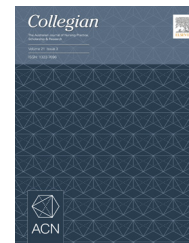




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The nurse navigator: An evolving model of care

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Summary 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.

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1. 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, communities to enable access to the type, level of services, support they need for optimal health outcomes (McMurray & Clendon, 2015). Some PHC nurses work in primary care (PC), predominantly

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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, skills to make a significant contribution to health reform (Carryer, Halcomb, & Davidson, 2015; Keleher, Parker, Abdulwadud, & Francis, 2009). As in many other western nations, the Australian health reform agenda is aimed at improving access, equity, efficiency, effectiveness of services (Bennett, 2013; Australian Government Department of Health, Ageing (DoHA), 2010; National Health, 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, chronic conditions (Garling, 2008; Hall, 2015; Primary Health Care Advisory Group, 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 usually poorly coordinated with inadequate communication from care providers (Burgers, Voerman, Grol, Faber, & Schneider, 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.

2. 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 programmes 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, Scutchfield, & Costich, 2015). The Swedish government followed suit, establishing the patient navigator role as part of the National Swedish Cancer Strategy (Bau Berglund, Gustafsson, Johansson, & Bergenmar, 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, Cohen, & Crosson, 2010; Lindsay, Tetrault, Desmaris, King, & Pierart, 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, 2014; Plant et al., 2013).

In Australia, a navigator role has been developed in the context of a Queensland pilot programme evaluating integrated care for people with complex and chronic conditions. This programme, the Gold Coast Integrated Care (GCIC) programme, 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, Rosenthal, Werner, Volpp, & Schneider, 2015; Willard & Bodenheimer, 2012), and this model has been supported in principle by the Royal Australian College of GPs and the Australian government (Janamian, Jackson, Glasson, & Nicholson, 2014). In the GCIC model, the navigators contact all patients who have been identified by their GPs as appropriate for the programme, conducting a telephone health assessment for each patient and explaining the processes within which they can navigate through the system

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