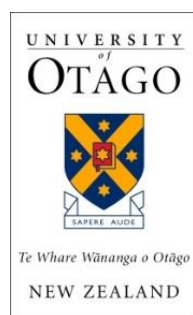


INTEGRATING HEALTH NAVIGATION AND INTERPRETING SERVICES FOR PATIENTS WITH LIMITED ENGLISH PROFICIENCY

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EXECUTIVE SUMMARY

New Zealand's increasingly diverse population means that many patients¹ come from linguistic and cultural backgrounds that make it more difficult for them to effectively access the New Zealand health system. The clinical risks of inadequate medical communication are well-known and for limited English proficient (LEP) patients, this can result from both linguistic and cultural reasons including simple lack of knowledge about our health system.

One approach for addressing this problem has been patient liaison or navigator services aimed at specific ethnic groups, most commonly Maori or Pacific. The provision of effective professional interpreting services in New Zealand has also recently increased. However, research on interpreting in primary care conducted by the ARCH (Applied Research on Communication in Health) Group in 2012-13 found issues with the narrow role boundaries of interpreters; often patients and their health professionals want help with practical matters that lie outside the narrow bounds of interpreting, the kind of assistance that health navigators may provide.

Given the recent development of the Pacific Navigation Service for primary health care in Wellington (run by Compass Health and Well Health PHOs under contract to C&CDHB), it was decided to research this group as well as the hospital-based Pacific Health Unit in Wellington to investigate their experience with how their service interfaces with interpreting services. Investigating the experiences of patients and health professionals using the services was unfortunately beyond the scope of this study.

While there are well-developed Hauora Maori navigation services, these were not selected for study because the vast majority of Maori patients do not have limited English proficiency and the issue of their interface with interpreters does not therefore arise.

This study was conducted in 2015-16.

Aim

To investigate the interface between health navigators and interpreters in overcoming barriers to health care for patients with Limited English Proficiency (LEP) in the Wellington region.

Method

We reviewed the international literature on the topic. We conducted individual or group interviews with two managers and six staff of the community-based Pacific Navigation Service (PNS), with the manager and three staff of the Pacific Health Unit (PHU) of Wellington Hospital, and with an independent contractor involved in the

¹ The terms “patient” and “client” are used interchangeably in this report, depending on the context. Navigators interviewed in this study use the term “client” while “patient” is used more generally as that used by health professionals. The term used at any given point within this report depends on what relationship is to the fore in the local context.

process to establish the navigation service. For the purpose of this report, the staff of both services will be referred to as navigators, although this is not the formal title used in the PHU.

These interviews elicited views and experiences regarding (i) the barriers to LEP patients obtaining quality health care, and (ii) their own roles, including how these intersect with other support services for this population. We conducted a framework analysis of the interview transcripts, with additional analysis of emergent themes.

Key Findings

The **literature review** found a wide range of barriers to health care for patients from culturally and linguistically diverse backgrounds (CALD). These were related both to the design of the health system (for example, complexity, and opening hours and locations of facilities) as well as to characteristics of the communities (for example, language and cultural features). The benefits of having some kind of health worker who is a member of such communities has been recognised for some time as an effective way to help overcome these barriers. The review highlighted the great variety of terms used for similar roles, but key attributes are that these workers are trusted by patients and that they perform a wide range of tasks.

The **interviewees** identified a similar range of barriers to those raised in the literature, plus some additional points such as the often incompatible communication styles of health professionals and of Pacific people in general, and the way that cultural attitudes like a deep sense of pride and a sense of deference to authority common in Pacific cultures can impact on how Pacific people engage with the health system.

The range of roles performed by navigators was also similar to those raised in the literature. There was an emphasis on the holistic and wide-ranging nature of the job. There are issues with raising and maintaining awareness of the service and what it does with health professionals and the public, and with resourcing. There was also felt to be some mismatch between the holistic aims of the service and the referral criteria which often focus on a single indicator such as DNA (Did Not Attend).

Our research found there is a significant overlap between the roles of navigators and interpreters in the study area, with navigators routinely interpreting for patients, especially in the hospital. Overcoming a language barrier was felt to be a major part of the navigator role, but navigators emphasised that they often did this in a qualitatively different way to that of a professional interpreter. In particular, participants felt that it was important to do more than to only interpret the words of the health professional, often explaining more fully in ways that their community will understand. However, it was also noted that this would not be so necessary if health professionals communicated more clearly using simpler language and visual aids, for example. In order to interpret effectively, navigators felt that some degree of health knowledge was important, as well as the greater depth of relationship afforded by the ongoing contact that a navigator often has with a patient. It was noted that critical conversations (such as informed consent) should require the use of professional

interpreters, possibly in addition to a navigator, but that clinicians did not always make use of these.

It was acknowledged that some formal training in interpreting is desirable for navigators so that they can have some form of accreditation but there was frustration with the lack of a course tailored to their needs.

Interviewees described what they saw as shortcomings in the professional interpreters they had seen in action, and saw the strictly confined role of professional interpreters as an impediment to providing the help needed to get the best outcome for patients.

The concept of an explicitly combined navigator/interpreter role was supported, partly because this is what is happening in practice already. Training and formal recognition of this is desirable as well as the formal development of the scope of practice to clearly delineate the role.

Limitations of the study

The study only investigated the issue from the point of view of those involved in health navigation in a single area of New Zealand (Wellington). The views of interpreters, health professionals and service users were not investigated.

Discussion and Conclusions

Navigators in the Pacific services studied here have a challenging and complex role. It is evident that they are fulfilling a genuine need in their community. As a group, they need a broad range of skills and attributes, the core of which are strong community networks, sound health knowledge, and well-developed cultural and communication skills.

Interpreting is more strongly interwoven into the role of the navigator in these services than the researchers had initially expected. There is some tension between the fact that this is something that navigators do (and do well), and the fact that they do not receive significant interpreting training or official acknowledgement of this aspect of their role.

Pacific navigators felt Pacific patients may prefer to be assisted by a navigator (or indeed a family member) rather than a professional interpreter. Navigators expressed concerns about the confidentiality of interpreters and it is likely that their communities have a similar perception. Pacific navigators are perhaps more likely to be trusted by their clients due to their association with a health organisation. Navigators are also able to spend more time with patients than interpreters can, and this allows greater development of personal relationships and encourages the development of trust. The Pacific aversion to using telephones also works against the use of telephone interpreters which is a common way of delivering professional interpreting but not so much for navigation services. It should be noted that there are rare examples where professional interpreters are employed by some general practices that have large numbers of patients from a particular ethnic community, and such

interpreters are also able to establish good relationships with patients and have a high degree of trust from their community.

Over and above this perceived Pacific dispreference for professional interpreters is the fact that Pacific navigators have a different view of the kind of language help that their community needs, compared to the strictly executed interpreting that is espoused by professional interpreting services. Pacific navigators believe that more is needed for their clientele to communicate health messages effectively and that professional training in health or social work is needed to be able to adequately support their clients. For this reason, they would be in favour of navigators receiving additional training in interpreting on a firm health or social work base, rather than interpreters receiving additional training in health. The desire for specific training in interpreting for navigators came with the proviso that such training needs to be tailored to the requirements of their role.

Reading between the lines of the many stories of unnecessary duplication or complexity caused by multiple staff interactions, we would suggest that LEP patients in general, including those within the Pacific community, can be better served by receiving assistance from a single person or team. Such a person or team is better able to get to know LEP patients and their circumstances and be able to assist with overcoming a range of barriers, including the language barrier. This needs to be officially recognised in policies and training.

With acknowledgement that multiple roles are performed by a single person or team comes a need for clear communication about these roles. There needs to be explicit discussion of role at a local level with patients, their families and clinicians to ensure that all understand what to expect and what the relevant boundaries are. It is also important that the navigation teams themselves continue their current reported practice of ongoing clarification of roles, as participants at times reported slightly different interpretations of their role boundaries, particularly with respect to assisting clients with non-health agencies.

We agree with the research participants about the importance of clear definitions for when a task is beyond the navigators' scope of practice and should be referred on to an appropriate professional (such as a professional interpreter, social worker etc.). There may be a need for professional supervision to manage these boundaries.

While individual navigators need to perform multiples roles, it is also true that the full breadth and depth of skills required by navigators cannot be expected to be present in any one individual but needs to be distributed across a team. This is especially true in terms of language skills. Allocating cases on the basis of best fit of navigator to case, as currently happens within each service, makes sense in this context. For example, cases may be assigned to specific navigators according to their training (nurse or social worker) or previous experience as well as according to their languages so that clients are matched with the most appropriate staff member for their situation.

The Pacific community is the only community (or more accurately, set of communities) with LEP patients in the Wellington area that has a formal navigation service. Our findings suggest that Pacific patients are effectively assisted to overcome a range of barriers, including the language barrier, by these services. We would suggest that other CALD/LEP communities beyond the Pacific community would also benefit from such a service in combination with interpreting services.

However, while Pacific navigators firmly believe that it is best for navigators to add interpreting skills to their training, rather than trying to train interpreters as navigators, this may not be the case in other CALD communities. Further consultation within such communities or those working with them (interpreters and health professionals) will be required to determine how services should best be designed for them. However, the views of the participants in this study suggest that meaningful health knowledge in those taking on such roles is likely to be a key element.

It is also important to delineate the most important barrier(s) affecting the outcome for each presenting client, and tailor the navigator intervention to that barrier. Again, a comprehensive service with well-trained staff covering a range of skills, training and experience would seem to be the best way to make this possible, since there are so many potential barriers to care.

The configuration of services – i.e. whether a service is based in a hospital or in the community or spans both – also needs to be sensitive to the best way to address particular barriers. For example, addressing DNA rates at hospital clinics and providing language services to inpatients is best done from within a hospital based service. Following up on families with outstanding immunisations is best done by a community based service. Navigation for a person with a complex condition (cancer or multiple co-morbidities) is best done from a service that is case-based that can span all sectors.²

The participants highlighted the effectiveness of working in such a way that the diverse needs of clients are met by a team with diverse skills. This strengthens an argument for developing more overlap or integration between the two services (community- and hospital-based) as this would create an even larger pool of skills to draw from. In addition, a more integrated service would also enable greater continuity of care across the settings which would further capitalise on the benefits of stronger individual relationships. Better integration with other services in the community is also desirable.

Also worthy of reconsideration may be the current focus on individual clients. Although not a question specifically addressed in this research, participant responses suggested that a household focus could be more useful and cost-effective in addressing barriers for a number of individuals in a single household. Given the

² Since the time of this study, the services have modified the model they work under to allow closer collaboration and a case management approach within a multi-disciplinary team context.

family structure of many Pacific households (and probably other CALD communities), a household approach may be more culturally appropriate as well as improving efficiency.

Overall, we believe the strengths of the current Pacific navigation services should be built on and lessons learned from their experiences are likely to be useful when considering similar services to assist other CALD communities. Further research into the views of other stakeholders in this area would be very desirable.

Recommendations/Implications

The following recommendations are suggested by our findings. Recommendations 1-3, it should be noted, are already happening to some degree but are important to highlight so that greater consistency across staff can be achieved.

- (1) The scopes of practice for the various types of navigators (depending on training and experience in other professions such as nursing and social work) need to be clearly defined and clear guidelines about when to refer on and to whom should continue to be developed.
- (2) Navigators need to be fully aware of the wide range of roles they perform and to have a clear idea of their individual scope of practice.
- (3) Navigators need to be aware of what role they are taking with any particular client at any particular time. This should be discussed with patients and health professionals to ensure clarity. They also need to be able to clearly assess when what is required is out of their scope of practice and to bring in additional help, such as professional interpreting services.
- (4) Systems for training and accrediting navigators as interpreters should be investigated with a view to explicitly incorporating interpreting into the navigator role.
- (5) Ways of providing navigation in tandem with interpreting should be explored for other communities, with consideration given to appropriate training, recruitment and funding.
- (6) Further work needs to be done to improve the communication skills of health professionals, including the use of visual aids, writing notes and rephrasing.
- (7) Professional interpreters need to be made aware of the existence of such health navigation services as there are and trained in when to call them in.

1. INTRODUCTION

New Zealand's increasingly diverse population means that the health system needs to improve its effectiveness for patients from Culturally and Linguistically Diverse (CALD) backgrounds.

The 2013 Census show that the number of people in New Zealand who were born overseas has now reached 1 million. Almost 2 in 5 people (39.1%) living in the Auckland region were born overseas, while the Wellington region has the second highest proportion of overseas born people – 25% in the 2013 census. Many of these people will have limited English with more than 87,000 not able to speak any English. Pacific people are prominent among these with Samoan speakers the third largest group of non-English speakers. (Statistics New Zealand, 2014).

The clinical risks of inadequate medical communication are well-known (Cohen, Rivara, Marcuse, McPhillips, & Davis, 2005; Flores, Rabke-Verani, Pine, & Sabharwal, 2002). For limited English proficient (LEP) patients, this can result from both linguistic and cultural reasons including simple lack of knowledge about our health system.

Strategies to address this problem include

- increasing availability and use of interpreting services,
- training of health professionals in cultural competence and the use of interpreters,
- the development of liaison services/patient navigators, and
- improving the health literacy of LEP populations.

Work is being done in each of these areas, with more professionally trained interpreters being made available and the limited introduction of health/patient navigators. This study has focused on the first three strategies and how they might intersect.

Recent research on interpreting in primary care had found that narrow role boundaries for interpreters (e.g. restricting them to nothing more than translating the words of the patient and health provider) are often problematic for participants. They are therefore not always adhered to (Stubbe et al., 2014). In addition, patients and their health professionals often want help with practical matters that lie outside the narrow bounds of interpreting; this is the kind of assistance that health navigators may provide.

In New Zealand, many hospitals and some primary health providers utilise the services of both health interpreters and other kinds of support services to provide assistance to patients in various categories who may or may not have limited English proficiency. Many District Health Boards, including Capital & Coast DHB, have a Pacific Health Unit or similar in their hospitals. A new development in primary care in Wellington is a Pacific Navigation Service. As with interpreters, anecdotal

evidence suggests there is some confusion relating to role boundaries and role limitations for navigators working with LEP patients.

Patient navigation services in New Zealand (although not by that name) have historically been focussed on Maori or Pacific groups in the form of various services aimed to assist such patients within the health system. More recently, navigation services have been developed within specific areas of health care such as cancer and mental health and these have generally developed in an ad hoc manner. This has resulted in unclear and inconsistent role definitions (for example, navigators engaging in interpreting without specific training), and limited training (if any) in patient navigation as such. Within Wellington, the Pacific navigation services are the only ones targeting whole communities with people who may have limited English proficiency (LEP), although other clinically focussed navigation services may also serve individuals with LEP. For this reason, our research has targeted this group, and has not investigated navigation within the Maori community.

An expanded role for interpreters to include health navigation is starting to be developed in various countries (e.g. Belgium, Italy, Ireland, Spain, Canada, USA (Verrept, 2012) and Romania (Roman et al., 2013)), with a range of different titles. This expanded role provides professional interpreting as well as help for patients to understand the health system and for health providers to better understand their patients' backgrounds and belief systems.

The aim of this study was to gain insight into the aims and aspirations of those responsible for establishing and defining the roles of Pacific navigation services in Wellington, as well those providing the services. In particular, the aim was to investigate the interface between health navigators and interpreters in overcoming barriers to health care for patients with Limited English Proficiency (LEP). This investigation aimed to explore this within the Pacific community as the only ethnically based one in which health navigation currently exists, but with a view to considering the applicability of an integrated interpreting/navigating role for other ethnic/linguistic communities who may have a need for it.

2. LITERATURE REVIEW

It is well known that CALD populations have lower health status than dominant groups in high-income countries such as the USA, UK, Australia and New Zealand (Hines, Andrews, Moy, Barrett, & Coffey, 2014; Maoate, 2013). For example, in the USA Latinos have higher rates of diabetes and diabetes-related complications than non-Latinos (Lopez & Grant, 2012), various ethnic minorities have lower cancer survival rates in the USA (Ward et al., 2004), and in New Zealand Maori and Pacific life expectancy remains less than for non-Maori/Pacific (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003).

2.1 Barriers to Healthcare

Our review of the New Zealand and international literature suggest there are many barriers to these populations obtaining healthcare. These may be divided into:

- Health System Barriers: barriers related principally to the way health services are provided; and
- Barriers relation to features of the population.

The main barriers in each category are listed below. In fact, many of these barriers overlap. For example, the cost of some health services may only be a barrier because of financial difficulties which may be more prevalent in the Pacific community than the general population.

Health System Barriers

- The **design of the health system**, including opening hours and location of facilities (CBG Health Research Limited, 2005; Foliaki & Matheson, 2015; Freeman, 2013; Southwick, Kenealy, & Ryan, 2012; Tiatia, 2008)
- The **complexity of health systems** (CBG Health Research Limited, 2005; Pei et al., 2012)
- The **lack of healthcare providers from CALD communities** (Foliaki & Matheson, 2015; Komaric, Bedford, & van Driel, 2012; Pei et al., 2012; Tiatia, 2008)
- **Attitudes of healthcare providers** (Changemakers Refugee Forum, 2011; Foliaki & Matheson, 2015; Southwick et al., 2012; Tiatia, 2008)
- **Cost of services** (Foliaki & Matheson, 2015; Freeman, 2013; Guirgis et al., 2012; Lawrence & Kearns, 2005; Southwick et al., 2012; Tiatia, 2008)
- **Physical access to services/transport**, relating to geographical location of services (CBG Health Research Limited, 2005; Komaric et al., 2012; Lawrence & Kearns, 2005; Southwick et al., 2012)

Barriers Relating to Features of the Population

- **Language**, including English language ability and knowledge of medical terminology (CBG Health Research Limited, 2005; Changemakers Refugee Forum, 2011; Guirgis, Nusair, Bu, Yan, & Zekry, 2012; Saras Henderson & Elizabeth Kendall, 2011; Komaric et al., 2012; Lawrence & Kearns, 2005; Southwick et al., 2012; Tiatia, 2008)
- **Cultural barriers**, including lifestyle, fear of discrimination, different perceptions of health (CBG Health Research Limited, 2005; Foliaki & Matheson, 2015; Guirgis et al., 2012; Saras Henderson & Elizabeth Kendall, 2011; Komaric et al., 2012; Lawrence & Kearns, 2005; Tiatia, 2008)
- **Health literacy**, including unfamiliarity with health systems and lack of information (CBG Health Research Limited, 2005; Foliaki & Matheson, 2015; Freeman, 2013; Guirgis et al., 2012; Saras Henderson & Elizabeth Kendall, 2011; Komaric et al., 2012; Pei et al., 2012; Southwick et al., 2012)
- **Lack of trust** (Freeman, 2013; Lawrence & Kearns, 2005; Tiatia, 2008)

Two barriers were mentioned only in New Zealand literature in relation to Pacific populations in New Zealand:

- **Employment** issues, specifically the inflexible employment circumstances common in this population (Foliaki & Matheson, 2015; Southwick et al., 2012)
- Heavy **family commitments** (CBG Health Research Limited, 2005; Foliaki & Matheson, 2015; Southwick et al., 2012; Tiatia, 2008)

2.2 How to overcome these barriers

One strategy to improve the health status of CALD populations is to try to overcome these barriers by deploying specific health workers who are members of these communities. It has long been acknowledged that minority populations benefit from interaction with the health system facilitated through a member of their own community who speaks their language and understands their culture, but also understands the health system (Love & Gardner, 1992).

It is not just CALD people who face barriers to accessing optimal care, and different roles have been developed to try to overcome these barriers. Some are focussed on particular disadvantaged populations for example those with low socio-economic status. Others have been developed to help the management of particularly complex health conditions such as multi-morbidity or cancer. Even within cancer care, there is a wide variety of programmes (Koh, Nelson, & Cook, 2011).

Four broad ways in which navigator-type programmes can be set up are outlined by Manderson et al, 2012:

- setting-based (e.g. community or hospital)
- disease based (e.g. stroke, cardiac disease)
- population-based (e.g. working poor, intellectual disabilities)
- role-based (e.g. focus on brokerage or advocacy, clinical interventions, or patient empowerment) (Manderson, McMurray, Piraino, & Stolee, 2012)

2.3 Terminology

The term “patient navigator” is one that is frequently used in the USA and in cancer care in particular. The use of this term in healthcare originated in the USA in 1990 when Harold P. Freeman M.D. established a patient navigator program in Harlem Hospital Centre, New York City, to reduce the death rate from cancer among the poor black population by reducing barriers to timely healthcare. (Freeman, 2013). The concept of navigation has since spread to other countries including Canada, Australia and New Zealand.

A related role in the health workforce is the “Community Health Worker”. They have a longer history than ‘navigators’ but often have a very similar role. First used in developing countries as a low-cost way to improve health, Community Health Workers were introduced in the USA in the 1950s and 1960s, with a role that encompasses health advising, information, referrals, translation services and advocacy for their communities.(Love & Gardner, 1992)

While the key terms for roles that aim to help patients overcome barriers to care have been community health worker and navigator, there is an extensive range of titles internationally for very similar or overlapping roles:

Table 1: Key terms for roles that aim to help patients overcome barriers (terms used in New Zealand are marked with an *.)

Navigator	Community Worker	Cultural terms
<ul style="list-style-type: none"> • Patient navigator • Health navigator* • Nurse navigator • System navigator • Clinical health navigator* • Community navigator • Community health navigator • Clinical Family Navigator* 	<ul style="list-style-type: none"> • Community Health Worker* • Nurse-community health worker • Community Health Advisor • Community Outreach worker • Lay health worker • Village health worker 	<ul style="list-style-type: none"> • Lay health cultural broker • Intercultural mediator • Cultural Case Worker* • Pacific Cancer Care Navigator* • Pacific Navigator* • Multicultural Health Broker • Multicultural Health Worker • Ethnic Health Care Advisor
Care-coordination	Nurse	Other
<ul style="list-style-type: none"> • Chronic condition care coordinator • Cancer Care Co-ordinator* • Care co-ordinator 	<ul style="list-style-type: none"> • Guided Care Nurse • Advanced Practice Nurse (APN) Transitional Care 	<ul style="list-style-type: none"> • Transition coach • Case Manager (RN)

In addition, there has been discussion of how to differentiate ‘navigators’ from ‘community health workers’. Though their roles do overlap considerably, key differences are that:

- navigators have a stronger focus on the individual patient rather than a community approach (Ferraro, Seguinot, Rabbani, Grasso, & Wang, 2014; Volkmann, 2012; Wells et al., 2008)
- navigators have a more explicit focus on overcoming barriers to care (Dohan & Schrag, 2005; Freeman, 2013; Manderson et al., 2012; Wells et al., 2008)
- community health workers are more likely to have a focus on general health promotion (Bidwell, 2013; Volkmann, 2012)

The term ‘navigator’ may be used in either the community or in clinics but in the USA is the more common term in clinic settings (Hou & Roberson, 2015). In New Zealand, the term has been used in the context of mental health and of cancer care and the use of navigators in the Pacific community has given rise to specific terms such as Pacific Navigator and Pacific Cancer Care Navigator.

Such workers (whatever they are called) may have a professional background (such as nurse or social worker) or may be lay workers, although community health workers are generally lay workers (Ferraro et al., 2014). Fillion has defined navigation as falling into three categories:

- self-navigation,
- lay navigation, and
- professional navigation (i.e. by a health professional) (Fillion et al., 2012).

It is debatable which is the best model (lay or professional) and for which context. An evaluation of cancer navigation programmes by Koh found that some programmes find lay navigators best, others advocate use of healthcare professionals, while some use both in a complementary manner (Koh et al., 2011).

Whether such workers are lay or professional has potential implications for their alignment with the patient or with the health system. The choice of terms also has implications for how they are perceived (Arvey & Fernandez, 2012). It has been noted that in the cancer context, the role may be health-system oriented (with a focus on continuity of care) or patient-centred (with a focus on empowerment) (Fillion et al., 2012).

2.4 Defining attributes of Community Health Workers and Navigators

A defining attribute of community health workers is community trust (Wennerstrom, Bui, Harden-Barrios, & Price-Haywood, 2015) and it has been argued that the best navigator would also be a community health worker (CHW) because:

“[a]bove all, CHWs are trusted members of the community they serve and, as such, are able to establish relationships, increase communication, and act as cultural brokers between the community and the health care system.” (Volkman, 2012)

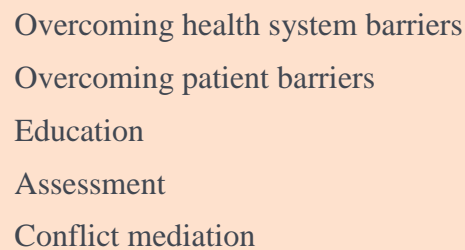
Key words in descriptions of both navigators and community health workers are “trusted” “natural leaders” (S. Henderson & E. Kendall, 2011) “bridge” and “safe passage” (Case, 2011) (Trevillion, Singh-Carlson, Wong, & Sherriff, 2015).

Some have questioned whether it is ideal to have a distinct position of a ‘navigator’ or whether the role of navigator could or should be performed by existing health personnel (Manderson et al., 2012; Ministry of Health, 2013; Thorne & Truant, 2010). Thorne et al (2010) question whether cancer navigation should be performed within the nursing role. Dohan & Shrag (2005) advocate for all staff to incorporate ‘navigation’ into their work because “stepping outside strictly defined roles ensures that there is organisation-wide responsibility” (Manderson et al., 2012).

Other writers are in favour of a discrete navigator role, arguing that they can be a single point of contact for patients in a complex health system (Collinson, Foster, Stapleton, & Blakely, 2012; Nutt & Hungerford, 2010).

2.5 The Role of Navigators and other similar positions

What navigators and others in similar roles actually do, or should do, has been extensively outlined, with a good deal of consensus, but some divergence. The main roles of such positions in the literature can be grouped into the following broad categories, from the more commonly mentioned to the least:



- Overcoming health system barriers
- Overcoming patient barriers
- Education
- Assessment
- Conflict mediation

The first two in particular cover a wide range of activities that are documented as part of the navigator role in one or more studies or contexts:

Overcoming health system barriers

(Krebs et al., 2013; Wells et al., 2008)

- **Care coordination** (Castañares, 2015; Collinson et al., 2012; Freeman, 2013; Krebs et al., 2013; Manderson et al., 2012; Nutt & Hungerford, 2010; Wells et al., 2008), including:
 - scheduling appointments, making referrals etc. (Enard & Ganelin, 2013; S. Henderson & E. Kendall, 2011; Hou & Roberson, 2015; Nutt & Hungerford, 2010; Seattle Children’s Hospital, 2014; Wells et al., 2008);
 - reaching out via phone, mail or face-to-face (Hou & Roberson, 2015);
 - collaborating with healthcare providers (Manderson et al., 2012)
- **Assisting with paperwork** (Wells et al., 2008)
- **Facilitating communication between patients and healthcare professionals** (Krebs et al., 2013; Wells et al., 2008)
- **System navigation** (Rotich & Kaya, 2014) (Castañares, 2015)
- **Helping with access to health services** (Collinson et al., 2012; S. Henderson & E. Kendall, 2011)
- **Advocating for patients to remove barriers to care** (Castañares, 2015; Hou & Roberson, 2015; Manderson et al., 2012; Verrept, 2008; Wennerstrom et al., 2015)
- **Advocating for needed and additional services** (Krebs et al., 2013)

Overcoming patient barriers

(Wells et al., 2008)

- **Translating/Interpreting** (Hou & Roberson, 2015; Pei et al., 2012; Rotich & Kaya, 2014; Verrept, 2008; Wells et al., 2008), including:
 - **supporting GPs to use interpreters** (S. Henderson & E. Kendall, 2011; Whop et al., 2012)
 - **“Assist[ing] with ‘understanding’ of information during patient-provider communication”** (Krebs et al., 2013)
- **Providing practical help** (Verrept, 2008; Waterworth, Gott, Raphael, Parsons, & Arroll, 2015) including:
 - **social support** (Wennerstrom et al., 2015)
 - **arranging transportation** (Krebs et al., 2013; Seattle Children’s Hospital, 2014; Wells et al., 2008; Whop et al., 2012)
- **Assisting with financial/insurance barriers** (Krebs et al., 2013; Wells et al., 2008; Whop et al., 2012)
- **Assisting with childcare issues** (Krebs et al., 2013; Wells et al., 2008; Whop et al., 2012)
- **Cultural mediation/brokering** (Hou & Roberson, 2015; Krebs et al., 2013; Verrept, 2008; Wennerstrom et al., 2015)

Education

(Castañares, 2015; Enard & Ganelin, 2013; Hou & Roberson, 2015; Krebs et al., 2013; Manderson et al., 2012; Marchand, 2010; Nutt & Hungerford, 2010; Pei et al., 2012; Rotich & Kaya, 2014; Verrept, 2008; Wells et al., 2008; Whop et al., 2012)

- *Being a resource guide or information support* (Collinson et al., 2012; Krebs et al., 2013; Nutt & Hungerford, 2010; Rotich & Kaya, 2014; Waterworth et al., 2015; Wennerstrom et al., 2015)
- *Explaining health terminology* (Whop et al., 2012)
- *Facilitating health promotion* (S. Henderson & E. Kendall, 2011)
- *Acting as a mentor* (Rotich & Kaya, 2014)
- *Coaching patients in active self-management* (Seattle Children's Hospital, 2014; Wennerstrom et al., 2015)
- *Training hospital staff in how to provide effective care across cultures* (Seattle Children's Hospital, 2014)
- *Pointing out problems to health care staff (intercultural mediator)* (Verrept, 2008)
- *Emotional/psychosocial support* (Collinson et al., 2012; Verrept, 2008; Waterworth et al., 2015; Wells et al., 2008; Whop et al., 2012) either directly or by referral; including:
 - *being a skilled listener* (Krebs et al., 2013; Marchand, 2010)
 - *supporting decision making* (Waterworth et al., 2015)

Assessment

- *identifying client needs* (S. Henderson & E. Kendall, 2011; Nutt & Hungerford, 2010)
- *assessing health status* (Manderson et al., 2012)
- *monitoring and addressing additional barriers* (Enard & Ganelin, 2013)

Conflict mediation

- *mediating between staff and patients when there is conflict caused by linguistic or cultural barriers* (Verrept, 2008)

2.6 Evidence of efficacy

There have been a number of international studies (but none in New Zealand) that evaluate the efficacy of individual navigation programmes, as well as several systematic reviews of:

- the effects of community health workers on various outcomes (Viswanathan et al., 2010)
- the effects of navigation for chronically ill older adults on various outcomes (Manderson et al., 2012)
- various interventions including navigation to increase patient participation of CALD populations with cancer care (Harun, Harrison, & Young, 2013).

The use of navigators in cancer treatment and screening has been the most widespread and has the largest literature to support it. For example, Cantril and Haylock (2013) found that the use of health navigators resulted in the following positive outcomes:

“increased screening levels, down-staging of targeted cancer diagnoses, shortened timelines from screening to diagnosis and treatment measures, improved treatment adherence, patient satisfaction scores and patient reported outcomes, and return on investment in the program” (Cantril & Haylock, 2013)

Similar results have been found in other contexts. Based on findings from a systematic review, Manderson et al (2012) suggest measuring effects in three areas:

- economic (i.e. optimising healthcare resources),
- psychosocial (improving experience with the system, e.g. satisfaction with care), and
- functional (impact on quality of life and capabilities).

There is evidence for positive economic outcomes in five of the studies in Manderson’s review (2012) as well as in a number of other studies of navigation or community health workers (H. S. Brown, 3rd et al., 2012; Elkin, Shapiro, Snow, Zauber, & Krauskopf, 2012; Enard & Ganelin, 2013; Lasser et al., 2011; Viswanathan et al., 2010).

Positive psychosocial effects are found in two studies in Manderson (2012) and in other studies (Ferrante, Cohen, & Crosson, 2010; Harun et al., 2013).

Positive functional effects have also been identified (Krebs et al., 2013; Velarde, 2013), including in five studies in Manderson (2012). However, Viswanathan et al (2010) found mixed evidence for this (Viswanathan et al., 2010) and Harun (2013) found navigation to be ineffective for treatment adherence (Harun et al., 2013).

As Toseland et al (1997, cited in (Manderson et al., 2012)) pointed out, we should be mindful of the ‘investment effect’ and remember the need to look for long-term benefits, rather than relying on studies which measure effects in the short-term.

2.7 Key requirements for ‘health navigation’ to work

One succinct encapsulation of what is required, at base, is that that community health workers need to be:

- Selected well
- Trained well, and
- Supported well (Castañares, 2015).

Looking more broadly, it has been noted that the key requirements for a navigator/community health worker programme to be effective are that:

- they be **integrated** into the healthcare team (Collinsworth, Vulimiri, Snead, & Walton, 2014; Manderson et al., 2012; Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995)
- they receive good **training** (Hou & Roberson, 2015; Nguyen, Tran, Kagawa-Singer, & Foo, 2011; Paskett, Harrop, & Wells, 2011; Pei et al., 2012; Waterworth et al., 2015)
- their **role** be **clearly defined** (Freeman, 2013; Waterworth et al., 2015)

Training needs to cover the wide range of possible elements that the multifunctional role entails (Pei et al., 2012) and needs to include such diverse elements as information on medical conditions and where to find resources, logistics such as transportation and interpreting, as well as interpersonal skills (Nguyen et al., 2011).

In addition, it is important that health professionals be trained so that they understand and value the role (Castañares, 2015), and also increase their cultural sensitivity and awareness (Pei et al., 2012).

From the opposite angle, there are a number of threats to the success of any such programme. Role definition features prominently:

The last thing that consumers, in particular, need is a host of new titles and terminology to cause more confusion. The lack of clarity around “who does what” may also potentially disrupt cohesion and collaboration among members of the care team...”

“The title alone... says very little about an individual’s professional discipline of origin, expertise, or proven competence”. (Watson, 2011)

Other possible risks involved in introducing navigation services are:

- that the role is female dominated (Villa-Torres, Fleming, & Barrington, 2015), with the possible result that it is less effective with males, as shown in one US study (Taylor et al., 2013);
- burnout if workers are ‘too committed’ to community, and/or are employed for too few hours and/or work many more hours than they are paid for (S. Henderson & E. Kendall, 2011);
- that the new role may be ‘perceived as a threat to other nurses or health professionals and the change would be resisted’ (Waterworth et al., 2015);
- that adding a new role may increase the complexity of an already complicated health system (Waterworth et al., 2015).

2.8 Intersection of health navigation with interpreting

There is little in the literature explicitly discussing the intersection between these roles. However, there has been discussion of problems experienced by interpreters with the traditionally narrowly defined role of the interpreter, which confines them to conveying as closely as possible the exact words of the speakers. Other participants

often expect interpreters to do more than this official role sanctions (Hsieh, 2006). As far back as 1984, for example, Native American interpreters experienced difficulties negotiating the various roles that others often expect of them (Kaufert & Koolage, 1984). Interpreters themselves vary in their definition of their role, with some considering that their role encompasses advocacy, cultural brokering and emotional support (Butow et al., 2012).

There are few explicit mentions in the literature of the intersection between the role of health navigators with that of interpreters:

- intercultural mediators in Europe who have always had interpreting as part of their role (Verrept, 2008).
- some recent navigator programmes in the US where staff are explicitly trained in interpreting skills (Pei et al., 2012; Seattle Children's Hospital, 2014).

3. METHOD

3.1 Data Collection

This study used qualitative methods to elicit the views of health navigation providers from two services in the Wellington area involved with the support of LEP patients in accessing health care. Face-to-face interviewing was used as the method most likely to elicit in-depth comments of high quality.

For the purpose of this report, the staff of both services will be referred to as navigators, although this is not the formal title used in the PHU.

Interviews were conducted with the managers of both the community-based Pacific Navigation Service (PNS) and the Pacific Health Unit (PHU) in Wellington Hospital, and with staff from each service who work directly with patients (both PHU staff and 6 of the 9 PNS staff). Staff were contacted and offered either group or individual interviews. Six interviews were conducted with 13 participants in total, in the following groupings:

Table 2: Interviewees

Service	Type of participant	Number
PNS	Managers (Clinical Services Manager of Compass PHO and Clinical Leader, WellHealth PHO)	2
PNS	Staff (3 nurses, 3 community support workers)	6
	Independent contractor involved with the establishment of the PNS	1
PHU	Director	1
PHU	Staff (Social Worker and Programme Coordinator)	2
PHU	Staff - Registered Nurse	1

The semi-structured interviews covered the following areas:

Table 3: Interview questions

Barriers	What are the main barriers to good health care for people from diverse cultures with limited English proficiency?
Current service provision	What opinions and/or experiences do they have of the current provision of support services (especially interpreting and health navigation/liaison) for LEP patients?
Roles	How do they understand their role(s)?
	How do they understand the relationship between their role and other support services for LEP patients, particularly between interpreters and health navigators, but including other services such as social workers?
	What difficulties do they experience with role boundaries?
Improvements	How could services be improved, for example through better role definition, reconfiguration of services, or potentially establishing a new role of bilingual health navigators (by whatever title)?

3.2 Data Analysis

All interviews were transcribed verbatim. A framework analysis was then conducted to collate the participants' views in the areas covered in the interviews, with additional analysis of emergent themes.

Illustrative quotations were selected from all 12 participants who contributed substantially in the interviews (one PNS navigator had to leave the interview early, leaving limited contributions).

All quoted participants were consulted on whether they wished to be identified or anonymous in the report and a draft of the results section with quotations from each interview (whether group or individual) was provided to each participant to check for accuracy. To protect anonymity as much as possible (as requested by participants), no identification code was assigned to each participant as this would have enabled participant contributions to be attributed to a particular service, based on the few quotes for which this unavoidably clear.

4. RESULTS

We first report on participants' views on the main barriers to Pacific people in New Zealand obtaining good health care.

This is followed by a section backgrounding the local introduction of navigation services as a strategy to overcome these barriers. This section continues with a general description of how the services currently work (referral processes, person specifications, key tasks, roles) as well as issues relating to boundaries and expectations and other difficulties faced by the services.

The final section focuses on the specific issue of strategies used to overcome language barriers including participants' views on the interface between their role and that of professional interpreters, and their reaction to the idea of a potential combined interpreter/navigator role.

4.1 Barriers to good healthcare

A wide range of barriers was mentioned by participants in interviews, either in direct response to a question or in the course of conversation. These largely align with the literature on LEP patients and Pacific patients reviewed earlier.

We have organised these into similar categories to those found in the literature (i.e. broadly relating to health systems (external) or to characteristics of the population (internal)) although in fact, many of them are inter-related.

4.1.1 Health System (External) barriers

There was quite strong feeling that a major barrier to Pacific people obtaining good health care was to do with the health system.

In my experience, I just have to say about 95% or even 99%, it's the services that have failed the people. It's never the patient's fault.

A range of issues was identified, both structural and to do with the communication skills of health professionals. They are summarised in the table 4:

Table 4: Summary of health system barriers

<i>Structural</i>	<i>Attributes of Staff</i>
Complexity	Attitudes
Inflexibility and insensitivity of system	Communication skills and habits
Poor administration systems	
Physical location of clinics	

Structural Issues

These were mentioned widely by both management and staff of the services.

Complexity

This was noted particularly by managers and in relation to secondary health care:

The hospital system itself is very daunting. When you walk into the hospital ... it's foreign, it's very clinical ... it just runs different than primary care and that's probably a barrier.

And the number of contacts. Sometimes you get a text, you get a letter, you get a phone call and you're not sure if - because they're all different ... it confuses you ... It might be the same topic but because you're getting three different angles on this, you know, it is muddly.

Inflexibility and insensitivity

Several participants noted that appointments were often made at times that did not suit the patients and/or that clinic or screening opening hours were at times which did not suit the working conditions or hours that Pacific people often work.

Some of the things, it's very minute and could be changed just by understanding what the person's circumstances are.

They keep booking that person without consulting them what time is best.

Inflexibility of staff when dealing with patients who are hard to reach was noted:

[A] patient [from] a hard to find family - no transport. ... we went in and I said "well, while we're here, we might as well get the flu vaccine". They told me they can't, have to book it for another day. ... And I said "Thank you. It's not going to happen. If you don't do it now, she won't come back".

That said, it was acknowledged that some systems have been changed to be more accommodating:

Breast screening has opened Saturdays where they can do clinics. ... they're starting to work later than the usual to accommodate those women.

Poor administration systems

Criticism was made of the poor interfaces between different systems:

Systems don't talk to each other very well ... we have lots of issues around appointments that people turn up for that were cancelled but somehow the letter hasn't quite got to them.

Deficits in straightforward administrative procedures (e.g. keeping details up to date) were also commented on:

They never updated their contact numbers and their addresses.

Physical location of clinics

The long distances to clinics from where Pacific people tend to live are often a barrier:

The barriers around having to ... come into town for their ... specialist appointments is problematic. And I think there's just a real push now to look at specialist appointments actually based in local areas where people live.

Long distances to travel at busy times also lead to problems with traffic congestion:

One of the big barriers is if you live out in Porirua and you've got to come into the city for an 8.30 appointment. That's actually really is a barrier because the traffic and all that and then you sit there for an hour and they're running late at the hospital.

Attributes of Staff (Health Professionals and other)

These were mentioned by the on-the ground staff in particular.

Attitudes

The attitudes of staff were raised as an issue when assumptions are made about Pacific people and attitudes formed accordingly:

I think it's the attitude of the workers as well. You know ... it's how they approach them, it's how they treat them when they come in for those things as well. And I guess that's another, the biggest barrier for people as well.

Some felt that staff sometimes came across as lacking respect for Pacific people:

I'm just trying to tell ... the medical centres and the people who are receiving patients that they be a bit more respectful and considerate.

Communication Practices

The communication practices of health professionals and support staff came in for some criticism, with Pacific Navigators mentioning a simple lack of communication:

They reschedule without telling them.....They're not communicating.

They also had strong ideas on how health professionals could improve their communication skills:

If they just, if they just summarise, like: "right, this is what you need to do now, this is your prescription for the blah, you take those tablets after three days. If it's not working, get back to the nurse." That is the sort of thing they need to do.

Some navigators reported that they sometimes suggest communication strategies to health professionals. One was using visual aids:

So sometimes I would ask the person or the specialist 'Can you get some diagrams? The heart diagram' ... because we're visual. Pacific people are very visual.

Another was explaining in simpler language:

That's why ... if they don't understand I ask them "Can you explain in lay terms, so that I can interpret - make sure that this person gets the picture" [instead] of bringing all this medical high tech words and then the person gets confused.

There was acknowledgement that some health professionals do have effective communication strategies:

There's one GP that I've worked with - her thing is to always write down. ... It's a very good form of communication to have it down there. People go back and re-read because you can't remember everything the doctor told you to do.

4.1.2 Barriers relating to characteristics of the population

The range of issues in this category are summarised in the following table:

Table 5: Summary of barriers relating to characteristics of the population

Health Literacy
Language Barriers
Cultural Barriers
Attitudes to authority
Pride
Communication/Learning Style
Collective Decision Making
Attitudes to Care of the Elderly
Previous Negative Health Experiences
Work Constraints

Health Literacy

This is an important barrier that was widely mentioned by both the staff and management. Aspects of health literacy ranged from general lack of awareness of the need for healthcare to understanding of more specific details:

They've got no idea why they need the healthcare - would be the biggest barrier.

A huge part of my role [is] in trying to make them understand. Not just information that's been given, but procedures that they need to go through and the treatments that, and the medications.

The interaction of health literacy with culture and English language proficiency was mentioned:

And I've found that there are people that can communicate very well in English with the doctors and yet when the doctors explained either medication, you ask

them again ... “oh I don't know”. So you find that there's that reality of at different levels they need literacy support.

Even if you think you're speaking English to someone who has good English, it is still not always interpreted the way you think you've said it.

Lack of knowledge of the New Zealand health system was another aspect:

It's their understanding about services....What different services do provide. ... there's a lack of thinking outside of the square about, you know, what could other services do to support me in terms of getting well.

Language Barriers

While lack of English language ability was often not mentioned spontaneously when participants were asked about barriers to health care for Pacific people, it was rated as “very high” by PNS staff particularly when they were specifically asked if they thought it was a factor.

There's a language barrier around that that they don't have words specific words for the medical terms

Inpatients and their families ... have language barriers ... it's preventing them from better health here in the hospital

Limited English was only one issue relating to language barriers. Staff also talked about problems with patients not understanding due to the way things are explained, even when patients have good English. This factor thus overlaps with both health literacy and cultural barriers, as well as the communication skills and styles of health professionals.

I think just the interpretation from your lips to my ears ... what I think I'm telling you or talking to you or showing or explaining to you isn't always interpreted the same way in the ears that are hearing it.

Cultural barriers

Specific aspects of Pacific culture were mentioned as a potential barrier to healthcare.

Quite often it's our Pacific people have different perception of things.

Several specific aspects were mentioned:

Attitudes to Authority

Did Not Attend (DNA) rates in particular can be affected by such attitudes:

Breast screening is one of the things that have actually dealt with women, a high number of women DNA-ed. And they said “Well, we don't know what to do with them anymore. We keep sending appointments; we ring them they said ‘yeah, book me in’”. So they book them in again. See out of respect the person doesn't really want to offend them, so they just keep on booking these appointments; the person doesn't turn up and doesn't tell them the honest truth out of respect, culturally. So you ring, the person goes “look, I don't

really want to go, I've got two places to work. I come from one to another, the appointment doesn't suit me".

Pride

Our people ... have humongous pride. They don't like to go and ask for things. They are very embarrassed to go and ask for help and this is why the majority of them would prefer to just plod along with what they have.

Communication/Learning Style

Two participants mentioned the visual style of Pacific people that is not so suited to receiving information in the 'wordy' manner that they described many health professionals using. This factor thus interacts with the previously mentioned barrier of health professional communication style.

Pacific people are very visual.

We visualise things and then we learn from them... some of our people ... if they look at things like this, it's too wordy. ... be good to have photos or something.

Collective Decision Making

This was mentioned in connection with Pacific families having a more collective attitude to decision making about medical care, and can include some family members having a stronger desire for traditional medicine than others:

For example, if a patient needs an operation or surgery and one daughter says "yes Mum's having it" and the other son says "no she's not having it because we can get a fa'fo or massage" or whatever it may be, that is a real delicate situation to deal with. ... And then the chief of the family jumps in and has his little two piece in the discussions and then it can get really out of hand and too complex.

Attitude to Care of the Elderly

A particular example of where cultural attitudes impinge on health care choices is in the area of aged care:

People feel that they have to look after their elderly people in the home... another huge thing is perception of our community and our church [with respect to putting elderly in a home]

Previous negative healthcare experiences

It was reported that attitudes of Pacific people to healthcare are often coloured by previous bad experiences they have had within the New Zealand health system:

There's a lot of fear around health.

They've been shattered sometimes ... and we're the in-between people to make things right between the doctor and the nurse and say "look this is why the patient doesn't want the smear any more - it was a bad experience from last time. It may not have been you but you know, this is why and then you understand why the rest of the family are not coming in".

Work constraints

One further barrier that may be cultural is a perception by some that they cannot get time off work to attend appointments. While this may sometimes be a reality (and something that can be improved by changing the system to allow for appointments outside work time), at times this is a barrier that can be overcome through communication:

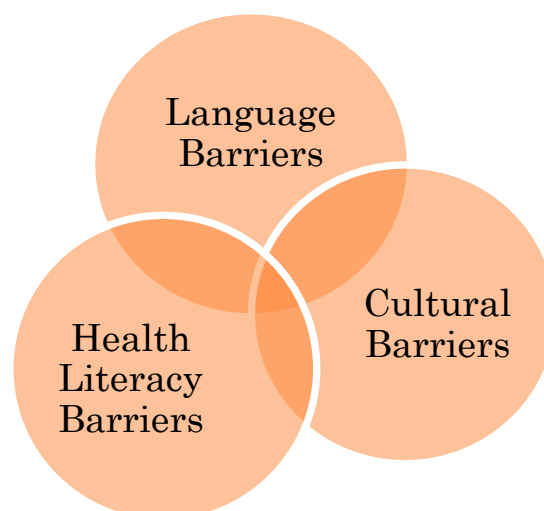
We receive some calls around people feeling they couldn't ask their bosses for time off because they were scared they'd lose their jobs. ... On occasion our administrator's actually rung the bosses and said "Look, this is ... a legitimate appointment, can you release them to come? Because otherwise they'll just end up being even more sicker and you won't see them and, you know, more sick leave". So most of the time they've been awesome, you know. They've released staff.

4.1.3 Inter-relatedness of Barriers

As mentioned several times above, many of the barriers outlined here are inter-related in that if changes were made to remove or ameliorate one barrier, then another barrier would not exist. For example, if health professionals changed their communication style to use simpler language and more visual aids, then the communication/learning styles of Pacific people would be less of a barrier.

In fact, the barriers of language, culture and health literacy may all overlap. Problems with understanding health information, for example, relate to health literacy but also to culture through underlying ideas about health and preferred learning modes, as well as to English language limitations.

Figure 1: Inter-relationship between barriers to effective healthcare



4.2 Background to the Pacific Navigation Service and Pacific Health Unit (CCDHB)

The director of the Pacific Health Unit (PHU) and an independent contractor, both of whom had been involved in the original planning and establishment of the Pacific Navigation Service, provided a summary of the history of the services.

The PHU in the hospital service was established around 2003, initially with a clinical team leader, a registered nurse and a social worker. A breastfeeding service and administrator were subsequently added on. A major focus of the service has been on Did Not Attend (DNA) rates and some research has been done to find out which types of appointments have the highest rates. In addition, some patients defined as ‘high flier’ DNAs (i.e. frequently missing appointments) were interviewed to explore what were the issues for them. Subsequent to this, there is now a policy that all Pacific patients with outpatient first specialist appointments receive a phone call from the administrator of the PHU two days out from their appointment (about 350 calls per month).

Both anecdotal and hard evidence of the effectiveness of the PHU was reported:

Pacific traditionally have had the highest DNA rate at about 29% which is really quite high. We’ve managed to get it down to about 14-15%.

Their admission rates to ED dropped and ... and if they did end up in hospital, their length of stay reduced compared to Pacific people ... that didn’t go through the navigation service.

Anecdotally, it was felt that talking to a Pacific person from the health system made a difference to Pacific patients:

I think that once Pacific people find out there’s a Pacific person on the other side of the phone, the conversation takes on a different shape. ... and it does become a conversation, not just a reminder call, because then the person starts talking about all the issues you know.

Around 2012, a new community Pacific Navigation Service was set up to provide a clearer referral pathway from the PHU for patients leaving hospital, and to avoid confusion and duplication seen as being caused by the previous provision of services by two separate organisations which were not so well integrated with the PHU or with Primary Health Organisations (PHOs)³. The new service was developed by Pacific health leaders and PHO Chief Executives through a process of co-designing that

³ Primary Health Organisations (PHOs) are not-for-profit organisations that provide primary health services either directly or through their provider members with the aim of ensuring GP services are better linked with other health services to ensure a seamless continuum of care.

included research into similar programmes overseas as well as consideration of compatibility of the Whanau Ora⁴ concept being developed locally.

Initially the service was set up and contracted to a joint Primary Care Alliance Trust (PCAT) comprised of two Wellington PHOs, Compass and WellHealth. This allowed each PHO to have their own team of navigators, but following a recent review, it has been recommended that they become a single team to provide more consistency of care. The team of navigators is made up of community support workers and community clinical nurses, with the majority being community support workers.

The new Pacific Navigation Service (PNS) is viewed as a way to overcome some of the barriers identified by participants. One staff member summarised the situation, highlighting the barrier of health literacy in particular:

It's no secret - our health status ... we are the poorest health in New Zealand... so if that way that will improve it, then it's to make people understand more about themselves and their illnesses and treatments and procedures available.

It was also felt that the PNS was effective:

the navigation service ... has good credibility with the community at the moment and we can prove that. There's evidence through, particularly Compass's data, that of the patients that went through the navigation service on Compass registers, ... their admission rates to ED dropped and their length of stay, and if they did end up in hospital, their length of stay reduced compared to Pacific people that are on Compass registers that didn't go through the navigation service.

It should be noted that further research is needed to establish whether patients and health professionals concur with the assessments of those involved in the Pacific navigation services.

4.3 Description of Current Pacific Navigation services (community and hospital)

At the time of the study, the services consisted of the following staff:

Pacific Navigation Service	9 staff (range of Pacific ethnic backgrounds, including Samoan and Tongan ¹)
Pacific Health Unit	2 staff (both Samoan)

⁴ Whānau Ora is a New Zealand initiative created in recognition of the ineffectiveness of standard ways of delivering social and health services, particularly for Māori. It places families/whānau at the centre of service delivery, requiring the integration of health, education and social services and is improving outcomes and results for New Zealand families/whānau.

Samoans form a larger group than other Pacific backgrounds among the staff (and among clients) and comments at times reflect their experience with specific reference to ‘Samoan ways’.

This section reports on how participants described:

The referral process for each service

The person specification for the roles including skills or attributes, and the spread of skills across the team and training:

Key day to day tasks performed by the teams

4.3.1 Referral Process (how do clients and navigators get together?)

The referral processes for the community Pacific Navigation Service and the Pacific Health Unit in the hospital are different.

Pacific Navigation Service

This service is situated within primary care. Clients are referred to this service from a wide range of sources including general practitioners, non-governmental organisations, hospital services and self-referral. There was individual variation around which was the most common source, with self-referral by clients most common for some navigators because of their personal networks. The navigators noted that rates of self-referral were increasing as the services become more known in the community.

The main reasons staff mentioned for referral by providers were when patients did not attend appointments (DNA), patients who have been difficult to reach, and when doctors have “difficulties” (including occasionally when a patient has not paid).

Pacific Health Unit

This service is situated within the hospital. Referral to this service requires the patient to tick a box on a form to signal their consent. If patients have consented, then doctors, nurses or social workers may phone or email the service to refer them, or patients may self-refer.

When patients have not consented but health staff feel they would benefit from the service, staff will have a talk with them:

If they do talk to a patient and they refuse our service but they still felt that this family needs assistance, then they still ring us and I would still go up and see them without consent. ...Just to have a chat and there are Samoan ways of approaching situations like that. So it doesn't encroach on their, you know, I always say “look, I know you haven't been, you haven't, you don't want our service” for example “but hear me out sort of thing and if you still don't want it then that's fine because it's all about you and your family”.

Reasons why patients refuse the service were felt to be fears around confidentiality, reluctance to have additional people to deal with, as well as lack of awareness of how the service can benefit them:

It's about reassuring them, because quite often a lot of our people don't want Pacific involved if they have - It's privacy. They don't want people to know about their stuff and that gets spread out in the community.

“Another person involved in my life, do I really need?” You know, “What can they actually - ... what support could they really provide me that I can't access somewhere else?”

When they understand more about what the service provides really, that's when they change their minds but... it's just how you approach. ... I guess for some people, it's not knowing what the service provides that is different from what the hospital provides.

One problem identified with the consent requirement is that there is no explanation on the form for patients about what the service provides. Because of this, the Pacific team have trained nurses in how to ask the question and what information about the service to provide when filling out the form with patients.

Staff in this unit identified the need for interpreting/translation as the main reason for referral in the hospital. This was an unexpected finding and highlights the importance of this research. This issue is dealt with further in the section on overcoming the language barrier (p. 50).

4.3.2 Person Specification for the role

It was noted by a manager that a wide range of skills is required for someone in this kind of role. Some of these are core skills that all need to have, but some may be distributed across the team. The way that the PNS is made up of both Clinical Nurses and Community (lay) health workers illustrates this.

Skills or Attributes

The skills or attributes required in the team include:

Language/Communication Skills

This was widely mentioned and includes skills in a range of Pacific languages, as well as general communication skills to deal with sensitive issues and to be able to communicate flexibly:

Language is the key to understanding.

It can be embarrassing because when we're doing sexual health.

There are words in our language that can be used but it comes with time and how you understand people.

We talk to the staff [about] being able to say something five different ways and that at least one of those ways is bound to connect.

Cultural Knowledge

“Cultural sensitivity” was mentioned as a requirement:

It's not just about speaking the language. It's about understanding our fa'a Samoan ways.

A person who could engage with the culture in the context of the patient.

At Least Basic Knowledge of Health and Health Care

Navigators need to have some level of knowledge about health and health care in order to do their jobs effectively.

There should be qualification and understanding, not that we're going to go nursing, but understanding the different diseases and what it is ... understanding that had empowered me to actually face my community, make sure that they understand.

A person who would have some clinical inkling but wasn't a clinician.

Just a baseline understanding around health... you don't have to have a health professional qualification to be able to talk to something, you just need to have an understanding about the mechanisms of what that might be.

It was emphasised by some that health knowledge needed to be communicated in a culturally appropriate way:

You have to have the health knowledge to understand what's happening and then have the context of that person to understand how to then communicate.

As noted below, basic training in health is something that can be provided to navigators after hiring if other desirable attributes or skills have been prioritised in the hiring process:

They might have an education skill that you might want so you can teach them some of the health stuff.

Personal Networks/Community Experience

This was mentioned particularly with regard to the community PNS where they make use of both personal and professional networks, often built up over years of working in the community in a range of roles. This enables navigators to access a wide range of resources and to operate effectively because they have built respect and constructive relationships.

The build-on is actually your community experience and how do you work in a community, which is not a skill that comes naturally to a lot of nurses.

You know them well, you've got the links into the community, you've got the respect from the community because you've been serving them for how many years, that gives you a lead way and [makes it] easier I guess.

That said, not all navigators have extensive community or nursing experience but such individuals can be effective as part of a team where others can step in where

required. For example:

(the service hires)...nurses with any level of experience ... we've got a new grad at the moment but normally in the roles like this we would look at someone who's done at least five years postgraduate work in a range of areas. And ... some of this stuff ... I mean it looks pretty daunting but a lot of it is actually just basic nursing skill, to be fair

Many of the community support workers in the PNS team come from a health promotion background with several having experience in Smoking Cessation and/or HPV immunisation programmes with Pacific, new migrants and refugees. Some have experience in the police or the court system as well. The nurses come from backgrounds that include midwifery, neo-natal care, practice nursing, aged care and community nursing. The front-line Pacific Health Unit staff at the time of the study (not including specialised breast-feeding promotion staff) were an experienced social worker and a nurse with previous experience in cardiac nursing.

Spread of Characteristics in a Team

Particularly in the larger PNS team, it was noted that it was important to have a team with a range of people according to ethnicity, skill-set, gender and age so that the clients can receive care from someone similar to them who has appropriate skills:

It may be an ethnic gap that we have and ... we might consider how that person might fit into the rest of the team.

It depends where you're trying to drive the service and where the gap is as to what you might look for in the skill set.

It's ... very valuable to have like older people in the team. We need a range of people to sort of fit this you know. We have young [NAME] here who's young, so any young ones come through I say "hey, this will be good for you".

They will talk amongst themselves and actually will say you might be the more appropriate person to go in and sometimes it can be a gender thing and it could be an age thing. So we might ask one of the senior staff members to go and see a family rather than one of the young ones go. And it might fit the other way sometimes, that a young one needs to go to understand quite what the issue is.

It was also noted that it can sometimes be difficult to find people with both the appropriate cultural background and the ability to deal with the necessary paperwork.

Training

Some participants mentioned the need for navigators to have some kind of appropriate training prior to taking on the job:

Could be nurse trained, social work, community worker but needed a benchmark qualification so that you can make some assumptions about what they knew and then top that up.

Others emphasised training after being hired:

You add skills and knowledge in a role and ... when I'm recruiting, I don't necessarily expect someone to fit straight into the team from a skills base.

To some degree, this has been related to the new Pacific Navigation Service being set up with a significant number of community support workers who have not always had formal qualifications in what they do. Policies regarding general community worker training are now changing to require more training and experience up-front:

All of my team so far have done the baseline core competencies course for support worker in the community. So we've made that a baseline course for anyone that we now ... employ to do community health work because it talks around health and disability, privacy, confidentiality, you know, boundaries, policies.

Navigators with a community worker background would benefit from more specific training in health, as this is felt to be key skill, as mentioned above:

It would be good to have some core work developed for primary health care workers in health.

The rationale for raising training levels was described as being two-fold: intrinsic improvement of the workforce as well as building credibility in the community:

That just gives you more credentials across the board around how people see a Pacific service. Because some who've had experience with a Pacific Service in the past wouldn't have had a very good experience ... They may not use a Pacific service again. So it's around building capacity but also building real credentials across a broader sense than just a Pacific community sense.

4.3.3 Key tasks – what do they actually do day to day?

There is a wide range of specific tasks that the services as a whole carry out. Within the services, what individual navigators actually do day to day depends partly on whether they are a registered nurse, a trained social worker or a community support worker. Some tasks are within the scope of practice of specific types of navigators (e.g. registered nurses) whereas others may be common to all staff.

Table 6: Specific tasks mentioned by participants

Tasks carried out by the navigation service teams:

Routine reminder phone calls for specialist appointments (PHU administrator)

Talking with clients by phone or in person (on home visits)

Assessing what needs to be done

Making a plan for action

Liaising with their networks (other professionals, organisations or individuals) by phone or in person

Making appointments for clients

Accompanying clients to appointments with doctors, in the hospital

Interpreting and translating, including helping to complete forms

Explaining medical procedures, medication etc.

Writing up notes

Administrative tasks e.g. checking lists of people for overdue screening tests or to establish contact

Other miscellaneous tasks that may benefit clients, e.g. arranging for a disabled parking permit for a car when needed, advising on preparation needed for cervical smears, putting clients in touch with other services such as insulation programmes.

4.4 The Role of the Pacific Health Navigator

4.4.1 How is the role defined?

Broad Definition

At a broad level, the key descriptions given of the role were that it is their work is **holistic**, not narrowly focused and, related to this, that it is **outcome focused** in the sense that they are focused on getting the best outcome for the patient rather than a strictly prescribed set of activities.

Holistic

It's everything ... It's more holistic the way we look at it.

Participants saw the role as looking at a big picture which includes a client's wider family and life situation:

She might actually pick up there's a bigger family need, transport, food, you know that sort of stuff ... there's a bigger picture.

One participant noted that the role could encompass almost anything:

Given that 'Navigator' within a New Zealand context is most associated with Whanau Ora, there is a holistic context associated with it. There would be hardly anything that will fall outside the role.

Outcome Focus

The staff in the services emphasised that their main concern was to get the best outcome for their clients (not to focus on cost savings or efficiencies for the health system, per se). This was expressed in the following ways:

To help Pacific people get the help they need and have the best outcome for them.

Trying our best to work together just for the betterment of and make sure the outcome of what we're working for... it's got a solution for it.

Specific Aspects of the Role

At a more specific level, the following aspects were identified as being key parts of the role:

- Literally navigating/supporting
- Helping overcome language barriers
- Educator
- Advocate for patients
- Mediator
- Liaison with other services
- Being a gatekeeper to the service

Literally Navigating/Supporting

It is clear that a key role for the Pacific Navigation Service is, as the title suggests, to assist patients to navigate through the health system:

They're navigating and holding the hand, more or less, of the person who needs to go through the health service which in itself is really complex and daunting and quite scary for people with English as a second language.

We support our patients in making sure, for myself, making sure that they can navigate the system out in the community and while they're in hospital.

Supporting Pacific peoples ... through the journey, their hospital journey.

Helping Overcome Language and Cultural Barriers

This is another key role that was widely mentioned, as staff members all use their language skills to communicate with patients, including interpreting for others or arranging for someone to act as interpreter:

Here in the unit we only deal with inpatients and their families that have language barriers that ... it's preventing them from better health here in the hospital. ... I personally don't take on families that can understand English and have good comprehension unless they specifically request for it. Otherwise it's mainly those with English as second language, limited English.

Within the community PNS, the nurses are expected to handle serious language issues:

If it was an issue around actually the language then ... the registered nurse should go in and do that appointment.

However, all navigators use their language skills to aid communication:

Language is the key to understanding.... We translate those instructions for them.

Another way they help to overcome language barriers, as noted earlier, is by coaching health professionals in more effective and culturally appropriate communication, such as asking them to explain in lay terms or to use a diagram and so on.

Educator

Another important aspect of the role is education. This part of the role extends to both patients (where navigators are overcoming health literacy and cultural barriers) and to health professionals (where they coach them in better communication skills for Pacific patients and in cultural sensitivity).

➤ Educating patients

This included expanding on explanations from health professionals:

Most ... come with children or family members that can speak the language but understanding is a totally different kettle of fish. ... That's a huge part of my role in trying to make them understand. Not just information that's been given,

but procedures that they need to go through and the treatments that, and the medications and “what are these medications for?”, because most like “have this three times a day”, that’s it. And then they don’t really explain “what are these for” and you know “what do they do” and what the most important things are, the risks. What are the risks with these medications and what they need to watch out for and that sort of stuff.

It was noted that the education role helped patients in future interactions with health staff:

The good thing about it is you’re educating the person and when they go into consult with the doctor and you’re not there, they know exactly what they want or the problem, if the doctor actually asks ‘you got a problem with you kidneys?’ ‘oh yeah I remember that word’.

Sometimes the education component may be quite minor, almost in passing:

Even as a prompt you don’t have to actually roll out like you do a whole education session but it might just be “have you thought about? It might be a good time to.”

➤ Educating health professionals

Participants emphasised that they also saw themselves as educating the health professionals in how to interact effectively with Pacific people:

Supporting staff to deliver to Pacific people in a way that we’re trying to build cultural competency and responsiveness

Advocate for Patients

Patient advocacy was a role that was widely mentioned, and navigators noted that it is something that differentiates their role from that of a professional interpreter:

Yes there is a boundary [for interpreters] whereas I advocate because I know more.

The navigator can ... actually act as a voice.

Advocacy may be direct where the navigator speaks up to staff when they see a problem for a patient:

If they say “oh no we can’t do this and that” and then I have to step in and say “can we look at other ways and see if we can find a solution for it?”

We’ve got a couple who are quite vocal who will go up and say ... “you’ve asked this patient to be here at 10 o’clock, they’ve only got \$5 for parking, you’re now two hours late, now it’s going to cost them more and they haven’t got any more money, so who will pay for the change and the parking?” So you know there are those sorts of things.

Their mere presence at an appointment also sometimes acts as indirect advocacy - several participants reported seeing what they considered improved performance from staff when they accompanied clients:

That's the best consult from the beginning to the end, oh perfect - nothing. Even they weigh, they measure, everything. I thought 'geez, I've never seen this before' but ... It's a shame that we have to be there for that to happen to our people but man, that's what we need to be there, that's what has to happen.

As discussed in the next section, the boundaries of the navigator role for those working in the community can be difficult to manage, to the extent that some may at times even accompany clients to other social services outside (though related to) the health system:

If I do go and work with them down to Work & Income, ... I always prep them. I say "Look, when we go down there, you're the one that's doing all the talking, I'm just going to sit back and listen unless I feel I need to jump in". And it's just amazing, just having that presence there. Work & Income staff will ask all sorts of questions and you know "anything else I can help you with?" It's amazing.

Mediator

A role related to that of advocate is that of mediator which was also mentioned by on-the-ground staff. Often this will involve helping both sides see the other's perspective. In this sense, they are at times cultural mediators when they can understand the underlying cultural attitudes of both sides (the Pacific and the Western medical) and explain to the other party:

That's a lot of the work that we do here is just to have those conversations with the staff and with patients.

And my role is ensure that the family understand where the medical staff is coming from and that the medical staff understand where the family's coming from.

Liaison with Other Services

This is specifically mentioned by management:

Part of our role is actually finding out who those people are [other health services involved with patients] and how we would actually do some joined up work together and we can do some joined up work.

Being a Gatekeeper to the Service

This was briefly mentioned by two participants, with management noting that this sometimes needs to be done (but can be delicate):

Part of the role is actually to explain to them each what the criteria are for services and the reasons why they don't meet that criteria. Not always an easy conversation to have.

4.4.2 Boundaries of the role

This can be an issue at two levels:

- a personal, micro-level for individual navigators
- an organisational level.

Individual Level

The holistic nature of the role, as described above, and the potential intersections with other organisations or professionals, means that awareness of boundaries is important.

For some, there was an acceptance that there will sometimes be a need to go beyond their role boundaries and, for example, give limited assistance to someone who doesn't strictly meet the criteria:

I will help from a Pacific perspective, even though it's not within – but I wouldn't spend too much time with those sort of people. I'll just find out information for them and refer them to, or if I know how to help them, then I educate them on how to go about it ... without spending too much time with those people.

It all depends because at the end of the day like I said and my priority's the patient, if something that they need, even if it's outside of my role and I know that the patient will benefit from it, then I have to step in and try my best to do it, for the benefit of the patient... I mean with our roles, you know, we're just trying to help really and it's natural. It's just natural really.

The thing is 'what is the task that you've been asked to facilitate?', and the only reason why you would go too far outside of that is that if you can't progress this without having to deal with this other issue.

It was acknowledged, however, that it is necessary to manage the boundaries of the role and that this is not always easy for Pacific Navigators.

That's very difficult because there's a real difficulty in separating your work self from your community self because they all serve their own communities in different ways outside of their job.

Staff are aware of the issue and consult each other and management or with the health professionals they are dealing with to clarify boundaries when necessary.

So they do cross over but they know when to, and maybe it's not right and they come and ask, "Do you think I should be doing this?" or "Can I do this?"

They talk a lot among themselves and then occasionally they'll ... make a beeline for me and ... just say "Oh you know, can we?" and we'll talk it out and we'll think about different ways of approaching it.

Stepping over ... the boundaries and that, it would be something that I will automatically notice, if that's the case. And it's just hard because for me, I always respect... the clinicians and the patients in both ways... And that's why I always ask questions and always reassure ... "Is that alright for me to do this?"

Is that okay for me to come and explain this to? Is that alright for me to deliver your message to?"

Organisational Level

The fact that there is a varied range of services available in the community with different focuses, means that knowing the boundaries at this level too can be an issue.

Out in Porirua in particular there are lots of services for lots of different ethnic communities. And we've always struggled sometimes to know who does what when and how. And it's still not clear I would say in some, because we have a lot of social workers are funded through different streams.

This issue is partially addressed through cross-organisational meetings.

I meet with Work & Income every month ... with our, we have a advocates in Porirua, so Budget Advice and Housing New Zealand and then we meet with any issues that we had come across with our patients or people that we've dealt with.

I would imagine that the navigators and other helping professionals will belong to networks so they would have professional monthly meetings and networks in Newtown or whatever or call meetings based around a client in common. ... So the "Strengthening Families" approach is that they will call all the professionals together who are working with a family or a client so that they know who's doing what and not to overstep each other's boundaries. The navigator's role is to weave through the traffic.

The competitive environment for services, where a number of different services compete for government funding and for clients, was seen as a problem in dealing with this issue. The history behind the setting up of the navigation service has also meant that some specific services (such as Smoking Cessation) have been reduced, but still exist and can overlap with the work of navigators.

It's not simple because ... a lot of the way things have been funded have set up a sort of competitive environment. And so when you have a competitive environment and you have to look at numbers as to who you see and how often you see people and things like that, it means that it's difficult to share your service because who ticks the number?

*...because a client, for providers is money, at one level.
So if you see someone's got asthma and you've facilitated their visits and things like that then you talk to them about smoking cessation but somebody else has the smoking cessation contract...*

4.4.3 Issues with expectations

Some issues with the expectations of both health professionals and patients were reported, mostly based on misunderstanding or lack of awareness of what the role of the navigator is.

Health Professionals

With the PNS being a relatively new service, it has taken some time to educate health professionals about the nature of the service and what they can expect from it.

Primary care's got better at understanding over the last three years or so and that was just because it was a new service and not understanding the referral criteria.

On the other hand, there was a feeling that other health professionals and managers sometimes ask for more detail than is really necessary about exactly what the navigators do:

We have lots of discussions with different directorates in the hospital around what we do and our staff go and do little presentations and ... they say their role is to help Pacific people get the help they need and have the best outcome for them. ... I think it's how we do that, I don't know if they need to know that so much. ... do you need to know that a Pacific RN or a Pacific community health worker does da, da, da and we've had some of those discussions around "How do you do it?", "Why do you do it?", "What do you do when you do that?" and I'm thinking "Why do you need to know?"

Staff do still experience some difficulties with some health professionals expecting navigators to go beyond their role or job description:

We had one last week you know "Could your Pacific navigator do this?" ... something to go and do ... give someone some medication or something in the weekend and I said "No, no, no, no, no. We do Monday to Friday, just like you".

I would suggest that the other professionals are quite happy to offload work to the navigator.

Patients/Clients

Patients also sometimes have expectations that navigators will do more than their role allows, which can be partly a general cultural expectation or a simple misunderstanding of the role:

So there is expectation in the community because of the relationships, and so they're put under a bit of pressure I think at times from their own communities as to what they can do for them.

As noted above, there is still some uncertainty about where the boundaries of the role are and whether or not it is appropriate for these navigators to engage with other social services outside the health system:

A lot of our families think "Oh great, you can take mum to the Work & Income" and I says "No, it's not my job" and they go "So what the hell are you here for then if you can't do that for mum?" And I says "I'm here to educate you, empower you to go and do these things for (mum)".

At times, there may be a problem with self-referrals where clients try to use the service as a way to get other services which they may not be eligible for:

Some people have an expectation of a service that is outside their, you know, they don't meet the criteria for and think that you might be able to create a pathway for them into a service or get some help. That's not exclusive to Pacific families.

4.5 Difficulties faced by the services

The services face a number of challenges connected to two aspects:

- the relatively recent creation of the community navigation service
- the way the services are set up and supported.

4.5.1 Problems relating to introducing a new service

Because the community-based Pacific Navigation Service is new, there are inevitable problems associated with the process of introduction:

Lack of awareness of the service
Resistance to change
The need to develop trust

Although the hospital-based Pacific Health Unit has been around for longer, it still experiences ongoing issues with this.

Lack of awareness about the service

This relates to both health professionals and to the community, where navigators find that there is a lack of awareness of what the service can do and appropriate and timely ways to use it:

Health Professionals

Navigators ran into a general lack of awareness of what they could use the service for:

I have a lot of those conversations – “You could send that family to Pacific Navigation and they could do that work for you”. “I hadn't thought of that”. You know, because it's just like “This is just too hard”.

Awareness of the optimal time to engage with the navigation services was also an issue, with a perception that they were often called in later than ideal:

It's a battle really that we are working with the wards, because most ... don't really come to us when the patient's admitted. They only come to us when they're stuck. So that is when we're sort of trying to pick up the pieces from ... the start of the journey of this patient in the hospital. ... But ... it's something we're really working on here is trying to build that relationship with the wards, clinicians.

Community

Participants reported a general lack of awareness of the service among members of the Pacific community, particularly in the hospital,

For some people, it's not knowing what the service provides that is different from what the hospital provides ... I think it's that understanding about "Okay, what else could your service provide on top of what they're providing?"

This wasn't helped by the process used to invite patients to use the service, where a simple tick box on a form is provided with no further information:

It's the understanding. Yes so, what service we provide, because it just says "tick the box" - doesn't really explain what we provide.

Reaction of practices to change and perceived extra demands

It was acknowledged that it was challenging in primary health care to introduce a new service into an already stretched and complicated system:

General practice is not very good with change and of course primary care is full of change. So we're forever sending out "We want you to do this, we want you to change that, we want you to add this, we want you to think about this. We've got all these targets, we need you to deliver this work". So there's, you know, forever challenges and "just by the way, could you have the Pacific navigator come in and do some work?" You know. It's sort of like "Oh". You know, it is difficult.

Need to develop trust

Building trust with both health professionals and the public was a general and ongoing concern.

It's building that trust which I think is getting there, it's just chipping away, chipping away, building that trust.

4.5.2 Problems relating to the design and resourcing of the services

There were a number of critiques made by participants of the way the services are set up and resourced, including:

Focus of the service
Integration into the care team/continuity of care
Resourcing
Lack of professional support
Make-up of the community Pacific Navigation Team

Focus of the Service

There was some feeling that the service was focused on surface-level objectives like reducing DNAs instead of addressing the fundamental question of whether people's health was improving.

I think this patient has not had an improvement of her diabetes stages all these years but they never called. So they only call us when they don't turn up.

Integration into the Care Team/Continuity of Care

Related to this issue is the fact that the navigators are not generally included in the care team early in the care of a patient, and often felt frustrated when they were brought in at a late stage. This relates to the previously mentioned issue with health professionals bringing the service in later than the navigators think ideal. For example, as illustrated in the following quotation, if one of the barriers that navigators are there to help overcome is lower levels of health literacy, then they need to be brought in to help with all phases of the patient's engagement with the health system.

The other problem is ... when the person turns up at the hospital, they have a plan, right? So literacy is very much part of that plan. They do a plan without the person, not being so involved because of those issues, not understanding fully. So they actually say "Yeah, yeah, yeah" or don't know the consequence of what their 'yeah' means. So ... they're not applying the plan ... and then when some things go wrong, it's not happening, that's when they call on us and we are not sure what the plan was because we were not (there in the first place).

It's hard to come in ... at the end as an afterthought. And then they look at you and then you're starting all over again an assessment and it's like "Oh, why are we going through all this?"

We should be part of that continuity of care instead of just refer on.

This lack of integration can lead to situations such as one navigator mentioned, where a patient receiving a hospital service has not been referred to the navigator they have previously dealt with but to another, thus affecting continuity of care. This is also a criticism of the communication practices of the health professionals in the hospital as they felt the situation would not have arisen if the patient had been consulted.

Resourcing

The hospital unit in particular is feeling the effects of limited resources which limits the number of staff they employ and limits the service to being only Monday-Friday, as shown in these comments from staff members:

The biggest issue for Pacific Health is the lack of resources.

I think if we had more resources, we would be able to tap into the ones that are missing out. Because we're only taking those with language barrier.... Those ... that understand English but still need assistance with navigating the system itself, both in the community and within the hospital ... quite often those people are missing out.

I think that the way we work would have changed, that we are able to go out there and support every request that comes through, but sometimes we don't. We're not able to go out there because there's no resources to go out there and support because ... sometimes when they request, [the nurse and social worker] will be attending other patients.

We don't work weekends so whoever comes through and needs support in the weekend or public holidays, they don't get that.

They [health professionals] think that we can come straight when they do call. That mentality that "Oh yeah, we'll call and they will be here straightaway". It doesn't happen like that. So ... it's something to do with resources really.

Frustrations with the need to spend time travelling between two different hospitals were also expressed:

My ideal would be to at least have another social worker and clinical nurse so that one can be based in each site. Because a lot of our time is consumed with travelling.

Lack of Professional Support

One of the side-effects of limited resources leading to a small team is the limited ability to provide professional support:

We've only got one social worker. There's challenges around the support that she needs around supervision because she's sort of not part of the main social work team but she has links to them.

There was some concern at some stage that the referrals that we were receiving ... were so focused on our translation/interpretation that [the nurse] was actually losing touch with the ... clinical skills.

Make-Up of the Community Pacific Navigation Team

There was some suggestion that the PNS should have a qualified social worker on their team to deal with some of the more culturally complex cases in accordance with a social work framework.

My biggest issue in the community is that they don't have a qualified social worker ... because of our social work framework.

4.5.3 Suggestions to overcome difficulties

Participants had suggestions for how to overcome many of the difficulties mentioned above. Some, like the development of trust, just take time. For the others, the following suggestions were made for each issue:

- Increasing awareness about the service
- Changing the focus of the service through referral criteria
- Improving integration into the care team/continuity of care
- Increasing resources

Increasing Awareness about the Service

It was acknowledged that work needs to be ongoing to raise awareness amongst health professionals and the community. In the case of health professionals, the work is mostly in person:

It's not a one knock and then the door will be opened. ... you've got to keep knocking for the door to get open and... it's the same thing as well with the hospital system. And ... because it's with the staff turnover and if we build a relationship with nurses here in this ward and then the next few months those nurses move on ... and then it's the same thing. So we try to build the relationship with them and the rapport.

Continuing broader efforts are needed with the community to raise awareness through the media:

I've just been to the radio [Samoan Capital Radio] yesterday as well and just to reassure our community we are here in the hospital.

Changing the Focus of the Service through Referral Criteria

To shift the focus to making a real difference to the health status of patients, it was suggested that the referral criteria could be altered so that navigators are brought in on the basis of different criteria, making for earlier interventions with patients:

I would like to see the reason they're sending us because they haven't made a difference in their status of care. I would like them to contact us like, let's say for example, if a patient comes in and within ... the twelve months we are increasing their insulin and their tablets but the result is not good. I would like them to call me six months after that ... maybe they don't understand the whole lot, so I can go through the literacy.

Improving Integration of Navigators into the Care Team/Continuity of Care

This was not explored in detail but there was a feeling that more could be done to enable this.

It's simply that we become part of that plan for that person, that we're aware of the plan, that we're part of the plan so we'll be able to support the person to be more integrated.

Increasing Resources

As with so many aspects of the health system, increased resources would enable the employment of additional staff to meet the needs of the community.

I think for this service in the hospital we need more resources to resource it ... adequately to be able to deal with support for the people who are coming through.

A particular focus was felt to be employing staff that provided a larger range of Pacific languages:

It would be quite nice to have a unit that actually staffed different language people that deal with Pacific, but of course it's budget, budget. ... or at least get somebody who can speak more than one language, you know. We can do it that way.

4.6 Overcoming the language barrier

4.6.1 Who needs language assistance?

Participants noted that, although many Pacific people speak English, there was still a high need for language assistance.

Samoans - about 80% of our people are needing the translations and ... some sort of assistance while in hospital.

The new Kiribati, the new Tuvalu communities who are just starting out, many Tongans are still very Tongan first language speakers ... and then there are Samoans who have migrated in different waves.

Sometimes, it is more a matter of client preference to use their own language.

I think there are some that have a preference to speak in their own language. That doesn't necessarily mean they lack proficiency. It's just that's where they're most comfortable.

This also depends on the age of the client:

If they're ringing an elderly person, it will always be in the Pacific language.

4.6.2 How is language assistance provided?

Participants reported language assistance (which may or may not be the same as 'interpreting') being provided in a range of ways, including the use of family members in some circumstances, through professional interpreters and through the PHU/PNS staff. There is a lack of clarity at times regarding language assistance and perhaps some slippage between the act of talking to a client in their own language to provide support and extra information and the act of interpreting for another.

Family Members

Family members provide interpreting for "everyday little bits and pieces" when a patient is in hospital.

Quite often in cases like that they always have a family member that can speak English. So for little everyday things, they're okay.

It was also noted that family members are still often used by clinicians, often out of convenience:

It's time consuming because you have to book it, you have to make sure the patient turns up on time, your doctor's got to be on time to be able to do that

appointment, so there's quite a bit of coordination around that and the simplest option would be "Oh actually they're coming with", and that's why family members are used all the time.

Professional interpreters

Professional interpreters are sometimes called in by health professionals, although often their first port of call for Pacific patients was reported to be the PHU staff. There was some mismatch between what some participants stated should be the policy on the use of professional interpreters and what actually happened, especially in the hospital.

If it's a critical conversation ... they probably should use interpreting services is my thinking.

The use of professional interpreters was said to be "haphazard" however.

PHU/PNS staff

A key role of PHU/PNS staff is to help overcome language barriers. Sometimes the language support can be done in the English language.

Quite often they understand English, so they just need that bit of extra support to explain the medication for example, so that can be done in English by [the PHU nurse].

The staff do, however, use their Pacific language skills a great deal in their work. This is both in direct conversations with clients and to interpret between patients and staff.

Management noted that navigators are used to interpret "a lot" by health professionals. The staff of both services also reported that they are often called upon to interpret and that health professionals don't have a clear idea of the distinction between navigators and professional interpreters:

[Hospital staff] try us first. The reasons why I believe is, for me anyway, ... because we know the health system.

When you go in as a navigator, [staff] still expect you to interpret and to understand so their perception of a navigator and interpreter is the same with them. They can't tell the difference.

The PHU staff state that the main reason for referral to their service is to help overcome a language barrier and they consider this a key part of their role, whether through their own language abilities or through bringing in another person with the language skill needed, sometimes from the PNS.

We've never got a professional interpreter in. We haven't needed to because we're always able to find within the capacity over both services, we can find someone, we can get someone in. ... we liaise with the Navigation Service team.

Navigators sometimes call on other professionals with the required language skills but outside the two services, when necessary.

If it's ... from other Pacific Island nations then I'll probably tap into the colleagues outside or inside and they will be able to help.... it's working really so why not use the resources that we can from wherever There are some other like Kiribati and that, it's hard to find because there's hardly any health professionals like nurses in that area, but we'll try our best. If it's not a nurse I try and get a social worker. Someone that can speak the language while trying to at the same time meet the presence of a clinical person.

Use of professional interpreters is seen as a last resort.

If that fails then we recommend back to the wards to use the interpreters, the language interpreters.

Some health professionals in the hospital do follow a policy of using professional interpreters, which staff found frustrating at times:

I'm a nurse. I'm not allowed to translate ... In the hospital if they call for interpreter, I'm not one of them, I will never be one of them.

They just make me feel down and not wanted, you know? Like I offered that I can translate. I'm a nurse.

4.6.3 Training in interpreting

It was recognised that interpreting is a particular skill that the navigation staff expect and are expected to do despite not having formal training in it:

I think that's where Pacific staff are taken for granted ... because interpreting is an extra skill, ... It's a skill base that is separate from what's necessarily in the job description.

Pacific staff are taken for granted because, you know, because you can understand a language, then therefore we expect you to use that language and ... we can't say 'no' to a patient, you know, "Sorry can't come and interpret it for you because it's not in my job description".

The PHU staff do receive a one-day training session in interpreting from Interpreting NZ. It was acknowledged by management that specific training for this aspect of their role was required by their navigators:

I think it's crucial ... I just think that having that interpreting training under their belt just makes them much more, it adds a bit more professional aspect to the role and it adds a safety aspect to it.

Maybe they need translation/interpretation-type qualifications or training to be able to, you know, monitor or review their practice around that particular area.

The navigation staff are, in general, keen to have interpreter training – “would love to”.

However, they did not feel that there was anything available that exactly met their needs and pointed out that other ethnic groups may have a similar need:

I've tried to access for them so it's not easy because it's through AUT and ... it's year long or two year interpreting training ... Interpreting Services do train but you have to be part of their workforce to train. So ... it's difficult because I think it would be really useful for, not just ours, there must be ... some of the refugee populations who have got people who are doing that but it's not in a formal way. So it's just getting an understanding of what's translation, what's interpreting, what is the role and that, particularly in health interpreting.

4.7 Navigator Views on interpreting and interpreters

There was a widespread view amongst the interviewees that interpreting in the health sector needs to be done by people with professional training in either health or social work. Many participants expressed the view that knowledge about health was necessary to adequately communicate matters concerning health and that language ability and interpreting training was not enough.

I think that if they chose to do interpretation and translation in a health setting, they would need a health qualification as well or some health experience. I really do believe that.

As far as health information's concerned, I would expect only the health trained professionals to be, if there was need to translate/interpret, to be those people. ... they don't all have that, have enough clinical professional background information to be accurate in their translations and interpretation.

Someone that can speak the language while trying to at the same time meet the presence of a clinical person.

Staff also considered that health professionals preferred PHU staff to professional interpreters for this reason too:

They try us first. The reasons why I believe is... because we know the health system

Staff reported observing situations in which professional interpreters did not have enough health knowledge or know the medical vocabulary to be able to interpret effectively for patients.

One navigator reported a family expressing dissatisfaction with an interpreter:

They hired one yesterday. They said to me "No, we don't need you to translate. We already hired one". So I got there and then the family complained to me that they didn't know, didn't understand what she was saying to their mother.

Another mentioned being consulted by an interpreter on choice of language:

One day I went in and the interpreter's there and ... he turned around and asked me "What's the word for such and such".

It was acknowledged that the professional interpreters need to be able to work in a wide range of settings which means that their level of depth in any one setting cannot be as great.

It doesn't matter how good they are, but for the information to be accurate and connect with the patient – which is different from the professional interpreter who will be called into all sorts of settings.

Other reasons that navigation staff believed that they were better suited to interpret for patients than professional interpreters were:

- Limited working hours of professional interpreters

They come in and then five o'clock, whatever time they finish work, they go and the consult's still going.

(Note that this implies that navigators are more flexible in their working hours, even though in fact they are also only employed from 9-5 on week days).

- Ability of navigator to establish relationship with patient

A navigator gets to be part of a patient's life because of the health things. ... They know the issue, they know the plans and they are more than that visit.

- Perceived lack of confidentiality of interpreters compared to health professionals

Navigators expressed the view that people would not be comfortable with having an interpreter present at a medical consultation because of confidentiality concerns (despite the fact that interpreters have a professional code of conduct that covers this).

I wouldn't feel comfortable like in myself, ... if I was just a lay person and then you have an interpreter just coming in ... I couldn't talk about everything. ... like if I see this person again somewhere ... at the shop or the church ... they've got the very sensitive information and it's only just interpretation. So that's really scary.

In addition, professional interpreters are sometimes used over the telephone and it was noted that Pacific people do not feel comfortable with this:

But with our people, face to face is a lot better ... than telephone. We don't do telephones. You get very little information from people because they don't know who they're talking to or who they're giving information to, whereas if they can see somebody they can, you know.

Participants all were of the view that strict interpreting for their clients was not sufficient. They viewed the interpreter role as limited and were therefore cautious in some cases about using the term 'interpreter' in connection with their role.

The worrying point for me in being called an interpreter itself is because it's got limitations. ... Because we work holistically for our people. ... What is an interpreter? Just interpret according to what's been said. You cannot do anything like support the person to the extent.

Participants were of the view that as people with knowledge of the health system, they were able to do more than an interpreter by explaining things in ways that their clients will understand from a position of having sufficient in-depth knowledge to do that.

When I do a translation I know the symptoms. I can ask the patient differently and he will come with the right answer whereas the doctor will say differently ... and I refuse to interpret what he said because that's not the way he will understand it. ... My point is the patient needs to know these in the way he understands, not the way that you and I understand.

I've attended family meetings where they've gotten a Samoan interpreter, and then I just listen to see whether, and he actually does a good interpreting, but I can still see that the family are not quite understanding what they're saying, so I intervene and put it in a way that makes our family fully understand what it is that the doctors are trying to say.

I think what our staff do is they translate in a way that provides a wider picture for Pacific people.

4.8 Attitude to potential combined interpreter/navigator role

When asked about the idea of having a role that was more explicitly a combination of health navigator and interpreter, the response was generally positive:

I think that makes sense. ... Health care assistant with an interpreting role, who knows? It's interesting, it opens up a whole new possibility, doesn't it?

The explicit addition of interpreter to the role would have a number of benefits, according to participants:

- Greater continuity of care for patients

At least with the navigator, they are there. So when they are there and they need to, then I think they should be the interpreter because you don't have to wait for somebody else and ... reschedule and they are part of the patient's journey.

- Greater clarity of role

It would really clarify what it is I'm interpreting when I'm doing it. You know what I mean? It would be actually "That is my role as an interpreter."

Combining the role of navigator and interpreter could be through adding to the role (and training) of either the navigators or the interpreters. Participants were not generally in favour of interpreters having additional training to become navigators as they believe that the in-depth knowledge required is not something that is easily or quickly acquired.

So are you asking me if ... translators and interpreters who are trained and certified could extend their boundary to become [navigators as well]? I think that if they chose to do interpretation and translation in a health setting, they would need a health qualification as well or some health experience. I really do believe that.

If it's the other way round, they're going to have a hard time trying to get into a health system or find a job in a health system. Whereas if people are already placed in the health system doing that and work with them to accomplish interpreting, it's easier.

We've got Pacific people who have worked in the health sector so they understand that context.

As well as general health knowledge, as part of the health system navigators have access to client files which gives them more contextual information that can aid communication.

A navigator comes with the files of the client and ... they will have that inherent knowledge of this, this, this and this that ... can help them inform the process.

4.8.1 Issues for implementing Interpreter/Navigator role

The creation of a combined interpreter/navigator would bring with it the need to switch between the two roles appropriately. This may be a challenge for some people.

So I suppose it's, yes navigators can be interpreters and at what point do they turn off being the navigator? Because often the navigator is the advocate. And at what point are they only the interpreter? Because, can it be a shared role? I think it can be, but it's not for every navigator.

As pointed out by interviewee quoted above, not every navigator necessarily needs to take on the dual role and this fits in well with the idea of distributing skills across a team.

It would also be necessary to work out which ethnic groups to prioritise for such a shared role.

We would need to understand where the demand was before that happened because there's still a place for English only speaking

There may be financial implications, whether they should be paid at a higher rate for such additional training and function.

If we make it part of the key tasks of the navigator's role where is the remuneration to support that added skill?

It all depends on the resources. And the money - "Oh we need to employ someone". "Oh where's the money?"

4.9 Summary of findings

The **literature review** found a wide range of barriers to health care for patients from culturally and linguistically diverse backgrounds (CALD). These were related both to the design of the health system (for example, complexity, and opening hours and locations of facilities) as well as to characteristics of the communities (for example, language and cultural features). The benefits of having some kind of health worker who is a member of such communities has been recognised for some time as an effective way to help overcome these barriers. The review highlighted the great variety of terms used for similar roles, but a key attribute is that these workers are trusted by patients and that they perform a wide range of tasks.

The **interviewees** identified a similar range of barriers to those raised in the literature, plus some additional points such as the often incompatible communication styles of health professionals and of Pacific people in general, and the way that cultural attitudes like a deep sense of pride and a sense of deference to authority common in Pacific cultures can impact on how they engage with the health system.

The range of roles performed by navigators was also similar to those raised in the literature. There was an emphasis on the holistic and wide-ranging nature of the job. There are issues with raising and maintaining awareness of the service and what it does with health professionals and the public, and with resourcing. There was also felt to be some mismatch between the holistic aims of the service and the referral criteria which often focusses on a single indicator such as DNA (Did Not Attend).

Our research found there is a significant overlap between the roles of navigators and interpreters in this region, with navigators routinely interpreting for patients, especially in the hospital. Overcoming a language barrier was felt to be a major part of the navigator role, but notably, they emphasised that they often did this in a qualitatively different way to that of a professional interpreter. Participants felt that it was important to do more than to only interpret the words of the health professional, often explaining more fully in ways that their community will understand. However, it was also noted that this would not be so necessary if health professionals communicated more clearly using simpler language and visual aids, for example.

In order to interpret effectively, navigators felt that some degree of health knowledge was important, as well as the greater depth of relationship afforded by the ongoing contact that a navigator often has with a patient. It was noted that critical conversations (such as informed consent) should require the use of professional interpreters, but that clinicians did not always make use of these.

It was acknowledged that some formal training in interpreting is desirable for navigators so that they can have some form of accreditation, but there was frustration with the lack of a course tailored to their needs.

Interviewees described what they saw as shortcomings in the professional interpreting they had seen in action, and saw the strictly confined role of professional interpreters as an impediment to providing the help needed to get the best outcome for patients.

The concept of an explicit combined navigator/interpreter role was supported, partly because this is what is happening in practice already. Training and formal recognition of this is desirable as well as the formal development of the scope of practice to clearly delineate the role.

It is important to note that this study only investigated the issue from the point of view of those involved in health navigation in a single area of New Zealand (Wellington). The views of interpreters, health professionals and service users were not investigated. The conclusions discussed below thus relate principally to the Pacific navigation services (both community- and hospital-based) from the point of view of the staff and management of these services.

5. DISCUSSION AND CONCLUSIONS

Navigators in the Pacific services studied here have a challenging and complex role. It is evident that they are fulfilling a genuine need in their community. As a group, they need a broad range of skills and attributes, the core of which are strong community networks, sound health knowledge, and well-developed cultural and communication skills.

Interpreting is more strongly interwoven into the role of the navigator in these services than the researchers had initially expected. There is some tension between the fact that this is something that navigators do (and do well), and the fact that they do not receive significant interpreting training or official acknowledgement of this aspect of their role.

Pacific navigators felt Pacific patients may prefer to be assisted by a navigator (or indeed a family member) rather than a professional interpreter. Navigators expressed concerns about the confidentiality of interpreters and it is likely that their communities have a similar perception. Pacific navigators are perhaps more likely to be trusted by their clients due to their association with a health organisation. Navigators are also able to spend more time with patients than interpreters can, and this allows greater development of personal relationships and encourages the development of trust. The Pacific aversion to using telephones also works against the use of telephone interpreters which is a common way of delivering professional interpreting but not so much for navigation services. It should be noted that there are rare examples where professional interpreters are employed by some general practices that have large numbers of patients from a particular ethnic community, and such interpreters are also able to establish good relationships with patients and have a high degree of trust from their community.

Over and above this perceived Pacific dispreference for professional interpreters is the fact that Pacific navigators have a different view of the kind of language help that their community needs, compared to the strictly executed interpreting that is espoused by professional interpreting services. Pacific navigators believe that more is needed for their clientele to communicate health messages effectively and that professional training in health or social work is needed to be able to adequately support their clients. For this reason, they would be in favour of navigators receiving additional training in interpreting on a firm health or social work base, rather than interpreters receiving additional training in health. The desire for specific training in interpreting for navigators came with the proviso that such training needs to be tailored to the requirements of their role.

Reading between the lines of the many stories of unnecessary duplication or complexity caused by multiple staff interactions, we would suggest that LEP patients in general, including those within the Pacific community, can be better served by receiving assistance from a single person or team. Such a person or team is better able

to get to know LEP patients and their circumstances and be able to assist with overcoming a range of barriers, including the language barrier. This needs to be officially recognised in policies and training.

With acknowledgement that multiple roles are performed by a single person or team comes a need for clear communication about these roles. There needs to be explicit discussion of role at a local level with patients, their families and clinicians to ensure that all understand what to expect and what the relevant boundaries are. It is also important that the navigation teams themselves continue their current reported practice of ongoing clarification of roles, as participants at times reported slightly different interpretations of their role boundaries, particularly with respect to assisting clients with non-health agencies.

We agree with the research participants about the importance of clear definitions for when a task is beyond the navigators' scope of practice and should be referred on to an appropriate professional (such as a professional interpreter, social worker etc.). There may be a need for professional supervision to manage these boundaries.

While individual navigators need to perform multiple roles, it is also true that the full breadth and depth of skills required by navigators cannot be expected to be present in any one individual but needs to be distributed across a team. This is especially true in terms of language skills. Allocating cases on the basis of best fit of navigator to case, as currently happens within each service, makes sense in this context. For example, cases may be assigned to specific navigators according to their training (nurse or social worker) or previous experience as well as according to their languages so that clients are matched with the most appropriate staff member for their situation.

The Pacific community is the only community (or more accurately, set of communities) with LEP patients in the Wellington area that has a formal navigation service. Our findings suggest that Pacific patients are effectively assisted to overcome a range of barriers, including the language barrier, by these services. We would suggest that other CALD/LEP communities beyond the Pacific community would also benefit from such a service in combination with interpreting services.

However, while Pacific navigators firmly believe that it is best for navigators to add interpreting skills to their training, rather than trying to train interpreters as navigators, this may not be the case in other CALD communities. Further consultation within such communities or those working with them (interpreters and health professionals) will be required to determine how services should best be designed for them. However, the views of the participants in this study suggest that meaningful health knowledge in those taking on such roles is likely to be a key element.

It is also important to delineate the most important barrier(s) affecting the outcome for each presenting client, and tailor the navigator intervention to that barrier. Again, a comprehensive service with well-trained staff covering a range of skills, training and

experience would seem to be the best way to make this possible, since there are so many potential barriers to care.

The configuration of services – i.e. whether a service is based in a hospital or in the community or spans both – also needs to be sensitive to the best way to address particular barriers. For example, addressing DNA rates at hospital clinics and providing language services to inpatients is best done from within a hospital based service. Following up on families with outstanding immunisations is best done by a community based service. Navigation for a person with a complex condition (cancer or multiple co-morbidities) is best done from a service that is case-based that can span all sectors.

The participants highlighted the effectiveness of working in such a way that the diverse needs of clients are met by a team with diverse skills. This strengthens an argument for developing more overlap or integration between the two services (community- and hospital-based) as this would create an even larger pool of skills to draw from. In addition, a more integrated service would also enable greater continuity of care across the settings which would further capitalise on the benefits of stronger individual relationships. Better integration with other services in the community is also desirable.

Also worthy of reconsideration may be the current focus on individual clients. Although not a question specifically addressed in this research, participant responses suggested that a household focus could be more useful and cost-effective in addressing barriers for a number of individuals in a single household. Given the family structure of many Pacific households (and probably other CALD communities), a household approach may be more culturally appropriate as well as improving efficiency.

Overall, we believe the strengths of the current Pacific navigation services should be built on and lessons learned from their experiences are likely to be useful when considering similar services to assist other CALD communities. Further research into the views of other stakeholders in this area would be very desirable.

6. IMPLICATIONS AND RECOMMENDATIONS

The following recommendations are suggested by our findings. Recommendations 1-3, it should be noted, are already happening to some degree but are important to highlight so that greater consistency across staff can be achieved.

- (1) The scopes of practice for the various types of navigators need to be clearly defined (depending on training and experience in other professions such as nursing and social work), and clear guidelines about when to refer on and to whom should continue to be developed within the services.
- (2) Navigators need to be fully aware of the wide range of roles they perform and to have a clear idea of their individual scope of practice.
- (3) Navigators need to be aware of what role they are taking with any particular client at any particular time. This should be discussed with patients and health professionals to ensure clarity. They also need to be able to clearly assess when what is required is out of their scope of practice and to bring in additional help, such as professional interpreting services.
- (4) Systems for training and accrediting navigators as interpreters should be investigated with a view to explicitly incorporating interpreting into the navigator role.
- (5) Ways of providing navigation in tandem with interpreting should be explored for other communities, with consideration given to appropriate training, recruitment and funding.
- (6) Further work needs to be done to enhance the communication skills of health professionals working with Pacific and other CALD patients, including the use of visual aids, writing notes and rephrasing when lack of understanding is apparent.
- (7) Professional interpreters need to be made aware of the existence of health navigation services where they exist and to be trained in when to call them in.

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