The purpose of this integrative review is to explore the presence of the oncology nurse as navigator on measurable patient outcomes. Eighteen primary nursing research studies were found using combinations of the following key words: advocate, cancer, case manager, coach, certification, guide, navigator, nurse, oncology, patient navigator, pivot nurse, and continuity of care. Nurse researchers identified nursing-sensitive patient outcomes related to the time to diagnosis and appropriate treatment, effect on mood states, satisfaction, support, continuity of care, and cost outcomes. Navigator roles are expanding globally, and nurses should continue to embrace opportunities to ensure the safe passage of patients with cancer along the entire trajectory of illness and to evaluate the implications for educational preparation, research, and practice of navigators of all kinds.

The American Cancer Society (ACS, 2010) estimated 1,529,560 new cases of cancer were diagnosed in 2010 and 11.4 million Americans with a history of cancer were alive in January 2006. Disparities exist in the incidence and mortality rates by cancer site, race and ethnicity, education, income, and gender (ACS, 2010). Although five-year survival rates for all cancers increased from 50% to 68% from 1975–2005, survival rates for African Americans during the same time period were lower, increasing from 40% to 59% (ACS, 2010). Barriers that interfere with timely screening and diagnosis of cancer increase the risk of death from the disease (ACS, 2010).

Patients with cancer can be considered vulnerable for reasons beyond possessing cultural, demographic, or socioeconomic disparities. 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. Multidisciplinary care is the standard of treatment for many types of cancers. In a discussion regarding development of multidisciplinary disease centers, Strusowski (2006) described how cancer care management by nurses integrates all aspects of patient care, including counseling, development and coordination of a plan of care, education, and symptom management. Navigation of complex care becomes necessary when treatment recommendations may include chemotherapy, radiation, and surgery. The purpose of this integrative review is to explore the presence of the oncology nurse as navigator on measurable patient outcomes.

At a Glance

- Outcomes data support the value of the nurse as navigator in oncology care.
- Navigator services should be expected to increase beyond oncology to other chronic disease management.
- Navigation practices based on patients’ needs and nursing competencies reflect the principles of the Synergy Model.

Background

Patient Navigation

Patient navigation was initially conceived by Harold Freeman, MD, and his colleagues at Harlem Hospital in New York in 1990 to assist medically underserved patients in overcoming barriers to cancer diagnosis and treatment (Fowler, Steakley, Garcia, Kwok, & Bennett, 2006). Freeman (2004) demonstrated the
impact of community outreach, education, and access to timely diagnosis and treatment, with a 31% increase in breast cancer survival rates from 1995–2000. Because of significant improvement in diagnosis and survival rates attributed to navigation services, the National Cancer Institute responded by implementing the Patient Navigator Academy to train navigators in 2005 (Fowler et al., 2006).

In a qualitative synthesis of published literature on patient navigation, Wells et al. (2008) examined definitions, qualifications, target populations, and intended outcomes of patient navigation. Wells et al. expanded the definition of patient navigation beyond removing barriers to diagnosis and treatment to include a provision for a defined set of health services that are required to complete an episode of cancer-related care. The end point of patient navigation, frequently provided by a trained layperson, was when services were complete or resolved.

Nurse Case Management

The patient navigation model shares characteristics with case management and patient advocate service models (Wells et al., 2008). Nurse case management practice depends on the population and organization being served and is defined by the American Nurses Credentialing Center ([ANCC], 2009), the source for certification in the specialty, as a dynamic and collaborative approach to facilitate, provide, and coordinate comprehensive care to assess and meet patients’ needs. By interacting with patients and families in a variety of roles, the nurse case manager can enhance quality, cost-effective outcomes by decreasing fragmentation and duplication of care (ANCC, 2009).

Nurse Navigator

Fillion et al. (2009) favored professionally led models of patient navigation that compare with comprehensive case management models through the cancer care continuum. Case management models involve assessment, outreach, and referrals; comprehensive models add advocacy, education, problem solving, and support (Fillion et al., 2009). Doll et al. (2007) defined the role of the navigator as interactive between patient and nurse, to mutually identify unmet needs, and tailored to help the patient move through the system as smoothly as possible.

Coordination of care and ensuring continuity of care were described as overarching roles and responsibilities in an integrative review demonstrating the value of the RN in ambulatory care (Swan, Conway-Phillips, & Griffin, 2006). Coordination and continuity of care were similarly important to the roles of patient navigator, nurse case manager, and nurse navigator in the literature. For the purpose of this review, nurse as navigator terminology will include breast health nurse, nurse case manager, oncology nurse navigator, oncology patient navigator, pivot nurse in oncology, and nurse navigator.

Theoretical Framework

The Synergy Model was developed by the American Association of Critical-Care Nurses and introduced and validated in 1997 as the framework for critical care RN testing and certification (Curley, 2007). Since that time, the basic premise of the Synergy Model for a nurse in any setting is that given the opportunity to know a patient and family and assess their goals, synergy between patient needs and nursing competencies can produce the outcomes important to the patient (Curley, 2007). The eight patient characteristics that span the continuum described by the Synergy Model from health to illness are stability, complexity, vulnerability, predictability, resiliency, participation in decision making, participation in care, and resource availability. The level of nursing competency to facilitate patient care varies from novice to expert and is based on identified patient needs. The nursing characteristics identified in the Synergy Model are clinical judgment, clinical inquiry, caring practices, response to diversity, advocacy or moral agency, facilitation of learning, collaboration, and systems thinking. One primary outcome of using the Synergy Model is that patients and families will be provided safe passage through the healthcare system, a concept quite familiar to the nurse as navigator.

Methodology

The databases searched were the Academic Search Premier, Business Source Premier, Cumulative Index to Nursing and Allied Health Literature® Plus, Cochrane Collaboration, Google®, Google Scholar, Education Resources Information Center, Ovid MEDLINE®, National Institute for Health and Clinical Excellence, PsycINFO®, PubMed, Registered Nurse’s Association of Ontario, Science Direct, and Turning Research Into Practice. The literature was searched from January 2000 to January 2010; key words searched used various combinations of advocate, cancer, case manager, coach, certification, guide, navigator, nurse, oncology, patient navigator, pivot nurse, and continuity of care. Research study reference lists and related article links also were reviewed. Although nurse navigation is a relatively new concept, nurse case management is not.

Eighteen primary nursing research studies were found, including three studies that explored the importance of continuity of care to patient outcomes. Of the 18 studies cited, 12 originated in the United States, 5 in Canada, and 1 in Sweden. Data were categorized according to the following themes: rationale for implementation of nurse as navigator, study patient populations, navigator educational preparation, and measurable patient outcomes such as the time to diagnosis and treatment, effect on mood states, satisfaction, support, continuity of care, and cost.

Results

Implementation of the Nurse as Navigator

In a concept analysis of the patient navigator role, Pedersen and Hack (2010) described patient navigator programs in the United States as focusing on marginalized community access to care as compared with a Canadian focus on more nursing-sensitive navigator interventions, such as care coordination, patient education, and links to community resources. Navigator roles are expanding globally, and the need for a nurse coordinator role
in cancer care is delineated by nurse scientists. For example, Seek and Hogle (2007) explained the rationale for developing a multidisciplinary lung cancer clinic after examining the negative effects of multiple medical visits on patients’ quality of life. A coordinator of clinical care was found to be the common denominator in benchmarking similar programs at the university level (Seek & Hogle, 2007). Similarly, Bowman and Grim (2008) described the implementation of a nurse navigator program in breast cancer as the result of a focus group meant to identify improvements for patients through transitions in treatment. Patients reported feeling unsure of their contact person for questions or concerns and feeling out of control and overwhelmed with information (Bowman & Grim, 2008).

Study Patient Populations

In the literature review, patients with breast cancer were the predominant population encountered, followed by head and neck and lung cancer populations. Of the 18 research studies in this review, 13 were primarily or heavily focused on patients with breast cancer, and three researchers’ studies focused on mixed cancer populations (see Table 1).

Navigator Educational Preparation

Bachelor’s prepared RNs constituted the majority of nurse case managers and nurse navigators in 11 of 15 studies. Because of the clinical knowledge and expertise required and complexity of the role, two specific navigator programs were developed with a requirement that the nurse be oncology certified (Bowman & Grim, 2008; Fillion et al., 2006). Advanced practice nurses were navigators in three studies, but standard medical care was not explained in one comparison to standard medical care plus care by an advanced practice nurse (Ritz et al., 2000). One navigator program used an individual with a bachelor’s degree in health sciences so that the RN would be available for patient teaching if the patient was navigated into the healthcare system in a timely manner (Schwaderer & Itano, 2007).

Time to Diagnosis and Appropriate Treatment

Negative effect on survival because of delays in screening, diagnosis, and appropriate treatment were motivating factors for development and study of nurse navigator programs in both underinsured and multidisciplinary care clinic patient populations (Bairati, Fillion, Meyer, Héry, & Larochelle, 2006; Palmieri et al., 2009; Schwaderer & Itano, 2007; Seek & Hogle, 2007). Goodwin et al. (2003) targeted an older adult population with breast cancer, aged 65 and older, because of an identified higher risk for diminished access to care, and to do so within five days of obtaining a pathology confirming diagnosis of cancer (Schwaderer & Itano, 2007). Targeted populations included underinsured, non-Caucasian, older adult patients living in identified socioeconomically depressed areas, who were referred for patient navigator services. Although outcome data were not yet available, the researchers did identify the primary barriers to care as being related to inadequate insurance coverage, transportation issues, and high copayments for prescription coverage.

Goodwin et al. (2003) targeted an older adult population with cancer, aged 65 and older, because of an identified higher risk for inadequate treatment. They used a model for case management intervention based on assessment, planning, implementation, and evaluation of patients with breast cancer in small- and medium-sized communities in southeastern Texas. Researchers found that women randomized to the intervention group with nurse case managers were more likely to receive appropriate treatment within the first six months of diagnosis than the control group without nurse case manager intervention. The same characteristics associated with lower rates of appropriate treatment in the control group, such as living alone, being a minority, and/or being age 75 years or older and unmarried,
<table>
<thead>
<tr>
<th>STUDY</th>
<th>PATIENT POPULATION</th>
<th>NAVIGATOR CREDENTIALS</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bairati et al., 2006</td>
<td>Breast cancer</td>
<td>No navigator</td>
<td>Human interventions facilitated breast cancer services.</td>
</tr>
<tr>
<td>Bergenmar et al., 2006</td>
<td>Breast cancer</td>
<td>No navigator</td>
<td>Continuity of care affected patient satisfaction.</td>
</tr>
<tr>
<td>Bowman &amp; Grim, 2008</td>
<td>Breast cancer</td>
<td>Oncology certified RN</td>
<td>Navigation program was helpful in the following five categories:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>education, support, empowerment, coordination of care, and advocacy.</td>
</tr>
<tr>
<td>Campbell et al., 2010</td>
<td>Multiple cancer diagnoses</td>
<td>RN</td>
<td>Navigator services were effective from staff perception and patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>perspective in regard to word terms: timely, access, financial, assistance, qualified, and satisfaction.</td>
</tr>
<tr>
<td>Fawcett et al., 2007</td>
<td>Breast and cervical cancer</td>
<td>80% of NCMs had a BSN or higher.</td>
<td>NCMs were least satisfied with the way clients were discharged from their service when treatment began.</td>
</tr>
<tr>
<td>Jennings-Sanders</td>
<td>Breast cancer</td>
<td>NCMs were BSN prepared.</td>
<td>Secondary analysis of intervention group in parent study by Goodwin et al. 2003; three open-ended questions were asked one year after diagnosis. NCM made positive impact on navigating the healthcare system.</td>
</tr>
<tr>
<td>Anderson, 2003</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jennings-Sanders et al., 2005</td>
<td>Breast cancer</td>
<td>NCMs were BSN prepared.</td>
<td>Secondary analysis of intervention group in parent study by Goodwin et al. 2003; analysis of factors that determined more NCM interventions</td>
</tr>
<tr>
<td>Palmieri et al., 2009</td>
<td>Breast cancer</td>
<td>RN</td>
<td>Surpassed the benchmark for time to diagnosis from abnormal screening</td>
</tr>
<tr>
<td>Pineault, 2007</td>
<td>Breast cancer</td>
<td>No navigator</td>
<td>Family and friend did not decrease anxiety, but social support by</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>healthcare professionals did.</td>
</tr>
<tr>
<td>Ritz et al., 2000</td>
<td>Breast cancer</td>
<td>APN-guided care</td>
<td>Patients experienced improved aspects of quality of life, but standard care was not described.</td>
</tr>
<tr>
<td>Schwaderer &amp; Itano, 2007</td>
<td>Multiple cancer diagnoses</td>
<td>BSN in health science</td>
<td>Main barriers to care were inadequate insurance coverage, transporta</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>tion issues, and high copayment for prescriptions.</td>
</tr>
<tr>
<td>Seek &amp; Hogle, 2007</td>
<td>Lung cancer</td>
<td>APN was navigator.</td>
<td>Time decreased from diagnosis to treatment.</td>
</tr>
<tr>
<td>Stephens et al., 2008</td>
<td>Breast cancer</td>
<td>Breast health specialists were master’s prepared RNs.</td>
<td>90% of patients experienced fear and anxiety postoperatively. Patients felt sources of disease-specific information were adequate, and a combination of social, physical, emotional, and spiritual support was equally important.</td>
</tr>
<tr>
<td>Strutkowski et al., 2008</td>
<td>Lung and breast cancer</td>
<td>PNO was bachelor’s prepared RN</td>
<td>No difference was found in symptom distress, fatigue level, quality of life, or healthcare usage. PNO was not oncology certified. 75% of usual care nurses were oncology certified with more than 10 years of experience.</td>
</tr>
<tr>
<td>Swanson &amp; Koch, 2010</td>
<td>Multiple cancer diagnoses</td>
<td>Researchers stated ONN should be RN trained in oncology, preferably certified.</td>
<td>Significant decrease was reported in distress scores of inpatients using ONN.</td>
</tr>
</tbody>
</table>

APN—advanced practice nurse; BSN—bachelor of science in nursing; NCM—nurse case manager; ONN—oncology nurse navigator; OPN—oncology patient navigator; PNO—pivot nurse in oncology
did not negatively affect receipt of appropriate treatment in the nurse case management group (Goodwin et al., 2003).

From a different standpoint, socioeconomic and racial demographics were not described or considered by the researchers to be essential to the exploration of the role of a nurse navigator in a mid-Atlantic U.S. multidisciplinary lung cancer clinic (Seek & Hogle, 2007). The nurse navigator helped to communicate the importance and coordinate the timing of multiple treatment modalities, which resulted in a decrease in the time from diagnosis to treatment from 29.3 days to 18.76 days in the first three months of implementation. At the end of the first year, the volume of patients with lung cancer increased by 48%, and 92% were able to initiate treatment within 14 days (Seek & Hogle, 2007). Emphasizing the impact of continuity in complex cancer care, researchers in a Canadian study investigating systems issues and events that could impede detection and treatment of breast cancer also were not as concerned with socioeconomic disparities (Bairati et al., 2006). Further supporting their work and interest in developing a conceptual framework for professional patient navigation, Bairati et al. (2006) found that events impeding care for women with breast cancer resulted from a lack of availability of services, such as waiting lists for mammograms, and that human interaction could accelerate the process.

Effect on Mood States

Researchers in two studies found that women awaiting diagnosis and treatment of breast cancer experienced anxiety and fear (Pineault, 2007; Stephens, Osowski, Fidale, & Spagnoli, 2008). Pineault (2007) used two instruments to measure anxiety and social support experienced by Canadian women awaiting diagnosis after abnormal screening mammogram results. A questionnaire was mailed and achieved a response rate of 66% (N = 631). Anxiety screening revealed that 51% of participants were more than slightly anxious during all phases of the prediagnostic stage. Pineault (2007) explained that as many as 75% of the respondents reported that family and friends did not help decrease anxiety, but support from healthcare professionals did. However, not all clinics in the breast screening program had anyone specifically designated to provide social support.

Stephens et al. (2008) found that 90% of newly diagnosed patients with breast cancer after surgery expressed fear and anxiety in response to open-ended questions in the immediate postoperative period. Specifically, 39% expressed fear of recurrence or metastasis of the disease, 31% expressed anxiety related to postoperative treatments, and 21% expressed anxiety related to an uncertain future. In response to a question about what information could be provided or how patients could best be helped at that time, most patients felt well informed because they received a handbook of disease-specific information. In response to what was most important in dealing with their diagnoses, women had difficulty separating the importance of social, physical, emotional, or spiritual aspects of coping with their illness, and 40% identified a combination of all aspects to be equally important (Stephens et al., 2008).

The National Comprehensive Cancer Network (2010) guidelines suggest that all patients with cancer should be routinely screened for distress. Swanson and Koch (2010) examined the role of the oncology nurse navigator on decreasing distress scores of inpatients with various cancer diagnoses. A convenience sample of 20 women and 35 men at a 261-bed midwestern U.S. hospital were routinely asked to rate their level of distress at bedtime during their inpatient stay. The researchers found a significant decrease in distress scores of patients aged 65 years or younger, as well as patients who resided in rural areas, who chose to be seen by the oncology nurse navigator. The mean age of patients was 66.2 years, with 35% classified as rural residents, and race and ethnicity were not reported as part of hospital admission data (Swanson & Koch, 2010).

Despite all the previous positive effects on mood states by nurse navigator interventions, a randomized clinical trial by Strutkowski et al. (2008) failed to show any significant effect of continuity of care provided by a pivot nurse in oncology on symptom relief and outcomes for patients with lung or breast cancer. No difference was found between the usual care group, in which patients may not have seen the same nurse consistently, and the pivot nurse intervention group for symptom distress, fatigue level, quality of life, and healthcare usage (Strutkowski et al., 2008). The pivot nurse in oncology was not oncology certified, but 75% of usual care nurses were oncology certified and had an average of more than 10 years of work experience that could have influenced their results (Strutkowski et al., 2008).

In a twist on variables, Jennings-Sanders, Kuo, Anderson, Freeman, and Goodwin (2005) examined how sociodemographic characteristics, depressive symptoms, and cognitive impairment affected types, amounts, and timing of nurse case management interventions for older women with newly diagnosed breast cancer over a 12-month study period. The researchers’ analysis revealed that African American race, lower education, living alone, and later stage of cancer predicted more contact by the nurse case manager (Jennings-Sanders et al., 2005). The Model for Nurse Case Management provided the conceptual framework for evaluating types and amounts of nurse case management interventions in various phases of the nursing process, a first step identified to affect quality of care and patient outcomes (Jennings-Sanders et al., 2005).

Satisfaction, Support, and Continuity of Care

Researchers in Sweden and the United States were interested in exploring the relationship of coordination and continuity of care on patient satisfaction (Bergenmar, Nylen, Lidbrink, Bergh, & Brandberg, 2006; Bowman & Grim, 2008; Campbell, Craig, Eggert, & Bailey-Dorton, 2010). Patient satisfaction was investigated at an outpatient clinic for patients with breast cancer in Stockholm, Sweden, with multiple-choice questions and one open-ended question asking for suggestions for improvements in the clinic. Responses included requests to decrease the number and increase the continuity of physicians involved in medical appointments, decrease wait time for appointments and procedures, increase collaboration between clinic and hospital, help with formulating questions and requests for information related to the disease, and improve accessibility to nurses and physicians between appointments (Bergenmar et al., 2006). Changes were made to medical appointments based on questionnaire responses in 2000 and 2001; when assessed
again in 2004, patient satisfaction in eight of 12 categories was significantly improved (Bergenmar et al., 2006).

In a retrospective analysis of the effect of a nurse navigator program on patient satisfaction conducted at a community hospital in Pennsylvania, only 530 of 1,472 women treated for breast cancer were eligible (Bowman & Grim, 2008). Qualitative responses to the helpfulness of the nurse navigator program fell into five common categories: education, support, empowerment, coordination of care, and advocacy. In a comprehensive community cancer center in the southeastern United States, Campbell et al. (2010) sought to determine the effect of a nurse navigator on patient and staff perceptions of patient readiness for treatment, patient access to care, and overall patient satisfaction. Researchers found statistical significance in favor of a navigator compared with non-navigator groups with relation to resources, timely access, qualifying for financial assistance, and overall satisfaction with care (Campbell et al., 2010).

A Canadian group of nurse researchers has had an ongoing interest in developing a conceptual framework for professional nurse navigation (Fillion et al., 2006, 2009). The purpose of the earlier qualitative study was to provide a description of the implementation of the oncology patient navigator role in the head and neck oncology area of a university hospital center and its effects, including role functions and outcomes, on continuity of care and patients’ and families’ adaptation to illness (Fillion et al., 2006). Patients, family members, university hospital center stakeholders, and network partners participated. Significant findings included positive changes in patients’ adaptation to illness by expression of better understanding of health problems, treatment, and care plans, and effect on continuity of care and services by expressions of improved communication between caregivers, which facilitated interdisciplinary work.

Fillion et al. (2009) further developed a professional patient navigation model of care through comparison of two separate cohorts of patients with head and neck cancer one year before (historic cohort) and one year following (exposed cohort) implementation of a navigation program. Mailed questionnaires focused on sociodemographic characteristics, several dimensions of patient satisfaction, adjustment to cancer and cancer-related problems, and quality-of-life indicators. With a 62% (N = 83) response rate in the historic cohort and a 64% (N = 75) response rate in the exposed cohort, the navigators’ effect on continuity of care in the exposed cohort was demonstrated by higher satisfaction and lower number of hospitalizations than the historic cohort. Patient empowerment was demonstrated by fewer social or communication problems and fewer concerns about the future, sexuality, and body image in the exposed cohort (Fillion et al., 2009).

As more cancer treatments were provided on an ambulatory basis, nurse case managers were found to have a positive effect on challenges faced by the older adult patients with breast cancer and their families in the home setting (Jennings-Sanders & Anderson, 2003). The themes indicated that patients found the nurse case management of coexisting medical problems, support, education, assistance with activities of daily living, and navigating the health system to be most helpful. Fawcett, Schutt, Gall, Riley Cruz, and Woodford (2007) reported similar findings, as they examined the frequency and correlates of nurse case manager activities in a cancer and cardiovascular disease risk-screening program in Massachusetts.

Cost Outcomes

The cost of care is always an important outcome in decisions regarding healthcare personnel providing patient care. Ritz et al. (2000) attempted to show that advanced practice nurses could reduce cost outcomes in interventions with women diagnosed with breast cancer. In the randomized clinical trial, 105 women in a control group received undefined standard care and 106 women in the intervention group received standard care plus the care of an advanced practice nurse. No significant differences in overall charges and reimburments were found between groups during the two-year study period (Ritz et al., 2000).

Also related to cost, the University of Pittsburgh Medical Center collaborated with urban and rural hospitals to obtain a grant from the National Cancer Institute Center to Reduce Health Disparities to fund a patient navigation program in 2003 (Schwaderer & Itano, 2007). It included providing resources to underserved populations and researching cost effectiveness and outcomes of the program. The economic outcomes of patients in the navigator program still were to be analyzed at the time of the study publication in 2007, but researchers expected hospitals to assume fewer costs because of receiving more reimbursement and providing less free care (Schwaderer & Itano, 2007).

Discussion

Nursing researchers have clearly identified important outcomes that result from the presence of the oncology nurse navigator. When evaluating models of care delivery, outcomes can be classified as pertaining to the patient, nurse, or organization (Curley, 2007; Wolf & Greenhouse, 2007). Curley’s (1998) early work with the Synergy Model cautioned that patient outcomes influenced by nursing care in one situation might be influenced by another healthcare provider discipline in another situation. When models of care delivery are chosen, desired outcomes should be identified, measured, and evaluated. The Association of Community Cancer Centers’ (2010) Patient Navigation Web site offers several examples of how navigation services have been thoughtfully implemented.

Although the importance of reducing barriers to timely diagnosis and treatment is essential to improve prognosis, the Synergy Model conceptualizes ensuring safe passage along the healthcare continuum through treatment recovery, survival, or death. Words and phrases that describe nurse case management models and professional patient navigator models of care also easily describe the conceptual framework for the Synergy Model. Those words and phrases include nurse interaction with patients and families to mutually identify unmet needs; inform, teach, and support; and coordinate and promote the continuity of care. When the nurse uses expert clinical judgment, systems thinking, and advocacy to identify complications early or promote adherence to appropriate treatment in the complex, vulnerable patient, safe passage has occurred. Other patient-identified goals
Implications for Nursing

Non-nursing navigators are the focus of training, clinical trials, and patient navigation programs and research through several public and private agencies, including the National Cancer Institute Center to Reduce Cancer Health Disparities (2010), the Health Resources and Services Administration (2010) Patient Navigator and Chronic Disease Prevention Demonstration Program, and the Harold P. Freeman Patient Navigation Institute (2010). Navigator services can be expected to increase beyond oncology to other chronic disease management.

Reflecting the growth of the role of nurse navigators in the United States is the emergence of two national organizations (American Academy of Oncology Nurse Navigators, 2010; National Coalition of Oncology Nurse Navigators, 2010). Standardization of the nurse navigator role also is demonstrated in the development of the certified breast care nurse (CBCN©) credential since 2008 (Oncology Nursing Certification Corporation, 2010) and the first certification examination for breast patient navigators in March 2010, despite a variety of healthcare professionals eligible to sit for the latter certification examination (National Consortium of Breast Centers, 2010).

This integrative review concentrated on nursing-sensitive patient outcomes in oncology, but the implications of the increasing presence of lay patient navigators include comparison of educational preparation and clinical roles, value of certification, and outcomes research for navigators of all kinds. Oncology nurses must continue to identify opportunities for patient and nurse characteristics to synergize so that patient outcomes can be optimized, ensuring the patient’s safe passage.

Conclusions

Jennings-Sanders et al. (2005) recognized that the Model for Nurse Case Management provided the steps of the nursing process. Navigation becomes the process by which nurses assess individual needs; plan for education, coordination, communication, and support; implement effective transitions through the illness trajectory; and evaluate the effect on patient, family, and organizational outcomes. Studies represented here reflect the momentum of the quality movement in health care and nurses’ demonstration and communication of their contributions. Increasing the visibility of the importance of nursing care will increase the demand by patients and organizations for high-quality patient care by nurses.

Author Contact: Mary Ann B. Case, RN, MSN, OCN®, can be reached at mabcase@gmail.com, with copy to editor at CJONEditor@ons.org.

References


Health Resources and Services Administration. (2010). Patient...


Receive free continuing nursing education credit for reading this article and taking a brief quiz online. To access the test for this and other articles, visit http://evaluationcenter.ons.org/Login.aspx. After entering your Oncology Nursing Society profile username and password, select CNE Tests and Evals from the left-hand menu. Scroll down to Clinical Journal of Oncology Nursing and choose the test(s) you would like to take.