



Dancing in Both Worlds

A Review of the
Aboriginal Patient
Liaison/Navigation
Program in British
Columbia.

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With gratitude,
Deepthi Jayatilaka
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Notes and Abbreviations

First Nations, Inuit and Métis peoples are collectively referred to as Indigenous peoples in this report – except when referring to “Aboriginal Patient Liaison/Navigation Programs,” or “Aboriginal Health Programs.”

APL/N:	Aboriginal Patient Liaison/Navigator (person) or the Aboriginal Patient Liaison/Navigator program
BC:	British Columbia
CHBC:	Child Health BC
CHN:	Community Health Nurse
CHR:	Community Health Representative
FH:	Fraser Health (Authority)
FNHA:	First Nations Health Authority
HA:	Health Authority
HCC:	Home and Community Care
HCN:	Home Care Nurse
HSIF:	Health Services Innovation Fund
IH:	Interior Health (Authority)
ISH:	Island Health (Vancouver Island Health Authority)
NH:	Northern Health (Authority)
PHSA:	Provincial Health Services Authority
PN:	Patient Navigation/Navigator
RHA:	Regional Health Authority
VCH:	Vancouver Coastal Health (Authority)

Executive Summary

Introduction

The six health authorities that govern the planning and delivery of the full continuum of healthcare in British Columbia (BC) have expressed commitments to patient centered care ([Appendix 2](#)). Patient centered care is an approach that respectfully and meaningfully involves patients in their healthcare decisions and journey. Patients who are active participants in their care have been shown to have improved health outcomes (Ngo-Metzger et.al., 2006.). However, there are statistically significant health disparities between BC's Indigenous peoples and other British Columbians. A key reason for this disparity is the barriers they encounter in accessing the healthcare system (Health Council of Canada, 2013). "Culturally competent healthcare builds trust, increasing the likelihood that Aboriginal people will go for care and stay with their treatment" (Health Council of Canada, 2013).

Programs that help patients to navigate the healthcare system as well as the cross-cultural clinical encounter are a strategy for achieving culturally competent healthcare (Betancourt et. al., 2002). In BC, all six health authorities have Aboriginal Patient Liaison/Navigator (APL/N) programs that aim to improve Indigenous peoples' access to healthcare. There is interest among these health authorities to assess the efficacy of the program and explore strategies for enhancing and, perhaps, expanding the program. The First Nations Health Authority (FNHA), a newly created seventh health authority in BC, has the mandate to collaborate with all levels of government to reform the way health care is delivered to BC's First Nations peoples. The FNHA and the Aboriginal Health Program of the Provincial Health Services Authority (PHSA) have commissioned an in-depth review of the program. This report provides what was learned in the review.

The Need

Patients and family respondents, APL/Ns and healthcare providers identified a range of issues that impact Indigenous peoples' access to healthcare. Fear and mistrust of government institutions resulting from ongoing colonization and institutional abuse; racism and negative stereotyping experienced within the healthcare system; miscommunication resulting from language and cultural barriers; dissonance between a euro-centric, fast paced and task oriented healthcare system and Indigenous world view, culture and practices; distance to healthcare and lack of resources for accessing healthcare at a distance are the key issues that prevent Indigenous peoples from accessing the healthcare they need.

The BC Program

Patient Navigation (PN) has been introduced as a healthcare intervention to reduce barriers that patients' encounter in accessing healthcare services (Koh et. al., 2010). The APL/N program in BC dates back to about 1986 and aims to improve the healthcare experience of

Indigenous patients within the hospital system. Today there are 49 APL/N positions across the six health authorities.

Cultivating a relationship between Indigenous patients and their healthcare providers and ensuring the cultural safety of the clinical encounter is the main role of an APL/N. They facilitate communication between patient/family and healthcare providers; provide emotional support to patients/families; advocate on behalf of patients; facilitate and/or provide practical support; facilitate spiritual care; facilitate cross cultural competence with healthcare colleagues; liaise with Indigenous communities and community organizations; document the services provided and promote the program.

Program Strengths

The APL/N program supports Indigenous patients who have previously experienced system barriers and system failures in healthcare to navigate the care system. While assisting individual patients, the program also enhances healthcare providers' capacity to provide patient centered care to Indigenous peoples. Patients and healthcare providers said that:

- Indigenous patients are comforted when they see a familiar and friendly Indigenous face, often the only Indigenous staff they will encounter at the hospital.
- APL/Ns improved communication and helped to build trust between the patient and healthcare provider.
- APL/Ns helped to bring cultural safety to the bedside, facilitating a better understanding of a patient's social circumstances and issues and barriers to care.
- APL/Ns helped to cultivate a relationship between the community and the hospital.
- APLNs have promoted an understanding of the importance of end of life protocols and death that is so important and experienced differently in Indigenous cultures.
- APL/Ns play an important role in assisting healthcare providers to learn about Indigenous history, culture and tradition; building their capacity to better serve Indigenous patients.
- Better communication, coordination of services and discharge planning resulted in greater adherence to treatment plans and reduced re-admissions to hospital.

This is the contribution that the APL/N program makes to healthcare in BC.

Program Challenges

BC's APL/N program has had an organic evolution that has resulted in inconsistencies in how each APL/N position is organized, supported and functions, even within a single health authority. APL/Ns identified a range of issues that impact their ability to serve Indigenous patients optimally. These include:

- Inadequacy of orientation to the position received at the time of hire,
- Quantity and quality of supervision received by some APL/Ns,
- Unequal workloads among APL/Ns (even within the same health authority),
- Lack of APL/N coverage on evenings and weekends (One APL/N per hospital works Monday to Friday during the day),
- Challenges in asserting the unique and value added role of APL/Ns, resulting in improper use of their role by some healthcare providers,

- Difficulty setting boundaries, particularly in situations where APL/Ns encounter prejudice and racism by their healthcare colleagues,
- Personal and professional trauma experienced by APL/Ns from their daily encounters with critical illness, injury and death and dying,
- Health authority policies on privacy and confidentiality that hinder access to information by APL/Ns and communication between hospital, external agencies and communities,
- Systemic issues that are repeatedly addressed at the individual level. (E.g. Lack of budget to pay for interpretation; scarce or non-existent services for urban Indigenous and Métis patients; lack of services and resources for the transient, homeless and repeat users of the Emergency Unit; lack of dedicated spiritual spaces etc.),
- Time and capacity for patient charting and other record keeping.

Enhancing the BC Program - Suggestions

Currently, all APL/N positions are funded by the six health authorities as a strategy for improving access to and the quality of care received by Indigenous patients at the acute care end of the healthcare continuum. To further strengthen the program's capacity to:

- promote a culturally safe clinical encounter between Indigenous patients and, primarily, healthcare providers in hospitals;
- facilitate seamlessness of services along the healthcare journey from home to hospital to home; and
- ensure that Indigenous peoples receive optimum, patient centered care; the following suggestions are proposed to enhance the cohesiveness, effectiveness, success and eminence of the APL/N program in BC.

Position Focused Strategies

Action	Lead Responsibility
Embed the APL/N role within a multidisciplinary healthcare team. Emphasize that the role's primary function is to support Indigenous patients to navigate the hospital system. Base the position at hospitals reaching out to community (as required).	RHA Aboriginal Health Programs
Negotiate with relevant stakeholders to ensure APL/N supervision provided by the lead of the multidisciplinary healthcare team. Underscore the "value added" nature of the APL/N role and develop guidelines, protocols and accountabilities for the position – vis-à-vis how the position works with other disciplines on the team.	RHA Aboriginal Health Programs working with Hospital Administrators
Provide comprehensive orientation to the role for new hires (on hospital policies and procedure, introduction to key hospital staff as well as the full range of administrative requirements, access to information such as emergency procedures, flow charts, maps or who to go to for particular information, and provide opportunity to observe a PL/N functioning in their role, opportunity to learn the required medical terminology and provide information and guidance on relevant meetings within the hospital and in the community). (See ICAP Resource Kit in Appendix 12).	RHA Aboriginal Health Programs

Ensure adequate supervision is provided to the position, especially on negotiating roles and responsibilities with other health disciplines as well as responding to community demands. Assist in clarifying appropriate boundaries for the position.	RHA Aboriginal Health Programs
Provide professional development opportunities to cultivate required competencies, especially related to negotiating boundaries (See <i>Harold P. Freeman Patient Navigation Institute in Appendix 12</i>) and career progression.	RHA Aboriginal Health Programs
Develop regional and/or provincial networks/communities of practice for APL/Ns to link with others, provide de-briefing opportunities, problem solve, share promising practices; cultivate leadership capacities, undertake professional development activities and be acknowledged for the valuable and credible role they play in the healthcare system. Consider re-focusing PHSA's current coordinating function in this direction.	PHSA Aboriginal Health Program and FNHA in collaboration with RHA Aboriginal Health Programs

Supervision Focused Strategies* (See *ICAP Resource Kit in Appendix 12*).

Action	Lead Responsibility
Support supervisors to understand the vision and priorities of the APL/N program and role.	RHA Aboriginal Health Programs
Develop strategies and standards to help operationalize that role.	RHA Aboriginal Health Programs
Support supervisors to cultivate skills and competencies to supervise across cultures.	RHA Aboriginal Health Programs
Connect supervisors to new initiatives and changing landscapes that impact Indigenous health (e.g. Provide information to and involve supervisors in events related to the evolution of the FNHA).	RHA Aboriginal Health Programs
Connect and support supervisors to participate in community initiatives and assume some of the community liaising responsibilities from APL/Ns (such as serving on committees). This could also diversify healthcare representation in the community.	RHA Aboriginal Health Programs
Develop a forum, even a virtual one, for supervisors to connect with other supervisors of APL/Ns (within RHA or across the province) to share successes, problem solve and learn from each other.	RHA Aboriginal Health Programs or PHSA Aboriginal Health Program (if the forum will be provincial).

* These recommendations are primarily aimed at supervisors of multi-disciplinary teams.

Program Focused Strategies

Action	Lead Responsibility
Promote the program at all levels of the organization.	RHA Aboriginal Health Programs
Cultivate Executive and Senior Management interest and buy-in in the program.	RHA Aboriginal Health Programs
Collect data to demonstrate need for and value of program.	RHA Aboriginal Health Programs working with Performance Management
Ensure there are adequate numbers of APL/N positions – especially in regional/tertiary hospitals.	PHSA Aboriginal Health Program collaborating with RHA Aboriginal Health Programs and Hospital Administrators
Establish transfer and communication protocols for transfer of Indigenous patients among hospitals.	RHA Aboriginal Health Programs working with Hospital Administrators
Create community patient navigator positions and or engage other hospital/health authority staff to pick up gaps created by APL/N focusing work within hospital.	PHSA Aboriginal Health Program collaborating with RHA Aboriginal Health Programs and Hospital Administrators
Provide funding for interpretation and Elder/spiritual services.	PHSA Aboriginal Health Program collaborating with RHA Aboriginal Health Programs and Hospital Administrators
Provide in-service to all discharge planners and connect them to healthcare personnel in Indigenous communities that feed into the hospital.	RHA Aboriginal Health Programs working with Hospital Administrators and FNHA
Conduct audits of re-admissions of Indigenous patients to understand reasons for re-admission; Use the Patient Safety Tracking System to track treatment outcomes of Indigenous patients with complex care needs.	RHA Aboriginal Health Program working with Administrators and FNHA

Organizational Strategies

Action	Lead Responsibility
Where appropriate and possible, provide services closer to home (e.g. Telehealth, Mobile Medical Unit, Mobile screening etc.).	RHAs working with PHSA and FNHA
Create welcoming physical environment within the hospital (with Indigenous art from the local area, Information in local language/s etc.)	RHA Aboriginal Health Programs working with Hospital Administrators
Ensure that frontline administrative staff provides welcoming reception.	RHA Administrators

Provincial Strategies

Action	Lead Responsibility
Build on regional health authority successes to develop provincial standards and common approaches for the APL/N program (on purpose, scope, role, competencies, orientation etc.) that can be localized; to enhance the consistency of the program within and among health authorities and minimize duplication of effort.	PHSA Aboriginal Health Program and FNHA collaborating with RHA Aboriginal Health Programs
Identify data needs and develop common criteria and tools for consistent data collection, analysis, interpretation and reporting.	PHSA Aboriginal Health Program and FNHA collaborating with RHA Aboriginal Health Programs and health authority surveillance programs.
Develop a framework and mechanism for ongoing outcome evaluation.	PHSA Aboriginal Health Program and FNHA collaborating with RHA Aboriginal Health Programs and health authority surveillance programs.
Clarify and adapt privacy/confidentiality policies to improve communication between health authorities and community based agencies.	PHSA Aboriginal Health Program and FNHA collaborating with RHA Aboriginal Health Programs.
Clarify roles, responsibilities and process for resolving patient complaints.	PHSA Aboriginal Health Program and FNHA collaborating with RHA Aboriginal Health Programs.
Enhance ICC training with strategies, resources and tools that APL/Ns can localize, to, in a consistent manner, support the integration of the ICC learning into practice.	PHSA Aboriginal Health Program collaborating with RHA Aboriginal Health Programs
Develop a structure/mechanism similar to the <i>Secretariat for Directors of Health</i> to seek APL/N input into FNHA decision making.	FNHA
Augment community based health literacy efforts with advocacy skills to empower patients and their families to ask questions, speak up and demand the care they deserve.	FNHA

Develop a comprehensive, updatable, electronic directory of information, services and resources available on Indigenous communities (services available, roles and responsibilities of personnel/positions etc.) that can be accessed by all hospitals across the province.	FNHA
Establish an avenue such as a 1-800 number that Indigenous patients can call to consult with APL/N (on navigating health care system and medical information/terminology) as not all hospitals and doctor's offices have an APL/N).	FNHA
Cultivate connections and working relationships between healthcare staff in Indigenous communities and relevant acute care staff (e.g. discharge planning staff) in hospitals.	FNHA
Clarify eligibility and coverage; streamline access to; and integrate an Indigenous lens into the decision-making of Health Benefits.	FNHA
Where possible, develop on reserve/closer to home Long Term Care for the elderly and disabled.	FNHA collaborating with relevant stakeholders.
Create an "Ombudsman" role/office that can augment health authority complaints resolution processes.	FNHA

Concluding Remarks

The APL/N program provides an important strategy for building a culturally competent organization and helps health authorities to realize their commitment to patient centered care toward Indigenous peoples. To further these organizational aspirations, the APL/N program could be purposefully positioned as an important strategy for achieving a culturally competent healthcare institution. This could begin with all seven health authorities making explicit linkages and messaging on how the APL/N program meets their respective health authority's strategic plans and priorities.

The FNHA, with a mandate to improve the health outcomes of Indigenous peoples and responsibility for the Health Services Innovation Fund (HSIF) would have a vested interest in the APL/N program to drive the program enhancement agenda forward. They can continue to support PHSA's Aboriginal Health program to leverage its provincial role and collaborate with regional health authorities to develop a provincial identity for the APL/N program – consistent in what it does across the province yet flexible in how it is implemented at the regional and local level. This work could begin with the seven health authorities collaborating to set provincial standards for the program on purpose, goals, objectives, scope, role, and expected outcomes that could inform the development of guidelines, protocols and accountabilities for the position at a regional and local level.

It is hoped that the suggested enhancements to the APL/N program proposed in this report will strengthen and expand the program; which in turn could increase and improve Indigenous peoples' access to timely and quality healthcare; leading to a more satisfactory healthcare experience. The First Peoples of this land deserve nothing less.

*"There was no respect. No dignity. My husband is a hereditary Chief. We are same as them (doctors and nurses). They need to be humble, need to come down to our level."
A patient's Spouse.*

Introduction

The six health authorities that govern the planning and delivery of the full continuum of healthcare in BC have expressed commitments to patient centered care ([Appendix 2](#)). The Institute of Medicine defines patient-centered care as "healthcare that is respectful of and responsive to individual patient preferences and values" (Ngo-Metzger et.al., 2006, p1). Patient centered care requires:

- a partnership between clinicians, patients and their families;
- consideration of patients' explanatory models, social environments, family context and cultural beliefs and practices; and
- respect for patients' preferences to promote active patient participation in the decisions that affect their health and well-being (ibid.).

Patients who are active participants in their care have been shown to have improved health outcomes (ibid.).

It is well documented that BC's (and Canada's) Indigenous population experiences statistically significant health disparities in comparison to other Canadians (FNHA, 2013). While there are many underlying socio-economic factors that contribute to this, a key reason for this disparity is the barriers they encounter in accessing the healthcare system (Health Council of Canada, 2013). Mistrust of the "system" stemming from their experience of colonization, residential schools and Indian hospitals; dissonance between Indigenous culture/world view and a euro-centric healthcare approach; and lack of cultural safety due to stereotyping and racism are the over-arching issues that stand between Indigenous peoples and the healthcare system. As a result, they delay seeking help, get diagnosed at a later stage of the disease (making treatment more difficult) and have a higher likelihood of dropping-out of treatment (ibid.).

"Healthcare workers are very privileged. They have their employment irrespective of the quality of care they provide."

Healthcare Provider

"Culturally competent healthcare builds trust, increasing the likelihood that Aboriginal people will go for care and stay with their treatment" (Health Council of Canada, 2013). Cultural competency includes not only an awareness of and respect for differences in culture but also the possession of skills and the competency to apply them effectively in all cross-cultural encounters (Brach et.al, 2000). Failure to understand and manage these differences can have significant health consequences for patients from diverse cultures. Cultural competency is about creating a health care environment that is free of racism and stereotypes where Indigenous people are treated with empathy, dignity and respect; care is

provided in a culturally safe manner and patients become partners in making decisions about their health (Canadian Medical Association, 2013). This makes culturally competent care an imperative for patient centered care.

To be effective, cultural competence requires an organization's commitment to institutionalizing practices and policies that are appropriate for serving diverse populations (Brach et.al, 2000). As a key step, programs can be developed to help patients navigate the healthcare system and the cross-cultural clinical encounter (Betancourt et. al., 2002). In BC, all six health authorities have Aboriginal Patient Liaison/Navigator (APL/N) programs that aim to improve Indigenous peoples' access to healthcare. While the origins or the subsequent development of the programs are not well documented, there is indication that some APL/N positions were introduced to BC healthcare about 20 years ago. In 2005, funding from the Adaptation envelope of Health Canada's *Health Services Innovation Fund* (HSIF) expanded the program to its current level of 49 APL/N positions across the province.

The [First Nations Health Authority](#) (FNHA), a newly created seventh health authority in BC, "aims to reform the way health care is delivered to BC First Nations to close gaps and improve health and wellbeing" (FNHA, 2013). They have "taken over the administration of federal health programs and services previously delivered by Health Canada's First Nations Inuit Health Branch – Pacific Region, to work with the province and First Nations to address service gaps through new partnerships, closer collaboration, and health systems innovation" (FNHA, 2013). The FNHA now has responsibility for the HSIF funding. For all these reasons, the FNHA has a keen interest in the success of the APL/N program.

Northern Health (NH), Interior Health (IH) and Island Health (IsH) Authorities have evaluated their programs for the HSIF funding. There is interest among health authorities to collectively assess the efficacy of the program and explore strategies for enhancing and, perhaps, expanding the program. The Aboriginal Health Program of the Provincial Health Services Authority (PHSA) in its provincial role, coordinates training (through conferences and webinars) and communication (through teleconferences and a share site) for the APL/N program. In this capacity the PHSA Aboriginal Health program, with support from the FNHA, commissioned an in-depth review of the APL/N program to (1) develop a provincial snapshot of how the program is organized; (2) gain an understanding of the benefits and challenges of the program and (3) seek direction on how best to enhance the program.

Guided by the principle that the provision of patient centered healthcare for Indigenous peoples is the responsibility of all healthcare providers, not just Aboriginal Health programs, the review set out to learn:

1. The history, rationale for and purpose of the BC program,
2. Current scope, role/s and functions of APL/Ns
3. Benefit to patients and
4. Benefits to healthcare; in order to analyze strengths and challenges and propose strategies for enhancing the effectiveness and success of program.

This report provides the intent, scope and approach of the project, description of the program and what was learned in the review.

Methodology

At the present time, the APL/N program does not have provincially agreed upon evaluation criteria. Therefore, this review began with a scan of journal articles to gain an overarching understanding of the purpose, organization, potential for impact and criteria for success of patient liaison/navigation programs. The majority of this literature consisted of evaluations of patient liaison/navigation programs in cancer care based in the United States. Literature on evaluations and reviews of Indigenous specific and programs in Canada were sparse, however, evaluations of the Northern Health and Interior Health APL/N programs and the review of the Vancouver Island Health APL/N programs were helpful in bridging the gap.

The information gathering for this review began with a focus group held at the Annual APL/N conference in November 2013. At this brief session, APL/Ns were asked to create a “wish list” of supports that could mitigate their everyday work challenges and enhance their effectiveness. Following this, project information was gathered primarily through key informant interviews, conducted primarily by phone. Aboriginal Health programs in each health authority appointed a key contact that provided an overview of that region’s program and facilitated access to APL/Ns to be interviewed. APL/Ns and HA key contacts in turn referred the healthcare providers that were interviewed.

Including the Indigenous patient’s (or their family members’) voice was a specific requirement for this review. To ensure representation from across the province and seek rural and urban perspectives, two focus groups per health region for a total of twelve focus groups with patients or their family members were originally built into the project. Planning focus groups, in particular, accessing patients proved to be a significant challenge for all health authorities. The exception was Fraser Health that helped to organize two focus groups. Telephone interviews were added as an alternative approach for gathering patient/family perspectives. APL/Ns and the *Patient Voices Network of BC* referred the patients or their family members who were interviewed for this project.

Information Sources

Number	Respondents
8	Aboriginal Health Program staff from Health Authorities
18	Aboriginal Patient Liaison/Navigator/Nurses
16	Healthcare providers in Health Authorities
6	First Nations Health Authority Staff
6	Community Health Representatives
15	Patients (3 from Burns Lake and 1 each from Comox, Chilliwack, Gingolx, Greenville, Kamloops, New Aiyansh, New Westminster, North Vancouver, Prince Rupert, Saanich, Surrey, Victoria)
2	Focus groups with patients (4 participants in Surrey; 8 participants in Chilliwack)

Patient Navigation – What is it?

Patient Navigation (PN) has been introduced as a healthcare intervention to reduce the barriers that patients' encounter in accessing healthcare services (Koh et. al., 2010). It is an approach that seeks to facilitate timely access to appropriate care and resources for individuals (Pederson et. al., 2011), particularly from disparate populations (Schwarderer et. al., 2006). Whether programs have a disease (i.e. cancer care) or population (i.e. Indigenous) focus, PN programs appear to target patients living in socio-economically disadvantaged circumstances (Koh et. al., 2010). PN addresses a multitude of personal, provider, cultural and health system barriers that patients encounter in their healthcare journey and provides customized care according to individual needs and values – to optimize healthcare response (ibid). Focusing their efforts on reducing barriers rather than duplicating an existing service area (Pederson et.al, 2010), PN has become a "value-added" service within the healthcare system (Wilcox et. al., 2010, pg.21).

"Not all Aboriginal peoples are homogenous. We should not assume that all Aboriginal patients are similar. Some navigate the system well and others at the extreme end are lost and bewildered. Comfort and connection with healthcare system is very different.....very dependent on background."

Healthcare Provider

The goal of PN programs is to provide comprehensive streamlined care for patients as well as their families; and assist patients to acquire an enhanced sense of preparedness to participate in their healthcare journey (Pederson et. al., 2011). The sought after, overarching outcome of patient navigation is the removal of barriers and the achievement of optimal health outcomes (Koh et. al., 2010).

This includes,

- Timely screening and treatment (Campbell et. al., 2010)
- Improved patient preparedness (emotional and informational) for treatment and post-treatment coping (Pederson et. al., 2011)
- Improved patient self-efficacy (ibid.)
- Improved adherence to treatment regimens (by decreasing barriers to care) (Campbell et. al., 2010)
- Improved patient satisfaction with healthcare (Campbell et. al., 2010; Pederson et. al, 2011) and
- Reduced use of emergency resources and specialist time by patients (Pederson et. al, 2011).

The Need

Patients and family respondents, APL/Ns and healthcare providers identified a range of issues that impact Indigenous peoples' access to healthcare. These issues are described next, grouped according to Historical Context, Attitude, Communication, Cultural Dissonance, Distance to Healthcare and Health Benefits.

"I knew that First Nations had more challenges accessing healthcare but had no insight on what the challenges were or the impact of power relationships and the need for culturally safe care."

Healthcare Provider

Historical Context

Nearly all respondents identified fear and mistrust of government institutions as the most significant issue that deter Indigenous peoples from accessing healthcare. This is an enduring legacy of colonization and history of systemic and institutional abuse which, Indigenous peoples say, continues to be their experience today. The healthcare system too continues to play a role in systemic maltreatment of Indigenous peoples. As one patient reminded, "Historically health system has treated Aboriginal people poorly. Routine sterilization was done on us....our blood was used for research and whole Nations were condemned. Nutrition research was done on us in residential schools. We have a whole layer of mistrust and fear of the healthcare system."

"I didn't know about residential school history. I am Caucasian, have been in nursing for over 20 years but I didn't know about the residential school experience."

Healthcare Provider

Attitude

Making matters worse, many healthcare providers are not aware of this history or how Aboriginal peoples experience these issues even to this day. When patients and family respondents were asked about their experience of accessing healthcare in BC, they said that there are many healthcare providers that make assumptions about "who we are and why we are there." They said that often, their concerns are dismissed or not taken seriously, are shown no respect or dignity and are made to feel unimportant and their lives not valued. And they said that some providers are simply rude. While they were reluctant to name their experiences as racism, many discussed their experiences of being yelled at, ignored, being treated differently and being at the bottom of the list for care. And, some family members who described themselves as "strong advocates" discussed their reluctance to speak-up within the health system, for fear of repercussions when confronted with prejudice and power.

"If I had a camera or tape recorder I could record how other people are treated and sent away and we are at the bottom of the list for care. I don't know if I should say this, that there is racism in hospitals. All people should be treated equally, irrespective of colour of their skin."

A Patient's Sister

APL/Ns said that Indigenous patients are fearful of Social Workers because it is a term synonymous with child welfare for most Indigenous peoples. They indicated that this was a particular issue for young families, where the patient is a parent of young children or the patient is a child. Child apprehension fears exist even when a family seeks healthcare assistance as some healthcare providers were described as being too quick to call the Ministry of Child and Family Development.

"I am usually a good advocate but I was scared to speak up because whatever I said could affect my husband's quality of care."

A Patient's Spouse

Communication

The communication issues that were described are multifaceted. Some APL/Ns indicated that despite residential school efforts to “beat the Indian out of Aboriginal children”, there are still many Elders who live in rural remote communities who either cannot speak English or are not fluent in it. Needless to say, this is a significant barrier to communication, particularly when the person is ill. APL/Ns and healthcare providers described Elders as “the most vulnerable” in the healthcare system.

“We are a shy people. We have trouble asking for help.”

A Patient

Many respondents highlighted communication as a major issue, even when English language capacity is not an issue. Communication was described as alienating because people have difficulty understanding medical terminology and acronyms or have difficulty following rapid fire speech used by many healthcare providers. As one healthcare provider put it “my Aboriginal friends say that we speak too much....that we use too many words.”

“When doctors speak they use language and words that we don’t understand.”

A Patient

APL/Ns said that in these circumstances some patients assume that pertinent information is being withheld from them.

Some patients said that they felt unheard by healthcare providers. They felt that assumptions about who they were and why they were there clouded healthcare providers ability to “listen” to the health concerns they were expressing. On the flip side, some Indigenous patients said that they often do not ask questions because they say they lack the confidence to do so.

“I am not being heard. I am not being taken seriously. They don’t listen to what is going on with my body.”

A Patient

Cultural Dissonance

The culture of healthcare is underpinned by euro-centric values such as efficiency and expediency that contribute to a task oriented and fast paced way of providing services. In the words of APL/Ns, healthcare is “fast paced, no time to explain or speak with you”, “very task oriented – not relationship oriented, “focus on the issue, not the whole person”, “no time to engage with you and explain” and “expects you to respond right away”. APL/Ns and patients/families commented that cutbacks in health care that have increased workloads of frontline healthcare staff have exacerbated this situation.

“I think all frontline healthcare staff should ask the patient every possible question to get the full picture. At least ask 3-4 questions to ensure they understand what is going on.”

Patients, family members and APL/Ns said that for Indigenous peoples, trust is built on relationship, not knowledge or expertise and they have different ways of communicating. An APL/N said that “Aboriginal people have a phenomenal ability to read body language.” “They will pay attention to how someone comes in, sits and speaks.” Several APL/Ns said that for Indigenous people, “silence is also a way of saying something.” “They will take time to think of what they heard before they respond” and “if they sit with no expression, it doesn’t mean

they are disengaged, apathetic or depressed.” As one APL put it, “My mother used to sit and listen to me for hours without saying anything and with no expression on her face and then would give me a response that touched on everything I said.” Time to deliberate and ability to relate were described as being very important to Indigenous peoples.

Distance to Healthcare

Lack of health services in or near the rural and remote locations that Indigenous communities are often situated in was identified as a major barrier to access by patients, their families and APL/Ns. In some communities this includes access to primary care, often the first step in the healthcare continuum. Distance also impacts peoples’ abilities to access screening programs. When the *Mobile Medical Unit* attended the community of Tsartlip in the Saanich Peninsula, south Vancouver Island, fifty two children were assessed and treated for respiratory ailments over a two day period. The APL/N and a healthcare provider associated with this effort said that “a mother started to cry because her two children had finally been diagnosed with asthma.” When they looked at the patient data, they were shocked at the number of emergency room visits that were made by the patients that were treated on these two days.

“We live in a community that is about two and a half hours by car to the nearest hospital. My elderly father was ill and he was taken to emergency by ambulance. They kept him in emergency and was discharged and returned home by ambulance. The return journey was one and a half hours by ambulance and as soon as father returned home, we got a call from the hospital asking him to return to hospital for a CT scan. So he had to get back in that ambulance to return to hospital. This was not easy for an 89 year old man. What happened was.....father was seen by two doctors. One discharged him and the other ordered the CT scan.”

A Patient’s Daughter

Patients and family respondents said that some people from rural communities have to travel great distances (four hours), sometimes on unpaved roads; and have to find their own transportation because public transit is not available. Lack of access to vehicles and money to pay for gas were identified as insurmountable barriers for many who live in poverty and isolation. Bad weather that makes some roads inaccessible was described as exacerbating the issue.

Community based healthcare providers identified continuity of care as an issue in communities that have minimum or no services and resources. When patients receive healthcare interventions in a nearby town or an urban center they often return home with care requirements but to communities that have no supplies, equipment or personnel that can support with follow through of those requirements. Patients were described as being discharged with prescriptions for medications and or supplies that are not stocked by the local pharmacy. Or they return to a community that has nursing services one day per week but with instructions for daily wound care/dressing changes.

The communication gap between hospital and community based care providers is an issue. Hospital nurses, social workers, discharge planners don’t value or respect nurses, social workers and other healthcare staff in First Nations communities. They are not included in discharge planning and relevant information is not shared.”

Community Healthcare Provider

Some respondents noted that it is common for patients that are dealing with major illnesses (often, diseases they have never heard of before) to be sent to regional or tertiary hospitals in urban centers and far away from home. Some were described as being away from their home communities for the first time – finding themselves in circumstances where they are required to navigate complex urban environments at a time of high vulnerability in their lives. APL/Ns said that patients and their families arrive in a state of shock and bewilderment, not knowing directions and/or how and where to take a bus – yet needing to make the appointments on time.

"Some are in urban centers for the first time, have not previously encountered the health system and is now there far away from home with a very sick child or family member. They are in a state of shock."

Healthcare Provider

Lack of financial resources was underscored as a major barrier when a patient needs to travel distances, particularly to urban centers, and one or more family members accompanies the patient. Funding for transport, affordable accommodation and money for food were identified as the most significant barriers to accessing healthcare that is at a distance.

Health Benefits (Non-Insured Health Benefits)

Issues of access (eligibility)

[Health Benefits](#) provides funding for medical transportation of patients that need to travel from their rural/distant communities to access health services. If the patient wishes to have a family member accompany her or him, a doctor must indicate that there is a medical need for a patient escort in order for the accompanying family member to be eligible for funding. The patient's need and decision was described as being insufficient. In the words of an APL/N, "Aboriginal people are treated like wards of the state....like children their whole life."

"Sometimes Health Benefits will approve four weeks of travel/accommodation for a patient even though the treatment course is longer, say seven weeks. Doesn't make sense."

Healthcare Provider

Access to Health Benefits funding always begins with a doctor's note or paperwork that is completed by a doctor. Patients, family members and APL/Ns said that, completing paperwork in haste, sometimes doctors miss information; forms which are rejected due to lack of all pertinent information. In these instances, patients said that they must return to the doctor to have the form filled out accurately. An APL/N relayed a story where "a doctor prescribed a pain patch to a cancer patient, and filled out the required form. When the patient took this to the pharmacy, the pharmacy rejected the form because the doctor had missed some information. So the patient had to return to the doctor to get this re-done. It took three days of going back and forth to finally access Health Benefits funding for the pain

patch. In the meantime, the patient had to find the funds to buy the patch because the patient was on Income Assistance and barely had enough money for shelter and food.” APL/Ns said that there are times when a whole family needs to move to an urban center because one family member is hospitalized for several months. This is a particular issue for young families who will have one child hospitalized for many months but have other children at home. Some of these families were described as falling through the cracks because they are assumed to have moved away from their home community which can affect their eligibility for travel benefits.

Sufficiency of coverage

The amount of funding granted by health benefits was discussed as an issue. An APL/N said that a man from a remote community had to travel to an urban center to receive cancer treatment. His treatment regimen was for seven weeks, during which time he was put up in a hotel with facilities for cooking. The expectation of Health Benefits was that the person would cook for self. In this instance, Health Benefits did not approve funding for a family member to escort and support him during his treatment. The man, unable to cope by himself in a strange environment, unable to care for himself during chemotherapy and lonely for his family, quit his treatment within a few days and returned home.

Patients and family respondents said that when Health Benefits provides funding for patient escorts, they provide travel funds for only one family member to accompany a patient. Consideration of Indigenous family structures and dynamics does not appear to factor into the decision-making.

Functioning as an “Extended Benefit” plan, Health Benefits places limits on benefits for a range of healthcare products and services. A patient that described themselves as a ‘senior’ said, “I need glasses but Health Benefits will only pay \$250. My glasses cost more and I have to find the balance. But I am on welfare.” Similar issues were expressed about dental coverage. Issues were also raised about doctors that prescribe medications which are not covered by Health Benefits, requiring the patient to return to the doctor to get a new prescription.

The BC Program

The History

The beginning of the APL/N program in BC is not well documented. Key informants indicated that the first position in

“My daughter (31) had an abscessed tooth. One side of her face was all swollen. She went to emergency but they said that she had to pay \$50 to call a dentist. My daughter is on welfare. She didn’t have the money so she went to her family doctor who gave her antibiotics. The swelling is now gone but she still has the bad tooth.”

A Patient’s Mother

They (Aboriginal patients) don’t have experience or confidence to speak up. Most is demanded of them when they are least able to cope emotionally, socially and financially.

Healthcare Provider

Northern Health was created in 1986 through advocacy and leadership of the Carrier Sekani Tribal Council. The first position in Interior Health was created in 1999 as a result of strong community advocacy to implement a recommendation of an inquest into the death of a First Nation Elder at the Cariboo Memorial Hospital. The first position in Fraser Health was created in 2000 as a result of strong advocacy by the Sto:Lo First Nation. The Fraser Health position was modeled after the APL/N position at the Women's Hospital and Health Center in BC, a position that was started in 1994. From the beginning, the aim of all these programs has been to improve the healthcare experience of Indigenous patients within the hospital system.

These first positions may have been added onto incrementally until 2005, when funding from the HSIF expanded the APL/N program in all health authorities (except PHSA). Today, there are three Patient Liaison positions and two Mental Health Liaison positions in Fraser Health; eleven Patient Liaison Nurse positions in Island Health; eleven Patient Navigator positions in Interior Health; nine Patient Liaison positions in Northern Health; three regular and two casual Patient Liaison positions in Provincial Health and three regular and five casual Patient Navigator positions in Vancouver Coastal Health. (See [appendix 4](#) for descriptions of each program).

Program Organization

The program is organized differently in each health authority.

- In all health authorities except PHSA and VCH, a small compliment of Patient Liaisons/Navigators are employees of community based organizations but are funded by the health authority.
- APL/N in all health authorities, with the exception of four of the five positions in FH and VCH and the contracted positions in IH are based in a hospital and liaise with the community. Others are based outside the hospital but provide services within the hospital.
- All APL/Ns work in a multidisciplinary context participating in case conferences, clinical care planning and discharge planning. APL/Ns in IH and NH are part of multidisciplinary teams and report to a supervisor of a multidisciplinary team. Others, including the three contracted APL/N positions in mid island at Island Health report to a supervisor within the Aboriginal Health program of that health authority. APL/Ns that are employees of community based organizations report to a person in that organization.
- In FH, IH, PHSA and VCH undergraduate degrees in social work or nursing and experience working in community and or healthcare are the basic requirements for employment. In Island Health, an undergraduate degree in nursing is the required base qualification while in NH, the requirement is a Social Service Worker Certificate.
- There is a vast difference in remuneration across health authorities for similar work (starting salaries range between \$40,000 and \$60,000) – a reason for this being the difference in required base qualifications.

"It helps to be hospital based and employee of health authority.... to be working within the hospital system. When you are outside the 'system' it is – very difficult to get in to hospital and get information. I have been in this position a long time and things have improved. Health authority ID also helps.

APL/N

Scope of Current Practice

The main role of an APL/N, as described by them, is to cultivate a relationship between the Indigenous patients and their healthcare providers to ensure cultural safety in the clinical encounter. APL/Ns receive referrals from healthcare providers across all areas of the hospital, community organizations and patients' families. They intervene throughout the continuum of a patient's healthcare journey from home to health facility to home, and serve patients anywhere along their life span from birth to death. Most APL/Ns provide services on a case by case basis and do not provide case management services. APL/Ns also address systems issues to promote cultural competency of the organization.

"When I attend the bedside, I say that I am 'visiting' the patient. This is a deliberate choice of words. Rather than say 'meet' or 'assess' we say 'visit' because it helps to build a relationship. When I introduce myself, I describe my position, what I do and share a little about my background. This helps to build a cordial/friendly relationship that can build trust."

APL/N

The following table details the type of service provided by APL/Ns, as described by them. Some of the activities listed, such as providing cultural safety education to the Ministry of Child and Family Development staff, are not routinely performed by all APL/Ns.

Function	Activity
Facilitates communication between patient/family and healthcare providers	Provides or facilitates the provision of language interpretation
	Interprets clinical information to patients
	De-mystifies the healthcare system for patients
	Facilitates/provides patient/family/community/cultural/historical information to enhance care planning
	Participates in rounds, bed meetings/discharge planning meetings
	Connects across service silos to help navigate the system
	Connects acute care with community based health services to ensure follow through with treatment plans
Provides emotional support to patients/families	Visits with families to build relationships and assess needs
	Supports and counsels patients and families to address fear and distrust of healthcare/institutions
	Address issues that are impact health but are seen as unrelated in the current healthcare context
	Provides short term counseling to patients and families
	Supports patients to ask questions and become part of the treatment team
	Assists patients and their families to navigate the complaints process
	Provide friendly visitation to Elders and the disabled in Long Term Care facilities
	Provides home visits (particularly for urban and isolated patients) to ensure follow through with treatment plans
Advocates on behalf of patients	Negotiates with healthcare providers to ensure that those patients who feel unheard or maltreated receive the care, referrals, tests and treatment they need

	Supports patients to navigate the complaints process
	Communicates with and/or support patients to navigate other systems (MCFD, EI employers etc.) that impact patient's health condition
Facilitates and/or provides practical support	Attends to patient/family needs in terms of food, clothing, accommodation and transport
	Works with Travel Clerks to arrange long distance travel and accommodation
	Accompanies patients to appointments
	Drives patients to appointment
	Finds shelter/housing for patients and help them get set up
	Fills forms and paperwork on behalf of patients
	Develops directories of community resources for healthcare colleagues
Facilitates spiritual care	Facilitates access to traditional healers/medicines, medicine men and ceremonies. Works with healthcare team to ensure safe combining of traditional and western medicines.
	Performs traditional practices such as smudging and brushing.
	Facilitates end of life services/ceremonies; provides accompaniment of body to the morgue, arranges viewing of body, contacts funeral home and stays involved with family until the body changes hands with the funeral home.
Facilitates cross cultural competence with healthcare colleagues	Raises awareness of and provides education on the history of colonization, residential schools etc. and its current impacts on Indigenous peoples.
	Introduces to Indigenous culture, traditions, practices and ceremonies.
	Helps to understand Indigenous concept of family, community and ways of being.
	Facilitates the incorporation of Indigenous practices (prayers, blessings, healing circles) in healthcare programs and operations.
	Provides follow-up support/education to staff, post ICC training.
Liaises with Indigenous communities and community organizations	Connects with Indigenous communities and services and stays up to date on Indigenous specific resources.
	Develops relationships with on reserve and urban services geared for Indigenous peoples.
	Represents clients of MCFD and other agencies to promote culturally safe services.
	Provide cultural safety education to MCFD and other agencies.
	Serves on committees (e.g. AHIP), participates in events.
Documents the services provided	Records service provided in patient charts.
	Records types and quantities of services provided to assess workload.
Promotes program	Develops publicity materials such as flyers and posters.
	Provides information sessions to healthcare teams.
	Provides information sessions to community organizations (e.g. Colleges/universities/nursing orientation etc.).
	Participates in community events (display tables).

APL/Ns bear different titles across the health authorities. In FH, NH and PHSA, they are referred to as Patient Liaisons. In IH and VCH, they are referred to as Patient Navigators. And in Island Health they are referred to as Patient Liaison Nurses. Despite these differences in titles, the role and function of APL/Ns are the same across all health authorities. That said, some APL/Ns see the role of a Navigator being somewhat different

from that of a Liaison. The patient navigator role is described as assisting individual patients to navigate their healthcare experience within the hospital system, recognizing that effective admissions and discharge planning that is part of that process requires adequate knowledge of and connections in the patients' communities. The patient liaison role is described as linking with and providing assistance with the myriad systems that impact a person's health – over and above the hospital system. Those who view their role from this lens will intervene in other systems such as helping families navigate the Ministry of Children and Family Development. However, as one APL/N pointed out, time spent helping patients with issues outside the hospital system (such as driving patients or even helping to navigate other systems) is time lost in serving a patient who may need support to navigate the hospital system.

Required Base Competencies

APL/Ns and healthcare providers identified the following competencies that ought to be the basic requirements to effectively fulfill the APL/N role and functions.

- Assessment skills
- Counseling skills
- Clear verbal and written communication skills; computer skills
- Knowledge of /understanding of medical conditions/terminology/acronyms
- Advocacy skills
- Experience working in community and knowledge of Indigenous history, culture, traditions and ways of being
- Strong understanding of Indigenous specific and other services
- Ability to think holistically (see health as the interconnectedness of physical, psychological, emotional, spiritual health)
- Confidence to mediate issues and negotiate boundaries
- Ability to engage others
- Facilitate rather than do everything and work with flexibility, humour and grace
- Ability to learn and work in a fast paced and highly structured environment

"God gave the [APN] to us. We couldn't talk to doctors and nurses. [APN] translated for us. And talks to client to make them feel at home. And comforts them."

A Patient

"We didn't know what we didn't know. I can see that things are getting better. [APN] has worked for a long time....building the trust that we have all been searching for. They don't stand in front making us do things but quietly interests us to try things....and change."

Healthcare Provider

Program Strengths

The patients that were assisted by an APL/N and healthcare providers said that Indigenous patients are comforted when they see a familiar and friendly Indigenous face, often the only Indigenous staff they will encounter at the hospital,

particularly in larger and urban hospitals. They said that APL/Ns improved communication and helped to build trust between the patient and healthcare provider.

Healthcare providers said that APL/Ns helped to bring cultural safety to the bedside, facilitating a better understanding of a patient's social circumstances and barriers and issues to care. They said that the 'Indigenous lens' improved care and discharge planning, improving adherence to treatment regimens and preventing re-admissions to hospital.

One patient shared the story of her experience. "I have been in and out of hospital my whole life. Last year I was in hospital for three months and three days. This was a big one! I had no visitors. I was sad. And no one knew what was wrong with me. [APN] took care of everything. She was very helpful. She was not judgmental. She really cared about you. If something happened with the doctor I could talk to her. She made sure that nothing was missed....made sure that all the doctors and nurses knew what was going on. She inspired me to get better soon. She helped me to get on disability. Without her help, this wouldn't be possible. They all said I wasn't going to make it but I showed them wrong. I don't think I would have made it without the support and encouragement of [APN]. And, I haven't gone back to hospital since....but I keep in touch with her."

"One person used to come in regularly to emergency, a 'frequent flyer'.....always came inebriated.... having fallen off a bike, hitting his head. [APN] knew him and his family history.....gave this background to the healthcare staff. So rather than seeing him as a nuisance, the healthcare staff got together and bought him a bike helmet. He now rarely comes in to emergency!"

"I can easily learn the resources but building the trusting relationship is harder. I am a white social worker"

Healthcare Provider

Healthcare providers said that APL/Ns also helped to cultivate a relationship between the community and the hospital and that this was important because the hospital is part of a community. They said that APLNs have assisted them in understanding the importance of and protocol for end of life issues and death that is so important and experienced differently in Indigenous culture. Healthcare providers also appreciated the important role that APL/Ns play in assisting them to learn about Indigenous history, culture and tradition; building their capacity to better serve Indigenous patients. Healthcare providers were unanimous in their expression that they "cannot do without the APL/N" in their hospital.

"Our APL/N is a facilitator - builds capacityand leaves a legacy."

Healthcare Provider

By all accounts, the APL/N program supports the Indigenous patients who have experienced system barriers and system failures in healthcare to navigate the care system and improve the cultural safety of their clinical encounters. While assisting individual patients, the program also enhances healthcare providers capacity for patient centered care in serving the Indigenous patient. Patients and healthcare providers said that better communication, better coordination of services and better discharge planning resulted in greater adherence to treatment plans and reducing re-admissions to hospital. This is the contribution that the APL/N program makes to healthcare in BC.

Program Challenges

In a milieu of organic program evolution, lack of clear program guidelines, and for many, minimum or no supervision, many APL/Ns have gone on to define their own role and function based on their strengths and experiences working with Indigenous people. A healthcare provider said that in some instances, job descriptions were developed by some of the pioneer APL/Ns based on their capacities and interests. APL/Ns are a dedicated and passionate group that strives to do whatever that is needed to “help our people”. All this has created inconsistencies, not only in how an APL/N fulfills their role but also how they experience their work. These inconsistencies are evident even within a single health authority.

While all health authorities are taking steps to build consistency and efficacy of their program the historical ‘ad hoc’ approach to program development has left its mark. Many APL/Ns said that at the start of their employment, they received little to no orientation to the position or the hospital environment. Some APL/Ns who are not hospital based said that they have greater challenges in understanding roles and responsibilities of other health disciplines. They said that most of the time, this is learned “on the fly”. Some APL/Ns receive almost no supervision. An APL/N said that in the five years that she has served in her role, she has had eight supervisors.

Many APL/Ns grapple with heavy workloads that increase as the program is promoted. It is up to APL/Ns to prioritize their work. There does not appear to be a formula for deciding which hospitals will have the APL/N service and how this position will be staffed. Within the same health authority, a small rural hospital with a total of 40 beds has a fulltime APL/N while a regional hospital with over 200 beds, receiving patient transfers from other hospitals, also has one fulltime APL/N. In most hospitals, there is a fulltime APL/N that works during the day, from Monday to Friday. Some APL/Ns cover more than one hospital; therefore, those hospitals have only part time APL/N coverage. Royal Inland Hospital in Kamloops is the only hospital that employs two APL/Ns. The two positions working a rotating schedule provide seven days of APL/N coverage.

At many of the hospitals, APL/Ns seem to be challenged in asserting their unique and value added role. APL/Ns and some healthcare providers said that there is a tendency among some healthcare providers to assume that they have no role in the care of an Indigenous patient; automatically referring the patient to the APL/N. Sometimes, APL/Ns also get used as Social Work assistants, attending to tasks (making

“I alone can’t change a person’s experience. I am here during the day, five days a week. What about evenings and weekends? We need to change the culture of the system.”

APL/N

“In the past, it was like....the patient is Aboriginal so go see them. I have now developed a consultation role. Sometimes, it is mediation and advocacy. A lot of time it is supporting a patient to navigate through the system. Sitting down and explaining what the doctor already explained....but in plain language. I say to the doctor....can you explain in simple terminology.”

APL/N

phone calls, completing paper work etc.) during times when Social Workers are busy. In smaller hospitals, healthcare providers expect APL/Ns to run errands and do other tasks because the APL/N knows the patient/families/communities. One APL/N said that sometimes he is called to provide 'security', particularly when Indigenous patients become aggressive. APL/Ns said that they have difficulty setting boundaries because "we are used to doing everything." Asserting themselves and setting boundaries become more of a challenge for those APL/Ns who encounter prejudice and racism by their healthcare colleagues.

The personal and professional trauma experienced by APL/Ns from their daily encounters with critical illness, injury and death and dying issues is a significant challenge. Patients of APL/Ns can be family members, friends or could be from their own community; and the concept of family within Indigenous society is broader than that of European societies. For example, a patient's death and how an APL/N is expected to participate in the death is quite different for APL/N in comparison to other staff. Indigenous patients/families and communities sometimes have difficulty differentiating the professional and personal role of an APL/N which makes boundary setting a challenge for the APL/N. For example, family and community places expectations on an APL/N's time (e.g. attendance at funerals, participating in related community/family events) for which APL/N must take time off from work - which counts against their vacation time.

Health authority policies on privacy and confidentiality become challenges for APL/Ns that are not based at a hospital, especially when they are not employed by the health authority. They have difficulty accessing patient information even though their role is to help a patient navigate the hospital system. Privacy and confidentiality policies were also described as hindering communication between the hospital and community agencies - critical for seamless discharge planning.

There are issues that result from systems gaps for which APL/Ns are required to find solutions on a case by case basis. Few APL/Ns have a budget to pay for interpretation; services for urban Indigenous and Métis patients are either scarce or non-existent; transient and homeless people that come into hospital for detoxification have no home or service to go to at discharge; repeat users of the Emergency Unit (over represented by Indigenous peoples) who are there due to issues of poverty, homelessness or lack of other services often require assistance that is beyond the capacity of an APL/N. In hospitals that do not have dedicated spiritual spaces and do not allow practices such as 'smudging' due to fire safety regulations, APL/Ns need to find alternative approaches for carrying out family requests for spiritual ceremonies and practices. Striving to do it all without enough support, many APL/Ns say that they struggle with compassion fatigue.

All health authorities are grappling with the issue of articulating the need for and value of the APL/N service. Each health authority has dedicated efforts at collecting data on and recording the services provided. APL/Ns said that they are required to record their interventions on patient charts and some said that lack of time to do this and their knowledge of charting were issues. Some health authorities are also attempting to quantify the services provided so some APL/Ns are required to record their interventions in multiple places (patient charting, workload counts, programs that attempt to quantify the service).

Since each health authority determines what data are collected and how it is collected, comparison of data across health authorities will likely be an issue.

Features of Effective Patient /Navigation Programs

The literature indicates that multiple strategies are required to create effective APL/N programs. The position needs to be clearly defined and supported, the organization must support the position to be effective and the APL/Ns need a forum to come together to learn from and support each other. Therefore, the strategies suggested in the literature have been grouped into (1) Position focused, (2) Supervisor focused, (3) Organization focused and (3) Group focused strategies.

Position focused strategies

- Clarify scope, role and function to minimize overlap with roles and responsibilities of other healthcare providers (BCCA, 2005; Pederson et.al. 2010 and 2011, Posenelli et.al., 2009).
- Establish position on a multi-disciplinary team (Wilcox et.al., 2010) and partnership approach to working with other team members (Posenelli et.al., 2009).
- Provide comprehensive orientation to role (to hospital policies and procedure, introduction to key hospital staff as well as the full range of administrative requirements, access to information such as emergency procedures, flow charts, maps or who to go to for particular information; and provide opportunity to observe a Patient Liaison/Navigator functioning in their role, provide opportunities to learn the required medical terminology; provide information about relevant meetings within hospital and in the community)(Posenelli at.al., 2009).
- Provide flexible, strengths based and timely supervision, including performance management (Posenelli et.al., 2009).
- Support boundary setting and navigating privacy/confidentiality issues (Posenelli et. al., 2009).
- Provide professional development opportunities (Posenelli et.al., 2009).
- Provide the infrastructure (office space, cell phones etc.) required for the position. (Posenelli et. al., 2009).

Supervisor focused strategies

- Provide training (e.g. Cultural Competency) and orientation to assume the supervisory role (Posenelli et.al., 2009).
- Connect supervisors to Indigenous mentors, peer learning opportunities and peer support networks (Posenelli et. al., 2009).
- Support personal and professional reflection and the cultivation of respectful and collaborative relationships with the Patient Liaisons/Navigators (Posenelli et. al., 2009).
- Encourage two-way learning between supervisors and patient liaison/navigators (Posenelli et. al.,2009).

- Connect to local communities and encourage the development of collaborative relationship to understand community expectations and norms (Posenelli et. al., 2009).

Organizational strategies

- Institute a whole system approach to improving Indigenous health; Cultivate Executive level “buy-in” and senior management champions for the program (Posenelli et. al., 2009).
- Provide stable long term funding for the program (BCCA, 2005).
- Adopt Human Resource policies and practices to promote culturally safe and effective workplace relations for APL/Ns and connect APL/N with a mentor in Human Resources to assist PL/Ns with workplace issues (Posenelli et. al., 2009).
- Evaluate outcomes to establish eminence of program (Campbell et. al., 2010; Koh et. al., 2010; Wilcox et. al., 2010).
- Embed the APLN program as one strategy among others to promote cross-cultural competence of the whole organization (Posenelli et.al., 2009).

Group strategies

To link with others, address common issues, share promising practices and undertake projects that can enhance the group,

- Develop and support networking opportunities for the Patient Navigators (Pederson, 2010; BCCA, 2005).
- Develop and support networking opportunities for supervisors of Patient Navigators (Posenelli et. al., 2009).

Enhancing the BC Program – Suggestions

The APL/N program in BC provides a service that improves the healthcare experience of Indigenous patients. Anecdotal information indicates that the intent of the program, from the beginning, has been to improve the quality of care provided to and the experience of Indigenous patients within the hospital system. While the APL/Ns provide a range of functions along a patient’s healthcare journey, the greatest value of their service is in assisting patients and their families to navigate the complex, confusing, highly structured and fast paced system within a hospital.

Currently, all APL/N positions are funded by the six health authorities as a strategy for improving access to and the quality of care to Indigenous patients at the acute care end of the healthcare continuum. To further strengthen the program’s capacity to:

- promote a culturally safe clinical encounter between Indigenous patients and, primarily, healthcare providers in hospitals;
- facilitate seamlessness of services along the healthcare journey from home to hospital to home; and
- ensure that Indigenous peoples receive optimum, patient centered care, the following suggestions are proposed to enhance the effectiveness, success, cohesiveness and eminence of the APL/N program in BC.

Guided by the features of effective PN programs identified in the literature, suggestions for improving the BC program are grouped according to the focus of intervention. Position and Supervision focused strategies aim to clarify and tighten the scope, role and function of an APL/N and provide them with the supports to perform in their role at an optimum. Program focused strategies aim to raise the eminence of the program, creating program cohesiveness and an identity, while creating an environment that will support APL/Ns to succeed. Organization focused and Provincial level strategies aim to address systemic issues that APL/Ns repeatedly address with individual patients; and could potentially augment, promote and institutionalize the systems change work that is spawned by the APL/N program.

Position Focused Strategies

Action	Lead Responsibility
Embed the APL/N role within a multidisciplinary healthcare team. Emphasize that the role's primary function is to support Indigenous patients to navigate the hospital system. Base the position at hospitals reaching out to community (as required).	RHA Aboriginal Health Programs
Negotiate with relevant stakeholders to ensure APL/N supervision provided by the lead of the multidisciplinary healthcare team. Underscore the "value added" nature of the APL/N role and develop guidelines, protocols and accountabilities for the position – vis-à-vis how the position works with other disciplines on the team.	RHA Aboriginal Health Programs working with Hospital Administrators
Provide comprehensive orientation to the role for new hires (on hospital policies and procedure, introduction to key hospital staff as well as the full range of administrative requirements, access to information such as emergency procedures, flow charts, maps or who to go to for particular information, and provide opportunity to observe a PL/N functioning in their role, opportunity to learn the required medical terminology and provide information and guidance on relevant meetings within the hospital and in the community). (See <i>ICAP Resource Kit</i> in Appendix 12).	RHA Aboriginal Health Programs
Ensure adequate supervision is provided to the position, especially on negotiating roles and responsibilities with other health disciplines as well as responding to community demands. Assist in clarifying appropriate boundaries for the position.	RHA Aboriginal Health Programs
Provide professional development opportunities to cultivate required competencies, especially related to negotiating boundaries (See <i>Harold P. Freeman Patient Navigation Institute</i> in Appendix 12) and career progression.	RHA Aboriginal Health Programs

Develop regional and/or provincial networks/communities of practice for APL/Ns to link with others, provide debriefing opportunities, problem solve, share promising practices; cultivate leadership capacities, undertake professional development activities and be acknowledged for the valuable and credible role they play in the healthcare system. Consider re-focusing PHSA's current coordinating function in this direction.	PHSA Aboriginal Health Program and FNHA in collaboration with RHA Aboriginal Health Programs
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Supervision Focused Strategies

Action	Lead Responsibility
Support supervisors to understand the vision and priorities of the APL/N program and role.	RHA Aboriginal Health Programs
Develop strategies and standards to help operationalize that role.	RHA Aboriginal Health Programs
Support supervisors to cultivate skills and competencies to supervise across cultures.	RHA Aboriginal Health Programs
Connect supervisors to new initiatives and changing landscapes that impact Indigenous health (e.g. Provide information to and involve supervisors in events related to the evolution of the FNHA).	RHA Aboriginal Health Programs
Connect and support supervisors to: participate in community initiatives and assume some of the community liaising responsibilities from APL/Ns (such as serving on committees). This could also diversify healthcare representation in the community.	RHA Aboriginal Health Programs
Develop a forum, even a virtual one, for supervisors to connect with other supervisors of APL/Ns (within RHA or across the province) to share successes, problem solve and learn from each other.	RHA Aboriginal Health Programs or PHSA Aboriginal Health Program (if the forum will be provincial).

- * These recommendations are aimed primarily at supervisors of multi-disciplinary teams. (See ICAP Resource Kit in [Appendix 12](#)).

Program Focused Strategies

Action	Lead Responsibility
Promote the program at all levels of the organization.	RHA Aboriginal Health Programs
Cultivate Executive and Senior Management interest and buy-in in the program.	RHA Aboriginal Health Programs
Collect data to demonstrate need for and value of program.	RHA Aboriginal Health Programs working with Performance Management

Ensure there are adequate numbers of APL/N positions – especially in regional/tertiary hospitals.	PHSA Aboriginal Health Program collaborating with RHA Aboriginal Health Programs and Hospital Administrators
Establish transfer and communication protocols for transfer of Indigenous patients among hospitals.	RHA Aboriginal Health Programs working with Hospital Administrators
Create community patient navigator positions and/or engage other hospital/health authority staff to pick up gaps created by APL/N focusing work within hospital.	PHSA Aboriginal Health Program collaborating with RHA Aboriginal Health Programs and Hospital Administrators
Provide funding for interpretation and Elder/spiritual services.	PHSA Aboriginal Health Program collaborating with RHA Aboriginal Health Programs and Hospital Administrators
Provide in-service to all discharge planners and connect them to healthcare personnel in Indigenous communities that feed into the hospital.	RHA Aboriginal Health Programs working with Hospital Administrators and FNHA
Conduct audits of re-admissions of Indigenous patients to understand reasons for re-admission; Use the Patient Safety Tracking System to track treatment outcomes of Indigenous patients with complex care needs.	RHA Aboriginal Health Program working with Administrators and FNHA

Organizational Strategies

Action	Lead Responsibility
Where appropriate and possible, provide services closer to home (e.g. Telehealth, Mobile Medical Unit, Mobile screening etc.).	RHAs working with PHSA and FNHA
Create welcoming physical environment within the hospital (with Indigenous art from the local area, Information in local language/s etc.)	RHA Aboriginal Health Programs working with Hospital Administrators
Ensure that frontline administrative staff provides welcoming reception.	RHA Administrators

Provincial Strategies

Action	Lead Responsibility
Build on regional health authority successes to develop provincial standards and common approaches for the APL/N program (on purpose, scope, role, competencies, orientation etc.) that can be localized; to enhance the consistency of the program within and among health authorities and minimize duplication of effort.	PHSA Aboriginal Health Program and FNHA collaborating with RHA Aboriginal Health Programs

Identify data needs and develop common criteria and tools for consistent data collection, analysis, interpretation and reporting.	PHSA Aboriginal Health Program and FNHA collaborating with RHA Aboriginal Health Programs and health authority surveillance programs.
Develop a framework and mechanism for ongoing outcome evaluation.	PHSA Aboriginal Health Program and FNHA collaborating with RHA Aboriginal Health Programs and health authority surveillance programs.
Clarify and adapt privacy/confidentiality policies to improve communication between health authorities and community based agencies.	PHSA Aboriginal Health Program and FNHA collaborating with RHA Aboriginal Health Programs.
Clarify roles, responsibilities and process for resolving patient complaints.	PHSA Aboriginal Health Program and FNHA collaborating with RHA Aboriginal Health Programs.
Enhance ICC training with strategies, resources and tools that APL/Ns can localize, to, in a consistent manner, support the integration of the ICC learning into practice.	PHSA Aboriginal Health Program collaborating with RHA Aboriginal Health Programs
Develop a structure/mechanism similar to the <i>Secretariat for Directors of Health</i> to seek APL/N input into FNHA decision making.	FNHA
Augment community based health literacy efforts with advocacy skills to empower patients and their families to ask questions, speak up and demand the care they deserve.	FNHA
Develop a comprehensive, updatable, electronic directory of information, services and resources available on Indigenous communities (services available, roles and responsibilities of personnel/positions etc.) that can be accessed by all hospitals across the province.	FNHA
Establish an avenue such as a 1-800 number that Indigenous patients can call to consult with APL/N (on navigating health care system and medical information/terminology) as not all hospitals and doctor's offices have an APL/N).	FNHA
Cultivate connections and working relationships between healthcare staff in Indigenous communities and relevant acute care staff (e.g. discharge planning staff) in hospitals.	FNHA
Clarify eligibility and coverage; streamline access to; and integrate an Indigenous lens into the decision-making of Health Benefits.	FNHA
Where possible, develop on reserve/closer to home Long Term Care for the elderly and disabled.	FNHA collaborating with relevant stakeholders.
Create an "Ombudsman" role/office that can augment health authority complaints resolution processes.	FNHA

A Promising Practice

The APN Program at the Royal Inland Hospital, Kamloops BC

The Royal Inland Hospital in Kamloops supports two Aboriginal Patient Navigator (APN) positions. The two staff members that currently serve in these roles have occupied the positions for five years. Both positions are based in the hospital and reach out to community.

The APNs are included as allied healthcare on a multidisciplinary healthcare team. They report to the Community Integration Health Services Manager. They work shifts to provide APN coverage seven days per week. The APNs work with other healthcare providers as partners and are treated with regard and are valued for their expertise. The APN program is well known, established and accessed at this hospital. The program is also well received in Indigenous communities.

The role and function of the APN at this hospital, as described by the two staff includes:

- Facilitating communication between patient/family and healthcare providers,
- Providing emotional support to alleviate fear and distrust of system,
- Facilitating physical support (interface with Health Benefits, referrals to Indigenous specific and community resources),
- Facilitating spiritual care (access to traditional medicines, healers, practices),
- Facilitating cross cultural education of health care staff (building knowledge of historical issues, cultural practices, family dynamics) and
- Connecting healthcare providers to Indigenous communities/resources.

Several factors have contributed to the success of this program. At the beginning, the Aboriginal Health Program did extensive promotion of the program across the hospital. When the positions were filled, new staff received extensive (three month long) orientation to the position. This included networking with healthcare providers where each department in the hospital spent time welcoming the APNs. And, the APNs were purposely placed in a location to ensure interaction with other staff - for example discharge planning staff. The two APNs were also provided with required tools for the job such as office space, pagers and cell phones.

A key success factor is the efforts that have been made to cultivate "Champions of the Program" among senior management. Senior managers who say that the "gaps will be huge" without the program. They describe the service provided by APNs as;

- facilitating safety and comfort for Indigenous patients by helping to build trust between patient/family and the health care system,
- possessing extensive knowledge of Indigenous communities and the resources available,
- being competent at navigating Health Benefits,
- supporting healthcare staff to understand Indigenous culture, particularly, cultural nuances not understood by those outside a culture,
- supporting healthcare providers to see/assess patient and their family situation from a different lens which improves the care plans,
- providing formal and informal education to raise awareness and understanding of Indigenous ways of being and doing and
- helping to understand the importance of spirituality in care of Indigenous patients.

Success Stories from the Royal Inland Hospital

Senior managers described the following stories to underscore the value of the APN program.

The MDR unit at the hospital had experienced a series of negative publicity. Staff wanted to clean-out the energies that was drawing bad publicity and invited APNs to perform a spiritual cleansing, which was done successfully.

When the new ICU was built, hospital administrators invited the APN's to bless the new unit before operations shifted to the new facility. And once the ICU shifted, APNs did a ceremony in the old ICU to release any trapped spirits.

A young man was admitted to the ICU but he was not responding to any of the treatment. He was near death when his family asked for an intervention by a traditional healer. The APNs working with ICU staff facilitated a traditional healing ceremony in the ICU. Shortly thereafter, the patient recovered and left the hospital resulting in a "world view" transformation for ICU staff. In the words of a senior manager: *"I have worked in healthcare for a very long time and this taught me that ours was not the only form of medicine. And the importance of healing the spirit."*

APNs routinely smudge in ICU and other areas of the hospital. When smudging is done in ICU, the fire safety system is temporarily turned off and an announcement is made to this effect. The fire system is turned back on once the smudging is completed.

Royal Inland Hospital was first hospital in the province to develop a spiritual room which is well used by Indigenous peoples for spiritual ceremonies as well as viewing deceased family.

The hospital is developing death and dying protocols which address end of life needs of Indigenous peoples. This will include clarification of roles and responsibilities of multidisciplinary team members as it relates to end of life needs. This protocol will be included in the nursing manual – hence will have the capacity to reinforce the roles and responsibilities of multiple disciplines in caring for Indigenous patients.

Further examples of promising practices, from across the health authorities, are listed in [Appendix 5](#).

Concluding Remarks

APL/Ns are a dedicated and passionate group that strives to do whatever that is needed to support the patient to receive the healthcare that they need in safety and comfort. Their work is also quietly transforming the healthcare system. This is important to Indigenous patients and their families as it helps them to better navigate the healthcare system. It is important to the healthcare providers as the program facilitates the provision of culturally safe care to Indigenous patients.

The APL/N program provides an important strategy for building a culturally competent organization; and helps health authorities to realize their commitment to patient centered

care towards Indigenous patients. To further these organizational aspirations, the APL/N program could be purposefully positioned as an important strategy for achieving a culturally competent healthcare institution. To direct this, the Aboriginal Health programs of the six health authorities could collaborate and use the learning from this review to clearly articulate how the APL/N program meets their strategic plans and priorities as well as the strategic plans and priorities of their respective health authorities.

Making these linkages more explicit and translating it to consistent messaging could help to “make the case” that will be essential for cultivating senior leadership “buy-in” in the program. Senior leadership endorsement and support will be critical for leveraging the relationships and resources that will be needed to implement many of the suggested enhancements proposed in this report.

The FNHA has the mandate to work with government partners to improve health outcomes of Indigenous peoples in BC. And, the FNHA is now responsible for the HSIF which has made a significant financial investment in the APL/N program across the province. This makes the FNHA a key stakeholder that could drive the program enhancement agenda forward. This could begin with the FNHA clarifying how the APL/N program promotes the priorities of the *Tri-Partite First Nations Health Plan* – an approach that would elevate the eminence of the program at the highest levels of healthcare decision-makers.

The promising practices described in this report indicate that the health authorities are already taking important and creative steps to enhance their APL/N programs and their reach and services to Indigenous peoples. The FNHA could continue to support the Aboriginal Health Program of PHSA to leverage its’ provincial role and collaborate with the RHAs to build on current efforts and develop a provincial identity for the APLN program - consistent in what it does across the province yet flexible in how it is implemented at a regional and local level. This could begin with the seven health authorities collaborating to set provincial standards for the program on purpose, goals, objectives, scope, role and expected outcomes that could inform the development of guidelines, protocols and accountabilities for the position at a regional and local level.

It is hoped that the suggested enhancements to the APL/N program proposed in this report will strengthen and expand the program; which in turn could increase and improve Indigenous peoples’ access to timely and quality healthcare; leading to a more satisfactory healthcare experience. The First Peoples of this land deserve nothing less.

“We have several Aboriginal staff and this really helps. The more faces in the system the more it helps. Where ever they go they are often the only one.”

Healthcare Provider

“If the APL/N role is to improve access, then we need to develop strategies at the provincial or regional level and localize them.”

Supervisor of APL/N

Appendix 1: Acknowledgements

Key Informants/Contributors

Name	Position	Organization
Fraser Health		
Brian Muth	Community Integration Coordinator, Aboriginal Health Program	Fraser Health
Dina Lambright	Community Integration Coordinator, Aboriginal Health Program	Fraser Health
Carol Peters	Aboriginal Patient Liaison	Fraser Health
Danielle Milano	Aboriginal Patient Liaison	Fraser Health
Maureen Phillips	Aboriginal Patient Liaison	Fraser Health
Rohit Kambo	Aboriginal Patient Liaison	Fraser Health
Donna Rugamas	Social Worker	Abbotsford Hospital
Karen Severn	Social Worker	Fraser Canyon Hospital
Wendy Bruins	Clinical Nurse Educator	Fraser Health
Interior Health		
Shawna Nevdoff	Practice Lead, Aboriginal Health Program	Interior Health
Barbara Mack	Aboriginal Patient Navigator	Interior Health
Deb Donald	Aboriginal Patient Navigator	Interior Health
Gloria Big Sorrel Horse	Aboriginal Patient Navigator	Interior Health
Jayne Taylor	Aboriginal Patient Navigator	Interior Health
Diana Moar	Aboriginal Patient Navigator	Interior Health
Kathleen Anderson	Transition Liaison Nurse	Williams Lake Hospital
Margaret Brown	Health Services Administrator	Royal Inland Hospital, Kamloops
Marianne Boak	Professional Practice Leader – Social Work	Royal Inland Hospital, Kamloops
Sandra Semograd	Manager ICU/SDU	Royal Inland Hospital, Kamloops
Dr. Steve Rollheiser	Physician/Hospitalist	Royal Inland Hospital, Kamloops
Viktor Gundel	Spiritual Care Coordinator	Royal Inland Hospital, Kamloops
Island Health		
Ian Knipe	Director Aboriginal Health	Island Health
Penelope Cooper	Manager, Aboriginal Health, South Island	Island Health
Dale Hunt	Coordinator, Returning Home Initiative	Island Health/Child Health BC/FNHA
Jane Fox	Aboriginal Patient Liaison Nurse	Island Health
Laurel Anderson	Aboriginal Patient Liaison Nurse	Island Health
Margaret Eastman	Nurse clinician Advance Practice Nurse Coordinator, Vancouver Island Complex Pediatric Respiratory Program	Victoria General Hospital
Kelly Phillips	Clinical Coordinator, Maternal Child Unit	St. Joseph’s Hospital, Comox
Anne Roberts	Manager, Social Work Department	St. Joseph’s Hospital, Comox

Northern Health		
Victoria Carter	Lead, Integration and Engagement, Aboriginal Health	Northern Health
Ken Solonas	Aboriginal Patient Liaison	Northern Health
Lloyd McDames	Aboriginal Patient Liaison	Northern Health
Yvonne Tupper	Aboriginal Patient Liaison	Northern Health
Jane Wilde	Director of Care, Prince Rupert Regional Hospital	Prince Rupert Regional Hospital
Joanne Cozac	Manager of Patient Care, Primary Health Care, Fort St John Hospital	Fort St. John Hospital
Shannon Croy	Chief Social Worker	University Hospital of Northern BC
Provincial Health		
Alanah Woodland	Lead, Aboriginal Health –Women and their families	BC Women’s Hospital and Health Center
Amanda Gonet	Aboriginal Patient Liaison	BC Women’s Hospital and Health Center
Susan Soloman	Aboriginal Patient Liaison	BC Women’s Hospital and Health Center
Pam Tobin	Director	BC Cancer Agency, Center for the North
Dana Marshall	Aboriginal Patient Liaison	BC Cancer Agency, Center for the North
Vancouver Coastal Health		
James Broasch		Vancouver Coastal Health
First Nations Health Authority		
Fiona McLeod	Community Health Practice Consultant	FNHA
Jane Mather	Senior Advisor, Health Services	FNHA
Nicole Cross	Regional Director Northern BC, Community Engagement	FNHA
Patricia Bell	Home Care Nursing Practice Consultant	FNHA
Renee Nyberg	Director, Benefits Management, Policy Development and Planning	FNHA
Sandra Garbitt	Hub Coordinator, North East	FNHA
Community Health Representatives		
Christina Peacock	Coordinator	Jenecee’s Place
Colleen Totusek	Health Director	Saulteau First Nation
Jacki McPherson	Health Coordinator and President- Health Directors Association	Osoyoos Indian Band and FNHA
Mabel Louie	Executive Director	Carrier Sekani Family Services
Nadeen Reginald	Health Benefits Advocacy Officer	Squamish Nation Yúustway Health Services
Nora Martin	Health Director	Tla-o-qui-aht First Nation

Appendix 2: Health Authority Commitments to Patient Centered Care

Fraser Health Authority

Our Vision

- Better health. Best in health care.

Our purpose

- To improve the health of the population and the quality of life of the people we serve.

Our values

- Respect, caring and trust characterize our relationships.

Our commitment

- To be passionate in pursuit of quality and safe health care.
- To inspire individual and collective contribution.
- To be focused on outcomes, open to evidence, new ideas and innovation.
- To embrace new partners as team members and collaborators.
- To be accountable.

http://www.fraserhealth.ca/about_us/strategic-direction/our_vision/

Interior Health Authority

Interior Health ... For your whole life

Our vision

- To set new standards of excellence in the delivery of health services in the Province of British Columbia.

Our mission

- To promote healthy lifestyles and provide needed health services in a timely, caring, and efficient manner, to the highest professional and quality standards.

Our values

Quality – We are committed to safety and best practice.

Integrity – We are authentic and accountable for our actions and words.

Respect – We are courteous, and treat each other as valued clients and colleagues.

Trust – We are free to express our ideas.

Our goals

1. Improve health and wellness
2. Deliver high quality care
3. Ensure sustainable health care by improving innovation, productivity, and efficiency
4. Cultivate an engaged workforce and healthy workplace

<http://www.interiorhealth.ca/AboutUs/StrategicDirection/Pages/default.aspx>

Island Health

Vision, Purpose and Values

- Created from the shared core beliefs of our staff, physicians, volunteers, and Board of Directors, Island Health's vision, purpose and values are the guiding principles we use to provide the highest quality health care services to the populations we serve.

Our Vision

- Excellent care for everyone, everywhere, every time.

Our Purpose

- To provide superior health care through innovation, teaching and research and a commitment to quality and safety — creating healthier, stronger communities and a better quality of life for those we touch.

Our Values

CARE will guide everything we do:

Courage: To do the right thing — to change, innovate and grow.

Aspire: To the highest degree of quality and safety.

Respect: To value each individual and bring trust to every relationship.

Empathy: To give the kind of care we would want for our loved ones.

http://www.viha.ca/about_viha/vision.htm

Northern Health

Organizational Values - The Beliefs that Guide our Work.

We treat people with:

- Respect: honouring diversity and treating people fairly
- Compassion: caring genuinely
- Empathy: understanding and earning trust

We demonstrate:

- Integrity: ensuring open, honest, ethical behaviour
- Stewardship: showing transparent, responsible and effective use of resources
- Quality: providing exceptional service guided by evidence

We work in a spirit of:

- Collaboration: working together to better serve the people of Northern BC
- Innovation: learning and finding better ways to deliver health care

Our Strategic Directions include:

- Integrated Accessible Health Services
- A Focus on Our People
- A Population Health Approach
- High Quality Services

<http://www.northernhealth.ca/AboutUs/Mission,VisionStrategicPlan.aspx>

Provincial Health Services Authority

Values

Our values provide a focus for how we approach our work. They collectively inspire behaviour that creates a dynamic and performance-oriented organization.

Patients first

We believe that all of our endeavors should be directed to improving care, access to care, and health outcomes of those who need and use our services across the province.

We believe that deliberate prevention and promotion initiatives can contribute to the better health of British Columbians.

We measure our success by the way we deliver on our commitment of better health and by the level of satisfaction and engagement of our patients and their families.

Our success depends on the contribution and commitment of each and every employee and partner, and this will be achieved through building and supporting an engaged workforce.

<http://www.phsa.ca/AboutPHSA/VisionMissionValues.htm>

Vancouver Coastal Health Authority

Our vision

- We will be leaders in promoting wellness and ensuring care by focusing on quality

Our mission

- We are committed to supporting healthy lives in healthy communities with our partners through care, education and research.

Our values

Service: We will provide outstanding service and respond to needs in a timely and innovative manner.

Integrity: We will serve openly and honestly in a caring and compassionate environment.

Sustainability: We will focus on effectiveness, efficiency, best practices and health outcomes, holding ourselves responsible for results

Our goals

We are guided by four organizational goals to achieve our vision.

1. Provide the best care
2. Promote better health for our communities
3. Develop the best workforce
4. Innovate for sustainability

Our strategic framework: People First

Our people first strategy shapes how we approach our vision, mission, values and goals.

<https://www.vch.ca/media/VCH-True-North-Strategic-Framework-2013.pdf>

Appendix 3: First Nations Health Authority

Why a First Nations Health Authority?

Statistically significant health disparities exist for First Nations people in BC and across Canada. The First Nations Health Authority aims to reform the way health care is delivered to BC First Nations to close these gaps and improve health and wellbeing.

BC First Nations, the Province of BC, and the Government of Canada have all determined that First Nations health disparities are no longer acceptable. A New Relationship between these Tripartite Partners was forged and a series of precedent-setting agreements led to the creation of a First Nations Health Authority.

This new health authority has taken over the administration of federal health programs and services previously delivered by Health Canada's First Nations Inuit Health Branch – Pacific Region, and to work with the province and First Nations to address service gaps through new partnerships, closer collaboration, and health systems innovation.

Copied from: <http://www.fnha.ca/about/fnha-overview>

Read more at: <http://www.fnha.ca/about/fnha-overview/mandate>

Appendix 4: Health Authority APL/N Programs at a Glance

Fraser Health Aboriginal Patient Navigator (APN) Program

The Sto:Lo First Nation initiated the APL program in the Fraser Region. They were aware of the Aboriginal Patient Liaison Program at BC Women's Hospital and wanted to model a similar program to assist their members who experienced challenges navigating the hospital environment. Following three previous attempts to get a program started, they successfully initiated the program in 1999. At the time, Carol Peters, a Sto:Lo member, was working as a Social Work practicum student at the Fraser Canyon Hospital. In this role, she was exploring the barriers encountered by Aboriginal peoples in accessing the healthcare system. With support from the Chief of Social Work at the hospital, she wrote a successful proposal in 1999 to institute an APL position for Fraser East and was hired as the first APL in 2000. Initially, this position was an employee of the Sto:Lo First Nation, through a funding arrangement with the Fraser Canyon Hospital and subsequently Health Services Innovations Fund (Health Canada). The program was expanded across Fraser Health with HSIF funding in 2005. Currently, all Aboriginal Patient Liaison positions are health authority employees.

Name	Location	Employment Status	Supervisor	Employer	Service area
Carol Peters	Fraser Canyon Hospital, Chilliwack	Full Time	Director Aboriginal Health	FH	Abbotsford Regional, Mission Memorial, Fraser Canyon and Chilliwack General Hospitals and Abbotsford, Mission, Chilliwack, Agassiz, Hope, and Boston Bar communities.
Maureen Phillips	Guildford Public Health Unit, Surrey	Full Time		FH	Burnaby, Royal Columbian, Eagle Ridge, Ridge Meadows Hospitals and surrounding communities.
Danielle Milano	Guildford Public Health Unit, Surrey	Full Time		FH	Surrey Memorial Delta, Peach Arch, and Langley Memorial Hospitals, Tsawwassen First Nation, Kwantlen First Nation & Semiahmoo communities
Laura Commodore	Mental Health Stó:lo Nation Health Services	Full Time	Health Services Manager	Stó:lo Nation Health Services	Abbotsford, Mission, Chilliwack, Agassiz, Hope, and Boston Bar communities.
Rohit Kambo	Mental Health Guildford Public Health Unit, Surrey	Full Time		FH	Surrey, White Rock, Langley, Delta, Tsawwassen communities

Interior Health Aboriginal Patient Navigator (APN) Program

In 1988, an Aboriginal elder by the name of Katie Ross was brought to the Cariboo Memorial Hospital emergency department. Katie had been injured in the same shooting incident that killed her husband. Though Katie said that she had also been shot, the nurse at the Outpost Nursing Station, the RCMP officer that interviewed her and the locum physician that admitted her to the hospital did not find the gunshot wound. Instead, Katie’s presenting symptoms were diagnosed as “shock” and “anxiety”; hence she was heavily sedated. A day later, Katie was found dead in her hospital bed. A Pathologist report indicated that she had died of an infection resulting from a gunshot wound which entered through her back and penetrated her abdomen. The Pathologist indicated that timely surgery could have saved Katie’s life.

The inquest into Katie’s death recommended that the hospital institute an Aboriginal Patient Liaison position with access to language interpretation. After many years of advocacy and proposal writing, in 1999, the Cariboo Memorial Hospital instituted the first APL position in the Interior Health region. Violet Stump and Mary McMillan served in this role prior to Barbara Mack who filled this position in 2006 and serves in that position to this day. With funding from the Health Services Innovation Fund (First Nations and Inuit Health Branch, Health Canada), the APN program has been expanded to other areas of Interior Health.

Name	Location	Employment Status	Supervisor	Employer	Service area
Barb Mack	Cariboo Memorial Hospital Williams Lake	Full time	Community Integration Health Services (CIHS) Administrator, Cariboo Chilcotin	IH	Williams Lake Hospital
Wayne Jack	Ki-Low-Na Friendship Society Kelowna		Director of Programming	Ki-Low-Na Friendship Center	Kelowna area, community
Diana Moar	Vernon Jubilee Hospital	Full time	CIHS Administrator North Okanagan	IH	Vernon Jubilee, limited community outreach.
Gloria Big Sorrel Horse	Royal Inland Hospital Kamloops	Full time	CIHS Administrator Kamloops	IH	Royal Inland Hospital in Kamloops
Jayne Taylor	Kelowna General Hospital and Penticton Health Centre	Full Time	CIHS administrator Kelowna	IH	Kelowna hospital, Penticton hospital, limited community outreach.
Deb Donald	Royal Inland Hospital Kamloops	Full time	CIHS Administrator Kamloops	IH	Royal Inland Hospital in Kamloops
Anni Muhlegg,	Castlegar Health Centre	Part time	CIHS Administrator Kootney Boundary	IH	Castlegar Health Centre and community outreach.

Michelle Isaac	Lillooet District Hospital and Health Centre	Full Time		Community Agency	Lillooet Hospital and community outreach
Kimberly Keen	Cranbrook Hospital	Part Time (3 days/week)		East Ktunaxa Nation	Cranbrook Hospital
Leah Phillips	Ktunaxa Nation Cranbrook	Full Time		East Ktunaxa Nation	Community outreach.
Lisa Sloat	Aboriginal Community Health Representative				

Required Qualifications: Undergraduate degree in Social Work or Nursing and Indigenous community experience.

Island Health Aboriginal Patient Liaison Nurse Program

Name	Location	Employment Status	Supervisor	Employer	Service area
Catherine Condy	Royal Jubilee and Victoria General Hospitals	Full Time	South Island Manager Aboriginal Health	Island Health	Victoria General and Royal Jubilee Hospital
Monique Pat	Royal Jubilee Hospital	Full Time	South Island Manager Aboriginal Health	Island Health	Victoria General and Royal Jubilee Hospital I
Carol Nelson	Nanaimo Regional General Hospital	30 hrs./wk	Central Island Manager Aboriginal Health	Tillicum Lelum	Nanaimo General Hospital
Jane Fox	Saanich Peninsula Hospital	Full Time	South Island Manager Aboriginal Health	Island Health	Saanich Peninsula Hospital
Pearl Dorward	West Coast General Hospital Port Alberni	Full Time	Central Island Manager Aboriginal Health	NuuChahNulth Tribal Council	West Coast General Hospital
Helen Dunlop	Cowichan District Hospital Duncan	Part Time 30 hrs./wk	Central Island Manager Aboriginal Health	Cowichan Tribes	Cowichan District Hospital
Vacant	Campbell River Hospital	Part Time 28.8 hrs/wk	North Island Manager Aboriginal Health	Island Health	Campbell River Hospital
Margaret Wilson	Port Hardy Hospital	Part Time 28.8 hrs/wk	North Island Manager Aboriginal Health	Island Health	Port Hardy Hospital
Teliah Vollick	Alert Bay `Namgis Health Centre	Part Time 10 hours	North Island Manager Aboriginal Health	Island Health	Namgis Health Centre
Laurel Anderson	St. Joseph's Hospital Comox	Full Time	North Island Manager Aboriginal Health	Island Health	St Joseph's Hospital
April Nelson (on Maternity Leave) Katelyn Thompson (Maternity coverage)	Tofino General Hospital	Full Time	Central Island Manager		Tofino General Hospital

Required qualifications: Undergraduate degree in nursing and experience working in Indigenous communities.

Northern Health Authority Aboriginal Patient Liaison Program

Aboriginal Patient Liaison Worker Program in Northern Health is described as dating back to the mid 1980's, a program that was initiated by the leadership of a Carrier Sekani Tribal Chief. At the time, community members were expressing concerns regarding the hardship and suffering that they, especially the Elders, were experiencing at the Prince George Hospital due to language and cultural misunderstanding. A hospital based position was envisioned that could translate Carrier Sekani language and culture to health care providers and the health care system to Carrier Sekani members who were receiving care at the hospital. The first position was created in 1986 by the Tribal Council with funding from FNIHB. At the time, the position was focused on supporting Carrier Sekani members only. In 1990, the position was transferred to Carrier Sekani Family Services and FNIHB funding supported this position until 1998. At that point, funding for the Prince George Hospital based position was assumed by the Northern Health Board and subsequently by Northern Health Authority. With changes in Northern Health (e.g. Prince George Hospital becoming a regional hospital serving the whole of the north) the scope of the position evolved to first cover all First Nations peoples from Northern Aboriginal communities; and subsequently to include all Aboriginal peoples (including Métis). In 2005, with funding from the *HSIF*, the APL program was expanded to other location across Northern Health.

Name	Location	Employment Status	Supervisor	Employer	Service area
Angie Combs	Wrinch Memorial Hospital	Full time	Interim Site Manager Wrinch Memorial Hospital	NH	The Hazeltons
Mary Wesley/ Matina Sampare (relief APL)	Prince Rupert Regional Hospital	Full time	Health Services Administrator – NW Health Services Delivery Area	NH	Prince Rupert, Haida Gwaii and area
June McMullen	University Hospital of Northern BC in Prince George	Full time	Executive Director, Health Services, Carrier Sekani Family Services and Chief Social Worker University Hospital of Northern BC. (NH)	CSFS	Prince George and region
Lillian Lewis	Dze L' Kant Friendship Centre, Smithers	Part Time 4 days/week	Executive Director (Dze L'Kant Friendship Center) and Health Services Administrator, Northwest Health Service Delivery Area (NH)	Dze L'Kant Friendship Center	Smithers
Lyndsey Rhea	GR Baker Memorial Hospital Quesnel	Full time	Manager, Medicine and Maternity	NH	Quesnel
Bev Lambert	Fort St. John Hospital	Full Time	Manager of Patient Care, Primary Health Care	NH	Fort St John, Peace Villa Care Facility & Community

Yvonne Tupper	Chetwynd General Hospital, and Dawson Creek General Hospital	Full time	Health Services Administrator, South Peace	NH	Dawson Creek, Chetwynd and South Peace Region of NE BC
Ken Solonas	Lakes District Hospital and Health Centre Burns Lake; St John's Hospital in Vanderhoof (on a referral Basis) and Stuart Lake Hospital in Fort St James (also on a referral Basis)	Full time	Health Services Administrator, Lakes District	NH	Burns Lake and area
Lloyd McDames	Mills Memorial Hospital in Terrace	Full time	Interim Director of Care	NH	Terrace and area

Required qualifications: Graduation from recognized program in Social Science and 1 year experience.

Provincial Health Services Authority Aboriginal Patient Liaison Program

Indigenous communities, working through the Native Brotherhood of BC identified a need for an Aboriginal Patient Liaison Program at Women's and Children's Hospitals. In September 1994, with funding from the Vancouver Foundation, Women's Hospital, Children's Hospital, Sunny Hill Health Center, Native Brotherhood of BC and 13 BC First Nation Bands, a program was created to serve Women's Hospital, Women's Health Center, Children's Hospital, Sunny Hill Health Center and GF Strong Rehabilitation Center.

Respected Elder Vince Stogan provided program guidance from the inception of the program and until his death in 2000. Since then, an advisory committee made up of diverse Indigenous communities guides the program. Currently two APLs provide services to all programs at the BC Women's and Children's Hospital campus. Coverage for Sunny Hill and GH Strong are no longer provided.

Name	Location	Employment Status	Supervisor	Employer	Service area
Susan Soloman	BC Women's Hospital and Health Center	Full Time	Aboriginal Health Program Coordinator	PHSA	All areas (including out-patient services/day programs and day surgery) of BC Women's Hospital, BC Children's Hospital and BC Mental Health and Addictions programs operating out of the Children's and Women's Hospital and Health Center campus
Amanda Gonet	BC Women's Hospital and Health Center	Full Time	Aboriginal Health Program Coordinator	PHSA	Same as above
Jennifer-Lee Koble / Bernice Albert (Casual – vacation and sick coverage)	BC Women's Hospital and Health Center	Part Time 0.2 FTE	Aboriginal Health Program Coordinator	PHSA	Same as above
Linda Stiller (Casual – vacation and sick coverage)	BC Women's Hospital and Health Center	Part Time 0.2 FTE	Aboriginal Health Program Coordinator	PHSA	Same as above
Dana Marshall	BC Cancer Agency, Centre for the North	Part Time 0.6 FTE	Professional Practice Lead Patient and Family Counselling	PHSA	BCCA – Center for the North

Required qualifications: Undergraduate degree in Social Work or Nursing

Vancouver Coastal Health Aboriginal Patient Navigator Program

Name	Location	Employment Status	Supervisor	Employer	Service area
Dion Thevarge (APN and Team Lead)	2750 Hastings Street East, Vancouver.	Full time	Regional Director, AHSI	VCHA	Lion's Gate Hospital, St. Paul's Hospital, Mt. St. Joseph's Hospital, Vancouver General Hospital, UBC Hospital, Richmond Hospital, G.F. Strong Rehabilitation Center, Holy Family (rehabilitation, geriatrics), Squamish General Hospital. All community health and mental health centers (Evergreen, Raven Song, Robert and Lilly Lee, Downtown, Pender, Three Bridges, Pacific Spirit, Central in North Vancouver and South) as well as home visits
Vacant	2750 Hastings Street East, Vancouver.	Full time	Team Lead, APN Program	VCHA	Same as above
Vacant	2750 Hastings Street East, Vancouver.	Full time	Team Lead, APN Program	VCHA	Same as above
Rochelle Johnson Jessica Lutwick (Casual Staff)		Varies	Team Lead, APN Program	VCHA	Save as above

Required qualifications: Undergraduate degree in health care, Social Work, Nursing or related discipline and two (2) to three (3) years recent, related experience working with Indigenous communities in British Columbia.

Appendix 5: Health Authority Promising Practices

Fraser Health

Debriefing Indigenous Cultural Competency (ICC) Training Sessions

Fraser Health has an annual allocation of 500 seats in PHSA's ICC training program. The Public Health Program of Fraser Health has made a commitment to train their total workforce by 2015. The Debriefing Session was an idea brought forward by a Clinical Nurse Educator (CNE) in Public Health. The goal was to provide staff that had completed the training an opportunity to debrief that experience and explore how the training could be integrated into their work.

Debriefing sessions are organized and promoted collaboratively by the CNE and two Community Integration Coordinators (CIC) in the Aboriginal Health Program. The CNE does the promotion and registration while the CICs organize the sessions and provide the facilitation. Sessions are structured in the format of Traditional Healing Circles, following protocols and practices such as beginning each session with prayer/song/drumming; and use of an eagle feather/talking stick or rock by the speaker. Sometimes, a Traditional Healer is also invited to support the session.

Sessions are offered in all three regions of Fraser Health for a total of nine sessions per year. Each session runs for two and a half hours and includes 10-12 participants. Participation in the debriefing is voluntary, is open to professional, clinical and administrative staff and sessions usually make up a mix of them. Each session has two circles with a break in between. The first circle focuses on the personal impact of the ICC training while the second circle focuses on professional impact and how this new knowledge and insight could be integrated into participants' practice. While the talking circles provide the platform for debriefing ICC training, it also introduces participants to a traditional Indigenous practice. For many, this is a new experience.

Feedback on what was learned and how to enhance the debriefing sessions is received via evaluation. Evaluations done to date indicate that the talking circles are powerful experiences for the participants; and many say that while the ICC training was impactful, the talking circles engaged their hearts and something changed as a result. Sessions are often emotional experiences for the participants.

Island Health

Button Blanket Wall Hanging Initiative

The Button Blanket Wall Hanging Initiative – a partnership between the Maternal Child Unit (MCU) of St. Joseph Hospital in Comox and the surrounding Indigenous communities, is led by the Manager of the MCU and the APLN. The aim is to build cultural safety for Indigenous

mothers that come to the MCU; supporting mothers to have a say is how things are done, creating a happy environment for them and allowing the beginning of life to happen at a different pace. Since "Button Blankets" are Nation specific, the concept of a "Wall Hanging" was adopted to ensure that people from all Nations were included and felt welcome. Creation of the wall-hanging began with Elders and women (who had given birth in the past 5 years) coming together to discuss their experience at the MCU in relation to cultural safety. Specific questions helped to draw out their experience. Following this the women and the APL/N came together to create the squares of the wall-hanging. They discuss their experiences and solutions to the issues they experienced as they sew the squares. When their schedules permit, MCU staff also participates in creating the squares and the discussion.

Parallel with this process, MCU unit staff was engaged in raising their awareness on cultural safety. This process began with a pre-knowledge quiz and was followed up with information/education sessions on working with Indigenous women and cultural safety. Once all the squares are completed, the wall-hanging will be brought to the hospital to sew the buttons. Elders will be invited into the hospital to support this process. Sewing on the buttons will create an environment where Elders, MCU staff and families (Indigenous and non-Indigenous) have the opportunity to visit, engage in informal exchange and learn from one another. This will continue for several months. When the wall-hanging is complete the Elders and women will gift it to the maternal unit.

The Mobile Medical Unit (MMU)

The four First Nations communities in the Saanich Peninsula of southern Vancouver Island meet monthly to discuss common healthcare issues. At one of these meetings, PHSA made a presentation on the MMU following which the Tsartlip Band continued communication with this PHSA program. In September 2013, the MMU was invited to spend two days in the Tsartlip community, giving all four communities an opportunity to access services provided by the MMU.

Vancouver Island Health's Aboriginal Health Program supports a Nurse Practitioner (NP) that provides primary health care in the four communities (1 day each in each community). The Nurse Practitioner also liaises with the Saanich Hospital staff and Family Physicians on behalf of patients. At the request of the community, the MMU came staffed with a Pediatrician, Pediatric Allergist and a Respiratory Technician among other staff (provided by PHSA). The NP was able to make the required referrals for this specialist service as 40% of the communities' population does not have a family physician.

Over the two days, the MMU assessed and treated 52 children for respiratory issues and provided a Chronic Obstructive Pulmonary Disease clinic for adults. A mother whose two children were assessed and treated was in tears because her two children had finally been diagnosed with asthma. When the healthcare providers looked at the patient data, they were shocked at the number of emergency room visits that were made by the patients treated on these two days.

The MMU is a great service that can reach underserved people who, for a variety of reasons, may not access healthcare via regular channels. Combined with Telehealth, the MMU could better serve rural remote communities easing people's burden to travel to far away healthcare services.

All Nations Healing Room – Royal Jubilee Hospital in Victoria

Indigenous communities identified the need for a dedicated space where patient's families could safely hold cultural/traditional ceremonies. With funding from a donor the new All Nations Healing Room was purpose built on hospital grounds. The facility is designed to look like a long house with welcoming poles, doors and panels inside the facility that were carved by Indigenous carvers. The healing room is equipped with a negative air pressure system that keeps smoke out of the hospital ventilation system; making it possible to perform smudging. During construction, the Fire Department was involved to ensure that the space met fire safety standards.

The facility is designed to easily roll in a patient bed and accommodate large families. The healing room opens to a courtyard that has a water feature and beach log. Drumming, singing, smudging and burning of candles are routinely carried out in this facility that is well used by families for Indigenous ceremonies from around the world. The healing space has gone a long way towards building trust between hospital and the community and Island Health is now committed to including these spaces in all new hospitals.

The Returning Home Initiative (VIH, CHBC and FNHA Partnership)

Funded by the HSIF, the Returning Home Initiative is a partnership project of Vancouver Island Health, Child Health BC (CHBC) and the FNHA. It is a three year pilot project which aims to improve health outcomes of Indigenous children with complex care needs living in central and north Vancouver Island. Complex care is defined as a child patient that is receiving care from more than one specialized physician.

The initiative, in the second year of the pilot, supports an Aboriginal Patient Liaison that coordinates care planning across the many healthcare providers that are involved with a patient. Referrals are received from a variety of disciplines. The APL/N has a bird's eye view of the child's healthcare needs and the range of healthcare providers that are involved in the child's care. The APL/N functions like a centralized communication hub among these various healthcare providers in acute care and facilitates communication between acute care, the family and community based care to ensure follow through with treatment plans and ensure continuity of care. Providing information and linking to resources and services, the APL/N is primarily a support to the family.

Since many children with complex care needs will receive healthcare at tertiary facilities such as the BC Children's Hospital, Sunnyhill Health Center and Vancouver General Hospital pediatric services, the APL/N coordinates care planning across these facilities – receiving

referrals from and making referrals to these facilities. The APL/N also follows up on treatment plans post discharge. The length of this involvement differs as needs of each child differs based on complexity of their medical issues. In the third year of the pilot, decisions will be made on criteria that will guide the provision of this follow up care.

Northern Health

Community of Practice

Northern Health's Aboriginal Health Program has a position (Lead, Integration and Engagement) dedicated to building cohesion of and strengthening the APL program. Implementing recommendations of the 2011 program evaluation is part of the responsibilities of this position. The position provides overarching support to the APLs but does not have supervisory responsibilities for them. The Lead also provides support to the Managers who are supervisors of the APLs to address their needs and provides tools and resources as appropriate.

On the recommendation of the evaluation, NH has implemented a "Community of Practice" for the APLs in NH. It is a forum that allows APLs to address common concerns amongst themselves as they receive a diversity of supervision experience. The Lead coaches APLs to develop their own ideas and solutions with communications strategies and health authority resources.

The Community of Practice is also a forum that helps the APL/N to identify and deliver system wide training needs. For example, patient charting was an issue for many APLs. Through a partnership with the College of New Caledonia a training module was developed and training was provided to APLs on patient charting. Training was delivered on the effective use of technologies to enhance the APL role and functions. Another important issue identified was how to help patients/clients/families and themselves to deal with grief and loss. A workshop and resources were provided on this topic. Developing common tools and approaches, for example, developing strategies to support health authority colleagues increase their effectiveness to work with Indigenous peoples and program promotion are undertaken by the group.

Training Module on Patient Charting

In healthcare, there is an obligation to document any contact that a practitioner has with a patient for transparency and accountability. Patient charting is also a means of documenting the nature and extent of a service provided and helps to assess workload. What is not charted is not counted. Northern Health uses a paper based patient charting system. Many APLs in Northern Health were not charting their interventions because they were challenged with both the time and the competency for charting. The Aboriginal Health program contracted with the College of New Caledonia to develop a training module and train all the APLs. The module and training were also videotaped for utilization in future training delivery. The training provided guidance on what to chart and when to chart –

establishing charting standards (e.g. use of common language/terminology to describe an intervention). The contractor trained all the APLs and provided some follow up support.

Discharge Planning at Intake/Admission

At the Mills Memorial Hospital, discharge planning starts at intake/admission. An intake assessment gathers information on the presenting situation, history and family and community supports available to the patient. With consent from the patient, the Aboriginal Patient Liaison (APL) works with community and family of Indigenous patients to ensure that they are apprised of the medical condition of the patient and supports and services are available for any ongoing care at discharge. Discharge planning is done through a team approach, usually involving the Head Nurse, Dietician, Social Worker (SW), APL, Occupational Therapist, Physiotherapist and sometimes a Pharmacist. APL and the SW working as a team will make referrals to required services (e.g. Alcohol and Drug, Mental Health, Diabetes care etc.) and arrange required supports (e.g. transportation) and equipment (bath rails/bath chairs and their safe installation, walkers and wheelchairs from the local Red Cross loan cupboard etc.). Referrals are also made to programs and services that will enhance the patient's social and emotional well-being such as Meals on Wheels program, adult daycare program (for social support and outings).

Often, patients come from rural areas where a Home Care Nurse (HCN) has sent the patient to hospital. APL will ensure follow up with the HCN sharing medical information (with consent of patient) and coordinating equipment, services and events that will be required at discharge. Where necessary follow up is also done to ensure that medical appointments are kept and medications are used accurately through communication with HCN.

Provincial Health

The Elders Program at Children's and Women's (C&W) Hospital

Women's Hospital and Health Center has a compliment of Elders on contract that are called upon to provide support to families in crisis. They provide emotional, cultural and spiritual support, especially in times of loss. Increasingly, elders are also called at births. The Elders come from a diversity of cultures and backgrounds and bring a diversity of expertise. Elders are remunerated for their services.

Aunties and Uncles Volunteer Program

This program at Children's and Women's (C&W) Hospitals has been developed similar to the "Friendly Visitor Program" at these hospitals. The program recruits and trains Indigenous volunteers to visit Indigenous patients who are transferred from distant communities and do not receive family/friendly visits. This program works closely with the Volunteer Program at C&W which provides training, does criminal records checks, required immunizations and an avenue for Indigenous volunteers to access other volunteer opportunities.

Vancouver Coastal Health

The Enhancement Project

With funding from the Vancouver General Hospital Foundation, Vancouver Coastal Health APN program is working on a project to accurately chart and track the service they provide; using LEAN Management principles. The goal is to use standardized and consistent data to enhance the VCH APN program – particularly their reach into rural and remote communities. The project is redesigning their database to capture patient data, the nature and duration of the intervention. The project is also developing codes to standardize interventions and also ease the recording of data.

Appendix 6: Culturally Competent Healthcare

Improving healthcare for Indigenous peoples requires a “whole-of-health systems” response. PNs and/or their supervisors alone cannot be left to forward this agenda (Posenelli et.al., 2009). PN programs are a key step in this direction as well as for enhancing the cross-cultural clinical encounter (Betancourt et. al., 2002). Success of PN programs requires executive level “buy-in” and senior management “champions”(ibid.) Executive and senior management personnel, however, must be supported with high quality awareness training, good data, policy background, promising practices, and informal relationships and formal partnerships between health care and community (ibid). “Rather than creating a role that fixes holes in the system, we should be fixing the system” (BCCA, pg. 36). The PNs can be a catalyst for system change and must be supported to play this role (ibid).

Cultural competence is a way to increase access to quality care for all patient populations. The ultimate goal of cultural competence is to achieve a healthcare system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background or English proficiency (Betancourt et.al., 2002). Culturally competent healthcare creates healthcare environments that are free of racism and stereotypes where Indigenous people are treated with empathy, dignity and respect and care is provided in a culturally safe manner (Canadian Medical Association, 2013). This includes trust, respect of patient beliefs, recognition of socio-economic and cultural factors; and patients become partners in making decision about their health (CMA, 2013).

Cultural and linguistic competence includes a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situation (Ngo-Metzger et. al., 2006). Culturally competent care is “the ability of any health care provider of any cultural background to effectively treat any patient of any cultural background” (Matus et.al, 2004, pg. 257). Clinicians become culturally competent only with the support and encouragement of the health system in which they operate (Brach et. al., 2000).

Qualitative and quantitative data on patients’ race/ethnicity, socioeconomic status, linguistic capacity, health literacy must support sound decision making (Ngo-Metzger et.al., 2006; Betancourt et.al., 2002; Posenelli et.al. 2009). Tools, benchmarks and quality indicators must be adopted to evaluate cross culturally competent care (ibid.). Successes must be based on patient satisfaction, good clinical outcomes, reductions in the barriers to care, the collaboration and partnership between health care leadership and community organizations (ibid.) Data must lead to strategies for systemic improvements and PN programs must be enhanced based on quality data (Posenelli et.al., 2009). Experiences of discrimination must also be investigated and structural system-wide improvements must be made (Ngo-Metzger et.al., 2006).

Barriers to Culturally Competent Care (Betancourt et. al., 2002; Brach et. al., 2000).

- Lack of diversity in health care leadership (Boards, among key decision-makers) and workforce
- Systems of care poorly designed for diverse patient populations
- Poor cross cultural communication between providers and patients

Benefits of Cultural Competence (Betancourt et. al., 2002)

- Elimination of barriers and improving access
- Elimination of health disparities
- Quality improvement of care

A Framework for Achieving Cultural Competence (CC) (Betancourt et. al., 2002).

Organizational CC:

The leadership (especially decision-making tables) and workforce of an organization represent the diversity of the population it serves; has prioritized recruitment and retention of diverse workforce; has Human Resource policies and practices to hire and promote staff from diverse backgrounds – setting targets for diverse workforce; and collaborates and partners with community organizations.

Systemic CC:

The organization has policies and procedures to promote cultural competence; has information and resources suitable to a diverse patient audience; collects data to monitor progress towards cultural competence goals (including detection of medical errors that may result from lack of cultural competence); and has programs to help patients navigate health care system to support their active participation in the clinical encounter. And the organization will also have administrative practices such as accessible location and hours of operation and will create welcoming physical environments (starting at the reception desk).

Clinical CC:

Providers understand how sociocultural factors influence access to healthcare and healthcare decisions and have respectful communication skills; mechanisms are in place for addressing racism; patients are empowered; on the job training and training programs of healthcare professional include skills training - not just awareness training; there is respect for and incorporation of alternative and traditional healthcare practices and health promotion and disease prevention practices are suitable for diverse audiences.

Appendix 7: On-Reserve Health Services

In October 2013, full control of Health Canada funded programs and services transferred to the First Nations Health Authority. Health Canada funded a range of programs and services in First Nations communities. All communities have a Nursing Station or Health Clinic and in most remote communities, the nursing station functions as the primary care facility. In some communities, the Nursing Station is part of a much larger Health Center.

Each First Nations community also has a Home Care Nurse (HCN) usually hired by the Band. In some communities, a HCN with specialized training provides primary care. Rural remoteness poses challenges for recruitment of healthcare staff so some communities do not even have a HCN, the most basic healthcare service available to First Nation communities. Yet other communities are served by a part time physician or Nurse Practitioner and have a full range of services, including Home Care Nursing, Community Health Nursing, Wellness Coordinators and mental health and addictions counseling.

Nursing Stations provide 24/7 services, including emergency services, while Health Centers provide services from Monday to Friday during the day. In some instances, Health Authorities augment these services by providing some services such as Home Care Nursing outside of these hours. Some of these arrangements are done through Memoranda of Understanding. Since communities are not equal in the services that are available, knowing the patient's particular community and the services and resources available are critical for effective discharge planning, follow through with treatment and the continuity of care.

Home and Community Care (HCC)

The role of HCC is to provide case management services for nursing, home support and allied healthcare services for the on-reserve population. The HCN assesses need, manages dialogue with physicians and pharmacists; makes arrangements for special equipment, supplies, medications and transport through Health Benefits; arranges personal care and housekeeping services; and arranges other services such as physiotherapy, occupational therapy and dietetics.

When a patient is in hospital a HCN may visit the patient in hospital to get to know the healthcare providers and will maintain communication with the hospital staff to learn how a patient will need to be supported with her/his treatment plan. HCNs play a pivotal role in the follow through of treatment plans and continuity of care, therefore, it is important to involve them in timely discharge planning.

Community Health Nursing (CHN)

As with HCN, there is funding for a CHN in every First Nations community though not all positions are filled due to issues with attracting staff to rural remote communities. The role

of a CHN is to do immunizations and coordinate communicable disease control, outbreak control (e.g. TB testing), and gastrointestinal infection control. CHN also has responsibility for the Maternal Child Health Program, providing pre and post natal visits and Well Baby clinics. A CHN will liaise with hospital staff in relation to the birth of a baby. Involving a CHN in the discharge planning is critical to ensure post-partum wellness of the mother and health and development of the new baby.

Community Health Representative (CHR)

The CHR is described as an unregulated and variable role – a position that is utilized by communities differently. In some communities a CHR assists a nurse with Well Baby clinics and immunizations. In other communities, a CHR might provide more in-depth services such as diabetes education and children’s oral health programs.

Home Support or Personal Support Workers

Most communities that have HCC programs also provide support workers – positions that are unregulated, therefore varied in the services provided. Accessed through a HCN, a support worker provides personal care needs of a patient (such as bathing), housekeeping and other activities of daily living.

Appendix 8: Health Benefits – An Overview

In October 2013 the full control of *Non Insured Health Benefits* was transferred from First Nations and Inuit Health Branch to the First Nations Health Authority. Currently known as [Health Benefits](#), the program operates similar to an extended health benefits plan. There is coverage for vision, dental, pharmacy and short term counseling for crisis intervention (e.g. Mental Health Counselling) – and places maximum funding limits for the products and services that are funded.

Health Benefits also provides funding for medical transportation, including accommodation and meal allowance for the patient as well as a patient’s escort (if deemed required by a physician). Medical transport was designed to assist First Nations patients in rural and isolated communities to access healthcare that is at a distance, therefore, it does not cover local transport.

The administration of Health Benefits is done through contribution agreements with First Nations communities and community based organizations. Travel Clerks hired by these organizations assess and process all medical transportation requests. There is an appeal process available to patients and families.

Appendix 9: Patient Comments

Assumptions and Attitude

"They should not assume or judge. My daughter took her 6month old baby to the hospital because he has not eaten anything for 10 hours and is tensing a lot. The mother is nursing him and only gives water in a bottle. And he is not a fussy baby. He is happy to sleep when tired. The doctor didn't want to listen to this explanation...asked my daughter three times if she was feeding the baby juice in a bottle. He couldn't hear that she wasn't. My daughter got so frustrated that she left with the baby."

"A lot of times services depends on family doctor. "My family doctor judged me and I ended up with a bad judgment. At the time I was 55 years old and to him, I was short, fat and Indian. He said I had COPD (cardiac obstructive pulmonary disease) and gave me medicines for it. I was on these medicines for 4 years. When this doctor retired, I found a new doctor who said she didn't see symptoms for COPD so she wanted me to re-do the tests. The tests said that I don't have COPD or any heart disease so I am no longer taking the medications. This earlier diagnosis affects me in many ways. For example, I can't get mortgage insurance. I work in education. I am usually assertive and outgoing. The doctor was white and had a lot of power. He is an authority figure who holds my life in his lands. So I let him do this to me."

"My husband had triple by-pass surgery in Vancouver. When he was discharged they gave us medications and clear instructions on how to take care of him at home. They said if there is any pain, we should go to emergency. So, we followed these instructions and went to emergency several times because of his chest pain and the local hospital was annoyed with us. So the doctor one time said something like "we have nothing to lose by sending him home." I was very upset....yes, the doctor has nothing to lose but I have something to lose if my husband didn't make it. So I asked the doctor to say this in writing. So the doctor said OK, we will do an ECG. That led to more tests and it turned out that my husband had to have angioplasty for 2 more blocked arteries. I am usually a good advocate but I was scared to speak up because whatever I said could affect my husband's quality of care."

"I have a hernia so my old doctor gave me many pain killers/narcotics. My new doctor questions why I am taking all these medications. She finds out why I am hurting and then treats me for it. She is taking medications away and suggesting other therapies."

"We don't have a health care system. We have a disease care system."

"Going to hospital or to see a doctor, for me, has been my most challenging experience. I am terrified to go to a walk-in clinic. I have been accused of drug seeking.....being a cocaine addict.....and wasting everyone's time. I am prone to migraines so one time I went to see the doctor at a walk-in clinic. I was wearing a hat and dark glasses to keep the light out so the clinic said to me "we don't give out narcotics."

"I was going to hospital a lot with my sister who was addicted to drugs. I have the feeling that the hospital really has no time or interest in people with addictions, especially if they are Aboriginal. They assume you are there to get some drugs so they give it to you and send you away - they deny it."

"Solution is to keep away from the hospital."

"Doctors and nurses should have some concern - see people as people. Try to make a personal connection.....not treat us like just a number."

"My adult son was addicted to drugs but then he got on a weaning program. He attempted suicide.....took some pills but then called me for help. I went with him to the hospital- we first saw a crisis nurse and then the doctor. Neither the nurse nor the doctor seemed to care. The nurse said if he really wanted to kill himself, he would have taken the whole bottle of pills - not just 10 or 12. She said 'he can get a job.' I said to the doctor that my son needs to be diagnosed properly. The doctor said 'what do you want me to do. Do you think he needs to see a Psychiatrist? As a mother I felt angry enough to hit somebody. I am a warrior woman but I didn't want to say anything. At the hospital there is a big board that says that abusive behavior is not tolerated. I was afraid that if I got angry, they would see it as abuse and throw me in jail. They [health care providers] can be abusive and uncaring....they have no consequences. I had to advocate for ourselves a lot before we got the help we needed."

"In hospital, attitude towards people with addictions is very poor. When I was in hospital for myself, they treated me very well because I had an 'acceptable' illness. But when I went to hospital with my son who has issues with addictions, the treatment was very different."

"What makes it easier for me.....to put it bluntly, they [healthcare providers] know I won't put up with abuse..... so they get the message that I won't tolerate any abuse."

"I visited emergency with my baby one time and the experience was very different. I didn't appreciate the attitude of the doctor we saw, who was still in training. He and the nurse were having a conversation about other things. The nurse stuck a thermometer in my baby's butt without asking and saying anything. I was sent to emergency by my Pediatrician. My baby was tilting her head to one side and the Pediatrician thought the hospital could do more testing. But the doctor at emergency asked why I was there...basically didn't do anything and referred me back to my Pediatrician. This doctor was really arrogant...didn't believe me and treated me as if I was stupid. I was upset that I even went there."

"We need someone to advocate for us....to find the right doctors/care. Advocates can be family."

"Being judged."

"Six years ago when I was pregnant I was in hospital for 5 months. Three of those months I was in a coma. My family wanted to do a spiritual ceremony with singing and drumming and the hospital allowed this. I am so grateful because without this I wouldn't be alive."

"I have Chrones Disease so I was referred to a Dietitian. She had no understanding of First Nations culture. She gave me very "stereotypical" information. Said she had a First Nations Food Guide but that had foods like Baloney and Bannock."

"My father was diagnosed with rheumatoid arthritis. He saw many doctors but got sicker and sicker. He got to a place where he couldn't walk. My sister came and took him to a hospital in the city. The doctor there did a biopsy and my father was diagnosed with lung cancer. The doctor there said that he would have had it for at least 5 years."

"Feel like our lives are not valued."

"No cultural awareness. What kind of training do they get?"

"Doctors want to give you pills, pain killers."

"My son got into trouble and got sent to hospital. He was discharged at 1:00 am and the nurse called and left me a phone message. She said 'he doesn't have a shirt and he is walking home.' We live in the north....it was cold outside. I think the nurse realized her mistake because she called again and left another message that my son will be staying in hospital until morning."

Communication issues

"They (doctors and nurses) need to listen to the whole story – act on hearsay."

"Sometimes we are not heard."

"We know what to do. We go organized with all the information. Health care works for us because we work with them."

"The system is set up to fail. Front line service providers are all over worked. They have no time to figure out these extra layers that affect peoples' care. Sometimes Aboriginal people don't say anything because they have had negative experiences in the past. Other times, Aboriginal people don't say anything because they come from backgrounds where you don't speak for yourself....someone else speaks for you."

"I had to do a lot of advocacy. I was shocked at how much work was needed."

"People have intense fear and vulnerability. Some people can't speak for themselves. Must create opportunity for them to be heard."

“Some doctors in ER listen to you. Some doctors don’t give a hoot.”

“I have had many interactions with the health system....many health conditions....and the system is good to me. In my community, they call me the one who dances in both worlds. I am fluent in my language, very involved in my community but I am also very involved in planning health services. But not all of our people are in the same boat. Some (elders) don’t understand English. They clam updon’t know what to say. They are scared. In hospital, especially when you are being diagnosed, it is very crucial to have someone well versed in both languages....able to translate.”

“Our people need help with follow-up care. They need nutritional information....people don’t know about diet for diabetes and heart disease. When a doctor explains, some don’t hear all this information and some think that the doctor is expressing his/her opinion.”

“Doctors need to listen.”

“Some doctors and nurses are helpful.”

“It will be good to have a 1-800 number to call and consult with APN. Because there are no APNs in every hospital or doctor’s office. Someone who could provide medical information. Explain some of the terms and words.”

“Encourage patients to take a note pad and write down what the doctor says. Also write down your issues and questions before you go to the doctor.”

“I have Long QT syndrome. My Cardiologist has given me a list of medications that I should not take. I was working out one day and my heart started to race so I went to the local hospital. A new doctor was there so I asked if he would call my Cardiologist. He was angry that I asked him this. Then a little later he came and asked the nurse to give me a drug intravenously. I asked if he has checked the list of meds I shouldn’t take. He said nothing to me and asked the nurse to administer the drug and very quickly my head felt like it was ready to explode. I told the nurse and she looked real nervous.later, my regular doctor called the Cardiologist. Even my regular doctor won’t tell me what drug I was given that day. So many people die in my community. We need to advocate for ourselves.”

Access to Health Care and Health Benefits

“We have to go a long way to get to the hospital or see a doctor. We have a medical bus but it leaves our community at 7:00 in the morning and gets to the hospital at 10:30. My husband is too ill to take this bus....it takes too long. So now we have to find our own transport.”

Health Benefits

"My husband was diagnosed with a cardiac issue and was on waitlist to go to Vancouver for surgery. Even though the doctor said that my husband will need accompaniment, his staff wouldn't give me a note so I could get travel approved for an escort. "

"I need a walker but a Physiotherapist has to come home to take my measurements. I can't go to the Pharmacy like other people can and get my walker."

"I need glasses with special lenses that are not covered by health benefits. And they only provide \$75 for frames. Where can I get frames for that amount. So I have to come up with the extra money for my glasses."

"The agency [Community based organization that administers health benefits] asks for things so I have to go to my doctor to have forms filled. And my doctor charges \$30 for filling out forms."

"A car ran over my daughter's foot. She was in a wheelchair for one year. She has been addicted to heroin and has been on the methadone program. She has a difficult time getting to the program because she has no money to take the bus and it is hard for her to walk because of the pain in her foot. When she doesn't show up, she is cut-off from the program. So she turns to heroine to deal with the pain."

"Can't get reading glasses because the full cost is not covered. I don't have the extra money that is needed."

"Dentures and braces are only partially covered."

"Welfare used to pay for taxi for medical appointments. They now give \$600-800/year towards transport but they give this in a lump sum. Not good to give this kind of money to poor people who will spend this money on food and other things they need."

Patient comments about APL/N

"[APN] Someone who knows what I am saying. Understands me."

"Previous APL was very quiet. Never heard from her. But the one in the hospital now is excellent."

"Saw the pamphlet and asked the nurse if the APL will visit but we never saw the APN."

"We need someone to advocate for us."

"I got cancer six years ago. I have problems again but I had to cancel three appointments because I couldn't get time off from work to go to my appointment. There is no back up to

operate the machine when I am not there. And, my employer doesn't believe me. So finally APL wrote to my employer and said that my cancer has come back and I need chemotherapy. Even then, my employer told Employment Insurance that I quit work so I couldn't get EI. APL helped me with this also. First Nations people need special Social Workers to help us fight for our rights."

"My baby was in NICU (neo-natal intensive care unit) for 110 days but I never saw an APN. I didn't know about this service and don't know how they could have helped."

"I have bad Arthritis and a rod in my shin because of an accident. I have no transport so I walk everywhere with a walker. The hospital/health center is a six block walk up hill. Sometimes my legs give out.....so I sit and rest on my walker. I walk everyday but when it rains and snows I don't go out. It is hard when it is cold. [APN] is very helpful to me. He signs me up for doctor's appointments, picks me up for appointments and is always there for appointments. I used to live far awayacross the lake. Problem to get to appointments...because of ferry. APN helped me to move closer to hospital...now everything is close.....doctor...grocery store."

"The first time I dealt with the APN was when my maternity doctor thought something was wrong with the baby and referred me for genetic testing. I was scared, alone and very stressed. The genetics department was really great but with all the emotions it was very confusing. The nurse called the APN who was really helpful. She went with me to the appointment and wrote down the questions and took down notes."

"My dad had congestive heart failure. He was 74 or 75 at the time. The doctor asked us to sign a DNR (do not resuscitate) order. I spoke with a nurse who advocated for us so the next day my dad was sent to Vancouver where they implanted 2 Stents. My dad died at age 86. You see, the level of care in rural outposts is not as sophisticated as Vancouver."

"MY 15 year old grand-daughter attempted suicide. She was hospitalized for 4 days. When she was discharged we didn't know how to deal with her. The Psychiatrist gave us no information. We were scared that what we say or not say might push her to try this again. We were lost. Finally, her school gave me the phone number for the APN and other resources. APN was beyond wonderful. She listened and guided to where I could get help. Grand-daughter wouldn't connect with anyone but connected well with APN so she is now providing counseling to my grand-daughter. This is short-term. Don't know what will happen afterwards. We are very lost in the system."

"APN gives us information that no one else has given. Helping me to get on disability."

"APN – drives for appointment. I have no money for the bus and it is too far to walk."

"APN – accompanies to appointments."

Appendix 10: Healthcare Provider Comments

Issues

"Staff don't understand how history has impacted mothering/family life today."

"Complaints processes don't always work."

"Staff always change....so there are always new people to deal with. Things get missed."

"They (Indigenous peoples) have historical issues, especially history with some professions. Social Work was involved in assimilation policies. So there is fear of social workers."

"They [APNs} do what I do."

"There are workers who assume that Aboriginal people always want something."

"Patients end up in NICU (neo-natal intensive care) for months. Causes real hardship for other children at home."

"Some are very timid about coming to healthcare, they are not attached to family or community. They don't talk. Just want to get help and get away. APN establishes contact. Makes it easier for them to come back."

"People look at Aboriginal Peoples and make judgments about their intelligence...work ethic."

The hospital experience.....the night gownseating porridge...so many reminders of residential school experience."

"Mistrust of government institutions like school and health care that have abused Aboriginal peoples. And don't serve their interest to this current day."

"Western concept of treatment. Role of family – can have 3 generations at bedside."

"Urbanization, homelessness, poverty, A&D, repeated cycles....all issues."

"Many live in communities off the beaten path, no bus service, transportation. And poverty is an issue."

"Need a structured orientation program."

"Would like a forum to come together with other supervisors, even via video conference. APL/Ns go to lots of conferences, but when they return there is not much clarity on what was learned."

"New strategies, goals, new initiatives, how to test a new way of doing things – supervisors need to be involved."

“Anything that helps us to understand the vision for APL program and how are we going to develop strategies to operationalize that vision and how we know where we are at.”

“Currently scoping roles and functions are developed on an individual basis.”

“Also develop tools and resources that APLs can localize and use.”

“Support APL to build on that key messages (of Cultural Competency training), provide vignettes that help to better understand what a bad experience looks like. A video that shows what insensitivity, discrimination, poor communication can look like.”

“When the new hospital was built, I remember moving in.....designers were asking APL about how to set up the spiritual space/healing room. Things like what was needed in room.....colour, pictures, seating. APL needed to go to a resource to find out. Who should be a resource for hospitals developing these? Also welcome to the hospital different pictures, wording, what else is needed to make the Aboriginal patient feel welcome. Create good patient experience, what else is needed?”

“Yes, we can look after the patient’s needs but how to improve the patient’s experience?”

“When we have concerns about the safety of discharging to home –for example, guardianship issues (with elderly people) APL/N communicates these concerns, explores home, community situations/resources and helps with discharge plans. ”

Major issue is elderly. Some come in at tail end as family can no longer care for them. While family has provided care all of their life, the physical demand of caring is too much. Then to come to town to be in Long Term Care facility – at very end of lifethey are in care, in town, very foreign environment....so they are very sad because they want to live on the reserve.”

Value of APL/N

“[APN] changed my perspective on how I approach a patient. I felt that I was treating people well but in our rushed way we may be perceived as speaking down to people.”

“Embracing different world view in clinical decision making.”

“ APL/N has had a big impact on education hospital wide.”

“They help to look at patients with Aboriginal lens.”

Liaise with com (relationship bldg., linking with other programs)

“Hospital is Integral part of community. APL/N helps to connect us to community.”

“Liaises with other APN in other hospitals and communities.”

“Cultural sensitivity and partnership that is brought to the bedside may not happen without them.”

"Social Work connects with community on an as needed basis (e.g. housing). APN have greater understanding of community/issues/resources."

"Advocates for family."

"Better understanding of FN language barriers/issues to care."

"APNs provide explicit instructions on how to get to hospital etc. without this don't know how they would manage."

"one day this young mom and dad who had their baby in NICU returned to the house in tears. They were saying goodnight to the baby and the nurse told the young parents to 'just leave because the baby can't hear you anyway.'"

"Life is challenging...but much more challenging when there is judgment."

"The patient was a mother of 4 children..... aged 12 years to 16 months. She had a brain tumour The father and the children were in crisis and the APN did a wonderful job rallying the community support around the family, letting schools/counselors know etc."

"Patients have care plans – standards stipulated by legislation."

"Social Worker and APN identify care needs. APN able to get greater history, APN sometimes provides frontline support for difficult cases (traumatic backgrounds, residential school history etc.). Nursing background helps to identify clinical needs but SW is still involved and is still the lead."

"Know APN in the community. Comfort in seeing an Aboriginal face."

"Death and dying protocol – how to respect in setting (large numbers of family will be in hospital – about 15-20, sometimes 30 to sit with family and offer prayers) the significance of family, numbers of family. We learned all this because in western world view, family is usually two family members."

"APL offers training in cultural safety/competency, cross cultural role."

APL/N understands safety, Bands.....relief to patient that someone understands."

"Building support and trust, facilitating cross cultural communication (western too verbal, use too many words). Having someone to navigate therapeutic journey. Consequences – sabotage of treatment. APL/N provides valuable role in brokering communication."

Facilitates cross cultural understanding, communication, trust."

"APN provides real value – no way to quantify – good job brokering two worlds, credible, helpful. Smart to call APL/N sooner than later."

"Sometimes APL talks too much. Represents health authority too much. Not listening. Not flexible."

"The requirement for nursing background is intentional because they understand and able to decipher treatment plans (medicines, engagement with nursing/physician/specialist. Medical terminology)."

"They work during day. No weekend and evening coverage."

"Need to collect data on number of patients served and nature of service provided."

"Social Workers work with Aboriginal patients just as anyone else. But sometimes we hit a wall....because we are not Aboriginal. Sometimes we can get the sense that a family is not comfortable working with us. That is when we get the APL/N to reach the patient. Sometimes there is discomfort working with white SW"

"Child protection – safety planning....the APL/N understands the dynamics. She works in partnership with SW ensuring cultural safety/appropriateness."

"My concern is how do we measure what we think is a good thing? A good feeling? Are we making a difference in patient outcomes? Are we making a difference for health outcomes? How do FN people feel about it? Home visits, driving etc. – is that more useful?"

"When APL/N is not here, it is hard to get by."

"Interpretation, friendly face, familiarity, APL/N knows a lot of people in town."

"Patient feel scared and nervous. APL/N role is to make sure the person is OK."

"APL/N service is not a nice to have – it is an essential service."

Appendix 11: APL/N Comments

Scope of work

"We communicate between patient and families and healthcare providers."

"Clients are not being heard or are sometimes mistreated."

"I provide short term counseling."

"I do a lot of advocacy."

"I support patients and families."

"I address whatever the issue – sometimes unrelated to health."

"We are the keepers of the stories. Other healthcare providers work shifts so gaps can happen. We look at everything." Services are siloed, so help to keep the silos connected. Patients are part of families and communities so help to connect to both. Everyone has a story."

"I assist/empower patients to navigate system."

"I participate in discharge planning/bed meetings (discuss admissions/discharges and ID places of congestion)."

"If you are ill and spending more time trying to navigate systems and not getting well....there is a problem."

"The system is fast paced....no one has time to speak to you, needing to do things yourself....these are very foreign to Aboriginal Peoples."

"Having someone actually engage with you and taking time to explain things."

"I alone cannot change a person's experience. I am here during the day, five days a week. What about evenings and weekends? We need to change the culture of the system."

"We need to focus on prevention and education. Build wellness."

"We need to build relationships to build culture of system. Learn how to look at things with other lens."

"It is important to build relationships (in a fast paced system, this is lost). Provide Education, Change system."

"Health is a very task oriented system. Relationships are dismissed."

"We need to be same for all people."

"Wards are co-ed. For privacy, curtains are drawn. Creates isolation. This creates discomfort for Aboriginal People."

"People have different ways of communicating. Aboriginal people have a phenomenal ability to read body language."

"I cover more than one hospital."

"Don't provide case management."

"Arrange spiritual care."

"I provide support to MCFD involved clients. Ensuring cultural safety of that experience. Providing education and support to MCFD SWs."

"I empower families to speak for themselves."

"I referrals from all departments...Emergency, Acute, Day surgery, Psychiatry etc."

"I provide psycho-social support (but can't do some things that only a SW can do – such as referring to OT/PT)."

"Educate health care workers on /history/culture/traditions/ceremonies."

"Arrange travel and accommodation through Travel Clerk – on reserve or with FN agency."

"I promote program and position."

"MY first job was getting to know which communities had nurses, and how often nurses attended community because of disparity of service in different communities."

"A nurse comes to community only one day/wk so there will be no follow up nursing care for a whole week."

"No nursing support, if a daily dressing change was needed, then RHA public health had to send in a nurse."

" Figuring out who provides financial supportif the patient need safety equipment etc."

"I started to develop lists of community resources and contacts to pass on to hospitals."

"If it is a very complex case, and I am the primary worker, then I will carry case short term."

"APL/N needs to understand medical conditions, vocabulary. My practicum and medical terminology dictionary helped."

"I provide support in Long term Care. I drive patients. Because I know the patients, sometime, staff counts on me to deliver messages or goods to patients (e.g. clothing left behind in hospital). I provide accompaniment to appointments."

"I get language translators. Cariboo Memorial pays for this. In other places, family or others do the translations. Not even honoraria are provided."

"In some cases, provide security (smaller hospital, FN abusive or inebriated client)."

"Sometimes I will do things that a patient or family is required to do themselves because FN have challenges with these (e.g. filling out forms)."

"I sometimes have found housing and got them set up."

"Dealing with transients and drifters is challenging. They come in for detox but have no place to go. These are 'frequent flyers' and my community has no shelters."

"We have a Hospice in hospital. So I get involved in end of life services/ceremonies. Everything from accompaniment to the morgue to arranging viewings and helping the spirit to return home. Contact funeral home – involved until body changes hands."

"I work pretty independently. While I work with teams and in an inter-disciplinary capacity, I am not part of a single core team because I work out of 2 (or sometimes 3) hospitals. My main role is to ensure cultural safety of clinical encounters of FN patients (representing family, community, culture) and cultural competency of the organization (addressing systems issues). I do a lot of advocacy."

"I am not trained in SW or nursing. I have a BA and significant experience working in a community setting. I think on the ground experience is what matters in this job. It is very important to know the nuances of working with FN communities.....for e.g. understand that silence is also a way of saying something."

"In the past, we used to support Community Patient Navigator positions whose primary function was to do the type of work I now do. That position had the ability to drive people to places and appointment, which is no longer supported in our region."

"I do home visitation and visitation at community care facility."

"I help with filling out forms and other paperwork."

How Work is structured

"I am part of a multi-disciplinary team and work closely with SW."

"I participate in teams (case conferences, clinical care/discharge planning etc.)"

"I was initially placed in community reaching into hospital. Now I am placed in hospital, reaching in to community. This is better because I am better known and get more referrals from hospital. But I am not so up to date on community resources. When we were placed in community, even though we were RHA employees, we encountered confidentiality issues."

"I intervene in other systems (like with employers or EI Benefits etc.)"

"Referrals come from clinicians (doctors, nurses, social workers etc.) or community (health center, HCN, GP) or family."

"Do program promotions (develop flyers, posters, provide info sessions). The more promotion is done, the busier I get."

"I have now become a 'Consultant.'"

"We have a very supportive Aboriginal Health team. Director is very clear on our boundaries – the give and take and having to negotiate and re-negotiate boundaries other healthcare providers. We have consultation back and forth articulating the need to set boundaries and then getting support to follow through role is multifaceted. Learning boundary settingit is hard because we are used to doing everything."

"We need to keep everyone engaged.... work with grace..... not be hardnosed. Flexibility and humour helps."

"Teaching patients that they have the right to stop the doctor to ask questions."

"Family are good advocates. They have that right and permission but I have to teach that they have permission to ask questions."

"So easy to prescribe drugs. I think they need to prove that the drug is needed. There are emotional, spiritual needs....but they are way too quick to prescribe."

"We are the eyes and ears."

Issues

"Access to care is issue. History of colonization, lack of services in own community and distance to healthcare are issues."

"Often family and patients say that no one is telling them anything."

"In Aboriginal communities Social Work is understood as being the same as MCFD – a particular issue for patients who are parents of young children or for parents of child patients. Aboriginal people are afraid to speak with Social Work (because some hospital SW call MCFD easily)."

"Fear and anxiety related to historical experience/institutions. Mistrust due to residential school experience as well as historical and current child welfare practices."

"Fear of the disease."

"Hospitals lack of historical knowledge, unable to re-frame Aboriginal peoples' experience from this and lack of respect."

"Communication between hospital and communities hindered by organizations privacy and confidentiality policies. Need to know what to share and when to share info."

"There are differences in communication style. Healthcare providers will usually explain their role and procedure...leaves no room for patient to ask questions. They use of medical terms and acronyms. Aboriginal people will assess youthe way you come in, how and where you sit etc."

"Healthcare providers need to explain why things are done. When examining a woman, a doctor put on 2 sets of gloves. She assumed that this was because the doctor thought she was dirty."

"Not all hospitals have a space where families can say good bye to loved ones who are diseased or do traditional ceremony around healing or dying like songs, drumming, smudging etc.)"

"Access to care is greatest priority for FN. No access to screening; cultural barriers; lack of knowledge – so people present at later stage, with poor prognosis. Things are changing with screening mobile unit, home based screening for colorectal cancer and pap tests for HPV. Person takes own sample and send for testing. Survivorship is also an issue because many patients return to communities that have no resources to help person get back to health and life. Things that are important for recovery such as diet, financial and emotional support. Lack of culturally competent care is also a barrier to access. People don't want to be treated differently. We need data to establish numbers."

"There is a perception that Indians get everything for free."

"Insufficiency of supervision an issue – lack of time and capacity to charting is an issue. Also lack of clarity between SW and APL roles."

"Can't smudge inside hospital."

"Not enough of us."

"Bedside is always priority. Up to us to prioritize."

"Accommodation, transport, food are the biggest issues. Hospital SW have access to resources."

"Complaints process – patients and families don't always know how to navigate this."

"Patients are sometimes discharged to the street."

"There was very little communication between on-reserve health, acute and public health. People were coming in to hospital that didn't know about follow up care, were missing appointments, had no help with transport and didn't know they could access funding for equipment and what services were available."

"Nurses didn't know who to contact, there was a big gap between hospital and communities."

"Our biggest issue is that we can't smudge inside the hospital due to sprinkler system. Drumming singing etc. OK but in ICU this has to be set up because some nurses are

nervous. Need to give heads up on cultural ceremonies. Still need to raise awareness. Getting better at it now.”

“Originally there were many requests from community to attend meetings and events. Now that the position is hospital based, I participate in community meetings etc. only in relation to hospital work. Aboriginal leads go to meetings in community. Any other work is by phone/email etc. It is better to work within the hospital. Prefer the narrower focus. Community work takes time away. Too much time away from hospital defeats the purpose of program.”

“PN is now a program and people now understand that it is here to stay. A lot of nurses and doctors refer patients, ask questions about communities and cultures. Now Discharge planning is more sensitive to peoples situations....they don’t discharge patients at 10 o’clock at night on a Friday. They know that some patients have to travel 4 hrs on a gravel road and there is not public transport.”

“Hospital is small enough so have built good relationship with staff. Can deal with issues.”

“I feel valued and respected by staff. At first it took effort to get established. Now doctors come to me.”

“ We do patient charting on the computer system. Would like more training....it takes a bit of time see a client and then have to chart. It is good to chart interventions. If a client is transferred to another hospital within our region, then the APL/N at the other hospital can see the history. We are able to share information, it is efficient, respectful of patient (patient doesn’t have to repeat the same information). Also, history is available for subsequent visits.”

“There are other FN staff at the hospital....such as RNs, care aids in senior care facilities. A lot more Elders now in care facilities. I deal with Home and Com care. Also interpreters and avail on call

“On Aboriginal Day I do a display in the cafeteria on our program and also on surrounding Aboriginal communities. Then some ask questions so I share community and celebration info with them. Gradual awareness raising.”

“Aboriginal Week in May – had speakers come in and do presentation to staff all week. But takes time to arrange this and also require funding. We had, for example, traditional medicines from different Nations, information on residential schools.... a bit of everything.”

“Most of the time a family interprets. When this is not possible we use interpreters. For assessments it is better to bring interpreter from outside. We have a contract to pay for this and we provide training on confidentiality.”

“Work hard on trying to find ways to help (e.g. specialized help for people with acquired brain injury).”

“Limits of health benefits is an issue.....some people don’t understand this that people have to use their own funds to top up, an issue because they don’t get much social assistance

funding. Accessing dental care is a challenge, first they have to travel long distance to get to a center, and then Health Benefits only cover so much. So often, they end up in hospital. Important to make sure what coverage is allowable, sometimes providers don't check, so important to educate doctors about eligibility, coverage and exceptions."

"No resources for urban FN."

"Elders still speak fluent language and traditional medicines are still being used. "

"Was involved in a LEAN project – that looked at roles and responsibilities in discharge planning."

"Racism is an issue. These positions (APL/N) should have been there from beginning. So the role would then be set in stone. "

"Privacy and confidentiality issues when sharing information. Sometimes information is shared with CHN in an Aboriginal community who discloses this to all and sundry. So need to educate community on confidentiality issues."

"How to help patients help themselves and how to help myself in that process."

"Bad weather makes transport more difficult."

Appendix 12: Resources

The Ngarngadji! Listen/understand! Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) Resource Kit brings together the good practice developed over many years within the Victorian acute healthcare system. In line with the Council of Australian Governments' commitment and investment in 'Closing the Gap', this package sets out clear direction to assist in closing the health inequality gap between Aboriginal and non- Aboriginal Victorians.

This excellent resource provides strategies for enhancing an Aboriginal Liaison Program and promoting culturally competent healthcare. It contains:

1. The ICAP Resource Project – Final Report
2. Orientation Guide for Aboriginal Hospital Liaison Officers
3. Orientation and Information for Health Service Managers (Supervisors of APL/Ns)
4. Cultural Competence and Awareness Information for Health Services
5. Practice Examples from Victorian Health Services (on a range of topics)

It is available at:

http://www.svhm.org.au/aboutus/community/ICHPtoolkit/Documents/Toolkit%20documents/ICAP%20text_3%20FINAL.pdf

Harold P. Freeman Patient Navigation Institute

The concept of patient navigation was founded and pioneered by Harold P. Freeman in 1990 for the purpose of eliminating barriers to timely cancer screening, diagnosis, treatment, and supportive care.

The HPPNI Patient Navigation Program is an intensive 2-day in person, or self-paced online training program that includes 10 modules, plus practicum (patient interaction) and case studies. Grounded in nearly 20 years of experience and viewed as the "gold standard" in patient navigation, the program emphasizes the Harold P. Freeman Patient Navigation Model, as well as information, standards, and principles on how participants can tailor the program to meet their organization's and/or community's specific needs.

The curriculum, taught by the foremost experts in patient navigation, including Dr. Freeman, is multi-faceted, comprehensive, and interactive. It includes practical experience and reflects on a combination of extensive, best practice research and information. The program focuses on cancer as the primary navigation disease, but is also applicable to other chronic disease categories to include mental health, infectious disease, diabetes, and heart disease.

Upon successful completion, students earn a Certificate of Completion signed by Dr. Freeman.

Available at: <http://www.hpfreemanpni.org/>

Building Bridges through Understanding the Village is an experiential workshop that helps to understand traditional Indigenous ways and values. A workshop geared to solutions rather than recriminations, the workshop explores in-depth the impact of Residential School and Canada's assimilation policies – often provoking emotional responses that participants say helped to better integrate the learning. The workshop is taught by Kathi Camilleri, an Indigenous woman, who has coordinated healing programs for over 16 years.

Available at: <http://klahoose.org/village-workshop-with-kathi-camilleri/>

Appendix 13: Literature Review

Barriers to care

The barriers to optimum care reported in the literature fall within two broad categories – financial and non-financial. Given that many of the studies were from the US, inadequate or lack of insurance coverage was identified as a significant barrier. Other financial barriers include lack of funds for prescription medications and lack of money, childcare and transportation. Non-financial barriers include language, cultural norms and issues, health beliefs, health literacy, mistrust of medical institutions, fear of pain, inadequate or ineffective communication and information, conflicting information from multiple providers, inconvenient hours, lack of time, long waitlists for clinics. Patient Navigation is a strategy that aims to address these barriers by helping patients to understand relevant information and communicate with others; and through the provision of psychosocial and practical support (Campbell et.al. 2010, Koh et.al. 2010, Pederson et. al. 2010 and Schwarzer et. al. 2006).

What is patient navigation?

Patient Navigation (PN) has been introduced as a healthcare intervention to reduce the barriers that patients' encounter in accessing healthcare services (Koh et. al.). It is an approach that seeks to facilitate timely access to appropriate care and resources for individuals (Pederson et. al., 2011), particularly from disparate populations (Schwarzer et. al.). Whether programs have a disease (i.e. cancer care) or population (i.e. Indigenous) focus, PN programs appear to target patients living in socio-economically disadvantaged circumstances (Koh et al). PN addresses a multitude of personal, provider, cultural and health system barriers that patients encounter in their healthcare journey and provides customized care according to individual needs and values, to optimize healthcare response (ibid). Focusing their efforts on reducing barriers rather than duplicating an existing service area, (Pederson et.al, 2010), PN has become a "value-added" service within the healthcare system (Wilcox et. al., 2010, pg21)

The goal of PN programs is to provide comprehensive streamlined care for patients as well as their families; and assisting patients to acquire an enhanced sense of preparedness to participate in their healthcare journey (Pederson et. al., 2011). The sought after, overarching outcome of patient navigation is the removal of barriers and the achievement of optimal healthcare outcomes (Koh et. al.).

This includes,

- Timely screening and treatment (Campbell et. al.)
- Improved patient preparedness (emotional and informational) for treatment and post-treatment coping (Pederson et. al., 2011)

- Improved patient self-efficacy (ibid)
- Improved adherence to treatment regimens (by decreasing barriers to care) (Campbell et. al.)
- Improved patient satisfaction with healthcare (Campbell et. al, Pederson et. al, 2011)
- Reduced use of emergency resources and specialist time by patients (Pederson et. al, 2011)

Role of the navigator

Review of literature shows that there is wide variation in PN programs (Koh et. al.). Yet, there is consistency across these programs in defining the role of a PN. What emerges as their key role is to serve as a guide to patients who find the journey through the healthcare system a confusing and frightening experience (Wilcox et. al.). In broad terms, the PN acts to expedite patient access to services and resources and improve continuity and coordination of care meeting informational, emotional and practical needs of patients' and their families (BCCA, 2005). Ensuring that patients receive timely treatment and follow-up, PNs strive to prevent patients from "falling through the cracks" (Wilcox et. al.).

While the design and delivery of PN programs vary (ibid) and the role of the navigator can be multifaceted, a framework for patient navigation programs aimed at addressing current gaps in health care has been proposed (Pederson et. al., 2011, p 204). The six integral components of this framework includes,

1. Provision of information
2. Facilitation of linkages to healthcare resources
3. Facilitation of decision making
4. Provision of emotional support
5. Facilitation of practical assistance
6. Identification and development of and referral to community supports

The PN roles and responsibilities described in the literature (Wilcox, Campbell) resonate with these six components.

Most PNs work as a member of a multidisciplinary team working in partnership with other healthcare providers (Pederson et.al, 2011). The specific role and function of the navigator is usually defined based on setting, health system context, and on population served (BCCA). It is recommended that PN intervention be focused on the high risk phases and service delivery gaps, on a time limited basis (ibid).

The few available evaluations/reviews of PN programs serving indigenous populations indicate that, Aboriginal Patient Navigators also play a significant role in cultural interpretation and advocacy with their healthcare provider colleagues (Posenelli et. al. 2009, Foreman et.al 2011).

What do they do

While the specific role and responsibilities of a PN is determined by the facility and domain in which they serve (Pederson et. al, 2010, p56), PNs provide a common repertoire of interventions. This usually begins with an assessment of patient needs for information, support and practical help. They then follow up with supportive care triage and provide customized care according to individual needs with the goal of improving patients' preparedness to participate in decision-making and follow through with treatment.

A key to their success is the quality of relationships that PNs develop both with patients and healthcare providers as they often serve as a conduit of information between patients and providers. Serving as a bridge, they will interpret and or reinforce what a physician or a provider has already told the patient and assist patients by providing resources to enhance their understanding. They intervene with counseling and support to reduce patients' and families' anxiety, advocate for patients, initiate consultation with other disciplines, coordinate healthcare services, connect to resources and support systems, streamline appointments, help patients access financial services, assist with transportation needs, identify appropriate social services and track interventions and outcomes. Where necessary they also provide language and cultural interpretation, manage complex care cases and provide community outreach and Outpatient support to ensure continuity of care.(BCCA, Campbell et. al., Koh et.al., Pederson et.al 2010, Posenelli et. al, Wilcox et.al).

Developing good working relationships with community organizations, particularly indigenous organizations, with regular face to face interaction and information exchange is seen as invaluable to the success of a PN program focused on serving indigenous populations (Posenelli et.al.). That said, PNs are a precious resource to be utilized effectively within a healthcare setting (ibid). Participation in cultural awareness activities, community visits and events lessen the availability of the navigator for patient contact (ibid). So does very personalized services such as transporting a patient (ibid).

Required qualifications for PNs

The PN is seen as an allied health professional, a role that has, for the most part, been filled by nurses or social workers (Pederson et. al. 2011, Wilcox). Some programs engage lay community members, especially those who have experienced and recovered from a similar health condition (e.g. cancer).

The sought for attributes of a PN includes: skill in empathetic communication, ability clearly assess physical and emotional care needs, ability to provide information and education to empower patients and families, having in-depth understanding of the healthcare system as

well as the roles and functions of healthcare providers and the resources in which they work, ability to develop cooperative relationships with healthcare providers, capacity to navigate their way through the complex healthcare system, ability to facilitate required care, empathetic patient advocacy and an in-depth knowledge of resources available outside the health care system and capacity to access these (Pederson et.al. 2010 and 2011, Posenelli et.al., Schwarderer et.al., Wilcox et.al).

How do PNs help patients and healthcare providers

A majority of the literature reviewed for this project were evaluations of patient navigator programs, primarily focused on cancer care, some of which were targeted on vulnerable populations. Many examined if these programs improved time from diagnosis to treatment and or cost reductions. On these outcomes, the effectiveness of patient navigation has not been well established. Inconsistent research design and or small sample sizes have been cited as issues (Koh et.al).

However, Satisfaction Surveys from numerous studies have consistently revealed that PN is highly beneficial to both patients and physicians. A reduction in problem solving time is seen to contribute to timely access to care and services. (Koh et.al, Schwarderer et.al., Wilcox et.al). While PNs did not expedite the time from diagnosis to treatment (e.g. PN did not help with wait times) PN did improve the numbers of patients that completed their treatment (Schwarderer et.al.). Patients also were assisted with transport, meals, accommodation and emergency relief funds that otherwise would have prevented them from accessing care (Posenelli et.al.).

While these outcomes have not been effectively measured, it is postulated that patients who feel better understood and form more trusting relationships with their clinician might seek out health care more frequently, might benefit from early detection and treatment and might be more likely to adopt preferences for clinically indicated treatment (Brach et.al.). More accurate communication of symptoms could lead to fewer diagnostic errors and greater adherence to treatment regimens (ibid). And the presence of minority health professionals in healthcare settings increase the "user friendliness" experienced by minority populations and hence accessibility (ibid, pg. 196)

Coordination of care/services, emotional support and education, patient advocacy and provider education – the services that PNs provide are significant aspects of patient centered care. (Campbell et. al.)

How can PNs be supported to do their best work

The literature points to the need for a clearly defined role and function and a broad range of supports to provide a sense of accomplishment for PNs and ensure success of the program. It is recommended that their scope of practice be prescriptive based on broadly defined goals and outcomes (BCCA, Pederson et.al. 2011, Posenelli et.al.); focused on mending gaps in the system (Pederson et.al, 2010) and reducing overlap with other roles in the

healthcare system (e.g. Case Manager, Social Worker, Clinical or Care Coordinator, Support Nurse, Patient Advocate, Community Health Worker); and developed based on needs of patients, existing strengths within communities and financial resources of RHAs.

PNs are best placed within an interdisciplinary team with adequate administrative support (Wilcox). Physicians, nurses, social workers, and all members of the team must be made to understand that the navigator role is meant to enhance, augment and help streamline patient care, not to overlap or infringe on care that is being delivered by other members of the team (Wilcox et.al.) Good communication among healthcare providers is a must (ibid) as well as a partnership approach to work, especially with other hospital clinicians such as Social Workers and Care Coordinators, to clearly delineate professional boundaries and work responsibilities (Posenelli et.al.). PNs must be encouraged to use common patient assessment tools which can serve two functions – directing care plans of individual patients and documenting needs and systems resources to improve services (BCCA).

Hired for a core set of competencies, PNs require intensive orientation to their role. Orientation to hospital policies and procedure, introduction to key hospital staff and the range of administrative requirements, access to information such as emergency procedures, flow charts, maps or who to go to for particular information, an opportunity to observe PN functioning in their roles and learn the required medical terminology and information about relevant meetings within hospital and in the community need to be included in orientation (Posenelli et.al.). Developing a generic orientation package that can be adapted with local information is important for building consistency in the PN role and function.

A flexible, strengths based approach to supervision, performance and professional development plans, competency development opportunities via access to in-house and external training and practical supports such as mobile phones enhance the performance of the PN and the success of the program (ibid).

Supervision is highlighted as a critical factor in the success of the PN role and program, particularly for indigenous PNs. On a multidisciplinary team, often, non-indigenous Managers supervise indigenous PNs. In the ICAP program evaluation in Victoria, Australia, strategies for managing difference was the key theme that emerged among supervisors of indigenous staff. Supervisory staff acknowledged the importance of two way learning, personal and professional reflection, respectful and collaborative relationships with the indigenous PNs and being open to accepting their advice.

The ICAP highlighted boundary setting and confidentiality as a key challenge. Working within their own communities, IPNs often know their patients. Another challenge is managing expectations of patients, their families and community organizations. Supervisors of IPNs are encouraged to get to know local communities and develop collaborative relationship to understand community expectations and norms in order to assist IPNs with boundary setting.

A requirement of a minimum standard of training and orientation to assume the role of supervisor is recommended, along with cultural competency training, Indigenous mentors, peer learning opportunities and peer support networks. Specific Human Resource policies

and practices to promote culturally safe and effective workplace relations and access to a mentor in Human Resources to assist PNs with workplace issues is also recommended (ibid).

Continuity of the PN role with stable funding is important to the success of the role (BCCA). The longer a person is in the role the greater the potential value. It takes time to develop relationships with healthcare providers and in the community. Evaluation of outcomes and effective management of resources are crucial (Koh et.al). Program evaluation provides objective information on how the program works and the benefit it provides (Wilcox et.al.) and is essential in evidence based refinement of the role and raising the eminence of patient navigators (Campbell et.al, pag.61). Developing a PN team or network that helps to link with support each other (Pederson et.al., 2011) and to communicate on promising practices and evaluation is recommended (BCCA).

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