Community Health Navigators (CHNs) Extending Care into the Community (CHECC)

Collaborators

Sydney Local Health District,
Central and Easter Sydney Primary Health Network,
Agency for Clinical Innovation,
Health Consumers NSW,
Sydney University, Swinburne University, Flinders University
University of Otago, University of Ottowa, Maastricht University

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Reasons to conduct this study

❖Increasing number of people experiencing chronic and complex conditions and co-morbidities

❖Increasing need for navigation support in complex and fragmented health and social care systems

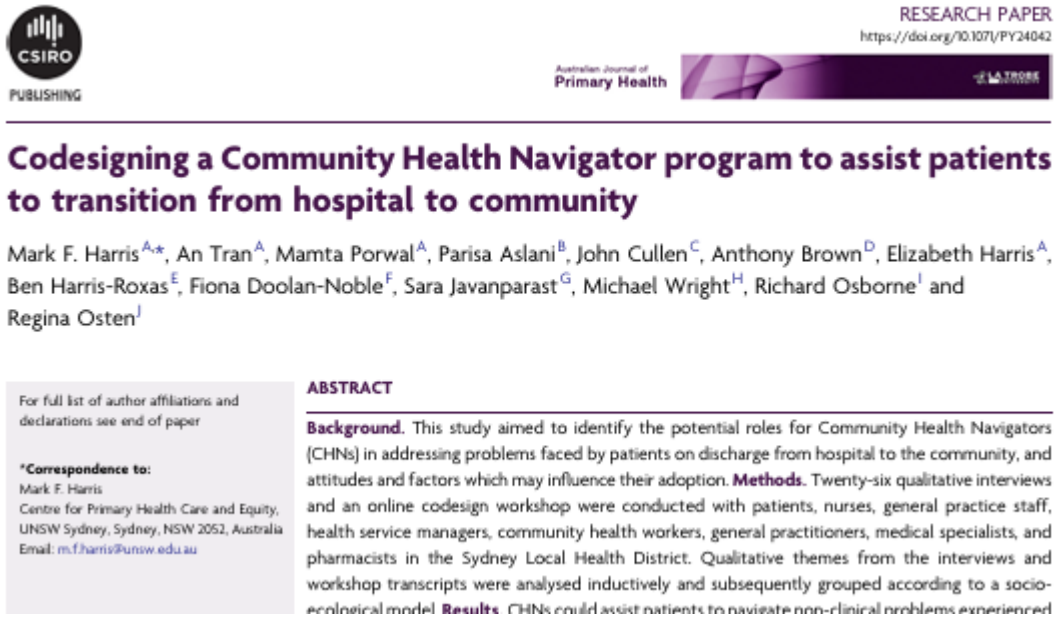
❖Evidence that roles such as community health workers/navigators can:

- Improve the experience of patients when interacting with these systems
- Improve equitable access for underserved populations
- Achieve measurable improvements in chronic disease management (e.g diabetes, cardiovascular health)
- Reduce hospital admissions and ED presentations

CHECC Study Design

Phase 1 – Co-design

Identify potential roles for Community Health Navigators (published)



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Codesigning a Community Health Navigator program to assist patients to transition from hospital to community

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ABSTRACT

Background. This study aimed to identify the potential roles for Community Health Navigators (CHNs) in addressing problems faced by patients on discharge from hospital to the community, and attitudes and factors which may influence their adoption. **Methods.** Twenty-six qualitative interviews and an online codesign workshop were conducted with patients, nurses, general practice staff, health service managers, community health workers, general practitioners, medical specialists, and pharmacists in the Sydney Local Health District. Qualitative themes from the interviews and workshop transcripts were analysed inductively and subsequently grouped according to a socio-ecological model. **Results.** CHNs could assist patients to navigate non-clinical problems experienced

Phase 2 – Randomised controlled trial (nearing completion)

- Identification of patients 40ys and over with chronic conditions on discharge from 4 hospitals in SLHD
- Randomisation to the CHN intervention or usual care
- Follow up of intervention and control patients at 6 months post randomisation

CHECC Community Health Navigators (CHNs)

3 CHN positions – based in a Community Outreach Team SLHD

Qualifications:

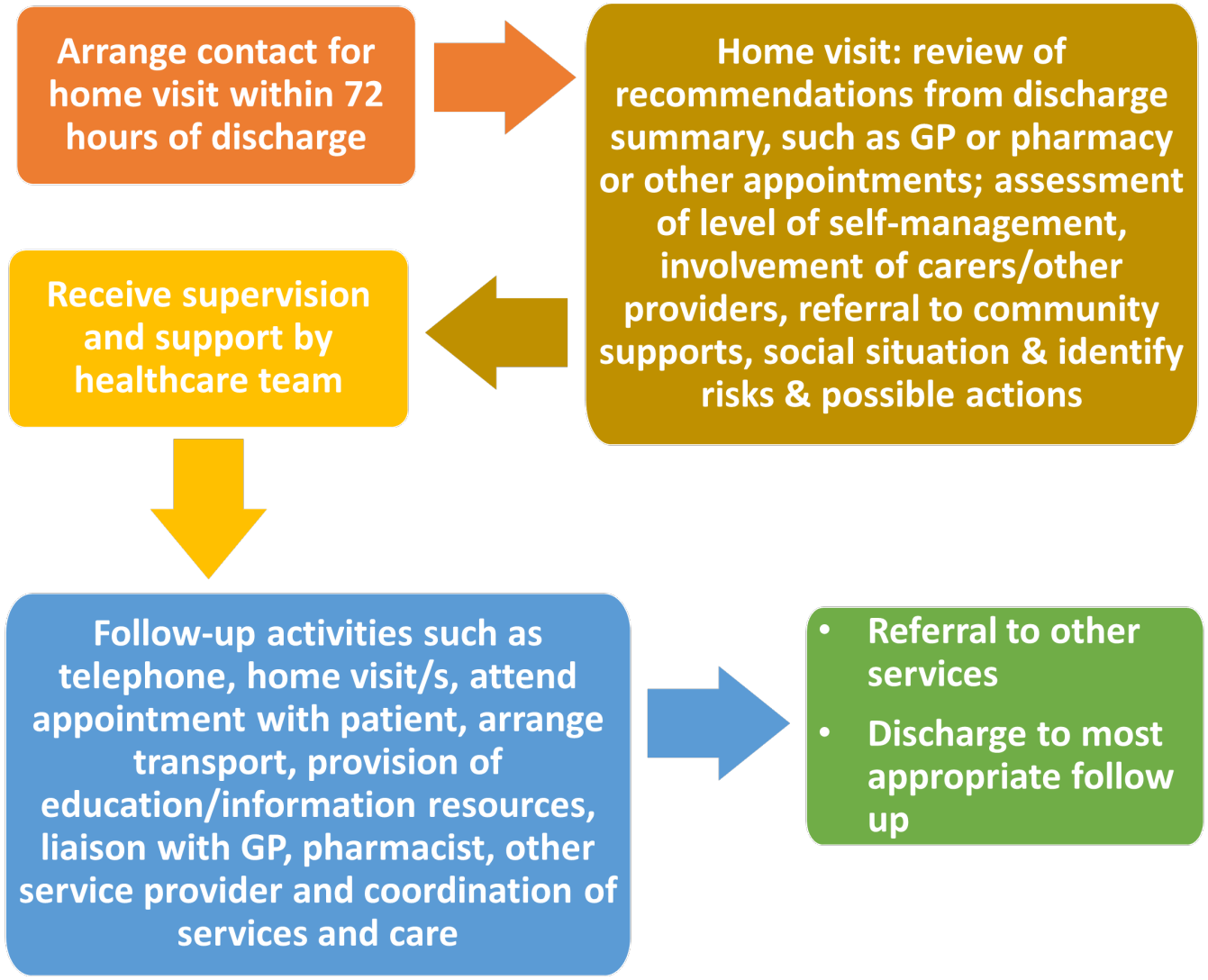
- AIN/Certificate III in Community Care or Aged Care (Health Care Assistant) and/or experience providing care to people living with chronic disease/frailty
- Speaking a community language advantageous

Training:

- 12 on-line training modules to prepare for the role
- SLHD training program for staff

CHN Intervention

- Build knowledge/ foster rapport
- Assess individual patient needs
- Use resources within SLHD to link patients to health, social and community supports
- Supervision and support provided through the team leader and the healthcare team



Qualitative Study

Method:

- Semi-structured interviews with prompts to promote discussion
- Interpretive thematic analysis (Braun and Clarke 2023)

Patient sample:

- Patients approached for I/V 2-3 weeks after CHN intervention
- Age range 64-91yrs
- All spoke English at home
- 10/12 born in Australia

Participant	Number interviewed	Included in the analysis
Community Health Navigators	3 (including 1 who left the role)	3 CHNs
Health Care Professionals	6	5 Health Care Professionals (1 withdrew their interview)
Patients	14	12 (1 withdrew; 1 excluded due to poor recall)
Total	**23**	**20**

Key Themes

1. Navigating CHN integration into a multidisciplinary hospital outreach setting

Broad support for the role
Challenges integrating the role
Establishing ‘fit for purpose’ supervision

2. Contribution of the CHN Service to support the needs of patients post hospitalisation

Services provided
Rapport building and emotional support
Patient satisfaction

3. Enhancing the CHN service

Better awareness
Service experiences/restraints

Supporting aspects of the intervention

Value to patients:

- Moral and emotional support/ Interception at the hospital discharge timepoint
- Information and advocacy
- Positive experience of care/satisfaction

Value to healthcare team:

- Better patient management/efficiency
- Allowed clinicians to work at ‘top of scope’
- CHN traits: knowledge, commitment to helping people

Value for CHNs:

- Positive about their role
- Supportive supervision/team leader

Challenging aspects of the intervention

- General lack of familiarity with ‘Community health navigator’ term
- Unclear role definition/ tension around professional boundaries
- Different levels of healthcare team exposure to CHN
- CHN knowledge and language skills regarding healthcare and procedures
- Administrative changes during implementation
- Wait times/availability of services navigated to

In conclusion……

- CHNs provided a valuable ‘safety net’ for patients transitioning home from hospital.

- Integrating a CHN role within a complex clinical care setting requires time, organisational commitment, and policy and guidelines to clarify role scope and address the interface with professional healthcare roles.

- Role awareness and promotion is required, as is dedicated supervision to support team cohesion.