The Nurse Navigator: An Evolving Model of Care

Anne McMurray, AM, RN, PhD, FACN

Emeritus Professor, School of Nursing and Midwifery, Adjunct Professor, Research Centre for Health Practice Innovation, Principal Research Fellow, School of Medicine, Menzies Research Institute, Griffith University and Queensland Health, Gold Coast Hospital and Health Services, Gold Coast Queensland.

Parklands Drive, Southport, Queensland, 4222

Phone 0409587850 Fax 07 55529144

A.McMurray@Griffith.edu.au

Helen Cooper, BN, GDipAcuteCareN, MBA, Managing Director Integrated Care Program,

helen.cooper2@health.qld.gov.au

Abstract

This opinion piece describes the role of the nurse navigator as a forward step in the evolution of nursing models of care. The article outlines the historical development of the patient navigator role and the potential of this role to be embedded in contemporary models of interdisciplinary primary health care practice across health settings. As the pivot person in the interdisciplinary team, the nurse navigator can make a significant contribution to health reform by working towards patient-centred care wherein patients receive timely, seamless, culturally appropriate guidance and support for developing health literacy. Having patients empowered by a level of health literacy that enables them to better navigate through the services they need has an important impact on their ability for shared decision-making. It also contributes to health system improvement by improving access, equity, efficiency, effectiveness and sustainability of health services. These improvements are most notable during transitions from acute to continuing care, where the nurse navigator can also be instrumental in achieving better service integration. The role of nurse navigator has enormous potential for assisting the rapidly growing population with complex and chronic conditions as well as others who are underserved or experiencing disconnected patterns of care.

Key words: nursing, nurse navigator, chronic conditions, cancer care, multidisciplinary care, health literacy, health reform, integrated care

4063 words

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Introduction

This paper describes the role of the nurse navigator as a forward step in the evolution of nursing models of care. The nurse navigator role is embodied within the philosophy of primary health care (PHC), wherein nurses work in partnership with individuals, families and communities to enable access to the type and level of services and support they need for optimal health outcomes (McMurray & Clendon, 2015). Some PHC nurses work in primary care (PC), predominantly in general practice, while others are attached to, or lead post-acute, community or long-term health services. All have a commitment to the health of the population, and use their knowledge and skills to make a significant contribution to health reform (Carryer et al., 2015, Keleher et al., 2009). As in many other western nations, the Australian health reform agenda is aimed at improving access, equity, efficiency and effectiveness of services (Australian Government Department of Health and Ageing (DoHA), 2010; Bennett, 2013; National Health and Hospitals Reform Commission, 2009). Existing models of PHC, either in general or community practice, are recognised as being unsustainable, particularly with population ageing and an exponential growth in the number of people with complex and chronic conditions (Garling, 2008; Hall, 2015). Patients with complex or chronic conditions often have unmet needs as they typically have to access sequential or simultaneous services from multiple providers in different locations with culturally appropriate care provisions. Their care is costly and typically poorly coordinated with inadequate communication from care providers (Burgers et al., 2010; Kuluski et al., 2013). In the Australian system, with its combination of public and private health providers, people with chronic conditions may also be subject to situations where clinicians and services lack the capacity to work effectively together; or where there is a lack of structures or clinical governance systems to support integration of services (Australian Medicare Local Alliance, 2012).

Coordination of services can be helpful in improving the patient journey if the services are provided in a way that is collaborative, holistic, inclusive, and responsive to people's needs and preferences in the contexts of their lives. As the most frequent users of the healthcare system those with complex and chronic conditions rely on guidance from health professionals to help them make appropriate choices through the many touch points of service. The health professional at the initial point of service is often the nurse, who, from a primary care position in general practice, a hospital discharge service, or a nurse-led clinic must identify realistic, local resources to help meet their immediate and long-term needs. In this role, primary health care nurses seek to ensure the advice they provide is tailored to the patient's condition, their expectations across the health trajectory, their level of health literacy and the social determinants of their lives (McMurray & Clendon, 2015). This is person-centred care (PCC), an important objective of PHC nursing. Nurses providing PCC do so as hands-on caregivers, case managers, or care coordinators, and nurse navigators may incorporate all or some of these roles in their practice. The major focus of their role is to enhance care transitions by building people's capacity for decision-making and self-management as they learn to navigate the complexities of the health and social services most appropriate to meet their needs. As outlined below, it is a unique and evolving role that accentuates nursing's contribution to PHC.

The patient navigator

The patient navigator role was first documented in the 1990s. Freeman (2013), a medical practitioner, coined the term 'patient navigator' in working with cancer patients in Harlem, New York who were poor, uninsured and underserved. He began addressing discontinuities in services for his cancer patients across their journey from diagnosis to treatment by lobbying policy-makers and service managers for patient navigators who would help patients across the 'discovery-delivery disconnect' (Freeman, 2013, p. 73). The objective of the new role was to help people understand and journey through the healthcare system so they would receive the treatment they required during all transitions across the continuum of care. His campaign was successful, and in 2005 the

United States (US) Government signed into law the Patient Navigator and Chronic Disease Prevention Act (United States Congress, 2005). This was followed by an American College of Surgeons decree that by 2015 all cancer programs in the US must have in place a patient navigator process (Freeman, 2013). With major changes in the American healthcare system impacting on many patients and their families, navigators are now considered crucial in helping the uninsured learn how to access appropriate insurance and the requisite services for their condition (Ingram et al., 2015).

The Swedish government followed suit, establishing the patient navigator role as part of the National Swedish Cancer Strategy (Bau Berglund et al., 2015). Lay patient navigators tend to be community health workers or outreach workers who develop trusting relationships that can overcome system barriers (Cantril & Haylock, 2013). They come from a range of backgrounds, including occupational therapists, medical assistants, social workers or nurses, with nurses being the most common among these groups (Bodenheimer & Smith, 2013; Doolan-Noble et al., 2013; Enard, 2013; Ferrante et al., 2013; Lindsay et al., 2014). Implementation of their role has been so successful in helping cancer patients the patient navigator role has been adapted to help high users of services, such as those with chronic conditions, to develop adequate knowledge to navigate the healthcare system (Dent, 2013; Doolan-Noble et al., 2013; Kuluski et al., 2013; Leaver, 2013; Plant et al., 2013).

In Australia, a navigator role has been developed in the context of a Queensland pilot program evaluating integrated care for people with complex and chronic conditions . This program, the Gold Coast Integrated Care (GCIC) program, is designed to link primary and secondary health services through a shared care record (SCR) and collaboration between local General Practitioners (GPs) and other health service providers by enrolling them in a type of patient-centred medical home similar to a multidisciplinary primary health care clinic, to ensure comprehensiveness of care planning. Similar models of care have been developed in the US and the UK with the intention of improving continuity of care and preventing unnecessary hospitalisations (Friedberg et al., 2015; Willard & Bodenheimer, 2012), and this model has been supported in principle by the Royal Australian College of GPs and the Australian government (Janamian et al., 2014). In the GCIC model, the navigators contact all patients

who have been identified by their GPs as appropriate for the program, conducting a telephone health assessment for each patient and explaining the processes within which they can navigate through the system without referrals back and forth between the GPs, specialists and the hospital. An initial contact by a service navigator from the coordinating centre signals the beginning of a four-stage holistic assessment process, which culminates in the development of a care plan and pathway underpinned by the SCR. This record is an electronically enhanced Information and Communication Technology (ICT) system that houses clinical informatics, patient registers, referral networks and ultimately, will provide telehealth and remote monitoring capability. Having the patient and service providers share electronic information increases the efficiency and effectiveness of services in a patient-centred way, given that patient preferences are included at each step. Current studies have shown that when medical, social, behavioural and financial information is available to inform patient decisions, the system is more likely to be empowering and personalised (Koster et al., 2015).

In the GCIC model the navigators launch the first stage of information sharing. This *Evaluation* stage is a telephone conversation wherein patients are encouraged to share demographic, social and cultural information as well as complete a structured assessment of the way they see their health and quality of life. These data are collected using a combination of open-ended questions and survey instruments to create a baseline of clinical and demographic data. Included is an assessment of patient activation, goal-setting, problem-solving and coordination, which creates a foundation for discussions with the patient to help tailor their health guidance to individual needs. For patients unable to communicate by phone for language, cognition or preference reasons, the navigator organises a visit to the patient at home or at the GP clinic. Both interactions are aimed at promoting health literacy, described by Redding (2013) as building knowledge and mobilising the patient and family's social and cultural capital to support their health decision-making. A diagnostic review/risk assessment is included in this step, which can include a medication review, mental health and frailty assessment, establishment of health goals and the need for extra supportive resources. The second step is *Discovery* where the patient meets with members of the multidisciplinary team to help tailor

their shared care plan (SCP) to their individual needs. This step is based on relationship building to encourage mutual decision-making, thereby entrenching the partnership as instrumental to care.

Step three, the *Patient-Centred Care Planning* stage, sees a review by the coordination team in collaboration with the patient's GP to ensure completeness of the information base for planning. At this stage, a member of the multidisciplinary team, a nurse or other team member, is appointed as the care coordinator. In the fourth, *Communication* stage, the designated care coordinator ensures that the patient and family understand and agree with the SCP, ensuring that all elements of the plan are documented for the SCR, the GP, the Hospital and Health Service record, and any other organisations or resources as appropriate, including addressing any guardianship issues such as advance care planning or power of attorney when required. This stage also focuses on health promotion and ascertaining patients' and carers' health literacy; that is, the extent to which patients and family members are able to access appointments, manage risks and undertake any self-directed management of their condition as mutually agreed. At this stage, patients assume control over their personal communication strategies, such as deciding who will have access to their SCR or other pertinent elements of care planning. Evaluation of the role is ongoing but early comments from the navigators indicate that they find their advice has helped people better understand the system and the roles of the multidisciplinary resources to which they are being referred. Patients have also reported being extremely satisfied with the service, and plans for the future include role redesign as a nurse navigator role.

Other navigator roles elsewhere require special skills. In many cases, navigators are appointed for their skills in helping families with acutely ill children navigate safe passage through the myriad of services they require, particularly for families with low health literacy (Jimenez et al., 2013). Some navigators are required to have special language skills, depending on the needs of the population, but many have in common a specific focus on health literacy; helping people develop a level of knowledge for active engagement in their care by using such tools as motivational interviewing to encourage shared decision-making and successful transitions through the health journey

(Betancourt, 2014; Lindsay et al., 2014). Enard (2013) reports that bilingual community health workers in the navigator role have been extremely effective, especially when they have been trained in peer-to-peer counselling. She describes their role as including communication, psychological, financial and social support. Evaluation of their role in case management shows that they provide more comprehensive management than usual case management, including ongoing follow-up (Enard, 2013). In the cross-cultural context, the role is one of culture broker, translating language or cultural customs or acting as a multilingual case manager, establishing person-centred and culturally relevant goals to help those struggling to understand new ideas and health practices (Lindsay et al., 2014). For example, researchers in Queensland developed the role of patient navigator for a culturally and linguistically diverse (CALD) regional area where residents were having difficulty understanding the healthcare system. They were able to provide training for lay multilingual residents who were interested in helping people of their cultural group learn to identify their health needs and access appropriate care in their community (Henderson & Kendall, 2011; 2014). The research team and service managers fostered close relationships with the navigators and the local GPs to coordinate services and undertake health promotion. Evaluation of the program revealed that the navigators felt they were acting as knowledge brokers; that they had been successful in building bridges within the community to improve health literacy and empower local CALD families (Henderson & Kendall, 2011). However, these Australian researchers also recommended maintaining a navigator-centric, grassroots role to avoid the program becoming overly bureaucratic (Henderson & Kendall, 2014).

Nurse navigators

Some navigator roles are nursing-specific, requiring the clinical knowledge of a registered nurse (RN). For example, some nurse navigators in Canada are cancer nurses, whose role involves helping bridge the service gap for cancer patients (Pederson & Hack, 2011). They act as 'pivot nurses', providing disease specific information and practical advice, emotional support, facilitate decision-

making, create links to resources, and help identify and develop community supports (Pederson & Hack, 2011). In Western Australia, cancer care coordinators are the focal point of contact throughout the patient care trajectory, coordinating care and providing patient education, but their role often expands to helping people navigate transitions through the cancer support system (Monterosso, 2012). This role is somewhat similar to the Jane McGrath Breast Care nurses who practise throughout Australia, sharing care and expertise while helping patients and families navigate through their journey. Another version of the nurse navigator role is the 'emergency journey coordinator', introduced in New South Wales in 2013 to help ease patient transitions through the emergency department (Asha & Ajami, 2014). Nurse navigators have been found to be particularly helpful for rural people and, in New Zealand (NZ) they have been used to support individuals in need who have few resources and multiple barriers. The NZ navigators focus on engaging with patients and their families to improve access to social support services, enhance health literacy and self-care ability. Evaluation data showed that they have reduced disparities and improved health outcomes. The researchers concluded that this model of care can be adapted to a range of population groups if it is based on a strong and predictable implementation strategy (Doolan-Noble et al., 2013). Their recommendations also included the need to appoint those best suited to the role; that is, irrespective of their background, the nurses should have essential skills in nurturing relationships with health and social care professionals (Doolan-Noble et al., 2013). Other navigator models have not yet generated sufficient research knowledge to guide role development, with the exception of Monterosso's (2012) cancer care coordinator role, which attracted high satisfaction ratings from patients and multidisciplinary team members.

In 2015 the Queensland government announced a major initiative to position nurse navigators throughout various hospitals and health services to help people transition between their GPs and other primary care services, through their hospital and community health journey to home (Queensland Health, 2015). The expectation of this program is that nurse navigators will be able to redirect many patients to existing programs, such as the Hospital in the Home (HiTH), and other

community supports with a view to reducing fragmentation of services, length of hospital stay and readmission rates (Queensland Health, 2015). A number of health service managers from various service units have successfully applied for the Queensland Health nurse navigators, including the GCIC program described above. The nurse navigators in this program will function in a different role to the lay navigators who enrol patients into the GCIC program. Their roles will be conjoint positions between general practices providing primary care, and Gold Coast Hospital and Health Services (HHS), which provides acute care. Because the SCR is integral to the program the nurse navigators will have full access to patient information at both the practice and the HHS level – a limitation often faced by primary care nurses in general practice. Once these nurses are appointed it will be important to evaluate the impact of these roles on a range of outcomes for patients, families and the community, as previous researchers have suggested (Plant et al., 2013). Other research will investigate the impact of the nurses' responsibilities, potentially informing the dimensions of the role in future and the requisite educational preparation for various navigator roles in the Australian context.

A previous systematic review of this type of role outlined the broad and varied dimension of the role, which included care planning and coordination, home visiting, community service provision, and patient and family education, with advocacy as the common feature (Manderson et al., 2012). The researchers also found variation among evaluation outcomes, with some studies focusing on economic feasibility of the role, and others on patient and caregivers' experiences and satisfaction (Manderson et al., 2012). Although all studies have shown wide agreement on improvements in timely care and transitions between services for patients with access to a nurse navigator, researchers have concluded that the lack of data on cost effectiveness may hamper widespread rollout of the role (Manderson et al., 2012; Simon et al., 2015).

In Australia, such a role, subsidised by the state or territory governments would be ideal in addressing the unmet needs of the rural population, as has been demonstrated in the rural

populations of Canada and New Zealand (Cantril & Haylock, 2013; Doolan-Noble et al., 2013; Pederson & Hack, 2011). Nurse navigators also have the potential to make a significant impact on transitional care for older people, whether or not they suffer from complex chronic diseases. A number of transitional care programs have implemented the role in other countries, finding that nurse navigators collaborating with other members of the multidisciplinary team can play an important part in early discharge planning, skilled home visiting or phone support, medication management, advocacy to remove barriers to care, patient and caregiver education, and assessment and management of health status (Abrashkin et al., 2012). This model of practice is now well developed in cancer care, where nurse navigators have moved from general service navigation to focusing on a specific disease such as breast cancer, sharing their in-depth knowledge of cancer care, the side effects and latest evidence-based interventions, as well as building referral alliances to strengthen the partnership between patients, nurses, and other health professionals (Cantril & Haylock, 2013). These nurses coordinate diagnostic evaluations and provide disease specific education and symptom support (May et al., 2013). Table 1 (below) illustrates the common and unique features of the nurse navigator role in relation to the roles of case manager and care coordinator.

A new model of care or old wine in new bottles?

Nurse-led models of care have made significant inroads into improving the health of populations, particularly in the context of general practice, where nurses and nurse practitioners are leading the way in helping their populations manage chronic illness (Carryer & Halcomb, 2015; Harvey et al., 2012; Parker et al., 2012). Some nurses' roles are described as care coordinators, while others are case managers, but both tend to focus simultaneously on the individual and family as they help people navigate the health care system with a single point of entry (Anderson et al., 2012; Watts & Lucatorto, 2014). Their roles are clearly entrenched in the primary health care ethos, where patient and family-centred planning and intersectoral collaboration are crucial to successful patient

outcomes. Like the case manager and coordination role, the nurse navigator helps bridge the gap between acute, post-acute and community care. The uniqueness of the navigator role lies in the fact that nurse navigators are specifically appointed with the autonomy to choose how best to help people transition through the system; whereas many care coordinators or case managers are often tied to a single service and the processes embedded in that service. All of these roles have a common aim of demonstrating the convergence of hospital and community care in a way that is distinctively person-centred, exemplifying the patient-as-partner approach to care. Partnering with patients reflects the contemporary global rhetoric in health service policy and planning, based on the need for care to be respectful of and responsive to individual patient preferences, needs, and values and ensuring that their values guide all clinical decisions (Prey et al., 2014). PCC is now mandated by the Australian Safety and Quality Health Service Standards, which requires all Australian health services to employ a system-wide PCC focus (Australian Commission on Safety and Quality in Health Care, 2011). This requirement is based on studies showing that patients who actively participate in their health decisions as they transition across services can help prevent the risk of adverse events caused by incomplete information on such things as medications, falls risks, wound infections or cognitive difficulties (Iedema et al, 2011; Longtin et al., 2010; Rathert et al., 2011). In practice, most primary health care nurses use a PCC model of care, and often act as service navigators, although the role description is a relatively new addition to our professional lexicon. The nurse navigator helps people identify resources, including general, specialist and multidisciplinary care in a way that reduces service duplication, tailors advice to individual and family needs, and provides timely, seamless, culturally appropriate access to appropriate and acceptable care, all of which meet the philosophical and practical elements of health reform, as well as the Quality and Safety Standard. Helping people learn to navigate the system through advocacy and respect can help them become health literate and build the capacity to manage their condition, irrespective of where they are in the continuum of care. Shared decision-making, expedited by appropriate technologies, can align patients' and clinicians' expectations, thus reducing unwarranted variations in clinical

practice (Legare et al., 2012). In this respect, the nurse navigators are not only working toward quality and safety and responsive care, but sustainability of the health system, which is more likely when services are integrated around patient needs rather than the needs of service providers (Australian Government, 2010; Ferrer & Goodwin, 2014; Lillrank, 2012; Minkman, 2012).

Implications for future practice and research

Managing chronic care requires role clarity, particularly in the context of interprofessional collaborative structures (Brault et al., 2014). In their current form, the roles of case manager, care coordinator and nurse navigator have considerable overlap, yet there remains a dearth of research into the relative effectiveness of these roles (Sutherland & Hayter, 2009). In future, nursing roles in managing chronic conditions can be expected to undergo considerable transformation, evolving with patients' needs, providers' experiences, technological and health system developments, and, as researchers have found, within various practice contexts and collegial interactions (Carmel & Baker McClearn, 2012). It is important from the outset to engage the nursing research community in tracking the outcomes of the nurse navigator model of care, particularly the patient outcomes that can be linked to embedding the role in general practice, where patients transition between acute and community settings. Future studies will also need to examine the efficiency and cost effectiveness of general practices where practice nurses (PNs) have decided to undertake the role of nurse navigator, and whether these roles generate satisfaction for the nurses, other practice staff and patients. One could expect that, especially with enabling information technologies such as the SCR, the roles will reduce the number of referrals between primary and secondary care providers. This research evidence will help inform service policies, health reforms, and validate the need for smart technologies, as well as linking nursing role redesign to patient outcomes. Undoubtedly, the evidence generated from these studies could also help reframe educational preparation for future nursing practice, which given population ageing, will most certainly focus on integrated care for those with chronic and complex conditions.

Conclusion

This article has outlined an important new PHC role for nurses. This unique model of care is responsive to one of the common complaints of a 'demand-capacity mismatch' that pervades contemporary healthcare systems (Bodenheimer & Smith, 2013). Our healthcare systems clearly need renewed consideration of existing models of care. As Bodenheimer & Smith (2013) suggest we should be empowering nurses and other members of the multidisciplinary team to reallocate clinical responsibilities for health promotion, coaching for self-care, medication management and a range of other functions that will help allay shortages of physicians while providing the best and most coordinated care possible. These issues suggest an urgent and critical need for nursing leadership to help find solutions to unstable and disconnected health services (Weberg et al., 2013). The nurse navigator may be one innovative solution for a smoother journey into and through the health system of the future.

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Table 1. Navigator, Care Coordinator and Case Manager Roles in Chronic Disease Management

Designation	Role, Knowledge Base	Major Focus
Nurse navigator	<p>Guided by primary health care principles</p> <p>Patient centred diagnostic monitoring and care</p> <p>Guidance for patients, care coordinators, primary and secondary care providers on appropriate, accessible, affordable and acceptable services</p> <p>Advanced knowledge of information technologies, health system, complex care needs, communication techniques, optimal outcome metrics</p> <p>Knowledge of population health, patient and family environment, community supports, insurance systems, advance care planning</p>	<p>Efficient, effective transitions through health system</p> <p>Continuity of care</p> <p>Health literacy for patient empowerment, self-management</p> <p>Identifying services that can be tailored to patient self-determined needs</p> <p>Efficient use of technologies to facilitate shared decision-making</p> <p>Communicating with patients, families and care providers</p> <p>Population approach, documentation of patient outcome indicators from pre-treatment to follow-up</p>
Care coordinator	<p>Guided by principles of primary health care</p> <p>Service coordination to promote continuity of care across settings and care providers for duration of illness</p> <p>May use case management approach</p> <p>Knowledge of patient and family, advance care planning, specific care needs, health system, insurance processes</p>	<p>Coordinating disease management processes</p> <p>Matching needs and resources for patient care, including home and community supports</p> <p>Ongoing liaison with multidisciplinary team, primary care providers and external services</p>
Case manager	<p>Guided by principles of primary health care</p> <p>Point of care monitoring, service provision and referral</p> <p>Requires specialised skills in relation to the 'mix' of chronic conditions, including primary diagnosis and co-morbidities, patient and family supports</p>	<p>Patient-centred management of condition</p> <p>Continuity of appropriate and accessible care</p> <p>May take responsibility for maintaining disease registry</p>

*Primary health care principles: access, equity, empowerment, health education and promotion, intersectoral collaboration, cultural sensitivity.