Up the Creek Without a Paddle: How the Care Navigator at SETFHT Helps Patients Steer Through the System

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Background

According to an article written by The Change Foundation, the concept of the patient navigator was developed at Harlem Hospital, in New York City in 1990. The role was originally developed to assist African American women with breast cancer, out of awareness that black women experienced more barriers with screening, diagnosis and treatment ("Health System Navigators: Band Aid or Cure?", 2013). This navigator model was peer based; that is, care navigators were African American people with lived cancer experience.

Nova Scotia was the first Canadian province to introduce the navigator model into cancer care, and the role has since developed in Quebec, Ontario, British Columbia and Newfoundland and Labrador. ("Health System Navigators: Band Aid or Cure?", 2013). The model has shifted, however, away from cancer care to chronic disease management and is now more focused on navigating system related challenges. The role has also changed from peer-led to health care professionals such as a nurse of social worker ("Health System Navigators: Band Aid or Cure?", 2013).

References

Childs, A., Edwards, D., & Himburg, S. (2013). *Introducing the system navigator to the family health team* (PowerPoint slides). Retrieved from http://www.afhto.ca/wp-content/uploads/D7-system-navigator-McMaster-FHT-Oct-2013-2.pdf

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Mikkonen, J., & Raphael, D. (2010) Social Determinants of Health: The Canadian Facts. Toronto: York University School of Health Policy and Management.

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Care Navigation at SETFHT

A Care Navigator, also called a Patient Navigator, Health Care Navigator, or System Navigator is someone with extensive knowledge of the health care system and community services. As defined by the McMaster Family Health Team, a Care Navigator "ensures all patients have equal and fair access to health care and essential social services and community resources" (Childs, Edwards & Himburg, 2013). The role involves patient advocacy, coordination of services/service providers and elements of case management.

At SETFHT, the Care Navigator is a member of the Mental Health Team whose goal is to ensure that patients are connected to appropriate long term supports while offering patient advocacy and case management services in the interim to assist with stabilizing a potential crisis.

Advocacy

Often patients are unaware of their rights and entitlements, are unsure of what questions to ask, and have difficulty advocating for themselves. The Care Navigator frequently contacts other service providers with and on behalf of patients to advocate for their rights as related to health care, legal, housing, finances, etc.

Education

An ongoing process that includes education to both patients and other team members. For patients, this means providing information about services available to them including but not limited to finances, housing etc.

Case Management

Involves assessment, planning and coordinating service on behalf of patients. This include components of advocacy, and patient education. The Care Navigator meets with patients, families and other service providers to discuss patient goals and action plans. For patients that require ongoing case management, especially related to mental health recovery, the Care Navigator refers to outside services.

Patient Story

Mary* is a 61 year old wheel chair bound woman, on ODSP, residing in Toronto Community Housing (TCH). She has history of bipolar disorder and OCD. The SETFHT Care Navigator met with Mary during an outreach visit to the building. Mary's unit is infested with bed bugs and cockroaches and the unit was not designed to be wheelchair accessible. She requested a transfer to another TCH building. Mary was assigned a Personal Support Worker (PSW) through CCAC; however, service was put on hold due to the unit's infestation.

Plan:

- Arrange meeting between Care Navigator, patient and TCH Health Promotion Officer to review transfer choices.
- Update transfer housing list to include seniors buildings/ supportive buildings.
- Coordinate with family physician to complete transfer form for accessible unit.
- Arrange Extreme Clean of unit through Visiting Homemakers Association (VHA).
- Coordinate respite care through CCAC.
- Coordinate treatment of unit through TCH.

Outcome: Patient accepted a unit in a TCH-supported seniors building.

*Not her real name.

Challenges

Social determinants such as income stability, employment, access to quality food, education and housing directly impact our health (Mikkonen & Raphael, 2010). This is evident at SETFHT, where many patients are living with complex medial issues complicated by mental health challenges, few social supports, limited financial resources and unstable housing. The biggest challenges we experience are systemic, such as long wait lists for mental health services and affordable housing.

In a recent report published by Housing Connections, as of June 2015 the total number of people on the central waiting list for social housing was 171,309, as compared to 170,060 in May 2015 (*Housing Connections Monthly Statistical Report*, 2015). Many patients we see are living precariously in unsafe rooming houses, shelters, even couch surfing or sleeping rough.

Another major challenge, is the availability of free mental health services. Free mental health services often mean short-term service and very long wait lists, and therefore not appropriate for those requiring longer term support.

Practical challenges include adherence to appointments and patient follow up. Some patient do not have the means to pay for transportation and, so often do not attend appointments or have to cancel last minute, making ongoing follow up difficult. Contacting patients by phone can also be difficult, again, because of finances. Also, when staying in shelter or unsafe housing, phones are often stolen or lost. In an attempt to improve accessibility, we will do outreach to patients if necessary.

Managing the expectations of coworkers about available services, specifically in regards to government financial assistance programs and affordable housing, is an ongoing challenge. For example, most staff are not aware of eligibility criteria for programs like Ontario Works or the Ontario Disability Support Program and assume that all patients are eligible, which is not always the case.

Additional Role

In addition to assisting patients directly, the Care Navigator at SETFHT is involved in assisting with our QIP goal of reaching patients after they have been discharged from hospital to encourage them to attend for primary care visits. Most of our patients attend Toronto East General Hospital. TEGH uses Hospital Report Manager (HRM) to send patient information on a daily basis for patients discharged from the hospital. The Care Navigator reviews these reports every few days and for those patients with the Health Quality Ontario-identified case mix group, she contacts them for primary care appointments if they do not already have an appointment booked with either their primary care provider or a specialist. For any patients with medication changes, she forwards this information to SETFHT's clinical pharmacist, who completes a medication reconciliation in the patient's chart.

Future Directions

It has been argued that Care Navigation evolved out of a need to help patients access services within a fragmented health care system ("Health System Navigators: Band Aid or Cure?", 2013). Care navigation has made some improvements to patient care, such as increasing coordination between hospitals, primary care and community services and improving access to community services. It does not however, address larger systemic issues such as funding for health care, education, mental health services, and affordable housing.