ORIGINAL RESEARCH

Depiction of a Novel Patient Navigator Program to Support Delayed Discharges Among Older Adults Admitted to Acute Care

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https://doi.org/10.5770/cgj.03.852

ABSTRACT

Background

A novel Patient Navigator Program (PNP) was introduced at a Canadian hospital's Reactivation Care Centre (RCC) to support transitions by helping older adults navigate the complexities of delayed discharge stays by improving their transition from hospital to home. The PNP was comprised of a community agency patient navigator who was embedded into the RCC setting to support transitions in care, and who followed patients up to 90 days post-hospital discharge. The purpose of this study was to describe the PNP, which included detailing the needs of patients (i.e., socio-demographics, case-mix, delayed discharge), the scope of service provision (i.e., referral process, follow-up duration), and patient outcomes (i.e., post-discharge location).

Methods

A cohort observational design was used to collect data on the PNP mainly via the patient navigator's clinical tracking sheet, and secondly via the hospital's administrative system. Data analysis included the use of frequencies and descriptive statistics.

Results

Between November 2021 and October 2022, 100 patients were referred to the PNP, with 70 patients (39% male; 61% female; median age of 81 years) being admitted to the patient navigator's caseload. The patient navigator provided follow-up care for a median of 58 days, and supported 76% of the patients (n=53) to return to their next point of care (e.g., homes or to a supportive housing setting).

Conclusion

The PNP led to a high proportion of patients being discharged back to the community. This study provides insights to providers and decision-makers interested in implementing PNP care models in a hospital in partnership with a community agency.

Key words: delayed discharges, frailty, observational study, patient navigation, transition of care

INTRODUCTION

A pressing challenge in acute care settings is the high occupancy rates in hospitals, which often includes patient stays categorized as delayed discharge.(1) A delayed discharge stay occurs when a patient no longer requires acute inpatient care services, but is unable to be discharged home or is waiting for appropriate care. Delayed discharges are a significant and persistent issue globally. In Canada, when a patient is deemed to be medically stable and no longer requiring acute care, they are identified as requiring an 'alternate level of care' (ALC).(2) The contributing factors for ALC include capacity issues in hospital and other parts of the health-care delivery system, such as lack of available home care, community services or long-term care beds.(3) As per CADTH Health Technology Review (2024), it is important to prevent older adults from presenting to the hospital, and/or to transfer them to transitional care programs.(4) Transitional care programs ensures that older adults receive coordinated care when transitioning across health settings.(5)

In Canada, there are several different models of transitional care programs, including: 1) in-hospital to prepare

patients in discharging out of hospital, 2) facility-based in an assisted living or long-term care temporarily, and 3) community setting to provide support in the home.[5] As noted by Barber *et al*.,[5] the characteristics defining hospital and facility-based transitional care programs are homogenous. Hospital-based programs provide services for older adults being discharged, where facility-based programs provide enhanced services for older adults that no longer need hospital care but require additional support before returning home.[5] However, community-based transitional care programs are heterogenous, in which services may include case management, discharge planning, support with activities of daily living, rehabilitation therapy, meal preparation, housekeeping, transportation to appointments, medication administration, assistive medical devices/equipment, referrals to community supports, and self-management.[5]

From 2016 to 2023, there were 45 hospital-based, 32 facility-based and 42 community-based transitional programs in Canada to support older adults.[5] While there are some guidance on eligibility criteria (i.e., post-acute illness, surgical procedure, or complex chronic conditions) and program length (i.e., between 3 to 4 months, up to 6 months), various service providers were identified.[5] The community-based transitional programs may include, but are not limited to, specialized nursing health professionals, care coordinators, rehabilitation therapists (e.g., physiotherapy, occupational, massage), personal support workers, social workers, dieticians, and navigators.[5] However, there were only four 'navigator-led' community-based transitional programs identified by Barber *et al*. and, of those, two were 'nurse navigators'.[5]

Patient Navigation Programs (PNPs) have been introduced across many countries to facilitate transitions of care,[6] which include supporting hospital-to-home transitions.[7] PNP offer a person-centred health-care service delivery model to create a seamless flow for patients as they journey through the care continuum.[8] These programs typically employ a patient navigator who engages with the patients and/or care partners to identify any barriers to accessing care, provide referrals to services, facilitate transitions of care, and promote self-management.[8,9] In recent years, PNPs have been introduced to support older adult patients with frailty or complex care needs in transitions of care from hospital-to-home.[10,11] However, there are no established practice guidelines or consistent evidence on the most appropriate transitional care model.[10]

A patient navigator may facilitate transitions of care across various settings (e.g., hospital and home) or sectors (e.g., health and social care),[6] thereby enabling older adults to remain in their homes and communities longer.[12] Key roles of the patient navigators depend on their skills and experience. Typical tasks might include identifying individual needs and barriers to care, educating patients and communities, and linking patients with different care providers.[6] There is growing evidence for the efficacy of PNPs for improving patient outcomes, including referral to appropriate services, better care transitions, and high levels of patient satisfaction.[13] Since patient navigators are often involved in multiple activities, including facilitating access to care for their patients through case management or care coordination, it is uncertain which specific interventions leads to positive patient outcomes.[12] Hence, obtaining a better understanding of PNP service provision would help inform what constitutes patient navigation, as well as generating knowledge regarding its implementation and impact for older adults and their care partners.[12]

At our clinical site, a large metropolitan hospital partnered with a community agency to co-design a new PNP to improve the continuity of care across care transitions, with the goal to better support transitions of care for older adults in returning home. In this PNP, the patient navigator (titled as a 'Community Transitional Worker') is a clinically trained social worker who was hired via the community agency partner. A unique feature about this transitional care model is that the patient navigator is embedded as part of the hospital's team, which meant that the patient navigator works alongside the clinical staff at the hospital. The patient navigator would assess the patient while in hospital, and support them during the transition back home. The reason for this embedded approach is that the patient navigator from the community would be more knowledgeable about the availability of community services, which would then facilitate safe discharges back to the community.[13] Upon referral to the PNP, the patient navigator assesses the patients' needs in the hospital, and coordinates with the hospital and community teams to work collaboratively to assist patients and care partners as they transition from hospital and back to the community for up to 90 days post-discharge, which may include a home visit.

The implementation of the pilot PNP was initiated in the hospital's acute care starting in November 2019, where 66% of the patients who were assigned to the patient navigator's caseload were able to be supported to transition back home or to a supportive housing setting.[14] Due to an increase in the number of delayed discharge stays at the hospital, another patient navigator was hired to support patients primarily in the hospital's Reactivation Care Centre (RCC) in November 2021. In Ontario (Canada), RCCs were implemented to support acute care hospitals to help patients at risk for a delayed discharge, or who were designated as having a delayed discharge, to help them transition back home or a supportive housing setting or to another care facility, such as a retirement home or long-term care.[15]

Given that little is known about PNPs working primarily in RCC settings, to support care transitions further research is needed to better understand their scope of practice and their impact in this particular care context.[16] The primary purpose of this study was to describe a novel PNP being offered in a RCC setting. Specifically, this included describing the types of patients (i.e., socio-demographics, case-mix, delayed discharge), the scope of service provision (i.e., referral process, follow-up duration), and patient outcomes (i.e., post-discharge location). Doing so will provide critical insights on this growing model of transitional care being used in Canada to support the needs of older adults and their care partners as they transition from hospital to home.

METHODS

Study Design

The present study used a cohort observational design guided by the 'Strengthening the Reporting of Observational Studies in Epidemiology' (STROBE)[17] statement to track a group of PNP patients assigned to the patient navigator's caseload who works primarily at a hospital-managed RCC. This research project has been approved by the Sunnybrook Health Sciences Centre—Research Ethics Board and SPRINT Senior Care. Since this was a retrospective cohort observational study, participant consent was not obtained.

Setting and PNP

The hospital opened the RCC unit with 60 beds in 2018 in Toronto, Ontario (Canada) to support patients when they no longer required acute hospital services and are waiting to be discharged or transitioned to another care facility. In November 2021, the PNP was initiated to support patients primarily in the hospital's RCC. The PNP consisted of a patient navigator employed by the community agency but operated out of the hospital's RCC primarily to support referred patients by health-care providers or by self-referral. Given there were two other patient navigators working in the hospital, one who primarily worked in the emergency and one covered the acute care hospital units, the third patient navigator would see the patients who were likely to be transferred to the hospital's RCC. In some instances, patients were identified in the hospital's emergency department, acute care, or rehabilitation program or by a community agency staff member.

Upon referral, the patient navigator would undertake an in-hospital clinical interview with the patients and/or care partners to identify the patients' health and social care needs. The patient navigator would then work collaboratively with the hospital's team to prepare the patient for discharge. To avoid duplication, if the patient already had a case manager, the patient navigator would provide an update to support the discharge process or would facilitate referrals to community services (e.g., meal delivery) and/or providers (e.g., primary care) for patients. Additionally, the patient navigator would (where appropriate) provide follow-up support to patients and care partners post-discharge, which may have included a home visit.

Participants

Participants in this study included patients referred and admitted to the PNP who were followed by the RCC patient navigator between November 2021 and October 2022. Patients who interacted with the patient navigators for more than three days were admitted to the patient navigator's caseload. Those who interacted with the patient navigator for less than three days were classified as consults.

Measures

A clinical tracking sheet was used by the patient navigator to document patients' profiles (e.g., socio-demographics), service provision (e.g., referral process, follow-up duration), and patient outcomes (e.g., post-discharge location). Patients' Medical Record Number (MRN; where available) were used to link data from the tracking sheet to the hospital's administrative Discharge Abstract Database (DAD)[18] based on the most recent inpatient acute care admission. For patients who were matched to our hospital's administrative system, information collected included case-mix, most responsible health condition, primary and secondary diagnosis, and whether the patients experienced a delayed discharge. The rationale for using the hospital's DAD was to capture the patients' case mix and, more importantly, other comorbid conditions being experienced by patients. A better understanding of the patients' most responsible health conditions, as well as primary and secondary diagnoses, is critical to contextualize how health status (medical, cognitive or mental health issues) would influence the discharge process to home.

Data Collection & Analysis

Data collected were 1) socio-demographics (i.e., chronological age, sex); 2) administrative (i.e., case-mix, delayed discharge); 3) PNP service provision (i.e., referral process, follow-up duration); and 4) outcomes (i.e., post-discharge location). Data were first screened and reviewed by the first author (GL). Open-ended descriptive comments detailing services provided by the patient navigator were coded by another member of the team (ME), which were then reviewed and verified by the first author (GL). As an additional check related to the coding of the data, findings were validated by the PNP management team (AK, NZ). Frequencies and descriptive statistics were used to analyze the data.

RESULTS

Between November 2021 and October 2022, there were 100 cases referred to the patient navigator who worked primarily in the RCC. Fifteen patients were unable to be contacted, 10 were consults, and five were deceased or declined the service. Hence, 70 patients were admitted to the patient navigator's caseload; however, only 45 patients were matched to the hospital's administrative system using the MRN. Twenty-five patients could not be matched due to missing MRN or did not have an acute care admission (e.g., referred from the community).

Demographics and Clinical Profiles

Of the 70 patients who were assigned to the patient navigator's caseload, 61% were female and 39% were male, and the median age was 81, ranging from 55 to 96 years of age (IQR=11.8, Mean=80, SD=8.9). For the 45 patients (64%) who we were able to match to the hospital's administrative system, the case-mix groupings were categorized into five main categories (see Table 1). The comorbid conditions in the same inpatient encounter were also captured where the majority of patients had various underlying comorbid conditions, including medical (e.g., respiratory, or neoplasm) (87%), musculoskeletal (e.g., fractures, or trauma) (51%),

cognitive (e.g. delirium, or dementia) (49%), neurological (e.g., brain injury, or Parkinson`s) (22%), and mental health (e.g., depressive, or behavioural) (18%). Of the 45 persons, 60% (n=27) were designated as ALC.

Service Provision

For referral process, 30% of the patients were referred by staff working in the RCC, 29% from acute care, and 17% from emergency. The other 21% were referred by community care and inpatient rehabilitation. For the remaining 3%, data on referral source was not available. Upon receipt of the referral, the patient navigator contacted the patient or care partners either on the same day (13%), within seven days (60%), between 8 to 14 days (6%), or ≥ 15 days (9%); with data missing for nine cases. The median PNP service length was 58 days (IQR=77.3, Mean=66 days, SD=50.2) ranging from 5 to 241 days. Data were missing for 18 cases.

In terms of services provided by the patient navigator to the 70 patients, 10 were referred for information on resources, and did not require further support. The other 60 patients received one or more services (see Table 2). Twenty-two home visits (31%) were conducted by the patient navigator.

Post-Discharge Location

Upon discharge from the PNP, the post-discharge location for the majority of patients (76%) was home or to a supportive housing setting. The remaining 24% were admitted back to acute care or to a palliative care setting (n=6), or transferred to another care facility (i.e., long-term care, inpatient rehabilitation or transitional care; n<6). Despite attempts by the patient navigator to contact all the patients for follow-ups, the discharge location was unknown for six patients. Out of the 27 patients designated as ALC, the patient navigator facilitated 81% of these patients (n=22) in returning home or to a supportive housing setting.

DISCUSSION

This retrospective observational cohort study provides an overview of a PNP that employed a community agency social worker who works alongside a hospital's team. To the best of our knowledge, this PNP model of integrated care appears to be unique in terms of its structure; specifically with regard to having the patient navigator being embedded as part of the hospital's team to address the patients' concerns while in the hospital and provide follow-up support once discharged. While the PNP offered a number of similar services that other typical care providers offer (i.e., social workers, discharge planners, and case managers) in terms of case management and discharge planning, the added value of the patient navigator was their ability to identify and provide ongoing supports to patients and care partners throughout their care journey. For instance, the patient navigator provided guidance and support with instrumental activities of daily living (e.g., link to homemaking and home services, schedule follow-up care), financial/legal aid (e.g., apply for grants/subsidies for low income patients, work with Power of Attorney/Public Guardian/Trustee), and end-of-life plans. The patient navigator also provided social supports to patients experiencing social isolation and care partners experiencing burnout.

The added value of a PNP for older adults is warranted since they may experience challenges navigating the health-care system due to declining physical, cognitive and/or mental health. As well, older adults who are socially isolated, precariously housed or experiencing other forms of structural or institutional marginalization due to their socio-economic status,[19] may require additional supports[20] that are more extensive than other models of care. Transitional care programs can play an important role reducing health-care disparities and inequities for older adults experiencing socioeconomic barriers and coordination challenges during transitions between care settings, and in improving care quality and health outcomes.[21] Thus, based on the patterns of referral and scope of services provided, the described PNP appeared to have been well-suited to help older adults and care partners navigate and obtain appropriate services to be able to transition back home.

Although this study is only descriptive in nature, there was a high proportion of patients (76%) who were discharged back home or to a supportive housing setting, providing some

TABLE 1.
Case-mix categories and examples

Case-Mix Categories	*Case-Mix Examples*	*Sample Size[a] (n=45) (%)*
Medical Conditions	Includes general symptoms, renal, pain, respiratory, gastrointestinal, infection, neoplasm	18 (31%)
Orthopedics Conditions	Includes fixation/repair, fracture/dislocation/rupture, trauma	8 (18%)
Cognitive Conditions	Includes organic mental disorder such as delirium, dementia, Alzheimer's disease	6 (13%)
Cardiology Conditions	Includes heart failure, cardiac intervention, hypertension, angina, myocardial infarction, vascular	<6 (11%)
Neurological Conditions	Includes brain, nervous system, hydrocephalus, paraplegia, intracranial injury, cerebral aneurysm/hemorrhage, Parkinson's	<6 (11%)
Other Conditions	Includes hearing loss, alternative level of care	<6 (7%)

[a]Based on the available case-mix from the hospital's administrative DAD dataset, 64% (n=45) of patients were captured; the other 25 cases were missing or could not be linked.

TABLE 2.
Examples of services provided by the patient navigator

Patient Navigator Services	*Interventions (N=70) (%)*
Referred for Information (e.g., identify patients' needs, provide information to the patient and/or their care partners on resources and/or services)	10 (14%)
Case Management (e.g., identify patients' needs, navigate and facilitate appropriate access to resources and/or services)	57 (81%)
Service Connection (e.g., connect to community programs and services such as personal support worker and transportation)	47 (67%)
Discharge Planning (e.g., plan/support care while transitioning from hospital to home, equipment needs, coordination)	31 (44%)
Provider Connection (e.g., connect to physician, allied health professionals, or other clinical services such as mental health and addiction)	17 (24%)
Housing Related (e.g., discuss housing alternatives and options, provide support while transitioning to another facility such as retirement home, supportive housing, long-term care)	15 (21%)
Social Concern (e.g., counsel patients who lives alone or are socially isolated, provide support due to emotional distress or risk of abuse)	15 (21%)
Care Partner Related (e.g., support family and/or care partners who are stressed, at risk of burnout or experiencing burnout)	11 (16%)
Instrumental Activities of Daily Living (e.g., link to services such as homemaking and home maintenance, support patients/care partners in managing their care needs such as scheduling appointments)	10 (14%)
Financial or Legal Related (e.g., provide support to patients/care partners in financial management or legal issues, apply for grants/subsidies for low income patients, work with Power of Attorney/Public Guardian and Trustee)	8 (11%)
End-of-life Planning (e.g., support patients/care partners in advanced care planning, liaise with palliative care providers, provide grief/bereavement counselling)	< 6 (6%)

evidence that the PNP was assisting to achieve intended outcomes. In particular, the program was able to facilitate discharges for a large proportion (81%) of the patients designated as ALC. A key strength is the PNP integrated model of care, in which the community patient navigator is embedded within the hospital setting enabling a quicker connection to potential community supports and leading to stronger relationships among the agency and clinical care teams. This aligns with previous research conducted by our team during the initial implementation phase of the PNP.[22] In key informant interviews among hospital and community health-care professionals, collaborative communication seemed to be a critical component in facilitating PNP implementation.[22] As such, fostering a collaborative culture may have contributed to a better discharge planning process, where the patient navigator helps to address the patients' health and social care needs.

Since there are no standardized transitional care models for older adults, the present study provides some additional evidence to the small but growing body of research documenting the impact of PNPs for older adults.[23] Similar to other reports,[6,24] the PNP described in this study is a promising model for improving access and continuity of care for older adults. Although the evidence on the effectiveness of PNPs is limited, there is also a lack of knowledge on community transitional care programs, including funding, discharge process, and integration with other health services.[5] The facilitators to the successful implementation of the PNP depends on: 1) clear consensus on the unique service provided by the patient navigator; 2) champions to promote patient navigation; 3) program ownership and accountability; 4) external system and organizational partnership; and 5) implementation climate where communication is vital.[22] Thus, further guidance on best practices for implementing PNP is needed.[25] Additionally, policy-makers interested in introducing PNPs should consider macro-, meso-, and micro-level factors, all of which influence the implementation and secure support from key interest groups and funders to ensure sustainability.[6]

Limitations

The data from the patient navigator's clinical tracking sheets primarily working in the RCC provided several important insights regarding the PNP. However, it was challenging to match the patients visit details using the hospital's administrative system, which resulted in missing data. Due to missing data, it is possible some ALC designations were not captured. For future evaluation work, we made recommendations to the patient navigators to consistently collect the MRN and the encounter number from the hospital's electronic system. In addition, since this study took place during the COVID-19 pandemic, further research is suggested to re-evaluate the impact of PNP post-pandemic. Lastly, only a few studies to date have demonstrated that PNPs can improve outcomes such as access to care, and reduce preventable emergency department visits or hospitalizations.[26,27] Thus, further research is

required to determine if patient navigator follow-up support services can potentially prevent emergency visits or decrease readmissions to the hospital, and/or help older adults remain in their setting of choice.

CONCLUSION

Further research is needed to evaluate the efficacy of this approach, but this descriptive study provides some important insights about the PNP service provision and outcomes. With the implementation of this patient navigator model of integrated care, working in the hospital and assisting older adults in care transition, the PNP led to a high proportion of delayed discharge patients being transitioned back to the community. By characterizing the PNP, the findings from this study may help decision-makers who are considering adopting similar programs in other hospitals to support older adults in transitions of care. This study highlighted considerations for decision-makers interested in implementing this new PNP care model in a hospital and partnering with a community agency, which may serve to inform health services planning and scaling transitional care programs.

ACKNOWLEDGEMENTS

We sincerely thank Karen Chan and Navin Goocool (Sunnybrook Decision Support) for their assistance with providing the data from Discharge Abstract Dataset.

CONFLICT OF INTEREST DISCLOSURES

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: GL, ME, SJTG and SLH declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article. TD, AE, NZ and EE serve in leadership roles at the hospital and community-based agency overseeing the Patient Navigation Program. No other conflicts of interest by TD, AE, NZ or EE were declared.

FUNDING

This work was supported by the Slaight Family Foundation. The views expressed are of the authors and the funding entity accepts no responsibility for them.

REFERENCES

1. Micallef A, Buttigieg SC, Tomaselli G, Garg L. Defining delayed discharges of inpatients and their impact in acute hospital care: A scoping review. *Int J Health Policy Manag*. 2022 Jun 29;11(2):103–11. doi: 10.34172/ijhpm.2020.94.
2. Guilcher SJT, Bai Y, Wodchis WP, Bronskill SE, Kuluski K. An interrupted time series study using administrative health data to examine the impact of the COVID-19 pandemic on alternate care level acute hospitalizations in Ontario, Canada. *CMAJOpen*. 2023 Jul 12;11(4):E621–E629. doi: https://doi.org/10.9778/cmajo.20220086
3. Ontario Health. The alternative level of care (ALC) leading practices guide: preventing hospitalization and extended stays for older adults. 2021 Sep [cited 2024 Dec 6]. Available from: https://quorum.hqontario.ca/Portals/0/Indicators-and-change-ideas/ALC%20Leading%20Practices%20Guide%20v1%202021%20(2).pdf?ver=2022-03-30-133617-273
4. CCADTH Health Technology Review. Strategies to reduce alternative level of care. 2024 Jul [cited 2024 Dec 6]. Available from: https://www.cda-amc.ca/sites/default/files/pdf/htis/2024/EH0126_ALC.pdf
5. Barber BV, Gregg EE, Drake EK, Macdonald M, Hickey M, *et al*. Transitional care programs for older adults moving from hospital to home in Canada: a systematic review of text and opinion. *PLOS ONE*. 2024 Jul 18;19(7):e0307306. doi: https://doi.org/10.1371/journal.pone.0307306
6. Budde H, Williams GA, Scarpetti G, Kroezen M, Maier CB. What are patient navigators and how can they improve integration of care? Policy Brief No. 44. Copenhagen: European Observatory on Health Systems and Policies; 2022.
7. Kokorelias KM, Singh H, Posa S, Hitzig S. Understanding the goals of older adults with complex care needs, their family caregivers and their care providers enrolled in a patient navigation programs. *J Appl Gerontol*. 2023 May;42(5):862–70. doi: 10.1177/07334648221144999.
8. Freeman HP. The origin, evolution, and principles of patient navigation. *Cancer Epidemiol Biomarkers Prev.* 2012 Oct 1; 21(10):1614–17. doi: https://doi.org/10.1158/1055-9965.EPI-12-0982
9. McBrien KA, Ivers N, Barnieh L, Bailey JJ, Lorenzetti D, Nicholas D, *et al*. Patient navigators for people with chronic disease: a systematic review. *PLoS One*. 2018 Feb 20;13(2):e0191980. doi: 10.1371/journal.pone.0191980
10. Lee JY, Yang YS, Cho E. Transitional care from hospital to home for frail older adults: a systematic review and meta-analysis. *Geriatr Nurs*. 2022 Jan 1;43:64–76. doi: 10.1016/j.gerinurse.2021.11.003
11. Kokorelias KM, Posa S, Das Gupta T, Ziegler N, Hitzig SL. "I think like if Albert Einstein and Superman had a baby, that's what it would take": The experiences and perceptions of community and hospital healthcare professionals in a seniors' patient navigator program. *Int J Care Coord*. 2021 Nov 25;24(3-4):1–7. doi: https://doi.org/10.1177/20534345211063482
12. Funk LM. Relieving the burden of navigating health and social services for older adults and caregivers. IRPP Study 73. Montreal: Institute for Research on Public Policy; 2019. Available from: https://irpp.org/wp-content/uploads/2019/11/Relieving-the-Burden-of-Navigating-Health-and-Social-Services-for-Older-Adults-and-Caregivers.pdf
13. Kokorelias KM, Gould S, Ziegler N, Landau S, Das Gupta T, Knoepfli, *et al*. Key informants' perspectives on implementing patient navigator programs within hospital settings. *Int J Integr Care*. 2021;22(S2):8. doi: doi.org/10.5334/ijic.ICIC21171
14. Liu G, Kokorelias KM, Knoepfli A, DasGupta T, Ziegler N, Guilcher SJ, *et al*. Describing the scope of practice of patient navigators for older adult patients with complex care needs [abstract]. *Int J Integr Care*. 2023. Available from: https://ijic.org/articles/10.5334/ijic.ICIC23518
15. CISION Canada. New reactivation care centre to offer specialized care for patients [News item]. 2017 Oct. [cited 2024 Dec 6].

Available from: https://www.newswire.ca/news-releases/new-reactivation-care-centre-to-offer-specialized-care-for-patients-653372653.html\

16. Reid AE, Doucet S, Luke A, Azar R, Horsman AR. The impact of patient navigation: a scoping review protocol. JBI Evidence Synthesis. 2019 Jun 1;17(6):1079–85. doi: 10.11124/JBISRIR-2017-003958.
17. EQUATOR Network. The strengthening the reporting of observational studies in epidemiology (STROBE) statement: guidelines for reporting observational studies. 2023. [cited 2024 Dec 6]. Available from: https://www.equator-network.org/reporting-guidelines/strobe/
18. Canadian Institute for Health Information. Case mix grouping methodologies help health care facilities plan and manage their services. 2022. [cited 2024 Dec 6]. Available from: https://www.cihi.ca/en/submit-data-and-view-standards/methodologies-and-decision-support-tools/case-mix
19. Provincial Geriatrics Leadership Ontario. Consensus Statement: Care for the Older Adult with Complex Health Conditions—Reframing 'Frailty' in an Ontario Context. 2022 May. [cited 2024 Dec 6]. Available from: https://geriatricsontario.ca/resources/consensus-statement-care-for-the-older-adult-with-complex-health-conditions-reframing-frailty-in-an-ontario-context/
20. Kokorelias KM, Sheppard CL, Hitzig SL. The role of patient navigation in supporting low-income older adults in their housing needs during hospital to home transitions: a qualitative descriptive study from Ontario, Canada. *Int J Care Coord*. 2023 Mar;26(1):26–33. doi: 10.1177/20534345231151209
21. Le Berre M, Maimon G, Sourial N, Guériton M, Vedel I. Impact of transitional care services for chronically ill older patients: a systematic evidence review. *J Am Geriatr Soc*. 2017 Jul;65(7):1597–1608. doi: 10.1111/jgs.14828
22. Kokorelias KM, Gould S, DasGupta T, Ziegler N, Cass D, Hitzig S. Implementing patient navigator programmes within a hospital setting in Toronto, Canada: a qualitative interview study. *J Health Serv Res Policy*. 2022 Oct;27(4):313–20. doi: 10.1177/13558196221103662
23. Liu G, Kokorelias KM, Knoepfli A, DasGupta T, Ziegler N, Guilcher SJ, *et al*. Characteristics and trajectory of older adults supported by a patient navigator program in a hospital setting: a cohort observational study. *Can J Aging*. 2024 Nov 14;44(1):1–10. doi: 10.1017/S0714980824000321
24. Liu G, Kokorelias K, Knoepfli A, DasGupta T, Ziegler N, Elliot E, *et al*. A new patient navigation model of care to support older adults in transitions of care: key considerations for implementation for policy-makers and health system leaders. *Healthc Manage Forum*. 2024 May;38(3):186–91. doi: 10.1177/08404704241288458
25. Kokorelias KM, Shiers-Hanley JE, Rios J, Knoepfli A, Hitzig SL. Factors Influencing the implementation of patient navigation programs for adults with complex needs: a scoping review of the literature. *Health Serv Insights*. 2021 Jul;14:11786329211033267. doi: 10.1177/11786329211033267
26. 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 Serv Res*. 2017 Dec;17(1):116. doi: 10.1186/s12913-017-2046-1
27. 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 Serv Res*. 2018 Dec;18(1):96. doi: 10.1186/s12913-018-2889-0

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