POWELL RIVER RESOURCE NAVIGATOR FEASIBILITY PILOT 2013-2014 EVALUATION REPORT

4/7/2014

A DoFP-IPCC Powell River Initiative

Evaluation Report on the Powell River Resource Navigator Feasibility Pilot. Prepared By L.Ringaert Manager VCH IPCC Evaluation with assistance from Y. Dosanjh, IPCC Lead, Powell River-Sunshine Coast and the following members of the IPCC Evaluation Team: R. Nanjiijuma; K.Hoyak, & S. Maharaj.

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EXECUTIVE SUMMARY

Context: Vancouver Coastal Health Integrated Primary and Community Care (IPCC) and the Powell River Division of Family Practice (DoFP) partnered together on a one year pilot project to determine the feasibility and value of a Resource Navigator (R-N) serving family physicians. The goal of the position was to assist physicians in identifying available health and social support services and linking their patients to these services.

Problem: Finding and connecting patients with the right community resources key issue for both physicians and other health professionals. "Community resources" includes a variety of aspects and can include resources for such aspects as transportation, housing, income assistance, food, recreation, care-giver respite, home cleaning services, peer support groups, condition specific support organization, etc. Many of the aspects fall under the social determinants of health that form a critical aspect of our patients' lives and medical conditions. It is understood that addressing these issues is essential to holistic treatment of the patient's condition, yet it is difficult to find the time and resources to address it. Physicians and staff find it difficult to keep up with all the myriad of resources that are out there and don't have efficient mechanisms to effectively navigate a complex system. Within VCH-IPCC several mechanisms are being piloted to address this issue. The Resource Navigator position is one of these innovations that are being tested.

Strategies Tried: The project was framed as an innovation project with the understanding that we were testing a new position, a new role with many unknowns and there was an expectation that various strategies would be tried and tested, opportunities would be allowed to emerge related to this new role and how it fit into the context would emerge. IPCC Evaluation was involved from the onset of the project and was framed as a developmental evaluation. The position evolved from the original model where the family physician would make a request for information and the Navigator would send information back to the physician. This model had several flaws so new processes were developed that were more efficient and effective for all parties. To address issues of slow uptake by the family physicians various strategies were tried including various marketing strategies including flyers, face to face office visits to explain the role; development of a "Tip of the Week" flyer; marketing at DoFP events and in March 2014, the production of a YouTube video. Through the growing connection with the community agencies and understanding of gaps, the R-N then arranged workshops and information sessions to bring the agencies and the physicians together. Another opportunity that arose was with the Emergency Department who was having similar difficulties to the physicians. In January 2014, the R-N started to regularly attend the ED and started to receive referrals from them.

Results: Between May 2013 & March 14, 2014, a total of 98 referrals were received and followed through. 64% of the total referrals from physician offices, followed by 12% from the Emergency Department, 10% from Vancouver Coastal Health staff and 8% from community agencies. Five workshops/information sessions were planned and hosted by the R-N. March 2014 was a key evaluation point and included a survey of the family physicians, emergency department staff, & the community agencies; a key informant interview with the Resource Navigator and a reflective session with the Steering Committee. Results indicated that 75% of the family physicians (n=12) and 66.6% of the total providers who responded were

extremely satisfied with the R-N and 66.6% felt the R-N had helped link their patients to resources. The majority of the community agencies who responded felt that better linkages had occurred between them and physicians and that they were seeing an increase in referrals. For the family physicians, the most successful aspects of working with the R-N were: communication with R-N (83.3%); improved awareness of community resources (75%); Referral Process (75%). The ED indicated that they were seeing a positive value in the position, but felt that they were just starting to understand the role, as the process was so new. The ED strategy was unexpected in the beginning and appears to be valued by the providers. An important added value of having a person as a resource navigator versus a web resource/list is that the R-N is able to listen to the patient and really understand what is needed, thus directing them to the right resource. Anecdotal accounts indicate that the patients feel that they are "listened to". The majority of respondents indicated that the position should continue as value had been shown; many felt that they were early days into the project and cultural shifts take a while to occur.

Analysis/Next Steps:

There were many successes demonstrated by this pilot. All clinics have now used the Resource Navigator and 17 different family physicians have made referrals. The Emergency Department is now using her services. A key factor that made this work was the "human element" of the ability of the resource navigator speaking with the patients/clients and getting a better understanding of their needs. The following story from the interview with the Resource Navigator, illustrates this point. Through some of the recent referrals from the Emergency Department-I-Care rounds, ***important cost savings*** have been shown through the Resource Navigator intervention. The relationship with the emergency department has been recent yet has shown several positive results.

A key challenge of the pilot has been uptake by the family physicians. A great deal of effort went into trying various strategies to increase referrals including shifting gears to include the Emergency Department and the hosting of a variety of workshops that brought community agencies together with the physicians. The workshops proved to be quite successful in creating more direct referrals for the community agencies from the physicians in particular. While lack of any patient contact was addressed midway in the pilot thereby allowing the R-N to contact the patient by phone, the current model has the R-N contacting the patient via phone only. This has pluses and minuses that have been discussed and also illustrates the need for a social worker position in Powell River. The recent You Tube video showing stories by the physicians on the value they have seen of the Resource Navigator was very positive and the impact of the video on attracting more physician referrals is yet to be seen.

The evaluation has demonstrated a great deal of positive feedback on the "value" of the position by those who have used the service. A critical question is what volume of referrals should we expect from the family physicians and from the emergency department? If we are viewing a cultural shift, how long should we expect the shift to take? Leadership will have to determine the "feasibility" of the position. The evaluation will assist the Steering Committee and the Collaborative Services Committee in determining next steps for the role.

Key Words: Integrating Primary & Community Care; Resource Navigator; Social Determinants of Health

ACKNOWLEDGEMENTS

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Many thanks to the Powell River Resource Navigator Steering Committee Who Contributed time and thought into this project

- Dr. Bruce Hobson - Chairperson, Powell River Division of Family Practice
- Dr. Pieter Rossouw - Member, Powell River Division of Family Practice
- Margaret Leitner - PREP, ED
- Pat Townsley – VCH-Director
- Yogeeta Dosanjh – VCH-IPCC Lead Powell River-Sunshine Coast
- Laurie Ringaert – VCH-Primary Care-IPCC Manager Evaluation
- Lin Johnson, - Admin Assistant, Recorder, Powell River Division of Family Practice
- Guy Chartier- Coordinator, Powell River Division of Family Practice
- Jo Ann Murray - Resource Navigator, Powell River Division of Family Practice

Our sincere gratitude to the patients, family physicians, emergency department staff and community agencies that worked with us over the past year.

Introduction

Integrating Primary and Community Care (IPCC) is a provincial initiative aimed at integrating physicians, health authority programs, and staff to provide more coordinated, effective and efficient care resulting in better patient, provider experiences, better patient outcomes, and greater cost effectiveness for the system. Powell River is one of the IPCC communities of care in which Vancouver Coastal Heath (DoFP), the Divisions of Family Practice (DoFP), First Nations, & Community Partners are brought together to create health care system improvements.

Finding and connecting patients with the right community resources has been found to be a key issue for both physicians and staff throughout the IPCC initiative. “Community resources” includes a variety of components and can include resources for such things as transportation, housing, income assistance, food, recreation, care-giver respite, alternative practices for pain and stress management (i.e. Yoga); congregate meal programs, home cleaning services, peer support groups, condition specific support organizations (i.e. the Alzheimer’s Association) and many others. Many of these items fall under the social determinants of health that form a critical aspect of our patients’ lives and medical conditions. It is understood that addressing these issues is essential to holistic treatment of the patient’s condition, yet it is difficult to find the time and resources to address it.

Physicians and staff find it difficult to keep up with all the myriad of resources that are out there and don’t have efficient mechanisms to effectively navigate a complex system of VGH and non-VGH community resources. Within VCH-IPCC several mechanisms are being piloted to address this issue. These include:

- A paper-based information folder for family physicians (Richmond)
- A phone app for family physicians (North Shore)
- A partnership between a clinic and community agencies (North Shore Health Connection Clinic)
- Several IPCC projects that focus on bringing together interdisciplinary discussions that include community agencies and/or specifically address social determinants of health (IPCC-DTES project, IPCC-RICP2-Familiar Faces project)
- Funding of specific community agency programs to help address aspects of the health care system that are not addressed by the health authority and help to promote integration of these agencies with the health authority and with family physicians and finally
- A person designated as a Resource Navigator (this project in Powell River).

Genesis of the Powell River Resource Navigator Strategy

In February 2013, the Powell River DoFP and the VCH-IPCC began to work together in partnership on a one-year pilot strategy to determine the feasibility and value of a new Resource Navigator position. Discussions were initially held at the Collaborative Services Committee. Funding was made available from VCH to the DoFP to manage the project.

Representatives from the DoFP and the VCH-IPCC came together and determined the scope of the project, the job description, hiring and selection process, a governance structure and an interview process. The Resource Navigator was hired in May 2014. A Steering Committee was established and began to meet in June 2014.

The project was framed and understood as an innovation project. There was an understanding that we were testing a new position, a new role with many unknowns and there was an expectation that various strategies would be tried and tested, opportunities would be allowed to emerge as the understanding of this new role and how it fit into the context would emerge. IPCC Evaluation was involved from the onset of the project and was framed as a developmental evaluation in this innovation project.

Goals & Objectives

The Goal of the project overall is: **"The Resource Navigator position/program is being funded for one year as a pilot to determine the feasibility and value of the position to Powell River physicians and the IPCC initiative."**

Goal of the Position[1]: is "*to assist physicians in identifying available health and social support services and linking patients to these services.*" It was determined that this would be a full-time, one year contract position with possibility of renewal.

> Reporting to the IPCC Regional Change Management Lead and the Division of Family Practice, the Resource Navigator will be responsible for sourcing available community, regional, and provincial health and social support services. They will determine the best method of keeping up-to-date listings of these services and the best methods of communicating this information to physicians. They will support physicians in linking patients to the most appropriate service.

Objectives:

- Establish and maintain effective relationships with physicians, MOAs, other health care professionals and health related organizations in the community, the region and the province;
- Source available health, social support, and health promotion services;
- Learn and use existing service databases such as eCHARD;
- Create, maintain, and evaluate a system of tracking and compiling a list of available health, social support, and health promotion services currently available;
- Develop resources to support Powell River physicians in identifying services and linking patients to currently available services;
- Provide support and advice to individual physicians and MOAs on available services;

[1] Note that these goals and objectives are extrapolated from the job description

- Track frequency of physician use and number of successfully linked patients;
- Track gaps in services and barriers to access of services;
- Prepare regular updates for the Division of Family Practice and the Collaborative Services Committee

The above goal of the position and the objectives were created from the job description. They then guided the evaluation questions.

Between February 2013 and March, 2014 there were four key phases of the project.

FIGURE 1

THE VANCOUVER COASTAL HEALTH IPCC FRAMEWORK

The Vancouver Coastal Health IPCC Framework was developed in 2013 after extensive experience and research on the integration process. Our work to transform health care need to involve three key areas:

1) Enablers:
- Structures: funding, IPCC Facilitation teams, Evaluation personnel, etc.
- Strategies: physician engagement, education, linked information systems, (Resource Navigator) etc.

2) Integration and Coordination Elements:
  - Patients and Community Agencies as Partners
  - Interdisciplinary Teams
  - Smooth Transitions
  - Sustainable Practices

3) Triple Aim Outcomes
- Improved Health
- Improved Cost
- Improved Provider Experience
- Improved Patient Experience

Our framework describes a theory of change that incorporates all of these elements for best-practice integration to be most effective. To understand how well we are doing with health care transformation,

we need to evaluate all three areas. The VCH-Integration Framework (2013) & Evaluation Plan frames these three areas and provides outcomes, measures & methods of evaluation based on best practices. For more detailed information on the framework and the accompanying evaluation framework please see: (VCH-IPCC Integration Framework & Best Practices Guide for Building and Integrated Primary, Acute, & Community care System (2013) and accompanying VCH IPCC Evaluation Framework (2013).

The framework guides this project as we view the Resource Navigator as an "enabler" (enabling strategy) to better coordination and integration between community resources/services and family physicians; and between community resources and the emergency department. The strategy particularly focuses on "community as partners", interdisciplinary teams to improve health outcomes, patient and provider experience.

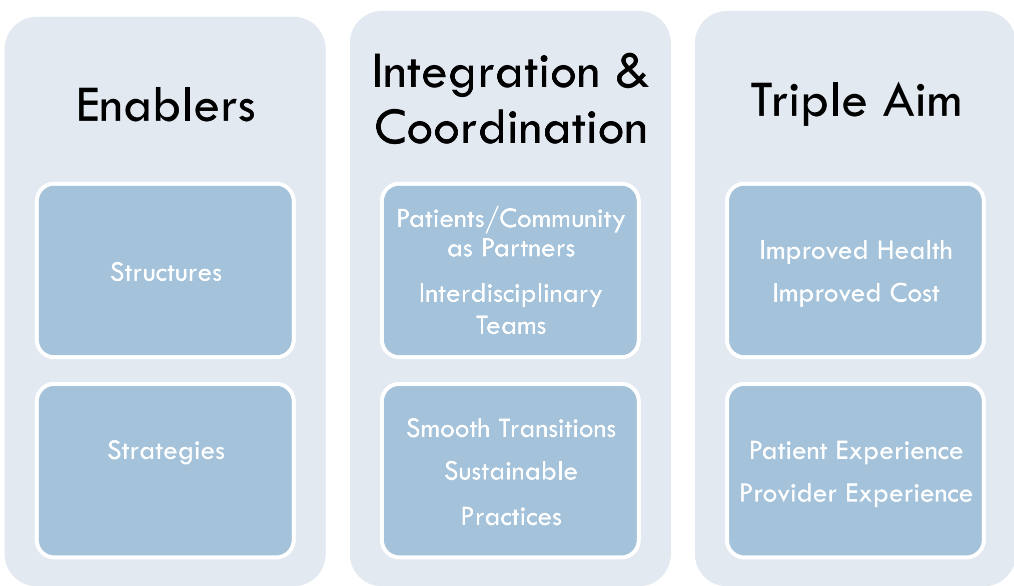


FIGURE 2

EVALUATION METHODS

An embedded developmental evaluation was part of the project since June 2013. Between June 2013 and March 2014, a number of methods were used including:

- On-going developmental evaluation and feedback as the project evolved;
- Assistance with setting up tracking systems to provide on-going feedback to the team, the Steering Committee and to provide information for the overall evaluation;
- Key Evaluation Point: March 2014
  - On-line Survey to Family Physicians and MOA's
  - On-line Survey to Emergency Department Staff & Physicians
  - On-line Survey to community agencies
  - On-line survey to the Resource Navigator Steering Committee
  - Reflective Session with the Resource Navigator Steering Committee
  - Key-Informant interview with the Resource Navigator

Key evaluation questions were agreed upon with to the Steering Committee and the Resource Navigator in the summer of 2013. (See Appendix). The following report is a synthesis of the evaluation, particularly of the data collected in March 2014 and is guided by the VCH-IPCC Integration Framework & Best Practices Guide for Building and Integrated Primary, Acute & Community Care System (2013) and accompanying VCH-IPCC Evaluation Framework (November 2013).

OVERVIEW OF THE EVOLUTION OF THE PROJECT & THE RESOURCE NAVIGATOR ROLE

When the project began, the principle focus was on assisting the family physicians with individual patient referrals. Another key focus was on the Resource Navigator familiarizing herself with the variety of resources available with the intent of developing a system of information transfer. As shown previously in Fig 1, Phase 1 (Feb-May) involved project planning; Phase 2 (May-August) involved Development & Testing of Processes; Phase 3 (September-Dec) involved further process development & testing, building on opportunities; Phase 4: (Jan-March) Process Refinement & Final Evaluation.

Phase 2 (May-Aug): Originally the envisioned model was as shown in Fig 2 (Model 1). It was to be simple where the physicians referred to the R-N who then sent the information back to the physician. Through a few months of trial it was discovered that the family physicians were not making many referrals. Various marketing strategies were then tried by August including emails & posters about the position and the development of a marketing strategy called “Tip of the Week” which included a highlighted resource for the physicians plus a description of the Resource Navigator role. This was sent to all the family physicians via email.

Unfortunately, in many cases when the R-N sent the information back to the physician, the physician did not have time to follow back with the patient. The R-N found she did not know if the information was adequate for the situation.

During this time as well, the Resource Navigator began to discover that the physicians were not aware of some of the key agencies and what they had to offer (discovery from physicians and from agencies) and saw an opportunity to host workshops that would not only educate the physicians as a group but also educate them on the Resource Navigator role.

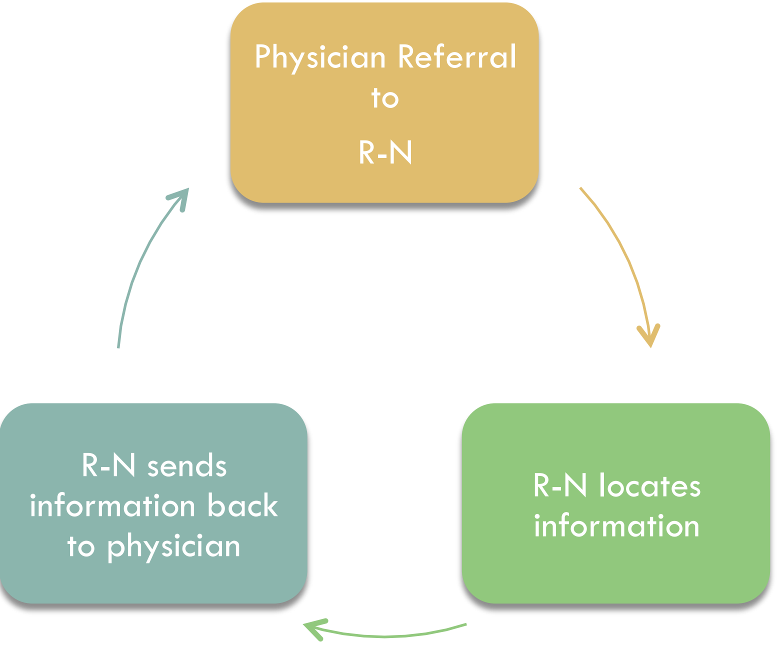


FIGURE 3 MODEL WITH FAMILY PHYSICIANS

Phase 3 (Sept-Dec): Five key changes were made to the project during this phase to address the lack of referrals from the physicians.

- The R-N could have direct contact with the patient after she received the referral from the physician
- The R-N began to make more direct in person visits to the family physician offices
- The R-N began to host workshops about targeted community resources and invited the family physicians and MOA's
- The DoFP began to do more intensive marketing of the position by mentioning the position at a variety of their meetings and events.
- Through the many connections that the R-N was making with the various community agencies, she also discovered that many of them needed to be better connected with each other
- An opportunity was discovered via the VCH-IPCC Change Lead, that the emergency department was having difficulty with dealing with connecting their patients with community resources. This opportunity began to be explored late November to December and then a targeted ED strategy started in January.

A new model of working with the Family Physician emerged (Fig. 4) where the R-N now was able to make phone contact with the patient. This allowed the R-N to better understand the patient's needs, allowed the time needed to go into more depth and also uncover other key needs: all time that the physician did not have. As well in the new model, the physician did not have to send the information to the client, thus saving the physician and their MOA precious time. As the model changed, more referrals began to come in. During this phase, the number of physician referrals continued to be low but began to steadily rise.

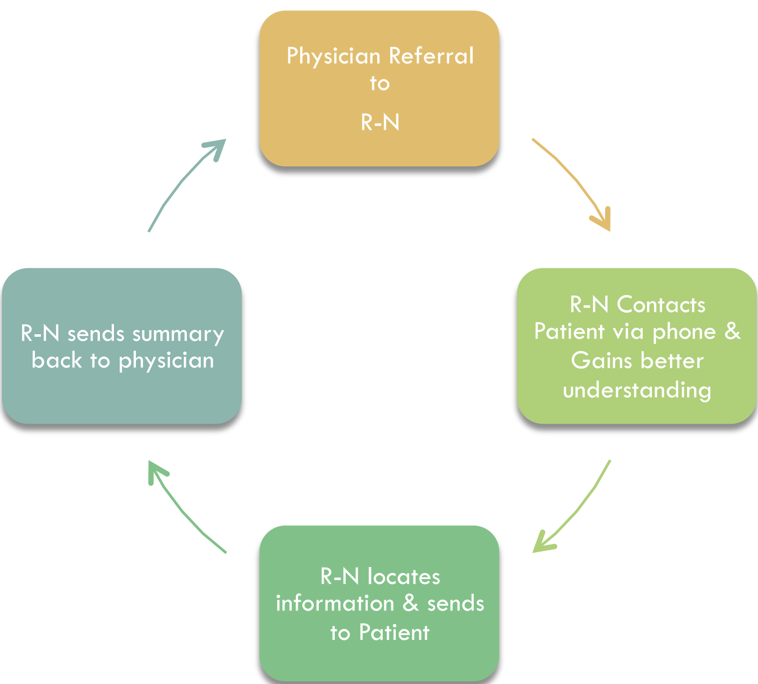


FIGURE 4

Phase 4 (Jan-March 2014): During this phase the emergency department strategy began where the R-N began to visit the ED and I-CARE rounds on a regular basis in the mornings. Uptake was slow by the emergency department as the two parties got to know each other and processes were developed and ironed-out for referrals. By the end of February the referrals began to steadily increase.

During this phase, family physician referrals also began to increase.

Another workshop was hosted for the family physicians and relationships and connections continued to build with the community agencies.

As result, by the end of Phase 4, not only had better processes been built for the Family Physician-Patient relationship, as well as with the emergency department, but also importantly, the DoFP is now being seen as a hub connector for the community agencies with physicians.

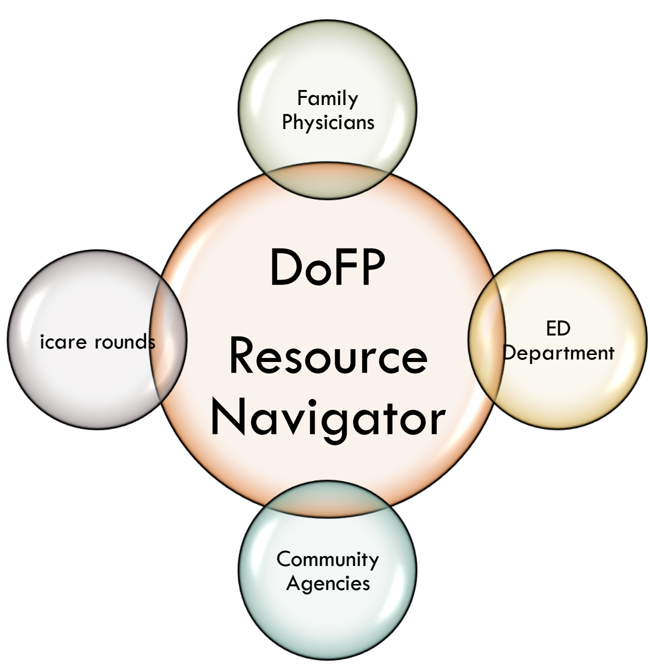


FIGURE 5

SUMMARY OF STRATEGIES TRIED:

The project was framed and understood as an innovation project with the understanding that we were testing a new position, a new role with many unknowns and there was an expectation that various strategies would be tried and tested, opportunities would be allowed to emerge as the understanding of this new role and how it fit into the context would emerge. IPCC Evaluation was involved from the onset of the project and was framed as a developmental evaluation.

The position evolved from the original model where the family physician would make a request for information and the Navigator would send information back to the physician. This model had several flaws so new processes were developed that were more efficient and effective for all parties. To address issues of slow uptake by the family physicians various strategies were tried including various marketing strategies including flyers, face to face office visits to explain the role; development of a "Tip of the Week" flyer; marketing at DoFP events and in March 2014, the production of a YouTube video.

Through the growing connection with the community agencies and understanding of gaps, the R-N then arranged workshops and information sessions to bring the agencies and the physicians together. Another opportunity that arose was with the Emergency Department who was having similar difficulties to the physicians. In January 2014, the R-N started to regularly attend the ED and starts to receive referrals from them.

SETTING UP A DATA BASE

One of the objectives of the project was to set up a database of resources by working with an existing database. There were several issues that arose with existing provincial resource databases. There were discussion about using "Fetch" from the Nanaimo Division Of Family Practice and "Pathways" from the Fraser Northwest DOFP. It was decided to await the development of Pathways at the GPSC level and a letter was submitted from the Powell River DOFP to support Pathways. We are now waiting for Pathways to be approved and piloted in July 2014.

Results

PROFILE OF THE REFERRALS AND ACTIONS TAKEN BY THE R-N

The resource navigator received 98 referrals between June 11, 2013 and March 14, 2014. The majority of those whose gender was tracked were female. The gender breakdown was as follows:

- 43 (44%) are female
- 36 (27%) are male
- Gender was not provided or relevant for 19 (19%) referrals (blanks)

There was a large age range for the referrals. Of the 98 tracked referrals, 30 % (29) were 66 years and above and 17.3% (17) were 20-55%, while 35% were not provided or relevant (See Table 1). The overall spread according to age at the time of referral is as follows:

TABLE 1

Age Range	Number	%
66 years and older	29	30%
56- and 65 years age	9	9.1%
20 – 55 years age	17	17.3%
13- 19 years of age	2	2%
0 -12 years of age	3	3%
Age Not Tracked	35	35%

**Of the 98 referrals, two were identified as First Nations. However, for the remaining 96 referrals First Nations status was not recorded.

The resource navigator received 64% of the total referrals from physician offices, followed by 12% from the Emergency Department, 10% from Vancouver Coastal Health staff and 8% from community agencies. The specific breakdown is as follows:

- **63** referrals from family physician offices, including referrals supported by MOAs
- **12** referrals from the Emergency department, including referrals supported by a Clinical Coordinator and 'PRGH' (Jan-March)
- **10** from Vancouver Coastal Health staff
- **8** from community agencies
- **5** were self-referrals

Primary Diagnosis and Reasons for referral:

Patients were referred to the Resource Navigator with a range of primary diagnoses. The greatest referrals were received for psychosocial, mental health and musculoskeletal diagnoses. The breakdown of the most prevalent diagnoses and groups of diagnoses, reasons for referral and actions taken is presented in Table 1 below:

Profile of the Diagnosis, Reason for Referral and Resource Provided

The most frequent diagnostic referral made was in the category of Mental Health/Psycho-Social at 26%. This was followed by nine other categories:

- **Mental Health/Psycho-Social (26%)**
- **Other (14%)**
- **Musculoskeletal (11%)**
- **Chronic Disease (6%)**
- **Child & Youth Mental Health (5%)**
- **Caregiver-related (4%)**
- **Multiple (4%)**
- **Cancer (3%)**
- **Cardiovascular (2%)**
- **19% of the diagnoses were not provided/not relevant in the tracking sheet**

Reasons for referral varied and included:

- **Home & Community care**
- **Social and home support for seniors**
- **“Mental Health” or “Psychosocial”**
- **Child and youth mental health services**
- **Caregiver resources & support**
- **Body &mind-body activities/services**
- **Violence/abuse related**
- **Community resources**
- **Multiple reasons**
- **Financial**
- **Transportation**
- **Physician services**
- **Food**

Referral Patterns 2013-14

The following two tables indicate the referral patterns over 2013-2014. The maximum number of referrals from the family physicians was 11 in September and December. These “spikes” may have been related to recent workshops that were hosted by the Resource Navigator. The average number of referrals was 6/month. For the emergency department, the number of referrals has grown from one in February to 12 in March.

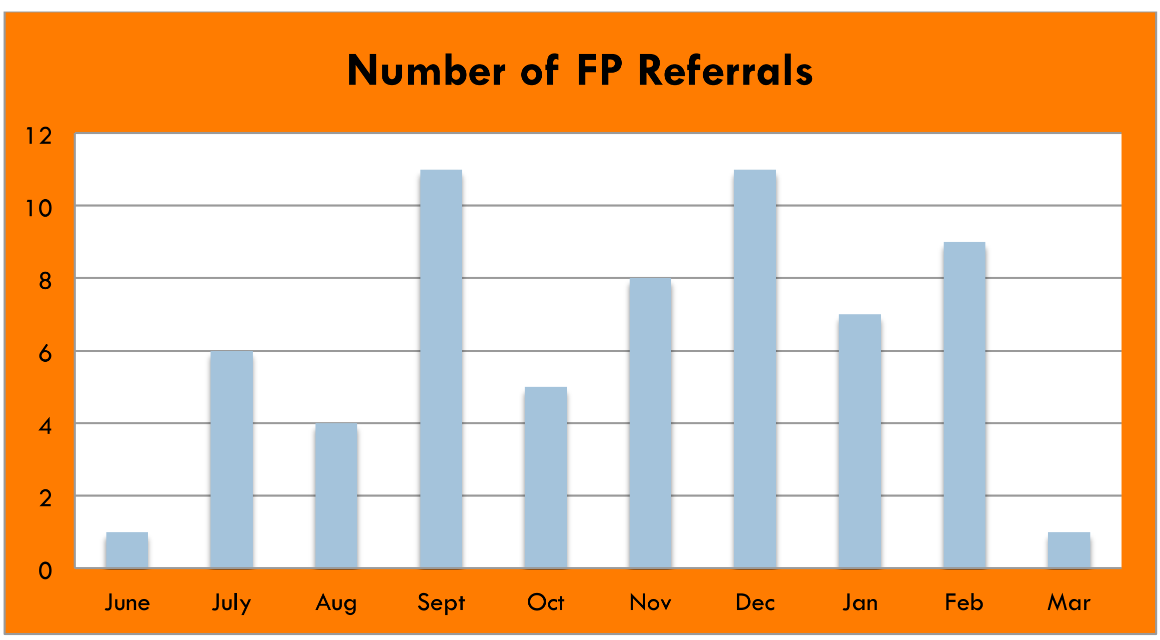


FIGURE 6

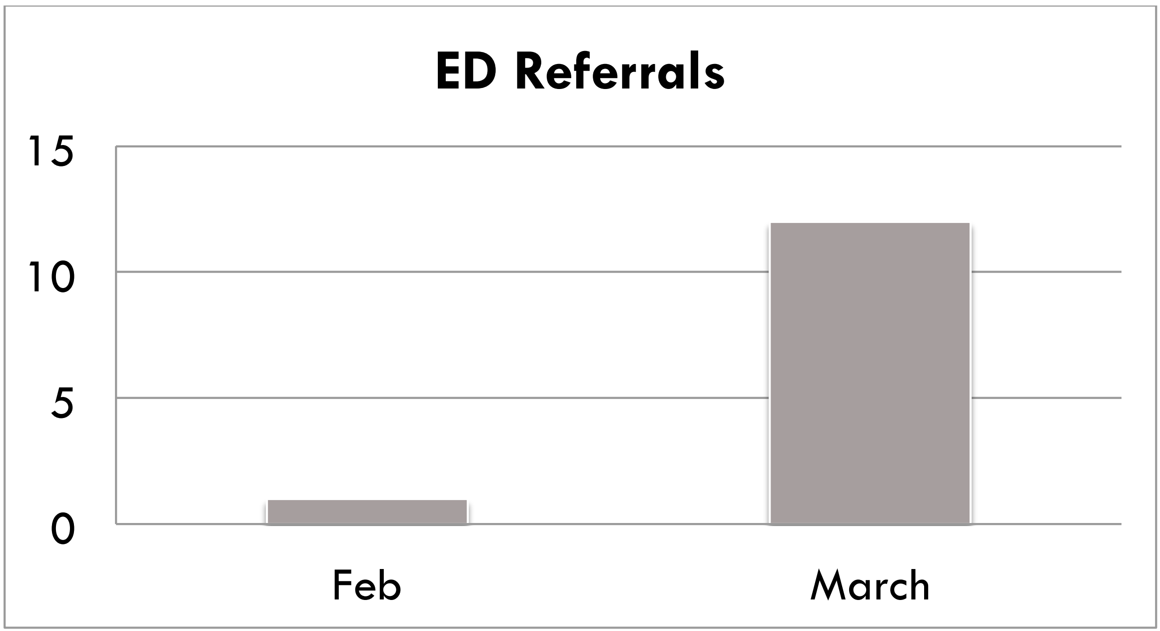


FIGURE 7

FEEDBACK FROM PHYSICIANS, MOA'S & THE EMERGENCY DEPARTMENT

To obtain feedback on the Resource Navigator role, a survey was sent the week of March 17, 2014 to all Powell River family physicians (n = 33) and MOA's and to the Powell River emergency department staff and physicians. Twenty-one (21) people responded to the survey:

- 12 Family Physicians
- 3 MOA's
- 6 ED Staff

9/21 (42%) had made a referral more than 3x, while five had made 2-3 referrals, four had made 1 referral and 3 had never made a referral. Of the three who had not made a referral, none were family physicians. When asked why they had not made a referral, one did not understand the role, one did not feel the need and one said that they had just not gotten used to this "great resource" available.

For family physicians the following table shows the number of referrals made by them:

TABLE 2

Frequency of Referrals	No. of Physicians (n=12)
Never	0
1	3
2-3	4
More than 3	5

Participants were asked to rate the Resource Navigator's role related to overall satisfaction as well as in relationship to some of the original objectives of the project. (See Table 2). Table 2 shows aggregated data for "Disagree-Strongly Disagree" and for "Agree-Strongly Agree" and also compares the total participants to the pool of family physicians.

For all responses, results were higher for the "Agree-Strongly Agree" categories and the Family Physicians positive responses were higher than the overall participants in all categories except "*has provided valuable resource information beyond my initial request*" (41.6% vs. 42.8%). However, in all cases, there was a higher

negative response rate (disagree + strongly disagree) for the family physicians than for the total participants except for the question "*helped me identify available health and social support services*" (16.6% vs. 19.1%).

Of particular note was the question "*I am extremely satisfied with the Resource Navigator*" where 75% of the family physicians agreed or strongly agreed versus 66.7% of all participants.

TABLE 3

	Total Participants		**Family Physicians**	
REGARDING THE RESOURCE NAVIGATOR'S ROLE, PLEASE RATE THE FOLOWING	Strongly Disagree Disagree	Strongly Agree Agree	Strongly Disagree Disagree	Strongly Agree Agree
• I am extremely satisfied with the Resource Navigator	23.8%	66.7%	25%	75%
• Helped me identify available health and social support services	19.1%	61.9%	16.6%	66.6%
• Helped link my patients to health and social support services	23.8%	61.9%	25%	66.6%
• Has resulted in improved time efficiencies for me	23.8%	61.9%	25%	66.6%
• Has resulted in better outcomes for my patients	23.8%	52.5%	25%	58.3%
• Has also provided valuable resource information beyond my initial request	28.6%	42.8%	33%	41.6%
• The Tip of The Week was Highly Valuable	28.6%	38.1%	33%	41.6%

Note: %'s for "neutral" & "N/A" are not shown

Workshops and Information Sessions

There were four workshops/information sessions that were organized by the Resource Navigator during the pilot period. Eleven (52.4%) of the total participants including 50% of the family physicians had not attended any session, while six total (28.6%) of the total and five (41.6%) family physicians had attended the Bounce Back session; four total (19%) and two (16.6%) family physicians had attended the First Link/Alzheimer's session; and four total (19%) and one family physician had attended the Advanced Care Planning.

For those who did not attend, (11) eight 72.7 % indicated that timing was the main issue while two (18.2%) indicated that they did not know about them. Of the 10 who did attend a workshop 60% were very satisfied or extremely satisfied with the workshop.

An important outcome of the workshops was the increased number of referrals that physicians made to community agencies after attending a workshop. The graphic illustration of this aspect of the work of the Resource Navigator is shown in Figure 6

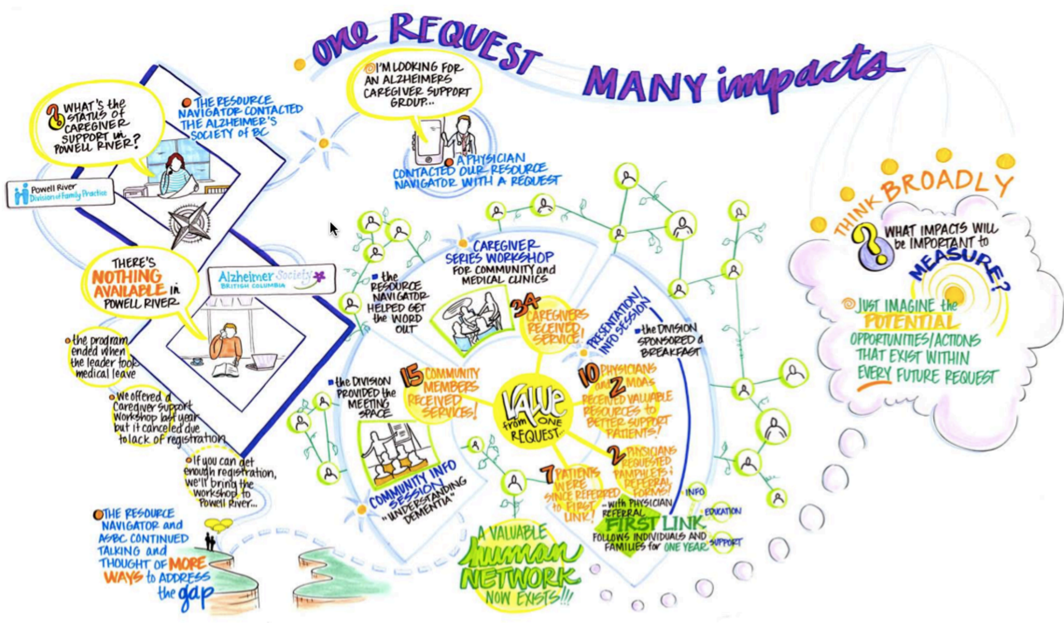


FIGURE 8

IMPACT OF THE RESOURCE NAVIGATOR

The graphic illustration in Figure 8 shows how one referral from one inquiry from a physician led to an Alzheimer's workshop for physicians and MOA's. This then lead to

- 34 caregivers receiving support
- 15 community members receiving support
- 10 Physicians and 2 MOA's received valuable information
- 2 Physicians requested pamphlets and forms
- 7 patients were referred to First Link.

FEEDBACK ON OUTCOMES OF THE RESOURCE NAVIGATOR SERVICE

Participants were asked to rate the outcomes of the Resource Navigator's service where proposed outcomes were determined from the original objectives of the project. (See Table 3). Table 3 shows aggregated data for "Disagree-Strongly Disagree" and for "Agree-Strongly Agree" and also compares the total participants to the pool of family physicians.

Perceptions of Total Participants Group

Generally all responses regarding outcomes were more positive than negative for the Total Participant group. The question showing the highest positive response was *"Referrals have lead to satisfied patients"* (66.7%) while the question with the highest negative response was "*there have been improved communication between services the patient is receiving and the primary care giver.* " (19%)

Responses differed when the Family Physician group was filtered, as there was a great percentage of negative response compared to the positive response for the physicians as a group. The average negative response rate was 10% higher & the positive response rate was on average 10% lower for the family physician group than the total group. However, like the overall group, the family physician group answered more positively than negatively for all questions except the question, "Referrals have lead to satisfied community agency providers", where positive and negative were even (25% vs. 25%).

TABLE 4

	Total Participants		**Family Physicians**	
AS A RESULT OF THE RESOURCE NAVIGATOR, PLEASE RATE THE FOLLOWING:	Strongly Disagree/ Disagree	Strongly Agree/ Agree	Strongly Disagree/ Disagree	Strongly Agree/ Agree
• Referrals have lead to satisfied patients	14.0%	66.7%	25%	58.3%
• Referrals have lead to satisfaction for me in my work/practice	9.5%	61.9%	16.6%	58.3%
• Referrals have lead to satisfied community agency providers	14.0%	38.0%	25%	25%
• There been improved communication between services the patient is receiving and the primary care giver	19.0%	42.8%	33.3%	25%
• More effective relationships have been established between community agencies and physicians	9.5%	42.8%	16.6%	41.6%
• More effective relationships have been established between community agencies and clients	5.6%	57%	8.3%	41.6%

Perceptions of Key Successes and Challenges for the Pilot project

In this question, respondents were asked to rate each response either in terms of a challenge or a success. For both the total group and the family physician group, each response was rated as more successful than challenging overall. For the overall group, the response rated as most successful was tied between "communication with the Resource Navigator" and the "Resource Navigator improved my awareness of community resources" (71.4%) while the response with rated as most challenging was "embedding the resource navigator into my workflow/practice".

For the family physicians, the responses rated as most successful were:

- Communication with Resource Navigator (83.3%)
- Resource Navigator improved my awareness of community resources (75%)
- Referral Process to Resource Navigator (75%).

For the family physician group, the responses rated as most challenging were:

- The value of the Resource Navigator position (33.3%)
- Marketing and support by the DoFP (33%)
- Embedding the Resource Navigator into my practice/workflow (33.3%)

Interestingly the response with the most difference between the groups was "communication with the Resource Navigator" where 83.3% of the family physicians rated it as successful and none indicated a challenge.

TABLE 5

WHAT HAVE BEEN THE KEY SUCCESSES AND CHALLENGES OF THE PILOT?	Highly- Somewhat Challenging	Highly- Somewhat Successful	Survey Participants
• The value of the resource navigator position was demonstrated	28.5%	52.4%	Total
	33.3%	58.3%	FP
• Marketing and support by the DoFP	33.3%	47.6%	Total
	33.3%	66.7%	FP
• Embedding the Resource Navigator into my workflow/practice	38 %	47.6%	Total
	33.3%	58.3%	FP
• Communication with the Resource Navigator	4.8%	71.4%	Total

	0	83.3%	FP
• **The Resource Navigator improved my awareness of community resources**	9.5%	71.4%	Total
	8.3%	75%	FP
• **A better system was created to connect me and my patients to community resources**	14.2%	61.9%	Total
	16.6%	58.3%	FP
• **Referral Process with the Resource Navigator**	19%	61.9%	Total
	16.6%	75%	FP

Comments on Key Successes and Challenges:

Qualitative comments were themed. Overall there were a great deal more positive comments than negative about the project.

- Position Has been Proving its Value
- Don't Stop the Position, Too Early
- JoAnn has been an asset

The Position has been proving its Value.

- Invaluable for the provider and their patients
- Is prompt and efficient with her work
- Have taught or made providers aware of resources in town
- Proactive: regular visits from JoAnn & helping with items beyond original reason for referral

> **"The Resource Navigator is very efficient to provide service, she solved our problem within 1-2 days with good response and a very good report was sent to me afterwards. It's a wonderful service to both my patient and myself. Thank you very much!"**

> *Jo Ann's involvement has been invaluable for my patients and for myself. She has brought many resources to my attention and taught me a lot about what is available. She has always been available, prompt and efficient with her work.*

Jo Ann has been very helpful with providing information for our patients and ensuring that I am aware of the resources in town and also in tracking down helpful information for our patients. She tends to these requests quite quickly.

We are Just Starting, Early Days, Don't Stop

- ER and Other Acute areas are just starting to understand the role and are valuing it.

The role of the resource navigator is just now being understood in ER and acute. The nurses have just started to send referrals recently. I believe that it is too early to accurately assess the need for this role as word is just getting out now.

I just found out about this person. I work in ICU. I expect that the Navigator will be a huge asset in the ICU as well and am looking forward to asking for her assistance!

"This is a good project and requires time to get the details right"

There is great potential for this role to expand our use of resources, to improve our relationships with community agencies, and to develop community engagement on a new level... I think stopping now would be premature given the time it takes to develop these relationships. Too often we get focused on metrics without thoughtful appreciation of the timeframes required to measure important outcomes. Significant changes to health and wellness cannot always be measured between political or budget cycles. Jo Ann is starting to break new ground in Powell River. I hope she can continue.

Jo Ann has been an Asset.

Jo Ann is very enthusiastic in the position and her energy is infectious. I like when she arrives and we just have a time to sit and chat about how things are going. It was a great choice in making her the Resource Navigator.

> ***Jo Ann is very enthusiastic in the position and her energy is infectious. I like when she arrives and we just have a time to sit and chat about how things are going. It was a great choice in making her the Resource Navigator.***

CHALLENGES

As with any project, several challenges were identified:

- Marketing the Resource Navigator Role and the slow uptake by physicians
- Link with the hospital was valuable, could have happened sooner
- Originally not allowing direct connection with patients
- Mentality of physicians who are generally not used to working interdisciplinary way, takes a shift in thinking for them to change
- Person hired in the role: perhaps consider a different person

Respondents' Recommendations for Next Steps:

The majority (75%) of respondents recommend continuing the position either as is or in an enhanced role. The five respondents who recommended not continuing the position did not provide reasons for their choice. Interestingly, 66.6% of the family physicians suggested that the position continue with 33.3% suggesting it discontinue.

TABLE 6

Response	Chart	Percentage	Count
Find funding to continue with the Resource Navigator position as it is		35.0%	7
Find Funding to continue with the Resource Navigator but enhanced role		40.0%	8
Do not continue with the Resource Navigator position		25.0%	5
		Total Responses	**20**

The following quotes illustrate the sentiments of many of those who were surveyed: that people are only starting to get on board, illustrating that a cultural shift is occurring.

> **As word gets around there would be more and more referrals made. This is an excellent program and I would like to see it continue. It would be a shame to cut it when people are just now starting to know about it and use it.**

> **This has been a Long time coming and I have great hopes for the enhanced care for the community**

COMMUNITY AGENCY FEEDBACK

Five community agencies responded to the survey. Three classified themselves as "local" from Powell River, while two classified themselves as Regional and one classified itself as "provincial". The majority of types of interactions included the Resource Navigator visiting their site to gather information and/or inform them of her services and/or connect the agency to other contacts or agencies. Two of the organizations had had Jo Ann organize a workshop/session that they presented at.

Community Agency Perspectives on the Resource Navigator:

There were two key theme areas that emerged from the survey and these include:

- ESTABLISHED A LINK BETWEEN COMMUNITY AGENCIES AND PHYSICIANS
- NEED FOR CLARITY ON ROLE OF THE NAVIGATOR

Established a link between community agencies and physicians

- Provides a key contact person for community agencies to liaise with to work with physicians
- Seeing more referrals from family physicians
- Family physicians are connecting families earlier to our agency (dementia) and allows us to provide information and support before a crisis
- Better able to connect community clients who don't have a physician

"The establishment of a link between community agencies providing services and physicians. It has been fantastic to be able to send information about programs and events to one person, who will then disseminate this information to the medical community. "

"Jo Ann is a very engaging person and has worked hard on establishing a link between the work physicians do and community agencies."

"We have established a positive relationship with the Division of Family Practice and are now working with local GPs to assist their patients"

> *"Has linked our agency with other service providers & community resources to engage and network"*

Need for clarity on role of the Navigator

- Uncertainty that the Resource Navigator does help to establish relationships between community agencies and physicians
- Relevance to the "on-the-ground" agencies needs to be more explicitly stated.

What should happen next?

- Most who responded recommended keeping the position, continue with workshops
- Keep the connection between the DoFP, the Vancouver Coastal Health and the community agencies.

> **"The Resource Navigator position should continue. It would be good if Vancouver Coastal Health in Powell River could work cooperatively with the Resource Navigator and the Division of Family Practice so that we can establish a continuum of care for people with dementia in the Upper Sunshine Coast."**

PERSPECTIVES FROM KEY STAKEHOLDER INTERVIEW WITH JO ANN MURRAY, THE PILOT RESOURCE NAVIGATOR

Jo Ann Murray was hired as the Resource Navigator for the one-year pilot phase (May 2013-May 2014). A reflective interview was conducted with her to gather her perspectives on the position.

Key Successes as Perceived by Jo Ann

- That physicians are starting to increase use of the service, and diverse physicians now using it (not just the same ones)

- Physicians, MOA's, ED starting to recognize the Resource Navigator
- Now have Involvement of all clinics
- DoFP: increased community profile and seen as a hub & resource. Being called upon to participate in many community endeavors
- We have the most updated resource foundation in Powell River
- Indirect assistance for Physicians has proven to be very valuable (workshops: Advanced Care Planning)
- Identifying gaps, connecting community with physicians, raising awareness of gaps
- Now that R-N can speak with patients, able to spend time with them and figure out the key issues
- Developed a streamlined referral process

The importance of the Resource Navigator Interaction with the Patient

A key theme that emerged from the interview was the importance the R-N's interaction with the patients/Clients in uncovering the key issues. The physicians only have a certain amount of time with the patients and oftentimes the referral that is received can be the tip of the iceberg or not quite the right thing that is needed. This is why having the resource navigator speak with the patient is so critical.

> *"I got a referral that just said "Seniors Activities, he's depressed'. When I get talking to him he is a loner, he doesn't like groups. So through my conversation, I was able to identify that he liked animals, his dog died last year so I connected him with the SPCA, and suggested dog-walking…so find what fits the individual rather than just throwing a pamphlet their way"*

Another aspect of this time that she is able to spend is that value it provides to the client who feel "listened to".

> *"One of the things that has happened in this role is that when I call up a patient, I'll often be on the phone for half an hour, 45 minutes, and then have people say "its just somebody listening". Even if it doesn't sound like a lot, for some people it's big. … They say they feel supported, not alone, because usually they leave the doctor's office and that's the end of it"*

Another story illustrates how the time spent by the resource Navigator on the case results in better outcomes:

> *"I got a referral for a gentleman with developmental delay. It was a pretty vague referral…they wanted the person to be more integrated. So took a lot of looking around, conversation, on-line research, looking at programs in town, talking to acquired brain injury people, and finally found a program through Careerlink. I don't know if he will follow through, but I know the physician was quite pleased with what I came up with…I am not sure you would have found that if you hadn't spent the time.so I am able*

to work through some of the complexities with people and recognize that there's no point in going that route if they are dead against it"

The Resource Navigator's role can have a direct or indirect effect for the physicians

Another key theme discussed was the importance of the workshops that emerged during the course of the project. The workshops were not part of the original design. Jo Ann discussed how one call from a physician resulted in Jo Ann contacting the agency; a workshop resulted for the physicians and community members. This then resulted in several referrals by the physicians to the Alzheimer's Association. This story was illustrated in Fig. 8.

The Powell River DoFP is now seen as a HUB for the community

This was an important outcome of the project. According to Jo Ann, the community agencies are now becoming comfortable with the DoFP as the HUB connector with the physicians. This was another important unexpected outcome.

Streamlined Referral Process Developed

Another important aspect of the position that occurred was the evolution of the referral form and the streamlined process for the physicians by the end of the pilot.

> *"We developed a referral form that is a better process because it got all the data for the evaluation, plus the case is standardized, plus the physician gets a note back. So there is a 2-way conversation that goes on between myself & the physician that doesn't require a phone call. Very streamlined"*

Key Challenges Discussed by the Jo Ann

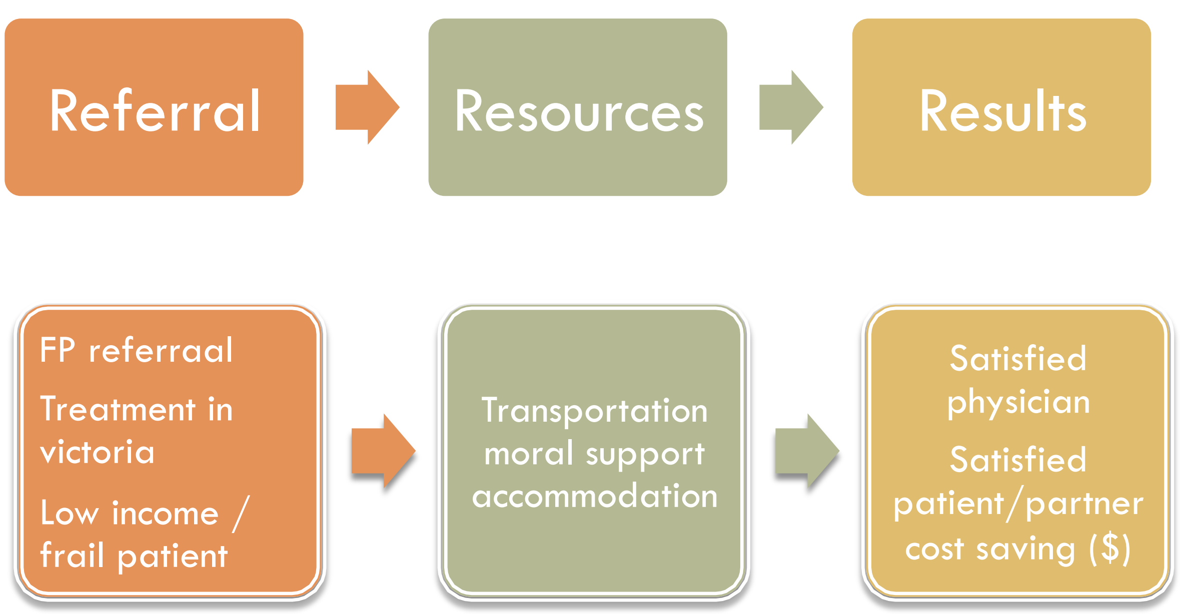
- Slow uptake from physicians
- Role was not well defined and was evolving
- Having two key people start at the same time who were not originally in the planning stage was difficult
- Physicians & MOA's not knowing what they don't know
- Not knowing what the physicians think of her work

CASE STUDY ILLUSTRATIONS OF THE IMPACT OF THE RESOURCE NAVIGATOR

The following three case studies were provided by Jo Ann Murray and Guy Chartier (DoFP Coordinator) during the April meeting of the Steering Committee. They illustrate the impact of the position. Of key importance is the reduction in length of stay (and therefore costs to the health system) through the intervention of the Resource Navigator.

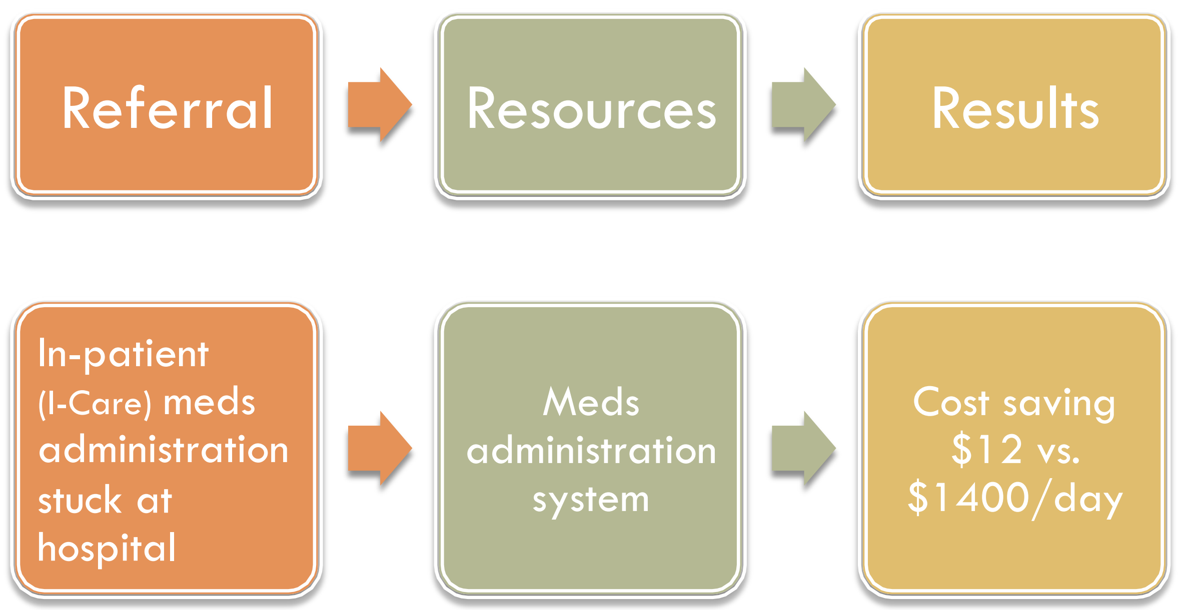
Case Study 1: VICTORIA VICTORY

A referral was made by a family physician to assist a frail elderly gentleman on low income, wife did not drive, who needed to travel to Victoria for treatment. The Resource Navigator was able to provide a list of low-cost accommodation and locate a "by donation" transportation service to Victoria that would pick him up and drop him off at Comox ferry. As well, R-N supported patient to contact the MD in Victoria to negotiate a shorter pre-op stay to reduce stress and financial burden. This also greatly relieved his wife of the stress of worrying about transportation and accommodation.



Case Study 2: Pharmacy Solution

A referral was made by ICare rounds: a patient was going to have to remain in the hospital since there were no Home Health resources to administer his medication at home. The Resource Navigator found out that a pharmacist was able to administer the medication for $12/day. This saved the health authority $1400/day (cost of keeping a patient in the hospital).



Case Study 3: Home Stay within Days

A referral was made via Emergency/I-Care Rounds for a patient was "stuck" in the hospital due to homelessness. The patient could not stay alone and could not live with family. The Resource Navigator located a private homestay with care support. The cost was $1000/month vs. $1400 per day if the patient had remained in the hospital.

COMMUNITY INVOLVEMENT ILLUSTRATIONS OF THE IMPACT OF THE RESOURCE NAVIGATOR

The following four groups/organizations/committees illustrate the impact of the position at the community level. Of key importance is the fact that those entities saw value in having the involvement of the Resource Navigator in order to better connect with the physicians in Powell River. The Resource Navigator currently sit on the following four groups/organizations/committees:

- School District 47 Health Committee Initiative: Early Years Test Site Meeting
- Better At Home: Advisory Committee
- School District 47 Health Committee: Quarterly meetings
- April Struthers: Community Response Network potential for PR

SUMMARY

Between May 2013 & March 14, 2014, a total of 98 referrals were received and acted upon. 64% of the total referrals were from physician offices, followed by 12% from the Emergency Department, 10% from Vancouver Coastal Health staff and 8% from community agencies. Four workshops/information sessions were planned and hosted by the R-N. March 2014 was a key evaluation point and included a survey of the family physicians, emergency department staff, & the community agencies; a key informant interview with the Resource Navigator and a reflective session with the Steering Committee. Results indicated that 75% of the family physicians (n=12) and 66.6% of the total providers who responded were extremely satisfied with the R-N and 66.6% felt the R-N had helped link their patients to resources.

The majority of the community agencies who responded felt that better linkages had occurred between them and physicians and they were seeing an increase in referrals. For the family physicians, the most successful aspects of working with the R-N were: communication with R-N (83.3%); improved awareness of community resources (75%) Referral Process (75%). The ED indicated that they were seeing a positive value in the position, but felt that they were just starting to understand the role, as the process was so new.

The ED strategy was unexpected in the beginning and appears to be valued by the providers. An important added value of having a person as a resource navigator versus a web resource/list is that she/he is able to listen to the patient and really understand what is needed, thus directing them to the right resource. Anecdotal accounts indicate that the patients feel that they are “listened to”. The majority of respondents indicated that the position

should continue as value had been shown and many felt that they were early days into the project and cultural shifts take a while to occur.

Analysis/Next Steps:

There were many successes demonstrated by this pilot. All clinics have now used the Resource Navigator and 17 different family physicians have made referrals. The Emergency Department is now using her services. A key factor that made this work was the "human element" of the ability of the resource navigator speaking with the patients/clients and getting a better understanding of their needs. The following story from the interview with the Resource Navigator, illustrates this point. Through some of the recent referrals from the Emergency Department-I-Care rounds, ***important cost savings*** have been shown through the Resource Navigator intervention. The relationship with the emergency department has been recent yet has shown several positive results.

A key challenge of the pilot has been uptake by the family physicians. A great deal of effort went into trying various strategies to increase referrals including shifting gears to include the Emergency Department and the hosting of a variety of workshops that brought community agencies together with the physicians. The workshops proved to be quite successful in creating more direct referrals for the community agencies from the physicians in particular. While lack of any patient contact was addressed midway in the pilot thereby allowing the R-N to contact the patient by phone, the current model has the R-N contacting the patient via phone only. This has pluses and minuses that have been discussed and also illustrates the need for a social worker position in Powell River. The recent You Tube video showing stories by the physicians on the value they have seen of the Resource Navigator was very positive and the impact of the video on attracting more physician referrals is yet to be seen.

The evaluation has demonstrated a great deal of positive feedback on the "value" of the position by those who have used the service. A critical question is what volume of referrals should we expect from the family physicians and from the emergency department? If we are viewing a cultural shift, how long should we expect the shift to take? Leadership will have to determine the "feasibility" of the position. The evaluation will assist the Steering Committee and the Collaborative Services Committee in determining next steps for the role.

APPENDIX 1: KEY EVALUATION QUESTIONS

- Overall Project
    - What Difference has the Navigator Position made?
    - Has this position addressed the original issues identified by the DoFP?
    - What are the successes, challenges and Lessons Learned?
    - Is this position sustainable? What are the next steps?

- Outputs
    - Has a sustainable system of tracking and communicating supports and services been established?
    - What service gaps and barriers have been identified?
    - Have sustainable communication methods (referral forms, processes, feedback, etc.) been established?
    - Has a comprehensive, usable compendium of resources/services been developed and includes local, regional and provincial perspectives?
- Physicians/MOAs Focus:
    - How many physician contacts, community contacts, how many referrals have occurred and what were they for?
    - Has GP awareness of community resources improved?
    - Has communication between GP and services improved?
    - Do the GP's feel there is a time saving for them?
    - Do the GP's have less frustration and less strain?
- Cross System Focus
    - Do the various services feel there is better engagement with GP's and clients as a result of the navigator?
    - Are the referrals appropriate and have lead to satisfied patients, health providers and community providers?
    - Is there improved communication between services patient is receiving and primary care giver?
    - Has effective relationships with physicians, MOA's and other health care professionals and community orgs been established and maintained?
- Patients Focus
    - Have the referrals/navigator role improved outcomes for the patients?
    - Do the patients say there they are satisfied with the service?
    - Is there better coordination of services for the patients?