

## CONFERENCE ABSTRACT

# The Nurse Navigator: An Innovative Role to Optimise Patient Transitions Across Primary and Secondary Care Settings

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**Introduction:** The Gold Coast Integrated Care (GCIC) Programme is aimed at maintaining safe, high quality and readily accessible transitions between care settings for people with complex and co-morbid conditions. We have found that the programme goal of optimising care transitions between primary and secondary services can be partially achieved through service coordination; however many patients require assistance in navigating services in a way that ensures timely, effective, adequate and patient-centred care.

**Practice Change:** The GCIC programme incorporates a unique and innovative nurse navigator role to achieve successful patient navigation through care transitions.

**Aim and Theory of Change:** The nurse navigator role aims to bridge the service gap between primary and secondary services by positioning a nurse in each of the general practices involved in the GCIC programme. The nurses undertake holistic patient assessments; risk management strategies; rapid response to patient needs identified through primary or secondary care service providers, multidisciplinary team members in the GCIC Coordination Centre or patients themselves; maintenance of patient information systems including a shared care record and disease registers accessible to all caregivers; coordination, liaison and patient-centred decision making; health promotion for patient health literacy and self-care, and ensuring the adequacy of collaborative structures and processes through referrals and brokerage services. Using the Transtheoretical Stages of Change Model the research team is tracking the evolution and actions of the nurse navigator role from precontemplation (preparation for the role), contemplation (collaboration between the nurses and general practitioners), preparation for change (tailoring their services to practice needs and the integration programme), actions to achieve integration (as described above) and maintenance (issues involved in sustaining the role.)

**Targeted Population and Stakeholders:** patients with complex and co-morbid conditions, general practitioners, hospital and health service providers.

**Timeline:** The initial 12 month evaluation of the nurse navigator role.

**Highlights:** (innovation, impact and outcomes). The role is an innovation of the GCIC programme and as such, evaluative data is being analysed annually to demonstrate patterns of nurse navigator responses to patient need, changes to referral pathways directly related to the role, the use and efficacy of information systems, and the usefulness of risk management strategies in optimising patient transitions.

**Sustainability and Transferability:** Evaluation data will indicate the extent to which this innovation can be transferred beyond the initial program and setting to regional and national services.

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**Keywords:** integrated care; chronic disease management; nurse navigator; change management; patient transitions

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