

Implementing a Trauma Nurse Navigator

Kayla Whiteaker
Erlanger Health System

Purpose: Due to lower than expected patient satisfaction scores, increased lengths of stay (LOS), high readmission rates and suboptimal communication standards, we implemented a trauma nurse navigator position on October 27th, 2017. Our ACS verified level 1 trauma center has 6 fellowship-trained trauma-critical care attendings and evaluates approximately 5,500 patients per year with 3,500 admissions. The trauma service has one team for admissions and regular hospital patients (floor team) and an ICU team for critical care patients. The floor team has 1 attending, 1 chief resident per 12-hour shift, 3 junior residents (2 general surgery, one emergency medicine (EM)), 1 nurse practitioner, and 1 trauma nurse navigator covering an average census of 25-40 patients. The ICU team has 1 attending, 3 residents (2 general surgery and one EM) and 1 or 2 critical care fellows for an average ICU census of 20 patients. We implemented a trauma nurse navigator directed at decreased LOS, improved communication, and lower readmission rates.

Resources: The necessary resources were salary support for the trauma nurse navigator, office space and a cell phone.

Description: Trauma patient satisfaction scores were low, LOS and readmissions were high and poor communication existed between consultants and ancillary services. The physician and nursing leadership of trauma services developed a plan for addressing these concerns with the implementation of a novel position called a trauma nurse navigator. The trauma nurse navigator is primarily responsible for meeting new admissions and identifying themselves as a resource during their recovery. The navigator is responsible for communicating with our ancillary services such as Physical and Occupational Therapy, Speech Therapy, and Case Management coordinating care and improving throughput. The navigator oversees our Screening, Brief Intervention, and Referral to Treatment (SBIRT) program. This role ensures screening of all admitted patients for substance abuse and appropriate referrals for those who screen positive. The navigator also helps with discharge planning and runs the weekly discharge planning meeting. Finally, the navigator is responsible for discharge call backs thereby assuring patients have their prescriptions and follow-up appointments. If post discharge problems are identified, early follow-up appointments can be arranged avoiding unwanted ER visits and hospital readmissions.

Effectiveness: The project was deemed effective as we've received positive feedback from the patients, family members, physicians, nurse practitioners, ancillary services, and case management about the position. We've also decreased our readmissions. Unfortunately, we were unable to determine if our patient satisfaction scores increased because our hospital changed to Epic in October of 2017 and thus was not reporting out patient satisfaction scores for a time period due to inability to transmit a patient list to the PRC provider. When we were able to create the patient list we then transitioned to a new provider. The new provider publishes the information in a different format thus making patient satisfaction comparisons difficult.

Lessons Learned: Our trauma nurse navigator is a valuable addition to our trauma team. The only "con" would be the expense of a full-time nurse salary but the expense should be offset by reduced readmission rates. Each institution must individualize priorities for a navigator as these may differ from institution to institution. Working through the priorities is a continual trial and error process until you achieve the goals as set forth by the program.

Other institutions could implement a similar role, even if there was no funding if they had other FTEs they could dedicate to the important pieces of the navigator role. If other programs had several nurse practitioners or trauma resuscitation nurses these job duties could be split up. The main roles that would be necessary with this implementation would be someone to introduce themselves to all patients and their family members. This person would be placing referrals for family support such as Ronald McDonald house referrals and Child Life Referrals. Another role that could be given to a different person would be completing follow up phone calls for all patients after discharge. This person would be responsible for confirming follow up appointments are scheduled, medications have been filled, and any of the patient's questions are answered.

Conclusions: Implementing the nurse navigator role was associated with significantly decreased readmission rates. If the post discharge phone call identifies a problem, an early follow-up appointment can be arranged preventing ER visits and readmissions. The role, however, was not associated with a decreased length of stay (LOS) as initially anticipated. We have come to appreciate that LOS has multiple contributing factors that are beyond the scope of a navigator such as indigent patients who don't qualify for rehab or skilled nursing and remain hospitalized until they are fit for discharge and insurance companies that delay approval of such transfers. Our total number of patients seen during the year prior to the implementation of the navigator role was 4,673 patients with an average LOS (trauma service admissions only) of 5.345 days and 86 patient readmissions. Within the 18 months after implementation we saw a total of 7,680 patients with an average LOS (trauma service admissions only) of 5.42 days and 41 patient readmissions. Despite increasing patient volumes we were able to decrease our readmission rates from 3.625% to 1.47% which we believe is directly related to our addition of the trauma nurse navigator role.