GUIDE 2: NAVIGATION PROCESSES

ARC: Access to Resources in the Community/Accès aux Ressources Communautaires

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Introduction

This Guide is the second of the three guides intended to assist organizations in implementing a social prescribing (SP) program. These guides are the product of work done under the SP program Access to Resources in the Community (ARC) which aimed to increase equitable access to health and social resources.

This guide is focused on navigation processes to help the Patient Navigators work with primary care practices to help patients experiencing social barriers (e.g., low literacy, social isolation) reach and use community health and social resources such as healthy eating, physical activity, mental health, or parenting support programs.

What is SP

Briefly, SP involves the identification of patients with unmet social needs in family practice, the engagement of these patients in acting on their needs, and the provision of navigation support to access the needed services.

The ARC SP model

The **ARC** social prescribing (SP) initiative aims to improve equitable **A**ccess to **R**esources in the **C**ommunity for primary care patients.

- Primary care patients and primary care staff often do not know what resources exist in the community that they could benefit from.
- Patients with social barriers (e.g., a lack of transportation or social support, and language or literacy barriers, social isolation, low literacy) face additional challenges in reaching these resources despite having received a recommendation from their provider and knowing their availability. As a result, patients may need further assistance navigating the health system.
- The ARC navigation services are delivered by a lay individual (trained) who provides outreach support to several primary care practices, using a person-centered approach to understand patient needs, expectations, priorities, and access barriers, and links the individual to the resource(s) that are best suited for them.

Role of the Patient Navigator

The Patient Navigator is an important link between patients, primary and community care by acting as an informational channel and champion for patients. He/she works with primary care practices to provide information, practical assistance, social support, and advocacy to patients to help them overcome barriers to access community resources (CR), and also provide regular updates to primary care providers about patient needs and the navigation services provided to support access to CR.

Navigation timeline

Determine the timeline for which the navigation service will be provided. For e.g., the ARC *Navigation services for each patient ended 3 months from the initial meeting, or when access to the appropriate resource is achieved, whichever came first.*

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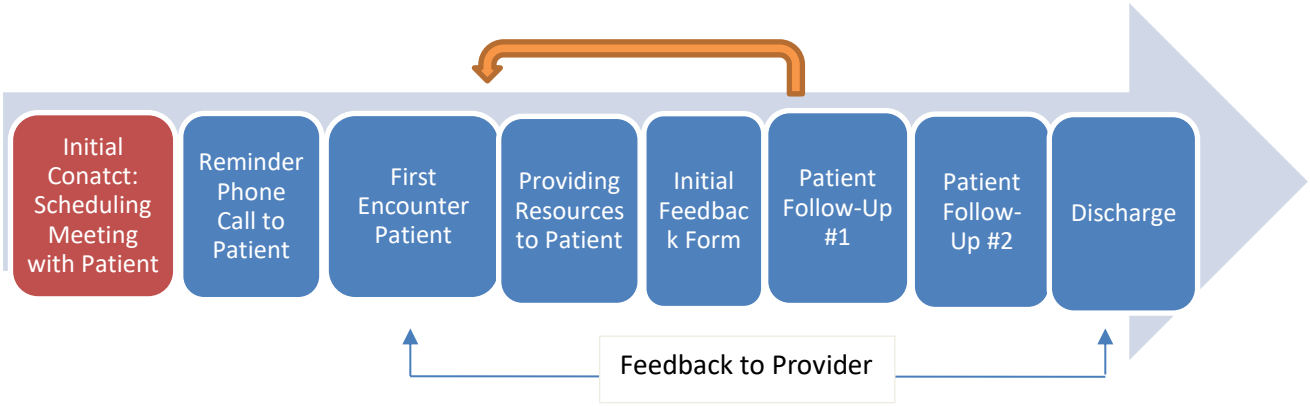
Navigation process

The ARC navigation process comprises the following steps:



Initial Contact

Upon receiving a referral from (Appendix Referral form) the primary care practice, navigator to follow the following steps:

1. Make an initial phone call to the patient within a week of receiving referral
2. Introduce yourself and identify that you received a navigation referral from their PCP
3. Provide them brief information on your (navigator's) role
4. Schedule a meeting and record details (e.g., meeting location, date and time; if a patient needs reminder call. The first encounter between the Navigator and the patient can take place:
    a. in one of the reserved offices at the provider's practice or
    b. in person at an off-site location (e.g., community health or recreation center, shopping mall, coffee shop) or
    c. at any other public area that excludes the patient's home or
    d. by telephone (e.g., due to situational/social or physical limitations)
5. Send reminder call to patient if required.

> *Note: It is very important to adhere to the meeting schedule during the first and any following meetings with the patients. These initial meetups help in rapport building and establishing long term relationships with the patients. There is high likelihood of losing patients at this stage if appointments are mishandled.*

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First encounter

> *Note:* The navigator will be trained on key navigation approaches (see navigation training guide). *Throughout each encounter with the patient, use Effective Communication Skills to collaborate with the patient to empower them and to support their health goals by helping them to access recommended CR. For more information about* ***Effective Communication Skills, see the ARC Navigator Training Online Module 8: Motivational Interviewing****. Please note that counseling is not part of the scope of the Patient Navigator, however, there are some elements of motivational interviewing (MI) that are applicable to promote person-centred communication e.g., OARS (open-ended questions, affirmations, reflective listening, and summaries).*

1. Introductions (begin the meeting with active offer of French, see Appendix Navigation Script)
2. Explain your role as a navigator (see Appendix Navigator Do's and Don'ts)
3. Review and discuss with the patient the referral form sent by their PCP
4. Conduct Comprehensive Assessment (see Appendix Summary and Planning Forms)
    a. Identify additional patient needs
    b. Help patient to identify their priorities
    c. Help patient identify social barriers that may limit patient from accessing a CR
    d. Understand patient preferences / expectations
5. Assist patients to prioritize their health goals and increase self-efficacy in accessing CR
6. Co-develop with patient a tailored Action Plan for accessing resources (see Appendix Shared Action Plan)
7. Schedule date, time and establish means of communication (e.g., by e-mail, telephone, mail, second in-person appointment, etc.) to:
    a. Provide the patient with CR information, within three business days following the initial encounter
    b. Follow-up two weeks following initial patient encounter

Research and identify CR

Identify resources that best suits patients' one or more needs as identified by their provider on the referral form, or additional non-medical needs identified with the Navigator.

Provide navigation support

1. Contact and provide patient with information for CR
    a. Informational support (e.g., description of services, contact information, location, and additional online information if available)
2. Offer additional support to potentially alleviate the identified social barriers
    a. Instrumental support (e.g., appointment booking, coordinate transportation or translation services, accompaniment, assist with paperwork etc.)

   b. Emotional support (e.g. use active listening, offer empathy and encourage patient's self-efficacy)
3. Orient patient on 211 navigation services to empower them and to improve their self-efficacy for future needs. For navigation services other than 211, explain how to call and request assistance to find a resource.

Follow up

The Navigator should follow-up with the patient **two weeks/ten business days** after the resources have been provided to the patient, by the requested mean of communication (i.e., telephone, or e-mail) and biweekly thereafter, as required. During this meeting

1. For each suggested CR identify the status of 'access'
   a. If navigation was accepted, document in Navigator Log under: yes/no.
   b. If no, identify the reasons 1) patient feels they can manage on their own, 2) patient does not want to access this CR, or 3) not a top priority.
      i. If not a top priority, follow-up in 2 weeks to see if they need assistance to reach CR.
2. Identify patients' need for further support

Discharge / end of navigation services

Navigation services are withdrawn when the patient has either reached or feels empowered to reach CR.

Ensure informational continuity with PCP

The Navigator will also be responsible for presenting regular updates to primary care providers about patient needs and the navigation services provided to support access to CR for patients.

1. Complete Appendix Navigator Feedback Form (Report time - Initial) and send to PCP within one to two business days from when you provided the patient with the CR information. This form should indicate the Navigator and patient's initial encounter as well as what the priorities and resources are. Indicate the approximate time of the upcoming follow-up with the patient, usually two weeks/ten business days.
2. In case patient expresses a new issue/s not listed in the referral form or an urgent situation, advise the [PCP] by completing the Navigator Feedback Form (Report time- interim)
3. When patient has either reached or feels empowered to reach CR, complete Appendix Navigator Feedback Form (Report time - final)

Process for Communication with (PCPs) and Practice Staff

The approach to and extent of communication between the Navigator, [PCPs] and staff will be determined on an individual basis. All correspondence with the PCP is recommended electronically through the EMR/ OCEAN, to ensure confidentiality and exchange of information in timely manner (e.g.,

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CR requires immediate confirmation from PCP to begin services or PC needs to communicate with Navigator). Other modes may include using hard copies (scan/ fax when navigator is based outside the practice). The communication mechanisms will be established during the practice set up process.

Navigator Log

The Navigator is responsible for documenting all communications and project activities on patient files, in the Navigator Log (see Appendix Navigator log). This log contains all the information pertaining to the patient, their priority needs (identified by the patient and by the provider), as well as the steps taken by the Navigator to locate appropriate resources. All communications/encounters are logged under each need, in order for the Navigator to stay up to date with the patient's access status.