Establishing a lay health navigator service on the West Coast to support those living with complex health and social conditions.

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What we will cover

- Who we are - whanaungatanga;
- What's in a name?
- A brief history;
- The burning platform;
- Gaining traction;
- Embedding the service;
- Extending the service across the system;
- Reflections;
- What next?

What's in a name?

- Community health worker/Kaiawhina;
- Care guides;
- Promotores de salud (the Spanish term for lay health advisors and educators);
- Health coaches;
- Peer educator;
- Lay health advocate;
- Link workers-social prescribers;
- Lay health navigator.

- *Dohan, D and Scragg, D. Using navigators to improve care of underserved patients: current practices and approaches. Cancer 2005, 104(4):848-55*

Our experience

- Lay health navigators are not encumbered by a pre-defined fixed set of criteria to meet.
- They take a flexible approach to their service and solve whatever problems arise – they remove barriers.
- Care for individual patients and their whanau.
- Usually last port of call.

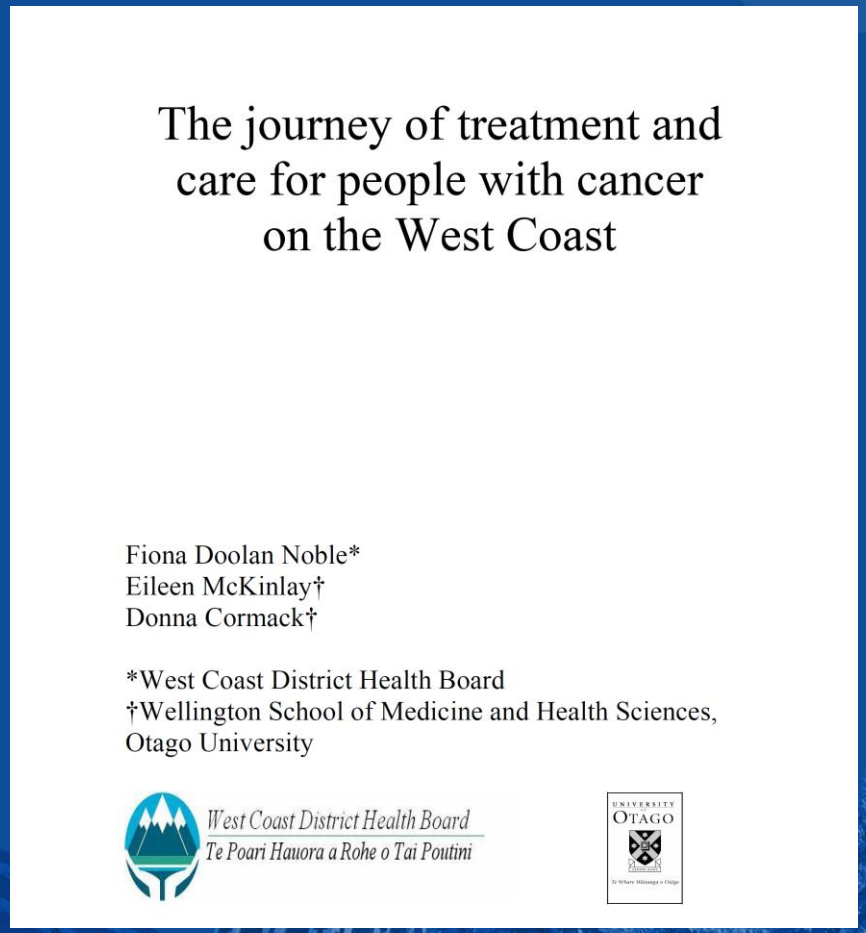
A brief history

- Patient navigation services were originally developed in the early 1990s to address inequities in access to care for cancer patients;
- More recently the approach has been adapted to address the needs of high risk patients, for example, older adults with multimorbidity;
- The structure and purpose of patient navigation services vary in relation to target population, disease focus, programme design and implementation.

Valaitis, RK., et al. Implementation and maintenance of patient navigation programs linking primary care with community based health and social services: a scoping literature review. BMC Health Services Research. 2017, 17:116

Our journey

The burning platform



The journey of treatment and care for people with cancer on the West Coast

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West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

- Living with cancer in a rural and remote area impacts on the cancer journey;
- Travelling for treatment and health care acts as a barrier and can alter choices for treatment and care;
- Organisation and co-ordination of care is limited by geographical distance and human resources, resulting in multiple small delays;
- Māori with cancer on the West Coast face particular challenges.

How do you chose your navigators?

- No right or wrong here;
- Our focus: what skills did they bring that a health professional may not have?
  - JP;
  - Living with a disability;
  - Cancer survivor;
  - Heavily involved in community groups;
- All recognised and trusted in their communities.

The pilot (2007-2010) evaluation findings

- Independent evaluation by Health Outcomes International:
  - Filling gaps in service delivery that were previously linked with poorer health outcomes for Māori and individuals living in rural areas;
  - Helping patients overcome practical and other barriers to treatment (e.g., transport, social support);
  - Increasing patient awareness and understanding of cancer, and associated treatments and supports;
  - Supporting patients to attend appointments, leading to more timely access to care and reduced DNAs;
  - Supporting uptake of cancer screening and other health services through health promotion efforts;
  - Changing negative assumptions of cancer as a death sentence and encouraging help-seeking behaviour;
  - Improving patient/whānau quality of life.

http://www.health.govt.nz/system/files/documents/publications/community-cancer-support-pilot-evaluation_0.pdf

So what happened next?

- Revised target population;
- Further training
  - Self-management
  - Key aspects of care for those with diabetes, heart disease, COPD.

Gaining traction

A growing demand

1st July 2010 – 30th June 2012

- Referrals totalled 296; 11% were Maori;
- 53% were male;
- 59% were ≥ 65 years;
- 59% lived in areas classified as highly deprived;
- The norm was ≥ 3 chronic conditions

1st July 2012 – 30th June 2014

- Referrals totalled 377
- 7% were Maori
- 44% were male
- 48% were ≥ 65 years
- 73% lived in areas classified as highly deprived;
- The norm was ≥ 3 chronic conditions

A growing demand

1st July 2014 – 30th June 20126

- Referrals totalled 375; 7.7% were Maori;
- 50% were male;
- 50% were ≥ 65 years;
- 64% lived in areas classified as highly deprived;
- The norm was ≥ 3 chronic conditions

1st July 2016 – 30th June 2018

- Referrals totalled 349
- 7% were Maori
- 50% were male
- 47% were ≥ 65 years
- 48% lived in areas classified as highly deprived;
- The norm was ≥ 3 chronic conditions

Types of services provided

- Logistical services
  - Coordination of appointments;
  - Transportation;
  - Accompaniment to appointments;
  - Referrals;
  - Provision of information.
- Relational services
  - Emotional support;
  - Negotiating broken relationships between clients and health/social care providers;
  - Strengthening relationships between clients and providers;
  - Communication with interdisciplinary team;
  - Support clients into residential care facilities/tertiary learning.

Key findings from a 2012 evaluation

- Those referred to and using the service were some of the most vulnerable in the community;
- The service is well utilised and valued by those working in primary care. For example: *"It has been a pleasure to work with X who is efficient, prompt, and very pleasant. X is a master in seeking community services to help when needed. This all helps other health workers to concentrate on their area of delivering care".* (PN)
- The complexity of those referred to the service suggests that referrers developed a level of confidence and trust in the lay led service.

Initial barriers	Ongoing obstacles	Facilitators to implementation	Facilitators to ongoing service delivery
Funding	Ongoing patch protection by a defined group of health professionals	Early stakeholder engagement	Referral to service easy – electronic referral within PMS
Lack of evidence for the role of lay navigators in the primary care setting	High use of locums in the region who are not used to the service	Extensive promotion of the service	Using patient successes to garner support of health and social care professionals
Patch protection by health and social care professionals	Constant evaluations of the service, not seen in other health services that employ health professionals	Ability to provide culturally appropriate service	Data collected and reported on quarterly
Scepticism around the employment of lay navigators	Lack of a recognised set of outcome metrics by which to constructively evaluate the contribution of the service	Needs for service identified from early local research study	Maintenance of relationships developed with wider health and social care community
		Findings from the evaluation of the original pilot	Responsiveness to feedback, ensuring service meets the needs of all stakeholders
			Opportunities for team members to enhance their skill set

MODELS OF CARE

CSIRO PUBLISHING

Australian Health Review, 2013, 37, 523–528
http://dx.doi.org/10.1071/AH12038

Case study

Evolution of a health navigator model of care within a primary care setting: a case study

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Helen Reriti[2] BN, RCpN, Executive Officer

Valuing navigators

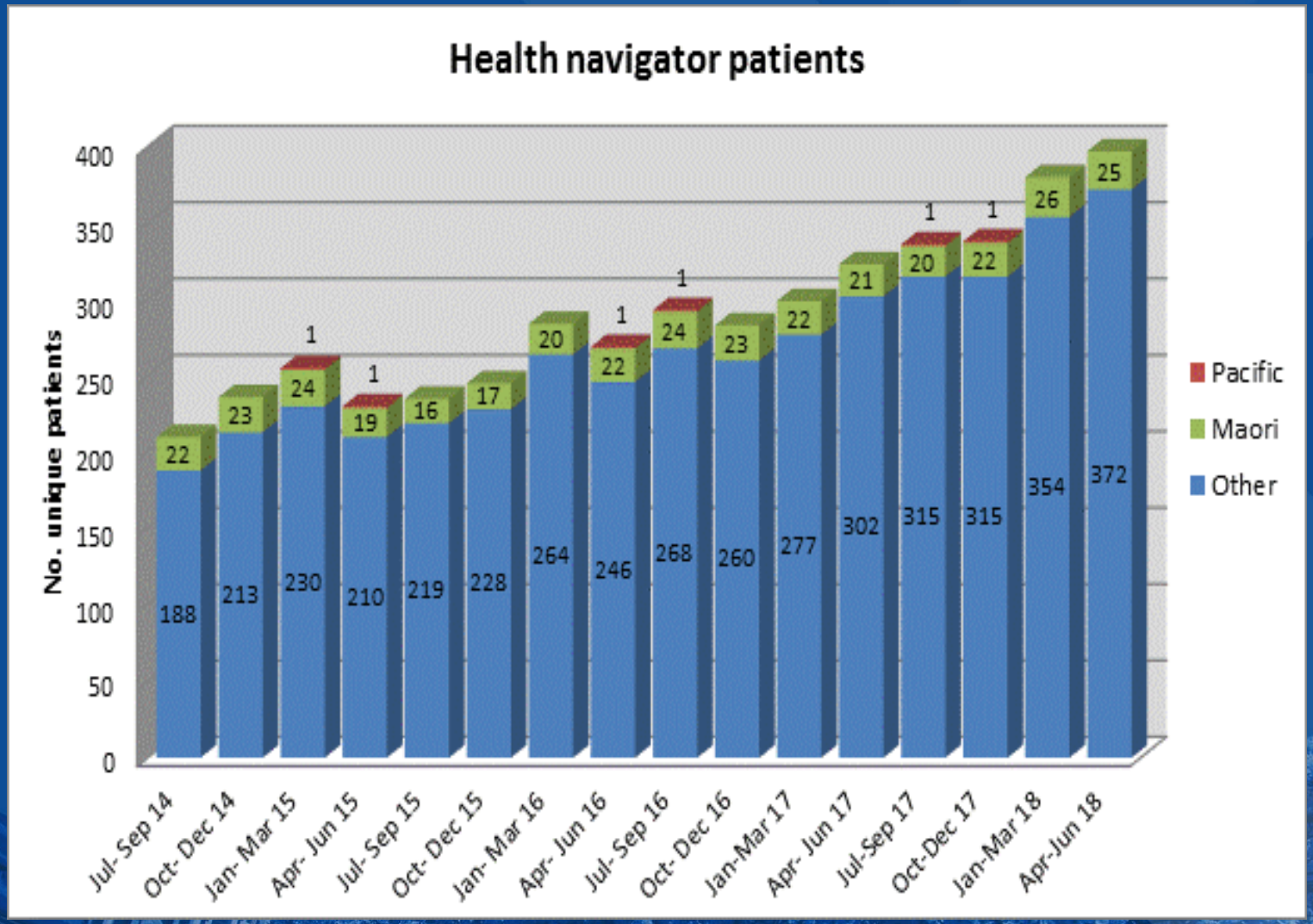
- Motivational Interviewing
- Mauri Ora Training
- First Aid
- Information Health Literacy and Privacy Training
- Cardiac workshop
- Treaty of Waitangi training
- Anxiety and Cancer across the lifespan
- Grief Support
- Advocacy helping people resolve their issues themselves
- Advanced driving competencies
- Caring for ourselves while caring for people with life limiting illnesses
- Health Literacy
- Te Whare Wananga o Awanuirangi Te Tohu Pokaitahi Hauora Maori
- He Papa Tikanga, Mahi Ora, Mauri Ora,
- Smoking Cessation training Jigsaw
- Cancer voices training
- Advanced Care Planning

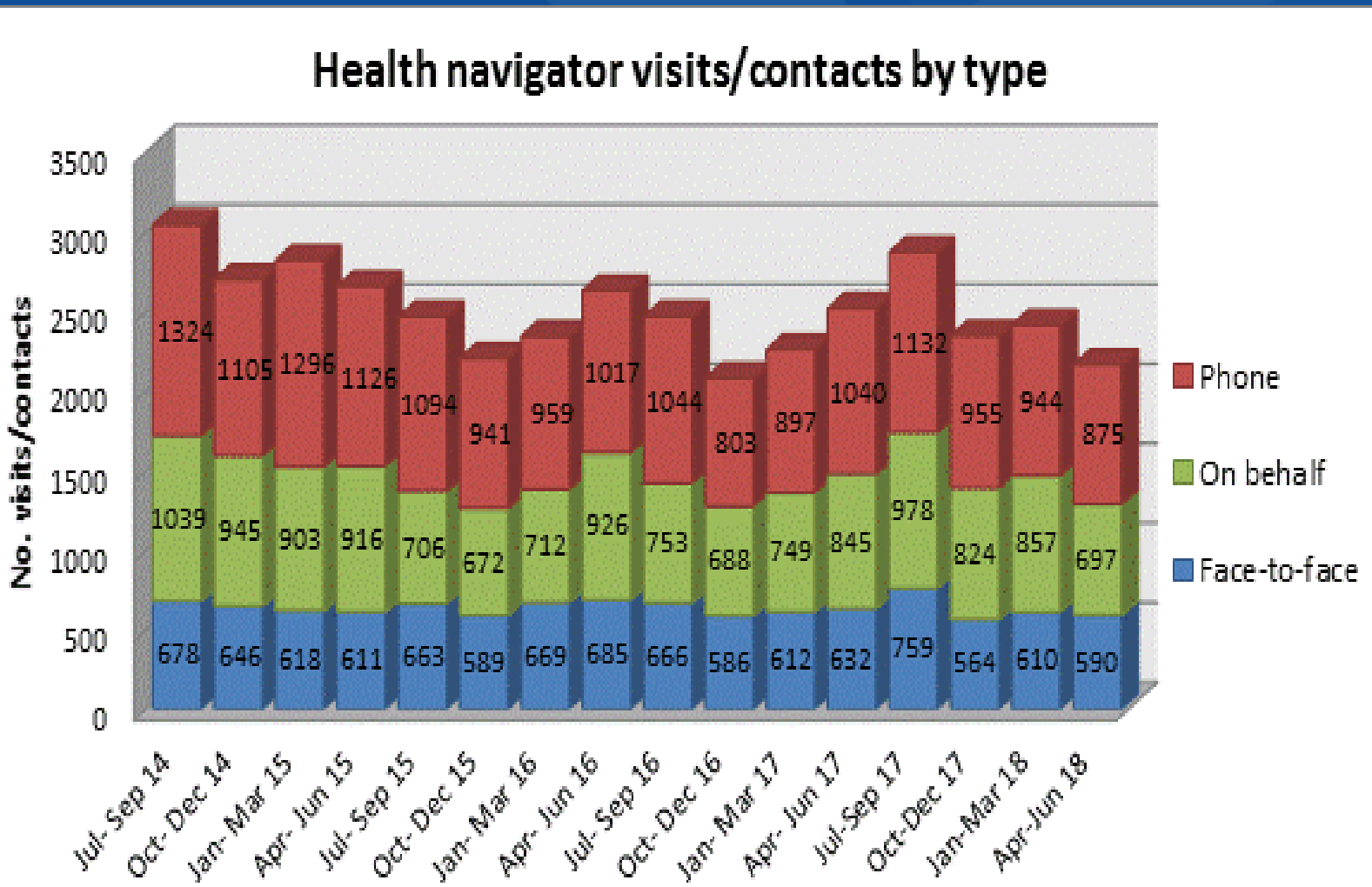
Embedding the service

Key roles/activities of the service

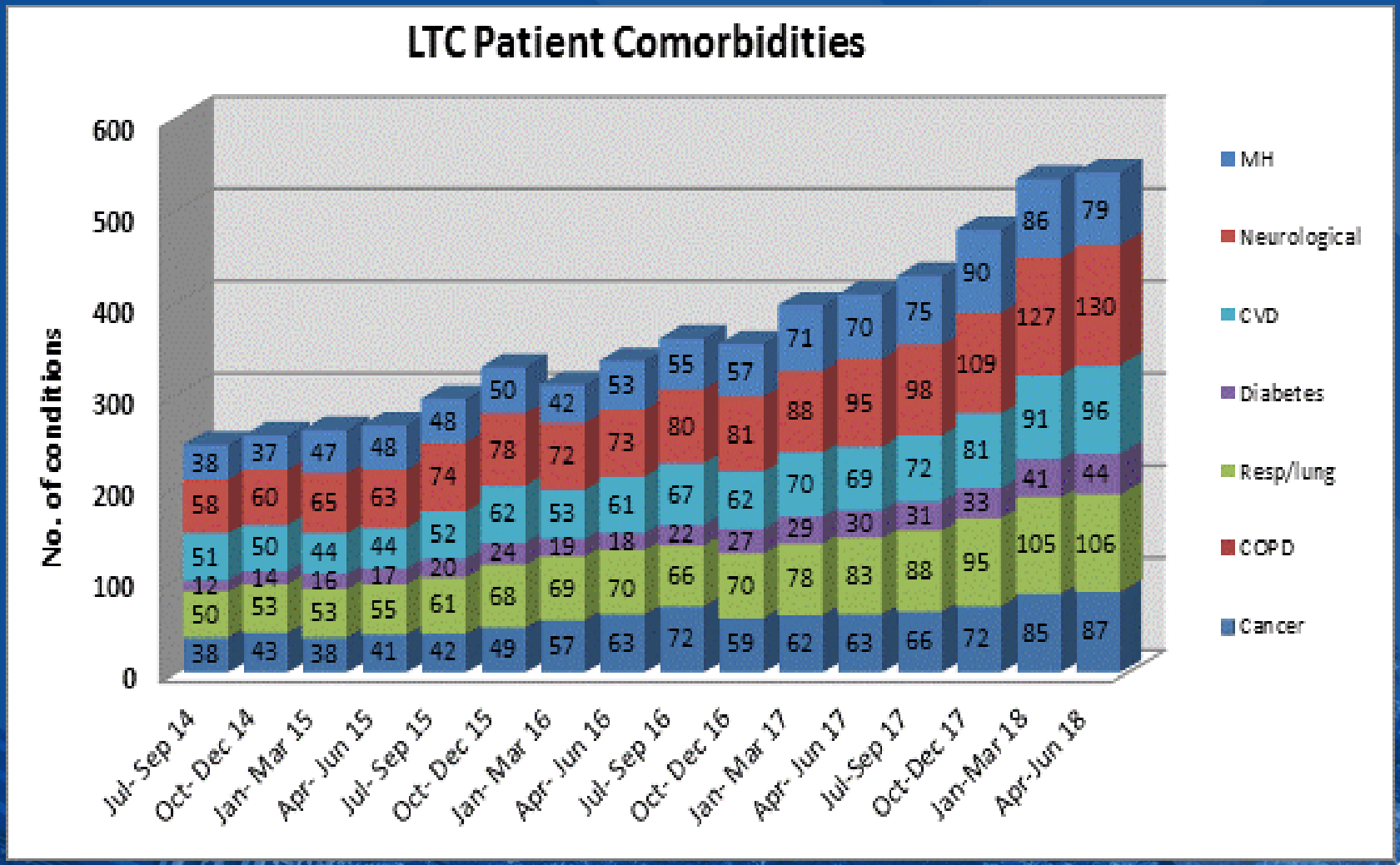
- Provide additional support for Long Term Conditions (LTC) patients and their whanau with complex social needs;
- Improve access to health care for these patients;
- Support the general practices and rural clinics in caring for these patients;
- Improve access to social support services for these patients;
- They contribute to improve health outcomes;
- Enhance patient health literacy and ability to self-care;
- Westport navigators attend the 'huddle' each morning with hospital, community and primary care staff;
- Participate in Local Cancer Network Meeting;
- Participate in fortnightly Palliative Care meetings (Hokitika and Greymouth);
- Participate in fortnightly Hokitika MDT meetings;
- Participate in CCCN IDT meetings;
- Participate in ACP steering group meeting;
- Participate in Buller West Coast Home Hospice Trust meetings;
- Attended Oncology MDT meeting.

Patient volumes over time




Health navigator visits/contacts by type
No. visits/contacts
3500
3000
2500
2000
1500
1000
500
0
1324
1105
1296
1126
1094
941
959
1017
1044
803
897
1040
1132
955
944
875
1039
945
903
916
706
672
712
926
753
688
749
845
978
824
857
697
678
646
618
611
663
589
669
685
666
586
612
632
759
564
610
590
Phone
On behalf
Face-to-face
Jul- Sep 14
Oct- Dec 14
Jan- Mar 15
Apr- Jun 15
Jul- Sep 15
Oct- Dec 15
Jan- Mar 16
Apr- Jun 16
Jul- Sep 16
Oct- Dec 16
Jan- Mar 17
Apr- Jun 17
Jul-Sep 17
Oct-Dec 17
Jan-Mar 18
Apr-Jun 18

Complexity of clients



2016-2017

University of Otago
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New Zealand

There were:

2,496
phone calls made,

3,035
contacts with other agencies,

3,784
face to face contacts with clients in 2016-17

1,198
clients

Provider outcomes 1

- The navigators provide a **unique and important function** in the **rural setting.** They **interact** with **patients** in **multiple settings**, taking them to appointments with GP's, specialists, and to the pharmacy. Because of this, they **often have valuable information and a perspective on the patient that others in the interdisciplinary team may not have.** Additionally, **they often have a relationship with patients who are reluctant to engage with health services**, and **act as important advocates for the individuals and provide a liaison role**.

Provider outcomes 2

- They (the navigators) **remove** the **logistical burden** and they **ensure** our **most vulnerable patients** are able to **access the care they need in a timely, supported and safe manner.** They are a **valuable source of information** for **building** up a **picture** of what the **lived experience of illness/ disability** is like for that **person-** how it is affecting that individual, their lives and their whanau/ community because **the team** are **part of the persons life outside of the consulting room**. They are an **essential part of the team** and **I can't imagine working here without them**.

Provider outcomes 3

- **Without the navigators** on board we would be **unable to access some of our most vulnerable patients**. By having the **ability to get people into the home** has **changed primary care delivery for the better**. The **geographic challenges** in **providing healthcare** on the **coast are unique** and the **navigators rise to the challenge daily**. **Low decile population** also provide **challenges** which are **admirably resolved** with the **extensive work the navigators** do **by networking** with all **agencies and other providers**.

Patient satisfaction

- X is simply outstanding – her **ability** to **relate** is second to none. She is **incredibly caring and also insightful** – these qualities suit her role as a Navigator beautifully. She **does not judge** which is a super **positive attribute** and makes my dealing with this disease so much easier. Also as time has gone on **my memory** is **not as good** so at least I can have that **peace of mind** knowing I will **arrive for critical appts on time**. There is **also the offer** to **attend appointments with me** which **I find brilliant** as then the Navigator is able to **reconfirm what the doctor had said and** when you are really unwell this can be quite vital.

- SOME STORIES BEHIND THE PICTURES AND A VIDEO

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Healthier
Choice

Embracing social media to help clients

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Introduction

Hello... my name is Chris Allan.

For almost 14 years my old Toyota van was home. I still have Ole Faithful, however, home is now a retired 11m School Bus, I call Rose.

For penniless homeless people, like me, finding somewhere to live is increasingly more difficult. I use to just park up and camp anywhere. Widespread anti-freedom-camping sentiment and new freedom-camping by-laws mean that I can no longer do this.

I moved to the Coast, at the start of 2009, in fulfilment of a promise I made to my dieing father... to live the rest of my life here... the place of my heritage and the homeland of my forefathers – my dad, grandfather, great-grandfather, and great-great-grandfather. This is the best move I have ever made... I love the Coast.

>>><<< <<<>>> >>><<<

I regularly read, or hear, media stories about people and organisations who have suffered loss through vandalism and theft - in some cases very significant loss. Farms, commercial sites - especially those located in the country, and vacant properties are the most significantly hit.

It has occurred to me that there might be a local (West Coast, South Island) property owner who would appreciate having someone living on some isolated vulnerable part of their farm, or on some commercial site of theirs, or on some vacant property they own, etc... keeping an eye on things... and that I ought to make myself available.

Being suitably domiciled on a property would be a win win situation: (1) I would have somewhere to live, and, in return... (2) an owner would have someone keeping an eye on things... and, effectively, have an onsite deterrent.

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Incidentally, I have actually been a proper licensed Security Officer, in the past.

During my training I learnt that 90% of a Security Officer's role, and effectiveness, is that of deterrent - most people of ill intent are deterred, by fears of consequence, when there is a real possibility of being observed and caught.

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My needs are simple...

All I would need is : somewhere suitable to park - reasonably firm and flat (level) ground; good day-long exposure to sunshine for solar electricity generation; some way of meeting toileting needs (even just a Bushman's toilet); access to water - in the event of drought; Spark & 2degrees cellular coverage (comms is essential).

I live a very simple quiet clean tidy life. I do not drink, smoke, or use drugs. I would not cause any problems for anyone... I would never have undesirables visiting. I have a 100% clean record - i.e. I have no record.

Are you interested, or, please, do you know of someone who may be interested - perhaps a local farmer, business owner, or vacant land owner... private sector or state sector...?

Please feel free to show my Introduction to anyone you wish. Thank-you.

Sincerely,

Chris.

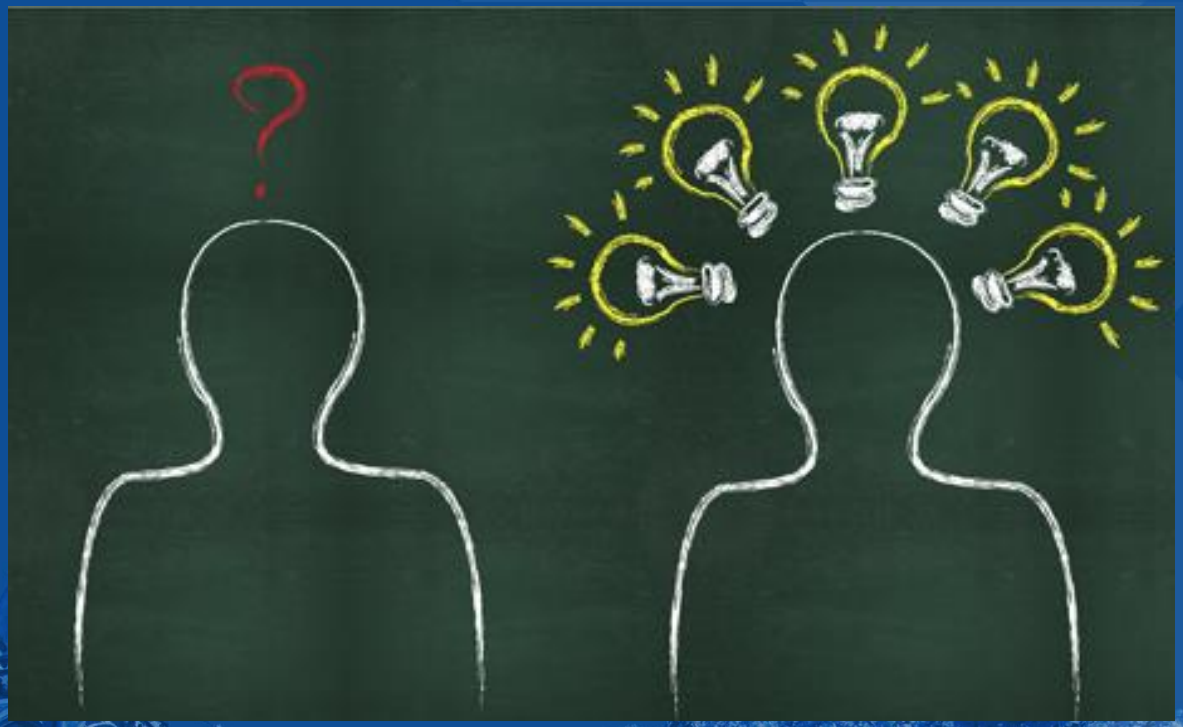
EMAIL : shimoithecat@gmail.com

POST : PO Box 547,
Greymouth, 7840.

Extending the service

- Navigators are now part of an interdisciplinary complex clinical care network (CCCN);
- Navigators also sit on the discharge planning team at Grey Base Hospital;
- A second part time navigator has been employed for the Kawatiri region (0.5FTE);
- Have trialled the use of navigators as providers of cardiac rehabilitation.

Some reflections



- The West Coast lay patient navigation service has shown that it:
  - Relieves health and social care professionals of many of the logistical and organisational demands created by complex patients in a fragmented health system;
  - Patients have a high level of satisfaction with the service and the service has a constant level of patient demand;
- Still need to determine:
  - 'How' navigators add value to those with multimorbidity still needs to be untangled;
  - Determining impact metrics for the service is a remaining challenge.

Where to next?

- An EOI has been submitted to the latest funding round of Health Research Council;
- Aim
- To explore how lay patient navigators working within primary care and as part of the West Coast District Health Board's (WCDHB's) Complex Clinical Care Network (CCCN) add value to the care of older adults living with multimorbidity with or without social complexity and improve their access to care across the health care continuum and how they support health and social care professionals caring for those with multimorbidity.

The final word goes to Dan and Steve