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POSTER ABSTRACT

Coordinated Access to Community Services

- Navigating Supports Together for Better Outcomes

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Background: North Simcoe, a region in central Ontario, Canada, is home to small towns and rural communities where disconnected health and social services have made it challenging for people to transition from hospital to home or live safely and independently. The Coordinated Access to Community Services initiative was launched to improve care coordination and build resilient communities through new partnerships among hospitals, primary care, and community-based supports.

Approach: This initiative strengthens care transitions and access to community supports across three service pathways:
•hospital (including daily multidisciplinary patient care reviews within specialized units and emergency services),
•Ontario Health atHome (the provincial agency coordinating home care), and
•primary care (family physicians, nurse practitioners, etc.).

Community Support Navigators are embedded within each pathway, acting as facilitators who bring together hospitals, primary care, and community organizations to form new alliances and operationalize integrated care. Their responsibilities include assessing individual needs, developing tailored care plans, connecting clients to government-funded resources, and providing ongoing follow-up. The initiative supports a person-centered, integrated approach, ensuring individuals receive appropriate support regardless of their entry point into the system.

During development, hospital partners co-designed and refined features such as evening and weekend on-call coverage and electronic records management. Stakeholders across the Primary Care Network helped integrate services in diverse care settings, with continuous improvements based on real-time feedback from patients, clients, and providers.

Results: From April to August 2025, two Community Support Navigators (1.5 FTE) served 103 individuals, primarily in hospital as other pathways were being activated. Supports included in-home personal care (26%), community paramedicine (20%), mental health/addictions (15%), food

security (13%), transportation (9%), social programs (8%), assistive devices (5%), health-related programs (5%), hospice (2%), and housing (1%). Nearly half of referrals resulted in timely service starts, with most clients receiving support within three to six months. The program's impact is seen in cases like an 80+ year-old patient at risk of needing non-acute care, who returned home safely with coordinated support for health, social engagement, and daily living needs.

Navigator involvement minimized hospital reliance, prevented long-term care admission, and restored well-being and independence. Hospital staff reported improved collaboration, more person-centered discharge planning, and greater confidence in patient outcomes. The model has improved patient and caregiver experience, reduced avoidable hospital readmissions and long-term care placement, and enhanced system efficiency. Early engagement of primary care providers and OH atHome coordinators ensures supports are initiated earlier, strengthening continuity of care and reducing hospital utilization.

Implications: Key learnings highlight the importance of early, coordinated intervention and robust partnerships across health and community sectors. The scalable and adaptable model demonstrates that integrated navigation improves patient outcomes, reduces hospital admissions, and enhances system efficiency. The initiative's success underscores the critical role of community supports in holistic care. By bringing together partners from across health and community sectors and keeping the focus on each person's needs, Navigators actively facilitate collaboration and new alliances. This integrated approach leads to better outcomes and helps people live safely and thrive in resilient communities.