Nurse Navigators

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Patients are frustrated with a health care system that is set up to treat individual illnesses and conditions, rather than provide holistic care. We have a health care system that does not value their time. *(Canterbury Health)*
What is the problem?

• More often than not, the disease is treated, not the patient

• Health is delivered in a transactionary siloed manner

• System dictates care not the patient

• Fragmentation starts with the funding model and heads downstream
We need to change thinking from delivering a product to delivering a holistic experience
Scope of the problem

• 4.6 million people in Queensland
• Almost half have a chronic disease
• Nearly 40% aged over 45 have 3 or more
• Chronic disease is the leading cause of death and disability
Queensland Government commitment to create 400 Nurse Navigator positions in Hospital and Health Services across Queensland

$105 million over 4 years has been allocated to fund this initiative to drive new and innovative models of care.
The Nurse navigator has the system knowledge and access, clinical skills and time to understand each persons needs and to partner with them to develop a plan of care that addresses their health needs and respects and values their time and circumstances.
Model of care

Pre-Nurse Navigator Model of Care

- Specialist clinics
- Private care
- Community Health
- Diagnostics
- NGOs
- Pharmacy
- Nursing homes
- Residential aged care
- Outpatient clinics
- Primary care
- Patient transport
- Allied health
- Hospitals
- Medical aides/devices

Post-Nurse Navigator Model of Care

- Nursing homes
- Primary care
- Specialist clinics
- NGOs
- Allied health
- Private care
- Community Health
- Hospitals
- Pharmacy
- Diagnostics
- Patient transport
- Outpatient clinics
- Residential aged care
- Medical aides/devices
Nurse Navigator model

- Coordination of Patient Centred Care
- Creating Partnerships
- Facilitating System Improvement
- Improving Patient Outcomes
Coordination of patient-centred care

- Provide patient-centred care coordination across the patient journey by enhancing systems integration and reducing fragmentation and barriers.

- Enhance patient quality of life:
  - Utilise and support the application of evidence-based patient centred care pathways that are responsive to changing patient needs.
  - Coordinate timely access to appropriate health and social services when necessary.
• Provide a central point of communication, engagement and coordination for all stakeholders involved in patient care (most importantly the patient and their carer(s)), ensuring are equal contributing partners in the patient care journey.

• Establish consistent and effective lines of communication across primary and tertiary care providers using innovative communication pathways where needed.
Improving patient outcomes

- Foster and encourage active patient engagement in the development of health care goals which promote self-management and seek to improve patient health literacy.

- Enhance health literacy to support patients and their families to make informed decisions about their health care options including advanced care planning (Advanced Health Care Directives).
System Improvement

- Possess high level systems literacy that allows the nurse navigator to promote cohesion across the health continuum to reduce fragmentation, duplication, time delays, inappropriate treatment and other barriers to effective patient centred care.

- Assess at a functional and systems level the barriers to effective communication with respect to referral pathways and the flow of information to support patient centred care.

- Continual improvement
Patient Focused Support

- Care Management Plans With Shared Decision Making
- Patient Centred Integrated Care Pathways
- Educate - Motivational Interviewing
- Peer Support Networks
- Reduce Barriers to Care
Patient Cohort Selection

Patient selection via data analysis and through clinician referral.
Comprehensive Evaluation

- Continuous Improvement model
  - Evaluate what is working and what isn’t and learn from it
- Comprehensive data set
- Emerging trends
- Listen to our patients and staff
Improving Patient Outcomes

- Reduced Length of Stay
- Reduced Avoidable Admissions
- Reduced Readmissions to Hospital
- Reduced ED Presentations
- Increased Patient Satisfaction
- Increased preparation of Advanced Health Care Directives
- Increased Health Literacy

Quality of Life
Moving forward

- 400 Nurse Navigators is just the beginning
- Data integration
- Engage Primary Care
- Funding models state and federal
- Change in culture: Break down silo’s, build trust, problem-solving
Questions