Expectations and Needs of Socially Disadvantaged Patients for Navigational Support of Primary Health Care Services

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Abstract

Background: Primary healthcare is the main entry to the health care system for most of the population, even for specialized care. In 2014, it was estimated that about 25% of the population in Quebec (Canada) did not have a regular primary healthcare provider. In 2017, after the introduction of a centralized waiting list to enroll unattached patients with a family doctor, nearly 540,000 patients, many of whom were socially disadvantaged, remained on the list. Socially disadvantaged patients often have more health problems, more complex care needs, and more difficult to accommodate life situations (e.g. two or more jobs, no work accommodation, care responsibilities, low income, lack of social network). They can also lack the skills needed to navigate a constantly evolving and complex healthcare system and, consequently, misuse the system. To overcome this problem, a partnership of health system managers, family physician leaders, community agents, and researchers designed, implemented, and evaluated a navigational support initiative. This study aimed to describe and understand the expectations and needs of socially disadvantaged patients towards navigational support interventions to improve their access to healthcare.

Methods: A descriptive qualitative study rooted in an international multi-site participatory study (IMPACT) was conducted with socially disadvantaged patients. Semi-structured individual face-to-face and telephone interviews were conducted with patients recruited at universal public primary health care clinics in Montérégie, some of whom received the evaluated navigational service. A thematic analysis was performed using NVivo 11 software.

Results: Sixteen patients living in socially deprived contexts were recruited. Three main expectations of patients for navigational support were identified: communication expectations (support to understand providers and to be understood by them, provision of communication tips, and help to improve communication between providers); relational expectations (emotional or psychosocial support); and pragmatic expectations (information on available community resources, information about the clinic, tips and tools for medical appointments, and physical support to navigate the health care system).

Conclusions: Our study contributes to the literature by identifying the many expectations socially disadvantaged patients have related to navigational services. This information can be used for navigational intervention design.

Background

Accessibility to primary healthcare

Primary health care (PHC) is the main entry to the healthcare system for most of the population, even for specialized care. In Canada, approximately 15% of the population report not having a regular primary care provider, with rates ranging from 25% in Québec⁽¹⁾. To address this important concern, seven provinces in Canada have implemented centralized waiting lists for unattached patients in primary healthcare⁽²⁾.

In Québec, nearly 540,000 patients are on a centralized waiting list for a family physician, and many of them are socioeconomically disadvantaged^(1, 2). Socially disadvantaged patients often have more, or more complex, health care needs than the average patient. They are also more likely to require health services from different professionals and organizations (e.g. specialists). This can cause them to have difficulty navigating the complex and constantly evolving healthcare system^(3–5).

To overcome this problem, a navigational support initiative was set up in Montérégie (Quebec). In the context of this initiative, the research team incorporated qualitative research to explore the expectations towards navigational support of socially disadvantaged patients who had been placed on the centralized waiting list. This paper reports findings from this short qualitative study, which we combined with a light review of the literature on navigational services.

Navigational services

Interventions involving a navigational service, defined as the assessment and alleviation of barriers to adequate health care by a trained lay person⁽⁶⁾, appear promising to improve access to PHC for various vulnerable sub-population groups, such as socially disadvantaged patients⁽⁷⁾, and to reduce socioeconomic disparities in healthcare⁽⁶⁾. Studies have shown that navigational services improve family physician affiliation for low-income and underserved homeless patients⁽⁸⁾, contribute to reduced emergency room use by disadvantaged patients⁽⁹⁾ and associated costs⁽¹⁰⁾, and facilitate the work of primary care teams by establishing better communication between the patient and the medical team⁽⁹⁾. Socially disadvantaged patients have had positive experiences with navigational services related to the emotional support received⁽⁶⁾ as well as to the presence, availability, and competence of the person providing the service^(6, 10).

Our literature review revealed two categories of navigational services. First, there are services that provide pragmatic support to patients, i.e. by assisting them with referrals to support groups and counselling services; with transportation^(11, 12); by providing information on existing resources^(6, 13, 14); by helping with appointment planning^(11, 12, 14, 15); with filling out documents⁽¹⁶⁾; and finally by increasing care coordination⁽¹⁶⁾. The second category of navigational services includes all services that help patients on a relational or interpersonal level. Helping with decision-making⁽¹⁶⁾; supporting follow-up care⁽¹⁰⁾; and providing emotional support by responding to emotional distress, listening supportively, and providing comfort^(6, 15) are in this category. Both types of service are delivered by various practitioners with or without professional and/or clinical expertise (e.g. nurses, social workers, health educators, community health workers, medical assistants, or volunteers)⁽¹⁰⁾.

Although the number of studies on navigational interventions or services increases every year, the literature suggests that most studies focus on outcomes. We have confirmed these findings with three to four different investigators. The number of studies on patients' perceptions of navigational services is

very limited, and the number on expectations is even lower. In addition, little is known about which type of patient navigation model is best suited for particular situations^(17, 18), indicating a need for studies that explore patient expectations and rely on participatory research or co-design approaches.

A better understanding of the expectations of socially disadvantaged patients could help decision-makers design, implement, and improve PHC navigation programs⁽¹⁰⁾. The purpose of our study was to describe and better understand the needs and expectations of these patients regarding a navigational service.

Context of the study

A PHC navigational intervention was implemented in Quebec as part of an international participatory research program aimed at developing interventions to improve access to PHC services for disadvantaged populations (IMPACT: Innovative Models Promoting Access to Care Transformation)^(19–21).

In Quebec, the research took place in the region of Montérégie, the second most populous region of the province, which has a population of 1.5 million. A local partnership composed of clinicians, managers, researchers, and policy makers was created to design, implement, and evaluate a navigational support intervention to address the access needs of socially disadvantaged patients. The goal of the intervention was to enhance the likelihood of establishing an enduring relationship with the new clinic by providing them with navigational tips and information.

In the participating clinics that offered a structured navigational support intervention, the intervention, titled “Service Accueil Patient” (*Patient Welcome Service*), consisted of recruiting and training lay volunteers to connect by phone with patients who had recently been enrolled with a family doctor through the centralized waiting list. The coordinator of the service was provided with a list of all patients that had been on the centralized waiting list and were now being enrolled at one of the four clinics. All patients who were contacted were also invited to take part in the study whether they benefited from the service or not. The trained lay volunteers contacted patients before their first appointment with the doctor to help identify their social and health needs, to prepare them for their first appointment, to provide information about the health care clinic and community resources, and to provide support for follow-up and health care referrals.

Methods

Study design

The study used a descriptive qualitative approach with semi-structured interviews of patients to describe and understand the expectations and needs of socially disadvantaged patients towards the navigational support intervention. We also relied on some quantitative findings collected using a phone administered survey. Our study took place between January 2017 and August 2018 in five PHC clinics (family medicine

groups) in Montérégie: four clinics offered a structured navigational intervention provided by a trained lay volunteer, whereas the fifth clinic did not offer any formal navigational support intervention.

Participant recruitment

We used a mixed sampling strategy (selection by criteria, purposeful sampling, and snowballing). We recruited both patients who had received the navigational service and patients who had not. We made this choice because it allowed for triangulation of data as well as enrichment of our findings regarding expectations of patients toward the navigational service that would prove useful to inform the design of future studies or navigational services. We sought to reach variation primarily in terms of patients' experience of access (i.e. types of difficulty encountered) and degree of social vulnerability, and their background in terms of gender and age. To be eligible, patients had to meet at least one criterion for material social disadvantage (material disadvantage: low education, unemployed, low income; social disadvantage: single; separated/divorced/widowed, single parent families)⁽²²⁾ and be at least 18 years old. Patients with severe mental disorders or who did not speak French or English were excluded. Patients not receiving the navigational service were recruited in person the clinic physician, or the social worker as those who did receive the service were recruited over the phone by the senior research assistant.

Data collection

Steps were taken to ensure that participants provided free and informed consent, with each participant signing a consent form agreeing to participate and for the interview to be audio-recorded before the start of each interview⁽²³⁾. Semi-structured individual interviews were conducted by telephone or at the clinic, at the convenience of the participants. Each participant received either financial compensation or a \$15 gift card. The interviews, which ranged in length from 25 to 60 minutes, were conducted by trained qualitative female assistants (one senior qualitative PhD researcher, with a special interest in access to healthcare services for the vulnerable and one master student, trained by the senior qualitative research assistant;). There were three interview schedules in total: one for patients who would not receive the structured navigation service; one at baseline for patients who would receive the service; and one for the same patients at follow-up after they received the service. The semi-structured interview guides were developed by a team of qualitative researchers and based on a literature review of primary care access issues, social vulnerability, and navigational services. All schedules included questions related to access to health care and services, expectations for navigational support in general, health care and service needs, and suggestions to improve the navigational support intervention (for patients who received it). This project was approved by the Research Ethics Committee of St. Mary's Research Centre.

Table 1
Sociodemographic characteristics of participants (n = 16)

General		
	n	%
Sex		
Female	9	56%
Male	7	44%
Age		
Average (sd)	49.4(13.8)	
Minimum/median/maximum	23/46/78	
Race/ethnicity		
Caucasian	15	94%
Black/ African-American	1	6%
Main language		
French	14	88%
Other	2	12%
Country of birth		
Canada	13	81%
Outside of Canada	3	19%
Insurance		
Public	13	81%
Public and private	3	19%
Length of time with family physician		
1 to 6 months	8	50%
7 to 12 months	4	25%
13 to 18 months	0	0%
19 to 24 months	4	25%
Civil status		
Single	5	31%

General		
In a couple/married	10	63%
Separated/divorced/widowed	0	0%
Unknown	1	6%
Family status		
Single	5	31%
Non-single parent family	11	69%
Schooling		
≤ Secondary 4 (10th grade)	5	31%
Secondary 5 completed (11th grade)	5	31%
University	6	38%
Employment		
Employed	7	44%
Unemployed	6	37%
Not available	3	19%
Number of chronic diseases		
0 to 2	13	81%
3 to 5	3	19%
> 5	0	0%
Total	16	100%

Data analysis

We used a thematic analysis method based on two categories of navigational services (pragmatic support and navigational services) identified in the literature review with a semi-open (deductive and inductive) and iterative approach to analyze our data⁽²⁴⁾. We used NVivo 11 software⁽²⁵⁾ to code and support analyses of the interview transcripts. An initial list of codes was established by the research team according to the two main categories of navigational service generated—pragmatic and relational support and four team members were involved in the final coding.

Results

Sixteen patients (n = 9 who received the navigational support intervention and n = 7 who did not receive the navigational support intervention) were interviewed. Nine participants had low incomes (less than \$24,000), and five had not obtained a high school diploma. More than half of the participants reported living with at least one chronic disease (see Table 1).

Participant expectations of navigational services in relation to needs

(results of thematic analysis, see Table 2)

Table 2.
Results of thematic analysis

Participant expectations of navigational services in relation to needs	Communication expectations related to needs	<i>Expectations in terms of understanding providers</i>
		<i>Expectations in terms of making oneself understood or heard by providers</i>
		<i>Communicating better; being accompanied</i>
		<i>Providing communication tips</i>
		<i>Communication between providers</i>
	Relational expectations and needs	<i>Emotional or psychosocial support</i>
		<i>Emotional support through physical accompaniment</i>
	Pragmatic expectations and needs	<i>Community resources</i>
		<i>Being informed about the clinic (e.g. policies, resources, or providers)</i>
		<i>Pragmatic tips and tools for medical appointments</i>
		<i>Physical support</i>
Absence of navigational expectations or needs	Navigation is appreciated but unhelpful	

Communication expectations related to needs

Communication expectations emerged in relation to the needs or desires of patients to improve communication with their doctor as well as with other health care providers. We identified the following

sub-themes: a) expectations to understand providers; b) expectations to succeed in expressing oneself or making oneself heard; c) tips to express oneself to providers; and d) communication between providers.

Expectations in terms of understanding providers

Communication expectations regarding navigational support were related to the difficulties experienced by our participants in understanding doctors, in particular the medical information or instructions they give patients:

“The guide person could also help me by asking health questions for me when I communicate with health professionals, especially doctors, and I don’t understand what they’re saying.” (the patient was a 36-year-old woman – PSI 06).

Expectations in terms of making oneself understood or heard by providers

Participants expected the medical consultation space to support or facilitate good communication and self-expression. They also expected the navigational service’s support to help them improve their communication with providers, notably their communication skills (e.g. how to prepare and how to express themselves or make particular demands, such as wanting doctors to ask more questions):

“(…) service could also help me explain my symptoms and talk.” (This patient has a university degree). PI 03

Communicating better; being accompanied

Some participants described feeling the need or the desire to be accompanied to medical consultations to help them explain their health problems or concerns (e.g. find the right words) or to advocate on the patients’ behalf (i.e. by making it easier for them to be heard and/or believed), especially because it was not always possible for them to be accompanied by an acquaintance:

“(…) I would like this person to know my needs (…) when I don’t feel comfortable asking questions about certain situations, that this person be there to do it for me.” PSI 01

Providing communication tips

Participants thought that a patient navigator could help patients by discussing their health appointment with them in advance and by providing other communication tips, including how to prepare questions or express one’s perceived needs or health situation, in advance:

“Yes. It helped me to prepare [for the first appointment]. I remembering using the pamphlet I received; I wrote down my questions.” PI 06

Participants who received the structured navigational support intervention expressed feelings of appreciation toward the communication support they received as part of the intervention. Participants

appreciated and found it helpful to prepare questions in advance and write down tips given by the volunteer. For example, the volunteer had participants write down all relevant questions to ask the doctor during the medical visit. Participants mentioned that this was appreciated, especially because they had not thought about doing this and also because it allowed them to think of their questions ahead of time and formulate them clearly. Consequently, they felt prepared and ready during the consultation, as expressed by this participant:

"She asked me to write down all the questions I thought I might ask the doctor. That's what I did beforehand, because I had questions to ask (...) So, I wrote down my questions on a sheet of paper, then I asked them (...) yes, because I hadn't thought to write down what I could talk about it with regards to my health (...)." PI 06

Communication between providers

Some participant specifically expressed an expectation that the navigator be a person to whom they could turn to receive information, including information from their health file, or that the navigator be a person who would facilitate the transmission of the information between health professionals and patients. This was seen as particularly helpful in cases when doctors were not available, easily accessible, or when consultation times were perceived as too short:

"I would like for us to talk together about all my concerns, all my problems, and for her to put together her file and go see my family doctor to explain it better. (...) they didn't evaluate me well, they are in a hurry (...) maybe because they have to see other people." PSI 02

Relational expectations and needs

Relational expectations relate to the expectations or needs of patients related to emotional support or psychological needs. We found that some participants expressed needs or expectations for the navigational service to provide emotional relief, a space to debrief after health appointments, or even to help advocate on patients' behalf.

Emotional or psychosocial support

Some participants expressed feeling stressed or anxious facing their health problems or because of the lack of clarity regarding their status in receiving health care and that a patient navigator could be a source of emotional or psychosocial support:

"(...) the volunteer (...) called me to tell me which doctor I had and on the day of my first appointment, it took a lot of stress out of me." PI 04

Alternatively, this person could support them when receiving bad news. As expressed by one participant:

"(...) I would like that person to be able to provide some emotional support when I get bad medical news, to support me." PSI 06

At least one participant also expressed an expectation that the person providing support be unrelated to the doctor, perhaps a lay person:

"(...) it could be someone I feel comfortable with. I would like it to be a person separate from the doctor."
PSI 01

As one of these quotes indicate, emotional support could take the form of simply being given information about the status of their request, i.e. being enrolled in a PHC clinic and having a regular family doctor. For this participant and others, not knowing how much longer it would be before they were enrolled with a family doctor was a source of anxiety and feelings of "restlessness". In such cases, a call from the volunteer navigator alleviated negative emotions and brought comfort and reassurance:

"The phone call came to me as a relief; I no longer knew where to look to find a family doctor. I was in the dark. So, I was quite pleased to receive that phone call; it took away some of the pressure and the stress of finding a family doctor." PI 04

Emotional support through physical accompaniment

A few participants linked emotional support to the desire or need to be physically accompanied to their appointments. In such cases, participants justified this need by explaining that they need to be reassured when they go to see a specialist.

"The guide would also be useful for me, for example when I have to go to see a specialist, I need someone (...) neutral to provide reassurance." PSI 04

Pragmatic expectations and needs

The most important expectation expressed by participants was that they would receive information on the availability and location of available resources, such as community resources. This was expressed by all participants who had not received the formal intervention, which included both women and men.

Community resources

Some participants who had health problems reported the importance of the navigator in advising them where to go for health and community care and services (e.g. specialists).

"(...) a person who (...) informs me about health services as well as about social services to go to for my health problem. For example, how to get a specialist (...). if the guide had been there, they would have been useful for me in this situation to give me the information (...)" PSI 04

Participants who received the structured navigational support intervention appreciated receiving pragmatic information from the navigator about resources available at the clinic or in the community.

"I appreciated the volunteer's assistance (...) she gave me (...) the leaflet containing information for any future problems." PI 08

In other cases, participants expressed a need for resources they could access that were compatible with their ability to pay or to reach (i.e. work accommodation issues):

"The volunteer who called me (...) She also sent me (...) the numbers of community organizations that I could contact if I needed them." PI 07

Being informed about the clinic (e.g. policies, resources, or providers)

Some participants expressed a need to receive information about the clinic's policies or usual procedures, such as which ones were currently seeing patients and what services they offered. Some patients would appreciate receiving information or knowledge about the clinic's on-site services:

"(...) for her to look for resources close to home for my needs (...) I would like this person to tell me which clinics have more availability (...) I don't know the clinics (...) I like that the guide helps me find my way through the health care system." PSI 01

Some participants also appreciated receiving information on how to book or cancel an appointment at the medical clinic where their family doctor was located because it gave them better knowledge on how to access the clinic's services, or to receive other practical information such as hours of operation:

"(...) then also to find out what to do if I want to cancel an appointment or make an emergency appointment. And also to call the clinic if I want to get an appointment." PI 06

Other patients reported needing or expecting the navigational service to provide information about the doctor:

"It would be good to receive more information about the doctor." PI 09

Pragmatic tips and tools for medical appointments

Many participants who received the structured intervention appreciated the pragmatic aspect of preparing for the medical consultation. This appreciation was expressed equally by men and women participants. For example, participants expressed that they appreciated having a reminder list of the documents they needed to bring to the consultation, such as their health insurance card and lists of drugs and health problems; or about how such tools and tips were useful because they acted as reminders of what to bring, what to ask, and what to do following the appointment (e.g. instructions or referral procedures):

"I appreciated the volunteer's guidance for the first visit with the doctor, how to prepare, what to bring, the health problems to discuss. I appreciated it because f (...)when I arrived at the family doctor's office (...) I knew what to say to them (...)." PI 08

“the call with the volunteer went well (...) yes, it helped me a lot, the information that (...) the volunteer gave me during the call, such as to bring all my health documents (...) She told me not to forget my health insurance card, my medication list. She told me what not to forget.” PI 01

Physical support

As with the other expectations, we observed that participants expressed their expectations in terms of their needs for physical support. Some participants, especially women and women living alone, would like a navigator to help them get around by accompanying them through the health system. This was mainly expressed by participants who had not received the navigational support intervention. One participant explained that their health problems, such as low blood pressure, sometimes prevented them from travelling on their own, and others, explained they weakened by their health problems so they desired mobility support:

“(...) I would need a guide (...) to accompany me to help me get around for example, when I’ve had low blood pressure drops, I’ve stepped on the sidewalk and then fallen down, the guide could help me with getting around.” PSI 04

“(...) I have difficulty getting around because. I weakened by my health problems (...) I would like them to accompany me in the health network (...).” PSI 06

Absence of navigational expectations or needs

In addition to the expectations described above, participants who received the structured navigational service had additional perspectives and expectations about navigational services that would be essential points to consider in the design or quality improvement of navigational services. The sub-theme “navigational service is appreciated but ineffective to meet patients’ actual needs” is what emerged most strongly.

Navigation is appreciated but unhelpful

Among participants who received the structured intervention, some expressed nuanced views on the usefulness and helpfulness of the service. Although almost all explicitly stated at least once during the interview that they thought the intervention was valuable, a significant number indicated that they did not benefit from or need the service. Some of these participants indicated that they were resourceful and autonomous or that their abilities to access care were adequate or not altered by the intervention. Others explained that they continued to do what they used to do to access the information they need, such as using the internet or the yellow pages:

“Yes, the information was useful, but I don’t really see how I can put any of this into practice. I only count on having a doctor. But yes, the volunteer was nice to her... I don’t consider that it changed how I access care”. PI 05

Discussion

This study allowed for the identification and understanding of the expectations of disadvantaged patients in Montérégie (Québec, Canada) regarding navigational support interventions or services for PHC services.

Our thematic analysis identified three main expectations indicated by disadvantaged patients: communication expectations (assistance in asking questions and explaining health problems), relational expectations (emotional support and informational continuity of care), and pragmatic expectations (information on resources and assistance in moving around the health care system). These themes are consistent with the roles and definitions of patient navigators found in the literature, such as the nine characteristics identified by Kelly et al.⁽¹⁰⁾: 1) advocacy; 2) care coordination (including transitions, discharge, and rehabilitation); 3) case monitoring and patient needs assessment; 4) community engagement; 5) education (including self-management and empowerment); 6) administration and research activities; 7) psychosocial support; 8) navigation of services (including referrals); and 9) reduction of barriers.

Regarding communication expectations, our findings indicated that patients expect patient navigators to help them communicate more easily and meaningfully with providers. Preparation for medical appointments, which sometimes included “rehearsals” with the navigator, was perceived as helpful to patients. This result is consistent with several previous studies that showed a positive relationship between navigational services and communication between the patient and the medical team^(11, 26, 27). Our results also confirm those of other authors that communication support is a navigational service appreciated by patients^(11, 26, 27).

Regarding emotional expectations, our findings indicated that participants were, at times, overwhelmed when attempting to access care and that their emotions could impede their abilities to access care. Similarly, expectations of bad news were possible impediments to their ability to access care, i.e. to communicate with health care providers. Thus, participants expressed expectations that the patient navigator would be able to provide emotional support and, perhaps, to advocate on their behalf, at emotional or psychological levels, to health care professionals. This is consistent with previous studies of participants’ expectations of navigational services⁽⁶⁾ and studies that identified emotional support as the most highly appreciated benefit by patients^(17, 28, 29).

Regarding pragmatic expectations, participants in our study expected the navigational services to help them obtain information about available resources, including where to go for care and how to make an appointment, services provided by the clinic, and specific resources tailored to patients’ realities, and support the flow of communication. The navigator acts as a bridge between the health system and the biopsychosocial needs of patients, particularly those who are disadvantaged. This is consistent with previous studies that found participants’ expectations of navigation service were associated with

assistance around informational needs and problem solving, such as how to arrange appointments and where to go for tests^(6, 11).

Finally, our findings also reveal important nuances of participants toward the usefulness of the services. For example, among the group who received the structured navigation services, some indicated that the intervention did not change how they approached health care access or improve their abilities. This was noted even among participants who indicated appreciating their interaction with the volunteers, feeling that the volunteer had been nice to them, or that the tips given were useful and appreciated. This concurs with previous findings, such as those of Ploeg et al.⁽⁹⁾, who found that, although some patients appreciate a navigational service, they ultimately did not find it resulted in any change in their lives.

Strengths And Limitations

Our study reflects the experience of a relatively small number of patients (n = 16). Nevertheless, we consider the sample size to be appropriate given our methodology. Indeed, we achieved a depth and complexity of data that would have been difficult to obtain through quantitative research⁽³⁰⁾. However, we advise caution in generalizing our results. Our sample includes patients living in a particular social context and receiving services from Quebec's public health care system, whose organization differs from that of other countries in several fundamental aspects. Our methods were also designed to ask questions specifically pertaining to the conceptual construct of access to care used in the larger study⁽³¹⁾ as well as the specificities of the situation of our participants, i.e. who had been on a centralized wait list to receive a family doctor and had been assigned to one. In addition, memory bias is a limitation of this study. Some participants may have had difficulty remembering the details of their expectations of the navigational service by the end of the intervention, especially if they had cognitive difficulties due to their health status. Finally, this study may have been affected by social desirability bias. As the interviewers necessarily mentioned at the time of the interview that the study was conducted in collaboration with the medical clinics where the family physicians of the interviewed patients were located, participants may have wanted to be perceived positively. Consequently, they may have been more sensitive to the subject matter of the study and may have deliberately omitted negative expectations or criticisms of navigational interventions or services in general.

Conclusion

Using a descriptive qualitative research approach, we identified patients' expectations of structured navigational services and captured the experiences of socially disadvantaged participants who received such an intervention. We found that disadvantaged patients had specific expectations and needs regarding navigation services and that they considered structured navigational services offered by trained lay-volunteers to be both feasible and acceptable. Preparation for medical consultations and information on available resources were key components of a useful and effective navigational service for socially disadvantaged patients. Our study provides relevant and useful findings and guidance that can inform

PHC providers and health care systems to design and implement navigational services for similar populations. Further studies are needed to explore the problems faced by disadvantaged patients receiving navigational services and how navigational services could be enhanced through co-design approaches with patients from this sub-population group.

Abbreviations

IMPACT: Innovative Models Promoting Access to Care Transformation

PHC: Primary healthcare

Declarations

Ethics approval and consent to participate

This project was approved by the Research Ethics Committee of the St. Mary's Hospital Research Centre de l'Université McGill, Montreal, Canada (ref. number SMHC-13-30B). Informed consent has been given by participants prior to the interview, whether written when the interview was taking place face-to-face or orally and recorded (electronically or audio) when the interview was done over the phone; the consent form has been approved by the same Research Ethics Committee.

Consent for publication

Not applicable

Availability of data and materials

The data that support the findings of this study are not publicly available due to them containing individual-level information that could compromise patients' privacy, all in respect to the ethical approval

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

CSNBP conceived the study and all authors participated in its design. CSNBP, MB and CL drafted the article. AAPP and ED commented on and helped revise the article. All authors read and approved the final manuscript.

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