CHECC: Community Health Navigators on Discharge from Hospital

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UNSW SYDNEY

HEALTH CONSUMERS NSW

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

NSW GOVERNMENT Health
Sydney Local Health District

ACI Agency for Clinical Innovation

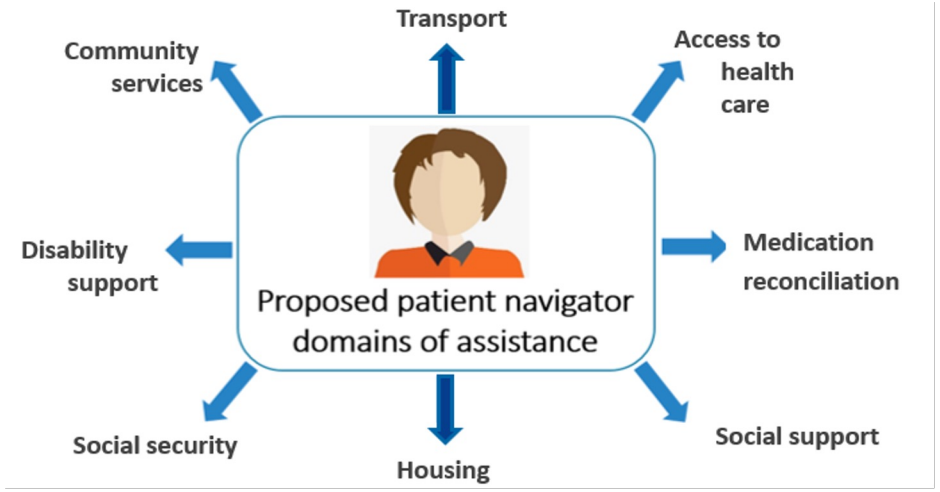
Collaborators

Professor Mark Harris, CPHCE
Prof Parisa Aslani (USyd)
A/Prof Jean-Frederic Levesque (ACI, CPHCE)
A/Prof Margo Barr (CPHCE)
Dr Anurag Sharma (SPH, UNSW)
A/Prof Ben Harris-Roxas (CPHCE)
Dr Michael Wright (CHERE, UTS)
Prof Richard Osborne (University of Swinburn)

Lou-Anne Blunden SLHD
Dr John Cullen SLHD
Deb Donnelly SLHD
Julie Finch SLHD
Nicola Swan SLHD
Nathalie Hansen CESPHN
Brendan Goodger CESPHN
Regina Osten, ACI
Dr Anthony Brown, HCNSW
A/Prof Fiona Haig HERDU/CPHCE
A/Prof Elizabeth Harris CPHCE
Dr Fiona Doolan Noble University of Otago NZ
Dr. Simone Dahrouge, (Ottawa, Canada),
Dr Sara Javanparast (Flinders University)
Dr. Pim Valentijn (Maastricht University, Netherlands)

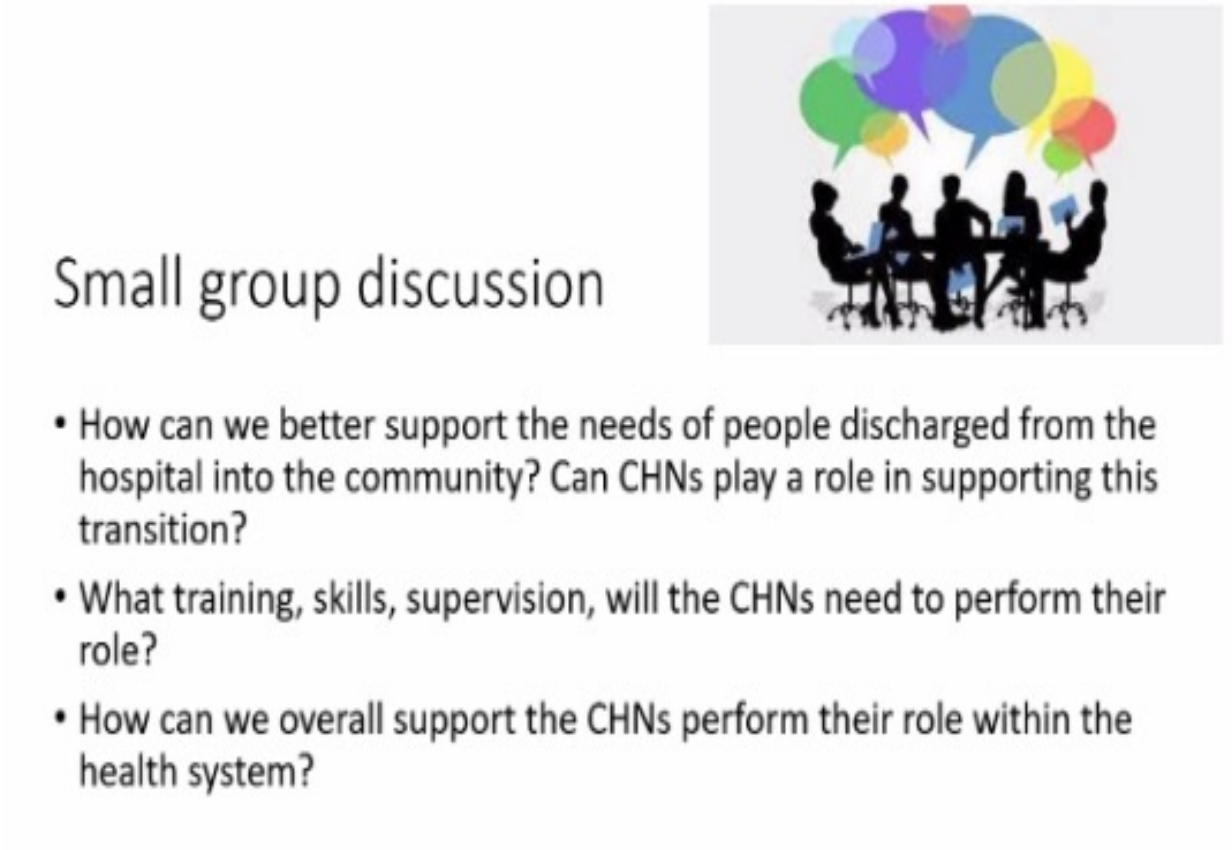
Aims

To develop, implement and evaluate the impact of a Community Health Navigator (CHN) delivered model of care supporting transition of care from hospital to community for patients who are aged or have chronic conditions on patient health and health service outcomes (including readmission).



Phase 1: Codesign (completed)

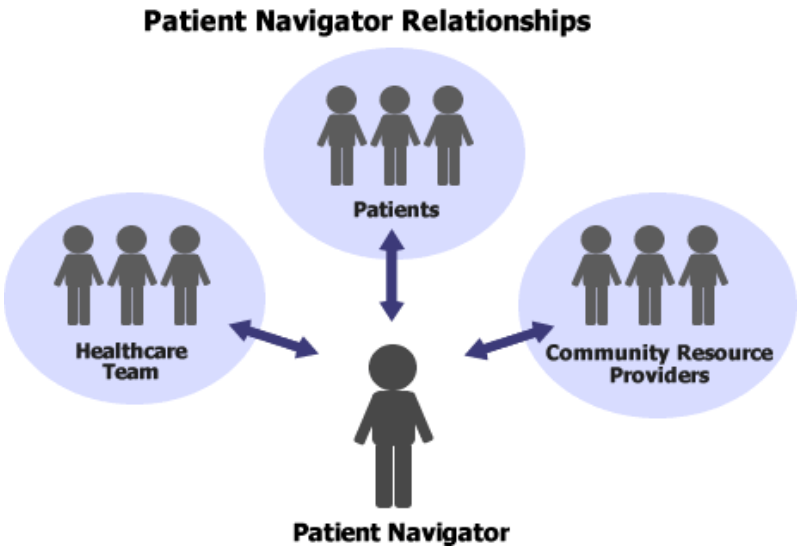
- 1:1 interviews (n=25)
- Online workshop (over 40 attendees) and 3 sub-group discussions
- Key SLHD staff from various faculties
- Qualitative analysis
- Publication being prepared



Training program

- Notes
- Presentations (video and slides)
- Quiz

1. Understanding the Australian Health Care System
2. Introduction to chronic disease
3. Preventive health care
4. Social determinants of Health
5. Community health navigators roles and responsibilities
6. Cultural mediation and language
7. Communication and self management
8. Community resources
9. Client needs assessment and problem identification
10. Professional responsibilities and boundaries
11. Medicines and medication adherence
12. Access to health care



Model of care

CHNs follow up patient on discharge from hospital.

1. Visit within 72 hours of discharge:
   - to build patient understanding and confidence
   - To identify problems in living environment including social isolation
   - Check medicines
   - Monitor self management

2. Action plan in consultation with SLHD Aged including:
   - ADL
   - Access to food
   - Housing
   - Changes to and access to medications
   - Visits to GP, FU with specialists, allied health
   - Language and cultural issues
   - Social support and isolation

3. Follow up visit within 2-4 weeks of first visit:
   - Review actions and monitor progress
   - Support self management using patient education materials
   - Communicate with patients GP pharmacist, allied health provider, community health services, aged and/or home care services and other health and/or social providers.

Additional 2-4 contacts as required

Evaluation: Trial Outcomes

- Hospital readmission
- Medication adherence (ARMS scale)
- Quality of Life (EQ_5D-$_5L$)
- Health Literacy (HLQ domains 4, 7 & 9: social support, navigating the health system, understanding health information)
- Patient Assessment of Chronic Illness Care (PACIC)
- Change in inpatient and ED use, GP services (MBS), Pharmaceuticals (PBS)
- Patient experience (BHI patient surveys)

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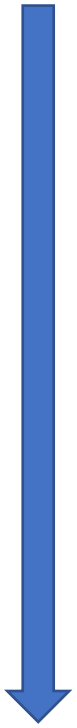
Phase 2: Randomised Controlled Trial



- Research Ethics and governance approval for 4 hospital sites
- Trial registration and data management plan
- Recruitment and on-boarding of CHNs.
- CHW training program and supervision plan
- Pilot and commencement of patient recruitment, randomisation, baseline data collection and intervention.