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The primary health care nurse of the future: Preliminary evaluation of the Nurse Navigator role in integrated care

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ABSTRACT

Problem/background: Nurse navigators in the Gold Coast Integrated Care program are co-located in general practices and a community coordination centre providing enhanced access to care for chronic disease patients through a multidisciplinary, multiservice, multilevel primary health care model, which has yet to be evaluated.

Aim: To evaluate the context, mechanisms and processes of nurse navigators' practice after one year.

Methods: The theoretical framework of realist synthesis framed the evaluation examining the relationships between context (the program), mechanisms and processes of enhancing patient access to care. Focus groups were conducted with seven of eight nurse navigators and 33 randomly selected patients. Surveys were completed by 55 general practitioners and 19 practice nurses, analysed using descriptive statistics and content analysis of free text. Patient and nurses' focus group data were thematically analysed.

Findings: All patients reported high satisfaction with the nurse navigators. Themes from the nurse navigator group included enthusiasm and engagement; constraints related to workload, variability and time; desire for a professional 'voice', and issues with the technological environment. General practitioners and practice nurses identified the importance of information, communication, coordination, advocacy, liaison and patients' positive health outcomes, with 73% of GPs and 84% of PNs reporting being satisfied with the NN role.

Discussion: The role is effective in enhancing access to care for chronic disease patients by bridging the gap between primary and secondary care. Their expertise and collaborative liaison with multidisciplinary health professionals has been well accepted by General Practitioners, Practice Nurses, patients and the nurse navigators themselves. Further development of the role over time is expected to show an impact on patient outcomes and value to the health system in the ongoing evaluation.

Conclusion: The role and scope of practice needs to be articulated across different contexts, and to advance evidence for practice and education for primary health care.

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Summary of relevance

Issue

The nurse navigator role has recently been introduced in Australia with few studies articulating the role, scope of practice,

educational preparation, impact on care coordination, patient or health professional satisfaction.

What is already known

Nurse navigators are positioned to assist patients and their carers manage their health and illness along the care continuum.

What this paper adds

Evaluation of the nurse navigator role in integrating care for chronic disease patients across primary and secondary services

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in one Queensland setting. Findings include nurses' role satisfaction albeit with the need for role clarity; and satisfaction with care from patients and other health professionals, primarily because of communication and care coordination.

1. Introduction

This paper reports on an evaluation of the nurse navigator (NN) role in the context of an integrated care program in Queensland, one year after its introduction. The Australian NN role has been developed as a response to the need to improve access, equity, efficiency and effectiveness of health services (Bennett, 2013; Australian Government Department of Health and Ageing, 2010; National Health and Hospitals Reform Commission, 2009). As primary health care (PHC) goals these are also the goals of practice nurses (PNs) committed to enhancing coordination and continuity of care (Carryer, Halcomb, & Davidson, 2015; McMurray & Cooper, 2017). Since their introduction into Queensland Health (QH) in 2015, nurse navigators have been practising throughout the state. Most are linked with specific hospital services such as maternal and infant care, paediatrics, or disease specific care such as cancer services, with some being community based. All share a commitment to assist individuals and families 'navigate' the health system and receive the services they require in the right place at the right time. However, the QH role has yet to be defined in relation to the nurses' scope of practice, interventions or educational preparation for the role. We have begun to address this gap in nursing knowledge by outlining the distinctive dimensions of NN practice in the Gold Coast Integrated Care (GCIC) program. NNs in the GCIC program are unique in being situated in general practice and the wider community to help bridge the gap between primary and secondary services. This paper reports on an initial evaluation of their role in helping chronic disease patients and their care providers manage their health and social care in the community.

2. Integrated care

Over the past decades IC programs have been developed and refined primarily throughout the United Kingdom (UK) and the United States (US). Although there are some differences, most revolve around patient centred care (PCC) strategies to link appropriate, acceptable and effective services to help people remain adequately cared for in the community and avoid unnecessary hospitalisation. Like those in the US and the UK (Curry & Ham, 2010; Faber, Grande, Wollersheim, Hemens, & Elwyn, 2014; Maeung, Davis, Tomcavage, Graf, & Procopio, 2013) the GCIC program was developed on the basis of Wagner et al.'s (2001) chronic care model (CCM). The CCM focuses on holistic assessment of individual risks, stratified to inform person-centred partnerships in developing coordinated care pathways for those the highest risk of illness episodes and fragmented care (Faber et al., 2014). As in other IC programs the GCIC model is multilevel, operating on the macro (shared governance between care organisations), meso (chronic disease status) and micro levels (care organised around individual patient needs) (Curry & Ham, 2010; Valentijn, Schepman, Opheif, & Bruijnzeels, 2013). IC models encompass six interrelated elements: health care organisation, delivery system design, clinical information systems, systematic decision support, patient self-management support and links to community resources. They are designed to reflect Faber et al.'s (2014) three levels of involvement: communication strategies to foster health literacy; consultation to gather direct patient input such as satisfaction and quality of life measures; and participation, including ongoing discussion of service and information needs.

People with complex, chronic conditions are among the most vulnerable to system barriers that obstruct smooth transitions

through the system. The impact of these barriers occurs on two levels. First, without ease of access to the care they need when they need it individuals and populations cannot achieve better health, and second, the health care system cannot provide value for money. IC programs respond to these needs by bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion (World Health Organization, 2008). Importantly, overcoming discontinuities in both information and services helps maintain person-centred care (PCC). PCC is based on the premise that shared understanding between patients and health professionals will lead to safer, better quality care transitions, continuity of care and effective, sustainable outcomes (Australian Commission on Safety and Quality in Health Care, 2014; Clinch & Benson, 2013; Truog, 2012). This partnership approach to care embodies the PHC principles of access, equity, empowerment, health education and promotion, intersectoral collaboration and cultural sensitivity. Together these principles are intended to guide nursing practice and models of IC (McMurray & Cooper, 2017; Valentijn et al., 2013).

3. The gold coast integrated care model

The GCIC model of care was developed to respond to a rapidly growing older population of Gold Coast residents with disproportionately higher rates of chronic and comorbid conditions than the Australian national average (Australian Bureau of Statistics, 2011; Cooper, McMurray, Ward, & Connor, 2016). Feedback from the local hospitalised population indicated a lack of coordination between the hospital and their general practitioner (GP) and confusion about how to access appropriate information and services. This situation is typical in multilayered health care systems such as ours, plagued by fragmented, disconnected services related to a complex interplay of funding arrangements and division of responsibilities (OECD, 2015; Osborn, Moulds, Squires, Doty, & Anderson, 2014; Schoen et al., 2011).

The GCIC program and its evaluation strategy began with invitations to all local general practices for volunteers to be part of a four year 'proof of concept' clinical trial in partnership with Griffith University, Queensland Health, the Gold Coast Hospital and Health Service (HHS), and the Gold Coast Primary Health Network (Scuffham, Mihala, Ward, McMurray, & Connor, 2017). Once an initial group of network practices (N = 14) was recruited and funding secured, a purpose built Coordination Centre (CC) was established to house a multidisciplinary team (MDT) of clinicians, including medical, allied health, nurses/nurse practitioners/and non-clinical service navigators. Patients were enrolled on the recommendation of the GPs, then contacted by a service navigator (located at the CC), who explained the program and gained verbal consent to continue the enrolment process. Each patient was then given a comprehensive, holistic assessment by members of the MDT. The assessment culminated in a care plan and clinical pathway jointly agreed to by the patient, a GCIC clinician and the patient's GP, at which time a formal signed agreement from all three parties was obtained. All information was then stored in a Shared Care Record (SCR), an electronically enhanced system housing clinical informatics. Information included the patient's risk assessments, longitudinal clinical history, existing referral networks and all clinically relevant data. The SCR is a dynamic document that continues to be updated for access by the CC team, GPs, PNs, NNs and patients themselves. The SCR provides not only specific proactive and reactive health care information, but a database of diagnostic information. This information has subsequently been used to create chronic disease registers with practice-based population indicators of prevalence according to specific conditions. Together with the SCR the disease registers provide precise, timely information that is expected

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