Australian Government
Cancer Australia

# Cancer Care Navigation in Australia – Policy Context and Opportunities for the Future

August 2025

# Statement of Acknowledgement

Cancer Australia acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of Country throughout Australia. We pay our respects to Elders, past and present.

We celebrate the ongoing connections of Aboriginal and Torres Strait Islander peoples to Country, culture, community, family and tradition and recognise these as integral to health, healing and wellbeing.

Cancer Australia acknowledges great diversity among Aboriginal and Torres Strait Islander peoples, and the contribution of the many voices, knowledge systems and experiences that guide all efforts to create a culturally safe and responsive cancer system that is equitable to all.

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# 1. Purpose

The purpose of this policy paper is to outline Cancer Australia's long-term vision for an integrated, multi-channel, multi-disciplinary cancer care navigation system in Australia, as an initial step to inform national policy development and future program implementation. This paper proposes potential policy opportunities across the cancer control sector that will enhance the patient, family, and carer experience, to progress the Australian Cancer Plan's ambition for improved outcomes for people affected by cancer.

The following definitions apply in this paper relating to the Australian navigation system:

**Table 1: Definitions**

| | |
|---|---|
| Integrated | A system with various parts or aspects of care that are linked or co-ordinated into a whole. Integrated care involves the provision of seamless, effective, and efficient care that is fit for purpose and person-centred. |
| Multi-channel | Using multiple communication channels and provider platforms to reach and engage with patients, caregivers, and the broader healthcare audience across the entire cancer journey. Individuals are empowered to access information and support across multiple touchpoints through face-to-face encounters provided in the various settings, or via various media such as websites, social media, mobile apps, telehealth helplines and portals, search engines, email, and more. |
| Multi-disciplinary | An integrated team approach in which medical, nursing, allied health and any other people involved in care consider all relevant treatment, care and support options and collaboratively develop an individualised plan for each person affected by cancer. Multidisciplinary care is considered best practice in the treatment planning, care and support for people with cancer. The person with a diagnosis of cancer, informal carers and the relevant community support personnel should be considered critical participants and partners with and within the care team. |

The key principles underpinning the Australian Cancer Plan informed the policy opportunities outlined in this paper. These principles are: (1) Person-centred; (2) Equity-focused; (3) Future-focused; (4) Strengths-based; (5) Evidence- and data-driven; (6) All cancers; (7) Encompassing the cancer control continuum; and (8) Collaborative.

## 1.1 Scope of this paper

Cancer Australia acknowledges that the opportunities described in this paper are **aspirational** in nature and present a **long-term vision** for cancer navigation in Australia covering the breadth and depth of the Australian health system and spanning health workforce issues, research and data, support services, and clinical services. Achievement of this vision will require whole-of-sector effort, including and extending beyond current investments in cancer care navigation through the Australian Cancer Nursing and Navigation Program and its delivery partners.

In this paper, Cancer Australia takes a broad view of the scope of cancer navigation, including those who require, and benefit from, navigation services. Several of the long-term considerations and opportunities described are relevant to all people *affected by* cancer, not exclusively people with cancer. Family members and carers of people with cancer may also access navigation services for support, particularly in community settings and for non-clinical services.

# 2. Introduction

## 2.1 What is navigation?

Navigation is a person-centred intervention that aims to empower patients, families and carers affected by cancer to facilitate safe and timely access to optimal cancer-related care and support. Navigation should:

- identify and assess barriers to care experienced by individuals
- overcome barriers experienced by individuals
- address disparities arising from contextual barriers
- occur right along the cancer care continuum
- be delivered to individuals, and support improved care at the system level
- be delivered by various personnel, with or without a third-party facilitator (e.g., digital technology), and with differing levels of clinical training, e.g., nurses, allied health professionals, community health workers and Aboriginal and Torres Strait Islander Health Workers and/or Practitioners.

Navigation includes support for people affected by cancer, including families and carers, to navigate the healthcare system, and address holistic, emotional, educational/informational, and other practical needs.[1]

Strong evidence demonstrates that patient navigation in cancer care is effective in improving outcomes and experiences across the care continuum, including by:

- improving cancer screening rates, particularly in underserved communities, for example by addressing cultural and linguistic barriers;
- reducing time to diagnosis;
- reducing hospital readmissions;
- addressing the cancer survivorship needs for people affected by cancer, such as adherence to surveillance appointments, improving the decision-making and treatment understanding of cancer survivors, improving patient satisfaction with their care, and improving cancer survivor quality of life.[2]

Evidence indicates that patient navigation in cancer care can reduce time from diagnosis to initiation of treatment, and there is also some evidence to suggest navigation can reduce patient fatigue and improve communication, as well as increase participation in clinical trials.[3]

## 2.2 Current state in Australia

The Australian Cancer Plan acknowledges that the current state of cancer care navigation in Australia is fragmented. Only a modest proportion of people affected by cancer access existing navigation models, and these people tend to be those with more common cancers. This creates significant inequities.

As such, there is a need to progressively establish integrated, multi-channel, multi-disciplinary navigation models that ensure the right support at the right time for every consumer across the cancer continuum. Nationally consistent and accessible models of cancer care navigation can guide and empower consumers to access the care and support

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[1] Chan RJ, Milch VE, Crawford-Williams F, et al. Patient navigation across the cancer care continuum: An overview of systematic reviews and emerging literature. *CA Cancer J Clin*.2023;73:565–589. https://doi.org/10.3322/caac.21788

[2] Supra n.1.

[3] Supra n.1.

they require across the care continuum, based on need and complexity. This would improve cancer experience and outcomes, and help empower all people affected by cancer, including families and carers.

Prioritising equity of access will also seek to ensure that all people, including priority population groups such as Aboriginal and Torres Strait Islander people and those from culturally and linguistically diverse (CALD) communities, receive tailored and culturally appropriate information and support.

## 2.3 Government investment in cancer navigation

On 17 November 2023, the Australian Government announced a $166 million investment for a new Australian Cancer Nursing and Navigation Program (ACNNP), highlighting its commitment to addressing the fragmentation of the cancer navigation system in Australia.

The ACNNP includes four primary components:

- Cancer Care Nurse Service: The cancer care nurse service, led by the McGrath Foundation in partnership with the cancer sector, will deliver around 250 Commonwealth-funded cancer care nurses in health and hospital services across Australia. This is in addition to the existing Commonwealth-funded prostate cancer nurses delivered by the Prostate Cancer Foundation of Australia. This activity also includes funding for the Lung Foundation Australia to continue the delivery of specialist lung cancer nurses between 2023-24 to 2025-26 to adequately support the transition of these tumour specific nurses to the cancer care nurses model by 2026-27.
- Cancer Navigation Service: Cancer Council will establish a Cancer Navigation Service that will build on their existing non-clinical in-person and telephone support services to connect people to culturally appropriate online information and support and refer people to cancer nurses, specialist tumour-specific support and First Nations cancer support, where available across Australia. The Cancer Navigation Service will also develop and implement a digital navigation platform to support a simple, secure and integrated cancer navigation service that can be accessed by phone, internet and portable devices.
- Child and Youth Cancer Hub: The Child and Youth Cancer Hub will deliver cancer navigation, support and counselling services for children and young people with cancer and their families. Canteen will lead the Hub in collaboration with Camp Quality and Redkite.
- Specialist support service: The specialist support service will provide specialist information, support and advice tailored to the unique needs of people with particular tumour types. The service will be delivered by the following organisations:

    - Bowel Cancer Australia
    - Breast Cancer Network Australia
    - Head and Neck Cancer Australia
    - Leukaemia Foundation
    - Liver Foundation
    - Lung Foundation Australia
    - Melanoma Patients Australia
    - Neuroendocrine Cancer Australia
    - Ovarian Cancer Australia
    - Pancare Foundation
    - Prostate Cancer Foundation
    - Rare Cancers Australia.

The Department of Health, Disability and Ageing is also delivering the Cancer Patient Support Program to provide grants for initiatives that will drive better outcomes for patients in priority populations and those with less common types of cancer.

In addition, in the 2023-24 Budget, the Australian Government announced the *Improving First Nations Cancer Outcomes* budget measure, which included $197.9 million funding for the National Aboriginal Community Controlled Organisation (NACCHO) to support the community controlled sector to respond to and support cancer care needs on the ground, tailored to local needs and priorities. The measure includes funding for up to 260 new positions, including cancer support officers and cancer liaison officers. Through this funding, the cancer support and liaison officers will support Aboriginal and Torres Strait Islander people navigating the cancer care system and enable them to receive holistic care tailored to their needs.

The delivery of these programs is an important step toward ensuring an equitable and accessible cancer care navigation system in Australia.

# 3. Cancer Australia's long-term vision for patient navigation in cancer care

## 3.1 Patient navigation in the Australian Cancer Plan

One of the ambitions in the Australian Cancer Plan (the Plan) is that people affected by cancer are partners in culturally safe, equitable and responsive cancer care, and health services and systems are trusted and supported for optimal experience, quality of life and cancer outcomes (Strategic Objective 2: Enhanced consumer experience).

To achieve this ambition, the Plan prioritises the development and implementation of integrated multi-channel, multi-disciplinary navigation models that ensure the right support at the right time for every person affected by cancer across the cancer continuum (Action 2.2.1).

Cancer Australia acknowledges that a fully integrated cancer navigation system will require collaboration and commitment across federal and state and territory governments. While the establishment of the ACNNP represents a significant first step towards realising the ambition of the Plan, achieving this aspiration will take time and require additional investment. The Australian Government will have a continuing role in providing leadership and investment at the national level, including investment in services and in digital health solutions. Continued state and territory investment in coordinated care, embedded into hospital systems and linked into primary care and community services, is also essential. Integrating national and state and territory systems and investment will better address the fragmentation experienced in cancer care navigation in Australia.

## 3.2 Long-term policy opportunities

To enhance patient experience and outcomes, an integrated, national multi-channel, multi-disciplinary cancer navigation model should span the breadth and depth of available treatments, resources, information, and supports offered across the health system, address the needs of families and carers where appropriate, and include the following domains:

- needs assessment
- education and information provision
- care coordination
- financial assistance
- psychosocial support (including the provision of culturally safe cancer care)
- self-empowerment
- language assistance

- logistics assistance
- supportive care and referral to clinical care
- advocacy.

Integrated navigation promotes and facilitates communication between health services, supportive care organisations, patients, and their families and carers, which, when provided in a coordinated and a timely way, supports optimal health care outcomes. Achieving integration will require leveraging and aligning innovative delivery methods including virtual care, telehealth, artificial intelligence (AI), primary care including general practitioners (GPs), specialist care including oncologists, and navigators into a cohesive navigation system. Partnerships between navigation services, both national and within jurisdictions, are essential and need to incorporate healthcare providers and services,[4] as well as additional supportive care systems such as those being established through the ACNNP. As such, integrated navigation promotes and facilitates communication between health services, supportive care organisations, patients, and their families/carers, which, when provided in a coordinated and a timely way, supports optimal health care outcomes.

Developing, refining, and evaluating an integrated, multi-channel, multi-disciplinary cancer care navigation model in Australia should address the following elements, each of which is discussed in the remaining sections of this paper:

1. Needs-based approach
2. Navigation workforce
3. Multiple entry access points
4. Needs identification and seamless escalation
5. Optimal Care Pathway focused activities
6. Leveraging digital and technological innovations
7. Research and evaluation
8. Leveraging state, territory, and international approaches to navigation to complement Australian Government investment.

## 3.2.1 Needs-based approach

Every person affected by cancer will have different requirements for when, where, and how they seek support to navigate their care across the cancer continuum. A needs-based approach to navigation can enable identification of individual needs and gaps in availability of support, and provision of safe and timely care and support to address those needs. A tiered needs-based approach is articulated in both the Cancer Council Care Coordination and Navigation Model[5] (adapted from Fitch 2008) (Fig. 1), and the Flinders Cancer Navigation Framework (Fig. 2)[6].

Both models highlight that all people affected by cancer require at least informational support, and people with greater need should be able to access additional assistance, ranging from education and coordination to intensive complex interventions. The four-tier Cancer Council model provides examples of navigation services that may be provided at each level of need.[7] The Flinders three-tier Framework also outlines mechanisms to provide such navigation services (i.e., peer-supported or professional navigation), and highlights that people will move between levels as their needs change over time. There are also other navigation models that are specific to particular delivery modes and population groups, such as models for navigation services within community settings for families and carers of people with cancer.

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[4] Supra n.1.

[5] Cancer Council Australia (website), *Introduction: Navigation in Cancer Care,* accessed 7th August 2024, https://cancer.org.au/about-us/policy-and-advocacy/treatment-care/navigation-cancer-care/introduction

[6] Supra n.6.

[7] Agbejule, OA., Crawford-Williams, F, Joseph, R, Chan, RJ. Needs-based Approach to Cancer Navigation. Caring Futures Institute, Flinders University, Adelaide, South Australia. 2024. https://doi.org/10.25957/7qej-mr36

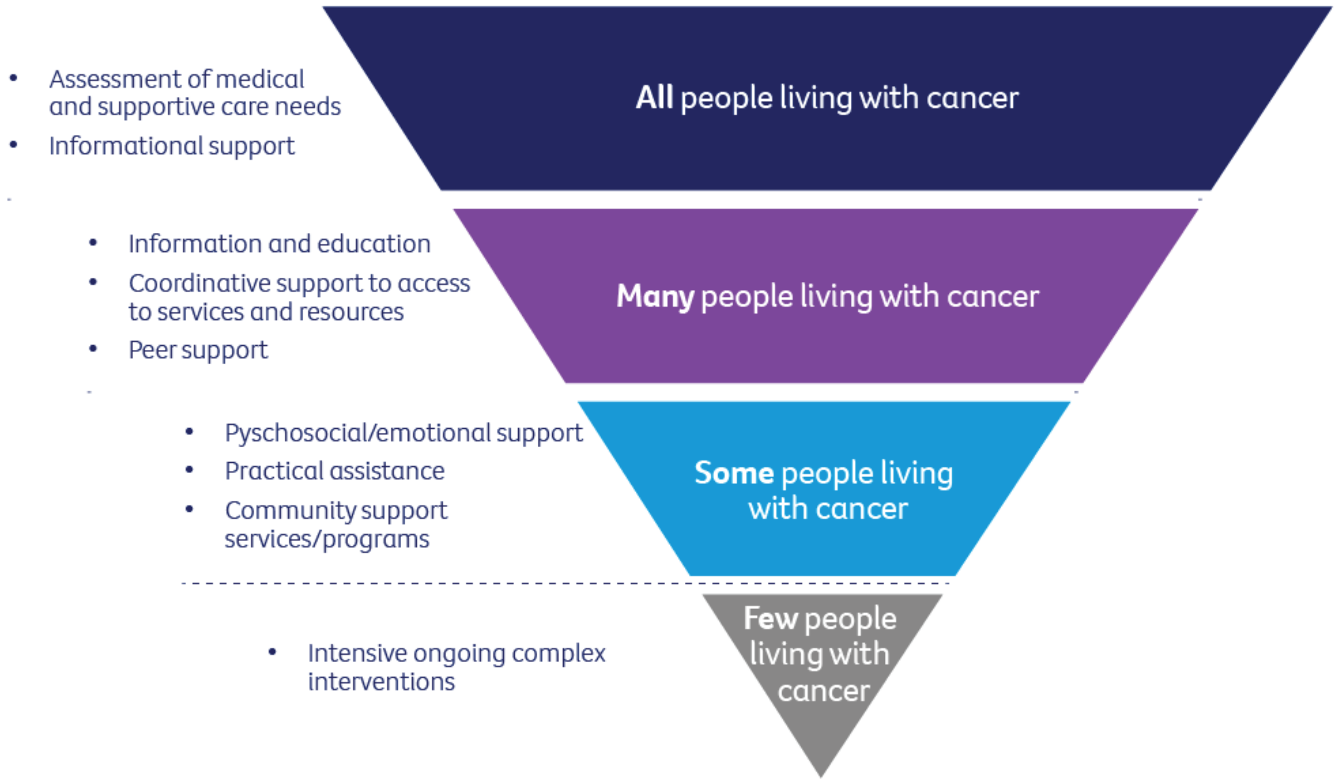
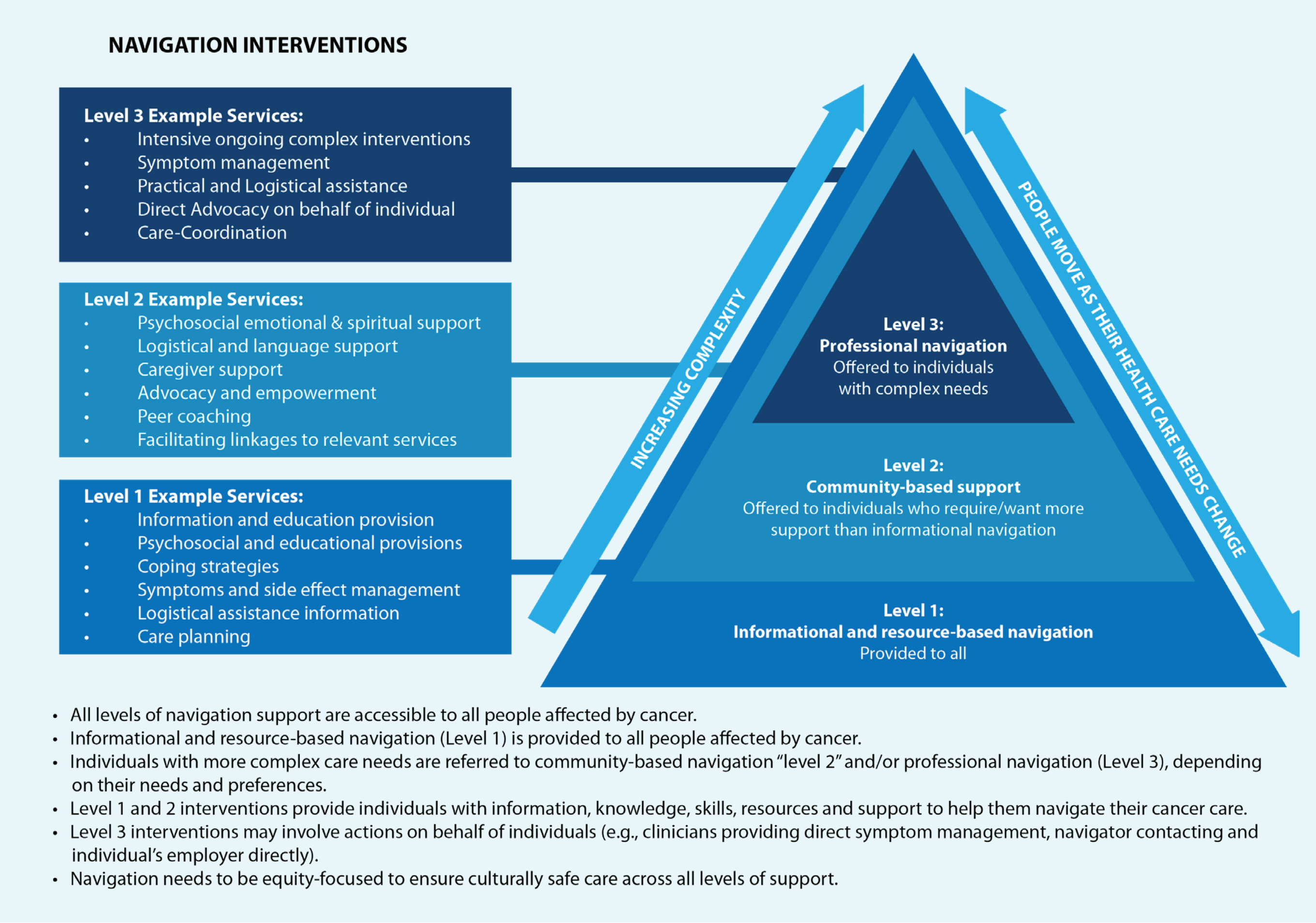


**Fig. 1. Cancer Council Care Coordination and Navigation Model**

Multi-channel navigation models should facilitate equitable access. To achieve equity, the models should specifically address the needs of priority populations, including Aboriginal and Torres Strait Islander people, adolescents and young adults, children, people from culturally and linguistically diverse (CALD) backgrounds, people living with disability, lesbian, gay, bisexual, transgender, intersex, queer, and asexual people, people in lower socioeconomic groups, people living with mental illness, older Australians, and people living in rural and remote areas.

Navigation models should foster a system that equips each person with the ability to self-navigate, where they are capable and confident to so do. To support this, a needs assessment should be a first step to entry into the navigation system. There is an opportunity to build on current validated tools for assessing supportive care needs to explore a purpose built, nationally standardised tool to assess navigation needs.

Evaluations of existing navigation programs and their effectiveness in addressing unmet needs could be used to inform the development of the tool. The tool would be used upon entry to the navigation system and at multiple time points, to facilitate mobilisation, escalation and de-escalation of navigation support. It would be embedded into the system, administered in-person or virtually, co-designed with healthcare and consumer stakeholders, and tested for validity and clinical applicability.



**NAVIGATION INTERVENTIONS**

**Level 3 Example Services:**

- Intensive ongoing complex interventions
- Symptom management
- Practical and Logistical assistance
- Direct Advocacy on behalf of individual
- Care-Coordination

**Level 2 Example Services:**

- Psychosocial emotional & spiritual support
- Logistical and language support
- Caregiver support
- Advocacy and empowerment
- Peer coaching
- Facilitating linkages to relevant services

**Level 1 Example Services:**

- Information and education provision
- Psychosocial and educational provisions
- Coping strategies
- Symptoms and side effect management
- Logistical assistance information
- Care planning

- All levels of navigation support are accessible to all people affected by cancer.
- Informational and resource-based navigation (Level 1) is provided to all people affected by cancer.
- Individuals with more complex care needs are referred to community-based navigation "level 2" and/or professional navigation (Level 3), depending on their needs and preferences.
- Level 1 and 2 interventions provide individuals with information, knowledge, skills, resources and support to help them navigate their cancer care.
- Level 3 interventions may involve actions on behalf of individuals (e.g., clinicians providing direct symptom management, navigator contacting and individual's employer directly).
- Navigation needs to be equity-focused to ensure culturally safe care across all levels of support.

**Fig. 2. Flinders Cancer Navigation Framework**

## 3.2.2 Navigation workforce

All people involved in cancer-related care play a role in navigation, as do administrative staff and dedicated professional and peer navigators. Navigation should be embedded into and across the existing cancer-related workforce, and optimally, the entire membership of cancer care multidisciplinary teams (MDTs) will be involved.[8]

The multidisciplinary cancer care principles outlined in the Plan include:

- team approach
- communication
- full therapeutic range
- nationally agreed standards
- involvement of patients.

These principles provide a flexible approach allowing for variation in implementation according to service location and cancer type. However, it is critical that the system articulates clearly defined responsibilities for members of MDTs for the following tasks:

- developing individualised plans
- liaising and communicating with healthcare providers
- providing links between acute and community services

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[8] Cancer Australia (Internal Report). *Patient navigation in cancer care: Critical analysis and knowledge synthesis 2022*. Canberra (AU): CA; (2022).

- assisting transitions across settings and providers
- monitoring and following up with patients.[9]

People with less complex needs may be well supported through self-management (with digital navigation support), peer-support, and a combination of navigation services provided by the existing MDTs and access to support services such as the virtual navigation service being established through the ACNNP.

In addition to navigation support through MDTs, which may include traditional hospital-based care coordinators focused on acute encounters, people with complex navigation needs may require support from a dedicated navigator, and in some instances, support from specialised services relevant to their cancer type. A dedicated navigator can identify needs, support culturally safe care, assist in coordinating care and support across acute, primary, and community care, and provide education and referrals to further support. All people affected by cancer should have access to a dedicated navigator if and when they need one across their cancer journey, regardless of the access point.

Dedicated navigation staff can be drawn from several sources including professionals with skills and experience in system-navigation, psychosocial, and community care, such as trained nurses, counsellors, social workers, allied health professionals, Aboriginal and Torres Strait Islander Health Practitioners, and other community-based navigators embedded within health services. All navigation staff across the health and community care workforce should complement the direct clinical care that is provided to patients through MDTs and through primary care services. Navigators should be able to connect seamlessly with tumour-specific specialist support services when needed, in a way that minimises the need for patients to share details of their cancer experiences with multiple health professionals.

Members of the same community for priority population groups should perform dedicated navigator roles, where available and appropriate (e.g., for Aboriginal and Torres Strait Islander people, people with CALD backgrounds or those in rural and remote areas).

The Aboriginal and Torres Strait Islander Cancer Plan (which complements the Australian Cancer Plan) highlights that a qualified and skilled Aboriginal and Torres Strait Islander health workforce across the health system is required to enable real change in addressing equitable outcomes.[10] Continuity of care based on high-trust relationships, meaningful rapport and relationships between Aboriginal and Torres Strait Islander Communities and healthcare teams, culturally safe mainstream services, and a holistic approach to care is needed to support Aboriginal and Torres Strait Islander people affected by cancer.[11] Aboriginal and Torres Strait Islander navigators can improve access to services; uptake of prevention, screening, and treatments; person-centred care; and facilitate culturally appropriate cancer care. All non-Indigenous health professionals (including navigators, and people providing cancer care) should receive training in culturally safe care and communication.

The navigation workforce should have access to consumer resources containing evidence-based information spanning the care continuum, including in early detection and supportive care, to support their work.[12] Additionally, education resources that are culturally appropriate and targeted should be available for Aboriginal and Torres Strait Islander people affected by cancer, developed in close consultation with community. This should complement a broader suite of resources that are in-language and tailored to the needs of people from CALD backgrounds.

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[9] Supra n.5.

[10] NACCHO (website). Aboriginal and Torres Strait Islander Cancer Plan, accessed 16th August 2024, https://www.naccho.org.au/app/uploads/2024/02/NACCHO_CancerPlan_Oct2023_FA_online.pdf (2023).

[11] Supra n.7

[12] Cancer Australia (website). For Aboriginal and Torres Strait Islander people: Resources for people with cancer. Accessed 16th August 2024, https://www.canceraustralia.gov.au/affected-cancer/atsi/resources-people (2024).

Digital technology can enhance self-directed navigation and self-management. The entire navigation workforce should, over time, have the appropriate capabilities to leverage digital systems. Achieving this long-term ambition will require access to and training in digital technology for all relevant healthcare workers. Skilled professionals with digital design and technical capabilities should support the navigation workforce, to ensure technology systems are functional, agile and fit-for-purpose, and to enable positive experiences and optimal outcomes for all people affected by cancer. Addressing these challenges is a whole-of-system issue that extends beyond individual navigation services.

## 3.2.3 Multiple entry access points

Clinical trajectories and cancer experiences are not linear. A fully integrated navigation system should enable all people affected by cancer to receive the information or support they require regardless of timing and entry point

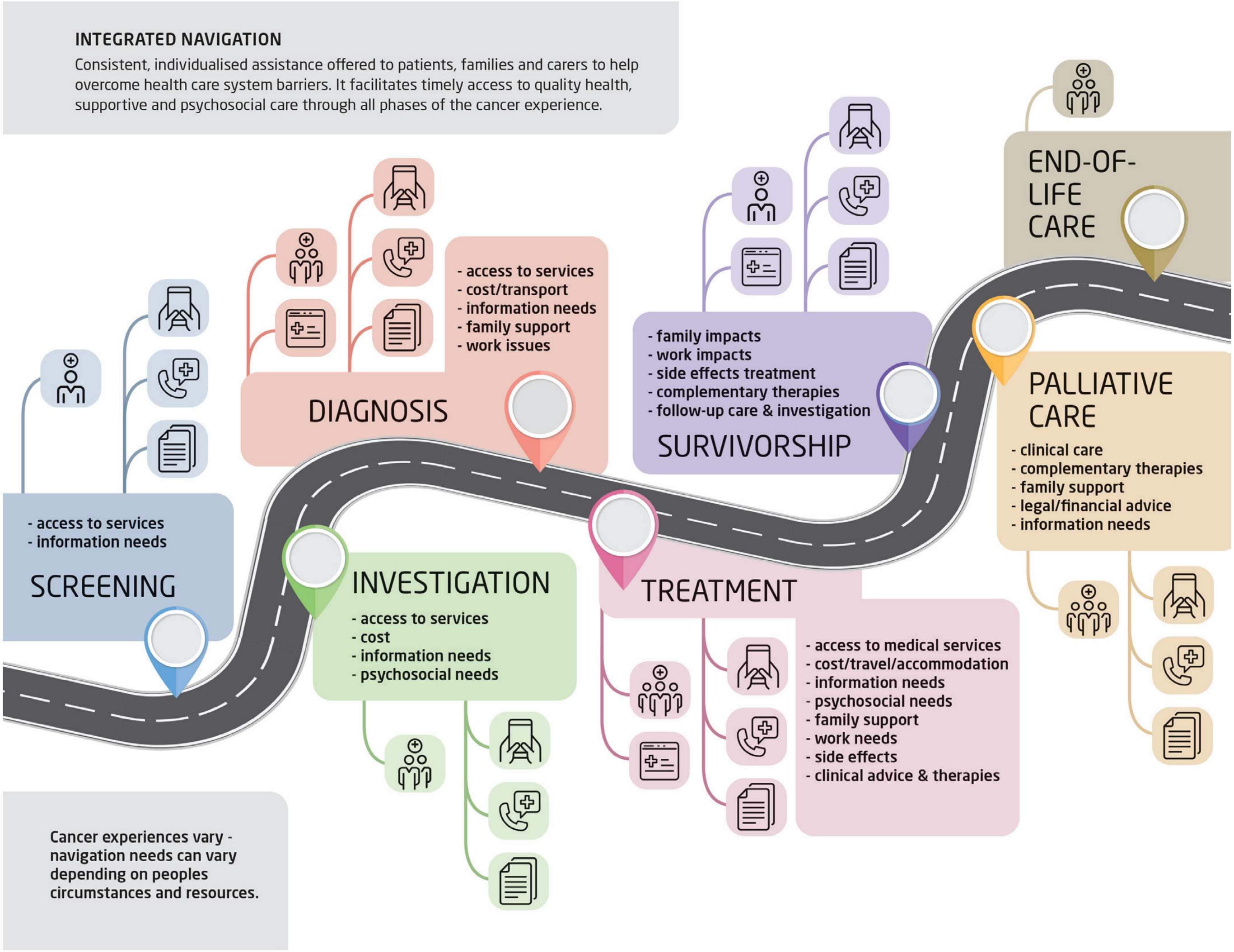

**Fig.3. Cancer care journey and multiple opportunities to access navigation**

location or method. Figure 3 shows the opportunities for patients to access navigation services along the cancer care journey.

By enabling multiple access points to enter the navigation system, including self-directed access, people affected by cancer will be able to self-navigate in a manner that places them at the centre of their care. Access points may include, but are not limited to:

- Cancer Council Australia's 13 11 20 service (telephone and email)
- Cancer Hub for child, adolescent and young adult (AYA) patients and their families (1800 431 312 and cancerhub.org.au)
- via digital services including mobile apps or internet portals
- acute care facilities
- residential aged care facilities
- primary care and community care settings, e.g., through GPs, Aboriginal Community Controlled Health Organisations
- services delivering comprehensive cancer care, and other specialist medical services
- screening services
- non-government organisations
- correctional services.

There are two key enablers of multiple entry access. Firstly, the person diagnosed with cancer and their support networks are enabled and empowered to *report* their needs. For example, individuals can contact Cancer Council though 13 11 20 at any time of their journey. However, additional strategies will be required to identify those who are not engaged or *prefer not to engage* with 13 11 20 or other existing navigation services. Secondly, there should be an integrated communication and referral system involving all clinical and non-clinical access points. Such a system would ideally be complemented by:

- agreed referral criteria that align with the person's needs and the navigation service scope;
- agreed protocols to support appropriate communication between navigation and cancer care services;
- agreed expectations on service responsiveness once a referral is raised and received; and
- a strategy for engaging and activating care provided by non-specialist cancer services, such as residential aged care facilities, primary care, and correctional services, to agree on actions depending on needs.

### 3.2.4 Needs identification and seamless support escalation and de-escalation system

The level of navigation support a person requires may vary at different points along the cancer continuum. Multi-channel navigation models must cater to the dynamic nature of a patient's cancer journey, as well as the needs of their families and carers. Systems should be put in place so that people affected by cancer can seamlessly enter the cancer navigation system and be triaged appropriately based on need, to enable timely access to more complex navigation interventions when required (e.g., contact with a cancer nurse, specialist support professional, or dedicated navigator).

As discussed in Section 3.2.1, needs assessment with a purpose-built, clinically validated tool should occur upon entry to the cancer care and navigation system and at multiple time points, with an option for self-directed assessment. Such assessments would support a seamless escalation and de-escalation model that responds to needs in real time with appropriate and timely navigation support. For example, this real-time assessment could identify people who have not yet received information on clinical trials, or been provided with a survivorship care plan, or the opportunity to conduct advance care planning. The needs assessment should be conducted at appropriate times in line with relevant Optimal Care Pathways (OCPs).

An escalation and de-escalation system does not yet exist and should be co-designed with healthcare and consumer stakeholders, with consensus on who is responsible for follow-on actions. Such a system is a whole-of-sector undertaking and goes beyond current investment in cancer care navigation, including the ACNNP. Digital innovations including AI and algorithm-backed pathways could support future developments in this space. Once a system is developed and implemented, it is critical that it is tested to ensure individuals are appropriately triaged and supported.

## 3.2.5 Optimal Care Pathway focused activities

OCPs are relevant to cancer navigation models and services in several ways:

1. Navigation models and services should be designed to support patients to access appropriate and timely care across all settings, and episodes of care in a manner and location that best suits them.
2. Each patient and their caregiver(s) should be introduced to the relevant OCP Guide to Best Cancer Care and associated resources, to support patients and caregivers to act as their own advocates for optimal cancer care.
3. OCPs should ideally be incorporated into digital navigation solutions.
4. Needs assessment should include, but not be limited to, whether certain services or aspects of cancer care have been offered (e.g., discussion of clinical trials, survivorship care plans, and advance care planning).
5. Timely and appropriate access to care, as outlined in the OCPs, is a key indicator of success in evaluating the effectiveness of navigation models and services.

### 3.2.5.1 Priority populations and OCPs

The Plan identifies 10 priority populations, some of which have dedicated OCPs (see list below). Currently, there are OCPs for Aboriginal and Torres Strait Islander people, and for adolescents and young adults. The National OCP Framework prioritises the development of new population based OCPs for priority population groups where one does not yet exist, to ensure consistent approaches to the delivery of culturally appropriate, optimal cancer care (Table 2).

**Table 2: Summary of priority population groups identified in the Australian Cancer Plan, and status of OCP.**

| Priority population group | OCP status |
|---|---|
| Aboriginal and Torres Strait Islander people | Existing OCPs |
| Adolescents and young adults | |
| Older Australians | OCPs in development |
| People living in rural and remote areas | |
| Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, and Asexual (LGBTIQA+) people | No OCPs |
| People from Culturally and Linguistically Diverse (CALD) backgrounds | |
| People living with disability | |
| People in lower socioeconomic groups | |
| People living with a mental illness | |
| Children | |

It is critical that navigation models and services enable people to identify their relevant population group(s) at *entry* to the cancer care and navigation system so that optimal cancer care can be tailored appropriately.

### 3.2.5.2 The role of navigation and navigators in OCPs

The OCPs contain key elements of care coordination. However, they do not yet reflect the broader intent of patient navigation. New OCPs and updates to existing OCPs should reflect the intent and coverage of newer principles, activities, capabilities and personnel within the Australian cancer care navigation system. Further, tumour specific OCPs should identify and integrate dedicated navigators as part of MDTs, as this specific workforce evolves.

## 3.2.6 Leveraging digital and technological innovations

Implementing an integrated, multi-channel navigation system requires technological innovation and embedding of digital health. Evidence suggests that there are person-centred benefits to using digital health solutions (e.g., web-based tools, mobile apps, and online patient navigator tools) in navigation,[13] such as the provision of tailored information, timely communication including support out of hours, and information sharing and connection with other relevant services. In this way, digital health approaches can support better coordinated care.[14]

As part of wider integration of digital health, AI technologies have the potential to assist people affected by cancer, and support cancer care navigation in a way that optimises a seamless navigation experience in combination with direct clinical and non-clinical support and care. AI also has the potential to address challenges in health workforce capacity, enabling healthcare professionals to attend to direct clinical care needs while technologies support them in streamlined administrative workflow and data collection.

Examples of AI and other digital technologies supporting a seamless navigation experience are displayed in Table 3, categorised into support and navigation, and clinical and data benefits. As discussed further in Section 3.2.6.1 below, their implementation in the Australian context should consider ethical, privacy, and safety standards and align with broader Government standards, digital health polices and frameworks.

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[13] Supra n.7.

[14] Supra n.7.

**Table 3. Examples of how AI and other digital technologies can benefit a seamless navigation experience**

| Support and navigation benefits | Direct clinical and data benefits |
|---|---|
| • Enable digital navigation system (collation of assessments, care plans, resources)<br>• Support electronic referral systems<br>• Support screening for need and escalation or de-escalation in care<br>• Support health personnel with tasks, including administrative workflow and patient outreach<br>• Conduct research and evaluation of navigation services<br>• Facilitate collection of Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs), and feedback to enable a timely response<br>• Provide timely support to address patients' informational, psychosocial, and instrumental needs<br>• Support coaching and self-empowerment<br>• Provide 24/7 information and support<br>• Accessible for people with mobility/transport issues or those who are isolated<br>• Provide greater access to patients living in remote areas[15] | • Support decision-support systems for clinicians and people affected by cancer<br>• Remote symptom monitoring<br>• Enable consumers safe and informed access to their own healthcare data<br>• Provide specialised support to health professionals, such as image analysis, medical device automation, and patient monitoring<br>• Improve the timeliness, completeness and consistency of data in state and national cancer registries<br>• Enable data linkage across local, state and national platforms<br>• Support health professionals with clinical documentation<br>• Inform system and service improvements, including identifying areas of unmet need at the population level (e.g., through the collection of PROMs and PREMs)<br>• Assist in addressing resourcing challenges by redirecting people to digital resources where clinical intervention is not necessary |

Several AI tools have been developed in the US to improve cancer patient navigation systems. Three of these tools are summarised in Table 4, with two developed to facilitate clinical and administrative support, and the other enabling person-centred navigation and shared decision making. These are presented to assist in understanding the wider context in which AI tools are being implemented to complement direct cancer care and, in some cases, aspects of cancer care navigation.

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[15] Supra n.7.

**Table 4. Summary of desktop search into AI tools in the US supporting cancer patient navigation**

| AI Tool | Type | Description | Other information |
|---|---|---|---|
| CareIntellect for Oncology<br>https://www.cnbc.com/2024/10/21/ge-healthcare-announces-time-saving-ai-tool-for-doctors-who-treat-cancer-.html | Administrative and clinical | CareIntellect for Oncology summarises clinical reports and identifies when patients are deviating from their treatment plans. The system can monitor disease progression and flag when a patient misses a lab test. It can also help identify relevant clinical trials for patients. | Developed by GE HealthCare. To be available to US customers in 2025, to be initially optimised for prostate and breast cancers. |
| iStar (Inferring Super-Resolution Tissue Architecture)<br>https://www.pennmedicine.org/news/ai-tool-brings-precision-pathology-for-cancer-into-focus | Clinical | iStar provides highly detailed views of individual cells and a broader look of the full spectrum of how people's genes operate, allowing doctors to detect cancer cells that might go otherwise undetected.<br>iStar can be used to determine whether safe margins were achieved through cancer surgeries and automatically provide annotation for microscopic images, paving the way for molecular disease diagnosis at that level. | Developed by researchers at the University of Pennsylvania. |
| i-SDM (shared decision making) tool<br>https://news.cornell.edu/stories/2024/05/ai-may-improve-doctor-patient-interactions-older-adults-cancer | Patient navigation tool in pilot phase | The i-SDM tool identifies treatment options based on patients' diagnoses, demographic information and priorities. It provides information on each option's survival rates, potential side effects and risks, along with links to high-quality online support resources.<br>i-SDM has been trialled for older adult cancer patients who lack high health literacy to become more involved in the clinical decision-making process and to improve comprehension toward treatment outcomes. | Developed by researchers at Cornell University. |

The emergence of AI in healthcare offers a promising avenue to support cancer care delivery and patients' ability to navigate the cancer care system through person-centred approaches. The viability of such tools should continue to be monitored to assess their potential efficacy and suitability in the Australian context.

### 3.2.6.1 Implementing AI and other digital technologies in the Australian context

Harnessing the benefits of AI-enabled patient navigation and digital care in Australia will facilitate the delivery of more efficient, scalable, and accessible navigation services and foster a more sustainable multi-channel cancer patient navigation system.

The implementation of such technologies in Australia requires consideration of ethics, privacy, digital literacy, personal data issues, and medico-legal risks, and should align with contemporary Government standards and best practice including guidance for the use of AI in healthcare. A digital navigation system must also have clear policies and procedures in place, links to appropriate information and services, and appropriately trained staff with the capacity and capability to deliver AI and other innovations.

Critically, implementation of AI and other digital technologies must support escalation when required. For example, people who access 'chat bots' on an online or telephone navigation platform may be escalated to a human support person or dedicated navigator as informed by pre-defined algorithms. This could occur in two ways, either individually or in combination: via a person selecting a prompt (i.e., 'I want to talk to a real person'); or via an algorithm-determined needs-based approach (i.e., responses to screening tools or questions that indicate complex or concerning navigation related issues). During business hours, consumers could be connected to a person immediately, and after hours they could be informed that they will receive a call back the next business day.

A digitally enabled navigation system in Australia must be able to clearly distinguish between complex navigation issues and acute clinical issues. For acute clinical issues, the system should clearly direct people to contact their healthcare team (i.e., GP, oncology provider) or seek urgent care (i.e., emergency department, urgent care clinic) rather than seek support from navigation services. In some situations, complex navigation issues and acute clinical issues will exist concurrently.

System design must also ensure that digital literacy levels, internet connectivity issues, and hesitancy to adopt new technologies does not reinforce disadvantage and inequity, particularly for priority populations such as older people or people living in rural and remote areas. The digitally enabled navigation system should be person-centred and responsive to the needs of all people affected by cancer.

## 3.2.7 Research and evaluation

It will be crucial to establish an evaluation framework to assess and report on the effectiveness of the navigation system at key points in its development and implementation. The Department of Health and Aged Care has engaged Nous Group to develop a comprehensive evaluation framework and monitoring system for the ACNNP. This evaluation aims to ensure robust assessment and continuous improvement of the ACNNP's effectiveness and impact. However, this framework will be specific to ACNNP program providers, and does not cover the wider cancer navigation ecosystem that needs to be developed and linked to the ACNNP over time.

Evaluation should capture implementation processes and outcomes on Reach, Effectiveness, Adoption, Implementation and Maintenance.[16,17] Regularly monitoring can provide service-level learnings and identify improvement opportunities. Research efforts should also evaluate innovations in care models to support the continued evolution of the navigation system in Australia. For example, as demand continues to increase for navigation services, research should focus on how Australia can develop more capacity in self-directed and peer navigation alongside navigation services provided by health professionals and supportive care groups.

The evaluation of navigation programs can be challenging. This was acknowledged by the US National Navigation Roundtable after more than a decade of implementing patient navigation programs in the United States.[18] Battaglia et al. (2022) acknowledged that available and useful data for reporting purposes is lacking, which is in part attributable to not building evaluation planning in the early stages of navigation program implementation.

Of the 750 navigation programs surveyed, only 25% of these programs identified 'navigated patients' versus those who had not received a navigation intervention. To enable future comparative analysis in outcomes and care indicators, it is critical for navigation service planners, the navigation system, and cancer care service providers to establish and implement an 'identifier' amongst navigated patients versus those who are not (and the date they enter the navigation system). While this is a challenging undertaking in the Australian context, it has the potential to yield significant benefit in understanding the impacts of navigation model and services in improving outcomes and experiences.

Meaningful evaluation requires good data. A fully integrated data system is ultimately the responsibility of the entire system and should align with existing healthcare data exchange standards such as the Fast Healthcare Interoperability Resources (FHIR). The National Cancer Data Framework will set the strategic direction for the collection, management, use, and ongoing development of comprehensive cancer data in Australia. A key aim of the Framework is to enable interoperability across the cancer data ecosystem through adherence to the FHIR standards. The Australian Comprehensive Cancer Network, in alignment with the National Cancer Data Framework, could be an opportunity for Network members involved in evaluation and quality improvement to collaboratively review effectiveness data and help drive navigation service improvements.

In addition to automatically collected digital data, PROMs and PREMs for cancer care should be collected to nationally monitor cancer care provision, provide information to drive local quality improvements, inform navigation services, and guide the work of non-government agencies supporting people with cancer. Capturing feedback from people affected by cancer can help shape cancer services to better meet people's needs and preferences and improve cancer outcomes. Examples of collecting PROMs and PREMs to improve cancer care are outlined in Section 3.2.7.1.

PROMs and PREMs need to be captured in a consistent way. The collection of both PROMs and PREMs on quality of care, and real-time needs assessments, should be standardised and digitally enabled, with special consideration given to the needs of priority populations (i.e., culturally appropriate and easily accessible). A five-year action of the Plan is to embed PREMs and PROMs into national performance monitoring and reporting for all public and private providers across the cancer care continuum. To meet this goal, Cancer Australia is currently working in partnership with the Department of Health and Aged Care and the Movember Foundation on the Australian Real World Cancer

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[16] Glasgow, RE, Harden, SM, Gaglio, B, Rabin, B, Smith, ML, Porter, GC, Ory, MG, Estabrooks, PA. RE-AIM planning and evaluation framework: adapting to new science and practice with a 20-year review. *Frontiers in Public Health.* 2019;7:64. https://doi.org/10.3389/fpubh.2019.00064

[17] Dwyer, AJ, Staples, ES, Harty, NM, LeGrice, KE, Pray, SLH, Risendal, BC. What makes for successful patient navigation implementation in cancer prevention and screening programs using an evaluation and sustainability framework. Cancer. 2022;128: 2636-48. https://doi.org/10.1002/cncr.34058

[18] Battaglia TA, Fleisher L, Dwyer AJ, Wiatrek DE, Wells KJ, Wightman P, Strusowski T, Calhoun E. The National Navigation Roundtable Evidence-Based Task Group. Barriers and opportunities to measuring oncology patient navigation impact: Results from the National Navigation Roundtable survey. Cancer. 2022;128; S13:2568-2577. https://doi.org/10.1002/cncr.33805

Evidence Network – Pan Cancer Project. As well as embedding consistent PROMs and PREMs into national reporting, this project includes the development of a digital platform to enable collection and real time assessment.

### 3.2.7.1 International and jurisdictional examples of PROM/PREM data collection

Examples from the United Kingdom, NSW and Victoria highlight several different approaches to the collection of PROMs and PREMs in cancer.

In the United Kingdom, the National Cancer Patient Experience Survey[19] is administered by an independent provider to people who have received inpatient or outpatient cancer care. There is a two-month window to respond to an online, paper-based, telephone, translated survey, with results available at a national or local level.

Similarly, the Victorian Healthcare Experience Survey program gathers and analyses experiences of people who have received care in the public health system.[20] This statewide survey measures, monitors, and reports on patient experience of healthcare delivery to provide consistent, benchmarked measures. Results are fed back to healthcare services, supporting person-centred quality initiatives. There are 19 surveys in the program (available in a range of languages), that target different patient populations and care settings, including cancer care.[21]

In New South Wales, the Bureau of Health Information (BHI) administers the statewide NSW Patient Survey Program, which collects and reports on patient experiences in the NSW public healthcare system. The survey collects patient information across all aspects of care including but not limited to overall satisfaction and outcomes, timeliness and care coordination, and whether patients were involved in decisions. The Program is designed to provide reliable measures of patient experience performance at the hospital and local health district levels, through several surveys including those related to cancer care experiences.[22]

Cancer Institute NSW has a Patient Reported Measures (PRMs) Program,[23] to allow NSW residents with cancer to provide timely feedback on their healthcare experiences and outcomes. The PRMs Program measures PREMs and PROMs and enables the cancer services and health professional to better understand the needs of people affected by cancer. Unlike the Victorian, and BHI NSW surveys, the Cancer Institute NSW's PRMs program is specific to measuring cancer experiences and outcomes in Australia.

The domains covered in the UK, Victorian and BHI NSW surveys, and the CINSW Program, are displayed in Table 5.

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[19] NHS National Cancer Patient Experience Survey (website), Tell us about your experience of cancer care, accessed 7th August 2024, https://www.ncpes.co.uk/ (2024).

[20] State of Victoria (website), Victorian Healthcare Experience Survey, accessed 7th August 2024, https://vahi.vic.gov.au/ourwork/data-acquisition-and-management/patient-experience-and-outcomes-data (2024).

[21] Supra n.17.

[22] Bureau of Health Information (website), About the NSW Patient Survey Program, accessed 4th March 2025, https://www.bhi.nsw.gov.au/nsw_patient_survey_program (2025).

[23] Cancer Institute New South Wales (website), Patient Reported Measures (PRMs), accessed 26th August 2024, https://www.cancer.nsw.gov.au/what-we-do/supporting-cancer-care/patient-reported-measures-program (2024).

**Table 5. Domains of questions/surveys in the UK National Cancer Patient Experience Survey, Victorian Health Experience Cancer Survey, BHI NSW Patient Survey, and Cancer Institute NSW PRMs Program**

| UK National Cancer Patient Experience Survey | Victorian Health Experience Cancer Survey | BHI NSW Patient Survey Program | Cancer Institute NSW PRMs Program |
|---|---|---|---|
| • Support from your GP<br>• Diagnostic tests<br>• Finding out that you had cancer<br>• Support from a main contact person<br>• Deciding on the best treatment<br>• Care planning<br>• Support from hospital staff<br>• Hospital care<br>• Your treatment<br>• Immediate and long-term side effects<br>• Support while at home<br>• Care from your GP practice<br>• Living with and beyond cancer<br>• Your overall National Health Service care<br>• Your condition<br>• About you<br>• Other comments | • Finding out what was wrong<br>• Deciding on treatment<br>• Surgery<br>• Radiotherapy<br>• Emergency department<br>• Follow-up care<br>• Information received<br>• Overall care<br>• Background | • Adult admitted patient<br>• Rural hospital adult admitted patient<br>• Emergency department patient<br>• Rural hospital emergency care patient<br>• Outpatient cancer clinics<br>• Admitted children and young patients<br>• Maternity care<br>• Virtual care<br>• Aboriginal patient experience<br>• BreastScreen NSW client experience<br>• Longstanding health conditions<br>• Outpatient<br>• Palliative care | • Level of distress<br>• Practical problems<br>• Family<br>• Emotional problems<br>• Spiritual/religious or other concerns<br>• Physical problems<br>• Symptoms (pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, feeling of wellbeing, shortness of breath) |

## 3.2.8 Leveraging state, territory, and international approaches to navigation

Lessons can be drawn from jurisdictional and international cancer care navigation approaches and models. The success of integrated, multi-channel navigation systems relies on collaboration with the organisations that deliver and implement these services. To achieve success, there needs to be coordinated effort across those who fund and those who design and deliver navigation services. Key actors include but are not limited to:

- Australian Government
- state and territory governments
- not-for-profit organisations
- consumers, community members, and consumer organisations
- commercial partners
- healthcare professionals and services
- academic partners.

It is difficult to map current navigation efforts comprehensively and consistently across the Australian states and territories. Adding to this complexity is that many roles across the cancer care workforce are already providing some level of navigation activities, and dedicated navigators are not yet a clearly and consistently identifiable workforce in Australia.

As part of the ACNNP's development and implementation, in 2025 the Department of Health and Aged Care will map the cancer navigation and patient support offered through cancer organisations in the sector. This will aid understanding of the support services offered throughout Australia. However, a comprehensive understanding of the services available within specific state and territory hospital systems is beyond the scope of this exercise.

Implementing the ACNNP has the potential to encourage further investment from funders and actors at the state and territory and local levels. There is an opportunity to build on the foundation of the ACNNP over time, with the ambition to foster an enhanced national navigation approach that minimises unwarranted variation including between the states and territories.

A nationally coordinated effort needs to consider equity and identify the following:

### At the national level

- What navigation support is available for all Australians?
- What navigation support is available for all Australians in each of the priority populations in the Plan?

### At the state, territory and local levels

- Who (which actor) is going to take on what responsibilities (financing and delivery of services)?
- Where are the (navigation) gaps and who is going to fill those gaps?

Below are several examples of navigation initiatives at jurisdictional, national, and international levels. While the list is not exhaustive, these examples serve to highlight opportunities for key actors in Australia to partner and collaborate in continual improvement of the navigation system (Table 6).

**Table 6. Examples of cancer patient navigation Initiatives at the national, jurisdictional, and international levels**

| Country | Organisations | Initiatives |
|---|---|---|
| Australia | Government of South Australia<br>Commission on Excellence and Innovation in Health<br>Flinders University<br>Caring Futures Institute | **State-level priorities and implementation planning**<br>The South Australia Commission on Excellence and Innovation in Health, in collaboration with Flinders University Caring Futures Institute, has released the *South Australian Cancer Navigation Framework and Action Plan*. Development of this framework involved wide and deep consultation with the Cancer Care Sector and not-for-profit organisations including Cancer Council South Australia. This Framework and Action Plan outlines 10 priorities to maximise strategies to support cancer navigation. For each priority, there are clear actions, current state of care and partnerships required to achieve the stated goals.<br>It aims to ensure consistency and synergy between national and state-based efforts in planning, financing, implementation and evaluation. |
| Australia | CANCER HUB | **Cancer Hub**<br>As part of the ACNNP, the Child and Youth Cancer Hub will deliver cancer navigation, support and counselling services for children and young people with cancer and their families. Canteen will lead the Hub in collaboration with Camp Quality and Redkite.<br>The Hub provides a 'one-stop shop' where specially trained staff identify every family member's needs and then actively helps them access the best support options for them. This includes:<br>• Practical help: organising accommodation, financial assistance, cancer education programs and more<br>• Emotional support: accessing free specialist counselling and other assistance to help young people, children and parents cope with cancer's many challenges<br>• Connection and respite: opportunities to connect with others in a similar situation and take a break away from cancer at fun events |

| Country | Organisations | Initiatives |
|---|---|---|
| Australia | The University of Queensland<br>Australia | **First Nations Clinical Nurse Consultants project**<br><br>This project aims to improve cancer outcomes by assisting Aboriginal and Torres Strait Islander people affected by cancer (patients and their caregivers) to navigate the complexities of the health system and cancer care, through the employment of First Nations Clinical Nurse Consultants. First Nations Clinical Nurse Consultants will be implemented and evaluated in three Queensland cancer centres. At one of the participating sites, the project also involves a feasibility study of an Indigenous Patient Navigator–led brief health behaviour intervention in Aboriginal and Torres Strait Islander cancer survivors (2022–2024). |
| Canada | Alberta Cancer<br>Foundation | **Alberta Cancer Patient Navigation Program**<br><br>The Provincial Patient Navigation Program promotes equality and accessibility in healthcare by focusing on people-centred support for three specific populations of Albertans living with cancer:<br><br>• Patients living in rural areas<br>• Adolescent and Young Adults Patients<br>• Indigenous Patients*<br><br>Since its inception, the program has helped over 40,000 Albertans navigate their cancer journeys. These patients reported that the program's staff contributed to a sense of stability and security, ensured timely access to necessary information, coordinated additional community supports, and offered individualized care to meet specific areas of need. Over 90 per cent of appointments with patient navigators took place virtually, saving Alberta's healthcare system over $1 million by alleviating visits to physicians and emergency rooms for non-emergent issues.<br><br>*This program employs Indigenous Cancer Patient Navigators. |

| Country | Organisations | Initiatives |
|---|---|---|
| Canada | MOVEMBER®<br>TRUE NORTH<br>UNIVERSITY OF TORONTO<br>DALLA LANA SCHOOL OF PUBLIC HEALTH | **Peer Navigation in Canada**<br>Originally called True North Peer Navigation was originally designed for prostate cancer patients and caregivers, but has since been rebranded as PeerNav and adapted for other cancer types. In this model of patient navigation, cancer patients are matched through a digital app with a volunteer peer navigator who has experienced cancer and is trained to assess needs and barriers to care, provides information and emotional support, and empowers a proactive approach to health. The digital app supports matching and communication between patients and navigators, includes a dashboard of features that helps navigators manage their assigned patients, as well as a library of resources. Cancer survivors are trained to be peer navigators through Bender's award-winning, competency-based online training course that teaches the social determinants of health, anti-oppressive practice, and motivational interviewing communication skills.[24] Navigators are supported in their role by a clinical psychologist. |
| United States of America | COLORADO<br>CANCER<br>SCREENING<br>PROGRAM | **Colorado Cancer Screening Program**<br>In 2006, the University of Colorado Cancer Center established a statewide colorectal cancer screening program to reduce disparities and improve colorectal cancer (CRC) screening for the medically underserved in partnership with the safety net system. The program, known as the Colorado Cancer Screening Program (CCSP), has integrated navigation into preventive screening for more than 35,000 patients. The CCSP adapted the Program Sustainability Framework and Clinical Sustainability Framework and Assessment Tools to measure the capacity of participating clinics to sustain the program beyond grant funding. Activities in the implementation plans included revising workflows for efficiencies, incorporating quality improvement strategies, and building a business case for patient navigation. |
| United States | AONN Academy of Oncology Nurse & Patient Navigators® | **Lung Screening Navigator Network**<br>The aim of the Lung Screening Navigator Network (LSNN) is to build partnerships among lung cancer screening coordinators and navigators by providing networking and education opportunities for lung cancer screening navigators and coordinators across the nation, thereby promoting best practices in lung cancer screening navigation related to the early detection. The overarching goal is to shift lung cancer staging at diagnosis from late to early stage by increasing the uptake and adherence to screening. |

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[24] Bender JL, Flora PK, Milosevic E, et al. Training prostate cancer survivors and caregivers to be peer navigators: a blended online/in-person competency-based training program. *Support Care Cancer.*2021;29(3):1235-1244. https://doi.org/10.1007/s00520-020-05586-8

| Country | Organisations | Initiatives |
|---|---|---|
| International | World Health Organization | **WHO Technical Brief on Navigation**<br>The WHO has published the *Patient Navigation for Early Detection, Diagnosis, and Treatment of Breast Cancer: Technical Brief* in October 2024. This document provides a range of resources on needs assessment, key performance indicators, monitoring and evaluation frameworks and relevant training resources. |
| International | MASCC<br>MULTINATIONAL ASSOCIATION OF SUPPORTIVE CARE IN CANCER<br>Flinders University<br>Caring Futures Institute | **MASCC - A Global Initiative to Advance Cancer Navigation for Better Outcomes (The GINO Project)**<br>In this three-year project (2023-2026), the MASCC and Flinders University Caring Futures Institute Team are developing:<br>• MASCC International Position Statement and Practice Framework for Patient Navigation in Cancer<br>• A Core Set of Quality and Efficiency Indicators for Patient Navigation Benchmarking<br>• Implementation guidance and a global community of practice for local adaptation |

# 4. Long-term goals to improve outcomes

Based on the elements of Cancer Australia's vision for patient navigation in cancer care outlined in Section 3, several long-term goals are proposed to advance the development, implementation, and evaluation of an integrated, multi-channel, multi-disciplinary cancer navigation system in Australia.

Delivering on these goals will be a complex whole-of-system undertaking. Coordinated short- and medium-term initiatives will be required across the sector to enable the achievement of these longer-term opportunities.

| # | Long-term goal | Relevant elements of navigation system |
|---|---|---|
| 1. | A national, linked-up, whole-of-system model facilitating multiple access points into the navigation system, that is needs-based, co-designed by and tailored to each state and territory, and which can be piloted, refined, implemented, and evaluated. | All |
| 2. | A purpose-built nationally standardised digital navigation system that can enable and facilitate:<br>• prospective identification of unmet navigation needs;<br>• the uptake of a nationally consistent triaging tool;<br>• self-directed navigation support;<br>• peer-supported navigation support; and<br>• data collection for continuous improvement. | All |
| 3. | Online platforms or centralised hubs that provide access to culturally safe information-based navigation, information and links on how to access peer-support based services, and information on referral to dedicated navigator roles, co-designed with community and priority population groups. | Needs-based approach; Leveraging digital and technological innovations |
| 4. | Aboriginal and Torres Strait Islander people appointed to dedicated navigator roles to optimise access to screening, prevention and care; treatment uptake; and culturally safe care. Delivered in partnership with the Aboriginal Community Controlled sector (e.g., NACCHO). | Navigation workforce |
| 5. | Consistent criteria-based approach to referral of people affected by cancer to MDT personnel and dedicated navigator roles in navigation services. | Multiple entry access points; Needs identification and seamless support escalation and de-escalation system |
| 6. | AI-powered digital tools (with an algorithm for escalation to human navigator) to enable escalation and de-escalation of navigation needs and support. | Needs identification and seamless support escalation and de-escalation system; Leveraging digital and technological innovations |
| 7. | Dedicated navigator roles for priority populations performed by people from the specific community, where appropriate. Delivered in consultation and/or partnership with peak community bodies (e.g., NACCHO, FECCA). | Navigation workforce; Optimal Care Pathway focused activities |

| # | Long-term goal | Relevant elements of navigation system |
|---|---|---|
| 8. | Clearly articulated points in the OCPs where navigation supports should occur (i.e., assessment of need, identification of appropriate navigation services, access to clinical trials, care planning, and GP shared care). | Optimal Care Pathway focused activities |
| 9. | OCPs updated to reflect the evolution of the navigation system in Australia. | Optimal Care Pathway focused activities |
| 10. | A national-level evaluation and monitoring framework to support the implementation of the navigation system, leveraging existing evidence-based public health evaluation approaches. | Research and evaluation |
| 11. | Key performance indicators for priority populations, determined in collaboration with key stakeholders. | Research and evaluation |
| 12. | Standardised PROMs and PREMs national survey on cancer care outcomes and experience with ongoing reporting that can inform quality improvement in the cancer care system and inform improvement of navigation models.<br>Survey available in different languages and formats (including online and paper-based), with support provided to complete it, to ensure representation from priority populations. | Research and evaluation |
| 13. | Ongoing shared-learning opportunities and communities of practice for all relevant key actors at the local, state, national and international levels. | Leveraging state, territory, and international approaches to navigation |

# 5. Conclusion

In this paper, Cancer Australia has outlined a vision for an integrated, multi-channel, multi-disciplinary cancer care navigation system, including key elements, considerations and potential opportunities for implementing this vision. Leveraging the potential generated by the Australian Government’s seminal investment to establish the ACNNP, many future advances are possible but will require coordinated efforts across the sector in partnership with consumers and community groups at the state and territory level. Shared learnings will be key to maximise equity and continuous improvements at the local, national, and international levels.