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Navigating Together: Empowering refugee and immigrant youth with special health care needs

Submission date
29/11/2025

Recruitment status
Recruiting

Registration date
28/01/2026

Overall study status
Ongoing

Last Edited
23/02/2026

Condition category
Other

[X] Prospectively registered
[_] Protocol
[_] Statistical analysis plan
[_] Results
[_] Individual participant data
[X] Record updated in last year

Plain English summary of protocol
Background and study aims
Youth with special healthcare needs often face complex challenges when transitioning from pediatric to adult healthcare services, and migrant youth experience additional barriers to care. This study aims to evaluate whether a co-designed patient navigator intervention can support migrant youth and their families during this transition by improving transition readiness, care coordination, family empowerment, and access to culturally safe care, while decreasing health-related family stress.

Who can participate?
Primary caregiver of youth 14-18 years old who is:
1) First- or second-generation migrant (defined as born outside of Canada or having parents born elsewhere, respectively). Migrants include immigrants, resettled refugees, refugee claimants (asylum-seekers), temporary workers or international students, and other individuals without formal immigration status (undocumented).
2) Youth with special healthcare needs aged 14-18 as defined by the CYSHCN Screener©, which identifies children who are experiencing one or more functional limitation or service use due to a physical, emotional, behavioural, developmental, or other health condition that has lasted or is expected to last at least 12 months
3) Followed by at least one pediatric care service expected to continue into adult care
4) Caregiver living in Canada <15 years

What does the study involve?
Participants will receive support from a patient navigator for 12 months, including individualized transition planning, care coordination, and culturally safe guidance. The navigator will contact families regularly (every 2–4 weeks initially, then every 3 months) via in-person visits, phone, video, text, or email. Participants will complete questionnaires at baseline, 6 months, and 12 months on transition readiness, care coordination, quality of life, and satisfaction. A subset of parents may be asked to take part in two interviews (at 6 and 12 months) about their experiences.

What are the possible benefits and risks of participating?
Risks:

Participation may involve answering personal questions about healthcare experiences and feelings of stress, which could cause emotional discomfort. Completing questionnaires and interviews may also be time-consuming. There may be other unforeseen risks. Participants may skip any question or withdraw at any time without providing a reason. If distress occurs, the research team will offer support and refer participants to appropriate resources. There may be other unforeseen risks.

Benefits:
Participants may experience reduced barriers during the transition to adult care and receive personalized support from a patient navigator. While personal benefit cannot be guaranteed, the study aims to improve transition processes for migrant youth with special healthcare needs and their families.

Where is the study run from?
The study will run from Montreal, Quebec, primarily at the Montreal Children's Hospital.

When is the study starting and how long is it expected to run for?
The study is expected to start on January 15 and will run for approximately 24 months, including recruitment, intervention delivery, and evaluation.

Who is funding the study?
TD Canada Trust Ready Commitment Grant.

Who is the main contact?
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Contact information

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Study information

Scientific Title
Evaluating the implementation and impact of a co-designed patient navigator intervention for migrant youth with special healthcare needs transitioning to adult care

Acronym
MiNav-Ado

Study objectives
To evaluate the implementation and impact of a co-designed patient navigator intervention for migrant youth with special healthcare needs transitioning from pediatric to adult care, using a mixed-methods design guided by RE-AIM to assess transition readiness, family experiences, and implementation outcomes at individual and setting levels

Ethics approval required
Ethics approval required

Ethics approval(s)
notYetSubmitted

Primary study design
Interventional

Allocation
N/A: single arm study

Masking
Open (masking not used)

Control
Uncontrolled

Assignment
Single

Purpose
Health services research

Study type(s)

Health condition(s) or problem(s) studied
Transition from pediatric to adult healthcare for migrant youth with special and/or chronic healthcare needs (e.g. asthma, diabetes, sickle cell disease, cerebral palsy, and developmental and behavioural disorders)

Interventions
Participants will receive a 12-month transition-focused Patient Navigator (PN) intervention. The PN is a full-time professional with training in trauma-informed care, cultural safety, systems navigation, care coordination, and communication skills. The intervention includes: (1) assessment of transition readiness at multiple time points (baseline, 6 months and 12 months); (2) tailored information and support; (3) co-created individualized transition plans; (4) care coordination; (5) introduction to adult services; and (6) support through transfer completion for youth aging out during the study. The PN will contact participants within 7 days of consent, then every 2–4 weeks for the first 3 months, every 3 months thereafter, and as needed. Contacts will occur in person (prioritized for first visit), or via video, phone, SMS, or email. All interactions will be tailored to participant needs and documented in a care plan. An interpreter will used for participants who require language support during interactions.

Intervention Type
Behavioural

Primary outcome(s)
1. Transition Readiness measured using Transition Readiness Assessment Questionnaire 6.0 (TRAQ 6.0) at baseline, 6 months and 12 months

Key secondary outcome(s))
1. Effective care coordination measured using 6 questions from the National Survey on CSHCN at baseline, 6 months and 12 months

2. Youth health related quality of life measured using PROMIS Pediatric Global Health 7 (PGH-7) sub-items at baseline, 6 months and 12 months

3. Perceived family stress measured using a Distress Thermometer at baseline, 6 months and 12 months

4. Family empowerment measured using the Parental Empowerment Scale - 12 item "Service System" subscale at baseline, 6 months and 12 months

5. Successful transition measured using a self-reported item asking youth or caregivers if the youth has had at least one appointment with an adult healthcare provider at baseline, 6 months and 12 months

6. Patient satisfaction with patient navigator measured using the Patient Satisfaction with Interpersonal Relationships with Navigators (PSN-I) at 6 and 12 months

7. Reach measured using : 1) tracking the total number of eligible participants from the multicultural clinic records; 2) collecting demographic data (e.g. age, gender, migration status, diagnosis etc.); 3) documenting reasons for participation or non-participation at baseline (upon consent) and monitored continuously throughout the recruitment period

8. Implementation measured using Fidelity checklists, implementation cost tracking, and tracking any adaptations to the protocol and materials at multiple time points; ongoing throughout the study

9. Stakeholder perceptions on reach, effectiveness, adoption, implementation and maintenance on intervention measured using semi-structured qualitative interviews at 6 and 12 months

Completion date
15/01/2028

Eligibility

Key inclusion criteria
1. Primary Caregiver of youth 14 to 18 who is First- or second-generation migrant, defined as born outside of Canada or having parents born elsewhere, respectively. Migrants include immigrants, resettled refugees, refugee claimants (asylum-seekers), temporary workers or international students, and other individuals without formal immigration status (undocumented)
2. Youth with special healthcare needs aged 14-18 as defined by the CYSHCN Screener©, which identifies children who are experiencing one or more functional limitation or service use due to a physical, emotional, behavioural, developmental, or other health condition that has lasted or is expected to last at least 12 months
3. Followed by at least one pediatric care service expected to continue into adult care
4. Caregiver living in Canada <15 years

Healthy volunteers allowed
No

Age group
Mixed

Lower age limit
14 years

Upper age limit
18 years

Sex
All

Total final enrolment
0

Key exclusion criteria
1. Caregiver who lived in Canada for over 15 years.

Date of first enrolment
01/04/2026

Date of final enrolment
15/07/2027

Locations

Countries of recruitment
Canada

Sponsor information

Organisation
McGill University Health Centre

ROR
https://ror.org/04cpxjv19

Funder(s)

Funder type

Funder Name
TD Bank Group

Results and Publications

Individual participant data (IPD) sharing plan

IPD sharing plan summary

Not expected to be made available