

Making the Case for Nurse

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Women diagnosed with breast cancer often experience devastation, anxiety, uncertainty, anger, and fear, which can turn the process of making decisions about their treatment plan into a daunting task.¹ In the midst of facing many challenges regarding their health and the diagnosis of cancer, patients struggle with additional issues, such as coordinating care, understanding terminology, knowing which questions to ask, locating resources, and communicating with their families and caregivers.^{1,2}

More than 20 years ago, Harold P. Freeman, MD, and colleagues first introduced the patient navigation concept into the healthcare system. His team put nurse navigation into practice after Dr. Freeman identified several barriers that affected the time to diagnosis and to treatment of cancer, including “lack of insurance, poor social support, poor coping styles, and poor health literacy skills.”^{2,3} Ultimately, Dr. Freeman’s work sparked a national movement, resulting in nurse navigation roles entering into the cancer continuum. The role, title, and description of patient navigation vary with disease, setting, and gaps in care—presenting unique issues that community cancer centers continue to address.

Educational Preparation and Certification

Over the past two decades, there has been an increase in nurses performing as navigators, evolution of the navigator role itself, and attempts to standardize the nurse navigator role—all of which have shown a need for nurse navigators to have additional oncology experience and specialized education. Although no specific professional experience, degree, or certification entitles a nurse to be classified as an “oncology navigator,”⁴ the majority of nurse navigators and nurse case managers are bachelor’s degree-prepared.⁵ When identifying the patients’ educational, physical, and psychosocial needs, the experienced oncology nurse can enhance and strengthen the nurse navigator role, as experienced oncology nurses often help with the development of individualized cancer care plans.^{1,2,6} An experienced oncology nurse “possesses a comprehensive knowledge base of pathophysiology of cancer, treatment modalities, disease progression, and systems management,” which leads to improved outcomes.²

There is a scarcity of research comparing bachelor’s degree-prepared nurse navigators with advanced practice nurse (APN) navigators. An APN navigator offers additional dimensions to program offerings, patient care, and symptom management. In other words, adding the APN role components of research, clinical practice, education, consultation, and administration into the navigator position results in more comprehensive integration of medical and nursing perspectives. The APN’s ability to measure and evaluate trends in patient responses and needs—along with micro- and macro-



The oncology breast care nurse navigator speaks with Mrs. Peggy Raper, a former patient at Henrico Doctors’ Hospital.

level changes affecting the particular patient population—can ultimately benefit oncology care.⁷

Oncology Nurse Navigator Role Components

The evolving definition of an oncology navigator is:⁸

- “A trained individual who facilitates timely access to appropriate healthcare and resources for patients and their families
- A skilled communicator who provides holistic care, empowering patients with education and knowledge about their illness
- An individual who is knowledgeable of the cancer system.”

The National Cancer Institute (NCI) further defines patient navigation within cancer care as “the assistance offered to healthcare consumers (patients, survivors, families, and caregivers) to help them access and then chart a course through the healthcare system and overcome any barriers to quality care.”⁹

Nurse navigators work within the multidisciplinary cancer team as a patient advocate, care provider, educator, counselor, and facilitator. It is the nurse navigator’s responsibility to ensure that every patient receives comprehensive, timely, and quality healthcare services.^{4,5,6,10} Navigation services include, but are not limited to:^{4,11}

- Coordinating care among providers

- Arranging transportation
- Scheduling appointments
- Offering financial services
- Providing assistance to help the patient overcome language barriers.

The nurse navigator also facilitates communication with and between healthcare providers, family members, and caretakers, and provides patient education as required.

Benefits to Patient Navigation

Although some organizations question the need for an oncology nurse navigator, as a skilled listener, coordinator, and counselor, the oncology nurse navigator offers educational and psychosocial benefits, with potential financial return on investment for the institution. Patient benefits of navigation services include increased patient satisfaction, decreased patient anxiety, decreased lengths of stay, and reduced treatment delays.^{1,6,12}

McPherson and colleagues describe a common need expressed by cancer patients for additional information from healthcare professionals.¹³ Therefore, one of the oncology nurse navigator's responsibilities is to help explain medical information and to review educational material with the patient once a breast cancer diagnosis is confirmed and throughout the cancer continuum.^{2,14,15} Conclusions drawn from the literature indicate that reviewing and providing information to patients reduces anxiety and improves patient satisfaction and improves patients' quality of life.^{10,12} Oncology nurse navigation improves the amount and quality of the information the patient receives and

positively assists in shared and informed decision making.¹² The advantage of information being provided by an experienced oncology nurse is that the subspecialty knowledge enhances the information the nurse navigator can provide.

The Henrico Doctors' Hospital Experience

Nurse navigation at Henrico Doctors' Hospital began in 2006 with breast imaging after the hospital conducted an evaluation of why patients were leaving the healthcare system. At that time, at least 20 patients per month were leaving the facility for diagnostic procedures at the "callback" point, when additional views and/or additional tests were required due to a radiologic finding on mammography screening. The "callback" is the earliest point in the breast cancer continuum and when most women become aware that something is not normal in their breasts. The Mammography Quality Standards Act (MQSA) requires patient notification of further testing within 30 days of the screening exam; this standard was being met by mail.

Table 1 (below) lists the outcomes of our analysis and identifies reasons for patient departures, including a significant lag time from screening to follow-up appointments due to delays in receiving the mail, the responsibility for making the return appointment falling to the patient, and a lack of protected time slots for returning patients within the schedule. This assessment served as a gap analysis and revealed from the patient's point of view those aspects of patient care and services that were lacking.¹⁶ For example, from the patient's perspective, communicating the need for additional testing by letter seemed very impersonal at an emotional and vulnerable time since patients receiving

Table 1. Gaps in Service Care Resulting in Patient Outmigration

- Patients learning of the need for additional views two weeks after original screening mammogram when they'd assumed that "no news was good news."
- The "return for additional views" letter elicited a highly anxious and, at times, almost hysterical response from women who thought this news meant they had breast cancer.
- Return appointments averaged two weeks from abnormal results. Due to their emotional state, the women wanted more expedient results.
- Time from suspicious finding to diagnosis and surgery averaged four to six weeks.
- Women wanted immediate testing that would provide answers.
- Well-known breast surgeons were affiliated with another healthcare system and when called by the referring physician, the patient was moved into the competitor healthcare system.
- To arrange a follow-up appointment, women had to call a centralized scheduling number. Operators at this centralized service had no information or background related to assisting patients from the mammography center and how to respond to these patients' questions or anxieties.
- Receiving information on the need to return for additional views resulted in women calling their primary healthcare provider (most often GYN) and not the mammography center. Thus, patients often went where the provider office staff arranged their visit.

The oncology breast care nurse navigator educates and coaches patients about the radiologist's recommendation regarding further testing.

the news that additional testing was indicated immediately thought they had breast cancer.

Recognizing patient distress at receiving this information by mail led to an immediate change of how and when our patients received their mammogram results. Now, within 24 hours of a screening mammogram, an experienced oncology breast care nurse navigator personally calls every patient and communicates the need for additional views and testing. The oncology breast care nurse navigator educates and coaches patients about the radiologist's recommendation regarding further testing. Although a letter is still sent to the patient, the nurse navigator can respond immediately to patients who assume that they have breast cancer and to patients who want to schedule their follow-up testing as quickly as possible in order to have answers. "Protected" daily slots for diagnostic testing are blocked within the schedule so that expedited services can be fulfilled. The option of immediate follow-up; prompt, personal education and coaching by telephone; and expedited testing helped closed the perceived "gaps" and change the patient experience at Henrico Doctors' Hospital.

Choosing a Navigation Model

Initiating nurse navigator services at the earliest potential point in the breast cancer continuum guarantees the patient the same healthcare contact in the event of a positive cancer diagnosis (about 2 to 4 percent of all screening mammograms). When we extended our navigation efforts across our hospital system in 2006, we used two navigation models at our various mammography facilities and hospitals. In the first model, one navigator was assigned at the point of diagnostic imaging, and patients were then transitioned to a different navigator after the point of breast cancer diagnosis. In our second navigation model, the nurse navigator followed the patient throughout the continuum of care—from suspicious finding through treatment. In this "entire continuum" model the nurse navigator follows the patient from "callback" to 12 months post-diagnosis. This navigation model offers several benefits:

- A consistent point of contact for the patient. During treatment, patients may see multiple providers, so the consistent presence of the nurse navigator can be even more valuable to patients.
- A way to respond to a patient's sense of vulnerability and anxiety at the time of diagnosis and with each new experience as she changes from one specialist or setting to another.
- An opportunity to provide personalized coaching to the patient as she goes through follow-up testing, surgery, and, if indicated, treatment.
- Improved information sharing between the patient and provider(s), as well as between providers.

- Standardization of processes. Nurse navigators can help improve the quality of care.
- Standardization within and between care settings, as nurse navigators traverse the continuum of care *with* the patient.
- A better opportunity to keep diagnosed patients within the same hospital or healthcare system for treatment.

After implementing our "entire continuum" navigation model in late 2005, Henrico Doctors' Hospital conducted a four-year downstream analysis of patients who had received services from the oncology breast care nurse navigator (see Table 2, at right). Of note are the significantly higher volumes of surgeries, infusions, radiation, and imaging tests in the 12 months following diagnosis in the second two years of the program. We attribute the improvement in patient retention and subsequent increased volume of services to: 1) the addition of an master's-prepared oncology clinical nurse specialist and 2) a palpable, growing acceptance of navigation by referring physicians, as their fears of losing "control" of their patients were allayed and they maintained the ability to choose specialists for their patients.

Table 3 (page 30) is a downstream analysis of the two navigation models. Consistency of the nurse navigator through the "entire continuum" reflects greater total generated revenues, with a \$3,000 greater contribution margin per patient in the "entire continuum" model, based on 12 months of more procedures and services in the retained patient group. Why is patient retention higher in the group that uses the entire continuum patient navigation model? Perhaps the oncology breast care nurse navigator's ability to respond to patients at a very vulnerable time in their lives and gain credibility and earn their trust through the early experiences of imaging and diagnosis have helped to improve patient retention. These findings are consistent with reasons that other community cancer centers choose to use the entire continuum patient navigation model.¹⁷ Today, we have extended the entire continuum navigation model across our network and throughout our hospital system.

Return on Investment

Our research identified many positive outcomes to nurse navigation. After implementing entire continuum navigation, our program saw similar results and trends, including:

- "Timely" access to healthcare and resources
- Empowered shared decision-making education, impacting patient choices and decisions
- Improved patient and provider satisfaction
- Decreased patient anxiety
- Reduced treatment delays
- The ability to ensure follow-up for mammography screening centers with remote access interpretation.

Table 2. Downstream Analysis of Entire Continuum Breast Care Nurse Navigation Model

January 1, 2006 – September 30, 2007 Henrico Doctors' Breast Care Nurse Navigation Patients				October 1, 2008 – September 30, 2009 Henrico Doctors' Breast Care Nurse Navigation Patients			
Patients between 01/01/2006 and 9/30/ 2007				Patients between 10/1/2008 and 9/30/2009			
Patients discharged between 1/1/ 2006 and 6/30/2010 downstream analysis				Patients discharged between 10/1/2008 and 11/30/2010 for for downstream analysis			
Tracked 1,709 patients that made up 1,713 suspect screenings (some patients were called back twice in consecutive years for additional views) in 2006 and 2007.				Tracked 1,118 patients from the callback point.			
Initial Screenings	Year	Cases		Initial Screenings	Year	Cases	
	2006	864			2008	307	
	2007	849			2009	811	
Grand Total		1,713		Grand Total		1,118	
Of the 1,709 patients, 1,656 came back to Henrico Doctors' Hospital for follow-up care (as measured by being within 180 days). Of the 1,656 patients, 68 had primary breast cancer diagnoses in subsequent visits.				Of the 1,118 patients, 138 had primary breast cancer diagnoses in subsequent visits.			
Breast Cancer Patients				Breast Cancer Patients			
Total Patients	68			Total Patients	138		
	Cases	% Cancer Pts.	% Screening Pts.		Cases	% Cancer Pts.	% Screening Pts.
Surgeries				Surgeries			
Lumpectomy	17	25.0%	1.0%	Lumpectomy	46	33.3%	4.1%
Mastectomy	12	17.6%	0.7%	Mastectomy	28	20.3%	2.5%
Surgical Total	29	42.6%	1.7%	Surgical Total	74	53.6%	6.6%
Radiation Oncology	22	32.4%	1.3%	Radiation Oncology	53	38.4%	4.7%
Chemotherapy	1	1.5%	0.1%	Chemotherapy	3	2.2%	0.3%
Breast Cancer Patients				Breast Cancer Patients			
Imaging Services				Imaging Services			
12 Month Time Period (365 days after suspect screening)				12 Month Time Period (365 days after date of initial contact)			
	Cases	% Cancer Pts.	% Screening Pts.		Cases	% Cancer Pts.	% Screening Pts.
Mammography	36	52.9%	2.1%	Mammography	112	81.2%	10.0%
Ultrasound	1	1.5%	0.1%	Ultrasound	85	61.6%	7.6%
MRI	13	19.1%	0.8%	MRI	57	41.3%	5.1%
CT	6	8.8%	0.4%	CT	77	55.8%	6.9%
PET	0	0.0%	0.0%	PET	21	15.2%	1.9%
Total	56			Total	352		

Here's how these benefits have improved our program.

Financial. Within weeks of the oncology breast care nurse navigator contacting patients by telephone for return diagnostics, our hospital saw an immediate improvement in retention of patients at the callback point. Prior to the nurse navigator involvement, 240 patients per year were leaving

our healthcare system. One year post-nurse navigator, the net reduction in patient outmigration was 212, with only 28 patients leaving in the first year at the callback point. Four years later, the number of women leaving the hospital at the callback point averages less than 10 patients per year.

In an attempt to quantify the financial impact of the

Table 3. Downstream Analysis Comparing Two Navigation Models*

October 1, 2008 – June 30, 2009				October 1, 2008 – September 30, 2009			
Facility #1 Breast Care Nurse Navigation Patients				Facility #2 Breast Care Nurse Navigation Patients			
Patients between 10/1/2008 and 6/30/09				Patients between 10/1/2008 and 9/30/2009			
Patients discharged between 10/1/2008 and 11/30/2010 for downstream analysis				Patients discharged between 10/1/2008 and 11/30/2010 for downstream analysis			
Tracked 941 patients from the callback point.				Tracked 1,118 patients from the callback point.			
Initial Screenings	Year	Cases		Initial Screenings	Year	Cases	
	2008	47			2008	307	
	2009	894			2009	811	
Grand Total		941		Grand Total		1,118	
Of the 941 patients, 204 had primary breast cancer diagnoses in subsequent visits.				Of the 1,118 patients, 138 had primary breast cancer diagnoses in subsequent visits.			
Breast Cancer Patients				Breast Cancer Patients			
Total Patients		204		Total Patients		138	
	Cases	% Cancer Pts.	% Screening Pts.		Cases	% Cancer Pts.	% Screening Pts.
Surgeries				Surgeries			
Lumpectomy	61	29.9%		Lumpectomy	46	33.3%	4.1%
Mastectomy	27	13.2%		Mastectomy	28	20.3%	2.5%
Surgical Total		88 43.1%		Surgical Total		74 53.6%	
Radiation Oncology		51 25.0%		Radiation Oncology		53 38.4%	
Chemotherapy		4 2.0%		Chemotherapy		3 2.2%	
Breast Cancer Patients				Breast Cancer Patients			
Imaging Services				Imaging Services			
12 Month Time Period (365 days after date of initial contact)				12 Month Time Period (365 days after date of initial contact)			
	Cases	% Cancer Pts.	% Screening Pts.		Cases	% Cancer Pts.	% Screening Pts.
Mammography	150	73.5%		Mammography	112	81.2%	10.0%
Ultrasound	94	46.1%		Ultrasound	85	61.6%	7.6%
MRI	51	25.0%		MRI	57	41.3%	5.1%
CT	85	41.7%		CT	77	55.8%	6.9%
PET	14	6.9%		PET	21	15.2%	1.9%
Total	394			Total	352		

*Facility #1 (unidentified) uses the navigation model where patients see one navigator during the imaging process and are transitioned to another navigator upon receiving a diagnosis of cancer.

*Facility #2 (Henrico Doctors' Hospital) uses the entire continuum breast nurse navigation model where patients see the same navigator from imaging through treatment.

oncology breast care nurse navigator, we reviewed a year's worth of patients who experienced the diagnostic imaging process after the callback point and tracked those patients for one year. We gathered data for those with a positive diagnosis, as well as those ruled out for breast cancer. From

that total number of women, we quantified the services they received in all other areas of the hospital for 12 months after the callback (lab, emergency room, other imaging, etc.) and reviewed the revenues these patients generated in terms of those other services (see Table 4, at right).

Table 4. Procedures Generated Per Patient*

Patients Without Positive Breast Cancer Diagnoses		
Services	Number of Patients	Percentage
Mammography	804	62.8%
Emergency Services	91	7.1%
Lab Services	39	3.0%
Radiology Services	55	4.3%
Surgical Services	36	2.8%
Ultrasound	40	3.1%
MRI	33	2.6%
Gastro./Endo. Services	28	2.2%
Cardiology	13	1.0%
CT	26	2.0%
Sports/Occ. Rehab.	10	0.8%
Infusion	7	0.5%
Vascular	15	1.0%
Nuclear Medicine	17	1.3%
EEG, EKG, EMG, ECHO	16	1.3%
Medical Services	10	0.8%
Oncology Services	4	0.3%
Other	9	0.7%
Orthopedics	8	0.6%
Progressive Care	7	0.5%
Respiratory Therapy	6	0.5%
Occupational Health	2	0.2%
OB/GYN	3	0.2%
PET	1	0.1%

*These 809 cases represent the patients (out of a total of 838) that returned for diagnostic screening after the nurse navigation call back in 2007 and did *not* have a subsequent visit with a positive breast cancer diagnosis.

Knowing the percentage of use of each hospital service by the non-breast cancer group, as well as the positive breast cancer group, we were then able to apply those percentages and associated revenues to the net reduction in patient outmigration of 212. With this historical data, we applied the procedure and service usage rates along with breast cancer incidence rates to the net reduction in lost patients to show the financial return of having the oncology breast care nurse navigator retain those patients. Of the 838 patients who were called back during that first year of nurse navigation, 809 did not have a positive cancer diagnosis, but went on to have additional visits and procedures within our institution, comprising a total of 1,280 billable services or procedures in the first 12 months post-contact.

Of those 838 callbacks, 29 patients had a positive breast cancer diagnosis, which resulted in 57 procedures that first year (Table 5, above).

The retention of 212 patients resulted in 315 breast diagnostic imaging procedures alone and \$125,000 in total net revenues. Incorporating all the services the 212 patients would generate in non-cancer services, as well as the 57 breast cancer services, the potential total net revenues would be \$350,000. The EBIDTA (earnings before interest, depreciation, taxes, and amortization) for one year of the oncology breast care nurse navigator's involvement easily covered the costs related to the position. These numbers

Table 5. Procedures Generated Per Patient*

Patients with Positive Breast Cancer Diagnoses		
Services	Number of Patients	Percentage
Had Mammography	26	45.6%
Had CT	3	5.3%
Had MRI	11	19.3%
Had Ultrasound	5	8.8%
Had Chemotherapy	4	7.0%
Had Radiation	0	0.0%
Had Lumpectomy	5	8.8%
Had Mastectomy	3	5.3%

*These 29 cases represent the patients (out of a total of 838) that returned for diagnostic screening after the nurse navigation call back in 2007 and received a positive breast cancer diagnosis.

reflect only one year's worth of patient retention and have the potential to increase with each incremental year that the non-breast-cancer patient stays in our hospital system.

Time to Diagnosis and Treatment. Nurse navigation can help reduce the time from suspicious finding to diagnosis and treatment.^{17,18,19} Connecting women who have a positive breast cancer diagnosis with the various specialists at weekly multidisciplinary clinics has resulted in increasingly faster turnaround times for patient results, test scheduling, and treatment onset. Additionally, in response to the national shortage of mammographers, the oncology breast care nurse navigator can review electronic screening reports and follow-up on screenings that are read remotely for facilities without a dedicated mammographer.

When we implemented entire continuum navigation, the lengthy time-to-return for diagnostic tests affected the time to diagnosis and start of treatment. These times varied by facility, but were as long as 8 to 12 weeks. Instituting the oncology breast care nurse navigator at the callback point had an immediate positive impact. Now within 24 hours of a screening mammogram we could contact women and schedule their return for diagnostic testing. Implementing entire continuum navigation has helped our multidisciplinary clinics shorten the time from suspicious finding to treatment to 2 to 4 weeks. Specifically, we were able to shorten the time from suspicious finding to diagnosis from 20 days in 2006 to 14 days in 2009 and to 10 days in 2010. Time from the multidisciplinary clinic to surgery was reduced from 27 days in 2009 to 19 days in 2010.

Operational Changes

Tracking patients and downstream analysis demonstrated the points of service for our breast cancer patients, allowing us to identify when patients left the system and strategize on how to retain those patients.

Surgery is the most common treatment modality for invasive breast cancer and is almost always part of the primary treatment approach. After reviewing the data in Table 2 (page 29), Henrico Doctors' Hospital immediately recognized the disparity in the 2006-2007 surgery rates when compared with the number of newly diagnosed patients. Investigating *why* the numbers were so low revealed that

Creating “protected” times within the schedule allows in patients for return diagnostic work as quickly as

patients were choosing a competitor facility based on surgeon preference. To combat this migration, the oncology breast care nurse navigator worked to “connect” patients with positive cancer diagnoses to our Breast Cancer Multidisciplinary Clinic. (For more on the clinic’s development see below.) Surgeons recognize that multidisciplinary care can improve quality, so they chose to participate in these clinics—not only growing our surgical volume, but also bringing patients back into our healthcare system if the surgery occurred at another facility. Bottom line: the Breast Cancer Multidisciplinary Clinic was an opportunity for our oncology-related specialists to connect with the surgeons and patients earlier in the continuum. These clinics were also an opportunity for patients to experience the specialist team prior to surgery and to hopefully choose to have their care at the same hospital.

Breast radiation-related volumes were low at the onset of the entire continuum navigation program. To help improve these volumes, we developed an affiliation with an academic center, began to participate in partial breast radiotherapy clinical trials, and included radiotherapy team members in our multidisciplinary clinic. Outcomes based on these changes were quickly evident, including increases in surgical volumes and downstream procedures and services (see Table 2, page 29).

The first two years of entire continuum navigation (2006 to 2007) also increased patient retention during the imaging phase, and the following years reflected both improvements in patient retention and downstream services. Net revenues and contribution margins increased by 30 percent in 2008 to 2009 compared with 2006 to 2007 revenues and margins.

Expedited Appointment Returns. Our patient scheduling system is operated by a central group of offsite schedulers. We modified our scheduling system so that our oncology breast care nurse navigator can now directly schedule patients. The benefits are two-fold: 1) the navigator has insight into what the radiologist is thinking, including the potential for add-on tests when the patient returns for additional views and 2) the navigator has insight into what the patient is thinking—her needs, emotions, and desires—based on the callback discussion. Creating “protected” times within the schedule allows the oncology breast care nurse navigator to bring in patients for return diagnostic work as quickly as they desire, sometimes even same day services. In response, the return time for diagnostic work-up appointments dropped from 3 weeks to 24 hours. Based, in part, on the oncology breast care nurse navigator’s ability to contact surgeons for expedient return appointments, the time to surgery was reduced from an average of 4 weeks to 2 weeks.

Multidisciplinary Clinic. With direction and support

from hospital administration, the oncology breast care nurse navigator developed our Breast Cancer Multidisciplinary Clinic. This clinic provides patients with one-stop evaluation and communication with multiple specialists. Clinic is preceded by a multidisciplinary conference in which pathology, radiology, surgery, medical oncology, radiation oncology, nursing, clinical trials, and psychosocial services are represented and confer together for the best treatment plan after reviewing the patient’s presentation and diagnostic workup. The oncology breast care nurse navigator gathers together all patient data for the treatment planning conference. This clinic is held weekly on Monday mornings during blocked times, with conferencing occurring for one hour and clinic beginning with the nurse navigator speaking to each patient. The patients are seen by the various clinicians, with the patient staying in the room and clinicians rotating in and out. The Breast Cancer Multidisciplinary Clinic is offered to all patients and their referring physicians so that treatment planning occurs prospectively.

The Breast Cancer Multidisciplinary Clinic not only contributed to breast cancer volume growth, but also improved the quality of care.^{20,21} Multidisciplinary clinics resulted in changes in diagnosis, interpretation, and treatment plans at a combined rate of 11 percent of those cases seen in the clinic in 2010. Specifically, we were able to decrease the time from treatment plan determination to surgery from 27 days in 2009 to 19 days in 2010. In addition, the patient experience is improved because the team of specialists is communicating collectively on a weekly basis. Finally, referring physicians, particularly those beyond the 25-mile primary service area of the hospitals, also like the multidisciplinary clinics. Their patients are now able to see numerous specialists in one convenient visit.

Satisfaction Metrics

Anecdotally, our program routinely hears from patients and families about their positive experience with the oncology breast care nurse navigator. Comments are unsolicited and are often raised in the context of resolving discontent with other experiences within the healthcare system. It seems patients find it easier to “forgive” flaws in the healthcare system because of their loyalty to their oncology breast care nurse navigator and our hospitals’ intent to do the “right thing” by their patients. The anecdotal satisfaction expressed is consistent with the experience of other programs that describe patient gratitude for appointments being consolidated and knowing that patients were not “alone” at such a vulnerable time.¹⁷ Patient satisfaction surveys are an area we need to refine further to obtain quantitative measures, as our current surveys do not capture specific oncology breast care nurse navigator involvement.

the oncology breast care nurse navigator to bring they desire, sometimes even same day services.

Currently, open-ended positive comments are added at the end of the telephone interviews and paper surveys.

As noted in our gap analysis, a prominent breast surgeon operated at a competitor facility. When women requested this physician at the time of diagnosis, the oncology breast care nurse navigator made all the necessary arrangements in a supportive and professional manner, without “steering” the patient. After our oncology breast care nurse navigator established trust with this surgeon and his staff, the surgeon ultimately “returned” patients to our hospital for adjuvant radiation or chemotherapy.

Increasingly referring physicians are recognizing the benefits our oncology breast care nurse navigator brings to their patients. Today referring physicians express strong support of our oncology breast care nurse navigator. Physician “fears of steering” patients to our hospital have steadily diminished as evidenced by increasing breast cancer volumes across our hospitals and accompanying downstream revenues. Physician satisfaction is seen as the reason behind the volume increase in positive breast cancer patients not previously associated with our affiliated mammography centers. In other words, we have seen an increase in patients being referred to the oncology breast care nurse navigator from outside the mammography callback process.

The return on “investing” in the oncology breast care nurse navigator is measured by various methods—qualitatively as well as quantitatively—with net revenue increases related to patient retention, specialty service volume growth, and the associated downstream revenues related to breast cancer treatment and follow-up imaging. 📌

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