# Patient navigation programs in Alberta, Canada: An environmental scan

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## ABSTRACT

**Background:** Patient navigation is a complex intervention that has garnered significant interest and investment across Canada. We conducted an environmental scan to understand the characteristics, gaps, and diversity of patient navigation programs in Alberta, Canada.

**Methods:** Patient navigation programs within Alberta Health Services (AHS) and the Primary Care Networks (PCNs) were included. The environmental scan was comprised of two phases. In phase 1, key informants were surveyed to identify known existing programs and their corresponding program contacts. In phase 2, these program contacts completed a telephone-based survey to provide program descriptions, eligibility criteria, and to identify gaps in navigation. Results were tabulated and summary statistics (for program characteristics) were calculated.

**Results:** There were a total of 44 AHS and 15 PCN programs. Nearly all programs included an individual acting as a navigator to direct patients to appropriate resources and services. There were pockets of patient subgroups that were particularly well-served by patient navigation; these included pediatric, cancer, and addictions and mental health patients. There were also identified areas for growth, including the need for greater awareness of the patient navigation programs, greater cohesion and streamlining of similar programs, and improved access for those living in rural areas.

**Interpretation:** In Alberta, Canada, there is a wealth of patient navigation programs, but also existing gaps relating to awareness of these programs, lack of resources, and inequitable access. These findings will be of interest to any who are engaged in the planning, development, and implementation of patient navigation interventions in other jurisdictions.

## INTRODUCTION

In health systems everywhere, there is an overwhelming array of health care services, payers, and providers. The burden of responsibility of navigating such a complex and patchy system defaults to patients and their families.[1-3] Fragmentation of the health care system poses a real risk to patient safety, with gaps in health care provision (e.g. missed appointments with specialists), patients receiving treatments that are not aligned with their wishes, psychologic distress for both patients and their family, and even death.[4] Patient navigation is a complex intervention that was borne to help patients traverse a fragmented and siloed health care system, with the hopes of reducing health disparities across the population.

The concept of patient navigation originated in 1990 with the creation of a program in Harlem, New York, where individuals, termed "patient navigators", worked with patients directly to identify individual barriers in the diagnosis and treatment of breast cancer, then connected them with resources to address these barriers.[5-7] The inaugural study showed more timely access and completion of diagnostic interventions.[5] Patient navigation has since been consistently shown to improve patient satisfaction and processes of care.[8,9] Given this promising evidence, the first navigation programs were implemented in Canada in the early 2000's; by 2011, there were programs in oncology in nearly all provinces.[10,11] Despite the surge of patient navigation interventions, there is no consensus on the definition of patient navigation in the literature.[12-14] In the broadest sense, patient navigation "facilitates patients' receipt of care from providers",[13] and "improves continuity and coordination of care".[15]

While early patient navigation interventions were modelled after the original Harlem experience, patient navigation has extended far beyond these bounds. First, it is no longer confined to the cancer care continuum, having been used for non-cancer patients to coordinate primary and specialist care, facilitate transitions from acute (hospital-based) care to outpatient care, and connect patients to community organizations and social resources.[16-29] Second, though the vast majority of interventions still depend upon individual navigators, navigation can alternatively be achieved through system-level interventions and web/paper-based resources.[30-32] For example, the World Health Organization calls upon primary care networks to deliver navigation and coordination functions at an organizational level,[33] and web/paper-based resources have been described to facilitate "self-navigation".[34-37] An example is online symptom-checker websites, where patients can self-identify symptoms, and are then directed as to the most appropriate place to seek care (e.g. primary care physician vs urgent care centre vs emergency department).

Despite the growth in both the number and diversity of patient navigation programs across North America, the current landscape in this area remains unclear. Specifically, whether patient navigation programs exist across the age spectrum, whether populations with certain diseases are better resourced with more programs, and what gaps remain in intervention delivery remain unknown. In Alberta, Canada, there has been significant investment into patient navigation, with a multitude of navigation services being implemented by the provincial health authority. Alberta Innovates, the province's research and development corporation, similarly awarded nearly $4 million of funding in a grant competition to patient navigation studies in 2019 alone.[38] We therefore conducted an environmental scan with the objective of identifying and describing the patient navigation programs within Alberta. These findings, and our general approach to

categorizing and describing navigation programs and the existing gaps, will be of interest to any who are engaged in the planning, development, and implementation of patient navigation interventions in other jurisdictions.

## METHODS

The environmental scan targeted patient navigation programs and interventions within Alberta Health Services (AHS), the provincial health authority, as well as the Primary Care Networks (PCNs, or team-based medical homes providing primary care). Approximately 80% of primary care physicians in Alberta are a part of a PCN; nearly 3.8 million Albertans (approximately 85% of the population) receive care at a PCN.[39]

The environmental scan was conducted in two phases. The objective of Phase 1 was to identify the patient navigation programs within AHS and the PCNs using key informants. The objective of Phase 2 was to describe the characteristics of the identified patient navigation programs. The study was approved by the Conjoint Health Research Ethics Board at the University of Calgary.

### Phase 1: Survey of AHS leadership

An invitation email for participation in Phase 1 of the environmental scan was sent to AHS leadership, from the office of the Vice President (Quality) and Chief Medical Office of Alberta Health Services. This email included a definition of patient navigation, examples of patient navigation programs, the importance of patient navigation in improving continuity and coordination of care, and the study objectives. A short survey was attached to this email, asking these key informants to list all patient navigation programs known to them, and the name and/or

contact information of the individuals who are involved with the program or who may have a detailed understanding of each listed program. Respondents were asked to email their survey responses back to the study team. Two email reminders were sent, each one week apart, after the initial invitation email to optimize response rates.

**Phase 2: Telephone interviews with program contacts**

A list of patient navigation programs, along with their respective program contacts if available, were compiled from the Phase 1 survey results. Programs not administered by AHS or a PCN were excluded. Duplicate programs were excluded. Programs that did not have a clear navigation component (e.g. programs that were provider-facing only with no patient contact) were excluded. For programs that did not have an individual listed as a contact person, or where contact information was missing, AHS leadership was consulted for this information.



An invitation email was sent to the identified individuals for each listed patient navigation program for participation in Phase 2 of this environmental scan. Non-respondents were sent two reminder emails, each one week apart. Participation involved the completion of a survey over a 15-minute telephone interview. Survey items included description of the patient navigation program, patient eligibility criteria for acceptance into the program, program characteristics including whether a referral is required, whether follow-up is provided, the geographic regions served, and the identified gaps within the program. The telephone interviews were conducted between October 2016 and July 2017.

**Data analysis**

Data from the telephone-administered survey from Phase 2 were collected initially on paper forms, then transferred onto Secure REDCap, a web-based data management application. Descriptive information about the programs were presented in a tabular format. Based on literature describing three general modes of delivery of patient navigation (see Introduction), all identified programs in the environmental scan were categorized into these three groups: 1) patient navigator; 2) web- or paper-based resources to facilitate self-navigation, and 3) structural/organization changes to facilitate increased efficiency and coordination of care. The categories were not mutually exclusive, and programs could be placed into more than one category. In addition, for each program, we noted whether it was episodic (one-time navigation) versus longitudinal in nature, and whether it was offered to the general population versus only certain population subgroups. Summary statistics were calculated for program characteristics. All results were stratified by whether programs were administered by AHS versus the PCNs.



**RESULTS**

In Phase 1, 39 key informants identified a total of 144 programs. Of these, a total of 49 were excluded for the following reasons: 33 were duplicates, 6 were not administered by either Alberta Health Services or the Primary Care Networks, 6 had no patient navigation component (e.g. not patient-facing), 2 no longer existed, and 2 had insufficient information provided to contact program staff to participate in Phase 2. In Phase 2, we requested telephone interviews with the primary contacts of the remaining 95 programs. We had a 73% program response rate and completed interviews with the key contacts for 69 programs. Of these 69 programs, 10 were ultimately excluded from the environmental scan after the Phase 2 interviews, when it became evident that the programs provided direct patient care rather than patient navigation (n=5), were

provider-facing only (n=3), or were found to be duplicates of other programs (n=2). A total of 59 programs were analyzed in this environmental scan (44 AHS programs, 15 PCN programs; see Appendix 1).

Of the non-respondent programs, 22.7% were PCN-administered, with another 11.4% being also clinic or outpatient-based. A total of 6.8% were web-based resources or patient portals. Approximately 10% of non-respondent programs were targeted for each of geriatric, pediatric, and Aboriginal populations.



**Program characteristics**

***Patient Eligibility***

The majority of the included programs were accessible by patients of all ages (see Table 1 for a summary of program characteristics, and Appendix 1 for a description of each program). A total of 36.4% of the 44 AHS programs were targeted to pediatric patients only, and 4.5% of AHS programs were specific to geriatric patients only. In contrast, none of the 15 PCN programs offered pediatric or geriatric specific navigational services. The majority of AHS programs were specifically targeted to patients with certain clinical conditions (most commonly those with addictions and mental health concerns, developmental or neurologic conditions, or cancer). Fourteen out of the 15 PCN programs were available to all patients, regardless of the presence or absence of any clinical condition. Of the AHS programs, 36.4% were available through self-referral. Similarly, patients could self-refer to 37.5% of the PCN programs. Nearly all patient navigation programs were outpatient-based, with only 4.5% of AHS programs serving the inpatient population.

### *Geographic coverage*

Nearly half of the AHS programs were offered in the Calgary Zone. The second most-served region was the Edmonton zone, with 20.5% of the programs offered there. Nearly a quarter of programs were available province-wide. Similarly, the majority of PCN programs served towns and cities in the Central zone. Four and three PCN programs were available to residents in each of the North and Edmonton zones respectively, with no programs identified in the Calgary or South zones. There were no province-wide PCN programs.

### *Classification of patient navigation programs*

Table 2 categorizes the patient navigation programs by method of delivery. Nearly all identified patient navigation programs included a dedicated individual acting as a navigator to direct patients to appropriate resources and services, or to help identify and overcome barriers to accessing care. Ten AHS and three PCN programs included structural or organizational delivery components to maximize efficiency and coordination (e.g. having a multi-specialty and/or inter-disciplinary team working together in one geographic location). Out of all 59 programs, only four (all AHS) included navigation in the form of web-based resources, and these were supplemental to the individual patient navigators in the same programs (i.e., they were not exclusively web-based). The majority of AHS and PCN programs did provide follow-up, though most commonly on an as-needed basis.

### *Gaps identified by respondents*

The unmet needs in patient navigation, as identified by respondents, were classified into four domains (see Table 3). First, respondents reported a lack of awareness of patient navigation programs by all stakeholders, including both patients and healthcare professionals. Information on these programs is not centralized nor is it easily accessible, being primarily transmitted through word-of-mouth. Second, respondents identified service gaps for certain populations, specifically for transitional periods, such as for children transitioning to adult care or for hospitalized patients being discharged back to the community. Third, geographic coverage of programs was noted to be a concern, where there is a lack of services provided for those residing in rural communities. Though the programs at urban centres may also serve rural sites due to their large catchment areas, there are few transportation options for these rural residents, resulting in disparate access across the province. Lastly, respondents noted a lack of cohesion and communication across programs, with programs functioning independently of each other. This issue is exacerbated by the inability to share patient information across the different programs.



## DISCUSSION

In this study, we have found an abundance of patient navigation programs across Alberta, serving a diverse population with many different sets of needs. We found that most programs in Alberta rely on individual navigators. Rather than being uniformly accessible across the population, programs tend to be concentrated in the urban centres and target patients of specific ages or socio-demographics or those with specific clinical conditions. These findings have important implications on where, for whom, and how patient navigation programs are developed not just in Alberta, but in other jurisdictions across Canada and internationally. This is, to our

knowledge, one of the first environmental scans of patient navigation programs conducted anywhere. This dearth of studies is striking given the rise, attention, and investment into patient navigation programs particularly within the last decade. Though there has been one prior environmental scan of pediatric navigation models in Canada,[40] the findings from that study were isolated to a narrow population, and did not represent the broader landscape of patient navigation.

Our study highlights the difficulty in defining and framing patient navigation. The literature describes patient navigation predominantly as a service provided by individual patient navigators. This is not surprising, given that the concept of patient navigation was born out of such an intervention, designed to help patients overcome barriers to access to health care. However, the patient navigation construct has since expanded and its definition has become considerably broader, such that many non-navigator led programs are now included. In our environmental scan, we found that the vast majority of programs continue to be led by individual navigators. This is likely due to a pre-existing understanding of patient navigation by study respondents, where only programs that involve individual navigators are considered patient navigation. Web-based resources are likely not being widely considered as patient navigation.

We also encountered the problem of study respondents identifying certain programs as patient navigation, which we did not consider to be as such. Examples included services that were targeted for providers rather than patients (even if the goal was to improve efficiency and/or coordination of care), or programs that provided direct patient care (e.g. outreach services to remote communities) with no "navigational" component to them. Further, we considered clinics

or programs with multiple services that expedited a clinical diagnosis and/or treatment to be patient navigation (a "one stop shop"). However, can the mere existence of a multi-disciplinary team within a clinic be considered patient navigation? The operationalization of patient navigation at a higher, systems level remains ill-defined. Our study therefore highlights the nebulous nature of patient navigation and the need for a cohesive understanding of what patient navigation is (and is not). This theoretical foundation is necessary and forms the basis from which all other work in this field can arise.

Our environmental scan has identified important gaps in patient navigation in the province of Alberta. First, there is a lack of awareness about these programs. Of note, an informal online scan revealed that many of the programs identified in our environmental scan do not have any online program information available to patients and/or providers. Public awareness of patient navigation programs is essential to their success, especially given that nearly 40% of the programs in Alberta Health Services are accessed through self-referral. A second area for improvement is the need for integration of similar programs across the province. For example, there are three breast health programs, offered in different cities, that have slightly different objectives, scope, and services across Alberta (Breast Health Program, Clinical Breast Health Program, Comprehensive Breast Cancer Program). Streamlining these programs into a single model of care may improve efficiency. Lastly, geographic access to programs was identified as a concern. Many specialized programs based out of Edmonton or Calgary technically serve a very large region due to the large catchment area of the facilities in these cities. However, respondents indicated that there is a lack of transportation options offered, resulting in a significant barrier to

their access; these programs are nearly exclusively accessed by residents of Edmonton and Calgary and their immediate surrounding areas.

There are limitations to our study. First, our findings are dependent on information provided by respondents; this is a limitation inherent to this study design. We relied on key informants to identify patient navigation programs across the province; we are likely missing programs, particularly smaller ones or those outside of the major urban centres. We attempted to mitigate this through the wide distribution of our Phase I surveys through the office of the executive leadership from Alberta Health Services (i.e. Vice President and Chief Medical Officer). Our response rate of 73% attests to the level of engagement from AHS and PCN leadership in promoting this study. Second, though we have provided definitions and examples of patient navigation, programs that do not meet the respondent's prior understanding of patient navigation may not have been identified as relevant and would be missed by our environmental scan. This is a limitation inherent to the field of patient navigation, given the lack of agreement on its definition and construct. Third, we may not have captured similar, or even identical, programs to the ones reported in this study, but at different sites. For example, an anticoagulation management services program was described for the North Zone, but we are aware of similar services across the province that were not identified, which may offer slightly different navigational services. Lastly, there may be some inaccuracies or missing data in the information provided by the respondents. For example, the patient eligibility criteria for the Partners for Better Health program were slightly different and broader than those found in a presentation online. The discrepancies may be due to inaccuracies and imprecision in recall.

These limitations notwithstanding, our study reveals a wealth of diverse patient navigation programs in the jurisdiction studied. These play an important role in guiding patients through a multifaceted health care system. This work not only highlights the diversity and strengths of services provided, but also identifies patient navigation gaps and areas of uncertainty in the patient navigation construct as a whole. The lessons learned are of relevance to health systems everywhere, as they inform an approach to evaluating and categorizing patient navigation, and potentially help to shape the delivery of patient navigation services and programs.



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**DATA SHARING**

Due to restrictions based on participant privacy, data are not available for use by other researchers. Descriptions of some of the programs included in the environmental scan is publicly available at www.informalberta.ca.

**CONTRIBUTORS**

Each of the four authors meets the authorship requirements as established by the International Committee of Medical Journal Editors in the Uniform Requirements for Manuscripts Submitted to Biomedical Journals. KT and WG conceived of the study and were involved in study design.

JK and NS conducted data collection. KT, JK, and WG were involved in statistical analyses. All authors were involved in data interpretation. KT drafted the manuscript and all authors critically revised the manuscript. All authors have read and approved the manuscript.

## CONFLICTS OF INTEREST

All authors declare that they have no competing interests.

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None

## REFERENCES


1. Romanow RJ. *Building on values: The future of health care in Canada*: Commission on the Future of Health Care in Canada;2002.
2. Health Quality Council of Alberta. *Understanding patient and provider experiences with relationship, information, and management continuity.* Calgary, Alberta2016.
3. Health Quality Ontario. *The reality of caring: Distress among the caregivers of home care patients.* Toronto2016.
4. Health Quality Council of Alberta. *Continuity of Patient Care Study.* Edmonton, Alberta: Health Quality Council of Alberta;2013.
5. Freeman HP, Muth BJ, Kerner JF. Expanding access to cancer screening and clinical follow-up among the medically underserved. *Cancer Pract.* 1995;3:19-30.
6. Freeman HP, Rodriguez RL. The History and Principles of Patient Navigation. *Cancer.* 2011;117:3539-42.
7. Vargas RB, Ryan GW, Jackson CA, Rodriguez R, Freeman HP. Characteristics of the original patient navigation programs to reduce disparities in the diagnosis and treatment of breast cancer. *Cancer.* 2008;113:426-33.
8. McBrien KA, Ivers N, Barnieh L, et al. Patient navigators for people with chronic disease: A systematic review. *PLOS ONE.* 2018;13:e0191980.
9. Valaitis RK, Carter N, Lam A, Nicholl J, Feather J, Cleghorn L. Implementation and maintenance of patient navigation programs linking primary care with community-based health and social services: a scoping literature review. *BMC Health Services Research.* 2017;17:116.
10. Walkinshaw E. Patient navigators becoming the norm in Canada. *Canadian Medical Association Journal.* 2011;183:e1109-e10.
11. Cook S, Fillion L, Fitch MI, et al. Core areas of practice and associated competencies for nurses working as professional cancer navigators. *Canadian Oncology Nursing Journal.* 2013;23:44-52.
12. Wells KJ, Battaglia TA, Dudley DJ, et al. Patient navigation: state of the art or is it science? *Cancer.* 2008;113:1999-2010.
13. Parker VA, Clark JA, Leyson J, et al. Patient navigation: development of a protocol for describing what navigators do. *Health services research.* 2010;45:514-31.
14. Dohan D, Schrag D. Using navigators to improve care of underserved patients: current practices and approaches. *Cancer.* 2005;104:848-55.
15. Gilbert JE, Green E, Lankshear S, Hughes E, Burkoski V, Sawka C. Nurses as patient navigators in cancer diagnosis: review, consultation and model design. *European journal of cancer care.* 2011;20:228-36.
16. Ferrante JM, Cohen DJ, Crosson JC. Translating the patient navigator approach to meet the needs of primary care. *Journal of the American Board of Family Medicine : JABFM.* 2010;23:736-44.
17. Binswanger IA, Whitley E, Haffey P-R, Mueller SR, Min S-J. A patient navigation intervention for drug-involved former prison inmates. *Substance abuse.* 2015;36:34-41.
18. Cantril C, Haylock PJ. Patient navigation in the oncology care setting. *Seminars in oncology nursing.* 2013;29:76-90.

19. Jolly SE, Navaneethan SD, Schold JD, et al. Development of a chronic kidney disease patient navigator program. *BMC nephrology.* 2015;16:69.
20. Benz Scott L, Gravely S, Sexton TR, Brzostek S, Brown DL. Effect of patient navigation on enrollment in cardiac rehabilitation. *JAMA internal medicine.* 2013;173:244-6.
21. Ahern DK, Stinson LJ, Uebelacker LA, Wroblewski JP, McMurray JH, Eaton CB. E-health blood pressure control program. *The Journal of medical practice management : MPM.* 2012;28:91-100.
22. Bradford JB, Coleman S, Cunningham W. HIV System Navigation: an emerging model to improve HIV care access. *AIDS patient care and STDs.* 2007;21 Suppl 1:S49-58.
23. Loskutova NY, Tsai AG, Fisher EB, et al. Patient Navigators Connecting Patients to Community Resources to Improve Diabetes Outcomes. *Journal of the American Board of Family Medicine : JABFM.* 2016;29:78-89.
24. Griswold KS, Homish GG, Pastore PA, Leonard KE. A randomized trial: are care navigators effective in connecting patients to primary care after psychiatric crisis? *Community mental health journal.* 2010;46:398-402.
25. Battaglia TA, McCloskey L, Caron SE, et al. Feasibility of chronic disease patient navigation in an urban primary care practice. *The Journal of ambulatory care management.* 2012;35:38-49.
26. Anonymous. Patient navigators show the way to faster flow. *ED management : the monthly update on emergency department management.* 2007;19:104-5.
27. Enard KR, Ganelin DM. Reducing preventable emergency department utilization and costs by using community health workers as patient navigators. *Journal of healthcare management / American College of Healthcare Executives.* 2013;58:412-28.
28. Balaban RB, Galbraith AA, Burns ME, Vialle-Valentin CE, Larochelle MR, Ross-Degnan D. A Patient Navigator Intervention to Reduce Hospital Readmissions among High-Risk Safety-Net Patients: A Randomized Controlled Trial. *Journal of general internal medicine.* 2015;30:907-15.
29. Lairson DR, Huo J, Ricks KAB, Savas L, Fernandez ME. The cost of implementing a 2-1-1 call center-based cancer control navigator program. *Evaluation and program planning.* 2013;39:51-6.
30. Carter N, Valaitis RK, Lam A, Feather J, Nicholl J, Cleghorn L. Navigation delivery models and roles of navigators in primary care: a scoping literature review. *BMC Health Services Research.* 2018;18:96.
31. Peart A, Lewis V, Brown T, Russell G. Patient navigators facilitating access to primary care: a scoping review. *BMJ open.* 2018;8:e019252.
32. Sofaer S. Navigating poorly charted territory: patient dilemmas in health care "nonsystems". *Medical care research and review.* 2009;66:75s-93s.
33. World Health Organization. *The World Health Report Chapter 3: Primary Care- Putting people first.* Geneva2008.
34. Robards F, Kang M, Usherwood T, Sanci L. How Marginalized Young People Access, Engage With, and Navigate Health-Care Systems in the Digital Age: Systematic Review. *Journal of Adolescent Health.* 2018;62:365-81.
35. Provincial Health Services Authority. Enhancing Care Through Navigation. 2018; http://www.bccancer.bc.ca/our-services/centres-clinics/bc-cancer–victoria/research-

initiatives/research-themes/enhancing-care-through-navigation. Accessed August 22, 2018.
36. Taylor P, Priest L. *Personal Health Navigator: A Patient's Guide to Ontario's Health Care System*. Toronto: Healthy Debate & Sunnybrook Health Sciences Centre; 2014.
37. Cancer Journey Portfolio. *Navigation: A Guide to Implementing Best Practices in Person-Centred Care.* Toronto, Ontario: Canadian Partnership Against Cancer;2012.
38. Alberta Innovates. PRIHS 2018/2019, Enhancing Care in the Community- Results. 2019; https://albertainnovates.ca/prihs-2018-2019-enhancing-care-in-the-community-results/. Accessed August 21, 2019.
39. Government of Alberta. Primary health care. 2019; https://www.alberta.ca/primary-health-care.aspx. Accessed January 21, 2020.
40. Luke A, Doucet S, Azar R. Paediatric patient navigation models of care in Canada: An environmental scan. *Paediatr Child Health.* 2018;23:e46-e55.

**Table 1: Summary characteristics of patient navigation programs**

| Characteristic | | Alberta Health Services (N= 44) n (%) | Primary Care Networks (N= 15) n (%) |
|---|---|---|---|
| Age group of patients served | Pediatrics only | 16 (36.4%) | 0 |
| | Adults only (excluding seniors-only programs) | 6 (13.6%) | 1 (6.7%) |
| | Seniors only | 2 (4.5%) | 0 |
| | All ages | 20 (45.5%) | 14 (93.3%) |
| Targeted clinical conditions | Cancer | 8 (18.2%) | 0 |
| | Cardiovascular Disease | 2 (4.5%) | 0 |
| | Kidney Disease | 1 (2.3%) | 0 |
| | Chronic Disease Prevention and/or Management | 2 (4.5%) | 2 (13.3%) |
| | Addictions and Mental Health | 10 (22.7%) | 2 (13.3%) |
| | Developmental or Neurologic Concerns | 8 (18.2%) | 0 |
| | Other | 2 (4.5%) | 2 (13.3%) |
| | No specific condition targeted | 11 (25.0%) | 9 (60.0%) |
| Self-referral possible | | 16 (36.4%) | 6 (37.5%) |
| Inpatient program for hospitalized patients only | | 2 (4.5%) | 0 |
| Follow-up provided | | 28 (63.6%) | 13 (86.7%) |
| Pilot project only | | 3 (6.8%) | 0 |
| Zones served | North | 5 (11.4%) | 4 (26.7%) |
| | Edmonton | 9 (20.5%) | 3 (20.0%) |
| | Central | 7 (15.9%) | 8 (53.3%) |
| | Calgary | 20 (45.5%) | 0 |
| | South | 3 (6.8%) | 0 |
| | Province-wide | 10 (22.7%) | 0 |

**Table 2: Categorization of patient navigation by mode of delivery**

| Program | Individual Patient Navigators | | | | Web-Based Tools To Allow Self-Navigation | | | | Structural or Organizational Changes | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Episodic | Longitudinal | General | Subgroup | Episodic | Longitudinal | General | Subgroup | Episodic | Longitudinal | General | Subgroup |
| **Alberta Health Services** | | | | | | | | | | | | |
| Aboriginal Hospital Liaison | | ✓ | | ✓ | | | | | | | | |
| Access Addictions and Mental Health-Edmonton | | ✓ | ✓ | | | | | | | | | |
| Access Mental Health-Calgary | ✓ | | ✓ | | | | | | | | | |
| Adolescent and Young Adults Program | | ✓ | | ✓ | ✓ | | | ✓ | | | | |
| Alberta Healthy Living Program Assistance | | | | | | | | | ✓ | | | ✓ |
| Alberta Thoracic Oncology Program | ✓ | | | ✓ | | | | | | ✓ | | ✓ |
| Anticoagulation Management Services | | ✓ | | ✓ | | | | | | ✓ | | ✓ |
| Autism Spectrum Diagnostic Clinic – Pediatric Navigation Services | | ✓ | | ✓ | | | | | | | | |
| Bonnyville Child and Adolescent Mental Health Program | | ✓ | | ✓ | | | | | | | | |
| Breast Health Program | | ✓ | | ✓ | | | | | | ✓ | | ✓ |
| Calgary Corrections Transitions Team | | ✓ | | ✓ | | | | | | | | |
| CancerControl Alberta Drug Access Coordinator | | ✓ | | ✓ | | | | | | | | |
| Cardiac Navigation - North | ✓ | | | ✓ | | | | | | | | |
| Cardiac Navigation – South | ✓ | | | ✓ | | | | | | | | |
| Child and Adolescent Addiction and Mental Health Psychiatric Program (CAAMHPP) Outreach Service | | ✓ | | ✓ | | | | | | | | |

| Program | Individual Patient Navigators | | | | Web-Based Tools To Allow Self-Navigation | | | | Structural or Organizational Changes | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Episodic | Longitudinal | General | Subgroup | Episodic | Longitudinal | General | Subgroup | Episodic | Longitudinal | General | Subgroup |
| Child and Adolescent Addiction and Mental Health Psychiatric Program (CAAMHPP) Network Liaison | ✓ | | | ✓ | | | | | | | | |
| Child and Adolescent Addiction and Mental Health Psychiatric Program (CAAMHPP) School Liaison | ✓ | | | ✓ | | | | | | | | |
| Child and Adolescent Addiction and Mental Health Program Psychology | ✓ | | | ✓ | | | | | | | | |
| Child Development Services | | | | | | | | | ✓ | | | ✓ |
| Children's Rehabilitation Services Coordinated Intake Program | | ✓ | | ✓ | | | | | | | | |
| Clinical Breast Health Program | ✓ | | | ✓ | | | | | ✓ | | | ✓ |
| Cochrane Community Health Centre Program Navigation | ✓ | | ✓ | | | | | | | | | |
| Community Care Access | ✓ | | ✓ | | | | | | ✓ | | ✓ | |
| Comprehensive Breast Cancer Program | | | | | | | | | ✓ | | | ✓ |
| Dementia Case Manager | | ✓ | | ✓ | | | | | | | | |
| Division Team Transition Away from Legal System | ✓ | | | ✓ | | | | | | | | |
| Family Support Specialist | ✓ | | | ✓ | | | | | | | | |
| Foothills Children's Wellness Network and Children's Rehabilitation Navigator | | ✓ | ✓ | | ✓ | | ✓ | | | | | |
| Health Link | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | | | |
| Home Care Case Management | | ✓ | ✓ | | | | | | | | | |

| Program | Individual Patient Navigators | | | | Web-Based Tools To Allow Self-Navigation | | | | Structural or Organizational Changes | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Episodic | Longitudinal | General | Subgroup | Episodic | Longitudinal | General | Subgroup | Episodic | Longitudinal | General | Subgroup |
| Integrated Support and Facility Living | | ✓ | | ✓ | | | | | | | | |
| Medical Assistance in Dying (MAID) | | ✓ | ✓ | | | | | | | | | |
| NDD Integrated Brain Health Initiative | | ✓ | | ✓ | | | | | | | | |
| NICU Hematology Oncology Transition Nurse | | ✓ | | ✓ | | | | | | | | |
| Northern Alberta Renal Program | | ✓ | | ✓ | | | | | | ✓ | | ✓ |
| Not Criminally Responsible (NCR) Rehabilitation Team - Transition to Community | | ✓ | | ✓ | | | | | | ✓ | | ✓ |
| Partners for Better Health | | ✓ | | ✓ | | | | | | | | |
| Rapid Response Complex Needs – Pediatric Navigation Services | | ✓ | | ✓ | | | | | | | | |
| Recreation and Aquatic Volunteer Service Specialized Rehabilitation Navigator | ✓ | | | ✓ | | | | | | | | |
| Rural Community Cancer Patient Navigator | | ✓ | | ✓ | | | | | | | | |
| Surveillance and Surgery Clinic – Pediatric Navigation Services | | ✓ | | ✓ | | | | | | | | |
| Traditional Wellness Counsellors | | ✓ | | ✓ | | | | | | | | |
| Transition Services | ✓ | | | ✓ | | | | | | | | |
| Well on your Way: Youth in Transition | | ✓ | | ✓ | ✓ | | | ✓ | | | | |
| **Primary Care Networks** | | | | | | | | | | | | |
| Camrose PCN | | ✓ | ✓ | | | | | | | | | |
| Edmonton PCN- Chronic Disease Management | ✓ | | | ✓ | | | | | | | | |
| Grande Cache PCN | | ✓ | | ✓ | | | | | | | | |

| Program | Individual Patient Navigators | | | | Web-Based Tools To Allow Self-Navigation | | | | Structural or Organizational Changes | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Episodic | Longitudinal | General | Subgroup | Episodic | Longitudinal | General | Subgroup | Episodic | Longitudinal | General | Subgroup |
| Kalyna PCN | | | | | | | | | | ✓ | ✓ | |
| Lakeland PCN Social Worker Outreach | | ✓ | ✓ | | | | | | | | | |
| Northwest PCN- Medical Social Worker | | ✓ | ✓ | | | | | | | | | |
| Northwest PCN- Perinatal Services | | ✓ | | ✓ | | | | | | | | |
| Red Deer PCN- Nursing Program | | ✓ | ✓ | | | | | | | | | |
| Rocky Mountain PCN Nurse Navigator | | ✓ | ✓ | | | | | | | | | |
| Sherwood Park PCN Mental Health Program | ✓ | | | ✓ | | | | | | | | |
| Specialist Linkages Program | | ✓ | | ✓ | | | | | | | | |
| Wainwright PCN | ✓ | | | ✓ | | | | | | ✓ | ✓ | |
| Wetaskiwin PCN- Mental Health | | ✓ | | ✓ | | | | | | | | |
| Wetaskiwin PCN- Prenatal and Women's Health | | ✓ | | ✓ | | | | | | | | |
| Wetaskiwin PCN- Targeted Care | | ✓ | | ✓ | | | | | | ✓ | | ✓ |

**Table 3: Identified gaps in patient navigation programs and services**

| Domain | Specific gaps and unmet needs |
|---|---|
| ***Awareness*** | Patients, physicians, and staff members are unaware of programs and services, including those:<br>-offered in their zone, through Alberta Health Services<br>-offered outside of their zone, through Alberta Health Services<br>-by organizations outside of Alberta Health Services |
| | Due to lack of patient awareness of programs, programs allowing for self-referral often have a high no-show rate |
| | Information on programs and services are difficult to find and predominantly transmitted through word of mouth |
| | Patients may be aware of programs but do not know how to access them |
| ***Resources*** | Many current patient navigation programs are at or over capacity |
| | There are a lack of resources and services for the following groups:<br>-children with complex needs who are transitioning to adult care<br>-adults (non-pediatric, non-elderly population)<br>-adults with mental health and developmental needs<br>-patients being discharged from hospital or other acute care facilities<br>-those not meeting eligibility criteria of the programs (e.g. young adults with cancer that is not treated by chemotherapy or radiation therapy) |
| ***Geography*** | Lack of transportation options both within cities and from rural residences to programs located at urban sites. It is cost prohibitive for patients to pay out of pocket to travel from rural residences to larger centers. |
| | Rural areas have fewer available services |
| | Patients and care providers from rural areas are unaware of programs and services that they can access at urban centers |
| ***Integration*** | Lack of communication and integration among programs within Alberta Health Services |
| | Lack of cohesive client care and communication across different government ministries |
| | Inability to share and access patient information across different programs, at all hours |

**Appendix 1: Description of patient navigation programs and services within Alberta Health Services and the Primary Care Networks**

| Name | Description | Patient Eligibility | Area(s) Served | Self-Referral Possible |
|---|---|---|---|---|
| **Alberta Health Services** | | | | |
| Aboriginal Hospital Liaison | The Aboriginal liaison provides spiritual and cultural support, help patients feel comfortable with the hospital environment by explaining what to expect while admitted to hospital, and helps builds relationships and trust between patients and health care providers. The program also helps patients access community supports at the time of hospital discharge. | Indigenous patients and families | Province-wide covering all zones | ✓ |
| Access Addictions and Mental Health- Edmonton | There are numerous public, private, and not-for-profit addiction and mental health services across the Edmonton Zone, all with individual referral processes. This program is a centralized intake process; a mental health clinician helps to identify appropriate services for client needs, directly schedules an appointment for the identified service, and provides education and directs clients to other resources as needed. | No limitations | Edmonton Zone | ✓ |
| Access Mental Health- Calgary | This is a phone-based service acting as a centralized point for information, consultation, and referral for resources in addictions and mental health. A staff member reviews client information and referrals to determine the main mental health concerns, then refers the client to the appropriate services and/or provides them with the appropriate information as needed. | No limitations | Calgary Zone | ✓ |
| Adolescent and Young Adults Program | A patient navigator calls each patient who has a new cancer diagnosis to explore any patient concerns, connect patients to available resources, and provide patients with a package of information. The patient navigation also refers to a psychologist and/or social worker as needed. | Young adults (17-29 years old) with a cancer diagnosis | Edmonton Zone | |
| Alberta Healthy Living Program Assistance | A zone-specific centralized set of programs is offered to provide health education, resources and classes for self-management of chronic diseases, supervised exercise programs. An administrator can speak to patients by phone to determine their needs and direct them to the appropriate programs and services | Adults (≥18 years old) with any chronic medical condition, or at risk of developing a chronic condition | Province-wide covering all zones | ✓ |
| Alberta Thoracic Oncology Program | Nurse practitioners manage referrals, determine the appropriate health care provider and/or specialist that the patient should see in the multi-disciplinary clinic, and complete initial patient evaluations and assessments. This program is designed to coordinate care across numerous disciplines (radiology, respirology, thoracic surgery) to expedite the diagnosis and treatment of lung cancer. There are separate North (Edmonton) and South (Calgary) programs. | Patients with suspected lung cancer | Edmonton Zone, Calgary Zone | |
| Anticoagulation Management Services | This pharmacist-led service coordinates all aspects of care concerning anticoagulation. This includes coordinating lab tests, directly managing dosing of anticoagulation medications, communication with family physicians, and providing medication-related information and support to patients as needed. | Patients requiring anticoagulation | North Zone (Athabasca, Boyle, Westlock) | |

| Name | Description | Patient Eligibility | Area(s) Served | Self-Referral Possible |
|---|---|---|---|---|
| Autism Spectrum Diagnostic Clinic – Pediatric Navigation Services | The program works with families to connect them to services, community resources and organizations (e.g. Autism Edmonton). | Families of children ≤ 18 years old with neurodevelopmental and/or motor needs that report poor adjustment (rating of 3 or lower on the family adjustment scale) | Province-wide covering all zones | |
| Bonnyville Child and Adolescent Mental Health Program | This is a multidisciplinary program formed through a collaboration among AHS, Covenant Health, the local school board, and the Town of Bonnyville. The patient navigator collects data from schools and conducts assessments, acting as the go-between between the schools and the families. The navigator connects the families with any resources that may be needed. | Youth 6-17 years of age with diagnosed or suspected attention deficit hyperactivity disorder, anxiety, and/or depression | Bonnyville and surrounding area (North Zone) | |
| Breast Health Program | This is a comprehensive diagnostic and surgical clinic for assessment and treatment of breast-related health concerns, through multidisciplinary management and collaboration amongst medical and surgical specialists. There is a dedicated primary nurse navigator who provides educational resources and one-on-one support to patients with breast cancer. | Patients with any breast-related health concerns excluding breastfeeding | Calgary Zone | |
| Calgary Corrections Transitions Team | This team provides assistance with addictions and mental health (e.g. by initiating mental health referrals), and connects and coordinates with community services in the community (e.g. to find employment and/or housing, accessing AISH, obtaining proof of identification, etc.) | Adults with addictions and/or mental health concerns referred from the health units of correctional services centers | Calgary Zone | |
| CancerControl Alberta Drug Access Coordinator | This program aims to provide access to medications that are not covered by the Alberta Cancer Drug Benefit Program. The program coordinator navigates through government programs (e.g. through social assistance), works with insurance companies and Alberta Blue Cross, and connects with drug companies to advocate for patient access to necessary cancer-related medications. | Patients with cancer | Central, Calgary, and South Zones | |
| Cardiac Navigation - North | There are 4 patient navigators in this program (2 provider facing and 2 patient facing):<br>-2 navigators manage consults and work with other navigators, clerks or managers to bring patients into hospital from other sites and services to get appropriate investigations and treatment<br>-1 navigator helps facilitate and coordinate electrophysiology appointments and interventions.<br>-1 navigator helps to facilitate and coordinate cardiac surgeries. They ensure that patients are ready for surgery, help determine priority of surgery, and facilitate patient-physician interactions | Patients requiring cardiac surgery and/or requiring electrophysiology interventions | Edmonton and North Zones | |
| Cardiac Navigation – South | There are 2 different nurse navigation roles. In the first role, a nurse navigator assists patients by managing the patient's symptoms and condition. A different navigator works with the referring physician's office to ensure that all | Patients requiring cardiac surgery | Central, Calgary, and South Zones | |

| Name | Description | Patient Eligibility | Area(s) Served | Self-Referral Possible |
|---|---|---|---|---|
| | patient information and testing that is required pre- cardiac surgery has been completed and that the information transmitted to the cardiac surgery team. | | | |
| Child and Adolescent Addiction and Mental Health Psychiatric Program (CAAMHPP) Outreach Service | Mental health clinicians, nurses and social workers bridge patients and their families post-hospital discharge, until their care is taken over by the community care provider team. | Children ages 5-18 with mental health issues discharged from the emergency department or hospital inpatient unit | Calgary Zone | |
| Child and Adolescent Addiction and Mental Health Psychiatric Program (CAAMHPP) Network Liaison | There are over 60 programs that serve children and youth in CAAMHPP. The Network Liaison's role is to advocate for patients by navigating referrals from one CAAMHPP program to another and ensuring that patients get the services they need. | Current clients of CAAMHPP who require additional services | Calgary Zone | |
| Child and Adolescent Addiction and Mental Health Psychiatric Program (CAAMHPP) School Liaison | The program liaises with school staff as children are transitioned back into the school. | Current clients of CAAMHPP transitioning back to school | Calgary Zone | |
| Child and Adolescent Addiction and Mental Health Program Psychology | Pilot project, providing support for patients and their family. | Children and adolescents 10-20 years of age involved in a minimum of two systems (health, education, social services, or justice), with at least one complex mental health concern | Calgary Zone | |
| Child Development Services | This is a group of clinics and programs (including autism spectrum disorder clinic, cumulative risk diagnostic clinic, consultative diagnostic clinic, and child abuse services) that work closely with patients and community resources, and provides educational support for patients and their families. | Children 0-18 years of age with cognitive, physical, and/or neuromotor developmental issues | Calgary Zone | |
| Children's Rehabilitation Services Coordinated Intake Program | The program is designed to help families find the appropriate service for their children by coordinating five different programs (speech therapy, occupational therapy, physiotherapy, audiology, and feeding) throughout the central zone. The program social worker identifies the appropriate service that meets the child's needs, initiates the referral to the service, and connects children and their families to these services and resources. | Children 0-17 years of age with a suspected or diagnosed developmental delay | Central Zone (Red Deer and surrounding area) | ✓ (children age >4 require referral) |
| Clinical Breast Health Program | A total of six nurse navigators provide support to patients from point of breast cancer diagnosis through to surgery and treatment. Navigators offer clinical, emotional and psychosocial support through face-to-face or telephone meetings with patients. The program also coordinates all diagnostic tests | Patients with confirmed (biopsy proven) breast cancer | Central Zone | |

| Name | Description | Patient Eligibility | Area(s) Served | Self-Referral Possible |
|---|---|---|---|---|
| | required, assists with appointment scheduling and transportation, and provides patient information and education. | | | |
| Cochrane Community Health Centre Program Navigation | This is an informal role, where a staff member speaks with patients to assess their needs. Based on these identified needs, the staff member will recommend – and if needed, provide a referral to – appropriate outpatient programs offered at the Cochrane Community Health Centre. | No limitations | Calgary Zone (Cochrane and surrounding area) | ✓ |
| Community Care Access | This is a single point of entry for home living, day programs, CHOICE (Comprehensive Home Option of Integrated Care for the Elderly), CAIL (Community Aids for Independent Living), supportive or facility living, and those requiring palliative care services. Patients are directed to the appropriate program and referrals to supportive living are made as needed. | Patients requiring community care, home care services, or supportive/facility living | Edmonton Zone | ✓ |
| Comprehensive Breast Cancer Program | This program's aim is the early detection and treatment of breast cancer. The program assists individuals through diagnostic testing ("going from test to test") and expedites consultation with surgeons as needed. | Patients presenting with a breast mass | Edmonton and North Zones | |
| Dementia Case Manager | A social worker assisted patients from the Seniors Health Clinic to access appropriate living and support services. This role is no longer active, as there is now a similar dementia care role through Home Care services. | Current patient of the Senior's Health Clinic with a diagnosis of dementia | Calgary Zone | |
| Division Team Transition Away from Legal System | A navigator connects patients to services that can address mental issues to decrease criminal behavior and presentations to the hospital. | Youth >12 years old and adults with indicators of mental health issues, charge with criminal offences and referred to the program by the crown prosecutor | Province-wide covering all zones | |
| Family Support Specialist | The family support specialist provides information to patients and their families, helps connect families with hospital and community resources, and helps out-of-town families find accommodations while their children are admitted to hospital. | Patients receiving care at Alberta Children's Hospital | Calgary Zone | ✓ |
| Foothills Children's Wellness Network and Children's Rehabilitation Navigator | Resources and contacts relevant for early childhood development are provided via a telephone-based navigator and through web-based (website and social media) and paper-based (postcard) methods. The Foothills Children's Wellness Network consists of local agencies, a governmental portfolio, AHS, child and family services, family community support services, and the Palix foundation, and aims to ensure that childcare providers have access to community resources. | Parents and any other childcare provider (grandparents, daycares, dayhomes, preschool services) for children 6 years and under<br><br>Pediatricians and any other professionals providing care for children | Calgary Zone (Okotoks, Black Diamond, Turner Valley, High River, Nanton, Claresholm, Vulcan, and surrounding rural areas) | ✓ |
| Health Link | Health Link provides a variety of services (both online and via telephone) including symptom-based triage (or health advice), access to a mental health helpline, tobacco cessation counselling, dementia advice, and general health information. It can also assist patients in finding an available family doctor as well as refer to addictions programs as needed. | No limitations | Province-wide covering all zones | ✓ |

| Name | Description | Patient Eligibility | Area(s) Served | Self-Referral Possible |
|---|---|---|---|---|
| Home Care Case Management | A case manager helps all patients entering home care to navigate through health care needs. This case manager works with the patient to identify programs to meet the patient's health needs, sets up required treatments, assist with transportation needs to appointments, works with the patient to achieve their personal health goals, coordinates care with allied health, and completes applications as needed for alternate living options. | Any patient requesting or requiring home care | Central Zone (Wainwright, Provost, Vermilion, and surrounding communities) | ✓ |
| Integrated Support and Facility Living | This program provides case management for seniors requiring supports at home. | Seniors requiring support at home, or those not able to manage at home | Calgary Zone (Didsbury, Strathmore, High River, Okotoks, Nanton) | |
| Medical Assistance in Dying (MAID) | The program follows government legislation to assist patients with MAID and to ensure that patient wishes are respected. The MAID team reaches out to the patient and family to understand their wishes and expectations, to offer the patient and family direction in the MAID process, to ensure that the family is aware of the different end of life options, and to provide patients with relevant resources. | Patients meeting Bill C14 criteria: Adults (≥18 years old) with mental competence, who have a grievous and irremediable medical condition requesting and providing informed consent to receive MAID | Province-wide covering all zones | ✓ |
| NDD Integrated Brain Health Initiative | Clinical programs and services are coordinated for patients and their families by a care coordinator. | Children 0-17 years old with complex needs relating to brain-related illness or injuries (such as epilepsy, developmental disabilities, and mental health concerns) | Calgary Zone | |
| Neonatal Intensive Care (NICU) Hematology Oncology Transition Nurse | Six month pilot program where the patient's primary nurse helped to navigate inpatient treatment protocols, interventions, and multi-disciplinary care, as well as organizing diagnostic tests and referrals. Nurses also helped patients and their families to connect with outpatient resources upon discharge. This pilot program has ended. | Patients of the Neonatal Intensive Care Units with Hematological/Oncological conditions | Central, Calgary, and South Zones | |
| Northern Alberta Renal Program | A patient navigator coordinates chronic kidney disease care, across 22 satellite dialysis units, home dialysis, and follow-up care. | Patients with kidney disease | North, Edmonton, and Central Zones, Northern BC, Northwest Territories, Saskatchewan | |
| Not Criminally Responsible (NCR) Rehabilitation Team – Transition to Community | Adults deemed not criminally responsible of a crime are referred for rehabilitation services, treatment and transition back to the community. This team advocates for the patient, identifying and helping the patient access services that may help with their rehabilitation. The team also helps the transition back into the community, connecting patients with community resources. This team also directly offers specific services and programs (e.g. addictions services). | Adults (≥18 years old) deemed not criminally responsible for a crime | Central, Calgary, and South Zones | |

| Name | Description | Patient Eligibility | Area(s) Served | Self-Referral Possible |
|---|---|---|---|---|
| Partners for Better Health | A case manager provides support for patients, acts as a resource, and helps the patient to access relevant health and social services. | Patients with 2 or more chronic conditions, or patients from a "vulnerable population" | Calgary Zone | |
| Rapid Response Complex Needs – Pediatric Navigation Services | A multi-disciplinary team works with patients to coordinate care and services for patients to meet their rehabilitation needs. | Children ≤ 18 years old with neurodevelopmental and/or motor needs who are followed by the Glenrose Rehabilitation Hospital | Province-wide covering all zones | |
| Recreation and Aquatic Volunteer Service Specialized Rehabilitation Navigator | A patient navigation receives referrals and provides first point of contact with patients who have been referred for intensive, multi-disciplinary, specialized rehabilitation programs. The navigator takes the patient's rehabilitation history, and facilitates his/her admission to the program. Once in the program, the navigator helps coordinate care provided by the multi-disciplinary team, and also connects the patient to community resources once discharged from the program. | Adults ≥18 requiring multi-disciplinary treatment or specialized equipment for specialized physical rehabilitation | Edmonton Zone | |
| Rural Community Cancer Patient Navigator | Patient navigators provide local support, including connecting patients to local community resources and services (such as social work, dieticians, rehabilitation and support groups). | Patients with cancer | Rural communities: Province-wide covering all zones | |
| Surveillance and Surgery Clinic – Pediatric Navigation Services | A patient navigator coordinates and helps patients and their families navigate appointments and diagnostic tests required pre and post surgery. Support is also offered pre and post surgery. | Children ≤ 18 years old with neurodevelopmental and/or motor needs being followed by a physical medicine clinic, who require surgery<br><br>Example of eligible patients include those with cerebral palsy or scoliosis who require surgery | Province-wide covering all zones | |
| Traditional Wellness Counsellors | Traditional wellness counsellors provide cultural and spiritual supports to Indigenous patients and Alberta Health Services staff. | Indigenous patients or Indigenous Alberta Health Services staff | Province-wide covering all zones | ✓ |
| Transition Services | Transition coordinators (nurses) in both acute care and the outpatient setting provides navigation services to find continuing care beds for patients who require supportive or facility living. | Adults (≥18 years old) with unmet care needs at home or supportive living facility | Edmonton Zone | |
| Well on your Way: Youth in Transition | This program helps to transition pediatric patients to adult care through two modalities. The first is a website, designed for youth 12 years and older, with information and resources regarding this transition. There is also a transition coordinator to provide resources and information as needed. | Children 12-18 years old transitioning from pediatric care at the Alberta Children's Hospital to adult care | Calgary Zone | ✓ |
| **Primary Care Networks** | | | | |
| Camrose PCN | There is a nurse navigator at the local University of Alberta satellite location in Camrose to assist students by directing them to appropriate services for any | No limitations | Camrose and surrounding area | ✓ |

| Name | Description | Patient Eligibility | Area(s) Served | Self-Referral Possible |
|---|---|---|---|---|
| | health-related concerns. When there is a need voiced by patients of Camrose PCN, PCN staff help patients determine and direct patients to the appropriate resources | | | |
| Edmonton PCN-Chronic Disease Management | There is an information line that patients can call with questions and for any information. Team members will also assist with referrals (made by family physicians) to the diabetes education centers and/or the adult bariatric clinic. | Patients with diabetes and/or obesity | Edmonton | ✓ |
| Grande Cache PCN | When the family physician makes a referral to a specialist physician, the patient navigator coordinates this appointment by providing appointment information to the patient, and by ensuring all diagnostic testing and pre-requisites for this appointment have been completed. | No limitations | Grande Cache and surrounding area | |
| Kalyna PCN | Different multi-disciplinary programs are offered to patients, including foot care, diabetes wellness clinic, geriatric assessment clinics, and nutrition programs. | Current patients of Kalyna PCN | Vegreville, Vermilon, Viking, Killam, Sedgewick, Tofield | ✓ |
| Lakeland PCN Social Worker Outreach | Social workers provide psychosocial support, provide counselling support, conduct home visits, and connect patients with community resources (e.g. housing, transportation). | No limitations | Lac La Biche, St. Paul, Glendon, Two Hills, Elk Point, Smokey Lake, Saddle Lake and surrounding First Nations reserves | |
| Northwest PCN-Medical Social Worker | A social worker works with patients and the local population to ensure that they have access to funding and services. This individual directs individuals to appropriate programs, helps with completing forms as needed, advocates for patients, sets up appointments, and arranges travel to appointments at larger centres. A second part of this role is to assist specifically with the neurodevelopmental clinic (team of physicians from Edmonton) and the local fetal alcohol spectrum disorder organizations to ensure that patients with FASD have a care team established. | No limitations | High Level, Fort Vermillion, Paddle Prairie Settlement, Fox Creek | ✓ |
| Northwest PCN – Perinatal Services | A nurse identifies any woman who may be pregnant (many of whom do not seek medical care or attention), sets them up with a physician, assists with getting blood work and ultrasounds completed and will do direct booking for individuals in Fox Creek. | Women who are currently pregnant | High Level, Fort Vermillion, Paddle Prairie Settlement, Fox Creek | ✓ |
| Red Deer PCN-Nursing Program | Nurses educate and help patients navigate through the available resources in the community, including health management and social resources (employment, income support, social benefits, job opportunities, housing options). Assistance is provided to access these resources, such as by teaching patients how to complete applications and forms. | Adults ≥18 years old | Red Deer and surrounding area | ✓ |

| Name | Description | Patient Eligibility | Area(s) Served | Self-Referral Possible |
|---|---|---|---|---|
| Rocky Mountain PCN Nurse Navigator | A nurse navigator provides assistance to the family physicians at this clinic to help expedite patient care and to help patients navigate through the health care system. For example, when a referral to a physician specialist is made, the nurse navigator coordinates this appointment, ensures that the patient has completed all required diagnostic testing prior to the appointment, and provides patient education on what to expect at the appointment. | No limitations | Rocky Mountain House and surrounding area | |
| Sherwood Park PCN Mental Health Program | Patients describing mental health concerns are seen by a program staff member to connect them with relevant local social programs, resources, and services. | Patients >10 years old describing mental health concerns | Sherwood Park/ Strathcona County | |
| Specialist Linkages Program | A navigator coordinates new consultation appointments with a physician specialist, as requested by the patient's family physician, with the patient and the specialist. | Individual requiring specialist consultation | Sherwood Park/ Strathcona County | |
| Wainwright PCN | Different multi-disciplinary programs are offered to patients, including geriatric assessment, prenatal assessment, and chronic disease management. There is additionally a referral coordinator for when patients are referred to physician specialists. | No limitations | Municipal District of Wainwright | |
| Wetaskiwin PCN-Mental Health | Two types of services are provided: 1) A psychologist and social worker provide patients with the available resources or navigate them to the necessary supports; 2) Mental health responders (total 2-5) in the Wetaskiwin emergency department ensure there is support available to connect mental health patients with the PCN or to other resources in the community | Patients with mental health concerns | Wetaskiwin and surrounding area | |
| Wetaskiwin PCN-Prenatal and Women's Health | Program staff assist patients in getting imaging appointments and in determining whether specialist care is needed (in Edmonton) for the pregnancy and any pregnancy-related complications. | Patients with chronic diseases | Wetaskiwin and surrounding area | |
| Wetaskiwin PCN-Targeted Care | The program primarily focuses on diabetes management and offers a centralized dietician and foot care specialist to work with patients. The RN and program staff will provide counseling for the patients if needed and assist patients in finding the appropriate resources. The RNs located in specific clinics will also take field calls from patients regarding questions about their care and assist in determining if they need an additional appointment to address their questions. | Women who are currently pregnant | Wetaskiwin and surrounding area | |