



Factors affecting implementation of Community Health Navigators (CHNs) for chronic and complex care patients discharged from hospital

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Setting

In the CHECC trial, CHNs were incorporated within a hospital outreach team in a local health district in Sydney. The team comprised multidisciplinary clinicians dedicated to follow-up care of patients post hospital discharge.

Role

The CHN role was essentially non-clinical. Three CHNs undertook on-line training and supervision within the workplace to provide practical support to patients recently discharged from hospital and transitioning from an acute care hospital to their homes (Table 1). Elements of the role included building rapport with clients and establishing a comprehensive understanding of any barriers they might face in accessing health, social and community supports and linking them with these supports. Role requirements were a background relevant to community or aged care services and speaking a community language was advantageous but not essential.

CHN intervention components

Contact →	CHN Home Visit →	Supervision →	Care Planning →	Navigation follow-up
Contact patient within 3 days of hospital discharge; discuss/offer a home visit	Review discharge summary recommendations, identify support needs, view home and social circumstances and facilitate referrals or service linkages	Ongoing support and supervision provided by the CHN/health service team	Develop an individualised patient care and follow-up plan with supervisory input	Follow-up via phone or additional home visit, including transport coordination, information provision, accompaniment to appointment, linkage with health and social care services, and coordination of provider appointments

Table 1

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

Methods

Qualitative interviews with HCPs (n= 5) and CHNs (n= 3) involved in implementation, and patients (n=12) with chronic and complex care conditions discharged from hospital explored their experiences of the CHN intervention (Ramirez et al., 2026). Thematic analysis was used to illustrate some of the facilitators and barriers identified in the trial related to implementation, the value of the role to support patient needs post-hospitalisation (Table 2), and to identify factors that would strengthen the role (Table 3).

Reference: Ramirez J et al., (2026) <https://doi.org/10.1186/s12913-026-14034-y>

Learnings about perceived Facilitators and Barriers to CHN Integration and Role

Theme	Findings
Operationalising Integration:	Belief about the relevance of the navigation role to support non-clinical patient management
Facilitators	- Checking on patients who might get missed - Linking patients with a general practitioner - Helping patients with paperwork "I guess that's where I see that role as being important ... because they can ensure that that link happens. ... if they've got a Webster pack that needs sorting and pharmacy stuff..." (HCP)
Barriers	- Lack of shared understanding about what Navigators do - Lack of opportunity for interprofessional collaboration - Need for formalised supervision structures and processes "....when does that role have to end, and be referred to a clinician?" (HCP)
Contributions of the CHN role to support patients:	- Patients were mostly satisfied with the service - Opportunity to re-review discharge summary recommendations - Practical assistance with linkage to My Aged Care - Provision of information about other health and social services - Reinforcement of recommended medication regimens - Reminders about appointments - Bridging communication between patient, pharmacist and general practitioner - Building rapport and providing emotional support post-discharge from hospital "...although I probably didn't need it as much as some other people might have needed [it]... knowing that if I did need it, [the CHN] was there...that's what I needed..." (Patient 9)
Implementation Barriers	- Mixed levels of awareness and understanding of the CHN role - Differences in levels of patient navigation need - System-level impediments affecting the availability of some services

Table 2 Opportunities to strengthen Integration and Sustainability of the CHN Role

Health services, patients, and consumers	External providers/services	Health services setting
- Promotion of and education about the role - Written information in multiple languages - Promotion of the value of non-clinical supports for consumers	Increased engagement to strengthen the CHN profile, role recognition, and awareness	- Increased clinician exposure to CHN work by co-location across sites - Policy and guidelines - Information about the role for new staff - More emphasis on sharing case reviews in MDT meetings to promote acceptance and learning - Dedicated supervision

Table 3

Reference: Ramirez J et al., (2026) <https://doi.org/10.1186/s12913-026-14034-y>

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