HealthLink
Huron Perth
Let's Make Healthy Change Happen

Patient Navigation in the Huron Perth Health Link

The primary role of a Lead Navigator is to provide individualized assistance to patients and families as they navigate through the continuum of care. The Navigator works closely with the patient and family/support person as well as the family physician, family health team members, community partners and specialized care to coordinate timely and appropriate care for patients. While there is a lead navigator for each patient, each provider in the coordinated care planning team maintains a role in supporting navigation within their area of expertise.

Benefits to the Patient	Benefits to the Providers
Central point of contact for the patient	Patients will be better supported throughout the Coordinated Care Plan process and movement within the health care system
Strong relationships among the partners involved in patients care across the spectrum (in house and external partners) will be developed	A shared documented plan of care for patients among involved partners
Referrals for patients to the appropriate resources will be made in a timely and effective manner	Seamless care will be provided when patients are transitioning to new or additional care teams
Partnerships with community partners will be created to ensure patients have access to required services to maximize supportive care	Act as a resource for staff, patients and partners about options for care aligning with best practice
Communicate with patients and families in person or over the phone in a variety of settings including at home, in hospital or during clinic visits	Effective communication with those involved in the circle of care
Education will be provided for patients using appropriate methods to meet their required knowledge needs at present and moving forward	Anticipate and proactively plan for patient care as part of the expected disease trajectory
Health promotion activities will be integrated into care planning to help patients work towards his or her optimal health potential	Identify gaps within the current system and work with appropriate partners to address these needs

The Role of the Lead Navigator	Role of the Other Providers in Supporting Navigation
Is a dynamic model: o Constant in the patient journey with deliberate hand-offs at times of transition	Navigate amongst their team/organization and in their resources within their organization
Accountable to the successful outcomes of the individual by ensuring: o Individual, family, and team understand the navigator role o Lead Navigator Transitions are smooth and supportive o Communication between all team members, inclusive of the individual/family is effective and timely o Regular follow-up with individual supports the care plan	Notifies the Lead Navigator to update the CCP based on a care visit or change in the patient's care plan
To coordinate and facilitate the care conference and complete the Coordinated Care Plan document	Inform relevant providers within their respective organization about patient status changes or updates
Help support the rest of the team in understanding their role	
Utilize resources to assist in setting up the coordinated care conference	
Essentially communicating with the patient and providers both inside and outside of the Care Conference regarding how the patient can be best supported in achieving their identified goals	
Two-way communication between the Navigator and the patient's team members	
Navigator communicates with Primary Care on an ongoing and consistent basis as Primary Care is where the bulk of the patient information is housed	

Identification of the Lead Navigator

- ✓ Has an existing relationship with the patient or the ability to establish a relationship with the patient from where the bulk of the patient's services are received based on the expectation of a long term role
- ✓ The role of patient navigation aligns with the health professional's current role and is resourced to carry out the work of the Lead Navigator
- ✓ In most cases, the provider identifying a patient will be the Lead Navigator. However, if this provider prefers not to function as the Lead Navigator, the Lead Navigator will be determined during the initial discussion with two other providers.
- ✓ The point in the health care system where the patient is identified will not necessarily be the organization where the navigator is from
- ✓ If navigator is from a developmental/community agency it may be appropriate for the navigator to partner with primary care or CCAC in order to support all of the navigator activities if some aspects of the Navigator role are out of scope for the community agency navigator (i.e. to support the clinical aspects and electronic communication)

Resources to Support Huron Perth Health Link Navigators

1. Each organization will have identified a contact person who is knowledgeable of Health Links; contacts can be reached through huronperthhealthlink@npfht.ca
2. The Huron Perth Health Link Navigator Working Group can be reached through huronperthhealthlink@npfht.ca
3. Huron Perth Health Link Micro Site - visit our website to access all Huron Perth Health Link care planning documents, links to professional best practise guidelines, community services and patient education: http://www.southwesthealthline.ca/libraryContent.aspx?id=21470
4. South West Self Management Program –Visit our website www.swselfmanagement.ca for a listing of workshops, resources and tools for both patients and health care providers related to chronic disease management.
5. RNAO Best Practice Guidelines:

Collaborative Practice Among Nursing Teams
http://rnao.ca/sites/rnao-ca/files/Collaborative_Practice_Among_Nursing_Teams.pdf

Care Transitions
http://rnao.ca/sites/rnao-ca/files/Care_Transitions_BPG.pdf

Developing and Sustaining Interprofessional Health Care: Optimizing patients/clients, organizational and system outcomes
http://rnao.ca/sites/rnao-ca/files/DevelopingAndSustainingBPG.pdf

Person and Family Centred Care
http://rnao.ca/sites/rnao-ca/files/FINAL_Web_Version_1.pdf

Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients
http://rnao.ca/sites/rnao-ca/files/Strategies_to_Support_Self-Management_in_Chronic_Conditions_-_Collaboration_with_Clients.pdf