Additional Data: Table 2: Summary of jobs roles relationships

	JOB	ROLE: PURPOSE				ROLE: FUNCTION		RELATIONSHIPS		
		Context & Jurisdiction	Client characteristics	Primary Focus	Theoretical model	Mobility/ Intensity	Actions (from taxonomy)	Professional Identify	Client and/or Whānau	Inter-disciplinary	Intersectoral
1	Whānau Ora Navigator	Whānau Ora is implemented through Ministry of Health (MOH), Te Puni Kōkiri, Ministry of Social Development (MSD) Three commissioning agencies: Whānau Ora Commissioning Agency (WOCA) for the North Island; Te Pūtahitanga o Te Waipounamu for the South Island and Pasifika Futures for Pacific clients. Each agency pays whānau ora navigators who work in Māori and/or Pacific providers who have clear community links and local areas of focus/concern	Clients and their whānau who are experiencing health and social challenges and lack a sense of control over their lives	Coming alongside whānau to help them get more control over their lives by identifying immediate needs, developing a plan based on whānau aspirations and reducing barriers in access to health and social services	Strengths based & Intensive	High mobility and high intensity	Engagement: 'Walk alongside' philosophy; culturally appropriate engagement, holistic wellbeing focus for all family and active building of connections between whānau members and beyond whānau, long term engagement Planning: whānau led and whānau driven aspirational goal setting Education, training and skills development: training in Māori values using mana enhancing focus; draws on whakapapa to create sense of identify and historical connection between past, present and future, expects reciprocity from whānau in creating opportunities for other members to contribute Emotional and motivational support: highly engaged and wrap around support	Cultural knowledge, shared community connections, shared lived experiences and shared values contribute to strong sense of role identity as whānau ora navigators within host organisation	Very engaged and fully committed so often deeply valued by whānau who credit them as 'lifesaving 'at times	Shared values with host organisation often mean sense of shared kaupapa (basis for action) but this can be unfamiliar to pakeha from different disciplines	Navigators often need to mentor whānau to be able to connect with intersectoral providers including government organisations so that whānau can engage with them on their own in future
2	Kai Manaaki (KM)	Employed by large Māori Primary Health Organisation (PHO) (National	Māori or Pacific clients often living in socially deprived	To provide wrap around support and walk	Combined model with strength based, intensive	High mobile and moderate intensity with 1-3	Engagement: extended engagement with culturally close person with strong cultural and interpersonal skills,	Similar to above where cultural community and interpersonal knowledge valued	Walk along side, understanding, whānau centred,	Work closely with other members GP practice	Interaction with other sectors (e.g. Work and Income NZ)

https://www.nzdoctor.co.nz/article/undoctored/living-wage-protect-whanau-ora-navigator-workforce 100 Whānau Ora Navigator roles in 38 different host agencies in the South Island managed through Te Pūtahitanga o Te Waipounamu (South Island Whānau Ora Commissioning Agency)

		Hauora Coalition-NHC):KM positioned in General Practices (GP) connected with this PHO	areas with poorly controlled diabetes so blood sugar levels that are too high	alongside client to help them take control of diabetes and address wider socio-economic determinants that impact on their health	and clinical features	visits and then regular follow ups; and group support	Holistic Assessment: detailed assessment Planning: Decision making support for lifestyle related changes (specific diabetes related-needs and broader goals to support engagement in health and social changes Coordination: navigation with health and social services to support health and wellbeing, case consultation with wide GP team. Monitoring: review	but in this programme KM also feel as though they are a key significant contributor in their own right to health care team	supportive, advocate	team, connect with NHC Hub	that impact on finances or other relevant issues
3	Māori Cancer Coordinator (MCC)	Pilot roles initially funded through midcentral DHB for Māori Organisations-largely rural	Māori and their whānau who have been diagnosed with cancer and are receiving lengthy and demanding treatment	Work across sectors with clients across continuum to make journey easier for Māori and their whānau	Cultural whānau ora model of relational navigation; strength based/intensive	Very mobile, very intensive	Engagement: culturally responsive and MCC may have lived experience Assessments: identification of needs Planning: facilitation of client and whānau planning and long term supports Emotional and motivational support; very significant Education: health literacy building, Coordination: navigating through system Facilitation: may also provide practical support like driving Other: NB: MCC are also requested by hospital to provide cultural duties above and beyond like karakia, and managing the body of the deceased	Likely background in whānau ora navigation, community health worker and /or lived experience	Very high level engagement, become like family and this continues after the client has passed, trusted, share their own resources (including financial)	Mixed relationship at times, somewhat misunder-stood but also called upon provide cultural services in hospitals; very complex coordina-tion so demanding role with cancer services	Likely draw of full range of personal community connections as underfunding means limited and non-sustainable resources
4	Pacific Navigator	Usually urban and based in either Auckland or Wellington, often employed by Pacific health	Pacific immigrants often from Samoa or Tonga, limited health literacy	Enabling clients to understand the system, the language	Cultural specific approach:	Highly mobile and possibly highly intensive	Engagement: through culturally appropriate communication Holistic assessment evaluation of needs	Member cultural community seems most significant identity; many don't have a clinical	Holistic wrap around service that considers al dimensions of health; whānau-centred	Shared values within host organisation can support professional	Often have strong intersectoral relationships with government

		provider with strong community links, may receive funding through Whānau Ora commissioning (Pasifika Futures) or other streams	and access barriers to health and social care services	those who work in it, how to access the system and advocating and building health literacy. Key purpose is to remove barriers to care			Navigating: linking with networks (organisations, individuals, professionals) Facilitating: may involve accompanying client to appointments interpreting, translating and explaining medical procedures and organisation appointments	background but may have worked as a community health worker but are valued for their cultural health language and community connections		integration within organisation	and non-government organisations including food banks, schools and housing related non-profit groups
5	Partnership Community Worker (PCW)	PCW is a unique role in Christchurch developed by large PHO (Pegasus) to meet needs 'underserved' populations	Clients are those who have difficulty accessing health care including Māori, Pacific, immigrant groups but also those with homelessness and range health and social issues	To provide a bridge and practical support for people having difficulty accessing the services by working to reduce barriers to access	Intensive	Highly mobile and can be highly intensive	Engagement: listening ear Emotional and motivational support: feeling understood Holistic assessment: identification of barriers Planning: some collaborative planning Coordination: advocating and facilitating by providing assistance via transport, advising on eligibility, navigating by linking services	Navigation role to reduce barriers, and build capability: links to community valued	Described as warm listening ear, who acts as a bridge between the client and services; PCW intentionally build positive relationships; providing support for transport significant part of their role	PCW is located within different host organisation historically has met with practice nurses to enhance access to primary health care	Due to co-location within host organisation has strong links with this organisation and community organisations related to the host
6	Case Manager (Private Insurance)	Clients hold private health insurance usually regarding income protection- in case of disability clients receive recompense as stipulated by their contract; case manager aims to minimise length on time receiving pay-outs to support return to employment	Clients have some form of health problem limiting them from working so are making a claim (often after being declined from ACC)	Primary focus is on determining eligibility and calculations for minimal risk to private company from lengthy time of pay-outs	Brokerage model with focus on reducing costs to company-	Low mobile; low intensity	Engagement: acceptance of referral if deemed eligible so may need clarify if anything was not disclosed and needs to be investigated Assessment: usually refer to specialist to assess needs such as neuropsychologists, GP, surgeons, employers Planning: identify likely length of time of work off work Coordination: navigating and linking into referrals, Monitoring: progress on	Few have rehabilitation focus so no other identity other than case manager	Collaborative relationship is expected; but presumably difficult to have therapeutic relationship	Receiving reports and advice from range of people – both internal including medical specialist and providers and external specialists	Work with IRD and employers regarding return to work

							readiness to return to work				
7	ACC Recovery Coordinator	Government provider of insurance, support for clients recovering from accidents; ACC seeks to fund services to help return to work and independent functioning; closely linked ACC legislation	Clients with a wide range of ages who have had an injury from an accident with primarily physical symptoms; some are recent injuries and others are decades old	To support clients in their recovery journey and fund services that support rehabilita-tion needed to return to indepen-dence or work	Primarily brokerage model (focuses on needs evaluation, referral to services, and oversight of care coordina-tion) but can involve some clinical features that tailor services and provide therapeutic input	Low mobile; usually over phone or text; low-medium intensity	Engagement: seeks establish partnerships with lots of careful listening. Holistic Assessment: gathers notes, background information, refers to health care professionals (HCP) for other assessments Planning: supports client planning and works with HCP Coordination: links with providers who are delivering. Education: Does not provide education or skills development but refers to specialist providers to deliver care.	No clear professional identity; new title and role after ACC restructure. significant amount of inhouse training and regular supervision provided	Organisation promotes people before process but tension at times as need to check people not taking advantage of system	Has large network of support within ACC to guide practice, Works with providers e.g. Physio or OT and GP	Suppliers of equipment
8	ACC Recovery Partner	Government provider of insurance; ACC aims to support clients in recovery and fund services to help return to work and independent functioning; closely linked ACC legislation	Clients with a wide range of ages who have had an injury from an accident that has led to moderate to severe injuries with high and complex needs and multiple stakeholders	For these clients the primary focus is on ensuring they have a good quality of life, supporting access to places they need to go, appropriate equipment for needs and support to be meaning-fully engaged with their community	Clinical	Varies depending on stage; can be intensive with 3-4x week during discharge planning stage from facility and less frequent once systems set up unless issues develop	Engagement: acceptance of referral is determined centrally, engagement initially is with next of kin, and health care team during rehabilitation stay and client as they become more able to participate. Assessment: no formal assessment but listening to their point of view.; referral to HCP and specialists for assessment, gather information to pass onto assessors; outcome assessment by HCP Planning: discuss with client different steps, likely support needs, managing expectations of return to home	Previously known as serious injury case managers and still refer to this title often	Key support role for next of kin especially when having difficulties with support carers	Significant inter-disciplinary relation-ships across multiple organisation	Work closely with large range of sectors including DHB, rehabilitation schooling, and justice systems

							Emotional and motivational support: often provides place to support processing anger and loss and reframing Advising: ways to access funding Coordination: Managing assessments, case consultation with schools Review plan and feedback and monitoring. Not advocacy				
9	Practice Nurse Case Manager	Primary Health Care role, usually working in GP practices who may be part of a Primary Health Organisation (PHO) who are using Care Plus funding to meet needs clients with long-term conditions	People with multiple long-term conditions (complex health needs) enrolled in GP practice/PHO and are struggling to manage their condition	Employed in GP practice to provide clinical support for clients with long term conditions that have been selected for case manageme nt	Clinical	low mobile and low intensity	Engagement developed through face-to-face conversations or over the phone; Planning: no evidence; Education regarding self-management and training and skills development, Emotional and motivational support-some. Coordination: In practices where funding available then can provide coordination between different health care services, and facilitate lines of communication between client and providers, Monitoring: limited	Nurse who uses case management processes for selected clients	Minimal home visits so contact mainly during face to face clinic visits	Connects with members of GP Practice team (GP, Health Coach, HIP, Community Support Worker) and services such as pharmacists and DHB staff – such as gerontologis ts, mental health teams and other specialists	Links with residential care, Age Concern, Home Support Services, ambulance and transport hospice
10 **11**	Behavioural Support: Health Improvement Practitioner (HIP) & Health Coach (also known as Wellbeing Team)	Funded through Mental Health funding but located in GP Practice via PHO contracts. Broad remit to add value to primary health care provision and reduce mental health	Clients of GP practice who present with any condition or age as a presenting problem, but who need lifestyle change to improve mental or	Client centred focus where onus on client to return and implement plan. Both HIP and Health coaches aim to provide	Informed by Primary Care Behavioural Health (PCBH) Model (Reiter, 2018) Distinctive features include	Roles (especially HIP) promoted as single session, but clients can see either member of 'Wellbeing Team' as often as	Engagement: strong partnership model with client driven and client-initiated focus; engagement between different team members facilitated by warm handover from other members health team. Assessment: Contextual assessment with specific	HIP- Registered health care practitioner with experience in mental health (often OT).; Health coaching worked as CSW; may have cultural knowledge and /or community knowledge	Service provided by wellbeing team focuses strongly on client's needs, goals and readiness to engage. Service structured to ensure service is accessible	Strong team focus between HIP and Health Coach within GP practice. HIP liaises closely with GP. Health Coach	Health Coach connects with relevant community organisations and cultural or spiritual support

		demands at population level	physical health. Many clients experience anxiety, or need lifestyle change or have long term conditions or interpersonal communication issues including parenting	behavioural support for health and wellbeing changes	warm handover, same day service, open door, no follow up, brief session focusing 'what's on top?', no wrong referrals	wish too Health Coach is very mobile in community and clinic; HIP appears primarily based in clinic.	outcome measures (Duke Profile, Hua Oranga) Planning: focuses on next steps so immediate Education, training and skills Focus on literacy and self-management skills (especially health coach) Emotional and motivational support: Key role Coordination: can provide support for client to navigates health and social services and provide feedback to practice team		and timely, often same day	works closely with Practice Nurse. HIP may liaise with secondary mental health services	
12	Needs Assessment Service Coordinator (NASC)	Different commissioning models for people who are 65 years or older as funding 'devolved' to DBH who purchase services from NGO providers; For those who are under 65 years old the MOH purchase home based support services directly; Structured role with standardised assessment process (InterRAI) tightly linked to funding options	Older adults or people with disability referred NASC after hospital discharge or self-family-GP referral if unmet needs	Aim support people at home by offering specific DHB funded services to avoid clients requiring institutional care	Brokerage model; needs based focus; goal maximise/ enable indepen-dence	Highly mobile but often only one face to face visit, so low intensity	Engagement: Yes Assessment: facilitated needs assessment using InterRAI; Planning for task-related supports and allocation of resources within fixed budget motivational and emotional support significant amount provided Education, training, skills development nil co-ordination does not include direct delivery but does work with providers to coordinate care	Registered Health Professional usually social worker	Individually focused, minimal engagement whānau; therapeutic helping relationships although minimal relational continuity	Strong relationship with Geriatrician, GP's and Practice nurses teams, client lawyers	Relationships with MSD/ Landlords; Residential facilities and day programmes, Home based Care providers, MOH Community Card Providers Spiritual and Cultural support
13	Local Area Coordinator (LAC)	This 2011 MOH initiative has been trialled in 4 sites; adapted from similar overseas programmes, an LAC is embedded	People with disabilities (often lifelong) who are seeking to become more independent	Connecting people with disabilities to community resources that can	Strengths based	Mobile and varying but could be intense in early stages; visit at home but	Engagement is essential and maybe complicated by hearing and other communication impairments Assessments: no formal assessments but	LAC's credibility seems based on quantity and quality of community connections	Works closely with client and their whānau who may often need to adjust how they	Minimal engagement with HCP and broader focus on informal	Connections with wide range of industry, education, and other community-

		in a community, provides a support person and direct and responsive funding people with disability.	from their family	help them achieve meaningful goals that enhance societal participa-tion		also take the client to community settings	discussion-based evaluation of needs, gaps, and strengths Planning Collaborative conversations including brainstorming and vision building; identification of small steps; support for relational/communication skills development; Emotional and motivational support- significant Coordination occasional advising but only minor coordination; some reviewing of goal attainment		interact with their child	community connections	based services;
14	Kaituhuno (Connector)	Enabling Good Lives (EGL) initiative now under Ministry of Disabled People; 4 pilot programmes – driven by disabled individuals	Often young adults with disabilities seeking more independence and societal participation	Strengths-based	EGL movement which is strengths-based approach and values lived experience; emancipa-tory focus	Very mobile and intensity varies; encourages self-responsi-bility of clients to manage care decisions and funding	Engagement: Lived experience considered to facilitate engagement, Assessment: holistic process using self-assessment and EGL principles; Planning with vision building and next steps: Training and skills development: intentional skills development with community resources; Emotional and motivational support: significant emotional support, advising from own experience; minimal coordination (either by client/family or systems team)	Lived experience is prioritised for these roles	An ally without conflicts of interest to avoid interfering with goals /preference of clients	Minimal if any relation-ships to other HCP	Role draws on personal community connections
15	Care Manager Older Adults	Community Located, DHB funded, managed by NGO usually	Community dwelling older adults who are at risk of becoming dependent and requiring institutional care	Maintaining client in their own home and ensuring both client remains safe and has	Clinical model that may have a capability enhancing aspect if applying restorative focus	Mobile and usually meets own home; low intensity with 1-2 sessions for assessments and then 3-	Engagement: high Assessment: may include comprehensive (holistic) assessment Planning: goal planning and develop shared care plans Coordination: between home-based health care	Primary identity often nurse or social worker	Trusting, supportive relationship with client; some clients may have next of kin who are geographical distant, or	Range of relation-ships with community services such as GP, pharmacist, NASC colleagues,	Key relationships include Housing NZ; police, welfare, age concern and fire and emergency

				opportunity to regain functional reserve		6 monthly reviews	services and other health and social service providers, engaging with multidisciplinary team Monitoring: multiple follow up		neighbours who are close. Role may involve protecting caregivers, encouraging shared care planning conversations	and community DHB providers.	
16	Cancer Nurse Coordinator	Works in each DBH across tertiary, secondary and primary care to coordinate cancer services	Recently diagnosed with cancer, particularly physically and emotionally vulnerable, need to access complex system	Provide care coordina-tion, psycho-social support and information support to help navigate all stages care	Advanced clinical role	Appears focused on hospital setting with less engagement with primary care; intensity may depend on regularity of hospital-based treatments	Engagement: acceptance referral if meet complexity criteria, Assessment: gathering information and listening Emotional and motivational support: significant Education: significant Coordination through navigating, facilitating, advocating, case consultation Feedback: to others involved in providing care	Advanced nurse specialist	Main point of call for client and whānau	Liaises with hospital based providers variety of disciplines; links with primary settings less established	Minimal
17	Case Loading Midwives	Midwives work in a distinctive context- before, during and after birth. As Lead Maternity Caregivers they have distinct legal requirements for care. An emancipatory philosophy influences their practice in NZ.	Clients who are pregnant choose their own midwife who provides continuity of care for them. (¾ NZ women select a midwife for care)	To ensure birth as 'normal' as possible, optimal clinical outcomes for mum, baby and whānau and work in partnership that also involves advocacy as needed	Clinical/ Intensive/ Strengths-based; strong focus on partnership, and a holistic view of health and wellbeing, and emanci-patory ethos	Very mobile and very intensive visiting women in their own homes for specific time frames; for those with complex social issues it can also be particularly intensive if additional assistance is needed/pro vided	Engagement: High Assessment: ongoing assessment of wellbeing of mother and baby Emotional and motivational support: High Education and training: High including training in breastfeeding or other mothering roles, education about health and wellbeing and Coordination: coordinating scans, hospital or other birthing situations, and other health related issues for mother or baby	Strong professional identify as midwife with associated emancipatory philosophy	Partnership and emancipatory approach and include whānau in this	Needs to work closely with fellow midwives to manage 24 hour care; connects secondary care like scan/blood tests and tertiary care birthing providers such as hospital midwives and obstetrician s; birthing suites;	Depending on social situation may feel need to be involved in social organisations if directly affecting care

18	Mental Health Workers	These workers are highly mobile and intensive often in people homes and community settings; they need to consider range legislation including mental health legislation, court-imposed legality and child protection orders	Clients have a diagnosed mental health condition but likely have physical and addiction issues; seeking make gains in health and wellbeing and reduce dependence on health care services	Supportive and proactive therapeutic relationship providing motiva-tional and emotional support to regain satisfying lives	Strengths based and intensive approaches that may also draw on holistic cultural models	Highly mobile and can be very intensive but tailored to stage of client recovery	Both community support workers (CSW) and registered health professionals are involved with planning and organising care but CSW have a smaller percentage of time and less complex clients to coordinate. Significant amount of emotional and motivational support required	Distinction between regulated and non-regulated; if regulated as OT or SW likely carry dual identity and practice both roles	Client centred and capability enhancing approach; variable engagement with whānau	Works closely with mental health clinicians from DHB, and clients GP	Budgeting, multiple community providers, WINZ, Oranga Tamariki, Police/Family Harm, Suicide pre/post vention ; Cultural court for local iwi

HEALTH NAVIGATORS

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