Key Takeaways – SME Chat Nurse Navigators and Shared Care

Nurse navigators are experienced clinicians who coordinate care for patients with complex health needs, ensuring timely access to a wide range of appropriate services across the health system.

Nurse navigators improve outcomes, enhance system efficiency, and in some cases, reduce hospital admissions. They work in collaboration with GPs, educating and empowering patients to manage their own health.

Read this CQU-led research paper titled 'Nurse Navigators - Champions of the National Rural and Remote Nursing Generalist Framework: A solution'.

Supporting WQ HealthPathways:

Care Coordination

SME

Simone Thomason (Nurse and Health Literacy advocate).

Topics Covered

Service Snapshot

- Established in 2017, the Nurse Navigator Service operates within the Central West HHS, based in Longreach and servicing surrounding communities including Ilfracombe, Stonehenge, and remote properties within an 80–100 km radius. Nurse Navigators can also be found within the North West HHS and the South West HHS.
- Four experienced navigators support patients across the region using a "cradle to grave" model, assisting people of all ages to access and navigate care.
  As rural generalists, they work across clinical areas, connecting health, community, and NGO

services to ensure coordinated, patient-centred care.
- Their primary goal is to improve engagement, reduce preventable hospital admissions, and enhance access for people facing barriers such as isolation, low literacy, or complex social needs.

Referrals and Pathway of Care

- Referrals are accepted primarily from GPs, hospitals, and other clinicians, with patient consent required.
- The service is transitioning to a clinician-only referral model supported by a structured triage process assessing chronicity, intensity, and social complexity.
- Navigators operate from within Community Health, focusing on holistic, non-urgent, wrap-around support rather than acute care.
- They provide regular feedback to referrers and advocate for clear flagging of navigator involvement within clinical systems (e.g. Best Practice).

Role in Shared Care

- Nurse Navigators complement GP care, not replace it. They act as an extra layer of support for patients with chronic or complex conditions, helping them understand and follow through on GP care plans, investigations, and treatments.
- Navigators often attend appointments to act as a “second set of ears”, reinforce key messages in plain language, and assist with follow-up tasks such as blood tests, imaging, and medication management.
- This partnership strengthens continuity, prevents care gaps, and builds patient confidence.

Supporting Patients with Barriers

- Navigators frequently assist people with low literacy, neurodivergence, anxiety, or social isolation.
- They use plain language, visual tools, and face-to-face explanations to overcome communication and digital barriers.
- Rather than assuming digital literacy, they tailor interactions to each person’s capacity and preference.
- By addressing the immediate issues that matter most to the patient, navigators build rapport, trust, and long-term engagement — enabling greater self-management and reducing dependence.

Examples of Impact

- Travel Support: Helped a 63-year-old man travel to Brisbane for diagnostics by coordinating meet-and-greet airport assistance — preventing care avoidance.
- Elder Advocacy: Worked with Public Guardian and Trustee to secure essential supports for vulnerable adults, including those facing romance scams or elder abuse.
- Health Literacy: Supported patients to complete complex forms (e.g., interlock applications),

which built trust and opened the door to ongoing healthcare engagement.

System Challenges and Improvements

- The team identified challenges with the Public Guardianship scheme, citing slow processes and inconsistent consent decisions that limit access to essential supports such as Meals on Wheels.They recommend more responsive, health-integrated, and locally coordinated guardianship processes.
- Navigators also note that the Nurse Navigator referral form is available statewide via the QH intranet (QuIPPs) but needs better visibility and accessibility in systems like HealthPathways.They suggest positioning the information under “Allied Health and Nursing → Nurse Navigator” with a clear summary of eligibility, referral steps, and suitable case examples.

Building Awareness and Collaboration

- The service continues to promote awareness among GPs, hospital teams, and new staff through orientation sessions and local relationship-building.
- Because “Nurse Navigator” can be confusing to patients, they often describe the role as a community-based nurse who helps coordinate care and connects services.
- Promotion relies on word-of-mouth, trust, and collaboration, not formal marketing campaigns.

Culturally and Literacy-Sensitive Practice

- The navigation model draws from US First Nations cancer navigation programs, adapted for Australian rural and Indigenous contexts.
- Navigators use visual and story-based tools, such as Leukaemia Foundation picture booklets, to explain complex procedures in culturally appropriate ways.
- This approach supports understanding and confidence among patients who may not engage with traditional written resources.

Key Messages for Clinicians

- Nurse Navigators strengthen, not duplicate, GP care.
- Referral requires patient consent and a clear description of barriers (not just diagnoses).
- Use plain, respectful communication and check for literacy challenges.
- Small, consistent actions—like reinforcing care plans—can make a major difference.
- Collaboration and early referral prevent hospitalisation and enhance continuity.

Useful Resources

- Leukaemia Foundation: Picture-based health literacy tools for First Nations Australians with blood cancer