

## **6 Interim findings: review of other system navigator models**

### Key messages

- A number of system navigation models have been developed in aged care and other sectors in Australia and overseas. However, there are a number of factors that make it difficult to evaluate the relevance of these models to the Australian aged care setting. For example:
  - There is great diversity among existing system navigation models
  - There is no agreed definition of 'a system navigator', or clarity regarding the boundaries between system navigation and other types of support and service provision
  - There is little evidence of the impacts of system navigator services that is directly relevant to the aged care setting.

Despite this, through evaluation activities AHA has identified some key strengths and weaknesses (both theoretical and experiential) of the various existing models.

- Overall, stakeholders favoured professional navigation models, noting that peer models could be used alongside a professional navigator model to perform complementary functions or provide lower-level support to consumers.
- Face-to-face service delivery was considered vital in order to meet the needs and preferences of older people generally. Outreach was also considered essential to address the aged care sector's current lack of engagement with vulnerable population groups. Online support was deemed least appropriate, although stakeholders noted that this may change for future generations of aged care consumers.
- Financial navigation was considered an important offering, though stakeholders noted that the skill set required to provide this service may be considerably different to that required for aged care system navigation more broadly.
- Stakeholders strongly supported a model built on robust, strategic design principles, and identified recruitment, training and support of a quality workforce as the most important of these.
- The majority of stakeholders felt that services needed to be flexible and holistic in order to meet the needs of a diverse population. A model that uses multiple modes of service delivery was reported to be most relevant to the Australian aged care setting.
- Good models of aged care navigation already operate across Australia, and stakeholders are keen to avoid duplication/repetition of effort in progressing a nationally consistent model of aged care navigation.

# 6.1 Introduction

This chapter describes existing and historical models of system navigation in aged care and other relevant sectors, and reports on stakeholders' views of how relevant these models are to the Australian aged care setting. It also provides specific insights into the components, design principles, and implementation challenges of these models.

In doing so, this chapter addresses the following evaluation objectives:

- **Identify and review existing and historical system navigator services, including aged care system navigator services and system navigator services in other sectors in Australia and internationally.**

*Section 6.3* builds on the discussion paper to present findings regarding alternative models of system navigation.

- **Identify stakeholder views on aged care system navigator models and opportunities for the future.**

*Section 6.3* also provides insight into stakeholders' views on the strengths and weaknesses of particular navigator models. This section also addresses specific design principles and components of the models to inform the development of future Australian aged care navigator models.

- **Identify potential aged care system navigator models to inform future policy considerations, including barriers and enablers to achieving intended outcomes.**

*Section 6.4* discusses the relevance of the identified navigator models to the Australian aged care sector. This section also identifies key implementation challenges and enablers relating to capacity, reach, funding, integration and research and data collection. Findings from this section will be synthesised with insights emerging from other evaluation activities to fully address this evaluation objective in the Final Report<sup>1</sup>.

Specific evaluation questions (including sub-questions) addressed are presented at the beginning of each of the following sections. Importantly, this chapter also contributes to addressing the following evaluation question:

- **What are the opportunities to enhance each trial?**

This chapter discusses alternative models of system navigation, their strengths and weaknesses, design principles and model components, and implementation issues that could be considered to improve the aged care system navigator trials being undertaken through the Measure. The majority of these trials are ongoing at the time of drafting this report.

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<sup>1</sup> Minister Colbeck has agreed to extend the Measure to 30 June 2021. As such, the timing of the Final Report will be confirmed as part of extension negotiations (underway at the time of drafting this Interim Report).

### 6.2 Methodology

This chapter is based on three key project activities:

- Environmental scan, which informed the development of the discussion paper
- Discussion paper response analysis
- External stakeholder consultations.

More details regarding the methodology are provided in the Evaluation Plan and discussion paper.

### 6.3 Interim findings: Models of system navigation

#### 6.3.1 What aged care or other system navigator models exist in Australia and internationally?

- How have they been designed and implemented?
- How are they funded?
- How are 'successful' outcomes of the models assessed?
- What are the similarities and differences compared to the Measure?

For the service sector models identified:

- What lessons can be learned?
- What barriers/enablers affect outcomes?

A number of system navigator models (in aged care and other relevant sectors) were identified through the environmental scan and consultations with external stakeholders. The key types of system navigation models identified, and subsequently described in the discussion paper, are summarised in *Table 6-1*. These have commonly been developed in sectors other than aged care.

In addition to the trials being undertaken through the Measure, a number of navigation models specific to aged care were identified (both in Australia and overseas). These, in effect, provide services similar to one or more of the models described in *Table 6-1*, and are provided by various organisation types—most notably local governments, PHNs and aged care service providers.

Further detail about the design and implementation of a number of aged care system navigator models is included in the discussion paper. These sources highlight, where possible, how the models have been designed and implemented, how they are funded, and how 'successful' outcomes have been assessed. However, the diversity and overlap of the models described above, the lack of an agreed definition of system navigators (and the boundaries with other types of support and service provision), and lack of research related to aged care system navigation, make evaluation of the models difficult.

Specific elements of system navigator models—including principles, components, strengths and weaknesses, relevance to the Australian aged care context, and implementation considerations—are discussed in the following sections.

## 6. Interim findings: review of other system navigator models

One defining element of system navigator models is the professional qualifications and experience of the navigator. Broadly, navigator services can be provided by:

- A professional (e.g. nurse, allied health care worker, other professional with relevant qualifications)
- A lay person (i.e. paid worker or volunteer without directly relevant professional experience)
- A peer navigator (someone with lived experience relevant to the setting or target population group).

**Table 6-1: Identified models of system navigation**

Model element	Description
<b>Patient navigators</b>	
Target population	Vulnerable populations/people experiencing barriers to health care
Aims	To ensure continuity of care, including prevention, detection, diagnosis, treatment, and survivorship to the end of life
Delivered by	Professionals (e.g. nurses) and lay navigators (depending on type of navigator activity)
Service intensity	Flexible level of service intensity and duration, depending on patient needs
Modes of delivery	Ongoing, one-on-one, face-to-face service delivery, including outreach
<b>Nurse/professional navigators</b>	
Target population	People with complex physical health conditions, vulnerable populations, and/or people with complex needs
Aims	To assist patients to move more easily through the health care system, including between hospital and community settings
Delivered by	Professionals only (e.g. nurses, allied health)
Service intensity	Flexible level of service intensity and duration, depending patient needs
Modes of delivery	Ongoing, one-on-one, face-to-face service delivery, including outreach
<b>Family navigators</b>	
Target population	Youth/families with developmental/mental health difficulties
Aims	To assist youth/families to navigate the complex youth mental health and addictions system
Delivered by	Professionals (i.e. psychologists, allied health)
Service intensity	Flexible level of service intensity and duration, depending on patient needs
Modes of delivery	Telephone screening/assessment; ongoing, one-on-one, and face-to-face service delivery, including outreach
<b>Peer navigators</b>	
Target population	Specific population groups (including but not limited to carers, people with a disability/chronic physical health condition, people from CALD backgrounds)
Aims	To assist people to access information, education, and training and/or to connect with different types of systems of care or services
Delivered by	Navigators with lived experience (paid worker or volunteer)
Service intensity	One-off or ongoing
Modes of delivery	One-on-one telephone; individual or group face-to-face (including outreach in some cases); hubs (community/online); or a combination of these

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<b>Model element</b>	<b>Description</b>
<b>Village and hub models</b>	
Target population	General community
Aims	To improve social engagement/connectedness and provide services/supports
Delivered by	Lay/peer navigators (paid or unpaid)
Service intensity	One-off or ongoing group interactions
Modes of delivery	Community hubs (physical/online)
<b>Financial navigators</b>	
Target population	Vulnerable populations and people requiring support to make a financial decision
Aims	To assist people to understand their financial options and the potential impact of financial decisions
Delivered by	Range of qualifications; unclear from the literature
Service intensity	One-off or ongoing interactions
Modes of delivery	One-on-one, telephone or face-to-face service delivery, including some outreach; or a combination of these

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### 6.3.2 Strengths and weaknesses of navigator models

Despite the variation and overlap between models of a given type (as characterised in the discussion paper and listed above), stakeholders noted a number of strengths and weaknesses associated with the design and implementation of each. These are summarised in *Table 6-2*. It should be noted that many of the strengths and weaknesses described here reflect stakeholders' views of the applicability of the models to the Australian aged care context rather than in their original settings. Where relevant, concordance between external stakeholder views' and the literature is noted.

**Table 6-2: Key strengths and weaknesses of system navigator models**

Navigation model	Strengths	Weaknesses
<b>Patient navigator</b>	<ul style="list-style-type: none"> <li>• Uses professional and lay navigators supported by quality training (the question of who should provide navigation is decided by the level of skills required at a given phase of a patient's disease trajectory or care journey)</li> <li>• Delivered face-to-face</li> <li>• Supports flexible, person-centred, holistic care</li> <li>• Improves patients' health literacy, engagement and self-management</li> <li>• Promotes linkages between relevant service providers</li> <li>• Draws on navigators' knowledge of/integration with other services/sectors</li> <li>• Includes outreach</li> <li>• Targets vulnerable populations</li> </ul>	<ul style="list-style-type: none"> <li>• Focus is clinical, disease-specific</li> <li>• Lay navigators may lack necessary skills/knowledge/experience</li> <li>• There is a lack of evidence regarding outcomes (e.g. regarding cost-effectiveness)</li> <li>• Model is relatively resource-intensive</li> </ul>
<b>Nurse/professional navigator</b>	<ul style="list-style-type: none"> <li>• Utilises the knowledge/expertise/skill/dedication of professional navigators (e.g. nurses, social workers, allied health workers)</li> <li>• Delivered face-to-face</li> <li>• Supports flexible, person-centred, holistic care</li> <li>• Improves service users' health literacy, engagement and self-management</li> <li>• Draws on navigators' knowledge of/integration with other services/sectors</li> <li>• Includes outreach</li> <li>• Targets vulnerable populations</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical, disease-specific focus may overlook importance of 'soft skills' of navigators</li> <li>• Navigators may lack capacity to provide navigator services due to other responsibilities (e.g. clinical practice)</li> <li>• There is a potential lack of cultural awareness/safety/acceptability compared with peer models</li> <li>• Delays may occur in consumers being linked to a navigator due to consumer demand</li> <li>• There is a lack of evidence regarding outcomes (e.g. cost-effectiveness)</li> <li>• Model is relatively resource-intensive</li> </ul>

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Navigation model	Strengths	Weaknesses
<b>Family navigator</b>	<ul style="list-style-type: none"> <li>• Focuses on holistic care, service matching</li> <li>• Considers importance of carers and families and their needs (in addition to consumers' needs)</li> <li>• Provides a central, known contact for family</li> <li>• Delivered face-to-face</li> <li>• Includes outreach</li> <li>• Focuses on building relationships with the service provider</li> <li>• Uses a multidisciplinary approach</li> <li>• May be particularly useful for service users experiencing cognitive decline, dementia or mental illness</li> </ul>	<ul style="list-style-type: none"> <li>• Assumes consumer has family and wants them involved in decision-making regarding care</li> <li>• There may be conflict between consumer and family preferences and priorities</li> <li>• Potential for elder abuse issues to impact care decisions (in aged care context)</li> <li>• There is a lack of evidence regarding outcomes (e.g. cost-effectiveness)</li> <li>• Model is relatively resource-intensive</li> </ul>
<b>Peer navigator</b>	<ul style="list-style-type: none"> <li>• Focuses on empowerment</li> <li>• Uses shared language, experiences, cultural identity, etc., which engenders trust, engagement, rapport and empathy</li> <li>• May reach service users unlikely to seek out a professional service</li> <li>• Can provide personal/emotional support</li> <li>• May cost less (compared with professional navigator models)</li> <li>• Promotes flexibility—can involve outreach</li> <li>• Targets vulnerable populations</li> </ul>	<ul style="list-style-type: none"> <li>• May be an unclear scope of practice across models</li> <li>• Risk of inaccurate information being provided</li> <li>• Inconsistent or lack of skills/experience/objectivity</li> <li>• Requires professional support/supervision</li> <li>• Volunteers may be hard to source and retain</li> <li>• Requires ongoing navigator training and support</li> <li>• There is a lack of evidence regarding outcomes (e.g. cost-effectiveness)</li> </ul>
<b>Village and hub</b>	<ul style="list-style-type: none"> <li>• Visible community presence, can be co-located with relevant services/organisations</li> <li>• Flexibility of service provision (e.g. from seminars to one-to-one support)</li> <li>• Supports community capacity-building</li> <li>• Facilitates integration into other community supports</li> <li>• Has the ability to reach large numbers of people</li> <li>• Attracts word-of-mouth promotion</li> <li>• Places few restrictions on eligibility for assistance</li> </ul>	<ul style="list-style-type: none"> <li>• May not meet the needs of people in complex situations</li> <li>• Relies on volunteers (issues with ongoing training, turnover etc.)</li> <li>• Lacks specialist navigation support (depending on model)</li> <li>• Requires physical access/transport</li> <li>• May best support individuals who are already well-connected</li> <li>• Supports information provision rather than navigation</li> <li>• Difficult to evaluate effect</li> <li>• Membership fees may be required, presenting a financial barrier for some people from vulnerable populations</li> <li>• There is a lack of evidence regarding outcomes (e.g. cost-effectiveness)</li> </ul>
<b>Financial navigator</b>	<ul style="list-style-type: none"> <li>• Removes financial uncertainty as a barrier to accessing aged care</li> <li>• May help avoid/identify/address financial elder abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Requires a different skill set to other system navigation models</li> <li>• There may be compliance/quality control concerns (e.g. for private providers)</li> <li>• Fee-for-service models may not be affordable for some</li> <li>• There is a potential lack of actual or perceived independence</li> </ul>



### Patient navigator

As a hybrid model (using both professional and peer navigators), the strengths of patient navigator models were reported to be the use of both professional and peer navigators, supported by standardised training and clear scopes of practice. This approach allows the strengths of both navigator types to be utilised, and potentially mitigates some of the weaknesses of each. These issues are further discussed in later sections of this report. The perceived relevance of a hybrid model is discussed in *Section 6.4.1*.

Patient navigator models are designed to improve service users' health literacy, engagement with health care and self-management capabilities. Some stakeholders noted that this approach has parallels with current concepts in aged care, particularly wellness and reablement approaches.

However, evidence regarding patient navigator models derives from the cancer care literature in the United States. While it has since expanded into other areas of chronic disease, and into other countries, it has not been specifically applied in the aged care context. Stakeholders reported that the disease-specific, clinical focus of the patient navigator model may limit its relevance to the aged care setting, and a lack of an independence of navigator services from service providers was also noted.

The existence of an evidence base to support implementation of the patient navigator model was noted as a strength, particularly in health care settings. On the other hand, the lack of data regarding patient outcomes and experiences, and the cost-effectiveness of the model, was noted as a weakness.

### Nurse/professional navigator

Stakeholders reported that the key strength of the professional navigator models was the knowledge, skill and professional supports provided by nurses and other types of professional navigators (such as allied health professionals). This included their knowledge of and integration with other services and sectors (e.g. through established referral pathways).

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"Such a model allows an experienced, independent allied health professional to work one-on-one and walk alongside a consumer to support them to understand how and where their needs can be met." – Independent aged care consultancy representative

"Professional navigators have the knowledge, values, expertise and ability to connect vulnerable and isolated people to suitable services." – Government representative

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However, as with patient navigator models, the literature examining the implementation, appropriateness, and effectiveness of nurse/professional navigation models is primarily chronic disease-specific. Stakeholders suggested nurse-led services in particular were likely to have a clinical bias that was less relevant to the aged care setting. They suggested that multidisciplinary services may allow for greater flexibility in identifying and providing relevant supports for individual consumers. However, it was noted that an aged care nurse navigator might be appropriate in rural communities.

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“An aged care nurse navigator model in rural communities would be very beneficial. They are a resource for their community not only for clients but for carers and families and other health professionals in the community. They can advocate not only for the individual but for aged care across the community.” – Government representative

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Professionals’ potential lack of capacity to fulfil a navigator role (e.g. due to clinical or other competing responsibilities) was noted as a weakness of these models, which was consistent with the literature. Stakeholders also noted that the nurse navigator role may be limited in its capacity to provide holistic, community-based services.

### Family navigator

While the family navigator model emerged in the literature in the context of youth mental health services, its relevance to the aged care setting was noted by many stakeholders.

Discussion of family navigator models generally raised similar themes to the professional navigator models, with the added benefits and risks of involving family members in the process. In particular, stakeholders noted the specific value of a family navigation model in supporting consumers experiencing cognitive decline, dementia or mental illness, and as a way of upskilling and empowering families to navigate the aged care system.

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“Carers and family members are critically important and should be considered in-scope for any future navigator models. They need access to timely, accurate and responsive support so they can ultimately take over the navigator role and relieve pressure on the system.” – Aged care service provider

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### Lay/peer navigator

While professional navigators were felt to be most valuable in the Australian aged care context, it was frequently noted that they could be supported by lay or peer navigators, for example to provide:

- Advice on less complex issues
- Support to less vulnerable people
- Basic information and complementary (e.g. social) support.

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“Peer navigators can augment, not replace, professional and family navigators.”  
– Government representative

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A lay/peer workforce could also be engaged to promote the availability of a professional navigator service (e.g. through community networks and hubs) and support consumers in interpreting information through shared language or culture. Gatekeeper models (which are described as organised outreach efforts designed to build the capacity of community members to recognise and reach at-risk older people who may require assistance but have little social contact), were seen as beneficial in this context.

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“The Gatekeeper Program is a fantastic model as it connects with multiple touchpoints in the community to support those in need or at risk.” – Aged care service provider

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Peer navigator models were noted to be particularly important for CALD communities and people who may be distrustful of professionals and service systems (including Aboriginal and Torres Strait Islander people, Forgotten Australians, and people who are LGBTI).

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“Some volunteers are community and peer leaders who are trusted members of the community...this means that people in need are often identified from ‘within’ the community by the leaders.” – Partner organisation representative

“In a CALD context, peer navigators could be useful but more as ‘spotters’ than navigators. Community leaders could be selected for training in basic aged care information, identifying possible clients and referring them to the nearest [navigator].”  
– Aged care service provider

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An important consideration is whether a lay/peer navigation model is staffed by paid workers, peer volunteers (who may be relatively unskilled/inexperienced) or professional/experienced volunteers (e.g. those with relevant background qualifications and/or experience).

Difficulties around recruiting, training and retaining volunteers, and maintaining professional boundaries and scope of practice, were consistently raised by stakeholders as key issues.

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“Peer roles and volunteers may not necessarily ensure best outcomes for clients, and may put them in a disadvantaged position, due to lack of or limited knowledge of the service system.” – Government representative

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Positive CALD Ageing Network (PCAN) representatives (comprising external stakeholders and partner organisation representatives) advised that peer/volunteer-only models that service culturally diverse populations carry the following risks:

- Peers/volunteers may themselves be vulnerable

Representatives argued that CALD volunteers/peers may have a history of trauma, arising from their lived experiences. They felt that peers/volunteers should be supported by paid professionals in order to minimise the burden or ‘emotional load’ for volunteers

- Reliance on volunteers may devalue the CALD workforce

Representatives suggested that peer/volunteer-only models potentially devalue the professional CALD workforce and perpetuate acceptance that this work should be unpaid.

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“Providing bilingual workers is our in-kind contribution. But it would be great if that could actually be recognised and acknowledged, and funded.”  
– Partner organisation representative

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“This type of pro-bono work is a big contribution and it needs to be acknowledged. We and the other organisations have been advocating for the Government to recognise this.” – Partner organisation representative

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### Village and hub models

As with peer navigators, village and hub models of system navigation support were seen by many stakeholders as important additions to professional navigator support. However, views on the strengths and weaknesses of these approaches varied depending on stakeholders’ views of what these models involved. Given the significant variation in how these models operate, it is difficult to summarise perceived strengths and weaknesses.

A key consideration, highlighted in the discussion of peer/lay navigator models above, is whether a hub is staffed by paid workers, peer volunteers or professional/experienced volunteers.

A key benefit of village models highlighted was the social connection and engagement they could support, rather than direct assistance navigating the aged care system. However, such engagement may indirectly promote consumer empowerment and therefore access to aged care.

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“Village and hub models appear most useful for those with low-level concerns, who are planning for future care and seeking information rather than services or are seeking simple (possibly episodic) services.” – Aged care service provider

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A particular benefit of village and hub models was establishing a visible, physical community presence to allow promotion/awareness-raising and community engagement. It was also reported that village and hub models could utilise professional *and* peer navigators, as well as financial navigators (or links to such services).

Stakeholders noted that the grassroots nature of these models makes them a useful complement to professional navigator models. They may also be particularly relevant in rural or remote communities where complementary hub-style services/locations are already established.

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“Councils and community centres can be a neutral place for people to find information, access basic support and then be linked in to ‘system navigation.’”  
– Aged care service provider

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Some external stakeholders and discussion paper respondents noted that while village and hub models may be working best for those who are already linked in to either social or mainstream supports, they may not be sufficient to improve access for people who are vulnerable.

Very few comments were made in responses to the discussion paper regarding virtual hubs. Much of the discussion regarding online navigator service delivery is relevant in this context (see *Section 6.3.4* subsection *Mode(s) of delivery* below), suggesting that virtual hubs alone would not be a useful strategy for consumer engagement, particularly in the short term.

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“Virtual hubs have their place in the service system, but they are unsuitable to be the sole provider of information, and may not ‘work’ for special needs groups.”

– Peak body representative

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### Financial navigators

Independent aged care financial navigation was generally supported by stakeholders, but it was noted that it likely requires a separate skillset to other navigation types. This assistance in accessing both community-based and residential aged care was generally considered by stakeholders to be important, due to the complexities relating to both eligibility (e.g. pensions, income and asset testing) and costs (e.g. bonds and contracts). It may also help to remove cost as a barrier to accessing aged care, if consumers are declining or delaying access to aged care because of uncertainty regarding the personal financial costs involved. Financial navigation services may also help to avoid, identify and/or address issues of elder abuse relating to finances.

“A budget plan, drafted in conjunction with the identified supports in ACAT’s assessment, assists an individual to understand clearly the cost and breaks down barriers to accessing and accepting a home care package.” – Hospital representative

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However, external stakeholders and partner organisation representatives reported that private financial navigators may charge fees for their services that may not be affordable for many Australians, and may further compound financial barriers for those individuals. Others reported that the ‘marketisation’ of the aged care system may mean that consumers are not being provided impartial advice, and may further complicate financial decision-making for people.

“In the era of consumer choice and control some service providers ‘snatch and grab’. So older people are receiving biased advice.” – Partner organisation representative

“Small brokerage consultancies have sprung up to fill the navigation need—these businesses are connected with a handful of providers and therefore not providing impartial advice.” – Partner organisation representative

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### 6.3.3 Design principles

The discussion paper identified 11 key design principles derived from the environmental scan and stakeholder consultations. Broadly speaking, all 11 design principles were identified by stakeholders as being important in an aged care navigation model, with overall mean ratings of importance ranging from 78 to 92 (out of a maximum rating of 100) (*Figure 6-1*).

“I’m afraid I think all of the design principles are important!”

– Aged care service provider

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**Figure 6-1: Discussion paper respondents' ratings of importance of suggested design principles for aged care system navigator services**



Note: A higher rating (out of a maximum of 100) denotes higher importance. Ratings have been rounded to the nearest whole number.

Discussion paper respondents highlighted the significant conceptual overlap between a number of design principles. For example, comments related to 'relationship-centred services' often included reference to 'flexibility and adaptability'. Similarly, comments regarding 'linkages and partnerships' often referred to 'integration'.

Across all discussion paper responses, the three design principles rated the highest for importance were *quality workforce* (mean rating of 92/100), *flexibility and adaptability* (89/100) and *linkages and partnerships* (87/100), while *defined target population* was rated the lowest (78/100) (Figure 6-1). However, it is important to note that there was some variability in the ratings of the design principles across different stakeholder groups that responded to the discussion paper. The mean ratings for each of the 11 design principles are shown in Table 6-3 by stakeholder group.

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**Table 6-3: Ratings of importance of suggested design principles for aged care system navigator services, by stakeholder group**

Respondent type	Quality workforce	Flexibility and adaptability	Linkages and partnerships	Relationship-centred services	Active participation	Clear scope of role and Practice	Implementation resources	Integration	Independence	Evaluation outcomes	Defined target population
Government department/ agency	<b>86 (n=19)</b>	<b>82 (n=20)</b>	<b>85 (n=20)</b>	<b>82 (n=20)</b>	76 (n=19)	78 (n=20)	<b>86 (n=19)</b>	78 (n=19)	71 (n=18)	78 (n=19)	<i>68 (n=20)</i>
Aged care assessment workforce/ provider	<b>95 (n=23)</b>	86 (n=23)	88 (n=21)	<b>91 (n=21)</b>	<i>79 (n=21)</i>	<b>92 (n=22)</b>	87 (n=22)	89 (n=21)	83 (n=20)	85 (n=21)	83 (n=22)
Aged care service provider	<b>93 (n=119)</b>	<b>90 (n=116)</b>	86 (n=116)	86 (n=118)	<b>87 (n=116)</b>	85 (n=120)	83 (n=117)	83 (n=112)	80 (n=112)	82 (n=110)	<i>77 (n=118)</i>
Peak body	<b>94 (n=21)</b>	<b>90 (n=20)</b>	89 (n=21)	86 (n=21)	89 (n=20)	88 (n=21)	<b>91 (n=21)</b>	<b>90 (n=20)</b>	<b>91 (n=19)</b>	88 (n=20)	<i>81 (n=20)</i>
Other*	<b>92 (n=44)</b>	88 (n=42)	<b>90 (n=44)</b>	87 (n=43)	<b>89 (n=42)</b>	<b>89 (n=44)</b>	84 (n=43)	<b>90 (n=44)</b>	86 (n=43)	84 (n=44)	<i>81 (n=44)</i>

Note: The three highest mean ratings reported by each stakeholder group are shown with bold text and highlighted in blue, with the highest rating/s shown in dark blue, and the second and third highest ratings shown in increasingly lighter shades. The lowest ratings reported by each stakeholder group are shown with regular text highlighted in light grey and italicised.

\*Respondents in the 'other' category included representatives of PHNs, local governments, community centres, hospital and health services, navigator services, aged care advocacy services, disability service providers and academic institutions/research bodies.

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That said, all five stakeholder groups gave their highest rating/s of importance to the design principle of *quality workforce*, with government representatives also rating *implementation resources* equally high. At the other end of the importance ratings, four of the five stakeholder groups gave their lowest rating to *defined target population*, while the fifth group—aged care assessment workforce/providers—gave their lowest rating to active participation.

Across all stakeholder groups, nine of the 11 design principles were rated in the top three most important. Given this very broad spread, an arbitrary scoring system was applied in order to estimate the *relative* importance of these principles; that is, their importance in relation to each other. Each of the 11 design principles received a score based on the number of stakeholder groups that rated them as one of their top three most important principles:

- Highest rating: three points (applied per instance of design principle ever having this rating from a stakeholder group)
- Second highest rating: two points
- Third highest rating: one point.

It is important to note that scores were applied based on relative ratings of importance (as set out in *Table 6-3*), and do not take into account the magnitude of ratings.

Based on this scoring system, the relative importance of the nine design principles (that were rated among the three most important by one or more stakeholder group) was estimated (*Figure 6-2*).

**Figure 6-2: Relative importance of the highest rated design principles for ACSN services**



As all five stakeholder groups gave their highest rating/s of importance to *quality workforce*, this design principle scored highest—by far—at 15 (*Figure 6-2*). The remaining eight design principles were clustered between relative importance scores of five and two. However, it is important to reiterate that the overall ratings indicate that stakeholders considered all 11 design principles to be important.

The 11 design principles are discussed in more detail below in order of relative importance, along with other principles suggested by stakeholders.



### Quality workforce

**Aged care system navigators should be appropriately qualified, trained, and supported (e.g. with ongoing training and professional development).**

As highlighted above, the importance of a *quality workforce* was clear from discussion paper responses. This design principle's top ranking—overall and by all stakeholder groups (*Figure 6-2* and *Table 6-3*)—indicates that it is a priority for implementation of an aged care navigator service.

Discussion paper respondents and external stakeholders reported that the aged care system navigator workforce should be suitably skilled and have relevant aged care expertise in order to provide the defined scope of services, and be adaptable to meet service user and community needs.

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“Staff must have in-depth knowledge of both the aged care sector and potential barriers experienced by those with diverse backgrounds, and how to best support them in a flexible and responsive manner.” – Aged care service provider

“The use of ‘aged care experts’ as navigators—as distinct from health or social work experts—is essential. The aged care system in Australia is constantly changing and will continue to do so to accommodate increasing demand. It is essential that navigators are abreast of these changes and the detail of services available.”  
– Aged care advocacy service

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Some stakeholders highlighted that aged care system navigators are essentially “the face of My Aged Care”. However, stakeholders expressed concerns that the My Aged Care contact centre itself does not currently have the flexibility or appropriately qualified and trained staff to undertake this role in order to meet the needs of target group(s). Stakeholders noted that this may particularly be the case when assisting culturally diverse groups and individuals.

Key attributes of navigators include having a clear knowledge of local services and service types (both formal and informal) as well as understanding of the needs of older individuals, their families and the community. Workforce diversity (e.g. to support diverse vulnerable populations) and recruiting navigators with relevant ‘soft’ skills (e.g. listening skills, problem-solving skills) were also deemed important. For Aboriginal Torres Strait Islander and CALD communities, bilingual navigators may be particularly helpful.

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“‘Quality workforce’ must include a diverse workforce that has the required competencies to deal with older people from all backgrounds and walks of life.”  
– Aged care service provider

“A good navigator needs to be practical, observant, and to understand aged care services and how they work.” – Peak body representative

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## 6. Interim findings: review of other system navigator models

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Training was reported to be an essential element of a *quality workforce*. The required components of such training were not often articulated, with many stakeholders referring to ‘adequate’, ‘appropriate’, ‘suitable’, ‘quality’, ‘standardised’ or ‘accredited’ training. Specific training elements that were mentioned include:

- Local aged care and other relevant services
- Person-centred care
- Dementia care
- Cultural competence
- Working with people from vulnerable groups
- Trauma-informed counselling and support
- Ongoing training and professional development.

Discussion paper responses tended to assume ‘workforce’ referred to recruitment, training and ongoing development of professional navigators, with some noting concerns regarding the use of peer/lay volunteers (discussed in other sections of this report). However, the importance of appropriate and ongoing training of lay or peer volunteer (as well as professional) navigators, as well as mentoring and supervision requirements, were consistently raised.

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Other workforce issues raised included staff support—for example, professional networks, career progression opportunities and “a pay scale that says ‘professional’”.

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### Implementation resources

**Aged care system navigator programs should include implementation resources/toolkits/guides to support consistent, high-quality delivery of navigation services.**

The design principle of *implementation resources* was reported to be of particular importance in aged care system navigator services by two of the five stakeholder groups—government representatives and peak bodies—who rated this principle as joint-highest and joint-second highest, respectively (*Table 6-3*).

Broader feedback on the importance of implementation resources included suggestions that their availability would help to avoid duplication of effort and support national consistency.

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“We do not need to reinvent the wheel.” – Peak body representative

“Implementation resources, toolkits and guides to support the consistent, high-quality delivery of navigation services is essential to ensure nationwide consistency.”

– Aged care assessment provider

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## 6. Interim findings: review of other system navigator models

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Beyond toolkits and guides, implementation resources could include development of or access to internal and external databases (including My Aged Care, National Health Services Directory, PHN), websites, audit tools, referral pathways and service user experience surveys, although it was noted that such resources should be adaptable to allow for local circumstances.

Many stakeholders mentioned the importance of adequate financial resources to support implementation of a navigator service—for example, to account for travel expenses in rural and remote areas; allowing time for navigators to learn about local services and build networks; attendance at partnership meetings; and other professional development, marketing and integration activities. Many of these issues have been captured in *Section 6.4*.

### Flexibility and adaptability

**Aged care system navigator models should be flexible, adaptable, and responsive to meet the needs of the service user and the required level of service intensity.**

The importance of *flexibility and adaptability* was also apparent from discussion paper responses, with three of the five stakeholder groups rating this in their top three most important design principles (*Table 6-3*). Indeed, having a flexible and adaptable approach was considered by stakeholders to be vital to person-centred and consumer-directed care.

Flexibility was mentioned in a number of different contexts, including:

- Time for interaction with service users who require different service intensity (to ensure access and equity for all)
- A stepped care approach (e.g. from information provision in group settings through to one-to-one system navigation for those with complex needs)
- Capacity to adapt service response to individual service users' needs and preferences
- Ability to respond to local, market and individual consumer needs.

Overall, stakeholders expressed strong support for navigation services that are able to consider individuals' needs, preferences, situations and communities on a case-by-case basis.

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“Having services that are ‘one size fits all’ is not always appropriate, as people have different needs in the community.” – Government representative

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### Linkages and partnerships

**Aged care system navigators should dedicate time to developing their knowledge of local services, building partnerships with other organisations and sectors, and performing promotional/integration activities.**

In discussion paper responses, two of the five stakeholder groups rated *linkages and partnerships* as their second most important design principle (*Table 6-3*).

Stakeholders felt that navigators needed organisational linkages and partnerships for three key functions:

1. To assist them in understanding the needs of, and suggesting appropriate service options for, people from specific population groups (i.e. partnerships and linkages with specific community groups and peak bodies).
2. To enable them to make appropriate referrals in the provision of navigator services and to facilitate information sharing (i.e. partnerships and linkages involving My Aged Care, aged care assessment services, aged care service providers and other local service providers as relevant).
3. To reach and provide access to consumers, particularly those from vulnerable populations (i.e. linkages and partnerships with communities, community groups and service providers in other sectors). For example, a navigator might work with other networks to educate 'gatekeepers' and reach vulnerable people through primary care and pharmacy networks, charitable organisations, police Vulnerable Persons Liaison Officers and others.

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"The navigator needs to understand the plethora of public and private service options, and where there are supply gaps, so that client expectations can be managed." – Aged care assessment provider

"Bridging communication and relationship gaps between relevant organisations and service providers would improve the My Aged Care journey for the older person."  
– PHN representative

"Outreach should not be a once-off exercise but a continuing initiative to find 'entry points' that could bridge these relationships in the community and develop trust."  
– Peak body representative

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To support linkages and partnerships, stakeholders suggested that local assets could be mapped and mobilised to support navigators and, ultimately, their service users. Assets could include individuals, community organisations, networks, non-government organisations, social hubs and businesses.

Stakeholders also noted that the value of navigators and their linkages and partnerships might be particularly important in implementing alternative supports in the period between the identification of aged care need and commencement of services, given that, anecdotally, this period has been getting longer in some instances.

### Clear scope of role and practice

**Aged care system navigators should have a defined scope of practice with roles and responsibilities that are transparent and commensurate with the skills and experience of the navigator delivering the service, including guidance on management of risk.**

Two of the five stakeholder groups responding to the discussion paper rated *clear scope of role and practice* in their top three most important design principles (Table 6-3).

Stakeholders noted that, on the one hand, a lack of clarity around scope of a navigator's role and practice could lead to unrealistic (service user) expectations and perceived failure; scope creep; confusion in the sector; and increased risk if navigators work outside their expertise, training and role description. This risk was generally considered greater with respect to peer/lay/volunteer navigators compared with professionals. On the other hand, rigid scope of practice definitions could restrict the usefulness of a navigator model in addressing individual service users' needs (see *Flexibility and adaptability* above).

What the actual scope of practice should be for an aged care navigator was not universally agreed. However, clear articulation of the 'fit' of navigator services within other current aged care system supports (e.g. My Aged Care, aged care assessment services, case coordinators and managers, advocacy services, specialist support workers) was proposed to avoid confusion, duplication and scope creep.

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"Role scope and parameters for navigators, case managers and care coordinators need to be explicit to reduce the potential for duplicated service delivery and waste."

– Aged care assessment provider

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### Integration

**Aged care system navigator models should aim to integrate fragmented and disconnected systems of care, and draw on existing local efforts/supports/infrastructure.**

*Integration* was rated in the top three most important design principles by two of the five stakeholder groups responding to the discussion paper (Table 6-3).

Many stakeholders felt that, ideally, the scope of integration would be broad—including formal and informal aged care services and support, the health and disability sectors, housing, community services, drug and alcohol and mental health services, dementia support, financial support and legal support. Better integration of these sectors and service systems was seen as being likely to reduce complexity and confusion among consumers. Some stakeholders felt that better integration of sectors and service systems may reduce or even negate the need for system navigation as a separate function in the future.

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"The silos that manifest between health and aged care are problematic."

– Peak body representative

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The knowledge and skill of the navigator in addressing gaps—by being aware of local services and supports as well as the needs of communities and individuals—were seen as key enablers of integration.

## 6. Interim findings: review of other system navigator models

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“The Aged Care System Navigator should be recognised and supported as a key role in the aged care system. The role has the potential to help older persons and their families navigate not just through My Aged Care but across the continuum of wellness, disability and aged care.” – Peak body representative

“The benefits of an integrated approach extend to the older person, caregivers, providers and the system at large.” – PHN representative

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It was noted, however, that such integration within and across systems was not necessarily—or solely—the responsibility of a navigator service, but rather, that responsibilities lies with the services themselves, as well as with governments (from local councils through to Australian Government policy and funding models).

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“It’s critical that all government agencies, local government, service providers and NGOs understand the system and are on the same page to ensure that consumers are provided with clear and consistent advice from all.” – Peak body representative

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At a more focused level, integration of navigator services with aged care assessment services was generally considered useful in providing early access and avoiding duplication of assessments. System navigation is largely outside the current scope of Aged Care Assessment Teams (ACATs) and Regional Assessment Services (RASs).<sup>2</sup> Such integration could be achieved through a navigator service working closely with assessment services, or by expanding the role of assessment services to more expressly include—and be better resourced to provide—system navigation. However, it was not clear from consultations whether stakeholders held a preference for one of these options over the other.

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“Currently navigators conduct a face-to-face [consultation] to gather assessment information, which in all cases has already been collected by other agencies.”  
– PHN representative

“Current Regional Assessment Services do not have enough ‘on the ground’ knowledge and are not funded to visit agencies, meaning they are often unaware of what is on offer.” – Aged care service provider

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However, while many stakeholders support integration of assessment and navigator services, a few called for clear delineation between these functions, perhaps because of potential conflicts of interest.

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<sup>2</sup> It is noted that one of the roles of RAS and ACAT is to provide ‘short term linking assistance or care coordination to vulnerable clients to address barriers that affect their access to aged care services’ (Department of Health, 2018). This support may include linkages to formal or informal services, and may also be conceived of as short-term case management or care coordination to the point of effective referral. It is designed to assist in linking vulnerable aged care consumers to the services needed in order to live in the community with dignity, safety and independence. In this context, ‘vulnerability’ relates to issues arising from circumstances such as homelessness, mental health concerns, drug and alcohol issues, elder and systems abuse, neglect, financial disadvantage, cognitive decline and residing in a remote location. The cohort for which these services might be provided is therefore more limited than those groups potentially benefiting from aged care navigator services. It is also relevant to note that *local engagement and networks* was proposed as an additional design principle in responses to a public discussion paper on streamlined consumer assessment for aged care (Department of Health, 2019).

## 6. Interim findings: review of other system navigator models

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Some stakeholder commented specifically on integration of IT systems to support the flow of information from My Aged Care through assessment services and aged care service provision, as well as to facilitate evaluation activities. This could also extend more broadly to other health care systems (e.g. through My Health Record).

### Relationship-centred services

**Aged care system navigator models should identify the context, needs and priorities of the service user, in order to provide a personalised navigation service. It should also recognise the importance and influence of the relationships that exist between the service user and others, including service providers.**

In discussion paper responses, *relationship-centred services* was rated in the top three most important design principles by two of the five stakeholder groups (Table 6-2).

Unsurprisingly, commentary around *relationship-centred services*—or person-centred services, as a number of stakeholders referred to them—echoed the discussion of *flexibility and adaptability* above. Stakeholders also identified cultural safety and culturally-appropriate service provision as integral to relationship-centred services.

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“Care planning needs to be person-centred and incorporate supports that meet an individual’s full spectrum of needs...This is why a key feature of the navigator must be to consider the breadth of support options that would contribute to each individual’s unique set of needs and preferences.” – Local government representative

“A person-centred service will be responsive and flexible to meet the needs of individual residents who fall into ‘temporary’ disadvantage due to functional and health decline.” – Local government representative

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Stakeholders noted that building trusted relationships with vulnerable individuals and communities takes time, but that the provision of person-centred services in itself helps to build trust.

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“Relationships are central to the success of working with vulnerable community members.” – PHN representative

“If the navigation is not personalised to the client’s needs and priorities and does not build on their existing relationships with service providers, this will only compound [the complexity of] the client journey.” — PHN representative

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In the context of relationship-centred care, the value of face-to-face navigation services was consistently highlighted for a number of reasons (e.g. disability, barriers to use of technology, need for relationship-building) and a number of specific populations (e.g. Aboriginal and Torres Strait Islander peoples, those from CALD backgrounds, those living in rural and remote areas of Australia).

## 6. Interim findings: review of other system navigator models

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“Person-to-person contact is more important than printed or other resources.”

– Peak body representative

“Our experience shows that consumers come to receive updated information and guidance, as they prefer to discuss their situation with a person [rather] than speak to someone over the phone. This may be due to hearing impairment, frailty, or a lack of understanding of the current system, which is changing at a rapid rate.”

– Aged care service provider

In some cases (and where relevant), contact with the same individual navigator over time was considered important in leveraging relationships to provide an optimal, person-centred service across the aged care spectrum. In the literature, this consistency was noted as a central element of nurse navigator and family navigator models (Hudson et al., 2019; Markoulakis et al., 2016; McMurray & Cooper, 2017).

“Navigators aim to develop meaningful relationships with families, giving them a space to voice their concerns and helping them find the right care” – Markoulakis et al. 2016 (p. 65)

Stakeholders reported that it was particularly important for individuals from certain population groups—including Aboriginal and Torres Strait Islander people, people from CALD backgrounds, and care leavers—to have contact with the same individual navigator over time.

“It is useful to have the same person supporting a client throughout their aged care journey—from understanding the system, accessing My Aged Care, choosing providers and adapting to future needs.” – PHN representative

### Independence

**Aged care system navigators should be independent from service providers, to foster the necessary trust and rapport required to reach people facing challenges when accessing and navigating aged care services.**

While overall discussion paper responses indicated that the design principle of *independence* was still considered to be important (*Figure 6-1*), only one stakeholder group—peak bodies—rated it in their top three most important design principles (*Table 6-3*).

“Independence, while valuable, is not as important as skilled navigators who are flexible and lateral in their thinking.” – Aged care service provider



## 6. Interim findings: review of other system navigator models

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“Trust and rapport with service providers can be built with community groups without the need for the navigators to be independent of service providers, provided that navigators have the right personal communication skills, approach, and flexibility in their roles.” – Aged care service provider

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That said, many stakeholders still insisted that independence was key for ensuring that service users could make fully-informed choices.

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“This is a big problem in the sector now it is deregulated: this has meant that more vulnerable people in the community are limited in their choice of services once they are ‘captured’ by a particular service provider’s navigators.”  
– Local government representative

“In an increasingly competitive sector, system navigators must offer independent advice to consumers and not be linked with any one provider.”  
– Aged care service provider

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For vulnerable people especially, information and navigation services provided by aged care service providers may, in effect, limit their choice as a consumer. The marketisation of the home care sector has provided choice for consumers, but has also—anecdotally—introduced ‘choice paralysis’ for some.

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“We are wary of private aged care providers offering quasi-navigation services...Some providers have website names that appear to be general information portals. It is fine for them to promote their services, but they need to declare their identity and interests and state clearly that they are not offering independent, objective information and assistance.” – Peak body representative

“Some people will opt to engage the first provider who contacts them, perhaps because of a friendly voice on the other end of the phone.”  
– Peak body representative

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As raised with respect to the design principle of *Integration* (see above), stakeholders commonly suggested that navigator services should be closely integrated with or even sit within Aged Care Assessment Teams, potentially providing independence from service providers while avoiding unnecessary system complexity or duplication and providing national consistency. However, it was noted that in some instances this independence is not guaranteed, for example where an organisation provides both aged care assessment and aged care services.

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“Independence is essential as we have already seen the bias when [a] RAS sits within an overarching NGO that provides CHSP services.” – Aged care assessment provider

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## 6. Interim findings: review of other system navigator models

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Local councils and PHNs were also suggested as good options for independent, local advice because they “have responsibility for the whole person, not just as a client”. Stakeholders also noted that local governments are increasingly ‘opting out’ of aged care assessment and service delivery functions.

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“If local governments get out of the service delivery space, they are well set up to provide an independent system navigator service.” – Aged care service provider

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Some stakeholders, however, noted that aged care service providers were currently providing a navigator role in a number of communities, and in some cases filling a gap in the sector.

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“It will be hard to find a workforce outside of service providers to do such a task. While [independence] would be helpful, viability is in question.”  
– Aged care assessment provider

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Some providers reported that they were trusted sources of information regarding aged care, and therefore this role was a natural fit. This may be particularly true in small rural and remote communities where choice and resources are limited, and for Aboriginal and Torres Strait Islander and CALD communities where the service providers are, perhaps, best placed to provide culturally-appropriate services and to assist with navigation support.

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“We are trusted. We have the links.” – Partner organisation representative

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Stakeholders also highlighted that service providers should not be *precluded* from providing navigator services, where appropriate, and that in many cases consumers approach service providers directly for information and support. In many communities, collaborations and networks already exist within the sector and are reportedly utilised to improve outcomes for service users.

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“An aged care organisation with strong infrastructure can provide both system navigation services and direct services, without any conflict of interest.”  
– Aged care service provider

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The concepts of co-dependence (between navigators and service providers) and transparency (where a provider offers navigation supports) are relevant in this context.

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“Linkages to service providers are not inherently negative, and can serve to enhance the integration of clients’ care.” – Aged care service provider

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### Active participation

**Aged care system navigation should enhance the capacity of service users (including individuals/carers/families) to be actively involved in navigating the aged care system.**

Two of the five stakeholder groups rated *active participation* in their top three most important design principles. One stakeholder group (aged care assessment workforce/providers) rated this principle as least important (*Table 6-3*).

While *active participation* was still seen by most stakeholders as an important principle for navigation services, this was tempered by the understanding that a number of older people, for a range of reasons, may lack this capacity. These reasons include socioeconomic factors (e.g. education/literacy levels), health status, cognitive capacity and personal circumstances. It was also noted that it is not uncommon for aged care entry to be precipitated by a health crisis or other circumstances in which service users and families may feel overwhelmed. Therefore, as a principle it may exclude those who are most vulnerable and unable to actively participate. On the other hand, some stakeholders were adamant that decision-making must remain firmly with the service user and their family—with the role of the navigator being to support service users in making their own decisions.

In reality, this may mean that navigators should ideally provide support to allow service users to make their own, informed decisions at the point of entry into aged care, but may not necessarily aspire to ‘upskill’ individuals to be able to navigate the system themselves in the future (e.g. when aged care needs change). However, at a broader level, the navigator role may include proactively engaging with and educating communities to facilitate them becoming more empowered service users when aged care services are required.

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“There is merit in active participation of clients in the navigation of the service system, yet the extent to which this is possible will be shaped by the cognitive capacity of clients, and how far they have progressed in accessing aged care services.” – Aged care assessment provider

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### Evaluation outcomes

**Implementation of aged care navigator programs should include an evaluation framework to monitor outcomes for service users and inform future policy decisions.**

Although none of the five stakeholder groups rated *evaluation outcomes* in their top three most important design principles (*Table 6-3*), discussion paper responses indicated that this principle was still considered important (*Figure 6-1*).

A number of stakeholders noted that evaluation data regarding navigation models would be useful in planning navigator services, measuring outcomes and improving services. Indeed, strategic data collection within a navigator service could be used to inform improvements not only within individual services, but across aged care and other sectors more broadly.

## 6. Interim findings: review of other system navigator models

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However, the onerous nature of collecting evaluation data (in terms of both staff time and financial resourcing), and the significant variability in navigation models and their maturity in the Australian aged care context, were highlighted. It was suggested that *evaluation should be supported and resourced externally/centrally in a standardised way* to allow relevant comparisons. This would also allow:

- Collection/reporting of aggregated data at multiple levels
- Provision of feedback to relevant government agencies to inform future policy directions
- Identification of consumer needs and service delivery gaps.

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“Evaluation I thought could be [rated] lower but at the same time if you do not have data you do not have evidence of what is working and what is not.”

– Aged care service provider

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Stakeholders highlighted that evaluation data should capture service user outcome and experience data, not purely outputs, and should include qualitative as well as quantitative dimensions. Service user experience data collection tools should be carefully designed so as not to make it too difficult for service users—especially those from vulnerable populations—to provide feedback.

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“High activity doesn’t guarantee great outcomes: lower activity numbers can be providing extremely good outcomes.” – Government representative

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### Defined target population

**Aged care system navigator models should focus on defined target populations, and prioritise those who are vulnerable or are experiencing barriers to accessing information and care.**

In discussion paper responses, four of the five stakeholder groups rated *defined target population* as the least important design principle (*Table 6-3*). Despite this, it is important to note that the general stakeholder ratings for *defined target population* were relatively high, indicating that this principle is still considered important in aged care navigator services (*Figure 6-1*).

That said, stakeholder perspectives on defining priority populations for navigator services were mixed. Some felt that defining specific target populations was important to ensure that the populations were understood and proactively reached (e.g. through outreach activities). Others felt that the definitions used in this context should be more inclusive to ensure they capture those *most* vulnerable. However, broad definitions of ‘vulnerability’ or prioritising “those experiencing difficulties accessing information or care” would lead to a very large cohort being ‘prioritised’. Some stakeholders argued that, in reality, most or all individuals accessing aged care could benefit from navigator support and should have access to such services.

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“We know that many consumers who would not fit into the standard definition of ‘vulnerability’ are struggling to navigate the system.”

– Aged care assessment provider

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## 6. Interim findings: review of other system navigator models

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“In regional, rural and remote areas...the model would need to be flexible to help service aged care clients who may sit outside the [vulnerable] box.”

– Government representative

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Because of these issues, a number of stakeholders suggested triaging and/or a stepped model of navigator services to assist both general and particularly vulnerable populations according to need.

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“It is important that navigator services are available to all older people who need assistance. However, particularly vulnerable populations may need specialised or more intensive navigator services, and these populations should not be adversely impacted by the demand for the service from better-resourced older people.”

– PHN representative

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### Other

A number of additional design principles were suggested by stakeholders, and are summarised (in no particular order) below.

**Accessibility:** Navigators should provide supports in a range of accessible modes including face-to-face, online, and over the phone. Accessibility also considers financial barriers (e.g. provision of free or low-cost services) and language/communication barriers (e.g. plain English and well-translated resources, use of interpreters). A ‘no wrong door’ approach could support equity of access for diverse populations and particularly for vulnerable individuals. Increasing community awareness (e.g. through marketing activities) may also contribute to accessibility.

**Inclusive design:** Service design should be informed by respect for diversity, cultural competency and user and community co-design.

**Innovation:** Navigator services should consider innovative ways of delivering services to maximise their reach, especially to marginalised or disadvantaged people.

**Responsiveness:** Navigator services should minimise time between identification of need and delivery of services.

**Sustainability:** Financial investment in a sustainable workforce is required to support commitment to the local community.

**Simplicity:** Navigator models should not be complicated or add further red tape/bureaucracy to the system.

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“The navigators must not become another layer or option for an older person to engage with the aged care system which is already overly complex and layered. Older people have literally no clue who is doing what or any idea of where to start.”

– Peak body representative

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### 6.3.4 Navigator model components

The discussion paper presented navigator model components in three key domains:

- Providers of system navigation services (i.e. professional vs peer/lay navigators)
- Elements of system navigator services
- Modes of delivery.

Stakeholder views relating to each of these are summarised below.

#### Navigator service providers

**Professional aged care system navigators should hold qualifications in aged care and/or relevant health, behavioural and/or social sciences.**

**Peer or lay navigators should have lived experience relevant to the target population of the model/service.**

As highlighted in *Table 6-4*, all five stakeholder groups indicated a strong preference for navigator models staffed by experienced and trained professionals rather than peer or lay individuals. Examples include health, allied health, and behavioural or social science professionals with experience in aged care.

**Table 6-4: Rated importance of provider type for aged care system navigator services, by stakeholder group (mean/100)**

Respondent type	Professional role	Peer/lay role
Government department/agency	82 (n=18)	54 (n=17)
Aged care assessment workforce/provider	94 (n=20)	60 (n=20)
Aged care service provider	88 (n=115)	69 (n=107)
Peak body	88 (n=20)	71 (n=19)
Other*	87 (n=41)	72 (n=39)
<b>Overall</b>	<b>88 (n=214)</b>	<b>67 (n=202)</b>

Stakeholders reported that the use of *peer/lay* navigators—even when appropriately trained—often raised issues relating to service quality and appropriateness, workforce stability, and navigator burnout.

“It is unclear if peer models would be effective, particularly in the absence of significant prior experience or knowledge of the service system.”

– Aged care service provider

\*Respondents in the ‘other’ category included representatives of PHNs, local governments, community centres, hospital and health services, navigator services, aged care advocacy services, disability service providers and academic institutions/research bodies.

## 6. Interim findings: review of other system navigator models

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“A lot of issues related to boundaries, confidentiality, training would need to be considered, which would be expensive with no guarantee of an appropriate navigator as an outcome.” – Aged care assessment provider

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Despite this, stakeholders noted there was some additional value in peer support services working alongside (rather than instead of) a professional navigator service. This might include peer/lay navigators working one-to-one with service users and/or within village and hub models to facilitate group education and support groups. Peer models may be particularly relevant in remote areas and among Aboriginal and Torres Strait Islander or CALD groups where translation of language and/or consideration of cultural preferences may be required. Peer navigator models may also help to avoid unnecessary/unhelpful levels of formality and professionalisation.

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“Peer and lay navigators are cost-effective and able to reach large numbers of the community through face-to-face interactions, social activities and local word-of-mouth.” – PHN representative

“Professionals and peer/lay navigators are equally important and should collaborate on a basis of partnership.” – PHN representative

“Peers can be professionals: we could have older people delivering paid, qualified navigator services. A navigator must be well-trained, well-supervised and deliver quality-assured outcomes.” – Peak body representative

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Some stakeholders noted that peer support could be provided separately to (but integrated with) professional system navigation models.

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“Peer support could come through carer support and groups other than a navigator.” – Aged care assessment provider

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### Navigator service elements

Overall, stakeholders rated *identification and assessment* as the most important element of an aged care system navigator service, with three of the five stakeholder groups giving this element their highest rating and a further stakeholder group giving this element their joint-second highest rating (*Table 6-5*). At the same time, the remaining navigator service elements were also rated relatively highly, indicating that all elements were considered important.

## 6. Interim findings: review of other system navigator models

**Table 6-5: Rated importance of various elements of aged care system navigator services, by stakeholder group (mean/100)**

Respondent type	Identification and assessment	Care planning	Level of service intensity	Financial navigation
Government department/agency	82 (n=18)	79 (n=18)	71 (n=18)	72 (n=18)
Aged care assessment workforce/provider	95 (n=19)	90 (n=19)	81 (n=18)	82 (n=20)
Aged care service provider	88 (n=115)	84 (n=113)	79 (n=114)	74 (110)
Peak body	79 (n=21)	68 (n=21)	86 (n=20)	81 (n=21)
Other*	85 (n=29)	81 (n=41)	87 (n=38)	85 (n=35)
<b>Overall</b>	<b>87 (n=212)</b>	<b>82 (n=212)</b>	<b>81 (n=208)</b>	<b>77 (n=204)</b>

### Identification and assessment

**Navigator services should have clear referral, intake, and holistic assessment processes to identify service user needs and goals.**

*Identification and assessment*—and particularly the current need for these functions at multiple levels throughout the aged care intake system—was raised as a key issue by stakeholders. As highlighted above, three of the five stakeholder groups rated this element as the most important element of an aged care system navigator service and a further stakeholder group rated this element as the joint-second most important element (see *Table 6-5*).

The integration of a navigator service with a streamlined assessment system (either through close linkages or expansion and resourcing of the assessment providers' role) was suggested as an ideal situation, enabling vulnerable service users to be identified at first contact and subsequently assisted through the system. This, however, does not assist potential service users reach the point of intake through My Aged Care.

“Identifying prospective consumers of a navigator’s service pre-My Aged Care requires working in partnership with community and health organisations to publicise how such a service can support individuals who may experience barriers in accessing aged care. Identifying prospective consumers of a navigator service post-My Aged Care can be done in collaboration with RAS and ACAT teams who can identify potential consumers at the point of assessment who have been given approval for various supports but need assistance to engage with the market, understand how they best fit (e.g. within the two community aged care systems) and ultimately make choices within the resources made available to them.”

– Independent aged care consultancy

\*Respondents in the ‘other’ category included representatives of PHNs, local governments, community centres, hospital and health services, navigator services, aged care advocacy services, disability service providers and academic institutions/research bodies.



## 6. Interim findings: review of other system navigator models

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### *Care planning*

**Aged care system navigator services should have a clear and consistent approach to developing service user care plans, in consultation with individuals and families (where appropriate).**

While three of the five stakeholder groups rated *care planning* as the second most important element of an aged care system navigator service, it was viewed by two stakeholder groups as the least important element (see *Table 6-5*).

Stakeholder comments suggested some confusion about what care planning meant in the context of navigator services compared with the aged care service delivery context. This highlights the importance of defining a navigator's scope of practice and its 'fit' within the system-wide (and even cross-system) context.

Avoidance of duplication and the integration of *care planning* across other elements of the system (e.g. identification and assessment) was consistently raised by stakeholders.

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"Navigators don't do care planning or assessment—they interface with those that do." – Aged care advocacy service

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### *Level of service intensity*

**Aged care system navigator models should offer a range of service intensities that are appropriate and responsive to changing service user needs.**

While two stakeholder groups rated *level of service intensity* as the most important element of an aged care system navigator service, it was viewed by two stakeholder groups as the least important element (*Table 6-5*).

Broadly speaking, stakeholder comments pointed towards the importance of being able to provide appropriate variation in the *level of service intensity* in contributing to flexible and person-centred care.

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"The future program should provide a combination of targeted navigator services for defined cohorts alongside universal, less intensive guidance and advice for the general population." – Aged care assessment provider

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Generally, variation in the required level of service intensity was linked to the relative needs of those from disadvantaged and vulnerable populations. However, stakeholders also noted the need for differing service intensity across the consumer journey—for example, from before accessing My Aged Care (e.g. online and in-person information and support, drop-in centres and community hubs) through to one-to-one navigation after contact with My Aged Care.

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"The level of service intensity and professional role need to be linked to the vulnerability and risk profile of the client." – Aged care service provider

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## 6. Interim findings: review of other system navigator models

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### *Financial navigation*

**Aged care system navigator models should, through the provision of information, support individuals to understand the financial implications of decisions related to accessing aged care.**

While two stakeholder groups rated *financial navigation* as the second most important element of an aged care system navigator service, it was viewed by one stakeholder group as the least important element (*Table 6-5*).

This type of navigation was considered important to help consumers understand the financial implications of accessing supports in different service systems (e.g. Commonwealth Home Support Programme [CHSP] versus Home Care Package [HCP] versus residential aged care) and make informed decisions. In particular, the potential financial impact of ill-informed decisions was considered a significant risk, and especially for vulnerable and disadvantaged populations.

However, whether this function should be the role of an aged care system navigator was queried, with some suggesting either integrated or stand-alone aged care financial navigation services should be available.

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“Financial navigation is essential due to the complexity of the issue and potential impact on consumers.” – Peak body representative

“The need exists, but who is best to do this? It is not the role of navigators to provide financial information, but navigation to financial planners, Centrelink, etc.”  
– Aged care service provider

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### **Mode(s) of delivery**

**Face-to-face** navigation services are useful to enhance user—navigator relationships and to build trust and rapport.

**Telephone** navigation services can improve reach to some population groups as well as those who are geographically isolated.

**Virtual/online** navigation services can provide a range of information about aged care services.

**Outreach** enables face-to-face modes of service delivery to particularly marginalised people that may not otherwise have access to services.

**Hubs** offer a physical or online location where a range of navigator services can be provided.

Four of the five modes of system navigator service delivery were generally rated as important by discussion paper respondents, with all stakeholder groups rating *face-to-face delivery* the highest (*Table 6-6*). The comments provided suggested that this was seen as especially important for vulnerable populations. *Online* modes of support were rated the lowest by far by all stakeholder groups.

## 6. Interim findings: review of other system navigator models

**Table 6-6: Rated importance of system navigator services' modes of delivery, by stakeholder group (mean/100)**

Respondent type	Face-to-face	Outreach	Hubs	Telephone	Online
Government department/ agency	91 (n=18)	81 (n=18)	60 (n=18)	62 (n=17)	35 (n=16)
Aged care assessment workforce/provider	94 (n=20)	92 (n=19)	73 (n=19)	55 (n=18)	44 (n=18)
Aged care service provider	91 (n=114)	82 (n=109)	66 (n=108)	67 (n=110)	50 (n=110)
Peak body	97 (n=21)	88 (n=21)	77 (n=20)	79 (n=21)	61 (n=20)
Other	92 (n=39)	86 (n=41)	70 (n=38)	73 (n=39)	58 (n=39)
<b>Overall</b>	<b>92 (n=212)</b>	<b>84 (n=208)</b>	<b>68 (n=203)</b>	<b>68 (n=205)</b>	<b>51 (n=203)</b>

### Combination/hybrid

Through discussion paper comments and stakeholder interviews, it became apparent that there is strong support for a combination of all modes of service delivery provided by a single navigator service. This was suggested to be particularly relevant to enable flexibility within service delivery and the provision of supports of varying intensity to assist consumers with varying:

- Levels of vulnerability, capacity and confidence
- Needs and preferences
- Degrees of progress in accessing aged care services.

It was noted that, for example, while *face-to-face* contact was generally viewed as extremely important, subsequent follow-up via *telephone* may be entirely appropriate. Alternatively, service users may first make contact through a group meeting at a *hub*, with further access via other modes. This may be a general model that reduces the resource intensity of service delivery, but may be of even greater relevance in rural/remote areas where a 'fly-in, fly-out' model could support initial *face-to-face* contact with *telephone/online* follow-up.

In addition, where *face-to-face* delivery is impractical, alternative modes of delivery should exist (e.g. in remote areas or for geographically dispersed populations).

"Clients are best served through a diversity of communication and engagement modes which match their communication preferences and needs (e.g. mobility, regionality, technological access etc.)." – Aged care service provider

"The modes of delivery are all simply tools to achieve the desired outcomes, with flexibility to address individual needs." – Local government representative

"As most [of the CALD community] have language and reading and IT challenges, it is important to offer information in as many forms as possible to enhance knowledge." – Ethno-specific organisation representative

## 6. Interim findings: review of other system navigator models

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### *Face-to-face*

Noting strong support for the provision of options regarding navigator service delivery mode, *face-to-face* delivery of aged care navigation was generally felt to be most important, and even essential, for many older Australian consumers. This is likely to be even more pertinent for those from vulnerable population groups. In discussion paper responses, all stakeholder groups rated *face-to-face* as the most important navigator service delivery mode (Table 6-6).

In this context, vulnerable people could include those from special needs populations as well as those with disabilities (e.g. hearing or vision loss, cognitive decline) or difficulties accessing or using technology. Beyond such practical considerations, building trust between navigator and service user was felt to be best facilitated through *face-to-face* contact.

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“The mode of delivery most needed is face-to-face: this is the component that is not available under the current system.” – Aged care service provider

“Face-to-face delivery is central to building trust, providing a space for users to ask questions and, most importantly, time to consider the information being provided.”  
– Aged care assessment provider

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Stakeholders noted that *face-to-face* service delivery could also support the *involvement of multiple family members* in discussions and decisions regarding aged care services.

However, the cost of one-to-one, *face-to-face* service delivery was noted, especially in the context of the burgeoning ageing population and ever-increasing need for this type of support. In addition, it was noted that these needs and preferences may change over time:

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“While the survey may have been biased towards face-to-face [service provision], it is not always practical or cost-effective, and will change over time as generations become more tech-savvy and connectivity in remote areas improves.”  
– Aged care service provider

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Stakeholders felt that *face-to-face* contact would optimise consumer engagement, build trusting relationships and allow navigators to get relevant information about a consumer that may not be disclosed by a service user or picked up by a service provider through telephone or online contact. Such comments often implied that the *face-to-face* contact would occur in a service user’s home, allowing the navigator to see first-hand that person’s living conditions, mobility, mental health, aged care and other needs and potential challenges. Home visits may also allow the service user to feel more comfortable and in control, and negate mobility and transport barriers.

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“So many people will not or cannot travel to metro centres for an appointment—we need to go to them.” – Peak body representative

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## 6. Interim findings: review of other system navigator models

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Other stakeholders comments implied that ongoing contact with a navigator service would mean ongoing contact with the same individual navigator to maximise the opportunities and efficiencies afforded by trust between navigator and service user.

While *face-to-face* service delivery was often taken to mean one-to-one services, the *face-to-face* nature of village/hub and outreach models was also noted by a number of stakeholders as a key benefit of these modes of delivery. These are discussed separately below.

### *Outreach*

The importance of *outreach* was underlined in discussion paper responses, with all stakeholder groups rating this mode as the second most important after *face-to-face* (Table 6-6).

*Outreach* was frequently referred to by stakeholders as a necessary pairing with face-to-face service delivery to reach individuals who may be vulnerable and marginalised and may otherwise 'fall through the gaps' left by other modes of navigator service delivery. It is worth noting that stakeholders' interpretation of 'outreach' included both visiting service users in their own homes (or other relevant community settings) and engaging with communities more generally (e.g. through partnerships/engagement with community groups, other relevant service providers, etc.).

It was noted that *outreach* activities facilitate the development of new aged care system entry points for vulnerable and hard to reach populations.

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"Meeting [consumers] where they are, or at least in the local community, is preferable." – Aged care assessment provider

"Outreach mode is a useful tool to engage with communities, provide information, training and peer-to-peer support. It can also be a good tool to secure a 'mandate of recognition/approval from relevant community leaders.'"  
– CALD organisation representative

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### *Telephone*

While overall discussion paper responses indicated that *telephone* contact was considered to be an important mode of aged care navigator service delivery, it was rated behind *face-to-face* and *outreach*, and on par with *hubs* (Table 6-6).

While its convenience was noted for more simple information exchanges, *telephone* contact was considered less appropriate for conveying and discussing complex information, or serving people who may experience a range of barriers to this mode (e.g. language barriers, hearing impairment, cognitive decline). Overwhelmingly, *telephone* support was considered appropriate for more able/engaged service users and as an adjunct to other service delivery modes, most particularly *face-to-face* (e.g. as an initial contact to arrange a *face-to-face* meeting or as a follow-up once background information has been gathered and a baseline relationship established).

## 6. Interim findings: review of other system navigator models

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“Many are either harassed by cold callers or have hearing issues, so the phone is not a good option unless the client chooses it.” – Aged care service provider

“Consumers are in their 80s plus—face-to-face contact with telephone follow-up builds the relationship.” – Aged care service provider

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### *Hubs*

Overall, stakeholder groups rated hubs behind face-to-face and outreach, and on par with telephone delivery. However, hubs were felt to have a potential role in improving visibility of navigator services and engaging the community (Table 6-6).

Many of the benefits of hubs related to the provision of *face-to-face* navigation services as well as representing *outreach* into communities. However, the challenges relating to these service delivery modes, especially in remote communities, were also noted to apply to *hubs* (see relevant sections above).

Stakeholders noted that *hubs* could support flexibility and integration of services—for example by housing professional and peer navigators, financial navigators and potentially aged care assessment services, and providing access to written and online resources.

It was suggested that *hubs* could be strategically co-located with other services to improve reach into specific communities (e.g. with an Aboriginal Medical Service) or with other services frequently visited by older Australians in general (e.g. primary/community health centres). Others noted that local councils might be ideal settings for aged care navigator hubs.

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“Hubs seem a natural form of supporting identified people within their communities in trusted, safe and familiar settings.” – CALD organisation representative

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However, stakeholders felt that some vulnerable populations may experience significant barriers to accessing hub-based services. Mobile hubs (and/or their staff) could potentially reduce this barrier and facilitate maximum reach.

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“The hub and worker need to be mobile: going to where people live, their communities. Not expecting older people to go to you.”  
– Aged care advocacy service representative

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### *Online*

In discussion paper responses, all stakeholder groups rated *online* supports as the least important mode of aged care navigator service delivery (Table 6-6).

## 6. Interim findings: review of other system navigator models

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“Generally, a lower cost service channel such as online resourcing is preferred to manage costs for high volumes, but the extent to which this would meet the needs of older adults has not been determined.” – Aged care assessment provider

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Most significantly, limited digital literacy among target populations and other barriers to *online* access were noted. Despite this, an *online* presence was considered to be important as a relatively low-cost adjunct to other delivery modes (rather than a primary mode of delivery), and may suit the needs of some (generally less disadvantaged) aged care consumers and their families. *Online* information could also be utilised by family members and other organisations supporting aged care consumers. Emails following other modes of initial contact could also provide a record of discussions and tailored information.

Stakeholders also noted that the digital literacy of older Australians is likely to increase considerably over time, meaning that *online* service delivery may become more and more important in future years. There may also be opportunities to integrate basic aged care navigation elements into existing, broader digital literacy programs for older people.

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“Navigation services could intersect with digital literacy capacity-building services (e.g. in library and local council settings) to empower people to navigate online resources and portals.” – Local government representative

“The delivery mode needs to be able to change over time. Currently the majority of clients in the aged care system are unlikely to want [online service delivery]. However, their families may, and within 10-20 years this function will likely be in greater demand than telephone.” – Aged care service provider

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Some stakeholders noted that videoconferencing in combination with *face-to-face* service user contact could allow remote family members to be included in information provision and decision-making within a navigator model. It was also raised as a potential alternative to *face-to-face* service delivery for those in rural/remote areas.

### Other components

Other components of an aged care navigator model deemed important by stakeholders included service user follow-up and feedback/evaluation, and carer support.

## 6.4 Interim findings: Promising models and implementation considerations

**Which system navigator models offer most promise for future investment/implementation in Australia?**

**How can these complement/build on existing supports and investments?**

**What other implementation considerations should be taken into account?**

This section presents preliminary findings from the environmental scan, discussion paper responses and consultations (to December 2019).

The information presented in this section has been considered along with data from other evaluation queries to provide suggestions regarding opportunities to enhance the trials as the evaluation progresses and other data sources become available. The information presented here will also be considered when outlining potential future aged care system navigator models, which will be presented in the Final Report.

### 6.4.1 Relevance of navigator models to the Australian aged care system

While commenting on the relative strengths and weaknesses of individual models of system navigation (as summarised in *Section 6.3.2*), stakeholder responses suggested that there is a potential role for *all* of the navigator models highlighted in the discussion paper in the Australian aged care setting.

Discussion paper respondents and external stakeholders strongly suggested that aged care system navigation should be provided through a holistic and flexible model. In particular, it was noted that flexibility may be best promoted through the use of a “hybrid” navigator model (e.g. combination of professional and peer navigators, opportunities to include family members, access to financial navigation, multiple communication channels, hubs and outreach).

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“They are all very good models, and definitely have a place. However, to truly have an impact there needs to be multiple models used to ensure that there are many avenues for people to access information to help them access the services they may require, along with targeted roles within the models for marginalised groups.”

– Aged care service provider

“Rather than focus on the respective merits of each model, we believe strongly that a hybrid model, reflecting the needs of the particular audience being served and the outcomes to be achieved, will be what is required.” – Peak body representative

“In my opinion, it would be nice to have a navigator model where all strengths are present. This ideally should happen if patient, professional, family, peer and hub [models] work collaboratively in an interprofessional team.”

– Aged care service provider

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## 6. Interim findings: review of other system navigator models

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Although stakeholders noted a strong preference for professional navigation models, it was often noted that these could be supported by peer navigators for lower-intensity information/service provision. In this way, peer and professional navigators could have different roles within the system, and support a 'stepped care' approach.

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"Peers are essential for identifying those who are isolated and in need in the community. Professionals are essential for identifying complex needs, or stepping in and doing a home visit when a client's needs are too complex for a non-professional." – Partner organisation representative

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In addition, it is possible that the development of an effective model of professional navigation might inform future opportunities for peers to have a more significant role.

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"As navigation establishes itself as a function, it may be advisable for this to be led by professionals in the first instance. Once the model is evaluated and training requirements for navigators are firmly established, peer navigators can be trained for maximum reach and effect." – Aged care assessment provider

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Many stakeholders noted that it is important not to "reinvent the wheel", with good work currently being done across the country to help consumers access and navigate the aged care system. In particular, many discussion paper respondents made reference to the A&S program in Victoria.<sup>3</sup>

There may also be opportunities to learn from existing models in other relevant sectors, such as Local Area Coordinators funded through the National Disability Insurance Scheme and the Carers Gateway.

### 6.4.2 Addressing implementation challenges

In the discussion paper, stakeholders were asked to comment on barriers and enablers to the implementation of an aged care navigator model with respect to the following categories:

- Capacity
- Reaching target populations
- Funding, independence and competition for services
- Integration
- Research/data collection.

Stakeholders' views, obtained through responses to the discussion paper as well as individual consultations with external stakeholders, are discussed under their respective categories below. It is noted that some of these have been already discussed as service design principles (see *Section 6.3.3*).

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<sup>3</sup> Note that 35% of discussion paper respondents were Victorian.

### Capacity

Barriers identified by stakeholders regarding capacity most often included the *time-intensive* nature of providing *tailored navigator support* to disadvantaged and geographically distant consumers with complex needs, and a general lack of funding to do it. While it was noted that many organisations are currently fulfilling a navigator role (including service providers, advocacy services and community organisations), very few of them are funded to do so, and their capacity to undertake this role is often limited. For individual staff members involved in system navigation, workload and prioritisation of consumers is a key issue, along with managing consumers' expectation of the navigator services where the scope may be more limited than consumers would like. It was noted that professional navigators needed sufficient time to network and learn about relevant local agencies, and that the navigator role should be separate or quarantined from clinical roles and expectations.

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"The process of explaining and assisting older people with navigating the aged care system, funding options, service options and financial considerations is a time-consuming process. The need to work with families adds additional challenges in regard to timeliness of decision-making." – Aged care service provider

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For most organisations, capacity to support rural and remote communities is often particularly limited, as travel time detracts significantly from direct service provision. Evaluation data collection and reporting requirements also contribute to capacity challenges, if overly onerous.

Enablers relating to service capacity included defining/delineating the role of navigators and determining the end point of interactions to avoid "scope creep" and allow what capacity exists to be focused strategically. Systematic prioritisation of waiting lists and managing service user and community expectations regarding the scope of the service may also be important implementation considerations. These activities may also help to minimise "competition" between community organisations for service users for similar or related services. Stakeholders expressed concerns about the effect of capacity issues on navigator staff.

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"A weakness of all models [of aged care system navigation] is the possibility of over-engagement and [navigator] burnout." – Aged care service provider

"If staff are not paid well and are overworked—like what we have right now—these models are useless." – Aged care service provider

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A focus on empowerment and independence, rather than case management, may also help to address capacity issues in some cases, although stakeholders acknowledged that the most vulnerable consumers will likely need more intensive assistance. *Diversity within the navigator workforce* could improve a service's ability to reach, engage and provide appropriate support for individuals and population groups.

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"Better staffing allows for a greater spread of people to find more of the target population and expand service provision." — Dementia Advisory Service

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## 6. Interim findings: review of other system navigator models

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Particularly for larger and/or less vulnerable community groups, presentations and seminars provided for large numbers of community members may be a good way of reaching many people through a single activity, potentially leaving more time to offer more intensive services to disadvantaged service users in a stepped model of service. Such a model could include involvement of a number of variously-qualified navigators, allocated to individual consumers or roles depending on level of need.

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“Give consideration to tiers of professional and paid navigator staff (nurses, allied health professionals, allied health assistants, certificate-trained staff) linked to the complexity and risks of the client and situation. Perhaps a specialist qualification could be established to broaden the cohort of people able to provide a professional navigator service.” – Aged care service provider

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In this vein, the use of peer/lay navigators in combination with (and supervised by) professional navigators may also help to bolster service capacity.

Networks and partnerships (e.g. between navigator services and community groups) may help to address capacity issues for both organisations and facilitate assertive outreach. Working with other community organisations to bring a consistent information offering to different target community groups, and support from quality resource materials and tools to support both navigators and service users will help maximise capacity. For navigator service providers, this might include development/involvement with networks, CoP, and professional development.

Given the importance of integration and networks and linkages as design principles, navigators should also be provided with dedicated time to develop and maintain key linkages (e.g. attending network meetings, orientation to funded agencies).

Building capacity within navigator services (e.g. resourcing, reach, training and professional development for navigators), other relevant services (e.g. primary care and other providers) and communities (e.g. through improving health literacy) will likely help to maximise all sectors' capacity to support aged care navigation.

Other factors that may promote capacity include:

- Ongoing, quality training for navigators (e.g. to understand scope of practice, develop cross-sectoral networks)
- Clear referral pathways for other services
- Video link capabilities (to reach geographically isolated communities).

Unsurprisingly, stakeholders noted that *appropriate funding levels* were needed to meet demand for navigator services and adequately resource the workforce.

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“[We need] secure block funding and career/salary progression for navigators to avoid high turnover and enable continuity of service provision.”  
– Peak body representative

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### Reaching target populations

Stakeholders noted that, while many older Australians would benefit from aged care navigator services, reaching target (vulnerable) populations to provide access to such services is difficult. Despite this, they confirmed the importance of providing a navigator service that is accessible to vulnerable populations, and the need for a proactive approach to facilitate this.

As noted in the discussion paper, engaging “hidden” populations may be difficult due to:

- Mistrust of the aged care system or systems more broadly due to prior life experiences
- Social isolation
- Low levels of awareness of the aged care system, or health and social systems more broadly
- Language/communication barriers (including low levels of literacy).

Other factors include geographic barriers, complex family circumstances (e.g. elder abuse, family violence), and financial barriers.

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“Reaching our most vulnerable needs a model that is flexible and has the capacity (time) to build trust.” – Sector support provider

“A trusted navigator entity with the right staff is needed.”  
– Aged care service provider

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Identified *enablers* included positioning navigators in communities, where they are *most accessible* to older people. ‘Housing’ aged care navigators within neighbourhood/senior citizens centres, ethno-specific community organisations for CALD populations, homeless and other relevant services, or co-located with other services commonly used by even socially isolated members of target populations were all suggested as useful strategies. Many older people are connected with primary care services, particularly at the point of changes in health status or health crises, and this could be one setting through which individuals might access professional aged care navigation services.

Engaging with communities and peer support programs could also be useful for reaching those from specific populations. Again, networks and referral pathways could assist in identifying those in need of navigator services, and connecting them appropriately. This includes engaging relevant community leaders as well as organisations.

It was noted that *co-designing services with target populations* and those who support and advocate for them would promote reach and relevance of the service, and potentially avoid wasted efforts. Employment of a diverse range of navigators (e.g. Aboriginal or Torres Strait Islander people, those from CALD groups, veterans etc.) would also *improve the reach and appropriateness* of navigator services.

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“There needs to be different strategies for different target populations, co-designed with the group.” – Aged care service provider

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Targeting not only individuals, but their *informal and formal support networks* may assist. For example, assertive, innovative outreach, based on local needs and characteristics, might represent an ideal strategy.

## 6. Interim findings: review of other system navigator models

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At a broader level, general community awareness of a navigator service can promote access. While generally stakeholders noted the need for aged care navigators to be high, this did not always translate to high demand, as many consumers did not know where to go for information (and often relied on individual providers).

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“I was part of a team that offered free aged care advice in conjunction with GPs and found it was very difficult to recruit clients to deliver the advice to. Marketing and hunting down people in need was challenging, which was a surprise as we all think people are out there desperate for help.” – Aged care service provider

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Building and promoting *clear and consistent branding* that is recognisable and appropriate to the audience may help to raise awareness of a national aged care navigator service. Creative ways of reaching specific population groups could also be considered (e.g. community radio). A visible community “presence” (discussed above) may also help (e.g. hubs in strategic locations to target older people in general and those from disadvantaged populations more particularly). Training and formal referral pathways for “gatekeepers” who work with vulnerable people already (e.g. through health and community sectors), could be another strategy, supporting a “no wrong door” approach.

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“Navigation services are like local bank branches in small country towns...they need to have a physical presence, even if that presence is part of another established organisation.” – Aged care service provider

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At the local level, community scoping and assessment (mapping) can assist in developing an appropriate model and system that reaches the desired target(s). “Universal” strategies could also be utilised to promote access to aged care navigation for all older Australians. Such approaches might include, for example:

- Providing an aged care information pack (including information about navigation services) when someone accesses the aged pension or superannuation
- Integrating of an aged care navigator function (or screening for need) within aged care assessment
- Utilising the 75+ health assessment as an opportunity to educate people about maintaining independence, services that may assist with this, and the aged care system.

### Funding, independence and competition for services

At a basic level, funding has already been discussed at it relates to service capacity and continuity and sustainability of a navigator model. It has also already been noted that providing navigator services for vulnerable population groups is likely to be more resource-intensive than providing such services to less disadvantaged groups. Despite this, offering services that are free of charge to disadvantaged people (if not all older Australians) was considered important.

Stakeholders highlighted the *importance of government commitment to stable ongoing funding* for any aged care navigator service model implemented. Funding of a navigator service needs to consider a number of activities beyond direct service provision, including adequate implementation resources, systems development (e.g. for tracking and referrals), transport and travel (in metro as well as rural and

## 6. Interim findings: review of other system navigator models

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remote areas), translating and interpreting services, community liaison activities, partnership development activities, staff recruitment, training and development, evaluation and quality improvement activities and administration.

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“The [aged care] navigator trials in New South Wales are a great example of a well-planned model not having sufficient resources to be implemented to its full capacity.” – Peak body representative

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Stakeholders noted the value in having a recognisable and independent service providing aged care navigation services, allowing both consumers and other relevant organisations (e.g. in the health and community sectors) to develop streamlined relationships and referral networks.

This may also allow differentiation between independent navigation services associated with My Aged Care and aged care service providers’ own models which have the potential to be affected by conflicts of interest.

Clearly separating navigation services from aged care service provision could help to mitigate any “competition” for service users between the two and allow navigators to remain (and be perceived as) independent. However, as noted earlier in the discussion of independence as a design principle, this may not be as important—or even desirable—in the context of some specific population groups.

Some felt funding for navigator services should be directed to community organisations to eliminate potential conflicts of interest. Local governments and PHNs were frequently cited as appropriate choices in which to “house” navigator services.

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“Local governments are the ideal hosts, underpinned by a strong code of ethics, governance structures and conflict of interest policies.”  
— Aged care service provider

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Aged care assessment services might also be ideally placed (noting that potential conflicts are not absent in all local government and assessment service settings).

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“It is imperative that service navigation is integrated into the streamlined assessment model being developed by the Australian Government.”  
– Aged care assessment provider

“The navigator model should not be considered separately to the My Aged Care system and the streamlined aged care assessment model. If the system is well designed from the beginning to “flow”, then [aged care navigation] does not need to be considered and funded separately.” – Local government representative

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It should be noted, however, that some aged care providers reported delivering navigation services that were independent in nature, and that this model worked well when appropriate governance was in place to avoid conflicts of interest having any bearing on navigator service delivery. In particular, this model was

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noted to be effective in smaller communities, where the number of providers is limited (perhaps even to one organisation) and/or where a provider is a “trusted expert” on aged care in the community.

### Integration

As discussed in *Section 6.3.3*, many stakeholders felt that ‘integration’ should be interpreted broadly to maximise the utility and effectiveness of an aged care navigator service. Many stakeholders noted that an ideal navigator model would not be limited to government-funded aged care services, but have a broader focus on promoting physical, mental and social wellbeing.

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“We do not want navigators to be set up just for funded aged care systems but other areas as well: health, community support, libraries, senior citizens clubs.”

– Aged care service provider

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Relevant services/sectors might include:

- My Aged Care
- Aged care assessment providers (and the new streamlined assessment model)
- Aged care providers
- Primary care providers, PHNs, community health and allied health
- Hospitals (public and private)
- Community health services
- Disability sector service providers and Local Area Coordinators (NDIS-funded navigators housed within partner organisation)
- Senior citizens/neighbourhood centres
- Peak bodies/community organisations (condition specific organisations such as Parkinson’s Australia, Dementia Australia, as well as community-specific organisations)
- Carer supports and networks (e.g. Carer Gateway).

Information sharing within these integrated networks—for example, systems that allow for consent and release of consumer information to other providers—would support consumer outcomes. For example, allowing navigators to have controlled access to shared data (e.g. through My Aged Care service provider portal, My Health Record etc.) was supported by a number of stakeholders.

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“One of the best systems I have encountered has arisen from a cooperative group of providers in a local government area gathering under the PHN banner. They have been able to cooperatively address issues in their specific community and build strong links to services across the health and community sectors. The strength of these networks creates benefits that build stronger communities as well as deliver better collaborative responses to client needs.” – Aged care service provider

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A key component of integration was *consistent and robust referral pathways* to facilitate the supports needed by individuals. Activities to support this might include mapping of consumers' care journey and current care, support and service options, and relevant partnerships with effective information sharing.

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"Meaningful coordination and integration can occur once the service landscape is clear and understood, and there is a sense of shared purpose among agencies and organisations." – Peak body representative

"System navigators need to be...very familiar with the community and have extensive professional connections." – Peak body representative

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In order to realise all the benefits of integration, the importance of resourcing navigators to *develop and maintain relevant linkages and partnerships* was raised by numerous stakeholders. Activities involved might include navigators' attendance at partnership meetings, seminars and conferences, promoting services through GP and other network meetings, community engagement and peer support networking. Such activities need to be recognised and rewarded in the model, including thorough research and evaluation activities (see below).

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"Linkages and partnerships don't happen when [you're] focused on output-based KPIs." – Aged care service provider

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### Research and data collection

Beyond comments about the utility of data-sharing activities (discussed above), research and data collection activities were not raised as implementation challenges as much as other barriers discussed above. However, it was consistently acknowledged that data collection was vital to inform what works with particular population groups, justifying investment and demonstrating need for growth of that investment over time, and embedding a culture of continuous improvement within the service. Despite this, it was also noted that some valuable aspects of aged care navigation may be difficult to evaluate, and that outcome measures (including consumer experience/satisfaction) were of particular importance.

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"A lot of what an effective navigator will do will not be easily measured. There is a risk that it will not be acknowledged and resourced."  
– Aged care assessment provider

"Throughput pressure inevitably and significantly undermines almost all the desired design principles." – Local government representative

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Stakeholders *warned against excessive administrative burden* (and burden on service users) associated with data collection, and noted that funding should be allocated for these activities. Standardised data collection tools and reporting guidelines could help ease administrative burden if well designed, but have the reverse effect if not.



### Other implementation issues

A number of other implementation issues were raised by stakeholders through responses to the discussion paper and other consultations.

#### *'Fix the system'*

Despite the perceived usefulness and need for aged care navigation services in the current Australian context, some stakeholders noted that the need for navigation (in any sector) was a reflection of unnecessary complexity within that sector, or disconnection between it and other relevant sectors. If this is the case, it was reported that efforts should focus on addressing these systemic issues, as opposed to helping consumers navigate them.

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"The explosion of scope [for navigators] occurs because there are so many gaps in the system, rather than a problem with the system navigation models."

– Government representative

"Integrated planning across services could be trialled as a novel concept."

– Aged care service provider

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In this context stakeholders raised a number of concerns about the lack of user-friendly, accessible information currently available through My Aged Care (both the website and telephone-based customer service centre). They suggested that low-level navigation assistance might be provided to consumers through the existing My Aged Care service.

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"Fix My Aged Care to be simplistic in design and contain clear and concise information." – Peak body representative

"The rationale for the My Aged Care website, phone number and portal was that it would be the 'one stop shop' of aged care. The federal government was to assume responsibility for the increasing ageing population." – Aged care service provider

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Apart from complexity/disconnection within and between sectors, the rate of change and reform in the aged care system presents implementation challenges for any aged care navigator model operating in this context. This is because it makes it difficult both to ensure navigator knowledge is up-to-date (e.g. through ongoing training and professional development) and to build accurate awareness within communities in general as well as important community "touchpoints".

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"All models rely on the navigator having in-depth knowledge of a support network fraught with complexity and change." – Aged care service provider

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## 6. Interim findings: review of other system navigator models

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### *Engage all stakeholders in design, planning and implementation*

To promote integration, it will likely be important to consider and engage a broad range of stakeholders in the design and implementation of an aged care navigator service.

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“Local government is part of the solution but the full strategy needs to be developed in full consultation with all stakeholders, including those not yet engaged.”

– Peak body representative

“A systemic, planned approach to the development of the model which incorporates responses to all the identified barriers and enablers. Those who have had recent experience ‘in the field’, including RAS and ACAT officers, should be involved in the planning process.” – Government representative

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### *Avoid duplication*

Many stakeholders reinforced that aged care navigation activities are already happening in a number of different settings, and felt strongly that the experience gained from these activities should not be wasted, and duplication of effort should be avoided.

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“A navigator model should harness existing systems or assets within communities.”

– Peak body representative

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## References

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