MAP Centre for Urban Health Solutions

The Navigator Program: An innovative patient navigation program for people experiencing homelessness in an acute care hospital

Improving transitions of care for people experiencing homelessness

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Today's goals

- Explain a hospital-based intervention to support people who are unhoused, how to implement, etc.
- Discuss findings from an evaluation that provide insight on program improvements and implementation in any hospital
- Overall, explore ways we can improve transitions of care from hospital to community for people who are unhoused

Motivation for The Navigator Program

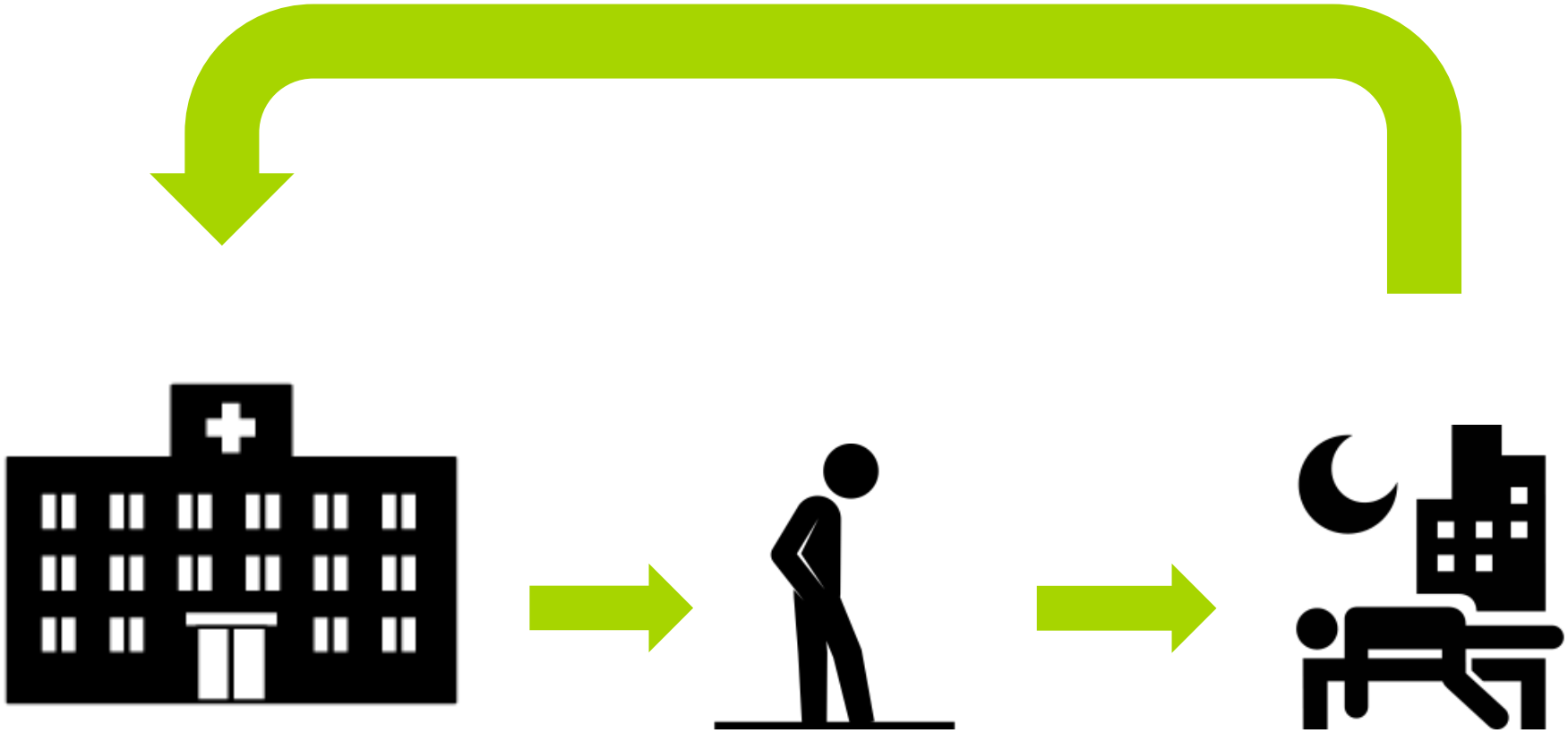
- ICES data for Ontario (2018-2020)
  - 13,420 Medical-surgical admissions
  - 10,335 Psychiatric admissions
- Rate of hospitalization per 100,000 individuals
  - Medical-surgical admissions: **3.8** x higher than housed individuals
  - Psychiatric admissions: **128** x higher than housed individuals

Motivation for The Navigator Program

- General Internal Medicine (@SMH):
  Readmission within 90 days = **27%**

- **Factors associated with lower readmission:**
  - Having a case manager or social worker
  - At least one informal support

What is the problem?



Part 1 :

The Navigator Program Model

Critical Time Intervention case management model

Goal: Improve **post-hospital outcomes** for adults experiencing homelessness after hospitalization and support people to **manage their own health conditions**.

The Navigator Program Model

- Stay in the hospital for treatment and make discharge plan a reality
- Connections and referrals to community-based providers
- Social-related matters during post-discharge period (transit, groceries, ID, taxes, etc.)
- Transfer information to health care providers and community-based providers/services

The Navigator Program Model

- Homeless Outreach Counsellors (HOC) based in the hospital on an inpatient unit
  - Our program has 3
  - Referrals from all hospital units except Psychiatry and Obstetrics and Gynecology
- 50% in hospital, 50% in community
- ~15-20 patient caseload
- ~90 days of service (flexible!)

The Navigator Program Model

- Patient comfort fund
  - Phones, transport to/from appointments, food, books, other entertainment, etc.
- Harm reduction approach
- Relationship-focused; patient-centred
- No special housing or shelter access

Assumptions

- Patients desire/benefit from care coordination, support in and out of hospital
- Poor communication between hospital and community-based services
- Hospital staff, and community service providers open to collaborating with Navigator Program
- Quality of care provided in hospital will improve with Navigator Program being hospital-based

Assumptions

- Access to health care providers and community-based services
- Poor/stigmatizing/discriminatory experiences in hospitals
- Building trusting, consistent relationships is key
- Need advocates in the hospital and in the community
- Hospital-based, embedded on a hospital unit
- Low cost, no extra work for hospital

Since 2019, The Navigator Program has provided services for

771 patients.

Of these, **517** have needed **medium to high service intensity**.

Part 2 :
Process Evaluation Design

Process & Qualitative Outcomes Evaluation

1: Understand:

- implementation
- mechanisms of impact/change
- context

2: Understand:

- experiences of participants getting program and participants getting usual care
- impact of program on experiences of care transitions

Methods

Interviews

- Implementation team (N = 4)
- HOCs (N = 2)
- Hospital workers (N = 14)
- RCT participants (intervention and control) (N = 40)
- Community service providers (N = 13)

Non-participant observation (~130 hours)

Field notes (program and research team meetings)

Database review (dose - # and nature of interactions)

Context

COVID-19

Housing crisis

Limited resources in community

Supportive hospital leadership

Funding

Implementation

Benefits to embedded on hospital unit

Limited knowledge transfer

Role clarity

HOC experience in community and with medical terminology

And then when COVID hit he [HOC-02] was doing all these things with the shelter hotels and was able to help us, that we didn't have access to. So I remember thinking at the time that we all need to have equal access ... The ability to pick up a phone call [a contact] should be the same. I think the argument that [HOC-02] had at the time was, "yeah, but I'm the one that's also making these connections so you're not going to have the same opportunity as me". So I remember during implementation there was a little bit of that conversation as to the fairness of how to get people where they need to go if we didn't have equal shelter access. (ID_I02)

Mechanisms of Change

Bridging function

Improved communication btw hospital and community

Improved connection btw patient and CSPs

Not supporting specific clients well (lost to follow up)

If we are following up with mutual patients, its easier for us to connect with them [HOC] to find test results or discharge papers. [I]f we know we are following someone who's been admitted we can connect with them instead of having to go through the hospital switchboard. And they are able to sometimes give us a heads up on where they are. They will give us a heads up and say, "Hey, [patient]s is in the hospital again. She is here for whatever it is." They can give us a straight on just what is going on, how long they will be there. (CSP_10)

Yes, there's been a good amount of trust, relationship building, collaboration, if needed. If they have a client that our [shelter] case manager is supporting then he is the one that directly connects with the HOCs or when they are on site they will kind of do a check in. St. Mike's isn't within our catchment or we are not always connecting with the hospital but we are trying to do what we can to support those patients, especially those who have been long term waiting for beds. (CSP_07)

Outcomes

Support and connection for program clients

Consistency, advocacy and reliability

Quick discharges

Limited clarity on what program can offer

In terms of the program, for getting me my meds. Yes, that is one that is very helpful, I must say, because at the time I didn't have the means to get it and whatnot. And access to doctors also, that was really helpful. Even having you guys – to speak to you guys in terms of my medical condition, or even the way to manage it and whatnot, has been a great help.
(ID_254_Intervention)

Improving Transitions of Care

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For more information, please see:

- Maphealth.ca/navigator/

Thank you!


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Ways of improving Transitions of Care

Clear guidelines in terms of that, like what falls into their standard work. I think if someone else were to develop a similar role or program, having that clear role identification, job duties for lack of a better term. You know, and how they integrate with the team. I think having them built into the program teams is key to the success for sure. (ID_I03)

I would say broadly it is extremely helpful to have Navigators who are embedded in the hospital but have relationships with people who are working in the community, just connect the dots you know what I mean? (CSP_12)

Giving them a little bit more time, a little bit more rest, trying to sort things out. Helping, I think they also help by making us feel more welcome when we are in the hospital. Make it feel like we are less like we are intruding and being than more like we are being invited in to help and whichever, and it's a nicer feeling. Yes. (CSP_10)