Supporting Communities Together:

Exploring Nav-CARE Volunteers and Community Connectors in Action.

Webinar Insights

Across the globe, organisations are working tirelessly to support individuals facing declining health and increasing social needs. As populations age and health systems strain under rising demand, the importance of addressing the social determinants of health, alongside medical issues, has never been more urgent.

A growing body of evidence highlights the profound benefits of tackling social factors such as isolation, food and income insecurity, and access to community resources. It has been shown that the outcomes of such action include improved well-being, enhanced health outcomes, and reduced costs for the healthcare system.

In response to this need, two innovative community-based programs – Nav-CARE and Social Prescribing (Community Connectors) – are making huge strides. They offer compassionate, person-centred approaches that empower individuals and strengthen communities.

This document captures the main insights from the webinar. It is intended as a resource for organizations and individuals exploring the adoption, integration, and/or adaptation of either or both programs in their own context.

Webinar Panelists:

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	Nav-CARE	Social Prescribing (Community Connectors)
1. Background and Goals	Nav-CARE (Navigation: Connecting, Advocating, Resourcing, Engaging) is an evidence-based program that provides, experienced, trained, and mentored volunteers who work with persons living with declining health, and their care partners, to improve their quality of life and enable them to age in place at home or in a home-like setting (e.g., long-term care). Developed through research led by the University of British Columbia – Okanagan and the University of Alberta, it helps persons and their families access resources and services in their community, while providing companionship and emotional support.	Grounded in the social prescribing model, Community Connectors focus on addressing the social determinants of health and improving well-being by coordinating access to community resources for vulnerable, older persons. Community Connectors are a paid professional who are based within local community agencies. As well as working with persons in the community, over a third of their time is spent building community networks and strengthening the relationship between the community-based seniors' services (CBSS) sector, healthcare providers, and local government services.

2. Program Delivery	The Nav-CARE program is typically delivered through community-based organizations such as hospice societies and organizations that have volunteers serving older persons and/or those with declining health. There are also some partnerships with health authorities and municipalities. The host organization has a volunteer coordinator who manages the delivery of the program, oversees referrals, training, and ongoing volunteer mentorship, and support. A Persons Journey: • The Volunteer Coordinator receives a referral. • Initial contact made and initial visit conducted with Volunteer Coordinator. • Volunteer navigator and persons matched. • Volunteer navigator and Volunteer Coordinator conduct a joint in-person visit. • Volunteer navigator conducts regular visits. The relationship is on-going (Long-term). The Volunteer navigator attends regular mentoring sessions/ has regular check-in's with the Volunteer Coordinator. If the Volunteer Navigator identifies any concerns during visits, they notify the Volunteer Coordinator or emergency services accordingly.	Community Connectors typically work within local community agencies such as multiservice nonprofits, senior centres, community centres, neighbourhood houses, etc. A Community Connector manages their own caseload but will work and liaise with other individuals and/or programs. A Persons Journey: • • The Community Connector receives a referral and reviews the person's needs and goals. • • Initial contact is made, and the Connector meets with the participant to build rapport and co-develop a personalized wellness plan based on their interests, strengths, and priorities. • • The Community Connector stays connected with the participant for approximately 6–8 weeks, offering guidance, encouragement, and support as the plan evolves. • • Together, they reflect on progress and next steps. The participant may transition out of the program or re-enter later if additional support is needed.

3. Key Roles	Volunteer navigators build trusting relationships with persons, help identify needs and goals, connect them to resources, and advocate on their behalf. They offer long-term emotional support and companionship, acting as a bridge between persons and community services often until the end of life.	Community Connectors assess individual needs, identify appropriate community resources, and support individuals in accessing those resources. Trusting relationships are formed but the relationship is time-limited (Short-term) to empower seniors to build confidence in navigating resources and to continue engaging with their communities independently. In addition, they help to build and develop community partnerships and networks between the CBSS sector, healthcare providers, and local government services.
4. Caseload and Duration of Support	Volunteer Navigators typically support 1-2 persons at a time depending on their availability. They provide long-term, on-ongoing support that is tailored to the persons needs. Relationships may last several months to years, depending on health status and goals.	Community Connectors serve up to 200 participants.. Variations in caseload exist due to size of community being served, complexity of participants, etc. Support is generally short- to medium- term (a few weeks to a couple of months) although persons can re-connect/re-refer if they need further support.
5. Compensation	The navigation role is voluntary and not compensated, although some organization may offer reimbursements for expenses. Organizations do however require a Volunteer/Program Coordinator to facilitate the program.	A Community Connector is a paid position.
6. Program charges	Nav-CARE is free at the point of delivery.	The Community Connector program is free at the point of delivery.

7. Target Population and Referral Process	Nav-CARE supports persons and their care partners with chronic illness, frailty, or declining health who may be socially isolated or need help accessing services. These persons may be living at home, in assisted living, or in long-term care. Referrals come from health and social care providers, community organizations, friends and family or persons can self-referral.	United Way BC Healthy Aging programs focus on serving four priority populations of seniors: low to modest income seniors, seniors who are socially isolated/lonely, seniors with low to moderate frailty, and seniors from underserved populations. Community Connectors support community dwelling older persons experiencing health and well-being challenges related to complex social, economic, and cultural factors. These could include: loneliness/isolation, physically frail or inactive, skipping medication due to financial constraints, lacking nutritious food due to income or mobility, without formal support systems, living in unsafe housing, frequently visiting the doctor or emergency room. Referrals typically come from health and social care providers (e.g., home health, hospital acute care teams, primary care, community agencies) although persons can also self-refer.
	If both programs are available in the community, referral decisions often depend on complexity. Community Connectors may handle complex cases initially, afterwhich, Nav-CARE volunteers can provide more long-term support.	

8. Training	The Nav-CARE competency-based training is available in both English and French. It consists of 7 online interactive modules that volunteer navigators complete at their own pace. The training typically takes around 6 hours. Module 1: Becoming a Nav-CARE volunteer Module 2: Addressing quality-of-life concerns Module 3: Creating community connections Module 4: Advocating with persons and families Module 5: Promoting active engagement Module 6: Facilitating virtual navigation Module 7: Supporting persons living with dementia Nav-CARE organisations also provide continuous learning opportunities so that navigators continue to grow in their role. If you are interested in the Nav-CARE program and the associated training, please send an email to nav.care@ubc.ca or connect with the Nav-CARE team through the website www.nav-care.ca.	The Community Connector training comprises two online, self-paced elements. Part 1 (approximately 2 hours) covers the foundational aspects of being a Community Connector and Part 2 (approximately ½ hour) aims to further enhance capabilities of the Community Connectors. Part 1 Module 1: Introduction to Social Prescribing Module 2: Community Connector Functions and Ecosystem Module 3: Community Asset Mapping Module 4: Essential Skills for Creating Connections and Building Relationships Module 5: Steps to Support Older Adults through Social Prescribing Module 6: Supporting Your Well-Being Module 7: Monitoring and Evaluation Module 8: Healthy Aging CORE BC and Joining Communities of Practice Part 2 Module 1: Equity-based Approaches to Care Module 2: AVOID Frailty for Healthy Aging The Community Connector training is designed for Community Connectors and those supporting them although it is available publicly: United Way BC - Healthy Aging - Community Connector Training

9. Integration with Existing Programs	The Nav-CARE program complements other programs in the community. By building strong networks between organizations and their programs, referrals between programs (inc. the Community Connectors program if available) can take place. If an organization already employs a Volunteer Coordinator, the coordinator can take on Nav-CARE responsibilities if they have capacity. As it requires specific training, and the need to provide ongoing support, mentorship, and training for volunteers, some organizations may prefer to designate a separate coordinator.	Social Prescribing programs complement other programs in the community. They are a cornerstone of Healthy Aging Community Collaboratives – groups of local agencies and programs that work together in an ongoing, intentional way to strengthen support for seniors in their community. By building strong networks between organizations and their programs, referrals between programs (inc. Nav-CARE if available) can take place. Community Connectors do not typically take on additional roles but liaise closely with other programs.
10. Funding	There is no specific funding for Nav-CARE. In the past, federal grants and research funding has been secured by the University of British Columbia – Okanagan for the program, however, now, the program is funded through the partner organization. As these are typically not-for-profit organization, funding comes from local government, donations, and in-kind support.	United Way BC's Social Prescribing programs are funded by the Province of BC.
11. Resources and Connection	Learn about Nav-CARE: If you are interested in learning more about the Nav-CARE program and the associated training visit the Nav-CARE website: www.nav-care.ca. Nav-CARE training and program: If you are interested in the Nav-CARE training and implementing the Nav-CARE program, please send an email to nav.care@ubc.ca or connect through the website www.nav-care.ca.	Community Connector training: The Community Connector training is designed for Community Connectors and those supporting them although it is available publicly: United Way BC - Healthy Aging - Community Connector Training The Social Prescribing Implementation Guide: The Guide is a public resource for anyone interested in learning about Social Prescribing in BC: Social Prescribing – Implementation Guide

Additional Audience Questions

How does the Community Connector role differ from social workers?

Community Connectors are compassionate professionals equipped with a diverse set of skills and attributes. While typically there are no specific educational requirements to become a Community Connector, Connectors must have strong knowledge of issues and challenges that seniors face in relation to healthy aging, experience supporting or working with older adults with different backgrounds, and knowledge of their community's resources, supports, and programs relevant to seniors. Some Community Connectors may be social workers, but others have a background in nursing, non-profit sector, gerontology, etc.

What's the website for social prescribing?

There is no specific website for social prescribing. You can access general information and resources for all United Way BC Healthy Aging programs here: https://uwbc.ca/our-work/#seniors

Are the Community Connectors involved in the Better at Home program?

These are two separate programs, so the Community Connector is not an employee working for the Better at Home program. However, Community Connectors are expected to work collaboratively with Better at Home, other Healthy Aging funded programs, local community resources, etc., to facilitate referrals and support for older adults. In some communities, the same agency will host both the Better at Home and Social Prescribing programs, though in other communities they are hosted by different agencies.