Community Needs Driven Research Network
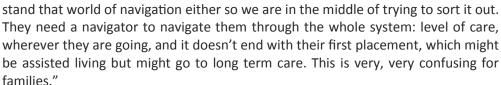
System navigation and transition of care

The biggest issue identified around system navigation was information and education for staff, families, clients, and the general public. A lack of information about roles and services provided by different levels results in a few issues:

1. Confusion;
2. Added time spent navigating; and
3. Impacts on care for staff and the client

Front-line workers do not feel they know how to navigate the system well, which is an even bigger problem for families who lack resources and education to navigate the system themselves.

What front-line workers said:

· "What they do is they hand you a list, and you start phoning and you hope that somebody at the end of the line will take that, and will know what to do."

· "It's very confusing for me as a new manager. I cannot imagine having a family member -- and we ran into this with transition all the time where the doctor doesn't really understand that world of navigation either so we are in the middle of trying to sort it out. They need a navigator to navigate them through the whole system: level of care, wherever they are going, and it doesn't end with their first placement, which might be assisted living but might go to long term care. This is very, very confusing for families."
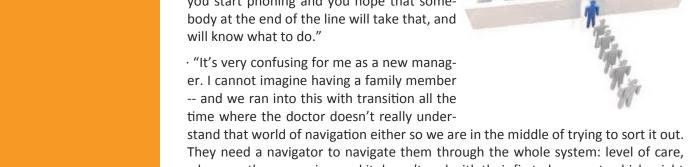
· "It's hard for US to keep track of who does what, let alone families. As you said, sometimes there's overlap, there's grey."

· "My goal in my life is to have a system navigator position somewhere in our health care system; this is my number one."

· "I think that there is more investigation that needs to be looked into regarding family knowledge and expectations pre-admission to long term care; in comparison to the reality of the services and the resources we have to offer."

Issues in transition of care:

There are many transitions to be made by each individual in continuing care (CC). The 3 main streams of CC in Alberta are: home living, supportive living, and facility living. There are many transitions not only between these streams, but also back and forth between acute and primary care to be navigated.

An important part of system navigation and transition of care is the time frame in which clients/residents are assessed, as well as the details of that assessment. Sometimes, clients are not thoroughly and adequately assessed and this causes them to be placed in a facility that may not be the best fit or meet their care needs.

Front-line workers thought:

· "To have more of that transition area and some research to show what is the best time frames, like how long is that assessment period, [be]cause if we were able to better place individuals in the right environment, we might be able to support it."

· "When at first we do assessments every three months and between the first two assessments a large proportion of our residents are much, much better, so we are thinking well is this the best place for them?"

Other issues in transition of care:

Participants talked about how the impact of this process (system navigation and transition of care) is often overlooked. Moving can cause challenging/ responsive behaviours to increase, or the client's functioning to decrease.

Participant-identified research topics:

Participants felt these topics would be useful to gain more knowledge on this topic:

1. The impact of relocation syndrome on clients; and
2. Tracking the experiences of clients and families as they move across the system

· "I would like to see research on relocation stress syndrome and the impact of that pre-admission visit, 'cause I know most don't traditionally do a pre-admission visit…and then you wonder why, if they're moving them, particularly to a dementia unit, where the behaviours increase—'cause I relate it to kind of like a woman wouldn't give birth at a maternity ward without touring it first, yet it seems to be okay to move these residents to a place, and where they live for the rest of their life, but they don't even get to see it."

· "Has anyone ever looked at tracking an experience of a person in the system? So from the time that someone is, I mean they are still, at home, they are using home care services, then they need to progress to the next step in the system, and actually following people through the system to try to identify experiences, inefficiencies, and to look at it from a system perspective?"

What is being done to address this issue?
1. Alberta Health Services has various initiatives underway to try and streamline and improve systems transitions. For example, documentation and process changes are being made to ensure that Calgary and Edmonton zones are the same.
2. Discussions are underway within Alberta, and with other provinces, to develop research grant applications to address issues related to transitions and system navigation.