Navigation Model to Support Patient Transitions to the Community

Article	Model Description	Resources Required	Outcomes	Economic Effect	Urban vs Rural	Population Focus (e.g., stroke, cancer, ABI)	Type of Navigation (e.g., system, community)	Country of Study	Comments
Going Home to Get On with Life: Patients and Carers Experiences of Being Discharged from Hospital Following a Stroke (2009)	Study to determine what constitutes a "good" experience transitioning from hospital to home following a stroke		Patients described models of recovery that include a sense of momentum, support and informed about what was happening.			Stroke		United Kingdom and/or New Zealand	Validates that patient focus needed for "good" transition to the community.
Transformation Para Salud: A Patient Navigation Model for Chronic Disease Self-Management	Chronic Care Model- includes six critical elements including health care organization, community resources, self-management support, delivery system design, decision support and clinical information systems. Navigators provide guidance and support throughout the continuum. Services designed to support timely delivery of quality care and ensure patients and families are satisfied with their encounters with the healthcare system.		Key messages: empowerment self-management provide knowledge and tools professionally trained navigator partnership between organizations communication incorporate caregiver client first focus on life roles and meaningful activity; client/family guides the role of the navigator		Community navigation through a health care nursing facility	Chronic disease including diabetes, hypertension, asthma, co-morbidities of obesity and depression	Patient navigation model using Community Health Workers	Texas, United States	
EBRSR: Community Reintegration (2013)	Reviews issues arising following discharge from hospital into the community		Issues include: social support, impact of caregiving on informal carers, family functioning, provision of information and education, leisure activities, driving, sexuality and return to work.			Stroke		Canada	
Patient-reported Outcome Measures Suitable to Assessment of Patient Navigation (2011)	Patient Navigator Research Program looked at : patient navigation lacks a common set of core outcome measures to consistently evaluate navigation programs. They show a model that outlines pathways between navigation activities and outcomes.	9 major research centres in USA	Model shows 5 areas of navigation: provide emotional support, education/coaching, liaison/advocate, referral to community resources, address instrumental needs/barriers. Also shows a variety of outcome measurement tools			Cancer			Used definition of patient navigation: individualized assistance offered to patients, families and caregivers to help overcome barriers and facilitate timely access to quality medical and psychosocial care from pre-diagnosis through all phases of the cancer experience.
What are geriatric care managers? (2011) article	Defined GCM as professionals (usually social workers or nurses) who assist older people and their families in meeting the elderly person's healthcare needs. This includes: filling out forms, doing needs assessments, identifying available community resources, screening and arranging for in-home services, resolving disputes among family members. They are advocates not gatekeepers.			Cost $50 - $100/hour and are not covered by insurance.		Elderly		United States	

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Translating the Patient Navigator Approach to Meet the Needs of Primary Care (2010)	Study of a cross-case comparative analysis of 4 community practices that implement patient navigation	Social worker was the navigator	Useful for patients with complex needs.	Needs to be integrated into primary care settings but this requires new practice and payment models. Without navigation, it leads to poorer outcomes and inefficiencies due to delays, failure to receive proper treatment or care being received in more expensive locations.		Elderly	Patient navigation for health care system	United States	Patient navigation is defined as the process of helping patients to effectively and efficiently use the health care system.
A Before and After Study of the Impact of Specialist Workers for Older People (2009)	Specialist Workers for Older People (SWOP) Service: Assess social and medical needs, produce individualized care plans, coordinate care and refer to appropriate agencies	Community Matrons (nursing background)	Non-significant reduction in hospital admissions; significant increase in routine GP surgery visits; number of emergency home visits decreased	Has potential to be cost effective		Elderly at high risk of emergency hospital admissions; aged 75 or over; on a maximum social care package; had two or more emergency admission between April and June 2004.		England	
Harold P. Freeman Patient Navigation Institute website	Founded in 1990 to eliminate barriers to timely cancer screening, diagnosis, treatment and supportive care. Navigation should be applied at some point between the point of an abnormal finding to the point of resolution of the finding by diagnosis and treatment. Also includes timely movement of an individual across the entire health care continuum from prevention, detection, diagnosis, treatment, supportive care to end of life care.	Can be trained lay navigators to professionals such as nurses and social workers	Has shown efficacy as a strategy to reduce cancer mortality and is currently being applied to reduce mortality in other chronic diseases. Barriers eliminated include: Financial, communication, medical system, psychological and others (e.g. transportation, child care)					Harlem, New York, United States	They offer a two-day intensive training program for navigators. The website offers navigation resources for navigators to access.

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The Origin, Evolution and Principles of Patient Navigation (2012)	Goal of navigation is to facilitate timely access for all to quality standard care in a culturally sensitive manner. Principles of patient navigation include: Patient-centered, timely, integrates a fragmented health care system, elimination of barriers, clear scope of practice, integrated into the health care team, cost-effective, trained navigator, point of beginning and ending, connections for disconnected health care systems, coordination.		Patient navigation can reduce the time from abnormal findings to diagnosis in breast, cervix, colorectal and prostate cancer	Will be cost effective because reduces the number of people having treatments for advanced cancer, as they are screened and diagnosed earlier			Cancer, helpful to those that are poor and uninsured	United States	
A Model Patient Navigation Program (2004)	Improved diagnosis and treatment for breast cancer at Harlem Hospital in New York. The study showed dramatic improvements in staging and five-year survival rates							New York, United States	
Patient Navigation: A Community Based Strategy to Reduce Cancer Disparities (2006)	Poor people face substantial barriers in seeking screening, diagnosis and treatment of cancer, they experience more pain, suffering and death, they make sacrifices in order to obtain care, do not seek care because they cannot afford it, feel there is an insensitive educational system become fatalistic and give up hope		The Harlem patient navigation program served as the model for the "Patient Navigator Outreach and Chronic Disease Prevention Act". Navigators eliminate barriers such as financial, communication, medical system and emotion/fear ensuring that treatment following screening occurs.			Cancer Black Americans Poverty		New York, United States	
History and Principles of Patient Navigation (2011) -same as above articles-									
Driving Status and Community Integration after Stroke (2009)	Study investigated the relationship of driving cessation on community integration		Drivers were more mobile and made more productive use of their time than non-drivers (even after accounting for stroke severity and use of alternative transportation). Drivers with high social support showed better community integration than did non-drivers and drivers with low social support. Among men, non-drivers fared substantially worse than drivers, whereas women (drivers and non-drivers) showed equivalent community integration.			Stroke		Michigan, United States	

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Patient Navigation for American Indians Undergoing Cancer Treatment (2011)	Study to assess patient navigation utilization and its impact on treatment interruptions and clinical trial enrollment among American Indian cancer patients	Hospital navigators who assist with coordinating appointments, insurance issues, following up on tests, obtaining medications/specialty services/devices, facilitating transportation and lodging, offer psychosocial support. Community research representatives provide cancer education, networking with local health resources and liaise between cancer centre, hospital-based navigators, patients and tribal governments.	Patient navigation was associated with fewer treatment interruptions and relatively high rates of clinical trial enrollment			Cancer	Patient navigation	San Diego, United States	
Examining Barriers and Supports to Community Living and Participation After a Stroke from a Participatory Action Research Approach (2006)	Study to focus on identifying community participation goals, barriers and supports/strategies. Research questions: to what extent are people accessing and participating in home, work and community environments of choice following a stroke? What factors do people who had a stroke, important others in their lives and access specialists identify as barriers to participation within and across participation environments? What factors are identified as important supports to participation within and across environments? Community participation is defined as the degree of connection that citizens with disabilities have to their physical and social surroundings.		Purpose was to design and create a consumer-directed, web-based, accessible system for collecting consumer-directed goals related to community living and participation, detailed community site participation audits and documentation of barriers and supports to participation. results in three areas: participation goals, barriers interfering with or preventing participation and support strategies used to promote, enhance and sustain participation.			Stroke		Chicago, United States	
What do Stroke Patients and their Carers want from Community Services? (2006)	Focus groups to discuss the long-term support needs of patients with prevalent stroke and their carers		Themes emerged: emotional and psychological problems, lack of information, importance of Primary Care as first point of contact			Stroke		South Birmingham, United Kingdom	

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Adopting a Common Approach to Transitional Care Planning	HQO tool to promote standardization in transitional care practices, within and across Health Links, for complex patients		Goals: Focus on patient-centred care, commitment to build on existing delivery organizations, representation across sectors, common targets and metrics. 3 categories and 9 practices. pre-transition practices (planning, patient/carer involvement, individualized assessments and care plans), transition planning (individualized transitional care plans, protocols for medication reconciliation, provision of information and resources) and post-transition risk and follow-up (standardized risk assessment tools, appointment booked with primary care provider and follow-up phone call within 48 hours). 2 added goals: standardized discharge summary and designated supports (transition coordinators/coaches)		Transition coordinators/ coaches	Complex patients discharging from hospital		Ontario, Canada	
Community Navigators: making a difference by promoting health in culturally and linguistically diverse (CALD) communities in Logan, Queensland	Community Navigator Model: draws on local natural leaders selected by community members who then act as a conduit between the community and health service providers. Duties include assess client needs, facilitate health promotion, support community members to access health services, support GPs to use interpreters and make referrals to health services	Navigators are lay community people who require training	The phenomenological approach was used to explore the lived experience of the community navigators. Three themes: Commitment to an altruistic attitude of servility allowing limitless community access to their services, becoming knowledge brokers with a focus on the social determinants of health and walking the walk to build capacity and achieving health outcomes for the community	Pay navigators for about 11 hrs per week but they actually work 40+ hours/week	Urban	Immigrants	Community health care system	Australia	
Peer Support for Stroke Survivors: A Pilot Evaluation	Benefits of Peer Support Program were looked at.		Provides important benefits including emotional support, affirmational support and informational support that provides encouragement, promotes feelings of hope, validates their experiences, decreases the feeling of being alone and provides useful information on resources that are available post discharge.		Urban	Stroke	Peer Support Program	Ottawa, Ontario, Canada	
Quality of Life of Stroke Survivors	Study aimed at identifying those factors that influence quality of life of geriatric stroke survivors 1-3 years post-discharge.		Community-based stroke survivors report a relatively low overall QOL. Areas of concern were ability to get around, ability to do things, not having a job, usefulness to others and stress. Depression was a great predictor of QOL, as was social supports.			Stroke		Alberta, Canada	

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Lit Review, Sudbury Research Project	Areas where research was reviewed included: trajectory/timeframe, definitions, concerns/needs/challenges after discharge home, recruitment, interview, interventions, factors predicting reintegration, scales/outcome measures, costs of stroke.		No outcomes reported; just a summary of the literature.			Stroke		Sudbury, Ontario, Canada	
Exploring the Role of a health system navigator to support chronically ill older adults through health care transitions. Thesis	Develop a framework for a system navigation role to enhance coordination of formal and community-based services to older persons with chronic disease through health care transitions. Key components of an integrated system includes: timely access to services, service provision to fill gaps in care, a multidisciplinary team approach, linkages across the continuum of care, system navigation support for patients, caregivers and health care providers and information systems accessible across sectors and health care providers.	Intensive Geriatric Service Workers (IGSW) in Waterloo-Wellington	3 system navigation models in the USA: CARE, Care Advocate Program and Patient Navigator Act. 2 models worldwide relevant to the Canadian system: COPA (France) and community matron role (United Kingdom). Document includes a table of potential outcome measures impacted by a system navigator role in three areas: health care system, health care provider and patient/caregiver outcomes. A table is in this document which describes the role of a navigator.			Complex high risk older adults			Typically a system navigator responsibilities are: home visits, phone support, care planning/coordination, patient advocacy/education and collaboration with health care providers. Two unique responsibilities for a system navigator role include: building capacity in the community for older adults to navigate the system; maintain phone support or a drop-in centre for older adults beginning to require a low level navigation support, similar to CCAC case management.
Navigation Roles Support Chronically Ill Older Adults through Healthcare Transitions: A Systematic Review of the Literature				Prevent hospital admissions or readmissions, accelerate discharges, improve access to care and the care quality as patients transition		Older adults with chronic disease	Patient/system navigators	Waterloo, Ontario, Canada	One study (Claiborne) had the role requiring a masters in social work reflecting the target population of stroke survivors and their caregivers and the psychosocial focus of the study's goals.
Mayo, N. et al, Bridging the gap: the effectiveness of teaming a stroke coordinator with patient's personal physician on the outcome of stroke. *Age and Ageing* , 37, 32-38.	For 6 weeks following hospital discharge a nurse stroke care manager maintained contact with patients through home visits and telephone calls designed to coordinate care with the person's personal physician and link the stroke survivor into community-based stroke services.	Two RNs for in-home and phone consultation follow up.	No evidence that this type of passive case management inferred any added benefit in terms of improvement in health-related quality of life or reduction in health services utilisation and stroke impact, than usual post-discharge management.		Urban	Stroke (mild)	Community	Canada (Quebec)	(From researchers) The question must be raised as to whether any of the interventions offered were potent enough to alter HRQL or health services utilisation. Most of the interventions were 'passive' in nature, such as providing surveillance, information and education and psycho-social support. It may be that these interventions are not sufficiently potent to alter health status as perceived by the subject.

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National Patient Navigation Consortium	Provides principles of patient navigation.		12 principles described include: -patient-centric healthcare service delivery model promoting timely movement through the healthcare continuum -serves to virtually integrate a fragmented healthcare system -core function is the elimination of barriers to timely care across all segments of the healthcare continuum -defined with a clear scope of practice that distinguishes the role and responsibilities of the navigator -cost-effective -who should navigate is determined by the level of skills required -define the beginning and end point of navigation -navigation can serve as the process that connects disconnected healthcare systems -navigation systems require coordination				System	United States	
National Transitions of Care Coalition, Improving Transitions of Care Findings and Considerations of the "Vision of the National Transitions of Care Coalition", 2010, 1-12	No specific model - speaks to principles & recommendations that would inform an effective model(s).		Outcomes not related to a specific model.			Older, chronic illness.	System	United States	Links to toolkits and resources to assist in transitions.
Parry, C. et al, A Qualitative Exploration of Patient-Centred Coaching Intervention to Improve Care Transitions in Chronically Older Adults, *Home Health Care Services Quarterly* , 24 (3/4), 39-53.	Coaching intervention to enhance self-management during care transitions. Patient-centred interdisciplinary team intervention - patients provided with tools and structured support that promote knowledge and self-management.	Nurse Transition Coach	Study suggests that self-management was enhanced. Qualitative data with positive responses from participants.		Urban	Over 60 years, chronic illness, likely to have multiple care transitions.	System	United States	Model based on four pillars - medication self-management, patient-centred record, follow up and, knowledge/self-management of condition.

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Wellness navigator: An innovative role in primary health care for occupational therapists. *Occupational Therapy Now* , Volume 15.5	One to one support and assistance covering a wide variety of needs beyond the medical.	Wellness navigator	Qualitative results positive from users of the model.		Both	All community residents whether ill or well.	Community	Canada	Very brief article giving high level idea of wellness navigator role.
Transitional Care for Older Adults: A Cost-Effective Model, Leonard Davis *Institute of Health Economics* , 9 (6), 1-4	Model of care delivered by nurse experts who follow vulnerable elders though their hospitalization and monitor their progress at home. Model included visits in hospital, at home and telephone calls by APN.	Advanced Practice Nurse	First study demonstrated cost savings for first six months post-discharge and less readmissions for the medical group (no change for surgical group). Second study focused on high-risk hospitalized seniors and demonstrated cost savings, fewer readmissions, reduced LOS. Long term (one year) saw intervention group have less hospital admissions, better outcomes and greater satisfaction with care.		Urban	Older adults who had been hospitalized foe medical & surgical conditions.		United States	The model involves comprehensive discharge planning by a master's prepared advanced practice nurse (APN) with gerontological expertise. The APN tailors post discharge services to each patient's situation, and provides follow-up care by telephone and home visits. The intervention is notable for its emphasis on identifying patients' and caregivers' goals, individualized plans of care developed and implemented by APNs in collaboration with patients' physicians, educational and behavioral strategies to address patients' and caregivers' needs, and coordination and continuity of care across setting
Navigating Life Post Stroke, NE LHIN, March 2011	The System Navigator's responsibilities will focus on improving community re-engagement such as participation, education, socialization, and transportation. Stroke clients will be followed for a minimum of one year post-stroke.	Stroke Community Re-Engagement Navigator			Both	Stroke	Community	Canada	

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Health System Navigators: Band-Aid or Cure? *Change Foundation, Panorama Panel* , September 2013	Includes recommendations from panel on the 'must-haves' for an effective navigation system: • navigator role needs to be clearly defined and performed by someone who has met provincial training requirements and meets a standard of practice. • navigators should not be expected to do it all • important to clearly define navigator role in relation to other healthcare providers. • navigator needs to have the necessary authority to communicate, and to initiate action, across the various points of care • navigator should not replace role of an informal caregiver, or decrease the responsibility of the patient or informal caregiver for taking care of the patient's health needs • navigator should not replace that of primary care providers or decrease their responsibility to fulfill their professional obligations • navigator should not replace that of CCAC care coordinators or decrease their responsibility to fulfill their professional obligations • potential for existing members of the care team to take on navigator role should be the starting point • question if a generalist or specialist approach would be more effective • must be culturally sensitive • must be process for matching navigators and patients that will foster trusting relationships. • navigation should focus on providing only what is needed, without introducing unnecessary additional costs or making navigation obligatory for patients or caregivers • must have an evaluation component that is linked to indicators that measure impacts such as changes in health outcomes, improved patient experience and more efficient use of health services.				Both	General Population	System	Canada	

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Principles of Navigation: Orienting Your Compass for Service, *Michigan Primary Care Association*	Not really a model but does define navigators, patient navigators and community navigators. Also, talks about a patient-centred medical home.					General Population	Community	United States	
Petereit, D. et al, Walking Forward: The South Dakota Native American Project, *Clinical Disparities in Native Americans* , 20(1), 65-70.	A patient navigator program that uses trained community research representatives (CRRs) to serve as lay health advisors. Specific objectives of the program are (1) to provide culturally appropriate public education on cancer prevention, development, diagnosis, treatment, and follow-up; (2) to improve access to early diagnosis and treatment; (3) to provide assistance to patients in "navigating" the health care and related insurance system; (4) to provide patients with resources for emotional and social support; (5) to provide logistical support for patients who must ravel to receive health care; and (6) to increase enrollment and reduce dropout rates in clinical research trials.				Both	Native American - Cancer	System	United States	
Anderson, Sharon & Egan, Mary, Models of Care Coordination, 2010	Literature review/environmental scan of existing 'care coordination' models with analysis across several domains.	Varied	Varied	Varied	Varied	Varied	Varied	Varied	Summary table pages 89-97.
Assess and Restore William Osler Health System Care Coordination Project, Central West LHIN, 2014	To pilot a Care Coordinator role for three months in the Assess and Restore (STAR) unit, where patients are frail seniors with complex needs	Assess & Restore Care Coordinator	LOS in Assess and Restore decreased from 14 to 12 days	LOS in Assess and Restore decreased from 14 to 12 days		Frail seniors	System	Canada	A Care Coordinator for the STAR unit would: Help to identify Assess and Restore patients earlier and thus more timely access to care (sees patient in ED or inpatient unit) Providing interdisciplinary care to the patient sooner (helps involve the team sooner) Ensure that target LOS for these patients are achieved Ensure that discharge disposition barriers are removed Ensure smooth and safe transition from transferring service (ED or Acute Care)

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Mant, J. et al, Family support for stroke: A randomized control trial. *Lancet* 2000, 356: 808-13.	Patients assigned to a family-support organiser (FSO). The nature and frequency of interaction was at the discretion of the FSO, and depended on the difficulties and requests of the families. . All participants in the family-support group received Stroke Association information leaflets, and were left a contact number for the FSO.	FSO (partnership with Stroke Association)	Family support significantly increased social activities and improved quality of life for carers, with no significant effects on patients. Only use of physiotherapy differed significantly between groups, with less use in the intervention group. Patients in the intervention groups also used the Stroke Association stroke clubs more and speech and language therapy less than those in the control group.		Both	Acute stroke patients discharged from hospital	Community	United Kingdom	The FSO made contact with all but one of the 156 followed up patients in the intervention group, with an average of one hospital visit, one home visit, and three telephone calls (other than those to make appointments), and liaised with one other service per family in the first 6 months.
Patient Navigation Programs. Report 7 of the Council on Medical Services	Describes various roles that patient navigators assume		Key messages: Foster patient empowerment; provide information; be of a supportive role not clinical		Did not differentiate between the two	All patients in health care system	Community	United States	supports "guiding principles"
Preliminary Lessons Learned from the "Native Navigators and the Cancer Continuum"	Strategies to elevate the awareness and availability of patient navigators		By adding series of community workshops, they greatly increase navigators' visibility and accessibility	Navigators helping community members to access timely and quality cancer services	Native communities quite mobile going back and forth between city and reservations. Research states urban, rural and reservation.	Full continuum of cancer care - American Native population	Community	United States	
Optimizing Stroke systems of Care by Enhancing Transitions across Care Environments.	Highlights stroke patients and caregivers experiences across care environments and strategies to improve transitions.		Is a need to enhance and standardize the provision of education, training and information provided to stroke survivors and caregivers to ease transitions across care environments	At societal level, additional financial resources or reallocation of resources could be made to enhance provision, availability and coordination of services for stroke survivors	Urban or rural	Stroke survivors and caregivers across care environment	Community	Canada	supports "guiding principles"
Effectiveness of a Care Coordination Model for Stroke Survivors: A Randomized Study	Study investigated efficiency of social work care coordination model for stroke patients.		Found that care coordination by social workers significantly improves health care reimbursement	Patients receiving care coordination significantly reduced their reliance on ER and increased utilization of outpatient physicians	Seems to be urban	Stroke survivors	Community	United States	

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Efficiency of a Care Coordination Model: A Randomized Study with Stroke Patients.	Evaluated the effectiveness of systematically integrating biopsychosocial interventions with coordinated delivery of care for stroke outpatients		Found that care coordination by social workers significantly improves quality of life and increased functioning and self management practices	Model effectively broadened care to meet needs of stroke patient while effectively using practioners' resources	Urban	Stroke survivors	Community	United States	Supports "guiding principles"
Using Navigators to Improve Care of Underserved Patients	Address 3 basic questions: 1. What is patient navigation?; 2. How are navigator programs organized?; 3. What is know about the effects and effectiveness of navigator programs?		1. Lack of a standard definition of patient navigation 2. Navigators play a reactive role by trouble shooting delivery of care to individual patients. 3. Navigators seek to provide "one-stop" assistance for barriers that arise across the cancer spectrum from prevention to survivorship	Reliable measurement of services and barriers would facilitate appropriate analysis of program costs, benefits, and cost effectiveness	Urban and rural	Cancer	Community	United States	Supports "guiding principles"
Evolution of a Health Navigator Model of Care within a Primary Care Setting: A Case Study	Case study outlines the evolution, purpose and effects of a lay-led health navigator in a deprives, sparsely populated rural setting		Service provided support to a group of unwell individuals, with few resources and multiple barriers to negotiate and effectively engaged with health and social care services while overcoming barriers and obstacles	Removed the burden of this work from an increasingly overstretched primary healthcare workforce	Rural	Those living with social complexity and other long-term conditions (e.g. cardiovascular disease, diabetes, chronic obstructive airways disease) as well as cancer	Community - Lay person navigator	New Zealand	Supports "definition and roles of Navigator"
Community Navigation for Stroke Survivors and Their Care Partners: Description and Evaluation	To describe the implementation of the Community Stroke Navigator service and the results of the evaluation	Non-profit organization	Study demonstrated that Community Stroke Navigation has the potential to improve community reintegration among stroke survivors	Study had no longer term follow up to determine the potential economic impact of Community Stroke Navigation	Urban	Stroke Survivors and Care partners	Community	Canada	Supports "guiding principles"
Wells, K Et Al (2008). Patient Navigation: State of the Art or Is it Science? American Cancer Society, 113 (8), 1999-2010	4 areas in which patient navigators frequently intervene: 1) overcoming health system barriers, 2) providing health education about cancer across the cancer continuum from prevention to treatment, 3) addressing patient barriers to cancer care, and 4) providing psychosocial support. The term 'navigator' (broad term) has been applied to any type of service that assists individuals in overcoming obstacles from screening to treatment and in coping with challenges during survivorship.	USA: Varied lay patient navigators to undergrad and grad degrees, RNs, NPs, SW, health educators, clinic staff, cancer survivors. Training for the role in the US studies in the Canadian studies few had navigation training, most were RNs or SWs had knowledge of case management	Increased screening rates, increased adherence to diagnostic follow up. Ledd evidence re: efficacy of Pat Nad in late stage cancer, delays in initiating cancer treatment or improving outcomes during cancer survivorship	Further research to determine cost effectiveness	Models exist of both	Cancer usually at risk or poorer population - inner city, Native Americans, low-income, minority and rural some models did not specifically target at risk populations - focused on medical centre and managed care patients	Health system mainly while addressing the diagnostic phase of the cancer journey until the treatment phase	United States and Canada	literature review: Key words navigator, navigation and cancer (2007)

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Vedel, I Et Al (2009). A novel model of integrated care for the elderly. Aging clinical and experimental research, 21 (6), 414-423	Increase the involvement of Primary Care , integrate health care providers into primary care, integration of primary and specialised care via community based geriatricians	Primary care, integration of health care professionals into the primary care team, including case managers	Appears may have reduced service utilization			Frail community dwelling elderly, seniors with ADL and cognitive impairment, isolated		France	
Stroke Association, London England. Job Description of Stroke Navigator, London Borough of Haringey (2012).	To provide stroke survivors and their families and carers in Haringey with information, provide advice and support to adapt to a life after stroke. 6 month reviews, primary and secondary prevention advice, advocating, goal oriented, person centered casework based support service primarily first 6 weeks. Support volunteer visiting programs	Degree prepared				Stroke	Community	United Kingdom	
Terna, T Et Al. Presentation of: The Positive Impact of the Stroke Nurse Navigator's Advocacy on Stroke Patient's Compliance Post-discharge (30 Days – 1 year). Alexian Brothers Neurosciences Institute, Elk Grove Village, Illinois.	Guided by Cancer Navigation Model . AVAIL study- telephone calls, coordination of care, education, act as patient liaison across the continuum , community outreach, provide stroke resources, make referrals	RNs - Stroke Nurse Navigator 2 part time roles	High rate of physician follow up appointments, improved trend of medication compliance, low percentage of neurovascular ED visits and hospitalization, improved trends in Barthel Index and QOL scores, , decrease in self reported smoking rates,		Community hospital catchment	Adult with Stroke 18-90 y.o, excluded Cancer, Dialysis and hospice out of catchment	Health care and community	United States	PowerPoint presentation/case study
WGTA Stroke Community Navigator Job Description	Assist with smooth transition to the community, link with inpatient team and SPC, coordination of care, follow up phone calls at 1, 3, 6, months and one year), education	RHP			Urban	Stroke		Canada	Job description

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Smith Center for Healing and the Arts Website. Community Navigation. www.smithcenter.org	Free navigation through area churches and partnerships with local associations, provide emotional support, information and facilitate access to screening, treatment and community services, reduce stress, empower patients, facilitate physical, emotional and spiritual healing, instruct and inform in integrative therapies	Training - professionals, survivors , lay people			Urban	Cancer, African American, underserved	Community	United States	Website: www.smithcenter.org
Evidence for Stroke Family Caregiver and Dyad Interventions. American Heart Association and American Stroke Association. 2014	Analyzed 17 caregiver intervention studies and 15 caregiver/stroke survivor dyad intervention studies. Searched from 1990-2012. Looking to provide evidence-based recommendations for the implementation and future design of stroke family caregiver and dyad interventions. Four questions were addressed: Do family caregiver and dyad interventions improve stroke survivor outcomes? do family caregiver and dyad interventions improve caregiver outcomes? what types of family caregiver and dyad interventions are most effective for improving stroke survivor and caregiver outcomes? what recommendations can be made for designing and implementing family caregiver and dyad interventions that improve stroke survivor and/or caregiver outcomes?		Best study showed that 3 to 5 inpatient sessions and 1 home visit consisting of tailored psycho-educational topics and skill-building strategies improved survivor and caregiver outcomes and reduces costs.			Stroke	Not about navigation	United States	They have a definition of family caregiver. May be useful in terms of elements that assist caregivers in our model.