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Nurse Navigator Role Description and Processes for Best Outcomes Among At-Risk Patients

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Judean LeRoy

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Walden University
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Abstract

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MSN, Otterbein University, 2011

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

The nurse navigator role developed in the 1990s to support African American female oncology patients' access to services. Successful in oncology, the role has expanded to support patients with diabetes, heart failure, and chronic obstructive pulmonary disease. A unique cost-effective opportunity exists for nurse navigators to fill the gap in transitional care, between the acute care setting and home, for chronically ill and other at-risk patients who are often readmitted within 30 days for treatment of the same disease. The purpose of the project was to refine the job description of the nurse navigators in a Midwestern acute care hospital. The Rosswurm and Larrabee model for evidence-based practice change supported the work. The key research question involved identifying the tasks, knowledge areas, and skills necessary for inclusion in a hospital-wide nurse navigator job description, to promote best outcomes for chronically ill and at-risk patients. Using the Oncology Nurse Navigator Role Delineation Study as the starting point, the project applied a qualitative design in reviewing the 13 nurse navigator job descriptions. The percent of nurse navigator job descriptions containing the job expectations from the delineation study was calculated and additional expectations were identified from the hospital job descriptions and the literature to create a new standardized job description containing 3 categories of job expectations: tasks, knowledge areas, and skills. Positive social change may result from nurse navigator role clarity in the hospital by decreasing service duplication, improving care collaboration, and ensuring role accountability.

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Dedication

This page is dedicated to God who provided the insight and means to make this possible as well as those leaders in the nursing profession who have been instrumental with making this part of my journey possible.

Acknowledgments

I wish to thank my husband and family for their unrelenting support during this journey. I would also like to thank Dr. Sue Bell for all her expertise, time, and encouragement throughout this project. She has taught me a great deal throughout this entire process. Finally, I wish to thank my preceptor Abby Nguyen and all the Walden University professors who were an iatrical part of this project.

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Section 1: Overview of the Evidence-Based Project

Introduction

"To say that the world of health care is in transition is to understate both the magnitude

and scope of the changes taking place in how illness is treated and how health is promoted

around the globe" (Kimberly & Cronk, 2016, p. 162). These changes can impact both delivery of

care and types of services rendered. "U.S. health care spending increased 4.3 percent to reach

$3.3 trillion, or $10,348 per person in 2016" (CMS.gov, 2016, p. 1). There is the added challenge

of trying to meet the consumers' needs while attempting to contain skyrocketing health care

costs for a population that is aging and thus at greatest risk for acquiring one or more chronic

conditions. "Private employers are increasingly demanding that health care insurers address these

cost through disease management programs and government health plans, notably Medicare"

(Garrett & Martini, 2007, 51).

Beyond cost, the health care system struggles for a variety of reasons, making it is

difficult for the health care system to meet the needs of people with higher risk conditions. Care

often lacks interdisciplinary coordination, leading to a combination of unnecessary testing or

duplication of services. Patients are often left with conflicting information from multiple

providers. This is a cost burden for the patient. This lack of coordination, in turn, can cause

confusion when navigating the health care system. This can impact the patient's quality of life,

perhaps through accelerated disease progression or acute exacerbation.

Often, this confusion within the health care system makes it difficult to access services as

an individual patient, creating an inadvertent barrier to appropriate medical care specifically for

their given condition. For the patient newly diagnosed with an acute or chronic condition, their

world is changed by added medical appointments, testing, and lack of knowledge of how this will impact their life. A chronic medical condition also can create undue stress for the patient who attempts to manage the condition only to become decompensated with acute symptoms or with an exacerbation requiring a hospital admission or readmission. If the patient had received help understanding the resources necessary for their condition, they might have been avoided. This support gap has now increased the risk of overall morbidity and mortality and created a cost burden for the patient and the family.

Health care organizations can facilitate navigation of the health care system for the high-risk patient. "A variety of strategies implemented at an organizational level have been developed to help prevent hospital admissions or readmissions, accelerate discharges, improve access to care and the care quality as patients transition between providers and health care settings" (Manderson et al., 2012, p. 114). This paper will provide an overview of the nurse navigator role, detail interventions to promote best outcomes for the at-risk patient with an acute or chronic condition(s), include a thorough review of the evidence regarding the nurse navigator role, and propose a plan to help patients navigate the health care system more efficiently.

Purpose Statement and Project Objectives

The purpose of this project was to determine which interventions used by nurse navigators promoted the best outcomes for the at-risk patient. The navigator role was first developed by Harold Freeman in 1990. This new model resulted from seeing a disparate number of African American women presenting with late-stage breast cancer, which was attributed in part to their inability to access needed cancer care services. The nurse navigator role was

developed to assist patients with a cancer diagnosis to get the benefit of the best possible

oncology care.

In recent years, this role has expanded to assist patients with chronic disease management

and other illnesses. Because this is a relatively new role for nurse navigators, the impact has not

been rigorously documented (Manderson et al. 2012). Outside of oncology, this role is being

pioneered to see if the use of nurse navigators can help contain costs by decreasing hospital

length of stay and avoiding costly penalties for certain high-risk populations such as persons with

heart failure (HF) or chronic obstructive pulmonary disease (COPD) who may have frequent

rehospitalizations, emergency room (ER) visits, and low satisfaction with the delivery of care.

As health care becomes increasingly complex and as more pressure is placed on acute

care settings to decrease length of stay and readmissions, the nurse navigator will likely become

more valuable. When patients come through the hospital door, they become at-risk for several

points of process failure which, in turn, hinders optimal care. "On average, in 2010, Americans

received 70% of indicated health care services and failed to receive 30% of the care they needed

to treat or prevent particular medical conditions" (AHRQ, 2014, p. 2). Barriers that may

contribute to lack of access include poor communication, health care illiteracy, inconsistent

medical management, and lack of accountability by either the patient or the provider.

Utilization of the nurse navigator role provides an alternative to minimize lapses of care.

Nurse navigator programs "seek to improve patient care by reducing barriers to care, through the

provision of information, social and emotional support, links to existing services and resources,

as well as patient referrals to service providers" (Whitley et al., 2011, p. 3617). The nurse

navigator can help the patient at any point of entry to the health care system and support her or him through to discharge and follow-up.

To understand the effectiveness of the role, the hospital or other employer must be able to measure the impact of the nurse navigators on the at-risk populations at each of the critical points where process failure can occur. For the high-risk patient, the organization must be able to articulate the process impact of the nurse navigator when the patient comes through the door, at discharge, and when making the follow-up appointments to provide optimal transitional patient care.

At entry to the system, the patient must be quickly identified as an at-risk patient based on an acute presentation, a 30-day readmission, or extenuating circumstances that could hinder optimal care such as health literacy or language issues, lack of family or a caregiver, or financial and transportation issues. Any identified barriers to optimal care need to be addressed by the nurse navigator prior to discharge.

Discharge is a second point of potential failure in patient care. "During the hospital to home transition, patients are at high-risk for adverse drug events, incomplete or inaccurate information transfer, preventable hospital readmission, and even death" (Davis et al., 2012, p. 1649). The patient may become overwhelmed with whom to see and what to do to manage their condition(s). They are discharged where further breakdown in disease management can occur. To help manage their new or chronic condition, the patient needs a strategy upon discharge to help with a plan of care.

Finally, follow-up is a third point of potential process failure for patient care. Before walking out the hospital doors, it is important that each patient has an appointment with the

providers who are best suited to care for their disease process and a way to get to that appointment. Collaboration with other health care team members is crucial to set up the patient for success when they are managing care in the outpatient setting. There are many resources in the community to help the patient manage his own care, but before discharge occurs, these resources must be arranged. It is not unusual for a hospital to discharge a patient on a Friday afternoon without the necessary services in place. If the patient cannot pick up his or her necessary medications, food, assistive equipment, or other supplies for managing his condition independently, he may be back in the hospital by Monday.

Significance to Practice

The significance to practice is providing appropriate high level care while being cost conscious. "As a nation, we spend 86% of our health care dollars on the treatment of chronic diseases" (CDC, 2015, para 1). People are living through acute injury and as a result living longer and developing chronic, progressive condition(s). According to Anderson (2010), "in 2009, 145 million people—almost half of all Americans—lived with a chronic condition" (p. 4).

There has been a great deal of push for a decreased hospital length of stay, reduced avoidable 30-day readmissions, and yet an increased patient satisfaction score to avoid penalties imposed on acute care organizations. According to the Centers for Medicare and Medicaid Services (2014), Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions." These expectations present challenges in health care delivery and could place the vulnerable and/or chronically ill patients at risk for increased morbidity and mortality.

Because of the increasing fragmentation, associated complexities, and limited resources, patients and their families need help to navigate the health care system. Those patients with persistent, chronic, medical conditions require additional support with access to care. Many organizations have adopted a nurse navigator program driven by the potential cost-effectiveness of the role. The significance is twofold. For patients, a nurse navigator provides an interpreter of sorts, helping the patients make sense of their disease process. On the health care provider and organization side, the goal is to decrease health care costs. The nurse navigator can provide continuity of care aimed at reducing duplication of testing, unnecessary testing, and readmissions perhaps, by setting patients up with the right services.

A nurse navigator is in the position for service access. According to Gilbert et al. (2011), the "core navigation functions include simplifying access and improving continuity of care, proactive navigation, assistance in overcoming barriers and/or disparities, patient advocacy, coordination of care, and support in achieving efficiencies" (p. 230). There is a need to implement strategies aimed at collaborative care coordination among healthcare providers. This placed the nurse navigator in the forefront to improve care and efficiency within the process.

Implications for Social Change

The implication to social change is to become a catalyst for improving health outcomes while providing quality services. Healthy People 2020 reported "access to health services means the timely use of personal health services to achieve the best health outcomes" (Healthy People 2020, 2015, para. 3). The aim of the nurse navigator role is to assist the patient through the continuum of the health care system while decreasing overall health care associated expenditures. According to the World Health Organization (2015), the United States ranks 37th

of all world health systems in its effectiveness and surpasses every other country in the money it spends on health care as a percentage of its gross domestic product.

This project is expected to improve society by helping patients improve health outcomes and/or quality of life by adopting care practices that are supported by the evidence. For patients, this will increase their overall satisfaction while providing them with a liaison to advocate for their direct care needs. For the health care system, the nurse navigator offers a higher level of care delivery that will be cost effective because it will avoid readmissions within 30-day and, as a result, decrease overall health care expenditures.

Project Question

The project question was as follows: What are the tasks, knowledge areas, and skills necessary for inclusion in a hospital-wide nurse navigator job description to promote best outcomes for chronically ill and at-risk patients? The consensus in the literature was that the nurse navigator role was geared toward decreasing fragmentation in health care delivery for patients and helping them to maneuver through the system; however, there may be ways to optimize and standardize the role within the project hospital for greater effectiveness of the rôle.

Local Context

The project hospital was an acute care facility with a total of 225 beds in southeastern Ohio. Currently, a total of 862 registered nurses are employed in various roles with a total of 16 nurses in the nurse navigator role. Two of these nurse navigators also function as case managers. The role of the nurse navigators is to identify those patients at risk for 30-day readmissions. There are five nurse navigators employed in cardiovascular services who see patients with heart failure, atrial fibrillation, acute coronary syndrome, or those in need of coronary artery bypass

graft surgery. Four nurse navigators are employed in oncology services who see patients with specific cancer diagnoses. The breast cancer nurse navigator is the only certified navigator. There are four nurse navigators who see patients with chronic obstructive pulmonary disease. Finally, the newest addition is a diabetic nurse navigator, formerly known as a diabetic educator.

Project Objectives

Based on the project question, six objectives were accomplished to incorporate evidence-based best practices for level of education, skill set, duties, policy and procedures, and the nurse navigator role at the project site. These objectives were as follows:

1. Review all 13 nurse navigator job descriptions at the project site.

2. Develop a comprehensive list of common job expectations and required skill set for the role from the various job descriptions.

3. Compare the list of common job expectations and skills to best practices for the nurse navigator role as identified in the literature.

4. Develop a new job description for the nurse navigator role.

5. Develop recommendations to standardize the nurse navigator processes and procedures at the project hospital.

6. Recommend a method for evaluating the effectiveness of the nurse navigator in reducing 30-day readmission rates at the project hospital.

Evidence-Based Significance of the Project

The evidence-based significance of the project is role refinement and implementation of best practices to achieve a higher level of patient care in a cost-effective manner. Titler (2008) defined "evidence-based practice (EBP) as the conscientious and judicious use of current best

evidence in conjunction with clinical expertise and patient values to guide health care decisions"

(p. I-113). In the role of the nurse navigator, the goal is to provide best care that is clinically

sound and based on practices that promote optimal patient outcomes. For example, heart failure

guidelines are often cited by the American College of Cardiology and American Heart

Association (ACC/AHA). The basis of these guidelines has been well researched, peer-reviewed,

and graded according to how well the evidence supports the recommendations. A nurse

navigator, in collaboration with the health care team, should have a thorough understanding of

the guidelines and ensure that they are being followed. What sets the nurse navigator apart from

other nursing roles is their interactions with patients to ensure continuity of care throughout and

beyond the current hospitalization with a plan to avoid harm or readmission. In the literature,

there is a great deal of research on defining the nurse navigator role in general, but no research

was found on patient care outcomes and realized cost-effectiveness to the organization.

Assumptions

An assumption in the development of the project was that use of the nurse navigator was

emerging as a role for assisting patients in a system that is complex and full of fragmentation. It

was assumed the role will be used increasingly in hospitals to support patients who are at a

considerable risk of becoming medically decompensated or whose circumstances necessitate a

liaison for access to care. Another assumption is older patients who have at least one chronic

illness are at a higher risk for morbidity and mortality and this risk increases when the patient has

more than one acute and/or chronic condition. These patients can benefit from nurse navigator

interventions to attain an optimal quality of life and slowed disease progression.

Summary

Health care is becoming increasingly complex and fragmented; it is challenged to keep up with delivery of care and the competitive types of services that it provides. This environment increases the chances of the patient falling victim to barriers in care. Organizations must avoid lapses in care due to inattention to these barriers and the nurse navigator role may be able to help patients at highest risk for falling through the gaps.

Since nurse navigators first emerged in hospital-based oncology patient care in the 1990s, the role has expanded to include many other areas and medical diagnoses. With the expansion of the role, it is necessary to understand which interventions used by the nurses in this role promoted the best patient outcomes. This understanding must be grounded in the evidence while considering the clinical expertise required to guide appropriate health care guidance at critical junctures in hospital care (admittance, discharge education, outpatient care service and resource planning).

While it was assumed the use of the nurse navigator role was vital in a system that is complex and fragmented, the ultimate benefit was that promoting the best outcomes for the patient yielded the most cost-effective manner. At the conclusion of this project, interventions that best support patients at risk for poor post hospitalization outcomes will be identified.

The next section will focus on the history of the nurse navigator as well as reviewing the literature as it pertains to the nurse navigator roles. The conceptual model of evidence-based practice will be discussed as it relates to the necessity for this project.

Section 2: Review of Scholarly Evidence

Introduction

The purpose of this project was to identify which nurse navigator interventions promoted the best outcomes for at-risk patients. "Whether care is delivered in an urban clinic or in rural private practices, patients may experience delays in diagnosis and treatment and receive fragmented, uncoordinated care" (Case, 2011, p. 33). Delivery of care in a complex health care system presents potential barriers for the patient and/or the care is not conducive to realizing evidence-based best practices.

In the subsection on specific literature, I will discuss the first navigator program introduced by Harold Freeman in 1990 and the role nurse navigators played in care coordination. Since then, the role has expanded beyond oncology to other areas of chronic disease and to patients considered to be high-risk, such as elderly patients and who experience barriers that threaten worse outcomes.

In the subsection on the general literature, I will discuss the nurse navigators' role(s) in coordination of care, including barrier identification and discharge planning to promote optimal outcomes for the patient. The purpose of the general literature review is to broadly outline the interventions that are necessary to decrease system fragmentation and to align the patient with resources to achieve optimal outcomes.

Finally, I will discuss the evidence-based practice (EBP) model. According to Satterfield et al. (2009), EBP "provides a useful framework for guiding health services research with an interdisciplinary and real-world perspective" (p. 384). The reason for establishing which nurse navigator interventions promoted the best outcomes for at-risk patients is based on which clinical

practices have proven beneficial for the patient (and their association with the health care system's delivery mechanisms). These clinical practices in turn will promote optimal and sustainable multidisciplinary care.

Specific Literature

Dr. Harold Freeman was the pioneer in development of the first nurse navigator role. He was involved in two Harlem hospital studies (1986 and 1995-2000) that demonstrated an increased 5-year survival rate of poor African American women with breast cancer who used a navigator program. "The 5-year survival was 70%, compared to 39% in the earlier Harlem Hospital study" (Freeman, 2006, p. 140). The survival rate demonstrated a need for a liaison to assist with access to care.

According to the Harold P. Freeman Patient Navigation Institute (2015), "navigators act as the support hub for all aspects of patients' movement through the health care system" (para 6). They were shown to be effective with removing barriers to care. "Although Nurse Navigator programs most commonly target cancer patients, the literature supports that opportunity exists to extend nurse navigator programs to other chronic diseases" (Pruitt & Sportsman, 2013, p. 593).

The role of patient navigator or nurse navigator has grown since being introduced in 1990 by Dr. Freeman. "The principal function of the navigator is to eliminate any and all barriers to timely screening, diagnosis, treatment, and supportive care for each individual" (Harold P. Freeman Patient Navigation Institute, 2015, para 6). Research is emerging in support of the nurse navigator for patients with chronic illness and other high-risk presentations; however, no research could be found that assessed the effectiveness of the role outside of oncology.

The literature search used the following databases: Cochrane Library, JBI Library, Medline, CINAHL, SAGE, and SocINDEX. The following key terms were used alone and in combination: *patient, navigator, nurse, pivot, discharge planning, hospital, care coordination, chronic disease, and coordination.*

The search yielded 5,665 potentially relevant articles. From the articles, a total of 27 articles were found to be applicable. After review of these 27 articles, eight more articles were excluded leaving a total of 19 articles. The articles were excluded for two reasons: they were not relevant or were duplicate articles; (b) included literature related to pediatrics, mental health, and dementia. It was felt, while these populations may be classified as chronic and/or high-risk, there are special considerations for care of these patients that are not suitable for this. Inclusion criteria included literature comprising of the following: (1) the nurse navigator role, (2) barriers to access of health care, (3) care coordination, and (4) discharge planning aimed at readmission rate reductions. Literature specific to the nurse navigator role included ten total articles, two of which focused on barriers to care or treatment; the other eight articles focused on the specific aspects of the navigator role. Three of the studies were randomized controlled trials, two were longitudinal studies, and one was exploratory. See Table 1 below.

Table 1

Specific Literature Delineating the Nurse Navigator Role

First Author	Inclusion	Aim(s) of the study	Details of intervention	Reported outcome(s)
Asgary et al.	Barriers to care	Identify and understand colorectal screening rates, predictors, and barriers to screening for homeless in New York City	Proposed intervention to improve colorectal cancer screening by including private shelter rooms for colonoscopy prepping. Patient navigators to assist with health care navigation, accompany to and from procedure, counseling at all	Patient who were homeless were less likely than domiciled patients to have up-to-date screening (19.7% vs 41.3%; p < .001). Homeless patients were significantly less likely to have had a previous colonoscopy (p < .05).

			encounters, and education to specific patient to curb misconceptions.	Nurse navigators are recommended to assist with barriers to care
Calhoun et al.	Nurse navigator role	To develop a patient navigator competency program	Randomized control design Standardized training for patient navigators with a goal to provide dissemination of information, skills, and competencies aimed at decreasing barriers by underserved papulations. Recommend national standardized training for all chronic disease navigators.	Curriculum training; n = 110, with a mean pretest score of 19.79 (SD = 2.76) and a mean posttest score of 20.74 (SD = 2.44) showing improvement in knowledge
Dennis et al.	Barriers to care	To assess if patient navigators and use of the Direct Endoscopic Referral System (DERS) would increase timely colorectal cancer screening for a large urban hospital in a predominately poor region	Retrospective analysis Hired 2 patient navigators and implemented the DERS to see if the number of broken appointments decreased for colorectal cancer screening and diagnostic colonoscopies. Study suggests when barriers are addressed, screening rates increased	The rate of broken appointment for both screening and diagnostic colonoscopies significantly dropped from 67% to 5%. Nurse navigator role in appointment increased compliance rates 3-fold (relative risk = 2.6, 95%, Cl = 2.2-3.0)
Gunn et al.	Nurse navigator role	To determine if published nine principle model of navigation mirrors the practice in breast cancer navigator programs.	Exploratory Study Observation of the navigators in the 10 programs for a total of 179.5 hours. Codes were used based on nine a priori themes derived from the nine-principle model	Found individual level principles were broadly consistent with the nine-principle framework; whereas program level principles were variable across programs
Horner et al.	Nurse navigator role	The aim was to test the effectiveness of a 16-week oncology nurse navigators (ONN) program compared to enhanced usual care to support cancer patients early in treatment.	Randomized control trial. Each patient (n = 251) was assigned to a group based on which primary care clinic they belonged to. The primary care clinics (n = 11) were randomly assigned to either the ONN program or enhanced usual care group.	The results were not disclosed in the article pending result analysis.
Jolly et al.	Patient navigator role	The aim of the study was to design a patient navigator role from lay-persons to help coordinate care, address system barriers and to	Proposed intervention was developing a patient navigator role using lay persons to assist CKD patients. Electronic medical record templates	The 2 hired patient navigators were trained and responsible for navigating patients enrolled in a clinical trial. They were trained in

		educate/motivate their patients.	were created and identification of barriers.	general patient navigation, specific education on CKD, and patient privacy and research training.
May et al.	Nurse navigator role	The aim of the program was to implement a GI multidisciplinary care (MDC) program with integration of a GI nurse navigator (NN) to optimize care of patients newly diagnosed with GI cancer	The intervention was: • Nurse navigator to contact patient within 2 days of diagnosis (goal 80%) • Cancer staging completed within 5 business days of referral (goal 80%) • 90% of the patients to be seen by GI MDC in 10 calendar days 70% of patients to start cancer treatment within 22 calendar days.	Result of quality indicators from 1/2010 to 8/2012 with use of GI NN includes the following: • Nurse navigators contacted patient within 2 days of diagnosis (outcome 89%) • Cancer staging was completed within 5 business days of referral (outcome 85% • 91% of the patients were seen by GI MDC in 10 calendar days 75% of patients were started on cancer treatment within 22 calendar days.
Percac-Lima et al.	Nurse navigator role	The aim was to understand if the use of a nurse navigator with Latina women having an abnormal pap smear result would decrease	Information was obtained over two-time periods (2004-2007, and 2008-2011) to establish if the use of nurse navigators verses no use of nurse navigators (comparison group) were influential with the following outcomes for Latina women with an abnormal pap smear result: • Missed appointment for colposcopy • Time to colposcopy Changes in severity of two-time periods	Nurse navigators were influential with: • Missed appointment for colposcopy decreased for navigated Latina women versus comparison group (p < 0.001) • Time to colposcopy was shorter for nurse navigated Latina women versus comparison group (p = 0.010) Changes in severity of two-time periods decreased for navigated Latina women verses comparison group (p < 0.001)
Redwood et al.	Patient navigator role	The aim was to have patient navigators in Alaska contact first	The patient navigators contacted the first-degree relatives by telephone or	The results showed a significant increase in colorectal cancer

		degree relatives of colorectal cancer patients to obtain colorectal cancer screening	mailed reminders.	screenings with the use of patient navigators
Wagner et al	Patient navigator role	To determine if a nurse navigator intervention improves quality of life and patient experience with care	Two-group clustered randomized controlled trial Study used adults with recently diagnosed primary breast, colorectal, or lung cancer (n = 251) who received either enhanced care (n = 118) or nurse navigator support for 4 months (n = 133).	No significant differences found between groups in FACT-G scores meaning NN intervention did not impact quality of life or delays in receiving care. However, patients reported significantly higher scores on the PACIC survey and reported significantly fewer problems with care, including psychosocial care, care coordination, and information

Most included studies that provided an overview of the nurse navigator role discussed some form of cancer navigation, although one study by Jolly et al. (2015) discussed implementing two nurse navigators to assist with care coordination and education of patient with chronic kidney disease.

Three studies discussed program development, including one by May et al. (2014). The study provided and discussed measurable interventions from the start of patient contact to start of the cancer treatment. This study concluded that there was a benefit in having a nurse navigator to expedite this process.

A randomized, controlled trial conducted by Horner et al. (2013) tested the effectiveness of a 16-week oncology nurse navigators (ONN) program; however, no results were provided. Another randomized study by Calhoun et al. (2010) looked at curriculum for training navigators and recommended national standardized training for all chronic disease navigators.

Overall, the literature referring to the nurse navigator role discussed either curriculum training, focused on a specific at-risk group, or found an increased compliance rate with care

needs by helping the patient overcome barriers to care. None of the literature specific to the navigator role discussed discharge planning.

Role refinement and assessment is crucial. The Oncology Nursing Society (ONS) conducted a study called the Oncology Nurse Navigator (ONN) Role Delineation Study in 2010. The purpose of the ONS ONN Role Delineation Study was to examine the job-function activities and knowledge required of the ONN, thereby providing an understanding of this new role (Brown et al., 2012). Based on information gathered from the respondents, a list of necessary skills, tasks, and knowledge was initiated to define the ONN role. A mean rating of 3.5 – 4.49 was considered to be very significant for understanding role delineation.

For tasks, 62% of the task identified were significant for the nurse navigator role. Those task rating at the highest includes: providing emotional and educational support, practicing in accordance to professional standards, advocation, orienting patients to the system, receiving and responding to referrals, pursuing continuing educational opportunities related the specialty and specific to the nurse navigator role, assisting with informed consent, multidisciplinary collaboration, identifying patients in need of navigation, and education.

Knowledge areas were considered to be 91% significant in accordance to the very significant rating scale. Higher on the list of knowledge included: informed consent, advocacy, symptom management, ethical principles, quality of life, treatment goals, therapeutic options, evidence-based practice guidelines, and scope of practice.

"The 12 skills included on the survey were rated on the same scale and the skill on the survey provided a sound basis for defining the skills needed within the navigator role" (Brown et al., 2012, p. 584). It was ascertained that, overall, more research was needed on this topic.

The study by Wagner et al. (2014), used a clustered randomized controlled trial to determine if the use of a nurse navigator intervention improved the quality of life and patient experience for those patients recently diagnosed with breast, colorectal, or lung cancer. It was noted that the Functional Assessment of Cancer Therapy–General (FACT-G) quality of life scores showed no significant impact of the nurse navigator on quality of life or delays in care. There was a significant difference on the Patient Assessment of Chronic Illness Care (PACIC) survey: patients reported fewer problems with care; in particular psychosocial care, care coordination needs, and information. The study also showed in the lung cancer patients a decrease of $6,852 in care costs among nurse navigator patients. There was no significant cost reduction in care of breast or colorectal cancer patients.

General Literature

The general literature included studies of discharge planning and care coordination, which are essential duties of the nurse navigators in the acute care setting at the project hospital. According to Russell (2013), "these hospital-based navigators primarily manage the patient's needs during the hospital stay and discharge planning and they work for the hospital" (para 6). When looking through the literature, this is a point of failure for the patient after they are discharge and before they can follow-up with their health care provider.

The nurse navigator's focus is to assist the patient through the health care system. The care coordination and discharge planning piece is intertwined in this role. Social workers and case managers have traditionally assumed this role with general patient admissions. Because the nurse navigators, social workers, and case managers do not always collaborate, this does not always allow for a more individualized plan of care to help the patient in terms of reducing ER

visits and readmissions for patients who are at risk. Unfortunately, no literature could be found to understand which interventions by the nurse navigator promote best outcomes for the at-risk patient.

Holliman et al. (2003) explored the role of social workers versus nurse discharge planners and found no significant difference in job roles. This was the only article found that met the inclusion criteria.

In terms of care coordination, eight articles were included. A cross sectional study by Bradley et al, (2013) was conducted to understand what strategies are independently associated with a reduction in 30-day readmissions. [Strategies that were associated with lower hospital RSRR included: 1) partnering with community physicians or physician groups to reduce readmission (0.33 percentage point lower RSRR, $p = 0.017$), 2) partnering with local hospitals to reduce readmissions (0.34 percentage point, $p = 0.020$), 3) having nurses responsible for medication reconciliation (0.18 percentage point, $p = 0.002$), 4) arranging follow-up appointments before discharge (0.19 percentage point, $p = 0.037$), 5) having a process in place to send all discharge paper or electronic summaries directly to the patient's primary physician (0.21 percentage point, $p = 0.004$), and 6) assigning staff to follow up on test results that return after the patient is discharged (0.26 percentage point, $p = 0.049$)] (Bradley et al. 2013, p. 2).

A qualitative study by Kainfar et al. (2014) was the only article found discussing chronic care coordination. Coordination elements of communication, relationship building, and care coordination were identified as essential elements for care coordination. For chronic care coordination, this connection is one which is open and interdisciplinary where collaboration is occurring. The relationship becomes the interaction between health care professional discussing

care coordination activities or by the patient and health care professional. Monitoring takes on the patient's overall status, or changes in status, and monitoring activities of other health care professional caring for the patient.

Legarin et al. (2011), did a randomized controlled trial to determine if a multimodal approach would decrease ER visits and readmissions in patients older than 70. They looked at specific risk factors of preventable readmissions which included drug related problems, depression, and malnutrition. They concluded the multimodal approach was effective at 3 months but not at 6 months. The authors concluded the following as an explanation of the insignificant effect at 6 months including: "contamination of the control group (acute geriatric unit physicians could have integrated parts of the treatment review and implemented them in the control group); lack of power (it was initially planned to include 800 participants), or lack of post discharge follow-up" (Legrain et al., 2011, p. 2026).

Often at discharge, patients are faced with multiple medication variations increasing confusion for the patient or provider trying to manage these changes. These changes can include increased or decreased dosing of a current medication, new medications additions, and/or medications discontinued. A knowledge deficit can cause potential harm to the patient or bring them back as a potential readmission. Kaanan et al. (2013) did a retrospective study to determine the number of adverse drug events after discharge. They found in their study, 242 patients (n=1000) had an adverse drug event. More than 50% of the adverse drug events occurred within 14 days post discharge. Overall, at 45 days post discharge, 35% were deemed preventable, 32% of drug events were classified as a serious event, and 5% were considered life threatening. "The findings of the current study serve to reinforce the importance of medication safety as a critically

important concern during this period of high vulnerability for older adults" (Kaanan et al., 2013,

p. 1897). The general literature is summarized in Table 2 below.

Table 2

General Literature Delineating the Nurse Navigator Role

First Author	Inclusion	Aim(s) of the study	Details of intervention	Reported outcome(s)
Bradley et al.	Chronic care coordination	To identify hospital strategies associated with lower readmission rates for heart failure patients	Cross-sectional study of hospitals participating in a web-based survey Risk-standardized 30-day readmission rate (RSRR) determined several strategies were effective with heart failure (HF) patients	1) partnering with community physicians or physician groups 0.33 percentage point lower RSRR, $p = 0.017$) 2) partnering with local hospitals (0.34 percentage point, $p = 0.020$) 3) nurses responsible for medication reconciliation (0.18 percentage point, $p = 0.002$) 4) follow-up appointments made prior to discharge (0.19 percentage point, $p = 0.037$) 5) EMR sent to primary care provider after discharge (0.21 percentage point, $p = 0.004$) 6) Follow-up of after discharge test results (0.26 percentage point, $p = 0.049$). reduction of 0.34 percentage point for each additional strategy used
Holliman et al.	Discharge planning	To explore the roles of social workers and nurse discharge planners and gain further understanding of the similarities and differences between these roles	Convenience sampling of Alabama hospitals who were members of Alabama Hospital Association Recommends social worker participation in advocacy, outcome research, and discharge planning	The role of the social worker and nurse discharge planner had no significant difference in job roles It was reported social workers were predominately hired in federal and state hospitals ($p < .01$); whereas private hospitals were more likely to hire discharge nurse planners. Nurse discharge planners were predominately hired in hospitals with less than 250 beds while social workers were more likely

				hired in hospitals with greater than 250 beds
Kainfar et al.	Chronic care coordination	The overview of coordination of care with implications to care of chronically ill patients	Interview of 12 different health care professionals involved in care coordination of chronically ill patients with CHF and COPD	Found through interviews communication, relationship building, and coordination of care as essential elements with CHF and COPD patients
Kanaan et al.	Care coordination	To characterize frequency, preventability, and severity of adverse drug events (ADE) within 45 days after hospitalization in patients older than 65	Retrospective analysis Comprehensive chart reviews conducted on patient's part of senior plan membership (n = 1000) to determine ADE	Out of 1000 patients, 242 had an ADE, with 35% preventable, 32% serious, and 5% life threatening. Over 6% (6.6%) met Beers criteria when looking at high quality of evidence and strong strength recommendations
Legrain et al.	Care coordination	To determine if a multimodal intervention could decrease ER visits and hospital readmissions in patients older than 70 at 3 and 6 months	Randomized, parallel-grouped of intervention-group (IG, n = 317) and control-group (CG, n = 348), open-label trial	The intervention to reduce ER visits and hospital readmissions was effective at 3 months but ineffective at 6 months. At 3 months, IG was 23% compared to CG at 30.5% ($p = .03$); at 6 months IG was 35.3% and CG at 40.8% ($p = .15$)
Mistiaen	Care coordination	To assess the effectiveness of follow-up phone calls up to 1-month post-discharge from the hospital in eliminating problems	Literature review of randomized and quasi-randomized control trials to determine if follow-up phone calls were effective in alleviating post discharge problems	Evidence of effectiveness of telephone follow-up was inconclusive
Rathert et al.	Clinical outcomes	To determine if patient centered care (PCC) influences patient outcomes	Systematic review of PCC and patient outcomes	Review of 40 articles reports an inconclusive result of PCC on patient outcomes. The studies did find stronger evidence for positive influence of PCC on patient satisfaction and self-care management
Shepperd et al.	Care coordination	To determine the effectiveness of individualized discharge planning compared to routine discharge planning not individualized	Literature review of randomized control trials	It was determined through the literature that use of individualized discharge planning was statistically significant in reducing hospital length of stay and readmissions. Hospital length of stay (- 0.91, 95% CI = -1.55 to -0.27, 10 trials) and readmissions (-0.82, 95% CI = 0.73 to -0.92, 12 trials)
Wee et al.	Care coordination	To evaluate if a national transitional care program for elderly patients with complex care needs and a limited social support system reduced ER visits and hospital readmissions	Dedicated care coordinators were used to educated and coordinate care needs and follow-up 1-2 weeks post-discharge. ER visits and hospital readmissions were	Use of care coordinator reduced ER visits and hospital readmissions 30 days post-discharge compared to patients without a care coordinator (0.5, 95% CI = 0.5 to -0.6

6 months post discharge	reviewed to see if the patients were previously seen by a care coordinator or no care coordinator (comparison group)	and 0.81, 95% CI = 0.72 to -0.90); and 180 days post-discharge (0.6, 95% CI = 0.5 to -0.6 and 0.9, 95% CI = 0.82 to -0.99)

The general literature provided evidence to support individualized discharge planning and care coordination aimed at reducing lapses in care, ER visits, and 30-day readmissions. "Systematic problems such as lack of patient education, and insufficient coordination between health professionals, especially during care transitions, contribute to readmissions" (Legrain et al., 2011, p. 2018). For a patient who is already at high-risk or with more than one chronic condition; this finding augmented confusion as to which evidence-based guidelines to follow by inadvertently increasing fragmented care. Another obstacle for patients was post discharge medication errors in general. Kanaan et al. (2013) cited multiple factors increasing the risk of medication errors post discharge including poor therapeutic monitoring, patients not restarted on medications, or patients started on high-risk medications without ensuring appropriate follow-up with their primary care provider.

Nurse navigators can play a critical role in coordination of care by partnering with the patient to reduce potential pitfalls. Legrain et al. (2011) substantiated this statement by reporting decreased readmissions with effective disease management programs.

Conceptual Models, Theoretical Frameworks

The EBP) model best suited to support the project outcomes is the Rosswurm and Larrabee conceptual model for change in EBP. [The model provides a pragmatic, theory-driven framework for empowering clinicians in the process of EBP and includes the following six steps: (1) assess the need for change in practice, (2) link the problem with interventions and outcomes,

(3) synthesize the best evidence, (4) design a change in practice, (5) implement and evaluate the practice change, and (6) integrate and maintain the practice change] (Pipe, 2007, p. 235). This model will provide the necessary means to increase knowledge about the nurse navigator role to develop and implement a job description conducive to organizational best practice in the use of the nurse navigator role. This structure will also avoid a haphazard reporting of the evidence as it unfolds in the project.

Summary

The role of the nurse navigator emerged in 1990, in an attempt to increase survival rates of poor African American women in Harlem. The nurse navigator role was to be the coordination of all aspects of care for patients throughout the health care system. The role of nurse navigator has grown beyond oncology to embrace patients including those at high-risk for increased morbidity and mortality and those with chronic disease conditions.

A literature review was conducted to determine what interventions used by the nurse navigator promote best outcomes for the at-risk patient. Literature for interventions beyond oncology could not be found. The literature review focused on aspects of the nurse navigator role to include the following: nurse navigator role, barriers to access of health care, care coordination, and discharge planning aimed at readmission rate reductions. From the search, 18 articles were identified for inclusion.

Of the studies included, three were randomized controlled trials, and two were literature reviews inclusive of randomized controlled trials. According to Terry (2015), these designs "provide health care professionals with information regarding the benefits of a specific health care intervention" (p. 84). These studies provide a strong evidence base for the proposed project.

Overall, many of the studies were either in support of the navigator role, recommended a navigator for barrier reduction and coordination, or implemented a program with utilization of a nurse or patient navigator. Further studies will need to be conducted to establish what interventions by the nurse navigator promote best outcomes for the at-risk patient.

The next section will discuss analysis of the project. This will include the approach to the project, the data collection, and project evaluation.

Section 3: Approach

Introduction

The purpose of this project was to determine the role of the nurse navigator and understand what job activities provided the best outcomes for patients considered to be at-risk. Each step will be discussed to provide an overview of the project as well as how the data were collected, analyzed, and evaluated. The role of the nurse navigator across the different areas of the project hospital was not clearly defined or outlined. The current job descriptions were reviewed, and recommendations made (see Section 4) to reflect specific tasks and skills of the nurse navigator as defined in the literature.

Project Design and Methods

For this project, a qualitative design was used to review the existing nurse navigator job descriptions and compare these findings to the literature on best practices. Expected tasks, knowledge areas, and skills were collected from the job descriptions and the literature on nurse navigators.

At the project site, the tasks, knowledge areas, and skills are not threaded within their job descriptions but more broadly as tasks to complete as they identify a patient in need of their services. Currently, different methods are being used at the project site to determine how the nurse navigators receive referrals to patients. The referral processes were conducted to determine where and how the information was being retrieved. All units are using the electronic medical record to determine who should be seen by the nurse navigator, but each unit is retrieving this information from a different report from within electronic medical record and is oftentimes generated by a diagnosis. The goal of having a universal report is to provide consistency in the

referral process—one standardized method for identifying patients at-risk for readmissions or with barriers to self-care management.

Finally, data were gathered to determine who was receiving the benefit of the nurse navigator; these data were compared to information about patients who could benefit from the service. This information was gathered from the different hospital reports to understand whether patients were missed due to admission diagnosis or whether there were other unidentified themes that resulted in overlooked referral opportunities. These data were used to demonstrate possible changes to the referral report so that all at-risk patients could be identified for referral to the nurse navigators.

The information (a) gathered for this project identified patients who could benefit from a nurse navigator and (b) proposed consistent interventions to be used by the nurse navigators in caring for patients. The goal was to identify best practices and adapt them to the nurse navigator role at the project hospital in order to decrease the fragmentation of care, increase role consistency across the organization, and establish a template for promoting and measuring optimal outcomes for the patients as well as the organization.

Population and Sample

Because the project used a qualitative design, the data were extracted from hospital documents (job descriptions) and reports being utilized within the organization. Approval for this secondary data analysis was obtained through the hospital Institutional Review Board (IRB) committee. The organization determines if projects require IRB approval prior to project implementation. The application process included completing an IRB application and presenting a PowerPoint overview of the proposed project to the hospital IRB committee. The IRB

recommended approval of the project, and key persons were contacted by e-mail to request the required information for data collection and analysis. IRB approval from Walden University also was obtained before data collection and analysis began; the approval number was 08-12-16-0459006.

There were no participants in this project, although human resources, current nurse navigators, directors and managers of nurse navigators, and employees in quality management and information technology were asked to assist with report identification and data extraction.

Data Collection and Analysis

Information was collected to understand the specific nurse navigator job requirements in conjunction with findings from the literature. Data collection included review of the current nurse navigator job descriptions and reports used in the hospital pertaining to the current patient referral processes. Themes from the job descriptions and data were identified and recommendations were made based on best practices identified through the literature review.

Challenges to Project Implementation

Each nurse navigator was interviewed to further understand current workflow and practices. This information was provided to the chief nursing officer (CNO) in a meeting. Information was collected on how each department utilized the nurse navigator based on interpretation of the role, which in turn influenced daily activities performed.

No consistency existed within the nurse navigator role across the organization. For example, not all of the nurse navigators consistently provide discharge planning and/or consistently enlist the services of the case manager. Case management had their own nurse navigator who did not consistently touch base with the unit nurse navigators. This finding could

constitute a point of failure for the patients if they did not have appointments made, medications reconciled to reduce errors, or the appropriate contacts made with community resources to reduce care barriers and decrease potential readmissions.

Most nurse navigators are not available on off hours or on the weekends. The exception was the oncology nurse navigators. The lack of daily availability potentially added to the patients' lengths of stay, increased duplication in services or testing, or delayed points of care referrals and coordination necessary for the patients to maneuver through the health care system. The gap in coverage potentially provided an increase in cost to the patient as well as the hospital system.

An overview of the literature was provided to the CNO detailing aspects of the role essential for positive patient outcomes with emphasis on discharge planning and follow-up, and a method for process and impact evaluation of the revised nurse navigator role and data generation processes was proposed.

A revised nurse navigator job description was presented to the CNO. The literature was used to make revisions that standardized the role for intervention consistency only. The information was compiled and laid out using the literature to define the role and the job descriptions to determine what the nurse navigators' role did for the patients to promote optimal outcomes while decreasing readmissions for the organization.

Project Evaluation Plan

Evaluation is essential for any project to understand outcomes and establish where positive changes may have been made. The evaluation for this project will occur after the objectives of this project are completed and the organization decides whether to implement the

revised job description and processes proposed as a result of the project. Evaluation places emphasis on selecting the right type of evaluation to support the program's goals and objectives. One evaluation type for assessment of the project's goal of implementing a new job description for the nurse navigators is a process evaluation. The process evaluation includes review of the impact of adding tools to capture patients who need to be referred to the nurse navigators and is expected to determine that patient care needs are better addressed through explicit accountability and quality matrices built for the role. Providing the right tools to identify at-risk patients and ensuring the tools are used will allow identification of the project's effectiveness in improving patient outcomes and impact on the organization's goal of reducing unnecessary 30-day readmissions.

For patients, this project is expected to establish consistency in how patient care needs are identified and met after referral to the nurse navigator. For the nurse navigators and the organization, this project provided a way to measure the role effectiveness with at-risk patients as well as a means to demonstrate the impact nurse navigators had on patient care outcomes such as decreased ER visits, hospitalizations, and rehospitalizations. Documentation of nurse navigator outcomes will establish or validate best practices aimed at identifying interventions that help to increase patients' quality of life while keeping them out of the acute care setting unless necessary. Organizational costs can be calculated to determine whether avoided CMS penalties supported the increased employment costs for nurse navigators.

The end product will be transparency of nurse navigator program outcomes as measured against outlined goals and objectives to sustain organizational cost-effectiveness and provide evidence-based care to patients. Monitoring the impact of the changes will be crucial for

program evaluation. For this project, the impact evaluation will determine if the project led to decreased 30-day readmissions in the chronically ill patients or not.

Summary

A new job description was developed to encourage consistency across the nurse navigator role in the hospital. The quality improvement approach was designed to identify those interventions that promoted effectiveness by meeting both the needs of the patients for expert transitional care support and organizational cost containment by decreasing 30-day readmissions. The change in job description and processes was accomplished by reviewing current job descriptions, the referral process, and which patients are seen or need to be seen by a nurse navigator. IRB approval was obtained from the project site hospital IRB and Walden University and, with help from key persons at the project site hospital, necessary documents and data for analysis were obtained. Recommendations for a revised nurse navigator job description were presented to the hospital leadership and a method for process and impact evaluation of the revised nurse navigator role and data generation processes were proposed for future implementation by the hospital.

The next section will provide insight to the findings from all the information gathered and a recommendation will be presented. Since this is a qualitative study, it will be important to provide the strengths and limitations of the project.

Section 4: Findings and Recommendations

Introduction

The purpose of the doctoral project was to determine what interventions used by nurse navigators promoted the best outcomes for at-risk patients and the hospital. Health care has become a complex system that has unintentionally created gaps in care for many patients. These gaps cause confusion for the patient because they do not know what questions to ask, what tests they need, who in the health care team is necessary to see, and what resources are available to assist them once they go home. Patients have their own set of challenges prior to entering the complex health care system; those most at risk have the most to lose in terms of quality of life. At-risk patients often are faced barriers to care before entering the hospital system as well as when they are within the hospital system. All these issues make the nurse navigator role essential (and invaluable) for identifying patients who need assistance in their interactions with the health care system. The ability to identify at-risk patients will yield the best outcomes to patients and to the organization.

Each inpatient department director and/or manager who had a nurse navigator on staff was contacted by confidential e-mail requesting information for the project as approved by the hospital and Walden University IRB committees. A consent form was attached along with written details describing the objectives for the project. The objectives of the project were explained in person and any questions were answered. The evidence was obtained after a voluntary, signed consent form was completed. The data received were current job descriptions and current workflow sheets if used.

The nurse navigator job descriptions were analyzed for similarities and differences across their roles in the hospital. The data were compiled and then compared to the list of tasks, knowledge areas, and skills essential for practice competency from the Oncology Nurse Navigator Role Delineation Study (Brown et al., 2012). The purpose of this analysis was to determine oncology nurses' essential job functions and activities and what activities were essential to the role of the nurse navigator (see Table 3). A new list was developed. It included a bridge between what had been established as essential to the role of the nurse navigator and what the project site included in its nurse navigator job descriptions (see Table 4).

Findings and implications

The previously published study, titled Oncology Nurse Navigator Role Delineation Study: An Oncology Nursing Society Report (Brown et al., 2012), provided the list of essential tasks, knowledge areas, and skills deemed important for the role (see Table 3). This list provided some items essential to the job descriptions that could aid in developing metrices for accountability within the nurse navigator role. This list did not, however, provide a means for evaluation, measurement of outcomes, nor support in identifying role value. Additionally, this list was exclusive to cancer patients and did not include aspects of care essential for patients at-risk or with other chronic conditions. A new list was developed to bridge what had been established as essential to the role of the nurse navigator in the literature (i.e., Brown et al., 2012) and what the project site had included in their job descriptions for the nurse navigator roles within the hospital (see Table 3).

Table 3

Tasks, Knowledge Areas, and Skills Table

Tasks	Knowledge Areas	Skills
Provide emotional and educational support for patients.	Confidentiality and informed consent	Communication
		Problem solving
Practice according to professional and legal standards.	Advocacy	Critical thinking
	Symptom management	
		Multitasking
	Ethical principles	
Advocate on behalf of the patient.		Collaboration
	Quality of life	
		Time management
Demonstrate ethical principles in practice.	Goal of treatment	
		Advocacy
	Therapeutic options	
Orient patients to the cancer care system.	Evidence-based practice guidelines	
Receive and respond to new patient referrals.	Professional scope of practice Legal and professional guidelines	
Pursue continuing education opportunities related to oncology and navigation.		
Collaborate with physicians and other health care providers.		
Empower patients to self-advocate.		
Assist patients to make informed decisions.		
Provide education or referrals for coping with the diagnosis.		
Identify patients with a new diagnosis of cancer.		

Note: From "Oncology nurse navigator role delineation study: An oncology nursing society report" by Brown et al., 2012, *Clinical Journal of Oncology Nursing*, 16(6), p. 584. Reprinted with permission.

The most comprehensive source of evidence obtained from the project site was the job descriptions of the nurse navigators. There was a total of 13 job descriptions for the various nurse navigator roles within the hospital. Of the job descriptions; three were from pulmonary services, two were from cancer services, five were from cardiovascular services, one was from case management, one was from neurological services, and one was from endocrinology services. Each job description followed the hospital template that required a job summary, a list of essential duties, a list of qualifications, a description of working conditions/physical requirements, and the organization's specific behavioral expectations.

For the purpose of this project, all the job descriptions were crosschecked against each item in Table 1 for specific tasks, knowledge areas, and skills pertinent for the nurse navigator role. Each item from the Brown et al. (2012) list of tasks, knowledge areas, and skills was examined for specific coordinating wording from the organization's job descriptions. If the items were found, they were tallied. A total was derived and divided by the total number of job descriptions (13) equaling a percentage of how many included the listed item. For example, under task, provide emotional and educational support for patients was tallied nine times. This result (nine) was divided by 13 with a result of 69% for this item. The additional items added to the table of tasks, knowledge areas, and skills were a result of themes noted through each individual job description and themes noted through review of the literature review. For example, one theme, discharge planning, was noted in the literature review.

In addition, the job descriptions were reviewed to determine if there were items that should be added to the Brown et al. (2012) list. These items were assigned a percentage (see Table 4) using the process explained previously. The purpose of this process was to determine what items involving the nurse navigator were conducive to the transitional care of patients at-risk and patients with one or more chronic conditions. Items identified for inclusion on the list were: involvement of the nurse navigator in discharge planning, follow-up telephone calls after discharge, knowledge of community resources and connecting discharged patients with them, as well as the education and experience requirements of a nurse navigator.

The literature defined post discharge as a point of failure for many reasons including patients not understanding new medications, not understanding with whom they needed to follow-up, nor resource availability in the community to assist with ongoing health care needs. Under tasks, providing follow-up telephone calls was added to the Brown et al. (2012) list and, under skills, discharge nurse was added for the nurse navigator in the acute care setting. Many of the job descriptions for the project site included the term "discharge nurse" (62%) and "provide follow-up telephone calls" (62%) as requirements for the job.

Being able to understand and use community resources was both beneficial in reducing readmissions within 30 days for the organization and essential for improving the patients' quality of life. All but two of the job descriptions (85%) included use of community resources as a necessary component of the nurse navigator knowledge and was, therefore, felt to be an important item to be included as an essential task for the nurse navigator role in work with at-risk patients.

Under qualifications for the nurse navigator, all job descriptions (100%) required a baccalaureate nursing degree. The experience required for the nurse navigator role varied between 3 years (54%) and 5 years (46%). Education was placed under knowledge and experience was placed under skills in the new job description.

Finally, a critical area necessary for assessment purposes was the need for an evaluation tool. For nurse navigators to be able to justify their role, there needed to be a tool in place for data extraction providing descriptors of patient type, resources used, and if the nursing actions were effective in 30-day readmission reduction. Because of the differences among settings where the nurse navigator role was enacted in the hospital, this tool needed to be implemented specific to patient population. From the job descriptions, (69%) clearly identified collecting and reporting of data as a job requirement; therefore, this item was placed under tasks in the new job description.

The job descriptions were then tallied to determine if the items from the Brown et al. (2012) table were included. A revised table was created with additions, subtractions, and changes based on terminology and percentages obtained from the job descriptions in conjunction with Table 3. See Table 4 for percentages derived from the review of the organization's 13 nurse navigator job descriptions.

Table 4

Revised List of Tasks, Knowledge Areas, and Skills Table with Percentages

Tasks	Knowledge Areas	Skills
Provide emotional and educational support for patients (69%).	Confidentiality and informed consent (54%)	Communication (100%)
		Problem solving (92%)
	Advocacy (62%)	
Practice according to		Critical thinking (92%)

professional and legal standards (31%).

Advocate on behalf of the patient (62%).

Demonstrate ethical principles in practice (15%).

Orient patients to the cancer care system (62%)

Receive and respond to new patient referrals (92%).

Pursue continuing education opportunities related to oncology and navigation (15%).

Collaborate with physicians and other health care providers (100%).

Empower patients to self-advocate (62%).

Assist patients to make informed decisions (69%).

Provide education or referrals for coping with the diagnosis (77%).

Identify patients with a new diagnosis (85%).

Additions

Providing follow-up phone calls after discharge (62%)

Community resources identification and connection

Symptom management (15%)

Ethical principles (38%)

Quality of life (15%)

Goal of treatment (31%)

Therapeutic options (100%)

Evidence-based practice guidelines (92%)

Professional scope of practice (0%)

Legal and professional guidelines (69%)

Education (100%)

Multitasking (92%)

Collaboration (92%)

Time management (54%)

Advocacy (62%)

Discharge nurse (62%)

(85%)

Experience requirements
(100%)

From the revised list, all of Brown et al. (2012) items were listed and reviewed against

each of the organization's job descriptions to calculate a corresponding percentage. This

calculation provided a view of what was already on the job descriptions and how the items

ranked accordingly. Found from the literature review were discharge planning and follow-up

after discharge. These items were not on the list by Brown et al. (2012) but were noted from the

job descriptions. Education requirements were noted in every job description and were added to

the revised list. These additions were also assigned a percentage. Finally, the words "cancer" and

"oncology" were removed from the revised table to keep the wording more neutral and flexible

for a variety of nurse navigator patient population(s).

The job descriptions for the hospital followed the organizational templates required for

position requirements. The items most frequently cited in the job descriptions were

collaboration; therapeutic options; communication; receiving and responding to referrals; and use

of evidence-based practice guidelines, problem solving, critical thinking, and multi-tasking.

These skills were found to be present in 90% or more of the job descriptions. The areas ranked

lowest for the job descriptions included demonstrating use of ethical principles in practice and

pursuing continuing education opportunities related to nurse navigation, quality of life, symptom

management, and enacting professional scope of practice. These areas were ranked as present in

15% or fewer of the job descriptions.

The role of the nurse navigator is becoming increasingly common in chronic care management. There is a great deal of data for the nurse navigators employed in oncology; however, data are limited for the usefulness of the role for patients who are considered at-risk. When looking at the hospital's job descriptions, the nurse navigator roles were specific to population and diagnosis. Each job description had outlined what was expected for a narrow range of patients. This finding was consistently presented in the job summary paragraph of each job description. For example, in the stroke nurse navigator job description, the nurse was described as caring for patients with ischemic or hemorrhagic stroke, or atrial fibrillation.

Also, it was clearly stated in the job descriptions where the patient should be referred and with whom initial contact should be made. Data related to the purpose and outcomes of these referrals and contacts are essential to understanding the nurse navigator role and how it is being defined by hospital structure and process.

The role of the nurse navigator is aimed at helping patients find and use necessary community and institutional resources when discharged. Assistance with arranging follow-up appointments with the primary or specialist health care provider, ensuring delivery of durable medical equipment, or arranging skilled care to address medical needs such as wound care and medication administration can facilitate the transition to home. The organizational goal is to decrease unnecessary illness exacerbations resulting in 30-day hospital readmissions just because the patient did not understand what resources were available and how to access them. This project outlined the nurse navigator role by specifying tasks, knowledge areas, and skills necessary to successfully transition hospital patients to home. The project can help to avoid

duplications or gaps in services and addresses major points of failure for the patients after discharge.

The implications for positive social change are to provide patients with a resource (nurse navigator) who is well equipped through education and training to use evidence-based best practices and processes to improve patient care in a cost-effective manner. Health care delivery is complex and constantly changing, which makes it hard for patients to understand and increasingly frustrating for patients and families. Lack of clarity and gaps between settings take away from coordination and continuity of care and decrease the overall quality of care, adding to poorer outcomes for patients at risk. Having a nurse navigator to identify patient needs and connect patients with necessary resources is a winning solution for all stakeholders.

Recommendations

Differences among the nurse navigator job descriptions were seen across hospital services. Some job descriptions, for example, required data collection and reporting and others did not. All the nurse navigator roles required general education for the role; however, most of the requirements were not tailored to the nurse navigator role itself or the specific knowledge necessary to support patients with chronic conditions requiring self-care management. Overall, there was no consistency in the tasks, knowledge areas, and the skills the nurse navigator role should encompass. Each service identified what the patients' needs were and how the nurse navigator should address those needs. Unfortunately, the lack of a consistent approach to the nurse navigator role may have increased fragmentation and confusion for the patients using the services.

The original intent of the nurse navigator roles was to decrease fragmentation, but without uniform job descriptions, the role may result in a higher likelihood of care gaps. The first recommendation, therefore, is for more consistency across the job descriptions as outlined in the literature (see Appendix A). A second recommendation is that all at-risk patients to be identified and an individual discharge plan be put into place as soon as the patients enter the hospital. A third recommendation is that quality matrices will need to be developed and completed for each patient to identify care gaps and, ultimately, to demonstrate the value of and justification for the nurse navigator role. Data analysis can identify 30-day readmissions and establish the potential causes or missed opportunities to ensure that at-risk patients have access to appropriate resources in the home and the community that will prevent unnecessary rehospitalizations.

Because of the potential for inconsistencies in the interpretation of the nurse navigator role in the hospital, a fourth recommendation is to place the nurse navigators under one department with an advanced practice nurse provider managing the department. The feasibility of this recommendation would need to be examined by the hospital. This recommendation places one, instead of multiple persons, in charge of the nurse navigators, which may improve role integrity; decrease lapses of communication among services, providers, or other resources; and increase collaboration with organizational leadership, quality managers, nursing departments, and affiliates for consistent, quality care. Finally, the fifth recommendation is the need for a new position specific to the nurse navigator department to assist with identifying and arranging community resources for patients prior to discharge. This person could assure that patients have the services they need in place the day they go home.

Strengths and Limitations of the Project

The main strength of this doctoral project was that it revealed for the organization how the nurse navigator roles are currently being defined and utilized in the hospital. Each service has developed and employed specific strategies to promote optimal care for patients to avoid unnecessary readmissions. All services are using established and credible evidence-based practice guidelines specific to the diagnoses of the patients. For example, patients with chronic obstructive pulmonary disease receive care as outlined through the Global Initiative for Obstructive Lung Disease (GOLD) standards (goldcopd.org, 2017). The finding was true for cardiology, endocrinology, neurology, and all the other hospital services utilizing the nurse navigator role. The new nurse navigator job description incorporated use of relevant evidence-based guidelines as a knowledge area expectation of the nurse navigator role.

A limitation of the project is the use of a convenience sample of nurse navigator job descriptions and internal referral data processes from one hospital. This sample may misrepresent the nurse navigator role and result in findings and recommendations that cannot be generalized beyond the project hospital. In hindsight, a survey completed by the nurse navigators may have been helpful to see what items they found most necessary and appropriate in the Brown et al. (2012) list of tasks, knowledge areas, and skills. Their input about how well the job descriptions reflected their duties and expertise would have been helpful in creating a more comprehensive and accurate picture of the nurse navigator role.

Another limitation identified for this project was the inability of the organization to provide outcome data related to the role of the nurse navigators. Some of the job descriptions for

the nurse navigator role required outcome data collection and reporting, but the processes to use for these purposes were not elaborated.

Summary

There was a great deal of research and data for the navigator role in oncology and the tasks, knowledge, skills necessary for success in the role. For the at-risk patients with an acute or chronic condition, there was a great deal of evidence supporting the need for the nurse navigator, but little evidence that really focused on which interventions promoted optimal outcomes for the patient. The purpose of this project was to determine what interventions were used by the nurse navigators based on the literature and job descriptions at one hospital.

In future projects, it will be essential to test the five recommendations to see if in fact these suggestions can be implemented and lead to decreased unnecessary readmissions, lower hospital costs, and increased patient satisfaction and quality of life. Future research will define interventions that are evidence driven and provide data about the nurse navigators' effectiveness for both patients and organizations. Follow up research should include whether practices used by nurse navigators are universal. This research would support the importance of their practices and improve patients' outcomes in turn.

Section 5: Dissemination Plan

The dissemination plan included providing the recommendations from this project to the CNO of the project hospital. The information provided comprised of the revised job description and comprehensive literature review with associated recommendations. A podium or poster presentation of the project is also planned.

The hospital is currently on the journey toward achieving "magnet status" as outlined through the American Nurses' Credentialing Center (ANCC) associated with the American Nurses Association (ANCC, 2018). This project was geared toward enhancing professional independent nursing practice to promote excellence in the delivery of care, clinical practice, and dissemination of findings toward best practices in nursing services. If accepted by the organization for implementation, the project findings will be provided to the education champion for dissemination toward the "Magnet Journey."

The audiences who may be most impacted by this project are the nurse navigators in the organization, quality management staff, and organizational leaders. This project defined necessary cost-effective tasks, knowledge areas, and skills for the nurse navigator role and offered recommendations for continued improvement through documentation of interventions and outcomes.

Analysis of Self

This project has been enlightening as a nurse practitioner and scholar. Overall, there was a great deal more to the potential solution than just stating the problem. It was informative to see how the nurse navigator role started and has evolved beyond oncology and what the different departments have done with the role. As an advanced practice provider, the project demonstrated

the importance of considering the literature for direction and seeing where the evidence may lead. Parts of this project assumed to be easier, were the most difficult parts of the project to complete. One example was the IRB process. This process was an experience that will be applied in addressing future practice problems to ensure a broad view is brought to investigation instead of assumptions that may be ill-guided.

Summary

Health care has become very complex and nurses must embrace and use their clinical expertise in support of patient navigation through the health care system. The goal of this project was twofold as it was geared toward both improving nursing care for patients and addressing the organization's interest in decreasing 30-day readmissions and providing cost-effective care. For nursing, it provided an avenue for assisting patients through discharge and the transition to home to delay or interrupt disease progression through best practices. For the organization, the project worked to decrease costs associated with unnecessary testing and avoidable readmissions. The project has established the framework for continuing to improve the quality of care delivered through consistent application of the nurse navigator role and recognition of the value a specific nurse navigator department may bring to the organization.

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Appendix: Project Hospital Job Description

Job Title: Nurse Navigator
Department:
Date Revised:

Job Summary
This position ……

Essential Duties
1. Identify patients with a diagnosis of….. Receive and respond to new patient referrals impacted by specific condition of ….
2. Provides ongoing emotional support and coordination of care the patient's specific medical condition.
3. Recognizes patient changes and concerns and determines best form of support for the patient.
4. Identifies and maintains materials and resources to provide educational support for the specific patient population.
5. Advocate on behalf of the patient throughout the navigation process. Empower the patient to advocate for their healthcare needs.
6. Assists the patient, family, and/or current support system to make informed decisions impacting care
7. Develops a collaborative relationship physicians and/or advanced practice providers, and other healthcare providers and/or departments within the hospital setting and in the community.
8. Assures continuity of care: communicates pertinent information regarding patient issues with other team members; recommends services consistent with the patient's care needs and benefits; manages efforts with goal of having measurable impact on improving patient's overall quality of life.
9. Coordinates patient education and care: serves as an ongoing resource for patients and families during diagnosis and treatment; collaborates with other care providers regarding how to best meet the needs and sequence care; assesses patient's learning style and health literacy to provide education at the appropriate patient level.
10. Provides telephone and face-to-face consultation with patients to answer pertinent questions throughout their hospital experience; provides educational information to patient/family/other support persons involved in care management; reviews information one on one prior to hospital discharge.
11. Provides a follow-up phone call within 24-48 hours after discharge to review information related to post discharge needs.
12. Participates in development of standards, the implementation and evaluation of policies and procedures; the development of and compliance with treatment guidelines and in the assessment of hospital practice patterns, identifying needed changes, and establishing measurable action plans.
13. Collects and reports data quality measures consistent with organizational needs.
14. Develops action plans to address opportunities for performance improvement relate to the specific patient population.

Qualifications
1. BSN Required, licensed registered nurse.
2. Three years of nursing experience, with 1 year of (oncology, lung, cardiac, etc.).
3. Certification requirement if applicable to specific patient population within 1 year of employment.
4. Current CPR certification or obtain within 30 days of employment.
5. Extensive knowledge of specific patient population (i.e., pathophysiology, symptom management, treatment guidelines, resource utilization, etc.)

6. Must be able to communicate effectively, timely, and in an open, honest manner. Must be able to explain information to patients and families in a way that the patient understands, and/or explain departmental or hospital procedures or governmental regulations.
7. Ability to read, analyze and interpret professional journals, technical procedures, or governmental regulations.
8. Ability to solve practical problems and deal with a variety of complex situations where only limited standardizations exists.
9. Ability to interpret a variety of instructions furnished in written, oral, diagram, or schedule form.
10. When applicable, adjusts the essential functions performed appropriately to the age and ability of the patient.

Working Conditions/Physical Requirements

The physical demands described here are representative to those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

1. Ability to sit, stand, stoop, push, pull, bend, and walk for extended periods of time.
2. Ability to lift 50 pounds to waist level.

This description reflects in general terms the type and level of work performed specific to the nurse navigator role. It is intended to be evidence-based and will be used to portray the specific duties of any one nurse navigator role.