

Evolution of Patient Navigation

Lillie D. Shockney, RN, BS, MAS

The role of nurses in patient navigation has evolved over more than four decades. Navigators in cancer care can guide patients through the physical, emotional, and financial challenges that come with a diagnosis of cancer and facilitate communication among healthcare providers. Navigation has the potential to improve patient outcomes and system efficiency. Oncology nurses are well suited to help patients with cancer navigate the healthcare system from diagnosis and treatment through survivorship and palliative care.

Interest is increasing in “patient navigation” as a way to improve continuity of care. The professional title of a navigator varies from “nurse navigator” to “GPS nurse.” The role of navigator has evolved over more than four decades (see Table 1). In the late 1970s and early 1980s, the prospective payment system was implemented to help reduce healthcare costs related to inpatient stays (Sloan, Morrissey, & Valvona, 1988). Each day of a patient’s hospitalization had to be medically justified for it to be a covered (i.e., reimbursable) service by insurers such as Medicare, Medicaid, and other third-party payors. Utilization review (UR) nurses were hired by insurers to review medical records retrospectively and identify any days of hospitalization that lacked (apparent) medical necessity. Such days would be carved out of the covered services for inpatient hospital stays, causing concerns for hospitals regarding reimbursement for care. Because people other than physicians were scrutinizing the necessity of healthcare interventions, including length of hospitalizations, relationships among UR nurses, physicians, and hospitals often were adversarial (Feldstein, Wickizer, & Wheeler, 1988; Restuccia, 1995).

By the end of the 1980s, the process of medical record review changed to concurrent chart review and was renamed utilization management (UM). The objective of concurrent review was to identify delays in treatment or discharge from the

hospital because of inefficiencies within the healthcare system. Hospitals across the country hired their own teams of UM nurses to review medical records during patients’ hospital stays and communicate with physicians and healthcare teams when more documentation was necessary to justify additional hospital days. The UM nurses, hired by the hospitals, identified specific inefficiencies and worked with healthcare teams to improve care delivery and subsequent reimbursement by insurers for hospitalizations (Wang et al., 2002).

During the 1980s and 1990s, another type of UM nurse, hired by third parties, also was introduced into hospitals. They conducted independent chart reviews and evaluated care delivery and length of hospital stays. They interacted with hospital-based UM teams rather than directly contacting physicians. Independent UM nurses noted that the most common reasons for delays in discharge and prolonged hospital stays were difficulties obtaining patient transfers to facilities with lower levels of care (e.g., skilled nursing facilities, rehabilitation hospitals) or delays in scheduling ancillary tests

(e.g., radiology tests not being available on weekends). Although independent UM nurses achieved more efficiency in care delivery, many of the changes were not systematically applied to benefit all patients. Also, relationships among independent UM nurses, attending physicians, and hospital management often were adversarial (Restuccia, 1995).

In the early 1990s, the concept of “case management” was introduced as another way to increase the efficiency of healthcare delivery. The philosophy and application of case management were quite different from UR and UM. Case managers most often were nurses who worked directly with healthcare teams caring for specific patient populations (e.g., cardiovascular accidents, oncology care, cardiac bypass surgery). These specific populations were identified as requiring complex or expensive care or requiring coordination of care over time. The goals of case management were to improve efficiency, increase adherence to treatment recommendations, provide links for patients to needed resources within the hospital and the local community, and ensure that care was effective, safe, and patient centered.

Lillie D. Shockney, RN, BS, MAS, is an administrative director, distinguished service associate professor of breast cancer, and associate professor in the Departments of Surgery and Gynecology in the School of Medicine at Johns Hopkins University and associate professor in the School of Nursing at the Johns Hopkins Avon Foundation Breast Center, all in Baltimore, MD.

Digital Object Identifier: 10.1188/10.CJON.405-407