Summary of discussion:

Mark: We've been working on community health workers and navigators over the past decade, in Sydney. There still are some research challenges. Those challenges, I don't believe, are about overall effectiveness, but there are specific questions that we need to answer, or at least provide clearer evidence on:

- Just how can community health navigators best play a role in improving health literacy and e-health literacy? There has been discussion about the role of the Internet and AI as replacements for human beings as navigators. I don't believe that's the case, particularly given that some of the most disadvantaged people have the least access to internet or AI and less capacity to use it wisely.
- How can community health navigators provide some glue to bridge the gap between the health services, the residential and community based aged care sector and the disability sector and the community sector more generally?
- Trish raised this morning about standardized measures to assess performance, and that's not without its challenges.
- What are the factors that influence the capacity to implement and sustain programs. So it's really all about particularly the challenges to implementation including how CHNs should be recruited, trained, supervised, and accepted, not just as part of the health workforce, not only by other health workers, but of course, by the community as well, and just how they can be integrated into health teams and sustainably funded.
- How do we develop career pathways for CHNs? There are lots of opportunities for development of CHN roles. And there's other opportunities, particularly as has been mentioned in aged care and NDIS, for example. But one of the challenges of all of this is to integrate it so that it provides potential career pathways across all these potential roles. We will only facilitate that if we start to integrate some of these initiatives and provide a more coherent approach.

Renee: The Care Finders project that Natalie Hansen mentioned helps the vulnerable aged to navigate the system. There are multicultural navigators, healthy aging hubs, integrated mental health hubs and other initiatives. CESPHN has nine different types of organizations delivering the aged care finders, and there's a mix of health, indigenous and community service providers. There are two organizations involved in the Multicultural Health Navigator services.

One of the key approaches in our commissioning cycles is, how do we design a model that fits both the community and the provider's needs. In evaluation we talk a lot about person related outcome measures and person related experience measures. There is because if the experience of consumers is excellent, but the providers aren't really happy, it's not sustainable. So, from an infrastructure and strategy perspective, PHNs have positioned themselves as honest brokers of these processes.

Mia:

One of the projects that I've been involved in with colleagues at UNSW, is looking at the role of navigators in integrated health and social systems, and how we can think about what those practices look like, and the effects that they have across systems. One of the challenges that this presents is, as soon as we start to expand the scope of what we talk about, then we also recognize that we need to be able to talk about effectiveness, even if it is purely in order to advocate for expanding services and funding. This becomes really challenging when you're working in multiple spaces, with different workforces, using different mechanisms for evaluation, which have different priorities.

We recently completed a review of international literature on this.
There's lots of labels that get used, but if we call them all navigators, and we can consider a patient who has a kind of constellation of needs that a navigator is supporting. There are some straightforward examples such as identifying appropriate places to access different care providers, being able to do things like facilitate transport, or thinking whether this person also needs someone to take care of their children while they access appointments? Do they need help navigating billing systems and insurance? Does this person need someone to walk with them to the police station to make a report about domestic violence so that they have the safety that they need to be able to care for themselves? There are many roles that have this label, the impacts may be different for people with different needs.
How do we look at a lot of the things that maybe don't come into the role description of a navigator, such as being that person who is mediating lots of power differentials, able to advocate for change, not just because they're passionate and have knowledge, but because they have a different status in a room with different people to the person they're advocating for. All this makes it challenging to Identify a skill set, develop a job description, and to train.

Tish: There is broad alignment of CHNs with policy and strategy across New South Wales and Commonwealth and increasing access, equitable health outcomes, efficient and effective use of resources, minimizing and mitigating preventable health conditions and adverse outcomes, both at a primary and secondary level, improving patient experience, meeting people where they're at. The humanity of health - the people both delivering and receiving health services are humans. Then at core, if we're not humane then, and I think community navigators and navigation is a lot about humanity. And this is embedded in policies: - Future Health, Closing the gap -the Aboriginal Health Plan, the disability inclusion plan, the first 2000 days, the LGBTIQ+, the youth strategy, suicide prevention, domestic violence etc. The concepts and intent of what we're trying to achieve through community health navigators is woven through the fabric of where New South Wales Health, and I think Health in Australia.

I sit in a lot of interagency spaces and within health spaces where you're trying think through the difficult problems of how do we make care better? And quite often, the answer is that we need navigators. But when people talk navigators, they're not actually very specific. It can be system navigation, eg My Aged Care and the NDIS. How do you how do we help people navigate a complex system? For that system, it can be about actually clinicians or the people engaging with the people coming together to navigate the complexity of supporting people with high needs eg through youth action meetings, through domestic violence action meetings. We do it in disability, where the complexity of the individual needs, requires clinicians or the key providers and the community workers to come together to sort their stuff out, so you're not having to try and sort it out at an individual level. And then we've got problems at a client and consumer level. And even in that, we often talk in different ways. We talked today about community strengthening and about building health literacy. We're also talking about individual navigation at different points in life. It might be disease specific, it might be and changed life point and so on.
I keep coming back to language because there's a need for us to be clear, because “navigator” is a is a broad umbrella, it's a universal term. If we want to embed and build into policy and strategy and go forward with funding, we need to be clearer about what problem we are trying to solve for whom, with what strategy, with what results, and with what outcomes. And that's tricky, because it varies, even for an individual. Perhaps there need to be hashtags that go with the word navigator to define how to fund for what service and with what model of care? One risk of being too broad is that the word “navigator”

could be replaced with “hubs”, or “place-based care”, because lots of people solving different problems are using the same words. Potentially, we end up with a plethora of navigation systems all trying to do different things for overlapping groups of people. And we then create a different version of duplication, of fragmentation.

What roles, training, support should community health navigators have? What should their role be in health equity?

Mark: Navigators are not a panacea for fragmented, disintegrated health and welfare systems. What they are all about is equity. There is strong evidence that the people who suffer most in our disintegrated, complex systems of health and welfare in Australia, are those who are disadvantaged, people from linguistically diverse backgrounds, Aboriginal and Torres, Strait Islander people and so on. Navigators are a critical tool for equity.
We have tended to create lots of little navigator roles in different areas, and partly that's in response to need, and is appropriate. But I think we now need to consider how we can bring that together. How can we have integrated recognized training that, may include different components for different settings, with different populations, different services, different needs, but where there's a basic base of core training, there's a basic core understanding of what the role is. For example, it's a non-clinical role, that it's about helping people to access information and services for their care, their health and well-being. This is true whether we're talking about aged care services or NDIS or specialist services within a hospital etc. This plethora of terms and roles is not unique to Australia. For example, in the US, they are also referred to as “promotores de salud”, lay health worker, outreach worker, peer health educator, and health advocate. However, although they have a lot of names, there’s a common understanding what they're about.

Renee: PHNs are organizations which could be commissioning navigators to be many different places, so there needs to be some sort of consistency in how we approach that. We need to know: what's the role, what's the responsibility, what's the scope of practice, and what's the skill set that you need? At least a rough mud map as to where to go. What's going to work in Canterbury is almost certainly not going to work in Wagga. Wagga. As a commissioner involved codesign, defining the role, the scope, the responsibilities almost ends up being a job description designed by the recipients of the care, which is not such a bad thing, but there needs to be some guidance whether from a workforce agency, or educational institutions. We need a mud-map so that when we commission navigation services we give some guidance that helps clarify role and responsibilities. Otherwise, as Tish alluded to, we'll end up creating additional silos.

Mia:
Defining language is carried over to credentialling and training. Clear language means that we can have conversations that are more precise and have clear meaning. Sometimes it is purely about the kind of authority that can be attached to a person and the access that gives them on behalf of other people. So there's different kinds of reasons for having a common language, having common training, having common credentials. There's a diversity of needs. Even within communities, there's very diverse needs. One of the implementation challenges is you really need to be able to have a very nuanced idea of what's happening before you can even think about how to translate it into a different context. There are plenty of examples of picking something up and plunking it down, and it doesn't have the effect that is expected.

This is an issue for training and credentials, and research that has been done in Australia and especially in other countries, such as the US, Canada and UK, In the US community health worker, is a title accepted by the Bureau of Statistics. But then we also see workers who have that title still in certain contexts, will call themselves something different because it is more acceptable or known to the person they're working with. That different word will have more meaning in that context. There needs to be a bit of flexibility there, even when the title exists behind the scenes.
There are important issues in training and credentialing - for example, some training models, such as classroom-based learning, are not accessible to everyone. One of the valuable things that navigators bring is lived experience, as a genuine form of expertise that needs to be recognized. We would not want to create a way of teaching and training that excludes some of the kinds of people who we really need in these roles. When we create these kinds of systems, and especially credentialing systems, we want to create pathways to recognize this kind of expertise in a way that isn't reinforcing the relegation of lived experience down the hierarchy of expertise.

From a policy perspective, what should we be aiming for in that time frame?

Tish: Mental health is working strongly on a peer workforce framework and that will come out relatively soon. The journey that they've been on has been over two decades - building the concept of peer workforce from a very marginalized one to a much stronger part of the workforce. Now teams will, if there's a funding opportunity, sometimes choose to employ a peer worker, rather than another discipline. It is backed with funding. Aboriginal Health is obviously the other big area. I think there are opportunities, as we go through the Scully reforms, and the national reforms that were referred to this morning.
The skill in these spaces is being able to articulate the case for CHNs in a way that makes sense to the policy makers: how they can help policy makers deliver the outcomes that they are trying to achieve. And then we can think about how to fund it. How do you build the narrative? How do you put yourself in the place that people are open to hearing about. It is important to define consistent core competencies while acknowledging that there are complexities.

Renee: There's been enough evidence out there. This is now a product that's embedded in the system. How do you best define and sell it to policy makers? A key thing is what measures of performance should be. It may involve transactional measures, process and impact measures, not really outcome measures, but you just got to package it and market it as best as possible. The risk is you design a product that is not tailored to everyone's needs. But if it meets 70 to 80% of the need and everyone who's delivering this tends to agree. But there's a trick to sell this, and it takes a bit of nuance as to how to market that with the policy makers that speaks to their needs

Mark: I agree that there is a body of research which supports this activity, and that we should be moving on to how to implement it. The challenge is how to do that in an integrated way. We implemented two separate co design phases in the development of both the GP project and the CHECC study following up people after hospitalisation. Although these involved different groups, they both identified a similar range of core roles and responsibilities and training needs. There are differences and we do need to tailor to these differences. But we also need to identify core skills and capabilities so that we can promote the CHN as a workforce. A key question for both the NSW and Victorian courses is: Where are those that we train going to work? Not everyone who went through the training got jobs or sustained employment.

We do need to have a clear idea about a a career path for these people, and that's one of the key tasks that we would like to discuss later. We also need to allow people to move across different settings and services. We need to recognize that peer workers can work in mental health or in post-acute care, if they've learned the same core set of navigation skills.

Questions and Answers

- There are many examples of CHN moving across different services, although they will need further training and education. But that applies to all health workers. It's just recognizing that this is a role that has some meaning, in which there's some prior learning and skill that is transferable from one setting to another. We don't have to start from scratch. We don't have to have separate workforces.
- There is tension between wanting to have people at that grass roots level that are really embedded in community, and also have them working on things that really address the needs of their community, being able to do things that are quite unique, that wouldn't be in anyone's job description, like this morning, we heard about going out and buying blankets for the family that's coming to stay. There are examples of both of these kind of things
- There are examples where we see people working in the communities. But those boundaries of time and space of where they are the navigator really start to erode. So we need to make sure that we have mechanisms in place to make sure that we are not creating people who are available to provide support 24/7,
- Navigators will not be replaced by AI? For vulnerable and disadvantaged groups,o ne of the roles of navigators is to help people to access and navigate the internet and AI.
- Credentialing can be a two edged sword. In the US they are worried about the risks of credentialing – especially for immigrants or refugees who may worry about being deported.