From Hospital to Home: A Qualitative Analysis of Community Health Navigators in Chronic and Complex Care Transitions

Jacqueline Ramirez[1] Sharon Parker[1] Carole Bandiera[2] Parisa Aslani[2] Anthony Brown[3] Fiona Doolan-Noble[4] Sara Javanparast[5] Fiona Haigh[1] Regina Osten[6] Sarah Wright[1] Ben Harris-Roxas[7] Debra Donnelly[8] Mark Harris[1]

UNSW International Centre for Future Health Systems

Context

- Three Community Health Navigators (CHNs).
- Located in Aged Care and Rehabilitation outreach and funded by Sydney Local Health District.
- Targeting patients ≥ 40yrs with chronic conditions discharged from hospital and speaking English, Arabic, Cantonese, Mandarin, Greek or Italian.

Description of Navigators

CHN role

To improve the transition from acute care to home through linkage to general practitioners (GPs), other health, social and community supports.

"…because they can ensure that that link happens…" H6

Recruitment and Training

- A certificate or higher in community care or aged care (healthcare assistant) and/or experience in a relevant field
- Speaking a community language advantageous
- Twelve self-paced online training modules and face-to-face/ online discussion sessions with researchers

CHN intervention

- Contact patient for home visit within 72 hours of discharge.
- Home visit to review recommendations on discharge summary and GP or pharmacy follow up.
- Assess level of self-management and carer/other supports.
- Review health appointments and issues of access, assess need for additional supports and facilitate referral for these.
- Assess social situation/environment and identify risks and possible solutions.
- Receive supervision and support by members of the healthcare team.
- Needs based follow up by telephone or home visit.
- Arrange transport, educational resources; attend appointments.
- Link with and coordinate appropriate service providers.
- Referral to other services or discharge to most appropriate follow up.

Methods

- Twenty semi-structured telephone/MS Teams interviews [12 patients, 5 Health Care Professionals (HCPs), 3 CHNs].
- Interpretive thematic analysis to explore the perceptions of patients, HCPs, and CHNs about the support provided by CHNs, and to determine what factors supported or impeded the role in this setting.

Successes and Challenges

Value to healthcare team

- Benefit for patient management
- Allows clinicians to focus on social and clinical aspects of patient care

Value for CHNs

- Positive about their role and role diversity
- Supportive supervision/Team leader

Value to patients

- Positive patient satisfaction and experience of care
- High levels of rapport building and emotional support
- Information (services & discharge report), practical support and advocacy

"…A lot of health services, they haven't heard of. So for example, My Aged Care…" C2

"It made it different because it stressed as of the beginning, it stressed out what is in the discharge paper and what are the steps to take…" P12

Challenges

- Low levels of familiarity with 'CHN' terminology overall
- Some health system constraints including lack of patient information, difficulty contacting patients and service wait times
- Issues of integration:
  - Clarity of role definition and scope of practice
  - Tension around professional boundaries
  - Different levels of healthcare team exposure to the CHN role
  - CHN knowledge/training and language skills
  - Administrative changes during implementation and need for structured supervision

What have we learnt?

- CHNs provide a 'safety net' for transitioning patients that is timely, appreciated and generally well accepted.
- Integration within a complex clinical care setting requires time, organisational commitment, and policy and guidelines to clarify role scope, address the interface with other professional healthcare roles and establish appropriate supervision.
- Improved role awareness and promotion in health services and the community generally is required.

[1]International Centre for Future Health Systems, University of NSW [2]Sydney Pharmacy School, The University of Sydney [3]Health Consumers NSW [4]Goldfields University Department of Rural Health, Curtin University [5]College of Nursing and Health Sciences, Flinders University [6]NSW Agency for Clinical Innovation [7]School of Population Health, University of NSW [8]Aged Health, Rehabilitation and Chronic Care, Sydney Local Health District

Reference: Parker SM et al., (2024) doi: 10.1136/bmjopen-2023-077877
Funding: NHMRC

More information: m.f.harris@unsw.edu.au