence and attitudes when working with youth, as well as commitment to youth engagement.

Conclusion: This research study enhances understandings of how patient-engagement efforts (e.g., via a YE strategy) influence the work of frontline staff. These findings will inform FNP and other navigation services regarding the results of staff training efforts, which can be used to guide future initiatives.

Title: Pathways to Supporting Social Determinants of Health Through Creative Community Partnership

Authors: **Stephanie Moynagh, MEd; and Jessica Reid, MSW, RSW.**

Abstract:

Introduction: COVID-19 has further compounded the impacts of existing social conditions on the health and wellbeing of families and communities, increasing the importance of engaging with clients and families about the non-medical needs that affect health outcomes. Holland Bloorview's collaborative navigation service, the Family Navigation Hub, partners with families and community service providers to address family-identified needs related to social determinants of health in a pediatric rehabilitation setting.

Design: This presentation will call attention to the importance of actively shifting from traditional to equity-oriented approaches which serve to strengthen family and community health. In addition to an overview of the navigation service, we will highlight the key components of our community partnership-building process and the impacts of personalized linkages between families and community partners through our innovative CommunityCONNECT event series.

Results: Key learnings will be shared regarding our partnership-building with a local food-security-focused organization, integration of Family Leaders into the program and the tensions inherent to addressing social needs with families facing systemic barriers in a wider social context of escalating food and housing crises.

Conclusion: Using equity-informed approaches, creative community partnership-building and shared decision-making between clinicians and families, a positive impact can be shown by strengthening connections between navigation programs and the local communities of families toward improving holistic health outcomes.

Title: An Environmental Scan of Patient Navigation Programs in Canada

Authors: **Cathleen M. Evans, MA, MScOT Candidate; Zoë A. Smith, BSc (Hons), MScOT Candidate; Simran Arora, MSW, RSW; Sander L. Hitzig, PhD; and Roula Markoulakis, PHD.**

Abstract:

Introduction: Patient navigation programs (PNPs) provide patients and their families with support and guidance in accessing healthcare resources. This is accomplished by identifying barriers to care and matching patients' unmet needs to appropriate health and social services. Although patient navigation is increasingly becoming a "norm" in Canadian healthcare, there is significant variation in its conceptualization and implementation. These differences lead to siloes, confusion, and misunderstandings of what navigation entails and for whom it is most beneficial.

This project outlines the methods for an environmental scan (E-scan) of existing PNPs across Canada. The main objective of the E-scan is to collect and synthesize information on what patient navigation programs are being offered to different patient populations across Canada. Its secondary objective is to gain an in-depth understanding of barriers and facilitators to their successful implementation.

Design: This project outlines the three planned phases of our environmental E-scan, namely: (1) a literature search of publications and grey literature on PNPs by Canadian authors, (2) an online survey to PNPs and, (3) individual follow-up interviews with professionals or groups of professionals working at Canadian-based PNPs.

Results: The e-scan findings to date will be provided, including anticipated results about the following characteristics of PNPs in Canada: (1) setting and location, (2) navigator role, title, and team composition, (3) patient population supported, (4) program description and scope of navigator tasks, (5) key barriers and facilitators to the navigator role, (6) priorities for future practice and policy, and (7) outcome metrics used to assess program impact.

Conclusion: By identifying the current status and scope of PNPs across Canada, this project will support efforts by stakeholders to develop, implement, and share best practices in the field, and inform future policy and research priorities.

Title: Creating a Community Health Navigator Community of Practice using Quality Improvement

Authors: **Fatima Shah**; Violetta Reznikov; Natalie C. Ludlow; Rachel J. Livergant; Amy Ferris; and Kerry A. McBrien.

Abstract:

Introduction: We created a Community of Practice (CoP) for a geographically disparate group of Community Health Navigators working across four Primary Care Networks (PCNs) within a program of research in Alberta. CHNs are members of the patient's care team, trained to address barriers to self-management and access to health and community resources. The CHN CoP, which includes virtual pan-PCN meetings and a CHN Hub website, provides a central space to explore the novel role of a CHN and participate in shared learning. A needs assessment informed elements of the CoP and our ongoing evaluation aims to identify best approaches for a CHN CoP to continue to support CHNs and their practice.

Design: Our iterative quality improvement (QI) approach includes member surveys and website usability testing, together with a formal planning committee to inform refinements in CoP structure and activities. An electronic survey of CHNs in August 2022 assessed CHN satisfaction with meeting structure and content. Website usability testing included website demonstration, user experience survey, focus group, and website analytics.

Results: All CHNs completed the electronic survey (n=19), which revealed that communication continues to be deemed essential to CHNs and there is a need for more CHN interaction and opportunities to share patient stories. Based on these results, we anticipate the CHN website discussion board may fulfill this need. A terms of reference manual was developed to provide structure and guidance towards the purpose of the CoP meetings. Website usability testing results are expected to reveal decreased barriers to use and increased user satisfaction and engagement.

Conclusion: A CHN CoP that includes multiple modes of communication, and a variety of activities can enable knowledge exchange and sharing of best practices. Iterative quality improvement and embedded QI strategies support continued practical improvements for the CHN CoP.

Title: YourCare+: A solution for social prescribing and service navigation

Authors: **Sydney Jones, BSc;** Lindsay Klea, BA; and Andrew Costa, PhD.

Abstract:

Introduction: Navigating care is complex and confusing. As Canada's aging population increases, access to health and social services is necessary to support aging in place. However, many caregivers and older adults are unaware of their care needs and what is available to them until it is too late. Further, staffing shortages in healthcare increase challenges for accessing timely support. The health system needs mechanisms for people to self-navigate.

Design: YourCare+ (www.yourcareplus.ca) is a central resource for older adults and their caregivers to support system navigation, manage care needs—and soon— digitally self-refer to home care and community support services.

The forthcoming YourCare+ Service Navigation Platform automates how people access health and social care. Leveraging our team's unique expertise in developing standardized health assessments, we modified a clinician-administered assessment survey into a self-report version that individuals or caregivers can access and complete online. Assessment results identify care needs and link them to health service databases that generate customized lists of nearby services.

Results: Since its conception in 2018, YourCare+ has reached over 29,000 users. We anticipate this number to grow as we pilot the Service Navigation Platform in the summer of 2023. Piloting opportunities exist in many areas, including supporting care transitions (i.e., hospital to home or community care), waitlists for specialized geriatric programs, and care coordinators recommending community services. Pilot insights, including stakeholder engagement and analytics, will be used in ongoing quality improvement efforts.

Conclusion: YourCare+ equips older adults and their caregivers with pertinent knowledge and a roadmap to navigate the healthcare system. While user preference, digital access, and tech literacy prevent the platform from being appropriate for everyone, it diverts a subsection of individuals able to digitally self-navigate, creating improved capacity for home and community care professionals. In conclusion, YourCare+ offers a promising solution improve access to timely and relevant services and support aging in place.

Title: Charting healthcare navigation: All hands on deck!

Authors: **Rosemary Kohr**, BScN, MScN, RN, PhD, Tertiary Care NP Certificate.

Abstract:

Introduction: Within the Canadian healthcare systems fragmented service delivery and access have created demand for change. There is significant internal and external pressure for organizations, institutions, and governments to provide more ways of allocating resources, including use of healthcare navigators. Over the past decade there has been a significant increase in job postings for healthcare navigators in Canada and career opportunities are on the rise. Many settings are looking at navigators as solutions to deal with the entrenched silos of care, as well as better management of existing gaps within systems.

Design: The approach of creating integrated care models currently in vogue reflects a more holistic way to address patient needs. Teams that function in a non-hierarchical collaboration can be very effective. The navigator role in this environment can connect and collaborate with all members of the healthcare team and provide the important bridge for both patient and healthcare providers.

Results: Within the literature, integration, and collaboration of all members of the healthcare team are described as requirements for good patient experience and outcomes. However, pressure to deal with increasing and often overwhelming needs of patients in a landscape of diminishing resources may lead to team disfunction. In the haste to provide the service of navigators, the preparatory steps may be overlooked. This can create confusion and frustration for those hired into the role as well as other members of the healthcare team.

Conclusion: Aside from the general team-building that should be part of developing any team, successful integration of the navigator role requires several important steps. This presentation will provide the participant with an approach to integrated healthcare team-building relevant to navigator roles. These steps can be used to improve collaborative scope of practice to optimize patient outcomes.

Title: Why do We Need a Typology for Patient Navigation Programs?

Authors: **Fedir Razumenko, PhD**; and Karen Tang, MD, MSc.

Abstract:

Introduction: Systems of classification are parts of the human-built information environment which contribute to knowledge generation. There are many layers of meaning involved in developing and implementing a conceptual classification of patient navigation (PN). This typology could be an instrument for organizing work practices in PN and for providing a research basis for systematic studies of PN. We argue that such a typology is necessary in healthcare because it has a potential to merge elements of practice, science, information systems, and bureaucracy to create more integrated care delivery mechanisms.

Design: While many programs are considered as PN interventions, their operations, characteristics, and targeted populations vary widely. Why have PN programs recently eclipsed case management, care coordination, and community health work initiatives despite clear overlap in their constructs? Our study explores conceptual underpinnings of what PN is meant to be and do by using realist synthesis methodology. In this realist synthesis, we have reviewed a wide-ranging set of PN programs implemented primarily in North America to create program theories of how PN is supposed to work and why these theories have evolved across different disciplines, such as nursing and social work.

Results: Our searches resulted in 74 included documents, from which data were extracted to produce context-mechanism-outcome configurations (CMOCs). These CMOCs underpinned our identified program theories that centred on the essential roles of empowerment, peer support, health equity, and continuity of care. We further refined our identified theories by turning to existing conceptual frameworks on PN to create a six-block conceptual foundation necessary to reproduce complex PN interventions in other contexts or jurisdictions.

Conclusion: Our analyses show that the typology of patient navigation is valuable because it ties PN into existing healthcare infrastructure that has a set of work practices and organizational routines which operate at patient-provider-system levels.

Title: Navigating Dementia NB: Supporting people with dementia, their care partners, and the care team

Authors: **Lillian MacNeill, PhD**; Shelley Doucet, PhD; Alison Luke, PhD; Karla Faig, PT; Karine Légère, RN, PhD Candidate; Sherry Gionet, RN; and Pamela Jarrett, MD.

Abstract:

Introduction: Dementia care is often fragmented, uncoordinated, and difficult to navigate. Patient navigation (PN) is one solution to address the care needs of people living with dementia and their care partners. Navigating Dementia NB/Naviguer la démence NB is a research project piloting a bilingual PN program in New Brunswick (NB) for people living with dementia, their care partners, and care providers. This PN program aims to proactively guide and support patients and their families through health and social care systems, matching client needs to appropriate services/resources.

Design: The program includes two components: six patient navigators embedded in primary care clinics/community health centres across NB and a peer-to-peer Facebook support group. A mixed method approach is being used to evaluate the program, which is being piloted for 12 months (July 2022-July 2023). Data for this evaluation is being collected from patient navigator charts, satisfaction surveys, and semi-structured interviews with navigation clients and stakeholders involved in creating and implementing the program.

Results: The purpose of the evaluation is to explore the program's effectiveness and determine whether it achieved the intended outcomes. The preliminary results will be shared.

Conclusion: The goal of Navigating Dementia NB/Naviguer la démence NB is to increase the knowledge of health and social services/resources related to dementia care, and to improve access to these services/resources through in-person and online patient navigation. Ultimately, we hope to promote positive experiences with health and social care systems for people living with dementia, their care partners, and care providers by improving communication pathways that promote the integration of care.

Title: Piloting an online support group for people living with dementia and their care partners

Authors: **Carol Marsh; David Black;** Lillian MacNeill, PhD; Catherine Freeze; Karine Légère, RN, PhD Candidate; Marion Rigby; and Alison Luke, PhD

Abstract:

Introduction: Different forms of peer-to-peer (P2P) support interventions are becoming increasingly common for people living with dementia (PWD) and their care partners (CPs). Virtual delivery is viewed as a potentially cost-effective and accessible way to provide support to this population.

Design: Navigating Dementia NB is an ongoing research project piloting a dementia patient navigation program in New Brunswick (NB). One aspect of this project was the development and evaluation of a P2P Facebook support group for CPs. Group moderators included members of the Patient and Family Advisory Committee (PFAC) and patient navigators (PNs). The goal was to offer a space for CPs to connect with other CPs and share and learn about services and resources. The Facebook group was piloted for 5 months. Data collection is ongoing and includes the collection of de-identified posts and administering online surveys to group members. This presentation will report on lessons learned from the perspective of the PFAC and members of the research team.

Results: The group had 47 members (35 CPs, 6 PNs, 3 moderators, and 3 administrators). Over half of the posts were made by PNs and moderators. Posts about personal experiences and seeking emotional support were more frequent than posts about sharing information about services and resources. Lessons learned include providing more moderator training, information on crisis situations, and enough time for the group to become established as a safe space for CPs. Also, moderators need to be active contributors to maintain member involvement.

Conclusion: While active participation from group members was low, surveys distributed to group members will provide further insight into how the group was used by CPs and PNs to communicate and exchange support. Lessons learned will be used to understand how P2P support groups may be more successfully implemented for this population in the future.

Title: A Depiction of a Patient Navigation Service for Older Adults with Complex Care Needs

Authors: **Grace Liu, PhD**; Amanda Knoepfli, MSW; Naomi Ziegler, MSW; Tracey DasGupta, MN; Kristina Kokorelias, PhD; Sara J.T. Guilcher, PhD; and **Sander L. Hitzig, PhD**.

Abstract:

Introduction: At our clinical site, large metropolitan hospital in partnership with a community agency, a new Patient Navigation program was introduced to bridge the care gap to improve the transition from hospital to home for older adult with complex care needs. The patient navigators (PN) are community-agency social workers embedded in the hospital care teams who work with patients and families to coordinate care plans in the hospital and support them up to 90 days post- discharge. The purpose of this exploratory study was to describe the characteristics of patients supported by a PN, reasons for referral and duration of PN service, and the patient's post-service discharge location.

Design: A cohort observational design was used to track the patients who were referred to the program (November/2019 to November/2021). The PN used a clinical tracking sheet to detail reasons for referral, duration (defined as first contact to discharge dates, excluding service ≤3days), and post-service location. Data analysis included frequencies and descriptive statistics.

Results: There were 90 patients (41 males:49 females) assigned to the PN caseload where the median age was 79. The top reasons for referral were connection to community services (59%), housing related (44%), discharge planning (42%), provider referrals (24%), social concern (23%), caregiver issues (17%), instrumental activities of daily living (10%), financial/legal related (6%), and end- of-life (4%). The PN service length was 74 days (average). The post-service locations for patients were home (66%), reactivation care (12%), deceased (9%), palliative care (4%), long-term care (3%), rehab (2%), acute care (1%), or unknown (2%).

Conclusion: The preliminary findings provide a better understanding of a novel PN service for older adults with complex care needs as it relates to scope of practice and patient outcomes. The research will help to make a case for implementing patient navigators in a hospital setting in Canada.

Title: Early integration of specialized geriatric services and community support services

Authors: **Rhonda Crouse**; Bradley Hiebert, MSc, PhD; Cheryl MacDonald, OT Reg (Ont.); Ellen Diorio; Jamie O’Leary, RSW; Katie Gillis, RN; Leah Barnes, RN; Leanne Turner, MHS; and **Lyndsey Butler, OT Reg (Ont).**

Abstract:

Introduction: Approximately 50% of referrals to coordinated intake at St. Joseph’s Health Care London for Geriatric Ambulatory Services have a goal related to cognition. 9% of these are referred to Geriatric Resource Nurses (GRNs), a Specialized Geriatric Service (SGS), who provide comprehensive geriatric assessments in an outreach setting. GRNs spend considerable time on system navigation and often refer to the Alzheimer Society, a Community Support Services (CSS) agency, post-assessment. To improve the outcomes and experiences of seniors and caregivers in Oxford County, a new care pathway was developed that further integrates Alzheimer Society Southwest Partners (AlzSWP) and GRNs.

Design: Patients referred to coordinated intake with a goal related to cognition and need for GRN were eligible to pilot this new pathway. Patients with or without their caregiver were offered a referral to AlzSWP to start system navigation and community support before the GRN’s assessment. Upon consent, they received an appointment with the AlzSWP First Link[®] Care Navigator (FLCN) before their GRN appointment. With consent, coordinated intake shared GRN referral information with the FLCN. To evaluate this new pathway, we: conducted semi-structured interviews with providers, patients and caregivers; compared pilot and non-pilot patients’ care journey; and reviewed pilot and non-pilot patients’ charts for differences in services accessed.

Results: This pilot pathway demonstrated an effective approach to further integrate CSS and SGS. Results indicate positive patient, caregiver and provider experiences from increased information sharing between CSS and SGS, earlier access to AlzSWP’s system navigation, and removing system navigation from GRN workloads, allowing them to work at the top end of their scope.

Conclusion: Learnings and ideas for expansion include the need for secure shared digital communication tools between CSS and SGS, increased focus for SGS in supporting the caregiver with community supports and building upstream linkages to CSS within SGS care journey.

Title: Alzheimer Society First Link® Care Navigation – 2021 BrainsCAN Survey Shows Positive Impacts

Authors: **Christina Stergiou-Dayment, MSW, RSW;** and Ryan P. Salewski, PhD

Abstract:

Introduction: A diagnosis of dementia is a life-altering event. It does not have to be a traumatic one. The Alzheimer Society's First Link® program provides a dedicated and consistent point of contact for families affected by dementia, providing education and support to both the person living with dementia and their care partner(s). This ongoing care navigation and coordination across providers guides the family to available supports and services suited to their care needs within and outside of the healthcare system, resulting in positive outcomes for individuals and the healthcare system.

Design: In 2021, an Ontario-wide survey conducted by BrainsCAN, a neuroscience research initiative at Western University, was distributed to clients of 29 Alzheimer Societies across Ontario. 1,912 care partners and 272 people living with dementia responded to the survey sharing their insights about navigation and program impacts on their quality of life and healthcare utilization, inclusive of emergency room visits and accessing long-term care.

Results: Connection to the Alzheimer Society has shown positive impacts including a reported reduction in avoidable visits to the emergency room with mean 2.11 fewer hospital visits for those noting that Alzheimer Society support helped them avoid crises. Furthermore, respondents reported a delay in admission to long-term care with almost 80% of care partners and 76.1% of those living with dementia stating they were able to live or provide care at home longer due to the Alzheimer Society's involvement.

Conclusion: First Link® Care Navigation provided by the Alzheimer Society enhances system efficiencies, provides a cost-benefit to the provincial healthcare system thereby alleviating pressure on hospital and long-term care capacity, and improves the quality of life for Ontarians affected by dementia. This highlights the importance and effectiveness of ongoing navigation with those affected by terminal disease to adjust care plans to meet their evolving and individualized needs.

Title: Telephone peer navigation for addiction helpline callers: Pilot findings and next steps

Authors: **Annette Peart, BOccTher, MHlthSc, PhD**; Freya Horn, BA, GradDipPsych; Dan Lubman, BSc (Hons) MB ChB, PhD.

Abstract:

Introduction: Addiction is the most stigmatised health condition, globally. There are many barriers to accessing care, compounded by high levels of stigma. Peer navigation for people experiencing addiction integrates lived experience and professional knowledge to support people experiencing addiction to engage in treatment and maintain recovery. This presentation reports on an Australian peer navigation pilot to empower people experiencing addiction to seek the information, care, and support they need.

Design: This pilot was undertaken in Victoria, Australia. Turning Point (Australia's leading addiction treatment, education, and research centre), with the Self-Help Addiction Resource Centre and Monash University designed and piloted a peer navigation intervention to promote access to care and support for people experiencing addiction who were not currently receiving treatment. The DirectLine Peer Navigation Project connected addiction helpline callers seeking information, support, or treatment (n=69) to a peer worker with lived experience of addiction and recovery.

Results: Participants (n=34) received six telephone calls over six weeks from the peer worker, to help them identify, find, choose, and gain access to a range of resources, and support them to overcome barriers to care. Peer workers aimed to enhance feelings of hope, empowerment, and self-efficacy, key elements of a recovery-oriented model of supporting people with addiction. Preliminary findings indicate participants improved their readiness and confidence to make changes in their substance use after the peer navigation intervention. These are vital steps in the pathway to seeking treatment, care, and support.

Conclusion: This presentation will describe preliminary findings, and outline barriers and facilitators to implementing the pilot, with key lessons for services and researchers. The next steps include further development of the model of care and potential expansion into other service areas.

Title: The Navigator Model: Improving Access for Post-Secondary Student Mental Health Care

Authors: **Kristin Cleverley, RN, PhD, CPMHN**; Andrea Levinson, MD MSc FRCPC; Julia Davies, RN PhD Candidate; and Emma McCann, BSc.

Abstract:

Introduction: There has been increasing interest in post-secondary student mental health across Canada, further exacerbated by the ongoing Covid-19 pandemic. Despite significant efforts to increase the capacity of campus mental health services, there is a substantial gap in research evidence in mental health service design and delivery for this population, particularly those with new-onset or acute care needs who may require hospital admission. This critical health system gap requires improved pathways for students between hospital and campus- or community-based mental health services. To ensure continuity of care, The CIHR-funded NavigateCAMPUS project will adapt and evaluate the Transition Navigator Model for post-secondary student mental health transitions.

Design: NavigateCAMPUS will tailor and evaluate the Navigator Model to support complex transitions from acute mental health services to campus- and community- based mental health, in partnership with patients and clinical staff across three hospitals and three post-secondary campuses in the Greater Toronto Area as well as national partners. The Navigator Model will be evaluated through a one-stage, single arm study with accompanying qualitative evaluation.

Results: In this presentation we will discuss early project success, including i) adaptation of the Navigator Model for post-secondary settings, ii) partnership development campuses and hospital and community-based services, and iii) co-design of study methodology with partners from student, clinician, and administrator groups. The evidence generated by NavigateCAMPUS is particularly important to Canada's ongoing commitment to improve post-secondary student mental health and responds to the demand for integrated and scalable solutions between post-secondary institutions and communities.

Conclusion: Utilizing the Navigator Model to improve transitions from hospital-based mental health services to campus- and community-based care has the potential to improve continuity of care for post-secondary students, increase satisfaction with mental health care, improve long term trajectories of mental health and functioning, and reduce burden on campus health and wellness services.

Title: CMHA, St. Joe's Mental Health Navigation Program

Authors: **Elly Litvak and Shannon O'Neil.**

Abstract:

Introduction: The Family Navigation Program (FNP), a program of Canadian Mental Health Association (CMHA), believes that family support is critical when a loved one engages with mental health services at hospitals. In 2014, a partnership between CMHA FNP and St. Joseph's Health Centre was forged. The two organizations collaborated and FNP designed a family navigation and support program. The goals of the first year was to serve 100 families and reduce Emergency Department (ED) visits. This was achieved in 2014 and every year since.

Design: The program uses a recovery orientated approach and navigators with the lived experience among their professional and academic backgrounds. It was developed with consultation of existing mental health family navigation programs in Canada. The program continues to be evaluated through yearly surveys of families served and hospital staff. The program was promoted through on-site presence, posters and brochures, and presentations by the navigator.

Results: The result is the development of an efficient, streamline program that includes navigation support while the loved one is in hospital, helping the family in understanding the hospital mental health system, liaise between the family and hospital staff, and preparing families for discharge. 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. Another take-away was that an opportunity to educate hospital staff about family recovery. An e-learning course for hospital staff was developed. It outlined Family Centered Care from a Recovery Framework. Evaluation of the course showed that staff improved their assessment and referral skills for families, while also changing the ways they support families.

Conclusion: The long-term vision for our program is to spread the family navigation model to other hospitals. It is also to recognize the importance of extending navigation services beyond the client/patient to those that support that person. Having a navigator with the lived experience providing that service increases overall well-being in the family, facilitates recovery, and expands the role of the lived experience in mental health.

Title: Fostering integrated care through relationships: The case of the Family Navigation Project

Authors: **Michelle Di Febo, BA, CCLS.**

Abstract:

Introduction: The Family Navigation Project (FNP) supports youth and families struggling with mental health and/or addiction concerns to connect to the right treatment resources. We will review the FNP's relationship-based model and how this person-centred approach creates a strong foundation for integrated care.

Design: Since its inception in 2013, the FNP has worked with over 5000 families and currently serves an average of 70 new families per month. Family Navigators engage with young people and their families to help them find their way through the complex MHA system. The frontline FNP team works collaboratively to provide expert individualized resource options specific to the difficulties the youth and family are experiencing and the goals they have expressed.

Results: Engaging and empowering individuals and communities are the central components to any integrated care strategy. FNP's relationship-based model creates opportunities for collaboration between the FNP team, youth, families and the greater MHA community. Developing these partnerships allows clients to work together with care providers to develop a comprehensive understanding of needs and goals. With this knowledge a flexible and networked solution can be developed for the client. Integrated care allows multiple services to come together to offer the right type of supports at the right time as well as adapt to the client's ever-changing needs over time.

Using case studies, we will explore how the Family Navigators use their skills in relationship-based care to understand client needs and support them in connecting to services within the MHA system and beyond.

Conclusion: Formal and informal ways to engage service users and service providers will be explored, including challenges associated with integrating supports across systems. The ways in which integrated care is supported by a relationship-based model at FNP will be shared.

Title: Recommendations to Improve Navigation of Mental Health and Substance Use Services

Authors: **April Furlong, MA**; Krista English, PhD; **Sarah Hamid-Balma, MA**; and Deborah Ross, MS.

Abstract:

Introduction: Poor access to mental health and substance use services is a well-known, long-standing, and critical challenge across Canada. In addition to long wait times, gaps along the continuum of care, disconnection and fragmentation between services, inability to pay, and concerns about stigma and cultural safety; individuals with mental health and substance use issues, and the people who support them, are challenged even to find reliable information about services and how to access them.

In 2021, the Provincial Mental Health and Substance Use Network was launched to facilitate collaboration between diverse stakeholders, including people with lived/living experience of mental health and substance use issues, with the goal of addressing system challenges for a more coordinated, effective, and accessible system of care. Early Network efforts to understand these challenges confirm that British Columbians need better information about services, as well as supports to navigate barriers to access. This is consistent with a recent analysis of requests for information submitted to the BC Partners' Heretohelp.bc.ca website, which showed that most requests relate to service access.

Design: In response, the Provincial Network is leading a project to develop recommendations to improve information and service navigation supports for mental health and substance use services. This work includes: 1) characterizing the nature of requests for information submitted to relevant provincial agencies, 2) an environmental scan of information and resources available at the regional and provincial levels aimed at supporting service navigation, 3) provincial consultations and a literature review to identify considerations and best and promising practices; and 4) a comparison of existing navigation needs to available and recommended resources and supports.

Results and Conclusion: This presentation will highlight the findings of this work and offer system-level recommendations to better meet the needs of individuals with mental health and substance use issues.

Title: Evaluation of a patient-oriented navigation program – Experiences from navigators' perspectives

Authors: **Hella Fügemann, MPH; Kathrin Gödde, PhD;** Ute Goerling, PhD; Nina Rieckmann, PhD; Christine Holmberg, Prof.

Abstract:

Introduction: The German healthcare system offers universal healthcare coverage.

Nevertheless, barriers to timely and patient-oriented care can occur along patients' care paths due to a fragmented organization of in-patient and out-patient care. In addition, existing support offers are often unknown both by patients and providers. To address these barriers, we developed a patient-oriented navigation program for people with age-associated diseases in Germany which focuses on the patients' individual needs.

Design: In a mixed-methods feasibility study our navigation program for people with lung cancer and stroke is being evaluated in the German healthcare context. Participants of the navigation intervention are supported by personal patient navigators in their care coordination for a year. For the process evaluation, qualitative interviews with navigators are conducted to capture their experiences with carrying out the navigation intervention.

Results: In our study, three navigators support a total of 122 study participants. Important tasks include emotional support, assistance with bureaucratic matters, gathering specialized information and organizing outpatient care. Navigation tasks overlap to a large extent in both groups of patients. In terms of their work environment interviews show that navigators perceive their work as meaningful and find the exchange within the team and the offer of supervision by an experienced psychologist important. Difficulties were a limited personal contact with the study participants due to the pandemic and the handling of patient needs that cannot be met.

Conclusion: For navigation of diseases that require complex care, such as lung cancer and stroke, it appears important to ensure that patients' social and emotional needs are met in a way that suits their individual wishes. For the navigators themselves, teamwork as well as the possibility of supervision are of great importance. The navigators' experiences can be used for a practice-oriented optimization of the navigation program.

Title: The NavMAP Standards for youth mental health and addictions navigation programs in Canada

Authors: **Roula Markoulakis, PhD**; Simran Arora, MSW, RSW; Sugy Kodeeswaran; Michelle Di Febo; Liisa Kuuter, MSc (MFT), RP; Cathy Walsh; Adina Hauser, MSW, RSW; Dr. Sander Hitzig, PhD; Dr. Kristina Kokorelias, PhD; Dr. Amy Cheung, MD, M.Sc.; David Willis, PBMD, MBA; and Dr. Anthony Levitt, MD, MBBS, FRCPC.

Abstract:

Introduction: Less than 20% of children and youth affected by mental health and/or addiction (MHA) concerns receive appropriate treatment. Navigation programs - aimed at supporting youth and their families find and equitably access MHA care – are growing in Canada; hence standards are needed to support effective delivery of these services. This project will gain an in-depth understanding of current approaches and practices in youth MHA navigation and develop standards to help guide these services.

Design: Realist Review and Synthesis methodology is being utilized to develop standards. This methodology helps identify context, mechanisms, and outcomes which helps obtain an understanding of how youth MHA navigation programs can perform optimally. The project is being conducted over several phases, which include defining scope, searching for evidence, appraising studies and extracting data, synthesizing evidence and developing conclusions, and disseminating findings. Community consultations, and environmental scans will also inform these stages. Researchers, administrators, clinical leads, MHA navigators, and youth and caregivers with lived experience are involved in all project stages.

Results: The national standards for youth MHA navigation programs will be organized around ten themes – Navigation Team Composition and Credentials; Service delivery; Service access; Needs of target population; EDI health equity; Lived experience engagement and outreach; Community collaboration; System resource options; Sustainability; and Outcomes. Along with offering a comprehensive understanding of youth MHA navigation services, these standards also promote evidence-based decision making when considering program models and approaches and when developing navigation care plans; thereby ensuring a proactive and integrated mental health system that supports youth and families in navigating and connecting with appropriate care.

Conclusion: Currently, practices and models adopted by youth MHA navigation programs differ and evidence has not been synthesized to develop comprehensive standards for these programs. Hence, to promote equitable and integrated access to MHA care, it is important to identify and describe current practices in youth MHA navigation by developing and sharing national standards.

Title: Navigation Capacity Building in Neurodisabilities

Authors: **Lucyna M. Lach, MSW, PhD; David Nicholas, PhD;** and Samantha Sutherland.

Abstract:

Introduction: The Neurodevelopmental Disabilities Resource Program was focused on 1) improving current navigational systems by making them coordinated, person- and family-centred, and 2) building capacity across the continuum of care.

Design: First, we built improved systems of navigation via regional pilot completion and evaluation of multiple projects: a parent-to-parent peer mentoring initiative, an overview of steps of navigation capacity development, and evaluation of impacts of the COVID-19 pandemic on families. Second, we increased the capacity of regional navigation networks through initiatives such as: provincial navigation summits, the publication of a Community Guide for navigation development; scoping reviews of (i) navigation approaches and outcomes, and (ii) family support processes in navigation. Finally, we evaluated the impact and processes of improved partnerships by developing policy recommendations, evaluating peer navigation, reflecting via an allegory-based review, and reviewing peer support.

Results: Examples of capacity advancement are noted. The Alberta team finalized 6 training modules that support the 2-1-1 telephone/navigation operators in guiding navigation support for families. They also have worked on the development and implementation of an integrated provincial approach to NDD navigation that is anticipated to advance system practice, proactively addresses stigma, and reduce service duplication in the aim of efficient service access and system-wide fiscal affordability. The Montreal team created policy briefs, presented recommendations to the board of directors of an Integrated University Health and Social Services Centre (CIUSSS), and are currently working with managers at the readapt/rehab directorate to implement recommendations. A national navigational capacity-building website was also developed (see bccndi.org).

Conclusion: Through capacity building achieved across regions, we have developed plans for next steps and sustainability of this initiative. Further, this work offers methods for building regional navigational advancement across Canada.

Title: Navigation and Nursing Student Partnerships to Enhance Interprofessional Competencies

Authors: **Melanie Lefebvre, MEd;** and **Laura Killam, RN, MScN, PhD Student.**

Abstract:

Introduction: Interprofessional education has been found to improve how working professionals collaborate with each other after graduation. We implemented a project where navigation and nursing students worked together and with their educators to accomplish this goal. The objective of this presentation is to explain how navigation and nursing students came together to 1) create a virtual simulation called the “Poverty Challenge,” 2) examine inequalities within our health and social welfare systems, and 3) prepare for effectively working together in the field.

Design: Historical and present context of the Poverty Challenge will be outlined. We emphasize how this project built interprofessional collaboration among future helping professionals. In addition, student feedback about how the experience helped them learn about inequalities in society will be outlined. We will include samples of student work. Insights about how it impacted their preparation for real-world work will also be included.

Results: Navigation and nursing students sometimes approach client/patient problems from vastly different perspectives. This can lead to tension and disagreements which are important to be recognized and addressed to ensure quality patient care.

Conclusion: It is important that helping-related educational programs include diverse perspectives outside of one’s main field of study to help equip students to collaborate with others more effectively in health care settings.

Title: A Collaborative Approach to Improving Health & Social Service Navigation for Family Caregivers

Authors: **Felicia Hart, BSW; Michelle Donald, OT Reg. (Ont.),** MHM; Bianca Feitelberg; Lisa Salapatek; Tara Dwomoh, MSc; Winnie Khuu, PMP

Abstract:

Introduction: Caregivers play an essential role in our healthcare system. Four million caregivers across Ontario provide an estimated three quarters of care, supporting family members and friends. 56% of caregivers find that organizing care is difficult, the majority would like one place to go for information, and for the system to be easier to navigate (Change Foundation, 2019). In 2021, the Eastern York Region North Durham (EYRND) Ontario Health Team formed an Access & Navigation Action Team with the goal of making improvements to current processes and ensuring standardized navigation for residents, including caregivers. This presentation will demonstrate how a collaborative Ontario Health Team approach to improve navigation can be developed utilizing existing resources, inclusive of caregiver supports.

Design: The Access & Navigation Action Team is comprised of eight member organizations including the Ontario Caregiver Organization (OCO), offering a 24/7 Caregiver Helpline service. The model design components include: Caregiver experiences/needs in planning and implementation; a service directory blending 211, ConnexOntario, and Healthline datasets; development of a standardized call flow process including warm transfer; protocols to support individuals and caregivers needing services; and development of an evaluation framework

Results: Caregivers are members of the action team during all planning phases; online service inventory launched in 2021 has over 6000 users; OCO identified as a primary referral source for navigators to warm transfer; caregivers needing support; 10+ service providers have committed to following the model; and standardized measures and data collection processes have been established to enable reporting on service needs and gaps in EYRND communities.

Conclusion: Navigation organizations have developed an improved process for caregivers and care recipients utilizing existing resources. This navigation model is recognized by Ontario Health and other OHTs as viable to scale and spread. Implementation is expected by March 2023.