



First Nations and Métis Health Service: Navigation Services Literature Review

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Introduction and Purpose

First Nations and Métis people suffer from a variety of health disparities, including diabetes, shorter life expectancy, infant mortality, and other chronic diseases; these disparities are experienced at a higher rate compared to non-Aboriginal Canadians (Adelson, 2005; Baba, 2013; Reading, 2009). Healthcare providers are aiming to reduce the gap in health disparities by providing programs to help First Nations and Métis people. The Saskatoon Health Region (SHR) identified navigating the healthcare system as one area First Nations and Métis patients need assistance and therefore, created the *First Nations and Métis Health Service (FNMHS)* to reduce barriers for this population.

The FNMHS is a program which addresses health system issues for First Nations and Métis people by providing a navigation service when in the care of the SHR. The program targets First Nations and Métis people admitted to the SHR and provides patients the opportunity to have more culturally appropriate care. Upon request from Gabe Lafond, Director of the FNMHS, the Office of the Vice-President Research and Innovation staff conducted a literature review to determine if there were similar programs to the FNMHS being offered and if these programs showed improved outcomes for the populations being served. The following literature review examines the evidence on programs that address health system navigation barriers for the First Nations and Métis population.

Background

The First Nations and Métis Health Service (FNMHS)

The goal of the FNMHS is to provide an integrated and culturally respectful approach to better serve First Nations and Métis people receiving treatment or services from the SHR. The program seeks to meet First Nations and Métis patient's complex care needs in a safe, caring, and respectful manner. The FNMHS works with First Nations and Métis patients living in urban and rural areas, as well as patients living on reserve in Saskatchewan.

It is important to note that First Nations and Métis people are the populations that the FNMHS largely serves. For clarity, the term Aboriginal refers to First Nations, Métis and Inuit populations in Canada, whereas the terms Indigenous or Native American refers to populations in the United States.

Services Provided

The FNMHS provides the following services:

1. **Cultural Support:** The service provides support in a culturally appropriate manner and offers links to traditional services, such as cultural ceremonies.
2. **Interpretation:** Language interpretation and translation is provided in Dené, as well as translation in conversational Cree for patients. FNMHS staff provide support through admission, medical procedures, recovery, and transfer of care.
3. **Facilitation of Health Services:** FNMHS assists patients and families to navigate issues that create barriers to accessing appropriate health services.
 - For First Nations patients, the issues often include the Treaty Right to Health and the cross-jurisdictional issues that may include discussions with Health Canada's Non-Insured Health Benefits (NIHB). The FNMHS works to ensure that patients have access to benefits under the NIHB Program, which can include transportation, accommodation, medical equipment, and meals.

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- For Métis and Non-status individuals, the FNMHS will advocate and support access to appropriate services and funding for individuals not covered by other insurance plans. This may include contacting organizations such as, Social Services, Veterans Affairs, and other relevant community organizations.
 - 4. **Community Service Referrals:** The FNMHS refers patients to community programs, such as the Saskatoon Food Bank, Saskatoon Tribal Council Urban Services, the Salvation Army, the Good Food Box, and the Friendship Inn.
 - 5. **Patient Advocacy:** The FNMHS advocates on behalf of the patient; initiates collaboration and communication between staff and clients to promote staff cultural competency; provides a voice for marginalized patients; and addresses cross-cultural issues when they occur.

Health Educators are the main service providers in the FNMHS who meet with the patients while in hospital. Patients are referred to the program mainly through the identification of their name as First Nations or Métis via the Admission Census at St. Paul's Hospital in Saskatoon, Saskatchewan. Patients may be referred to the service by doctors, nurses, social workers, or family members; or patients may access the program via walk-in at the main office in St. Paul's Hospital. Once a patient has been identified, a Health Educator will meet the patient, explain the service, and will determine if they can be of assistance.

Programs similar to the FNMHS exist in Canada, such as the Aboriginal Health Program in the Winnipeg Health Region. Yet, in the current literature search there was no published evidence to show outcomes of these Canadian programs. This may be due to a lack of formal program evaluations being conducted and published; and/or a lack of subsequent reporting in peer-reviewed journals. However, there is a growing body of literature on patient navigation.

Patient Navigation

Patient navigation was first established in the 1990's by Dr. Harold Freeman (Freeman, Muth & Kerner, 1995). The program was introduced in Harlem, New York to address barriers for low income African American women with cancer. Barriers to care included limited resources (i.e. no health insurance); communication and information obstacles; medical system issues (i.e. missed appointments); as well as fear, distrust and emotional challenges (Freeman, 2013). The barriers that initiated patient navigation in Harlem, New York correspond with the health system barriers that the First Nations and Métis population in Canada often face today.

Principles of Patient Navigation

Freeman, the founder of patient navigation developed nine principles of navigation (see Freeman, 2013):

1. Patient navigation is a patient centered healthcare service delivery model, which focuses on promoting timely movement of an individual patient through complex healthcare systems.
2. The purpose of patient navigation is to eliminate barriers to timely care across all phases of the healthcare experience.
3. Patient navigation may serve to integrate a fragmented healthcare system for individual patients.
4. Patient navigation should be defined with a clear scope of practice that distinguishes the navigator role from other support workers.
5. Patient navigation services should be cost-effective and should correspond with the training and skills necessary to navigate a patient through a specific phase of the care continuum.
6. The navigators should possess the necessary skills at each phase of navigation.

7. In a given healthcare system, there should be a point where the navigation begins and ends.
8. Patient navigation can serve as a process that connects disconnected healthcare systems.
9. Patient navigation systems require coordination, which may best be carried out by assigning a navigator coordinator. The navigator coordinator would be responsible for overseeing all phases of navigation within a healthcare system.

Roles of the Patient Navigator

The duties of a patient navigator depend on the local need and typically include transportation; education; arranging clinical appointments; facilitation of medical insurance; emotional and social support; and assistance with language and cultural barriers (Dohan & Schrag, 2005). Navigators tend to be members of the community they serve and may be ethnically trained in the target population (Fischer, Sauaia & Kutner, 2007). The role of patient navigators is commonly reactive, as they troubleshoot patients' problems as they arise (Dohan & Schrag, 2005). The barriers that navigators address are often not known in advance, but arise upon interactions with patients (Dohan & Schrag, 2005).

Depending on the structure of the healthcare team, there may be overlap between patient navigators and other health professionals. Dohan and Schrag (2005) developed a figure to differentiate the role of patient navigators compared to other support workers, specifically in cancer care. Figure 1 demonstrates how the roles of other support workers may overlap with the roles of patient navigators.

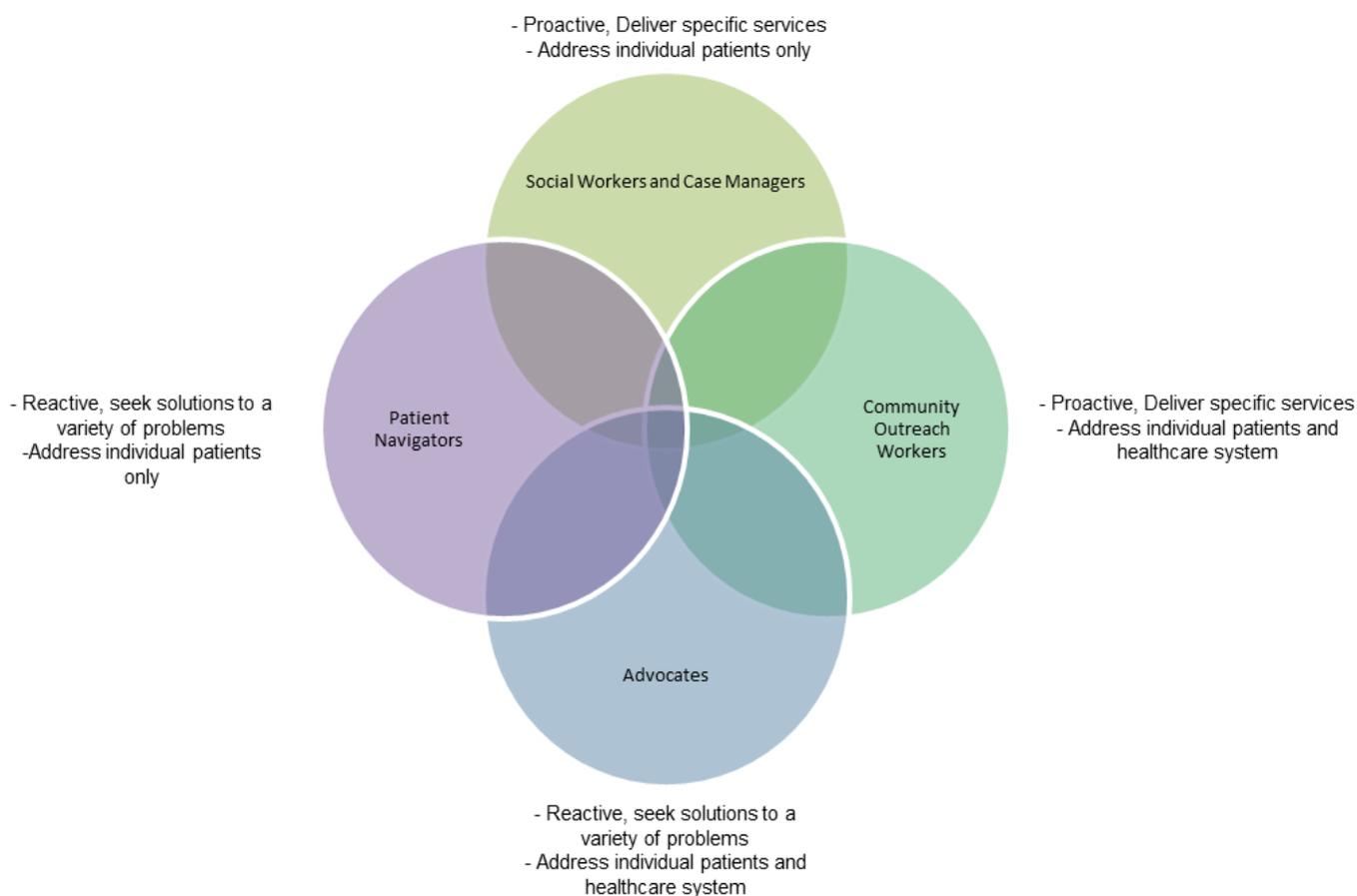


Figure 1. Patient Navigator and Other Support Roles. Figure from Dohan & Schrag, 2005.



As demonstrated previously, the services that patient navigators provide are comparable to the services that the FNMHS provide. Patient Navigators may be considered similar to the Health Educators in the FNMHS. The principles and roles of patient navigation align with the FNMHS; therefore, allowing comparisons to be made. The following literature review will examine the outcomes of patient navigation in the general population, and will specifically investigate patient navigation in First Nations and Métis populations.

The Evidence

Patient Navigation in the General Population

Patient navigation in the general population has been shown to have positive outcomes (Paskett, Harrop & Wells, 2011; Wells et al., 2008) and improve patient and staff satisfaction (Campbell et al., 2010). Wells et al. (2008) published a literature review of 45 articles on patient navigation programs for cancer care in the United States and Canada. The review showed that patient navigation improved cancer screening rates for three types of cancer, with improvements ranging from 11 to 17 percent. There were improvements in the adherence to follow-up visits ranging from 21 to 29 percent and improvements in the timeliness of resolving screening abnormalities for patients screened for breast, cervical, colorectal, and prostate cancer (Wells et al., 2008).

In 2011, an update of the Wells et al. (2008) paper was published (Paskett et al., 2011). Since the 2008 review was conducted, there was a considerable amount of new literature on cancer patient navigation released (Paskett et al., 2011). The updated literature review found 33 new articles that met the inclusion criteria.

Of the two literature reviews on patient navigation (Paskett et al., 2011; Wells et al., 2008), the findings highlighted four main themes. The first theme was that patient navigation programs and the backgrounds of the patient navigators are diverse; and are relevant to the local need. Paskett et al. (2011) stated that there is not one type of patient navigator program that fits all medical settings or systems. The second theme was that patient navigation was provided to both underserved patients, as well as patients from the general population. Third, patient navigation was typically goal-oriented with a focus on reducing barriers to achieve a specific healthcare goal. Finally, individual patients may benefit from patient navigation services; however, the most prominent evidence shows the impact of patient navigation through cancer screening interventions.

A study by Campbell et al. (2010) investigated whether patient navigation in cancer care improved patient and staff satisfaction. Two surveys were developed; one for patients and one for staff. Patients who received navigation services were significantly more satisfied with their overall care compared to patients who did not receive navigation services; specifically they were more satisfied with the resources that were available to them, the timeliness of the information they received, and the assistance they received with financial issues (Campbell et al., 2010). For the staff, 85 percent indicated that patient navigation decreased barriers to care for their patients and 80 percent indicated they were satisfied with the impact patient navigation made on their patients who received the services (Campbell et al., 2010). This study included all diagnostic, treatment, socioeconomic, and ethnic groups; therefore suggesting that patient navigation may be beneficial for all patients, regardless of their health status, socioeconomic status, or ethnic origin.

It has been shown that patient navigation for cancer patients in the general population has positive outcomes (Paskett et al., 2011; Wells et al., 2008) and improves patient and staff satisfaction (Campbell et al., 2010). Although patient navigation literature has been focused on cancer patients,



more recent literature has targeted populations at a high risk of receiving inadequate cancer services; for example, for cultural reasons or social and economic disparities (Paskett et al., 2011). These populations include underserved urban patient populations, underserved rural populations, and the Native American population (Paskett et al., 2011). The remainder of the literature review is focused on patient navigation in Aboriginal and Indigenous populations.

Patient Navigation in Aboriginal and Indigenous Populations

Of the literature reviewed, there were no programs targeting the First Nations and Métis population in Canada. The evidence that was obtained was conducted in the United States on Native American cancer patients. In 2012, two literature reviews were published that examined patient navigation in Indigenous populations with cancer (Eschiti et al., 2012; Whop et al., 2012). The articles in the literature reviews focused on the background and descriptions of programs, along with their intermediate outcomes, such as adherence to cancer screening. Eschiti et al. (2012) noted that few outcome measures have been examined, indicating a need to investigate the impact of programs. There is currently no consensus on a definition for patient navigation (Dohan & Schrag, 2005; Fischer et al., 2007), making it even more difficult to evaluate the outcomes of navigation. After reviewing the outcomes of the studies published in the two literature reviews, there is evidence to suggest that patient navigation in Indigenous populations with cancer resulted in less treatment delays (Guadagnolo et al., 2011a; Petereit et al., 2008), increased enrolment in clinical trials (Guadagnolo et al., 2011a), and improved adherence to breast cancer screening (Dignan et al., 2005).

A main theme highlighted in the literature reviews by Eschiti et al. (2012) and Whop et al. (2012) was the importance of cultural competency in patient navigation programs for Indigenous people. Eschiti et al. (2012) stated that the key for successful navigation is cultural competency and recognized that it has been a successful strategy to combine both community and culturally sensitive care into patient navigation programs. Whop et al. (2012) reported that building trust across patient navigators and the community was imperative. This enabled patients to trust the patient navigator and in turn, allowed for openness in discussing their concerns (Whop et al., 2012). Furthermore, Whop et al. (2012) reported the important features for patient navigators to possess; including an Indigenous background, culturally relevant education materials, and use of the local language.

From the two literature reviews on patient navigation in Indigenous populations (Eschiti et al., 2012; Whop et al., 2012) and from a thorough search of peer-reviewed articles, three main patient navigation programs were identified: the Walking Forward Program, the Northwest Tribal Cancer Navigation Program, and the Native Sisters Program. Multiple studies have been published on different aspects of each program, including their backgrounds and outcomes (Burhansstipanov et al., 1998; Dignan et al., 2005; Guadagnolo et al., 2011a; Guadagnolo et al., 2011b; Molloy et al., 2007; Northwest Tribal Cancer Navigation Program, 2012; Petereit et al., 2008). The following section will discuss the relevant articles in each of the three programs, including their activities and outcomes.

The Walking Forward Program

Background on the Walking Forward Program

The Walking Forward Program was developed to increase cancer survival rates among Native Americans in Western South Dakota and the Northern Plains (Molloy et al., 2007). This area has some of the largest reservation-based Native American communities in the United States and has some of the poorest census tracts (Guadagnolo et al., 2011). Nearly half of the residents live below the poverty level (Guadagnolo et al., 2011b; US Census Bureau, 2000) and the unemployment rate is approximately 80 percent on some reservations (US Census Bureau, 2000).



The goal of the Walking Forward Program was to identify barriers to care and to develop a sound methodology to overcome these barriers for Native American cancer patients (Molloy et al., 2007). Primary functions of the patient navigators staffed in the program included:

1. Addressing healthcare issues;
2. Developing relationships and collaborating with care providers;
3. Tracking interventions and outcomes;
4. Advocating for pain control, treatment needs, and side-effect management;
5. Handling end-of-life issues; and
6. Ensuring durable medical equipment (Molloy et al., 2007).

The patient navigators also provided crisis management throughout the continuum of care (Molloy et al., 2007). Day-to-day activities included coordinating appointments; managing insurance issues; facilitating transportation and accommodations; and communicating with patients, families, care providers, and other service agencies (Guadagnolo et al., 2011a; Molloy et al., 2007).

Walking Forward Program Findings

The Walking Forward Program has decreased the number of treatment delays for Native American cancer patients (Guadagnolo et al., 2011a; Petereit et al., 2008), improved patient satisfaction with healthcare (Guadagnolo et al. 2011b), and carefully incorporated cultural competency in the program for the population being served (Molloy et al., 2007). An early study evaluating the effectiveness of the Walking Forward program showed that Native Americans who received navigation services during cancer treatment had on average three fewer days of treatment interruptions compared to Native Americans who did not receive patient navigation (Petereit et al., 2008). Having fewer treatment interruptions was considered an important finding, as it may lead to higher cure rates for some types of tumors (Petereit et al., 2008).

The sample size of the early study by Petereit et al. (2008) was 116 patients and the average number of interactions between patients and patient navigators was 15 (range 1 to 95) during cancer treatments. Interactions were defined as either person-to-person contact or telephone contact. After treatment, the average number of interactions between patients and patient navigators was 4 (range 1 to 26) (Petereit et al., 2008).

A more recent study conducted on the Walking Forward program also showed that patient navigation was associated with fewer treatment interruptions (Guadagnolo et al., 2011a). The study included 332 navigated Native American cancer patients and 70 non-navigated Native American cancer patients. Results showed the average number of days of treatment delay in the navigated patients was 1.7 compared to 4.9 days in the non-navigated group (Guadagnolo et al., 2011a).

Of the patients included in the study by Guadagnolo et al. (2011a), 49 percent resided on a reservation over 160 kilometers from the cancer treatment centre. The median distance patients lived from the cancer centre was 195 kilometers, with road conditions often reported as poor. Very few patients did not speak English (2 percent); however, 36 percent of patients spoke the local Lakota language (Guadagnolo et al., 2011a).

Thirty-seven percent of patients in the Walking Forward Program sought navigation services through self-referral or by someone outside the program staff, 36 percent were referred through a patient navigation staff member, and 27 percent were referred by their treatment physician or oncology nurse (Guadagnolo et al. 2011a). The median time of the initial contact between the patient navigator and a patient was 40 minutes and the median time the navigator spent on subsequent contacts was 15 minutes. The median number of navigator contacts per patient was 12 (range 1-119 contacts) (Guadagnolo et al. 2011a).



Guadagnolo et al. (2011a) tracked the reasons for referral to the patient navigation program. See Figure 2 below for referral reasons.

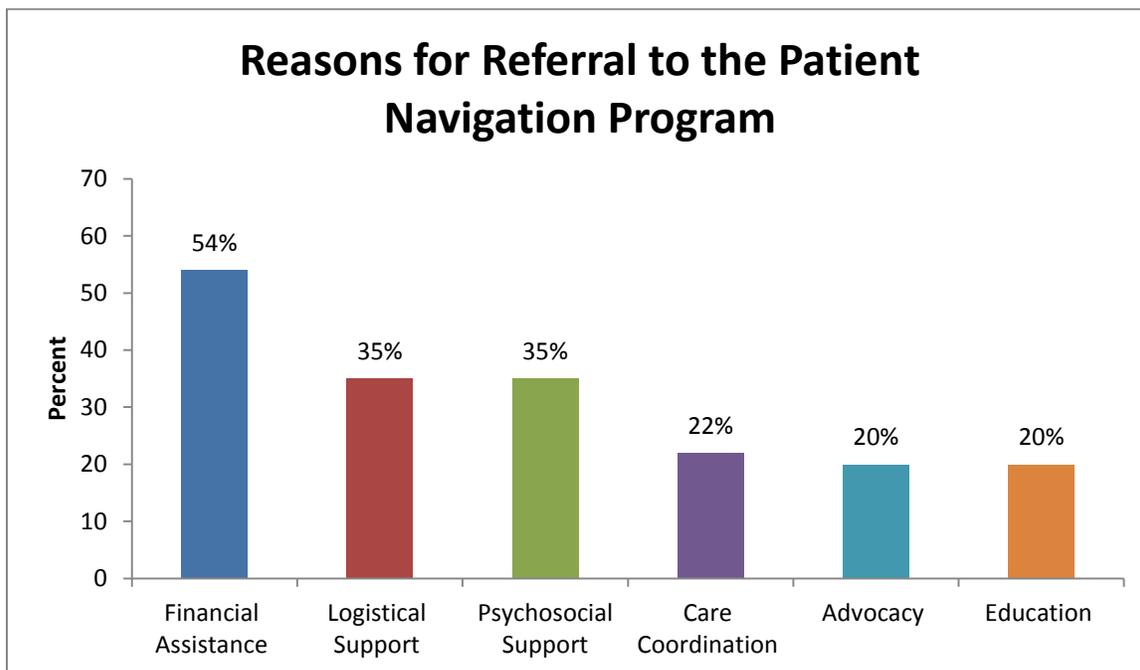


Figure 2. Reasons for Referral to the Patient Navigation Program. Data from Guadagnolo et al. (2011a)

Guadagnolo et al. (2011a) also noted the reasons for accessing patient navigation services for subsequent visits through the first five contacts with a patient navigator. The data showed that the number of patients accessing patient navigation for care coordination decreased after the first visit; however, requests for financial assistance and psychosocial support increased after the first visit (Guadagnolo et al., 2011a).

Guadagnolo et al. (2011b) conducted a study on the Walking Forward Program to examine whether patient navigation influenced patients' satisfaction with their healthcare. The study administered pre and post surveys to a Native American cancer patients. Data was collected using an instrument developed from a literature review and focus groups with the Native American community, cancer patients, and the program staff. All surveys were administered through face-to-face interviews by culturally competent staff.

Guadagnolo et al. (2011b) showed that patients' satisfaction with their healthcare was significantly improved after patient navigation, compared to their perceived scores before navigation. Patient navigation significantly improved patient satisfaction on the following items: the overall care they received at the hospital/clinic; the dignity and respect shown from healthcare providers; understanding their cancer treatment; being listened to by the doctor/nurse; and the availability of the doctor/nurse to answer questions about cancer. In addition to studying patient satisfaction with patient navigation, Guadagnolo et al. (2011b) also investigated the levels of medical mistrust among Native American patients undergoing treatment in the Walking Forward Program. The importance of trust and cultural competency in the Walking Forward Program is discussed in the next section.



Cultural Competency and Trust in the Walking Forward Program

A large component of the Walking Forward Program was cultural competency. A widely accepted definition of cultural competency was not found in the literature review; however, Jirwe et al. (2006) described four common components of a culturally competent program; including: an awareness of diversity among people; an ability to care for individuals; a non-judgmental openness for all individuals; and enhancing cultural competency as a long-term continuous process (Jirwe et al., 2006). An article by Molloy et al. (2007) describes the importance of cultural competency in carrying out culturally meaningful interventions. Molloy et al. (2007) stated that awareness and validation of the historical trauma that the Native American population faced was critical in interactions with patients and families to gain trust and establish a shared view. Negative historical occurrences were still part of conversations within the Native American community, which was the cause of trust issues between patients, families and healthcare providers (Molloy et al., 2007).

In the development of the Walking Forward Program, program staff recognized the importance of incorporating culturally appropriate communications with the Native American patients. In collaborating with the community, the Lakota language and cultural norms were worked into the program (Molloy et al., 2007). For example, the program's name was changed from '*Enhancing Native American Participation in Radiation Therapy Trials*' to '*Walking Forward*', which in Lakota translates to "walking forward in good health" (Molloy et al., 2007).

The Walking Forward Program used culturally competent strategies with each patient; culturally appropriate and respectful terminology; and conversational etiquette in interactions with patients (Molloy et al., 2007). Program staff allowed for quiet pauses in conversation, which indicated careful consideration to the Native American patients. Quiet pauses are not to be interpreted as inattention, misunderstanding, or mistrust; as could be the case in other cultures.

Program staff recognized the Lakota community did not always identify with authority figures or follow the recommendations of medical professionals (Molloy et al., 2007). Molloy et al. (2007) stated that many Native American patients preferred visiting a native healer and participating in traditional ceremonies before agreeing to participate in a proposed cancer treatment. However, this often led to delayed opportunities to participate in clinical trials for the patients (Molloy et al. 2007).

The Walking Forward Program also valued the importance of establishing authenticity and trust with Native American patients and families (Molloy et al., 2007). Petereit et al. (2008) stated that an establishment of trust with the patients and reservation communities was critical to the implementation of the program. The program offered a warm handshake upon arrival to the hospital and ensured a friendly environment (Molloy et al., 2007). Molloy et al. (2007) stated that pairing patient navigators with healthcare providers helped build trust across the healthcare team.

Guadagnolo et al. (2009) conducted a study on medical mistrust and healthcare satisfaction to determine if there were differences in attitudes between Native American and Caucasian patients. The study showed that Native American patients had significantly higher levels of medical mistrust and lower levels of satisfaction with healthcare compared to Caucasians. When further analyses were conducted, race was the only factor that significantly predicted higher mistrust and lower satisfaction with care (Guadagnolo et al. 2009).

Guadagnolo et al. (2011b) investigated if medical mistrust would change in Native American patients after they participated in the Walking Forward Program and had received patient navigation services. The study showed that there was no significant change in medical mistrust after receiving patient navigation services. Authors suggested that the history of colonization, its implications for Native American communities, and the persistent health disparities of the population played a much larger role



than originally thought in determining trust with medical professionals (Guadagnolo et al., 2011b). It may be unrealistic to expect that the presence of patient navigators can help overcome the trust barrier for Native American patients during the course of cancer treatment (Guadagnolo et al., 2011b).

The Walking Forward Program has decreased the number of treatment delays for Native American cancer patients, improved their satisfaction with healthcare, and has carefully incorporated cultural competency in the program for the population being served. The Walking Forward Program has many elements that are similar to the FNMHS; however, the Walking Forward Program services are targeted to Native American cancer patients. There may be differences between patient navigation in First Nations and Métis people and Native American people, as well as differences in navigation for cancer compared to other medical diagnoses. More work needs to be done to determine if the benefits of patient navigation for Native American cancer patients is generalizable to First Nations and Métis Canadians with diverse medical conditions.

The Northwest Tribal Cancer Navigator Program

Background on the Northwest Tribal Cancer Navigator Program

The Northwest Tribal Cancer Navigator Program was established due to concerns that Native American and Alaska Natives experienced higher cancer morbidity and mortality rates due to limited access to care and inappropriate cancer services (Northwest Tribal Cancer Navigator Program, 2012). The program was created in a rural setting to serve Native American and Alaska Native communities. The purpose of the program was to help reduce barriers to cancer care, improve clinical outcomes, and improve quality of life by providing navigator services (Northwest Tribal Cancer Navigator Program, 2012).

Patient navigator duties encompassed a wide range of activities, which matched the needs of the patients seeking care. Daily activities included assisting patients and their families with psychosocial support, coordination of resources, translation services, facilitation of services, and education. Patient navigators also interacted with healthcare providers and worked with patients' home communities to form partnerships, networks, and provide information on the cancer services available (Northwest Tribal Cancer Navigator Program, 2012).

Northwest Tribal Cancer Navigator Program Findings

Evaluation of the Northwest Tribal Cancer Navigator Program revealed that Native American and Alaska Native patients were very satisfied with their cancer care. The program provided support and guidance to patients; and supported and raised awareness about cancer care in the community (Northwest Tribal Cancer Navigator Program, 2012). The program enrolled 151 patients between 2006 and 2010 in patient navigator clinics. There were an additional 1036 patients eligible for the program that were enrolled at comparison clinics, and therefore did not receive patient navigation. The Northwest Tribal Cancer Navigator Program (2012) stated that the high number of patients at comparison clinics reflected the larger size of the comparison clinics and the limited case loads of patient navigators.

The Northwest Tribal Cancer Navigator Program tracked the most common activities that the navigators performed. Forty-eight percent of all patient encounters involved a form of patient education, including clarifying a diagnosis or treatment plan, helping a patient weigh decisions about their care, and understanding side effects or how to take medications. Communication among various care providers (38 percent), charting for the clinic (37 percent), and listening/counseling (36 percent) were the next most common activities carried out by the patient navigators (Northwest Tribal Cancer Navigator Program, 2012).



When patients were asked which services they used the most, they reported the most common was assistance with referrals (74 percent), followed by assistance with transportation (58 percent), scheduling appointments (58 percent), assistance with communication (55 percent), and referrals to a support group or counseling (55 percent) (Northwest Tribal Cancer Navigator Program, 2012). See Figure 3 for the most common patient navigator activities as perceived by the navigated patients.

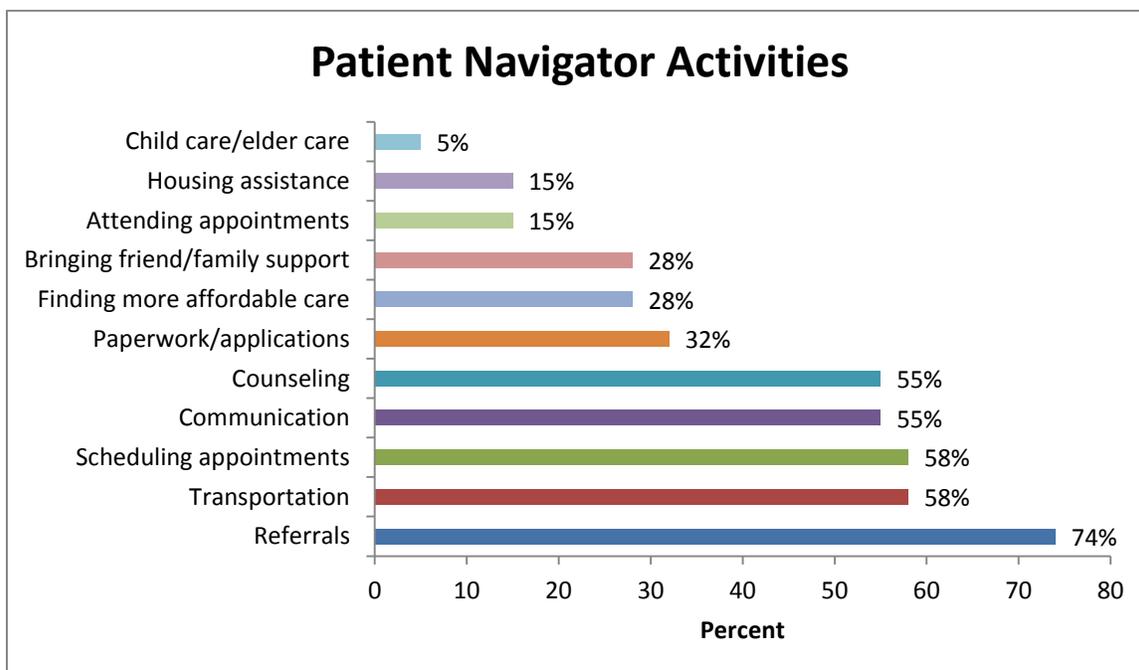


Figure 3. Patient Navigator Activities. Note: The data in this figure represents the perceived patient navigator activities by the navigated patients. Data is from the Northwest Tribal Cancer Navigation Program (2012).

Interestingly, the program showed the services that had the most impact on patients were not the most commonly used services (Northwest Tribal Cancer Navigator Program, 2012). The services that navigated patients reported had the most impact were assistance with paperwork/applications, housing, scheduling appointments, transportation, referrals, and finding more affordable care (Northwest Tribal Cancer Navigator Program, 2012).

Program participants were also asked about their satisfaction with the Northwest Tribal Cancer Navigation Program. Fifty-five percent of navigated patients rated their overall satisfaction with the program as 'excellent' and 30 percent rated their overall satisfaction as 'good' (Northwest Tribal Cancer Navigator Program, 2012). When asked if they would recommend the program to a family member or friend who became ill (Northwest Tribal Cancer Navigator Program, 2012).

The program staff conducted qualitative interviews with navigated patients and reported that Native American patients perceived the navigator program as a service that provided support and guidance through their cancer journey (Northwest Tribal Cancer Navigator Program, 2012). Supports included understanding their cultural beliefs; helping them make decisions about their healthcare; delivering information and resources; communicating with care providers; providing a sympathetic ear; assisting with financial issues; scheduling/attending appointments; and referring to other programs for support (Northwest Tribal Cancer Navigator Program, 2012). When program participants were asked which



traits patient navigators should have, they responded that the ideal patient navigator should have knowledge of, and provide the following:

1. Cultural Awareness: Understand spiritual practices, cultural beliefs and traditions;
2. Information and Resources: Provide information about healthcare issues, answer questions, and be knowledgeable about new treatments and alternatives;
3. Communication and Decision Making: Communicate with healthcare providers and with patients using lay terminology and language that is easily understood;
4. Emotional Support: Listen to patients and be a shoulder to lean on;
5. Financial Support: Provide referrals for financial assistance, help with paperwork, connect with insurance companies, and assist with financial supports from tribes, such as with gas vouchers or housing; and
6. Other Support: Help schedule appointments, make home visits, and provide referrals to other services (Northwest Tribal Cancer Navigator Program, 2012).

The Northwest Tribal Cancer Navigator Program has supported and improved communication about cancer with the Native American and Alaska Native community (Northwest Tribal Cancer Navigator Program, 2012). The program improved access to care, brought support to the communities, raised awareness about cancer prevention, and built partnerships with other community groups to assist with financial distress, transportation costs, and other participant needs (Northwest Tribal Cancer Navigator Program, 2012). Navigators became fixtures in their communities, conducting presentations and coordinating events, which in turn led to documented increases in cancer screening (Northwest Tribal Cancer Navigator Program, 2012).

A review of the Northwest Tribal Cancer Navigator Program revealed that Native American and Alaska Native patients were very satisfied with their cancer care. The program provided support and guidance to patients; and supported and raised awareness about cancer care in the community. This program was of benefit to both the communities and patients. The Northwest Tribal Cancer Navigator Program has aspects similar to the FNMHS; however, caution should be taken in generalizing these findings since the population being studied was Native American and Alaska Native cancer patients.

The Native Sisters Program

The final program found in the literature review was the Native Sisters Program. This program focused on recruiting Native American women to mammography screening to maximize the potential for early diagnosis of breast cancer (Whop et al., 2012). The program employed patient navigators, termed Native Sisters, who identified and recruited Native American women for breast cancer screening. The Native Sisters also attended screening appointments, provided assistance and support to the patient and family, and helped families navigate their way through the healthcare system, if diagnosed with cancer.

The program used two different types of navigation, face-to-face and telephone navigation; and compared breast cancer screening rates with a control group. Dignan et al. (2005) showed that adherence to breast screening guidelines over a 1 year period increased by 12 percent in the telephone navigated group, increased by 11 percent in the face-to-face group, with no change in the control group (-2 percent). Although this program showed improved breast cancer screening rates, it suffered major limitations, including a 29 percent loss to follow-up (Whop et al., 2012).

Although the Native Sisters Program is a navigation service targeted for Native American patients, it was focused on women with breast cancer, with the goal of maximizing early diagnosis. The published literature on the Native Sisters Program was limited. Where there was evidence, it was not applicable to



the FNMHS. The target population and the goals of the program do not align with the goals of the FNMHS; therefore due to limited relevance, this program is not discussed further.

Conclusion

Of the evidence examined, there was a large gap in the literature for programs similar to the FNMHS. Therefore, the review focused on patient navigation literature, which allowed some comparisons between programs to be made. However, the published literature focused solely on cancer patients in the United States, did not investigate any First Nations or Métis populations in Canada, and did not report on programming for patients with other medical diagnoses.

Of the literature that was reviewed, three patient navigation programs were identified: the Walking Forward Program, the Northwest Tribal Cancer Navigator Program, and the Native Sisters Program. There is evidence to suggest that the outcomes of patient navigation in Indigenous populations with cancer result in less treatment delays, lead to improvements in adherence to breast cancer screening, and support and raise awareness about cancer care in the community. Furthermore, the programs showed improved patient satisfaction and highlighted the importance of cultural competency.

There is much more work that needs to be done to further advance the literature in this area. There is a strong need for published evidence from programs in Canada (relevant to the First Nations and Métis population), a need for published evidence on the outcomes of healthcare services for illnesses other than cancer, and a need to identify strong outcome measures to provide further evidence that patient navigation programs have positive and worthwhile impacts. Although cost-benefit analyses were not in the scope of this literature review, investigation into the cost-benefit of these programs would be useful. In conclusion, patient navigation services for programs similar to the FNMHS can be found in the United States for Indigenous cancer patients, with the programs showing some positive impacts. There remains a large gap in the literature for peer-reviewed programs and their outcomes for First Nations and Métis populations in Canada.

Methodology

Peer reviewed literature was retrieved through searches in the following electronic databases: MEDLINE, PUBMED, CINAHL and SCOPUS with the help of a Health Sciences librarian. A grey Literature search also was conducted on Google. In addition, any relevant articles identified in reference lists that did not come up in the literature search were reviewed.

The following key search terms (searched individually and in different combinations) were used in conducting the literature search:

- Patient Navigation
- First Nation(s)
- Métis or Metis
- North American
- Indians
- American Indians
- First Nation and Métis
- Aboriginal
- Indigenous Health
- Navigation Program(s)
- Health Navigation
- Australian Indigenous Health
- Hospital Navigation



- Nurse Navigation
- Immigrant Hospital Navigation
- Newcomer Navigation
- Cultural Health Navigation

Articles obtained from the search were narrowed by reading through the titles to determine their relevance. The shortlisted articles were ranked on a scale of 1 (most relevant) to 5 (least relevant) following a review of their abstracts. A total of 79 articles were ranked. The most relevant articles to the review were thoroughly read and used in writing this review.

References

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