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Care Navigator Role in the Management of Patients' Access at a Mental and Behavioral Health Clinic

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Executive Summary: Staff Education Project
Care Navigator Role in the Management of Patients' Access at a Mental and Behavioral
Health Clinic

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Summary

Health care delivery in rural areas of the United States is challenged by delay in timely care access, provider shortages, inconsistent and fragmented care, increased emergency room (ER) visits, and associated higher patient morbidity and mortality. Through staff meetings and brainstorming sessions, staff members and administrators at a rural mental and behavioral health clinic (RMBHC) identified the clinical practice problem to be addressed by this doctor of nursing practice (DNP) project as patients' untimely access to and inconsistent use of necessary health care services. A literature review provided support for the care navigator (CN) role in mental and behavioral health settings to improve patient access to services, adherence to treatment, and satisfaction with care. The project question sought to address whether education would improve clinic staff knowledge and perception of the addition of a CN role in care delivery to patients at RMBHC. The staff education was presented to 11 clinic staff members, and nine participants completed a pretest and posttest knowledge and perception questionnaire and an evaluation of the education. Data analysis using descriptive statistics showed a modest knowledge gain of 8.7% (from 82.54% to 91.27%). All the participants agreed that the CN would be an important and complementary addition to the clinic staff and could provide patients with the support necessary to access the clinic services in a timely manner. The intended long-term goal of the project was to increase ease of the clinic's use and timely access to clinic services for early diagnosis and patient-centered interventions leading to positive social change. Using evidence-based practices to improve clinic access and navigation of clinic services is expected to increase the quality of mental and behavioral health care delivery in the rural population catchment area.

Background

According to White et al. (2024), a mandate of nursing education and professional practice is to examine the provision of health care and clinical processes to ensure they include quality, updated, evidence-based, efficient, and safe care that produces the desired and expected patient outcomes. This investigation was the springboard for identifying the gap in practice, generating the DNP clinical practice question (see White et al., 2024) and developing the project management activities and tools for successful project completion (see Sipes et al., 2024).

The clinic where the project took place has a catchment area of 40,000 persons. The population is served by 12 staff members, including the clinic administrators, the intake and referral team, the medical assistants, three mental health care providers, a doctorate-prepared mental health nurse practitioner, and the sole rural area psychiatrist.

To identify the gap in practice, gain problem clarity, plan the project direction, and develop the educational presentation and evaluation tools for this doctoral project, I used the project management activities and tools as described by Sipes et al. (2024). Additional data collection was guided by White et al. (2021) and included evidence obtained from clinical site visits, stakeholder analysis, a SWOT (strengths, weaknesses, opportunities, threats) analysis, and an organizational readiness assessment. Staff interviews and preliminary data collection on issues that were negatively affecting patients, staff, and workflows was conducted. Overwhelmingly, the provider shortage, delays in patient access to care, fragmented versus holistic health care delivery, increased ER visits, and the attrition rate in continuity of care compounded by medication noncompliance surfaced as significant gaps in practice. Of these issues, the identified gap

in practice selected for the DNP project was the notably and unacceptably fragmented care that patients were receiving at RMBHC. The care quality and processes were carefully reviewed, and the administrators and staff brainstormed the barriers and facilitators to patients' access to and use of appropriate health care. This investigation was conducted as described in Dang et al. (2021) to aid in the mitigation of the identified negative impact of the gap in clinical practice and the effects on the quality and safety of clinic patients.

Additional patient-related barriers reported by staff were the lack of transportation, financial and food insecurities, poor social support, patchy internet and phone services, and inability to access and navigate required health care services. Notably, staff-related barriers were the lack of consistent care processes, heavy workload, and workflow issues due to the attrition rate or failure of patients to adhere to appointment schedules or initiate and/or complete the intake process.

Finding a way to address the many barriers to safe, quality patient care formed the basis for the clinical practice question that used the PICO (population, intervention comparison, outcome) format as described by Hickey and Giardino (2021). The PICO question guided the review of the literature and led to the identification of the CN role to address the gap in practice and the current barriers to optimal care delivery in the clinic. The resulting final project question was centered on the need for this new clinic position to address the identified gap in practice and to garner support for the position from the staff. Therefore, the clinical practice question guiding the project was: Will staff education increase staff knowledge and perception of the role and importance of a CN role at RMBHC to improve patients' outcomes?

Supporting Evidence

Data obtained from interviewed clinic staff cited barriers to timely care access were patient related, for example, negative social determinants of health (SDOH), low mental and physical health literacy, low decision-making capacity, inability to navigate services and lack of familial support as well as stigma and professional bias or unrelatedness. Staff-related evidential barriers to holistic patient care access included provider shortages, delay in the referral-intake process, workload and attrition rate due to mode of communication, for example, ground versus electronic mail delivery. Facility-related issues were the limited physical space (office), appointment delay (approximately 3 weeks to see a nurse practitioner and 3 to 6 months to see the psychiatrist for patients older than 16 years and those under 16 years and complex cases respectively. The human, material (structural), and financial issues showcased the need for employment of a CN to mitigate the practice problem with the provision of a liaison health care provider to address barriers to timely care access.

As part of the data acquisition for the project, an extensive literature search was completed using the Walden University database to access CINAHL Plus with full text. The search used the keywords *care navigator*, *barriers or facilitators to mental and behavioral health care*, and *rural versus urban settings*. The literature analysis was limited to 10 articles published within the last 2 decades. The literature review also pointed to the need for a CN in RMBHC. For example, the performance of comparative analyses (Giardino 2021; White & Hickey, 2024) of facilities revealed that the use of a CN in care management of mental and behavioral health patients leads to an increase in medication adherence, increased medical compliance (follow-up care and physical health

maintenance), and decreased ER use. This success led to an increased complement of CNs by 600% in the span of 6 years with an increase in patients' independence and compliance of 75% in 6 months, with only 25% of patients requiring frequent supervision support.

Additionally, research evidence revealed that the life expectancy of patients with mental health issues is 15 to 25 years less than that of the general population due to the lack of timely intervention and/or support (Griswold et al., 2010). Blackburn and Nuzhath (2023) suggested that lack of access to quality care increases ER visits, morbidity, and mortality and results in poorer overall quality of life. This evidence is compounded by factors related to physical health maintenance such as increased risk of comorbidities, including hypertension, hyperlipidemia, and obesity and diabetes related to treatment with atypical antipsychotics (Griswold et al., 2017). Faulkner et al. (2025) found that 25.7% of patients with mental and behavioral disorders had undiagnosed obstructive sleep apnea, which further impair memory and cognitive behavior as well as increase comorbidity risks for hypertension.

Finally, in a position paper, Davenport (2017) stated that the use of CNs in the care management of mental and behavioral health patients decreased ER visits and hospitalizations by approximately 60% within a 3-to-6-month period. This finding led to integrative, collaborative health care delivery across the multidisciplinary health team for improved patient safety and outcomes as well as care quality improvement, with better processes and workflows to ensure timely patient care access.

Strength of Evidence

The evidence as referenced by staff interviews, site visits, and comparative analysis of facilities signifies the strength and relevancy of the qualitative and quantitative findings. This evidence gives further insight into and an understanding of the practice issue. The literature review and synthesis included Levels 1, 2, and 3 evidence, as described by Dang et al. (2021). This research driven, higher tier evidence included qualitative (perception), quantitative, and randomized control trials, which were evaluated for significance, relatedness, and rigor for applicability to inform intended practice change (White et al., 2024). Notably, only one position paper/expert opinion was used based on its relatedness to propel implementation of integrative and collaborative care management associated with quality, patient-centered outcome (Davenport, 2017). This position paper alluded to aligned with the intent of the doctoral project. All the supportive evidence gave credence to the specific goals/purpose of the doctoral project were attainable and should result in beneficial project outcomes.

Staff Education Project Development

To enable development and successful implementation of Dang et al. (2021), stakeholder analysis and selection is critical. This project management activity leads to the effective buy-in process, wooing, and presentation of project purpose intent to critical stakeholders (see Sipes, 2024), such as the chief nursing officer (CNO), the psychiatrist, clinicians, clinic administrators, and intake referral team. These persons were instrumental in qualitative and quantitative data collection and development of information on the progression of the project for dissemination (see Sipes, 2024). These stakeholders (CNO, psychiatrist, and preceptor) and faculty provided the necessary

guidance and mentorship to maintain focus on the project's purpose, phases, and intended outcome for successful progression.

Additional project management tools such as an organizational readiness assessment, a SWOT analysis, and use of a GANTT chart (see Dang et al., 2021 and Sipes, 2024) were used to gather data on the barriers, facilitators, and the timeline to address factors that could derail the project. The use of these tools encouraged the project team's commitment and accountability to achieve project tasks.

The analysis of the evidence was achieved through a guided process of practice gap identification, literature review, and literature synthesis to identify evidence-based methods to address the gap in practice, develop the project question, and create the materials to be used in project implementation (Dang et al., 2021). The literature evidence was categorized according to rigor, relatedness, hierarchical strength, and applicability to inform practice change (Dang et al., 2021). The research evidence related to the care navigator role were Levels 1, 2, and 3, with high to moderate quality that consistently supported the rationale for a practice change through staff education. The evidence also supported staff education to garner support for the CN role in the management of mental/behavioral health patients for better outcomes, such as timely quality care access, improved processes, collaborative services, and decreased morbidity, mortality, ER visits, and health care costs.

An evaluation of the project outcomes was done before and after a 20-minute PowerPoint staff education presentation to 11 participants. The PowerPoint presentation provided evidence that showcased the beneficial role of the CN as an advocate and therapeutic liaison clinician to aid in timely care access and navigation of services for

improved patient outcomes. A pretest and posttest questionnaire was administered to assess staff knowledge and perceptions of the CN role. The participants also completed an evaluation of the education.

Results

One coded packet of pretest and posttest questionnaires and the education evaluation survey was provided to each participant. Two packets were excluded as one person did not return the packet and another person returned an incomplete packet. While all 11 staff members attended the education presentation, the assessment attrition rate was 18.18%, resulting in a final number of nine participants whose data were included in the analysis. The education was followed by calculation of the pretest and posttest scores to attain an improvement in the knowledge score of 8.7% (see Table 1). The small improvement in the knowledge score was perhaps reflective of the participants' educational level, skill set, and prior knowledge of the CN role as well as socialization to the project by change champions and leaders (White et al., 2024) within the clinical site. With seven of the nine participants scoring between 75% and 100% on the pretest questionnaire, there was little room for improvement on the posttest questionnaire. In fact, the scores on the posttest decreased for three of the participants. Importantly, the education significantly improved the scores of two of the participants; one participant's score improved from 35.71% to 100% and the other participant's score improved from 53.57% to 71.43%.

Table 1*Pretest and Posttest Results and Knowledge Gain Percentage*

Coded participant	Pretest results	Pretest %	Posttest results	Posttest %	Knowledge gain %
1	28/28	100.00%	28/28	100.00%	0.00%
2	28/28	100.00%	28/28	100.00%	0.00%
3	21/28	75.00%	20/28	71.43%	-3.57%
4	28/28	100.00%	28/28	100.00%	0.00%
5	10/28	35.71%	28/28	100.00%	64.29%
6	15/28	53.57%	20/28	71.43%	17.86%
7	22/28	78.57%	24/28	85.71%	7.14%
8	28/28	100.00%	27/28	96.43%	-3.57%
9	28/28	100.00%	27/28	96.43%	-3.57%
Average		82.54%		91.27%	8.73%

While the knowledge gain was small (8.7%), the perceptions of 100% of the participants was that the role of a CN would positively impact patient outcomes and was necessary to the provision of holistic quality care at the clinic. Unrequired written comments such as the “evidence supports change” and the change “will decrease clinical staff workload” were indicative of a positive buy-in process and the adaptability of the clinic staff to the change process.

Conclusion

The literature evidence, support of critical stakeholders and the positive buy-in process of the clinical staff are indicators that the change process will be supported and adaptable. However, a limitation is to attract funding to support employment of CN, develop a job description and salary scale, and allocate office space in the clinic’s temporary location. Recommendations to ensure the CN role is implemented include attracting benefactors, developing a grant proposal, and enlisting human resource personnel to develop a job description and pay scale as well as the CN position within the

organizational chart. Finally, socialization of the CN roles and responsibilities within the facility, community, patients, and the collaborative health care teams are paramount to the change process.

Importantly, while the doctoral project was accepted with excitement for its implementation, it would be imperative to do a quarterly evaluation of the use and benefits of a CN to ensure care access, quality, and navigation of services that improves patient safety and outcomes. Financial outcomes also are reasonable and important to address as the research findings of Brooks-Carthon et al. (2024) showcased the billions of dollars in Medicare and Medicaid payouts for patients with mental and behavioral health issues. Future reduction of health care costs is dependent on a decrease in ER use through timely access to care and ongoing outpatient clinical care. A decrease in health care costs through improved care access and navigation may mitigate clinical staff workload excess and associated staff attrition due to burnout and job dissatisfaction.

The mitigation of the doctoral project gap in clinical practice (limited access to clinic care) and inappropriate use of the ER due to the inconsistent use of clinic services could have a positive societal impact by minimizing staff distress and attrition, improving staff retention, and increasing patient safety and patient/family satisfaction with care. These factors, as well as the integration of a CN as an integral health care team member, could facilitate a clinic, community, and patient/family collaboration. The intended outcome is ease of clinic use and timely access to services for early diagnosis and patient-centered interventions. Furthermore, the reduction in overall costs could provide more health care dollars for disease prevention, comorbidity treatment, and improved quality of life for patients and families in the community. Prevention of the inappropriate and costly

provision of health care in the ER could lead to allocation of health care dollars toward community health campaigns and staff education to increase mental health literacy, decrease mental health care stigmatization, and fund CNs in health and social services (Brooks-Carthon et al., 2024).

The intent of this project was to ensure a holistic collaborative health care setting with improved access and navigation of services for patients with mental and behavioral health issues. The metaphoric bridge to these services will be the employment of a CN to mitigate the gap in practice and ensure timely access to appropriately allocated resources that will improve health care for patients, families, and the entire population within the catchment area of the clinic. Rural clinics are challenged to deliver quality care with limited resources. Staff education and engagement as a part of a larger quality improvement project may ensure that all staff members have the knowledge and perceptions to facilitate positive social change for patients with mental and behavioral health issues in this rural area.

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