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The Community Liaison Model

Improving Access to Health and Social Services for Quebec's English-speaking Communities

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This Report

This report explores the role of community liaison work in improving the health and well-being of individuals and communities who face barriers in their access to public healthcare services. Of specific focus is the CHSSN[1] liaison model as a promising community-based response to reducing the linguistic and cultural barriers experienced by Quebec's English-speaking communities.

For the purpose of this report a review of research literature concerned with the topic of community liaison and improving health and healthcare access was conducted. CHSSN reports and datasets were consulted and ten hours of structured interviews with CHSSN and five selected NPI[2] networks carrying out the liaison approach were conducted in February 2022. The questionnaire guiding the interviews is included in Appendix 1.

This report proceeds with a (1) discussion of the literature followed by (2) lessons learned from CHSSN and NPI networks engaged in community liaison work across the different regions of Quebec. (3) A summary concludes the report.

What is the role of Community Liaison in Health?

A community liaison, whether a role filled by an organization, a team or an individual, acts as an intermediary between organizations and the people they serve (Schaaf *et al.*, 2020; Kok *et al.*, 2017; Torres *et al.*, 2014). Despite the aim of universality by a healthcare system such as Quebec's, there are marginalized populations who face barriers in accessing the health system due to attributes such as their language use, cultural norms, racial membership, physical and/or mental disability, geographic isolation, and others. Community liaisons are often positioned to meet the unaddressed needs of "communities on the margin" (Torres *et al.*, 2014: p.72) by reducing barriers in their access to the public health system – a key social determinant of health.[3]

According to the literature, community liaison workers (also referred to as community health workers, patient navigators and outreach workers) are typically found in two different situations. In one, they are drawn from the targeted community but employed by the healthcare system and work as members of a supervised health team. In the other, and this appears to be the prevailing case in Canada, community liaison workers are based in autonomous community organizations and work in collaboration with public institutions. The latter is the case in the context of Quebec's English-speaking population. While the recruitment and retention of bilingual health professionals within the public system is a well-documented challenge for language communities in a minority context throughout Canada, (Savard *et al.*, 2017; de Moissac *et al.*, 2017) in Quebec, the right of professionals to work

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[1] CHSSN is the acronym for Community Health and Social Services Network. https://chssn.org/about/
[2] NPI is the acronym for Networking and Partnership Initiative. https://chssn.org/projects/npi/
[3] The Public Health Agency of Canada states that health services are a key determinant of health. Both access to care and quality of care affect one's health.
https://www.healthypeople.gov/2020/about/foundation-health-measures/Determinants-of-Health

solely in French makes this challenge even more difficult. This is borne out by evidence of the low rate of health professionals drawn from Quebec's Anglophone population (Pocock, 2017: p.88).

The role of community liaison is many-sided. It generally serves more than one function with some functions gaining prominence due to the nature of local community needs, the type of access barriers faced by a group and the resources available for addressing these barriers. For example, a community liaison may be called upon to implement an intervention designed to educate a local immigrant population in chronic disease management (diabetes, heart-health) or provide support for patients in navigating services when barriers such as language use or disability are evident or sit on health boards and committees as advocates for culturally appropriate care, or all three. A community liaison worker may be found working in medical clinics and hospitals as well as a range of settings such as community centers, nursing care facilities, schools, detention centers and even employment service offices.

The duration and change over time of a community liaison approach among participants will also shape the characteristics of its practice in any selected period. For example, coordination among the players in a newly launched community outreach program or a new patient navigator service often sharpens with time and experience. This, in turn, lays the ground for a more efficient and stable interdependence in the joint efforts of the community liaison, public health agency and local vulnerable community involved. Put simply, there are stages in the development of the community liaison role and its impact.

Community Liaison Successes and Challenges

According to a scan of the literature, an array of positive outcomes for patients and their communities, health professionals and for general health and social system performance may be attributed to successful community liaison work. Assessment shows,

- Patients and caregivers of vulnerable communities experience increased health literacy, increased use of health-related programs and services, reduced use of emergency health services, improved trust in health system professionals and staff and greater inclusion in the decision-making regarding their health care (Pearl *et al.*, 2017; Valaitis *et al.*, 2017; Shommu *et al.*, 2016; Harris *et al.*, 2015).
- Health professionals report experiencing improved awareness of unmet needs in their service region, improved communication and cultural competency in serving patients from marginalized communities, improved management of chronic conditions and overall improved success in gaining patient adherence to treatment recommendations and protocols (ENTITE2, 2019; Pittman *et al.*, 2015; Shommu *et al.*, 2016).
- For hospitals, clinics, and other health-related settings the improved use of services meets their objective of improving the health and quality of life of citizens and reducing system costs (Valaitis *et al.*, 2017; Torres *et al.*, 2014). By reaching patients earlier in their illness and better management of emergency care the demand for

more costly critical procedures and hospitalization is reduced (ENTITE2, 2019; Shommu *et al.*, 2016). In some cases, community liaison efforts are responsible for initiating the link between a patient, or group of patients, and a family doctor who will monitor their health profile to ensure timely attention and a continuity of care.

- For community organizations offering health services and support to a vulnerable population, community liaison work contributes to their objective of health equity and a strengthened capacity to address the social determinants of health (Shommu *et al.*, 2016; Torres *et al.*, 2014). The trust established with the public system in health often spills over into improved advocacy and engagement by minority citizens within other sectors such as education, employment and economic development, and justice.

In terms of challenges, the literature indicates that the role of community liaison can be undermined by the interrelated factors of lack of role clarity, lack of training and overburdening (Valaitis *et al.*, 2017). Recognition of community liaison as a legitimate role among other health experts operating within the health and social service system is often hard won. Lack of clarity concerning the approach and its place in improving health care can result in poor inclusion within the system, disregard for training and workers who are spread thin in meeting an unreasonable level of what can often be conflicting demands. This same lack of status can weaken their capacity as cultural brokers to influence health service system priorities or resource allocations based on their identification of local culture and needs. Where funding is intermittent and establishing the role of community liaison in response to health inequities is uneven, the emergence of a support network and knowledge exchange among these health workers is made more difficult.

The Case of CHSSN and the NPI Networks

Formed in 2000, the Community Health and Social Services Network (CHSSN) is a non-profit provincial organization that responds to the health and social service access challenges -geographic, linguistic, and cultural - of English-speaking communities located in a majority French-speaking Quebec.[4] The CHSSN hub and its 22 regional community networks (NPI) across the province are focal points for innovative strategies aimed at improving the health of their local English-speaking communities by reducing health inequities and improving their position with respect to this key social determinant of health and well-being.

Legislative and Policy Context

Quebec's English-speaking minority communities access their health care through public agencies that are subject to the *Charter of the French Language* wherein French is recognized as the sole official language in the province and the Quebec government has the legislative and policy-objective of making it "the normal and everyday language of work,

[4] Further description at https://chssn.org/

instruction, communication, commerce and business." [5] In the 1980s the campaign by English-speaking communities to see legislative recognition of guarantees culminated in Bill 142[6] which amended Quebec's *Act respecting health services and social services* to provide a qualified right for English speakers to receive these services in English.[7] Key elements of the revised legislation include (1) the requirement for regional planning authorities to develop access programs for services in English subject to the resources of the institutions in each region and for (2) the designation of a limited number of institutions that would be permitted to offer their range of services in the English language.[8]

In Quebec, Regional Access Committees (RAC) (one per administrative region) are mandated to advise the health and social service institutions on their access programs of services in English.[9] As interview testimony provided by this report will confirm, a winning condition for community liaison work in the case of CHSSN and its networks has been their pro-active approach towards the RAC. As active participants – in some instances even committee leaders – the NPI networks refer to the connection between their organization and this planning body as vital to the sustainability of their community liaison work with local public health agencies and institutions.

The Situation of Quebec's English-speaking Communities

Aside from language barriers in their access to a public system organized primarily to serve a French-speaking majority, Quebec's English-speaking communities face the challenges of geographic dispersion and regional disparity, socio-economic vulnerability, low critical mass and a high level of cultural diversity.

Geographic Dispersion and Regional Disparity: More than one million English speakers living in the province of Quebec are located in communities dispersed over a large territory (three times the size of France) and together form 13.8% of the total Quebec population. They live in diverse demographic circumstances ranging from a population of 622,165 English speakers in the urban region of Montreal to some 1,080 living in the more isolated area of the Lower Saint Lawrence (Pocock, 2021). As a result of their different regional concentrations and geographic locations their physical proximity to public health and social service provisions varies widely.

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[5] *Charter of the French Language*, CQLR c C-11, http://canlii.ca/t/52lls consulted July 27, 2020.

[6] http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=5&file=2002C66A.PDF

[7] https://www.legisquebec.gouv.qc.ca/en/document/cs/S-4.2(Article 15).

[8] A designated institution is an institution that is acknowledged by the Government of Quebec as required to make its health and social services accessible in the English language to the English-speaking population. https://www.educaloi.qc.ca/en/capsules/health-and-social-services-english

[9] Quebec Community Groups Network (QCGN) https://qcgn.ca/initiatives/health/

Socio-economic Status: Poverty is a general predictor of a higher rate of health problems and increased reliance on public health services. Quebec's English-speaking communities experience higher rates of low-income, unemployment and greater income inequalities within their population compared to the Francophone majority with whom they share the provincial territory. A 2012 study produced by the Institut National de Santé Publique du Quebec (INSPQ) shows "income inequalities are greater in the Anglophone population of Quebec at every level when compared with Francophones" (INSPQ, 2012: p.24).

The 2016 Canadian census tells us that the rate of unemployment is higher in Quebec's English-speaking population (8.9%) compared to the francophone majority (6.9%). It is also much higher in some regional communities. For example, the unemployment rate of English speakers in Côte-Nord is 25.3% compared to 11.6% for French speakers. English speakers in Gaspésie experience an unemployment rate of 24.4% while that of their French-speaking neighbours is 15.1% (CHSSN, 2017).

Cultural Diversity: Quebec's English speakers are notably distinct from the majority population in terms of their heterogeneous composition (religious affiliation, ethnicity, visible minority[10] status) and this heightens the need for culturally and linguistically sensitive access to services. For example, one-third (33.6%) of Quebec's English speakers are immigrants compared to 8.8% of the French-speaking majority. More than one quarter of the English-speaking population (27.9% compared to 7.8% of Francophones) are also members of a visible minority. One third (33.2%) of this sub-group live below the low-income cut-off (LICO), compared to 17% of the English-speaking non-visible minority population and 13.8% of the French-speaking non-visible minority group (CHSSN, 2017).

The CHSSN Community Liaison Model

From its inception, CHSSN and the NPI networks have adopted a partnership approach in their efforts to reduce barriers and improve access to health and social services for Quebec's English speakers. This entails forging sustainable, intersectoral, partnerships between non-profit community organizations serving the English-speaking population and public institutions primarily in the domain of health (Pocock, 2021). This is noted in the literature as a winning condition for the emergence and success of the community liaison role (Torres *et al.*, 2014; Valaitis *et al.*, 2017). Over the years, the collaboration initiated by regional NPIs with their public partners has laid the ground for liaison work by improving awareness of barriers to access including monitoring specific points of service[11] and engaging with health

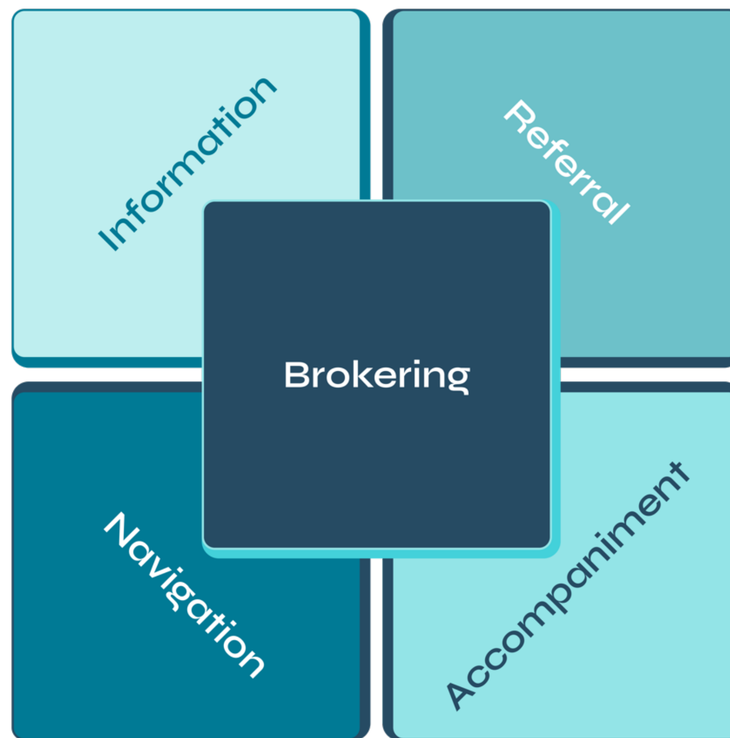
[10] A visible minority is defined by the Government of Canada as "persons, other than aboriginal peoples, who are non-Caucasian in race or non-white in colour".
https://www23.statcan.gc.ca/imdb/p3Var.pl?Function=DEC&Id=45152

[11] Since 2005, CHSSN has regularly conducted a province-wide survey of Quebec's English-speaking communities which includes inquiry into different medical treatment settings (doctor's office, hospital emergency, CLSC services, hospital stay, etc.) to assess language of access. See CHSSN. (2020) *Baseline Data Report 2019-2020. Time Series Report: CHSSN-CROP Surveys 2005-2019. Access to English-language Health and Social Services in Quebec*, Provincial Profile.

authorities (both regional and provincial) in finding solutions for English-speaking communities.

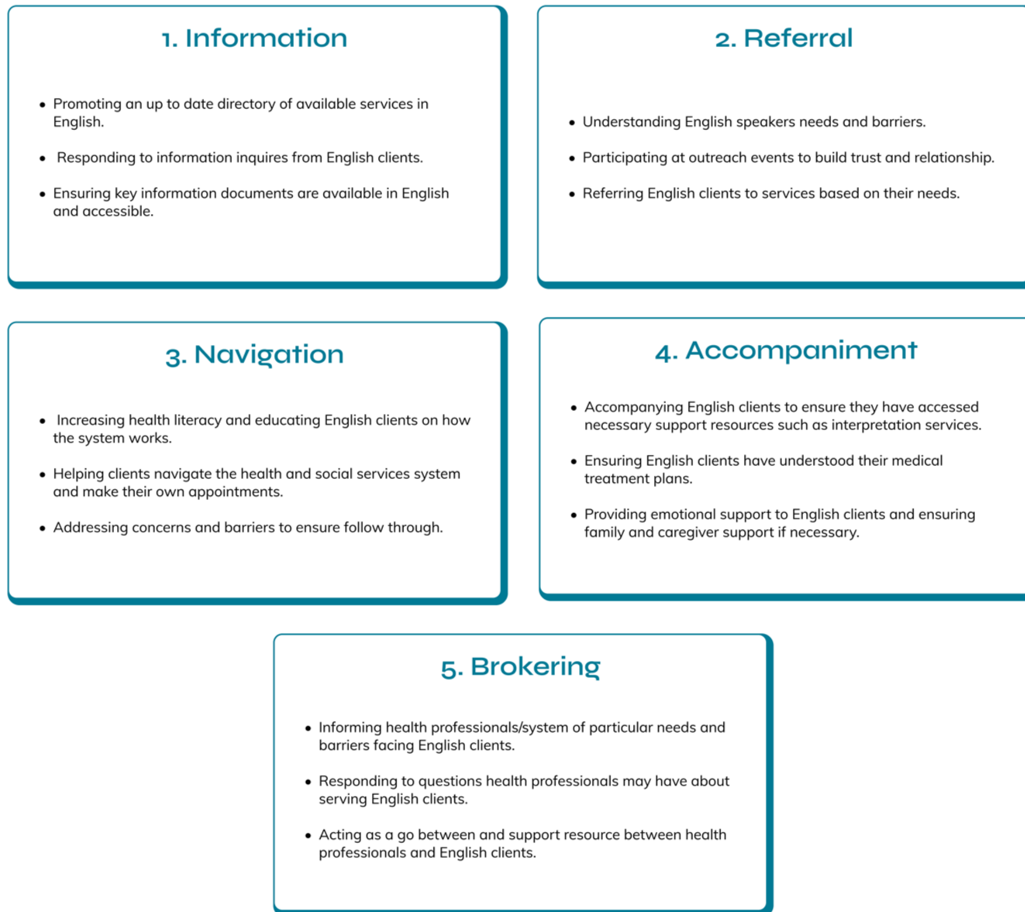
Based within an NPI community organization and in strong collaboration with their CISSS or CIUSSS, community liaison work to improve access to health and social services for the English-speaking population. To achieve this, the liaison worker may focus on one or more of the five inter-related activities illustrated below.

Community Liaison Model



CHSSN 2021

https://1omae22rkruy1i4j5xh07m9u-wpengine.netdna-ssl.com/wp-content/uploads/2021/08/CHSSN-CROP-Times-Series-Provincial-Profile.pdf



In the words of Russell Kueber, Director of Programming at CHSSN, their liaison model has emerged as a "grassroots, community-based approach" rooted in the lessons learned from the communities they serve and their record of successful collaboration with local health and social service teams. "In many ways, our networks have long been positioned as intermediaries between their local populations and the regional health agencies that serve them. It varies from network to network, but their workers now have a history of doing information and referral, patient navigation and accompaniment, and cultural brokering although they may not have always defined their role in precisely these terms. Over our 20 plus years, the barriers in services have become increasingly targeted and likewise so has the NPI response."

Located in English-speaking regional community organizations and as members of the community themselves, CHSSN and its network liaison workers, armed with guiding protocols,[12] are on the frontline with health professionals and social workers responding daily to unmet client needs. Their unique location allows them to view the problem from all sides and to grasp the way language barriers impact the lives and work of all involved. On

[12] Community liaison workers are given instruction on ethical issues like confidentiality and some navigation techniques like how to contact clients, other community organizations and local health and social services.

any given day, the typical scenario is that a community liaison worker finds him or herself called upon to assist an English-speaking client (and their caregivers) in navigating the system, in enrolling and participating in a health-related program, or in managing an appointment where language is a barrier to following the standardized process. In the case of an ER visit, or larger health emergency such as the COVID-19 pandemic, their precise communication and immediate support saves lives.

Reporting indicates that in the absence of a community liaison, the task of navigator and cultural broker falls to medical staff and health professionals who can be overwhelmed for these tasks and often consider them to fall outside their already demanding job description (CHSSN, 2019; ENTITE2, 2019). In the absence of either a community liaison or bilingual health professional, the task of go-between is commonly left to a random bystander such as another patient or hospital personnel who happen to have some English language skills. Too often, the task falls through the cracks entirely. As underlined by the literature, lack of recognition surrounding the important role of community liaison means the healthcare of a large vulnerable population is met, at best, in an unpredictable "hit or miss" fashion. As is documented among Canada's official language minorities both inside and outside Quebec, ill individuals will predictably feel that the request for linguistic and culturally appropriate care is not a legitimate expectation and that they must resign themselves to the added risk that barriers represent to their physical and mental health. (ENTITE2, 2019; Drolet *et al.*, 2017; CHSSN, 2019). The result is that their contact with the system is highly stressful, unnecessarily delayed or, unfortunately, avoided entirely (Bowen, 2015).

A Promising Practice to be Expanded

With their years of on-the-job experience in the community liaison role, there is strong evidence that NPI networks have become trusted intermediaries offering support to English speakers and, equally important, to the health teams who have increasingly come to depend upon them in managing the barriers that challenge the minority language population in their regions. The 2021 *CHSSN Survey of Health Partners and Professionals* asked professionals whether they felt that community health networks provided them with knowledge, skills and support in meeting the needs of the English-speaking community. A robust 87% of health partners and 93% of health professionals who answered the survey reported feeling supported by NPI.[13]

The offer of community liaison support from NPI networks has been met with a notable increase in demand from clients. In response, in 2021 CHSSN networks and other member organizations selected further development of this role as a top priority to be recommended by the Health and Social Services Priorities Committee (HSSPC) in its advice to Health Canada on improving health and social service access and enhancing the vitality of

[13] CHSSN administrative satisfaction survey of health partners and professionals. August 2021. Unpublished.

Quebec's English-speaking communities.[14] Since its beginnings, CHSSN has consulted with community organizations and exercised its voice in shaping the funding decisions regarding action plans supporting official language minority communities in Quebec and in all other provinces of Canada in redressing their health status.

Lessons Learned from Community Liaison Workers

The following snapshots of community liaisons in the field of health are drawn from a series of structured interviews conducted with CHSSN and 5 organizations drawn from CHSSN's twenty-two networks. The interview guide is available in Appendix 1 of this report.

The selection of exemplars was based on two primary concerns:

1. An interest in gathering information that reflects the disparate predicaments and characteristics of the English-speaking communities served by these regionally based non-profit organizations (rural/remote/urban, small /large, socioeconomic status, cultural composition).
2. A concern to reflect the differences among NPI networks in terms of their stage of community liaison development. (new /longstanding organizations, years of NPI community liaison implementation)

The following extracts are drawn from the original videotaped interviews held in February 2022. Any edits to the recorded words drawn from the dataset have been validated by the participating interviewees.

Community Health and Social Services Network (CHSSN), Quebec City/Capitale-Nationale
Jennifer Johnson (CHSSN Executive Director) and Steve Guimond (CHSSN Patient Navigator Project)

Steve Guimond is coordinator of the CHSSN inter-regional patient navigator project based in Quebec City of the Capitale-Nationale region. As patient navigator, he assists English speakers who are required to travel from the North Shore, Lower North Shore, Magdalen Islands, and Gaspésie -anywhere east of Quebec City – to access healthcare services and expertise unavailable in their region. Generally, patients are referred to the patient navigator service through NPI networks located in these more isolated regions, often through word-of-mouth. Most patients are unilingually English, their ages range from two years to ninety, often they are without accompaniment and coping with advanced medical needs such as cancer treatment, heart surgery and pediatric concerns. The patient navigator's task often begins with contact from a patient subsequent to referral by their NPI in their region. This is followed by identification of their travel and medical needs and walking them through the CHSSN website module designed to offer a preview of their lodging and hospital destinations in Quebec City. He then accompanies them through their journey from the arrival of their flight, transportation to their lodging and assistance with living

[14] CHSSN administrative survey of the community networks on development priorities. August 2021. Unpublished.

arrangements, accompaniment to their appointment(s) during their stay in the city, through to their return home and follow-up on their recovery at home. According to Guimond,

> *These individuals, seriously ill, face language barriers at every stage through the healthcare process. Their reception and admission at the hospitals are the most problematic with system agents who do not speak English. It starts with online communication or phone messages that are impossible to decipher, figuring out appointment locations, general hospital admission forms and consent forms that are all in French (similarly department registration), through to information concerned with recovery and follow-up upon release. Nurses tend to be somewhat more bilingual but there is a high turnover among them and of course, post-COVID, system shortages have worsened. Once a patient reaches a doctor, language barriers are generally not as much of an issue ... Social workers and nurses are slowly getting to know me, but the system network is big. One of the biggest challenges is getting the word out to them as to my role.*

Both Jennifer Johnson (CHSSN Executive Director) and Guimond agree with evidence from the 2020 evaluation of the CHSSN patient navigator role. It emphasizes its positive impact on reducing anxiety for both the patient and health professional, improving communication of health system information, and improving overall health literacy (Anastasopoulos,2020). The reduction of stress and misinformation and the improvement of self-care lowers the likelihood of return visits. In Johnson's words,

> *We have evidence now of the inter-regional patient navigator role functioning well. The improved awareness of the situation of English-speaking communities means not always "going against the stream" and, importantly, the connection between navigator and system translation services continues to improve. In terms of next steps, our patient navigator here in Quebec City needs to be granted the status of recognized volunteer by the system upgraded from simply community person as it now stands. Provincially, we now have a replicable model for other regions who are also designated centers for inter-regional health and social services.*

African Canadian Development & Prevention Network (ACDPN), Cote-des-Neiges/Greater Montreal Area
Tania Callender (ACDPN Executive Director)

Tania Callender is the Executive Director of the African Canadian Development & Prevention Network located in Cote-des-Neiges and an NPI network serving the English-speaking black community of Greater Montreal. ACDPN works to improve access to health and social services for their clientele with specific focus on their status as a double minority facing barriers not only due to language but also culture. As community liaison, they find themselves intervening directly as navigators and cultural brokers between families and social service staff and indirectly as advocates pressing for change in the policy and processes of the public system. Their clients include families with socio-economic challenges, many young single mothers, all of whom are often unilingual or have only basic

French language skills. Black seniors who are unilingually English-speaking also form a sizable portion of their clientele. At this point in their development, ACDPN community liaison list health and social service professionals located in schools and in health agencies among their clientele as they are now regularly contacted by them for a co-intervention. According to Callender,

> *Through our programs and services, our Senior's Wellness Center for example, we are known and trusted by community members. We are known to system workers through our partnerships. Through agencies like Batshaw Youth and Family Centres, for example, we are known by health professionals for our involvement with youth protection services at our CIUSSS[15]. They notify us of a referral for child protection services and our liaison responds to learn more background on the case. We then make first contact with the family to "lower the temperature" and build trust with the family. Often, they don't know what is going on – youth protection services in the Barbados are structured differently- and they are very afraid of their child being removed from their home. Communication from the schools – phone messages, documents, emails -all in French adds to their confusion and fear. In the best scenario, we bring the family and the health professional together in a "culturally safe" space and try to advance the family out of the system. Sometimes the matter is solved by diverting the case to community services... to community organizations in our network that serve the same clientele. At closer look and with cultural expertise, the issue may simply be help needed with missing a coat or with housing and not with a more serious charge that requires youth protection involvement. Often more long-term accompaniment by ACDPN is needed. There is an enormous over-representation of black youth in youth protection and much of this can be attributed to a cultural disconnect.*
>
> *The biggest improvement we observe as a result of our community liaison work is the reduced stress of our clients. It cannot be overestimated. With our referral and navigation assistance our seniors are much more likely to follow through on a doctor's appointment and they are more receptive to health information from a health professional when it is in English and offered in a culturally safe place. Another important improvement is the empowerment of the patient. Young and old learn they have rights and responsibilities and how to advocate for themselves. They have a right to request services in English and to be treated equitably and with respect.*

Assistance and Referral Centre (ARC), South Shore/ Montérégie Centre
Chris Lapointe (ARC Executive Director)

Chris Lapointe is the executive director of ARC which has locations in Greenfield Park, St-Jean-sur-Richelieu and Candiac. As an NPI network, ARC serves a large population of some 96,540 English speakers residing on the South Shore of Greater Montreal. A substantial

[15] CIUSSS is the acronym for Centre integre universitaire de sante et des services sociaux or Integrated University Health and Social Services Centres.

portion of their clientele are English-speaking seniors (50 years and over) and about 35% are allophones many of whom are newcomers to Quebec. Their work as intermediaries between the English-speaking community and the public health and social service system involves them in the full range of tasks delineated by the CHSSN community liaison model. With English-speaking patients, the first stage of support from ARC liaison often begins with a request for assistance in deciphering a recorded telephone message from medical staff. When it comes to health partners and professionals, the request is for ARC's assistance in delivering services or an adapted program to a substantial segment of the patient population that they have difficulty reaching. Arc's community liaison work is the trusted bridge across an entrenched disconnect between the patient needs of a marginal population and health providers limited by a complex bureaucratic system. According to Lapointe,

> *Often the client comes to us - let's say, for example, the Afghani gentleman who comes in fairly often - with a telephone message on his phone. The message is all in French, with medical lingo, from a medical secretary speaking too quickly. We sit down with him, listen to the recording, and try to assist in making sense of it. Or we call the health and social service receptionist, sort things out, and then call back the client. The next question from the client is "where do I go?" This is where providing navigation information starts and this can involve another set of calls. Finally, the appointment or tests have an address but then there is still the hurdle of following through. Often there are barriers at this point because of high anxiety due to being ill, anticipation of communication difficulties and little previous contact with Quebec's hospitals and clinics. Take COVID for example. There was a lot of misinformation for everyone, and fears were compounded by linguistic and cultural barriers. We have found that knowledge and referral often need accompaniment to be effective so we would go along to the vaccination center with the patient. After this we can follow-up with the patient and inquire if things are going smoothly, if they have what they need, and so on. Over the years, ARC has established a network that extends into the system so that we can notify the health professionals and staff who are our regular contacts of any clients needing linguistic and culturally appropriate care. By walking through the process with the client and helping them to open doors we are in a sense training them. They are empowered to take things in their own hands next time. Health professionals, in their turn, learn they have a creditable, one-stop, organization to turn to in delivering an adapted program and connecting with a network of community organizations across the territory.*

In terms of next steps, ARC plans to build on their liaison strengths by continuing to "put a face" on the hospital. Health sessions, including mental health, hosted by ARC brings health professionals together with vulnerable community members in a setting where the stress

surrounding hospital protocol is reduced, and participants are “humanized”. The greatest challenge is sufficient human resources to meet the growing demand that confront community liaison workers from both their community and their network in the health and social services sector.

Committee for Anglophone Social Action (CASA), Gaspe Coast/Gaspésie
Kim Harrison (CASA Development Officer), Matthew Munroe (CASA Health & Social Services Mobilization Officer), Shannon Marsh (CASA Program & Activity Officer) and James Robson (CASA Patient Navigator)

The CASA NPI team serves the English-speaking population of Quebec’s Gaspe Coast and have offices located in New Carlisle and Pointe-a-la-Garde. CASA is a community organization with a long history on the Gaspe Coast and an established record of bringing together community members, a regional network of community organizations and the partners, professionals, and staff of the health sector in their area. The English-speaking communities of the region are located in small towns and villages across the territory and are required to go out of the region for specialized healthcare services. Their patient navigator finds himself accompanying seniors who are typically unilingual and coping with chronic conditions that can take them to Rimouski four hours away and to Quebec City. A large portion of CASA’s clientele are low-income youth and young families (18 to 35 years) who are experiencing psycho-social difficulties and related needs that require navigating social services. Counselling for addiction and specialized mental health services in English can be as far away as Montreal and the waiting list is long. According to Harrison,

> *CASA has been doing liaison work for a long time but has only more recently seen it through the lens of the CHSSN community-based model. Now we see more clearly what we have been doing all along. CASA is always busy with information and referral. This ranges from adapted information sessions at our Senior’s Wellness Center to translation of French language tools from the public system like a prenatal kit that can serve as the basis for pre-natal workshops. We do navigation and accompaniment with vulnerable youth and families connecting them to services and answering calls from our CIUSSS and schools. We have recently established a patient navigator role and these activities will be aimed primarily at our seniors and patients needing specialized out-of-region services. Our cultural broker is working closely with partners, other community organizations and CIUSSS staff. Each MRC has a social development committee. Working closely with our regional access committee is crucial. There are tables and committees concerned with regional mental health services, housing, school bullying and so on where English speakers need to be represented and have a voice in the planning. This opens doors.*

There is consensus on the CASA team that their community liaison work has brought about a shift with the way community organizations work with the public system. Whether at an organizational or interpersonal level, the key improvement is reduced anxiety and fear.

We know both sides. On one side, there is the stress of the patient who is ill, or maybe afraid of losing their children, in approaching a situation where communication is a barrier and, on the other, the stress of the health worker who, too, fears an interaction where they may not be linguistically competent or where they are seen as threatening. Our presence can change the nature of this encounter entirely. Trust is huge. We help the health and social service system perform better.

In terms of challenges, the team sees the community liaison role as needing more recognition.

There is turnover among public health and social service workers and so our liaison network extending into the system needs constant renewal. Recognition of our role and our reliable contribution would make this less of a hurdle.

Centre for Access to Services in English (CASE), Mauricie/ Centre-du-Quebec
Shannon Keenan (CASE Executive Director)

Shannon Keenan is the Executive Director of the Centre for Access to Services in English (CASE). CASE serves the small population of some 6,065 English-speakers living in the Mauricie and Centre-du-Quebec regions. With locations in Drummondville and Trois-Rivieres, CASE was incorporated in 2017 and is among the newest of NPI networks. To date, CASE liaison clients are primarily English-speaking seniors, families with young children looking for health services and immigrants who are allophone and often newcomers. While CASE liaisons respond to patient needs that touch on all aspects of the liaison model, as a network still in the early stages of development they are primarily occupied with information and referral. Building awareness of the community among its members and organizations, among health professionals and system staff and among health managers and decision-makers is a crucial introductory step. As community liaison workers, they host information sessions adapted for English speakers, help patients navigate public services ranging from a recorded phone message all in French through to mediating between health users and health services in resolving a formal complaint, and increasingly, they answer referrals originating from the CIUSSS English page website. According to Keenan,

The English-speaking communities of our territory only represent 1.2% of the regional population. When we began, they simply were not on the radar so awareness of language barriers surrounding access to services among health professionals and partners was very low. Now they call us if a language issue arises or any other matter concerning the English-speaking community. We are present at eight different tables. The translation of the CIUSSS website was an important project for our liaison work. Not only does it reduce barriers at a key point of contact with the healthcare system – it also gives us visibility as a community organization serving the English-speaking community. Both community members and health system workers have a place to turn. The barriers involving reception are perhaps the most challenging. Online communication, phone messages, documents, staff who are not bilingual. It is

easy to get lost. We all struggle with medical terms. Our seniors In Trois-Rivieres are more bilingual than in the Drummondville area but when they are ill and stressed, their competence in their second language is not the same. Assistance with navigation and accompaniment – just a few words of English - can reduce anxiety enormously and allow them, their caregivers and the health professionals, to focus on what matters medically.

In terms of next steps, Keenan would like to see more training for NPI community liaison workers.

They may know their communities well but do not necessarily have a medical background and, at least initially, little familiarity with the local system. The healthcare system is a large place to navigate – it has a language and protocol of its own. Some sort of liaison training would facilitate their first steps into the system rather than merely learning on the job.

Neighbours Regional Association (Neighbours), Rouyn-Noranda /Abitibi-Témiscamingue Sharleen Sullivan (Neighbours Executive Director), Nathalie Chevrier (Neighbours Health Coordinator)

Located in Rouyn-Noranda, Neighbours is a community organization incorporated in 2003 to serve the English-speaking population residing in the Abitibi-Témiscamingue region. As an NPI network they are active in all areas of community liaison work with the addition four years ago of an English Health Service Agent (EHSA) devoted primarily to navigation and accompaniment. The majority of requests for the assistance of their English Health Service Agent includes the native population of their region (90% English-speaking), young lone mothers, unilingual seniors (typically women) and healthcare system professionals and staff. The primary task of the health agent is to accompany patients in their contact with health professionals with the aim of reducing stress and ensuring complete comprehension of information for both. The work of the health agent takes her to a range of medical settings - all hospital departments, to seniors' residences and activity centers, CLSC appointments – and she may accompany a patient for a period of months or follow-up on their situation even as they travel out of the vicinity of Rouyn-Noranda. According to Sharleen Sullivan (Executive Director) and Nathalie Chevrier (Health Coordinator),

While COVID has had an impact, ordinarily our health agent is located at our hospitals. Our agent is authorized and has a security badge for entry. She makes cold calls at the nursing stations of the different departments and checks the waiting rooms for patients who may be struggling with language in figuring out the process or filling out forms. She may be found in a corner of the room during a doctor's consultation with an English-speaking patient or, sometimes, she will be holding a patient's hand. The doctor is in charge and speaks to the patient directly while the health agent is there for support when clarification is needed…Our agent visits long-term care facilities where English-speaking seniors are living in a French milieu to do health checks. Often care in this setting is improved with cultural brokering. The resistant or seemingly irrational behaviour of a senior, for example, is better understood by staff when their

> *language and background is explained by our agent. For many of our seniors, the navigation assistance and accompaniment of our health agent makes the difference between pursuing treatment or not. For example, we had a senior who was having trouble with her eyes. She was diagnosed with cataracts but completely refused treatment. With delay, surgery is much more difficult and left untreated cataracts lead to impaired vision and even blindness. Still, her anxiety surrounding surgery and aftercare, her distrust of health professionals and inability to comprehend her situation added up to refusing to access services. With the offer of accompaniment by our health agent she was persuaded to get surgery. In so many cases like this, our health agent makes a big difference in the quality of life of English speakers. It might be a young Cree mother and newborn, or a youth who needs mental health services – so much depends on getting through the door to services.*

Both Sullivan and Chevrier underline the improvement their community liaison work has brought to the encounter between English-speaking patients and health professionals and staff. The reduced anxiety and improved trust is a positive outcome for all involved. With experience, the health professional is less defensive and less wary of communication errors and the patient is calmer knowing they have some control. In terms of next steps, they would like to expand the role to better meet the needs across their region.

Interview Summary

Improvements: Despite differences in their circumstances, there are many strong points of agreement among the community liaison workers interviewed. When asked to comment on the improvements they observe due to their liaison role (see question 6 and 7 of Appendix 1), they unanimously selected "improved comfort and reduced stress" not only for patients and families but also for health professionals as the #1 improvement among others. The capacity of those who occupy the community liaison role – whether as an organization, a team or an individual - to be agents of change[16] not only in the engagement of marginal community users with health professionals and staff but also at the level of system planning and policy was also echoed by all interviewees.

Challenges: With respect to challenges, the interview participants agree that there are medical situations where language continues to be a barrier to access, and where their liaison services are not well-received. "There are floors of the hospital that will not permit our accompaniment". Overcoming language barriers in the area of mental health services is a pressing but complicated matter for all. So, too, liaison workers attest to the overburdening of their role. They refer to "phones open for client calls 24/7" and being forced to "cut their seven-day work week back to five days." The demand for their support as intermediaries outweighs the time and energy of available manpower.

[16] Schaaf *et al.*, 2020 discuss the bridging role of community health workers in terms of a continuum which characterizes their work as social change agents effecting change in the health system and other determinants of health as an advanced position.

Conclusion

Upon examination, the experience of NPI networks and their community liaison model offers important insights for both policy and practice in efforts to improve health equity, reduce linguistic and cultural barriers for marginal populations as well as improve their status vis-à-vis key social determinants of health. In terms of official language minority communities in Canada and comparable nations, the example of linguistic and cultural adaptation in the case of the Quebec's English-speaking communities offers a valuable contribution to the study of community development strategies in the health sector.

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Appendix 1

Interview Questions

Community Liaison Worker in Health and Social Services

The CHSSN model for the role of community liaison among their NPI network includes several aspects including information, referral, navigation, accompaniment and brokering. The following questions are a guideline for exploring community liaison work in your region.

1.What type of liaison services does your organization provide the English-speaking community to help them access health and social services?

2. In your opinion, what are the top three liaison activities in highest demand from the English-speaking community in your region?

3.What client groups in the English-speaking community served by the liaison role in your region use this resource most frequently? (Elderly, recently immigrated, single parents, health professionals, specific health issues such as cancer, perinatal care or mental health challenges etc.)

4. How does the community and your health partners learn about the community liaison services offered by the NPI in your region?

5.In your opinion, what are the greatest challenges your organization faces in implementing the liaison role in your region? (Role clarity, recruitment and training, valuing of liaison, funding, trust, etc.)

6.What types of improvement do you observe for patients/caregivers resulting from the community liaison role? Examples are welcome.

- Improved access to health care services for patients.
- Improved comfort and reduced stress for patients/families/caregivers.
- Improvement in system information for patients.
- Improvement in health literacy for patients/caregivers.
- Improved information and advice between health staff/professionals and patient/caregiver.
- Improved quality of life and well-being of caregivers.
- Improvement in advocacy and empowerment for community members.
- Other

7.What types of improvement are observed for health professionals and partners resulting from the liaison role? Examples are welcome.

- Improved compliance with treatment prescribed by professional. (Less delay, improved continuity of care etc.).
- Reduction of ER visits.
- Improvement in information/communication between health professionals and partners and patient/caregiver.
- Improvement in cultural competence by health professionals/staff.
- Improved patient satisfaction.
- Improved community representation/input on health governance structures.
- Other

8.In your experience, in what medical situation(s) are liaison services most effective in reducing language barriers.

- Reception at hospital
- Doctor's office
- CLSC clinic
- Online appointments
- Testing
- Overnight hospital stays
- Hospital recovery at home
- Homecare
- Other

9.What future development of the liaison services offered by your organization would you recommend?

10. Final comments____