NATIONAL NEWCOMER NAVIGATION NETWORK

RÉSEAU NATIONAL DE NAVIGATION POUR NOS NOUVEAUX ARRIVANTS

NEWCOMER NAVIGATION

from Coast to Coast Report on N4 Outreach and Site Visits

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FOREWORD

N4 would like to acknowledge the contribution of all the stakeholders who gave their valuable time and insight, which informed this report as well as our funders, Immigration Refugee Citizenship Canada. The support, guidance and sharing was crucial to the formation of the N4 platform. We are honoured to share with you the results of this work, to advance our ability to connect, learn and collaborate around newcomer navigation, with the ultimate goal of ensuring an equitable experience for our newest Canadians.

EXECUTIVE SUMMARY

INTRODUCTION

Newcomers to Canada face linguistic and cultural barriers in accessing health and social services. The National Newcomer Navigation Network (N4) is a national network for the diversity of professionals who assist newcomers in navigating the complex Canadian health and social services system. To inform the development of its N4 Platform and online certificate program in newcomer navigation with Saint-Paul University, N4 undertook a pan-Canadian needs assessment of both sectors.

METHODS

The 1st phase of needs assessments included cities with pediatric healthcare centres from July 2019 to March 2020. The aim of the needs assessment was to map out strengths and gaps in knowledge mobilization for newcomer serving professionals. During the calls and site visits, an orientation to N4 was followed by an orientation to their organization and a facilitated discussion. The results were analyzed for themes.

FINDINGS

The N4 team met with 401 stakeholders from 125 organizations, including children's hospitals/rehab centres, general hospitals, newcomer clinics, community clinics, and settlement organizations, among others.

The provincial umbrella organizations for settlement and national partners in healthcare provided strategic level guidance around N4's outreach approach and facilitated some connections and meetings.

In the healthcare sector, newcomer navigation work was typically completed by many members of the team, alongside their regular job duties. Their common challenges to ensuring health equity included a context of inconsistent access to interpretation services, knowledge of how to deliver culturally safe care, and provider referral refusals due to concerns over financial compensation or lack of access to other supports needed by newcomer patients. The settlement sector was challenged by uncertain or short-term funding models, tensions over mandates and lack of consistency in staff on-boarding for service delivery. Successes included ingenuity in forming partnerships, problem solving, increased awareness and implementation of trauma-informed care, diversity among settlement teams, and wrap-around services. Strong partnerships existed between regional newcomer clinics and settlement organizations, but lacked in other areas. There was a consistent desire to build cross-sectoral partnerships at all levels (regional, provincial, and national).

Participating settlement organization had developed a number of educational resources for staff, to assist them in their newcomer navigation work. In particular, many duplicating development of resources related to introductory information to trauma-informed care and cultural competency. Participants voiced a desire for a wider breadth of educational topic including partnership development, cultural competency, trauma-informed care, vicarious trauma, and best practices in newcomer navigation. As it pertains to resources, common requests included a guide to IFHP billing, templates to advocate on behalf of clients and families, and client-facing handouts in multiple languages. Data collection, specific to newcomer clients, varied by organization. Participants from healthcare were interested in collecting additional sociodemographic data about patients as well as service-utilization data. All participants were interested in data sharing and learning how inter-organizational comparisons could be developed. There was also interest in learning more about the programs and services provided by other organizations, standard length of appointment times for initial healthcare assessments, and provision of trauma-informed care.

DISCUSSION

The site visit data greatly informed the development of the N4 online platform. The sharings of the professionals from the health and settlement sector pointed to their desired opportunities for intersectoral learning, connection and collaboration. The needed education and resources identified through this needs assessment have informed the learning framework that guides the eLearning resources available on the N4 platform. By providing one platform in which to eLearning across both sectors, partners can easily search for and find support through curated quality offerings, avoiding duplication of efforts and easing access. N4 will then focus its efforts in new educational offerings to leverage subject matter experts to fill any gaps observed, again promoting efficiency in knowledge mobilization for both sectors. Findings have also been used to co-develop an online newcomer navigation certificate program, hosted by Saint-Paul University. The N4 CoP Model will provide facilitated data driven projects to solve some of the system level challenges identified in this report. Finally, N4 aims to address some of the challenges identified regarding data access, collection and usage through the database component of the platform.

CONCLUSION

The needs assessment provided a wealth of information about the state of newcomer navigation across Canada. It provided crucial information to guide the direction of N4 and ensure that the online platform and online program are responsive to stakeholders' needs. Phases 2 and 3 of the needs assessment will further inform the N4 Platform features, membership and content. Facilitating knowledge mobilization across newcomer-serving organizations by supporting learning, connection and collaboration can ultimately improve the experience of newcomers in navigating their services.

INTRODUCTION

High immigration in the past few years (and our plan going forward) has been a key component of government efforts to grow the workforce and counter an aging demographic. Indeed, Canada's last plan is for over a third of a million newcomers over the next 3 years. Newcomers (immigrants and refugees) to Canada however face many linguistic and cultural barriers in access to health and social services impeding their successful integration.[1] Newcomer navigation, the act of helping newcomer clients to navigate the complex health and social service systems, can mitigate linguistic, cultural and other barriers to an equitable experience.[2,3] To date, a lack of cross-sectoral collaboration and lack of national connections within healthcare providers with an interest in newcomer health, has impeded a consistent and equitable experience for newcomers during their settlement.

The National Newcomer Navigation Network (N4) was founded in 2019 from a federal innovation grant aimed at closing this gap. The goal is to develop a national network for the diversity of professionals who support newcomers in navigating the complex Canadian health and social services system. By providing opportunities for connection, learning and collaboration it is aimed that the silos between the systems are broken down. By sharing learnings a better informed and more efficient system is promoted and the well-being and integration of newcomers is supported.

NEEDS ASSESSMENT

Recognizing that there were a wealth of existing resources, training and subject matter experts in newcomer navigation within the health and settlement sectors, N4 began its work by conducting a national needs assessment. The aim was to curate and mobilize this knowledge, understand the remaining gaps in knowledge to be addressed, plan to fill those gaps, and foster connections, collaborations and learnings among the various professionals across Canada. This report summarizes the methodology and learnings from the 1st phase of the needs assessment, as well as describe the implications for N4.

METHODOLOGY

As N4 planned for the needs assessment, the initial plan was to have phased approach, with each phase focusing on three professional groupings; pediatric healthcare, adult healthcare and the settlement sector. As outreach to the sectors began, it became clear that incorporating settlement and healthcare needs assessments by geography (cities) would lead to a better understanding of local services as well as exemplify the cross-sectoral approach we were wanting to foster. Thus the 3 phases were adapted to combine a health sector (pediatrics or adult healthcare) within a city. As the host organization (CHEO) was a pediatric healthcare organization and had existing partnerships to build upon. The focus of the 1st needs assessment phased included the pediatric hospitals in the nine participating provinces in Canada, and their local settlement agencies. Where required, the national pediatric healthcare (Children's Healthcare Canada) supported the outreach through providing connections. The outreach to the settlement organizations was guided by the provincial umbrella organizations for settlement, or less frequently, healthcare would identify and be able to link N4 to those they felt were significant partners in the settlement work.

Initial outreach strategies were used, including emails and phone calls, with the aim to set up in-person visits. Outreach information included a brief background to the project but importantly for relationship building, it was helpful to outline the background, successes and challenges of the host organization (CHEO) in the field of newcomer navigation to forge that collaborative partnership. Engagement from the healthcare field was sometimes challenged due to a lack of clear accountability for health equity or an awareness of the impact of the needs of newcomers to mitigate to ensure an equitable healthcare experience. In the hospital environment, most commonly Social Workers had an understanding of the challenges of newcomers and would be able to facilitate introductions or coordination of the site visits. See Appendix A for a full list of participating organizations.

Rather than prescribe who should attend the needs assessments sessions, a co-design approach was used with the N4 team outlining the goal of the needs assessment and the site visit contact(s) then leading an invitation list for participation. In addition to the attendee list, the N4 team remained flexible to the format of

the proposed visit. At times, there was a single group who were present together. For other organizations, their preference was for multiple meetings with sub-groups or individual sessions. Others preferred a multi-organization meeting so they could include key established partners. Thus the length and structure varied within the needs assessment however the goals remained consistent.

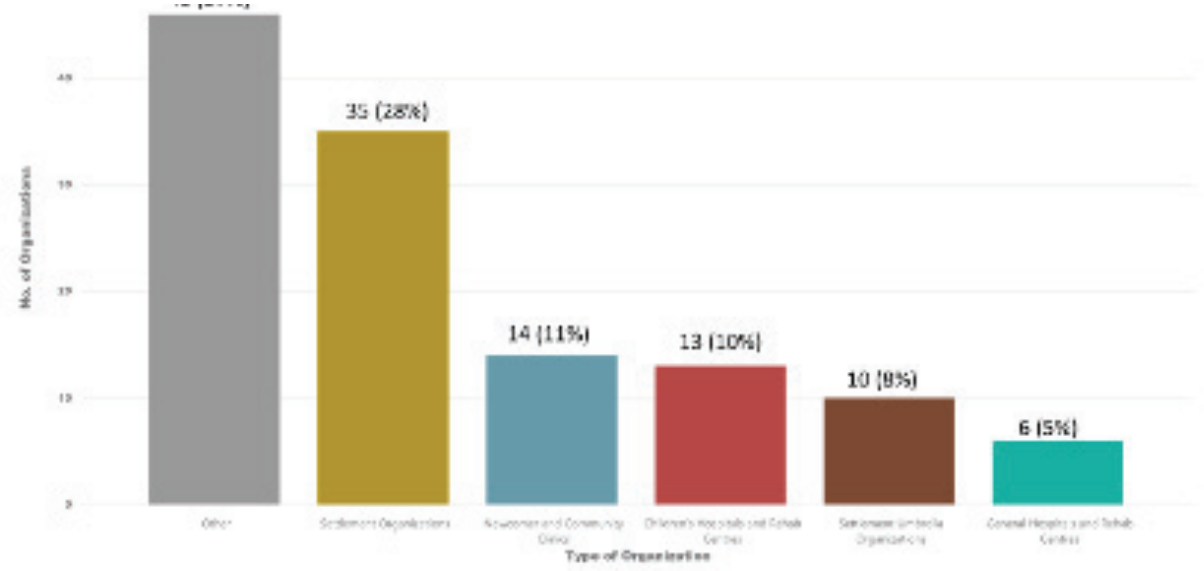
The structure of site visits included: (1) N4 presentation, (2) question and answer period, (3) facilitated discussion using a semi-structured interview guide (Appendix B), and (4) site tour. It should be noted that these needs assessment visits had the additional goal of soliciting potential candidates for the N4 on-line certificate program in newcomer navigation which was co-developed with Saint-Paul University (details can be found at newcomernavigation.ca). A minimum of two N4 team members were present during the site visits to assure that while a presenter from N4 spoke or guided discussions, conversations could be documented for future analysis. Site visits were debriefed between the team members to assure a fulsome capturing of the conversations. The site tours were an appreciated way for the sites to showcase their services in a tangible way. It also allowed the N4 team to gain insight into service delivery models and to further expand the developing partnership with the host organization.

The notes during the site visits were summarized and shared back with the lead staff from the host organization for review and validation. Once validated, and the site visit notes were entered by the N4 team into Nvivo software to assist with a qualitative analysis of the discussions for key theme extraction.

FINDINGS

In all, the N4 team met with 401 stakeholders from 125 organizations during Phase 1 of the needs assessment (Figure 1). Organizations included settlement organizations (direct service providers and umbrella organizations), newcomer and community clinics, children's hospitals, children's rehabilitation centres, and general hospitals across Canada. As word grew about N4, many partners reached out, including, educational partners, local health authorities, arms-length health organizations, and relevant committees/working groups (classified as other).

Figure 1. Phase 1 Meeting Participants by Organization Category



Stakeholders from 28 cities in all ten provinces participated in this needs assessment (Figure 2). Although the province of Quebec was excluded from the formal scope of N4, individual organizations in Quebec reached out and requested information about the intended platform.

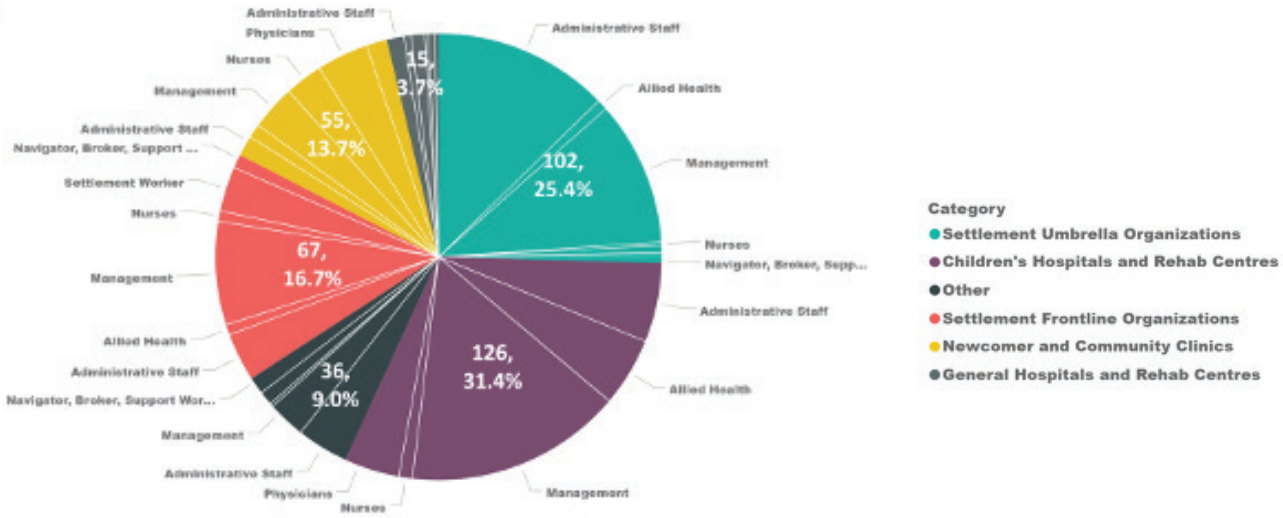
Figure 2. Outreach and Site Visits by City

Legend

Vancouver, BC
Victoria, BC
Burnaby, BC
Edmonton, AB
Calgary, AB
Lloydminster, AB
Moose Jaw, SK
Prince Albert, SK
Regina, SK
Saskatoon, SK
Tisdale, SK
Battleford, SK
Humboldt, SK
Winnipeg, MB
Hamilton, ON
London, ON
Ottawa, ON
Sudbury, ON
Toronto, ON
Montreal, QC
Saint John, NB
Moncton, NB
Fredericton, NB
Charlottetown, PEI
Halifax, NS
Antigonish, NS
St. John's, NL

Over the course of 55 calls and 49 in-person visits, the team spoke with a diverse group of stakeholders. The target audience for outreach was purposefully broad, as many staff are actively involved in supporting newcomers to navigate our health and social service systems. Some of the many staff involved included administrators (e.g. coordinators, administrative assistants, clerks, educators), managers (e.g. program managers, senior-level executives), allied health members (e.g. social workers, dieticians, occupational therapists), nurses, physicians, navigators/cultural brokers, and settlement workers. See Figure 3 for the full breakdown of meeting participants by type and organization category.

Figure 3. Meeting Participants by Type and Organization Category



DIFFERENCES IN GEOGRAPHICAL CONTEXT

Participants shared information about their local community with the N4 team, including client/patient demographic information. Participants listed many languages (e.g. Arabic, Kurmanji, Phillipino, Spanish, Tagalog,) and countries of origins of the newcomer clients they served (e.g. China, Dijbouti, Pakistan, Haiti, Honduras, Iraq, Nigeria), which speaks to the diversity of clientele served and hints at the challenge in meeting clients' needs in a culturally and linguistically appropriate manner. Countries of origin and language varied by city reflecting the diversity of refugee newcomer allocation to cities by federal decision-makers. It was noted that the settlement agencies had this information readily available as it is a data collection point for their agency, whereas healthcare providers were sometimes unsure of this information and no hospitals collected this data point, making service planning more challenging. The immigration status of the newcomers (government sponsored refugees, privately sponsored refugees, refugee claimants, temporary foreign workers, asylum seekers, and economic immigrants) and length of services offered by participating organizations were dependent on each program's funding source, provincial health coverage rules or their organization's need to priorize those deemed most in need of support.

Interesting were differences in newcomer navigation goals by geographical region. For the East coast and prairie provinces, there was a strong desire to retain newcomers to their area, with an emphasis on their local success as feeling welcomed to the community including future employment. For large urban centres such as Toronto, there was less of a focus on a welcoming community and more of a focus on being able to meet their basic needs, with equal support for any choices of secondary migration where cost of living would be more aligned to their quality of life, particularly for refugees whose employment and financial status are more challenging than immigrants.

MODELS OF SERVICES

While consistently a role for the settlement sector, few healthcare organizations saw newcomer navigation as a skill set to designate to roles. Rarely was a staff designated to assist newcomers in navigating through the system as a formal function. More typically, many team members would support their needs alongside what they considered to be their "regular job responsibilities" with no central expertise or collaboration of efforts. Healthcare staff frequently mentioned that newcomer navigation was not a skill or knowledge they had received training about or had a clear source of expertise to consult. Notable within the settlement sector were seven participant organizations who were members of a national case management program, National GAR Case Management - Client Support Services, aimed at helping newcomers to navigate their communities. This program is further explored under the subsection of education materials and resources.

Skill sets sought for frontline workers differed between sectors with settlement emphasizing the diversity of their staff (culture and language) to reflect their community and service delivery experience as secondary which could be taught. There was not however consistency in how service delivery was incorporated into staff on-boarding. The healthcare sector, on the other hand, did not mention diversity as an asset in their human resources, instead focusing exclusively on service delivery experience (clinical expertise) with designated formal training. This resulted in expertise in culture and language proficiency were viewed as expertise to be externally sourced but a lack of consistency in whet. A concrete outcome is that within settlement, newcomers are able to communicate in their maternal language whereas this rarely occurs within healthcare for newcomers who cannot speak an official language, despite both sectors mentioning communication as key to successful service delivery. Most healthcare providers expressed a preference for in-person interpreters, to facilitate comprehension of non-verbal cues. The exception was a preference for telephone interpretation for sensitize topics which have been stigmatized such as mental health issues, particularly when there was a relatively small linguistic community for the client. There was sometimes a lack of understanding in healthcare between a settlement worker language proficiency versus a trained medical interpreter leading to inappropriate requests during visit accompaniment by settlement staff within healthcare.

CHALLENGES IN NEWCOMER NAVIGATION

Access and Use of Interpretative Services

Participants frequently mentioned the challenges associated with access and use of interpretative services within healthcare services by both sectors. Interpretative services were reportedly underutilized in hospital and community clinics. Reasons for underutilization included: perceptions that the services were cumbersome, the time associated with learning and using these services, cost of services, and lack of awareness about these services. Provinces where this was less challenging was that in which the healthcare system had a centralized interpretation system which they funded. One interesting model was a partnership between a hospital and local settlement organization which provided both access to the hospital's internal booking system so that the settlement workers could ensure interpreters were scheduled as needed for clients' medical appointments, to mitigate this challenge.

Provider Refusal to use IFHP Billing and Impact on Access to Health Services

Government sponsored refugees and refugee claimants' healthcare coverage varies by province with most falling under the Interim Federal Health Program (IFHP). Physicians can bill the federal government for services provided to these newcomers, under a fee-for-service model, similar to provincial healthcare plans but with a separate process. Participants reported that in some instances, community providers refused to see IFHP patients, either due to lack of awareness about the extent IFHP's coverage of services, the resources needed to participate in the billing procedure, concerns about the timeliness of reimbursement, or anticipated longer length of appointments for these patients. Participants explained that appointments with these newcomers is known to take longer as medical histories are complex and fragmented, language and cultural barriers exist, and providers may have to wait for the availability of phone interpretation; all contributing to decreased efficiency of their medical practice. Thus, there was strong and consistent anecdotal evidence of a lack of equitable access to primary care across Canada.

Funding and mandate

Participants from settlement organizations, newcomer clinics, and community clinics spoke to the effect that funding had on service provision for newcomers. Many programs operate on non-permanent funding sources (grants and short-term service agreements) and many had multiples funders including federal, provincial, municipal and charities. This impacted their ability to recruit and retain staff due to ever shifting priorities of their funders and their challenges to demonstrate impact to their differing mandates and goals, particularly within the short funding streams necessary to secure ongoing funding. Whereas healthcare has more stable funding from singles sources, they do not have a set budget for newcomer-specific services. In some cases, community clinics had targeted resources for a set number of newcomer patients in their core/ operational budget; however, they acknowledged that there were gaps and long waiting lists.

To further complicate funding challenges, participants expressed concerns and confusion over mandate as it related to meeting newcomers' health needs. To address gaps in services, many settlement organizations have established partnerships to have a healthcare assessment and processes such as accompaniments to client medical appointments, in-house counselling services, and health promotion services. Settlement participants expressed mixed opinions about these services; some felt the programs were necessary and useful, while others expressed concern that it took away from already stretched budgets and should fall under healthcare.

Lack of Inter-sectoral Collaboration

Both healthcare and settlement consistently spoke to the lack of inter-sectoral communication and collaboration. Frequently, the N4 Team was asked to pass key messages between the two sectors during site visits. While some knew of key partners in the other sector as a source of knowledge or for collaboration, most frequently there was a lack of knowledge on how to breakdown siloes in their work with the same newcomers. Some cities have Local Immigration Partnerships (LIPs) however it was rare that hospitals were at these tables to hear and be part of building solutions for newcomers.

SUCCESSES IN NEWCOMER NAVIGATION

Creative Problem Solving

While it was clear that organizations faced incredible challenges in delivering high-quality services to newcomers, they used innovative solutions to address these challenges. One example is the settlement sector recruiting community volunteers to transport patients to medical appointments in areas where public transportation was limited. The creation of rapid-response teams and committees to coordinate services during the peak influx period of Syrian refugees is yet another example of creative and responsive decision-making. A final example is the use of local volunteers to assist newcomers with system navigation, in order to address staffing limitations; the volunteers are trained by the host organization and matched with a newcomer client for a period of 1-2 years.

Increased Awareness of Trauma-Informed Care

Trauma-informed care was frequently mentioned as an area of recent or ongoing focus. For those individuals that had received training in this area, they reported being better able to serve clients and to meet them where they are. Many individuals requested additional resources and educational resources on this topic.

Diversity of Staff

The diversity of staff was a particular strength, mentioned by many settlement organizations. Cultural and linguistic diversity was thought to contribute to the high quality of services provided. Additionally, many staff had lived experience as newcomers and, therefore, could relate to the settlement experiences of their clients.

Multi-Disciplinary Teams & Wrap-Around Services

When asked to reflect on strengths in service provision for newcomers, many stakeholders brought forward the multi-disciplinary nature of their teams. They mentioned the importance of holistic, wrap-around services to support newcomers in their settlement, with particularly intensive supports needed at the onset. For example, a dietician may support clients to make healthy eating choices through education, meal planning, and grocery trips. A psychologist, trained in trauma, may support newcomers to cope with their most pressing challenges that are inhibiting their daily functioning, e.g. fear of fire that is preventing them from cooking with a stove. A health promoter may provide clients with information relevant to the social determinants of health such as grocery shopping, recreation and the importance of social outings. When multi-disciplinary teams were co-located this process was further streamlined, allowing quick and easy referrals and collaborative problem-solving among teams. See Figure 4 for an example of this in practice.

Figure 4. Multi-Disciplinary Team Breakdown. Mosaic Newcomer Clinic, Calgary, AB.

Inclusive environment

A particular strength that N4 observed during our visits was the efforts made to promote an inclusive environment. Some tangible examples of this were welcome signs in many languages, signage to display provincial or federal health insurance information, world maps with pins to indicate clients' country of origin, and pictures depicting the diversity of staff and clients (Figures 5, 6).

Figure 5. Multilingual Welcome Sign - Alberta Children's Hospital, Calgary, AB.

Figure 6. Map Depicting Clients' Countries of Origin – Newcomer Health Clinic, Halifax, NS.

PARTNERSHIPS

Current Partnerships

There was great diversity in the number and type of partner organizations mentioned. These included, among others: academic institutions, community mental health services, dentists, family physicians, local health authorities, interpreters, pharmacies, public health units, specialty services, employment assistance agencies, housing agencies, religious institutions, schools, parent/youth committees, and non-profit organizations. Where newcomer/community clinics were able to be established, their cross-sectoral relationships with settlement organizations were particularly strong. In some cases, they were located in the same or adjacent buildings, facilitating communication between staff and reducing barriers for clients.

Desire for More Cross-Sectoral Relationships

Stakeholders from both sectors voiced a desire to build stronger cross-sectoral relationships. There were some differences observed in rural and urban settings, with rural healthcare organizations having greater awareness of available services for newcomers and stronger relationships with newcomer-serving organizations than urban hospitals. This was felt to be due to the small size of communities and fewer organizations involved, reducing the complexity of this task.

EDUCATIONAL MATERIALS & RESOURCES

Internal Educational Materials for Staff

Trauma-informed care and cultural competency were the most frequently mentioned topic areas as they pertained to internally developed educational materials for staff. Educational materials around cultural competency explored subtopics such as cross-cultural communication, working alongside interpreters, parenting, pain, end-of-life care, and health literacy, among others. Many organizations developed educational materials for staff, as needed, by linking to community partners and organizing for in-person workshops or learning events. Commonly, settlement organizations would partner with medical/dentistry/nursing faculties at local universities to facilitate learning events.

External Educational Materials for Staff

Seven participating organizations were members of the National GAR Case Management - Client Support Services (CSS), a nationwide program providing tailored settlement services and navigational support to government-assisted refugees (GARs), to meet their complex needs.[4] The CSS offering of knowledge mobilization such as standards of practice for intensive case management and a community capacity building toolkit were praised and saw the benefits it brought to clients. They felt similar resources would be useful. Provincial umbrella organizations for settlement develop and make available eLearning materials around diverse topic areas such as cultural competency, managing stress and preventing burnout, mental health, trauma, and supporting an inclusive and respectful environment. Participants from settlement organizations commonly consulted their provincial umbrella organizations for educational materials. Other frequently consulted organizations/resources for staff education include the Centre for Addiction's and Mental Health – Immigrant and Refugee Mental Health Project, the Canadian Paediatric Society - Caring for Kids New to Canada platform, and the Canadian Evidence-Based Guidelines for Newly Arriving Immigrants and Refugees.

Desired Educational Materials for Staff

Participants were keen to have more educational materials pertaining to developing partnerships in the community, ensuring culturally competent workplaces, trauma-informed care, vicarious trauma, and best practices in newcomer navigation across Canada. Most organizations were eager to partner with other providers in their community to support their clients; however, they weren't always sure how to do this most effectively. Many duplications in the development of educational resources on cultural competency existed while other topics remained as gaps. Trauma-informed care was an area where many organizations had developed high quality educational resources, but these were not widely accessible. Both vicarious trauma and best practices in newcomer navigation to support staff development were frequently mentioned as an unmet need.

Desired Resources for Staff

Participants requested specific resources about billing under IFHP, advocating for patients and families, and client-facing handouts in multiple languages. Billing under IFHP generated lots of discussions among healthcare providers. Lack of knowledge about how to bill for IFHP among community providers was a barrier for newcomer patients in accessing primary care. To address this, some administrators at newcomer clinics provided individual coaching on billing with IFHP to community providers. A general tutorial/resource guide to billing with IFHP could alleviate the pressure on individual clinic staff. On a related note, many providers expressed frustration in understanding coverage benefits and limitations for refugees. A quick consultation guide identifying services covered under IFHP could help with this challenge. Where coverage was not sufficient, providers reporting being asked for letters to advocate on behalf of their patients for additional medical supplies. Additionally, they commonly provided letters to support immigration, housing, and income assistance applications. Ready-made letter templates that providers can use to advocate on behalf of patients and families were mentioned as a desired resource. Lastly, N4 observed duplication in the translation of client-facing handouts on common health topics. Health and settlement participants expressed a desire for a "one-stop-shop" for client-facing handouts on common health topics, available in multiple languages, as well as picture-based to support clients with limited literacy.

DATA

Currently Captured Data

As it pertains to data, there were marked differences in the quality and quantity of data collected about newcomer clients. Typically, newcomer clinics and settlement organizations collected more information than hospitals and community clinics. Other organizations (i.e. educational institutions, arms-length government organizations, local health authorities) often conducted their own surveys and research and fed this information back to healthcare and settlement, to inform practice. These findings are explained in greater detail below.

Settlement organizations and newcomer clinics typically collected comprehensive demographic, service utilization, and referral information about clients. Demographic information may include age, gender, language(s), level of education, country of origin, accommodations (e.g. interpretation support, disability), immigration status, and length of stay in Canada. Within hospitals and community clinics, immigration status was infrequently captured, limiting tracking of newcomer patients through the system. In the event that interpretation support was needed, language was captured, and therefore, these patients could be identified. Service utilization and referral information was captured for all patients, however, there was often no way to differentiate the subset of newcomer patients, other than those whose healthcare coverage was through IFHP.

Partnerships with academia allowed for more opportunities to collect, collate, and analyze sociodemographic data. For example, one hospital was involved in a study around complex needs; residents reviewed medical charts to identify patients with complex needs (including language and cultural barriers), and subsequently provided additional supports. Participating academic institutions discussed research with newcomer populations pertained to settlement integration and retention, food security, and complex needs. Arms-length health system organizations, such as the New Brunswick Health Council, offer another method for sociodemographic data collection and analysis. These types of organizations conduct surveys around health system performance and publish reports which inform practice. Participating arms-length health system organizations conducted research in the area of attachment to a family doctor, unmet needs for mental health services, and communication (language and cultural barriers), as they relate to newcomer populations.

Desired Data

Participants from hospitals were interested in collecting more client-specific sociodemographic data, e.g. country of origin, language(s), and years in Canada. They were particularly interested in service utilization data pertaining to use of interpretation services e.g. languages requested – available/unavailable/delayed, time with interpreter, and if this was sufficient to meet needs, no show rates and reason associated, as well as data around safety events associated with language barriers. There was discussion about the potential to flag newcomer status through electronic records and some concern about the ethical implications and unintended harms. From the settlement side, participants discussed how to facilitate information sharing between government bodies, local settlement agencies, and newcomer/community clinics. For example, Immigration, Refugees, and Citizenship Canada (IRCC) completes medical backgrounds of all refugees, however, there is no agreement in place to transfer the complete files to local settlement agencies or primary care clinics. Some local settlement agencies and newcomer clinics established data sharing agreements, in order to streamline referral processes and reduce duplication of paperwork for clients.

As it pertains to information about other organizations, participants from health and settlement were interesting in knowing the type of programs and services provided for newcomer clients, standard length of appointment time for initial assessments with clients/patients, type of data sharing agreements, and whether they had experience if the provision of trauma-informed care.

DISCUSSION & NEXT STEPS

Information presented in this report highlights some of the key barriers and successes in providing care to newcomers across Canada's complex health and socials service systems. It demonstrates that despite the differences in each province's model of care, there are many similarities. In addition to highlighting the status of newcomer navigation, it may serve as a roadmap for future initiatives.

Evident in this report, there were common challenges identified in newcomer navigation work. These included inconsistent use of interpretative services in healthcare, provider refusal to use IFHP billing/see newcomer patients, short-term funding models, and tensions over mandates, which all serve to negatively impact equitable and consistent access to quality services. Ample research documents how insufficient interpretation support for patients reduces the quality of care provided,[5] delays care-seeking [6–8], and increases the risk of adverse health outcomes. [5,8] Provider refusal of newcomer patients results in decreased access to care.[9] Short term funding models are likely to increase staff turnover,[10] and reduce the quality of services; [10,11] this may be heightened in the settlement sector due to the vulnerable populations that staff are working with, and the importance of building trusting relationships. Finally, tensions over mandate may cause confusion and may erode relationships with external partners.[12]

The challenges outlined in this report likely come as no surprise to professionals working in the field, however, the question of how to address these remain. These are complex, system-level challenges that require long-term strategies and policy changes to effect change. The N4 Community of Practice (adapted from the Ottawa CoP Model) offers one venue to address these challenges by forming set groups of multi-disciplinary and corss-sectoral working groups to develop data-driven best practices of policy statements. Ultimately, the N4 CoP topic areas will be decided on by its members. Nonetheless, results from the needs assessment provide an informed starting point for this discussion.

In addition to challenges, this reported highlighted several successes in newcomer navigation. We heard countless examples of ingenuity and creativity in programming, data sharing, and partnership development, among others. Through its Platform, and in varying formats (webinars, conferences, videos, articles and guest blogs), N4 will periodically showcase promising practices in newcomer navigation so that others may learn and build on these experiences.

As evident in this report, there was a clear desire for enhanced cross-sectoral partnerships between healthcare and settlement sectors. The N4 platform has the capacity to support this at the local, provincial, and national levels. The platform offers multiple ways to engage with partners across sectors, including through the discussion board, database, eLearning, and community of practice – all aimed at providing stakeholders with a space to exchange knowledge, data, tools, and resources. Furthermore, the network actively supports collaborative problem-solving and collective action.

N4 observed both duplication and gaps in educational materials for staff. N4 has curated, vetted, and made available a variety of eLearning/resource materials which had already been developed (i.e. modules, webinars, toolkits, tip sheets) on the online platform to encourage future duplication and cross-sectoral sharing. Members can easily search for and find educational materials on any given topic. Where gaps exist, N4 will work with subject matter experts to fill these gaps by creating original content. As it pertains to best practices in newcomer navigation (a requested topic area for educational materials), the CoP model will advance efforts in this area through its proven model.

The findings that data collection varied by organization type are not unsurprising; settlement organizations and newcomer clinics specifically target this populations and therefore, are typically more aware of their needs, and how data can help to understand and meet these needs. It is only in recent years that healthcare has been pushed to collect sociodemographic data to inform the understanding of disparities in access and outcomes. A current example of this is the push to collect sociodemographic data in relation to COVID-19. In areas where organizations have started to collect this information, trends point to newcomers being at higher risk of the virus.[13]

N4 aims to fill some of the gaps in data, by working with organizations to collect and share information across organizations through the database section of the platform. Data shared through the platform will not be client-specific, rather, it will pertain to organizational data such as programs and services provided for newcomer clients, among other items. N4 will also spotlight success stories across Canada, some of which are likely to speak to using data effectively to inform practice. N4 will also work with subject matter experts to develop educational resources pertaining to best practices in data collection, analysis, and sharing for newcomer clients.

CONCLUSION

The outreach and site visits completed to date have provided useful information about the state of newcomer navigation across Canada. N4 has leveraged this information in the development of its online Platform, in order to best meet members' needs. Further outreach and site visits are planned, targeting locations with high numbers of refugees (not already captured in this report) as well as the adult health sector. A future report will highlight additional learnings from those endeavors and further evolve the N4 Platform.

APPENDIX A. PARTICIPATING ORGANIZATIONS

Host Organizations

AAISA (Alberta Association of Immigrant Serving Agencies)
Access Alliance Community Health Centre
Alberta Children's Hospital
Alberta Refugee Health Coalition
AMSSA (Affiliation of Multicultural Societies and Service Agencies)
ANC (Association for New Canadians)
ARAISA (Atlantic Region Association of Immigrant Serving Agencies)
Aurora Family Therapy Centre
British Columbia Children's Hospital
Bridge Care Clinic
CAMH-IRMHP (Centre for Addictions and Mental Health - Immigrant & Refugee Mental Health Project)
CCIS (Calgary Catholic Immigration Services)
CCR (Canadian Council for Refugees)
CHEO (Children's Hospital of Eastern Ontario)
Children's Healthcare Canada
Children's Hospital of Winnipeg
CISSA ACSEI (The Canadian Immigrant Settlement Sector Alliance - Alliance du secteur de l'établissement des immigrants)
COSTI Immigrant Services
CSS (Catholic Social Services Edmonton)
East Edmonton Health Centre
HealthcareCAN
Holland-Bloorview Kids Rehabilitation Hospital
Hôpital Montfort
Immigrant and Migrant Women Association of Halifax
Inter-Cultural Association of Greater Victoria
IRCOM (Immigration & Refugee Community Organization of Manitoba)
IWK Health Centre
ISANS (Immigrant Services Association of Nova Scotia)
Janeway Children's Health and Rehabilitation Centre
Jim Pattison's Children's Hospital
Kliniek on Main
London Health Sciences Centre
MANSO (Manitoba Association of Newcomer Serving Organizations)
McMaster Children's Hospital
Montreal Children's Hospital
Moose Jaw Multicultural Council
MOSAIC BC
Mosaic Family Network Winnipeg
Mosaic Refugee Health Clinic
Mount Carmel Clinic
Multicultural Health Brokers Cooperative
New Brunswick Health Council
Newcomer Health Clinic
NewtoBC
OCASI (Ontario Council of Agencies Serving Immigrants)
OLIP (Ottawa Local Immigration Partnership)
Peace by Chocolate
Prince Edward Island Refugee Health Clinic
REACH Clinic
Regina Community Clinic
Regina Open Doors Society
Saint John Local Immigration Partnership
SAISIA (Saskatchewan Association of Immigrant Serving Agencies)
Sick Kids (The Hospital for Sick Children)
St. Michael's Hospital - Newcomer Clinic
Stollery Children's Hospital
Transcultural Mental Health Consultation Service
University of Manitoba
University of New Brunswick
University of Victoria
Welcome Place (Manitoba Interfaith Immigration Council)
Winnipeg Regional Health Authority
YWCA Hamilton
YWCA Prince Albert

Other Attending Organizations

Battleford Resource Immigration Centre
O' Brien Institute for Public Health, University of Calgary
University of Calgary
Peter Lougheed Centre
Northeast Community Health Centre
University of Alberta
Edmonton Mennonite Centre for Newcomers
Centre de santé Communautaire Hamilton/Niagara
Urban Core Community Health Centre
City of Hamilton
Wesley
YMCA Hamilton
Humboltd Regional Newcomer Centre
Lloydminster LIP
Saskatchewan Polytechnique
Moose Jaw Multicultural Council
CHEO
The Ottawa Hospital
Centretown Community Health Centre
Somerset West Community Health Centre
IRCC
Capital Rainbow Refuge
Carleton University
CESOC
Champlain Local Health Integration Network (LHIN)
City of Ottawa
Decision Support
Government of Canada
Jewish Family Services of Ottawa

Ministry of Tourism, Culture and Sport
Ontario Ministry of Heritage, Sport, Tourism and Culture Industries
Ottawa Birth and Wellness Centre
Ottawa Chinese Community Service Centre
Ottawa Employment Hub
Ottawa Food Bank
Ottawa Public Health
Ottawa Public Health - Health Equity Unit
Ottawa World Skills – Employment Centre
Reseau des Services de Santee n Francais de l'Est de l'Ontario
Rideau-Rockcliffe Community Resource Centre
Service Canada, Employment and Social Development Canada
uOttawa
Western Social Science
Youth Services Bureau of Ottawa
Catholic Centre for Immigrants
OCISO
Ottawa Community Immigrant Services
The Catholic Centre for Immigrants
OLIP
Prince Albert Parkland Health Region
Prince Albert Multicultural Council
Catholic Family Services-Regina
Royal University Hospital
Global Gathering Place
Laurentian University
Northeast Newcomer Services
Women's Hospital Winnipeg
Society for Manitobans with Disabilities
West Central Women's Centre
A&O
Family Dynamics
NEEDS
Neighbourhood Immigrant Settlement Workers
New Journey Housing

APPENDIX B. SEMI-STRUCTURED INTERVIEW GUIDE

Interview/Focus Group:

Question Route for Targeted Conversation with Managers and Staff Working with Newcomers

Local Context

- What are the top languages and countries of origin of your newcomer clients/patients?

Partnerships

- Describe any partnerships that you have within the hospital that support this work (internal).
- Describe any partnerships that you have outside of the hospital that support this work (external).

Newcomer Navigation work

- What is working well in your role?
- What are some challenges in your role?
- What are the major challenges that newcomers are facing? (e.g. finding housing, transportation, trauma, etc.)

Education

- Describe any training or education you/your staff have received to support newcomers.
- Describe any additional training or education that you feel would be beneficial for you/your staff in their work with newcomers.
- What topics are most relevant for education?
- Are you currently engaged in other learning on this topic?
- If so, where? Through which organization?
- What do you think are key learnings for the other sector (i.e. settlement/healthcare)?

Data

- What data do you currently collect around newcomer clients/patients?
- What data would you like to know about newcomer clients/patients?
- What comparative data from other sites would be helpful to have?

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