
McMaster
University
HEALTH SCIENCES
Department of
Family Medicine
McMaster
Family Health Team

Introducing the System Navigator to the Family Health Team

Anne Childs, McMaster FHT Coordinator
Dan Edwards, System Navigator
Sundée Himburg, System Navigator

McMaster University HEALTH SCIENCES
Department of Family Medicine
McMaster Family Health Team

Presenter Disclosure

- **Presenters:** [Anne Childs, Sundee Himburg, Dan Edwards]

- **Relationships with commercial interests:**
  - **Grants/Research Support: nil**
  - **Speakers Bureau/Honoraria: nil**
  - **Consulting Fees: nil**
  - **Other: nil**

Disclosure of Commercial Support

- **No support received**

- **<u>Potential for conflict(s) of interest</u>:**
  - No potential for conflict

Mitigating Potential Bias

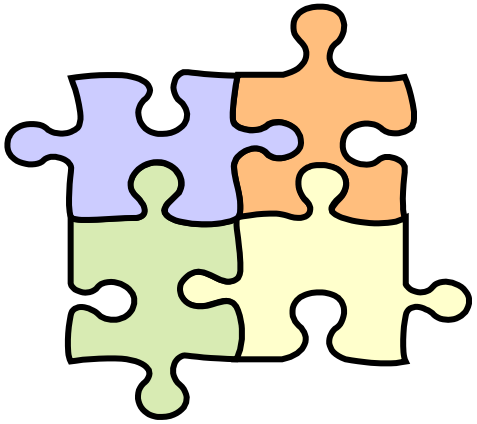
- No mitigating bias

McMaster Family Health Team

- Located in beautiful Hamilton, Ontario
- Two sites: McMaster Family Practice (MFP) & Stonechurch Family Health Centre (SFHC)
- Academic Family Health Team, clinical teaching sites for the Department Family Medicine
- Priority of expert clinical care and excellence in family resident education
- 32 physicians, ~ 80 family medicine residents, ~ 40 allied health professionals, ~ 30 IP learners
- Services > 31,000 patients & > 115,000 visits/year

Why a System Navigator?

- Identified need that there are issues a patient faces that may be bigger/different than health
- Recognized as an important part of the team
- There are resources in the community that are not being accessed/utilized



The System Navigator in Primary Care

- What is the difference between Case Manager & System Navigator?
- What is the educational requirement for this role (is there one?)
- Complex medical patients/challenging patients?
- Do we even know this role?

Developing the job description

- Ensure that all patients have equal and fair access to health care and essential social services and community resources
- Provide support and advocacy
- Work with all members of the Family Health Team (FHT) and community partners
- Facilitate access to care and resources

…Job description…

- Develop the case manager role within the primary care setting (FHT)
- Collaborate with the IP team in the evaluation of services provided
- Regular (i.e. weekly) case review with the IP team to assess needs and service delivery of complex patients

Qualifications

- University Degree in Health or Social Sciences field; or College Diploma with five (5) years work experience in the Health and/or Social Work field
- Experience or knowledge of the health care system and community-based resources
- Good interpersonal, oral & written communication skills and proven ability to work as a team member
- Demonstrated initiative and experience working independently with minimal supervision
- Work experience in primary care would be preferred

Making the Case to the Ministry

- The **Case Manager/System Navigator role** will enhance the links between the community resources and the needs of the patients, freeing up the clinical team to deliver care
- This role will work with the primary care clinical staff, will seek out the appropriate resources and ensures that all patients receive optimal care

Making the case…

- This role supports seamless and efficient use of limited resources within the FHT and throughout the community
- This role will navigate the health and community care system thereby freeing up time for the clinical staff to care for patients
- This essential role will enable the team to efficiently and effectively manage the clinical priorities of the patients

Introduction of the role

- Orientation to the unit, the staff & the patients
- Shadow staff, case finding, 'getting to know the team'
- Develop a referral/consultation process
- Communicating with the team, the patient, the community

Case Review - Dan

- Wife 68 year old female, Husband 71 year old male
- Wife's asthma and allergies have worsened in current living environment
- Both have mobility devices and extensive health issues
- Introduced by family physician at time of health appointment
- Family needs modified 2 bedroom apartment that includes healthy living conditions

What would you do?

- What would be your plan of action?
- What are some ideas or strategies that could help these patients?
- Thoughts/views?

First Assessment

- Family has done excessive housing search throughout the Hamilton and Burlington area
- No issues with budget
- Family was resourceful
- Called local housing providers that were in the community
- Appointments were made to view different apartments throughout the city and start the application process

Issues

- Needs of the family were high because of their requirements that they wanted in the apartment
- Mainstream market rent did not meet their needs
- Housing programs were not accessible

Plan of Action

- Organized three apartment viewings
- Supported with the viewing process of the apartments
- Completed the applications with the family
- Liaised with the property managers
- On-going support is still being received

Achieved Outcomes

- Family received affordable and suitable housing
- Relationship building with the 'new' health care team
- Family felt supported by the Family Health "Team"

Future Outcomes

- Improvement with health
- Reduced number of necessary medical visits
- Improved quality of life
- Increased knowledge and support within the community

Case Review - Sundée

- B is a 60 year old woman
- Complex medical history - Pick's Disease, Diabetic Neuropathy in legs and hands, Vitiligo, Right eye Glaucoma, and Dementia II
- Separated and estranged from spouse since 2006, Son is POA
- *Was* residing in staffed lodging home with open access
- Assessed by Geriatric Psychiatry

Current Prescribed Medications

DEXLANSOPRAZOLE 30MG CAPSULE (DELAYED RELEASE)

APO METOPROLOL TAB 50MG

ASA 81 MG

DOM-LORAZEPAM .5MG

SOFLAX CAPSULES 100MG

LASIX 20MG

LIPITOR 20MG

AVA-METFORMIN 500MG

AVA-RAMIPRIL 5MG

REMERON RD 15MG

SENOKOT TABLETS 187MG

APO SULFATRIM DS TAB

PMS-TIMOLOL 0.5%

Complex Issues

- Worsening dementia – rapidly in last 6 months
- Refusal to take medications
- No personal care
- Alcohol addiction
- Not residing at lodging home

Complex Issues

- Lessening appetite
- Wandering behaviour
- “Non-compliance” with assessments
- Victim of crime in last 6 months
- Sex trade to meet needs

This is your patient

What would you do?

How did I Intervene?

- Referral to System Navigator June 2013
- Flagged as part of Health Links Project based on emergency room visits in the previous year
- Case planning meeting with Complex Care team, FHT System Navigator, Geriatric Psychiatrist, Lodging Home Coordinator, CCAC care coordinator and patient's son
- Issues identified: Safety, worsening dementia - wandering

How did I Intervene?

- August 2013 - patient attended her lodging home with pain in her leg
- Lodging home staff attended with patient at the Family Health Team Clinic (instead of ER)
- Physician addressed medical needs, and System Navigator coordinated care plan with the care team…such a simple sentence….

Current Outcomes

- Patient is stable currently as an in-patient for mental health services on a locked ward
- She is being assessed for Long Term Care in a locked environment and being followed by family physician
- She is safe, taking her medications and cared for.

System Navigator in Complex Care

- Coordinate & connect the various people/supports involved with the patient
- Liaise with the Team/MRP in managing the various services
- Liaise with patient and family involved with care with the goal of improving engagement and continuity across services
- Advocate for services
- Navigate the system - Whose job is it?

Integration of the role…so far…

- This is a non-clinical role, different from administrative
- Flexibility and autonomy in practice is essential
- Linkages between community and primary care strengthened
- Workload management

Work load management

- What to measure and how to measure ‘it’
- Oscar EMR – flexible/individual
- Consult form development
- ‘Who to refer to the system navigator’…
- One quarter data (April – June, 2013), 778 encounters with patients

Next steps/sustainability

- Accurate and meaningful reporting
- Quality of life assessment
- Changes in the reporting matrix's such as ED visits, Hospital admissions etc…
- Increased understanding & collaboration with community partners

- Thank You
- Questions….?


McMaster
University
HEALTH SCIENCES
Department of
Family Medicine
McMaster
Family Health Team