Evolution of Patient Navigation

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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.
Table 1. Timeline of the Evolution of Patient Navigation

<table>
<thead>
<tr>
<th>TIME FRAME AND FOCUS</th>
<th>ROLE</th>
<th>RELATIONSHIP WITH OTHER PROVIDERS</th>
<th>SETTING</th>
<th>METHODOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970s: utilization review</td>
<td>Monitor use and delivery of services.</td>
<td>Adversarial</td>
<td>Inpatient</td>
<td>Retrospective chart review</td>
</tr>
<tr>
<td>1980s: utilization management</td>
<td>Evaluate appropriateness, medical need, and efficiency.</td>
<td>Adversarial</td>
<td>Inpatient</td>
<td>Concurrent chart review</td>
</tr>
<tr>
<td>1990s: case management</td>
<td>Assess, plan, implement, coordinate, monitor, and evaluate.</td>
<td>Collaborative</td>
<td>Involved in patient care</td>
<td>Hands-on care</td>
</tr>
<tr>
<td>1990s: patient navigation</td>
<td>Identify and reduce barriers to access to care, diagnosis, and prescription.</td>
<td>Collaborative</td>
<td>Underserved patients</td>
<td>Community outreach</td>
</tr>
<tr>
<td>2000–present: patient navigation</td>
<td>Identify and reduce barriers to access care, diagnosis, and prescription.</td>
<td>Clinical collaborative</td>
<td>Across the continuum of care</td>
<td>Hands-on care and coordination of care</td>
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From Case Managers to Patient Navigators

Most physicians viewed nurse case managers as important team members, keeping patients on a clinical pathway. Finally, the case manager (and patient) were working with the healthcare team. The responsibilities of nurse case managers included addressing barriers to timely care delivery, facilitating communication among members of the healthcare team and the patients and families, educating patients about their illnesses and treatments, addressing psychosocial and financial issues that could impact or delay care, arranging for timely consultations, and planning for the next phase of care (e.g., discharge, additional services, transfer to a facility with a lower level of care, home care).

At the same time that hospitals were implementing the case manager role, third-party payors also were using case managers to ensure that care was provided in a timely and cost-effective manner. Subsequent studies have validated the effectiveness of case management (Goodwin, Satish, Anderson, Nattinger, & Freeman, 2003; Riegel et al., 2002). During this time, a physician at Harlem Hospital, Dr. Harold Freeman, coined the phrase “patient navigation” (Freeman, 2009).

He saw the patient navigator role as one way to address disparities in health care and improve access to care for underserved people. For example, navigators could help improve access to mammography in African American women and facilitate earlier diagnosis of breast cancer (Freeman & Chu, 2005). Additionally, Freeman saw patient navigators as responsible for educating the community about the importance of cancer screening. In Freeman’s model, the goal of patient navigation was to facilitate timely access to high-quality cancer care in a culturally sensitive manner for all patients (Freeman, 2009). The goal later was adopted by the National Cancer Institute (2006).

In 2005, the Cancer Patient Navigation Act was created to help ensure that patients with cancer received high-quality, coordinated care (U.S. Department of Health and Human Services, 2010). The role was described as guiding patients through the physical, emotional, and financial challenges that come with cancer diagnosis.

Creating a Navigation Program

Creating a patient navigation program must be done thoughtfully. Before implementation, cancer centers should perform analyses of the care delivery process as seen through the eyes of their patients. Additionally, critical appraisal of the system will provide a wealth of information regarding the true barriers to the delivery of cost-effective and high-quality care. One common barrier is access to care, which may include difficulty scheduling appointments or prolonged wait times that may result in less adherence to recommended care. Other common issues in oncology care include the following:

- Financial and economic issues
- Differences in language, which may prevent patients and families from understanding treatment recommendations
- Cultural and ethnic diversity requiring tailored interventions
- Communication among the healthcare team, patients, families, and other healthcare providers
- Transportation problems that impact patients’ ability to receive health care
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- Emotional concerns for patients, including distress and fear, which may prolong decision making and delay interventions
- Given the complexity of cancer care and the number of healthcare providers often involved in a patient’s care, a system analysis is crucial to understanding the flow of care. Upon completion of the analysis, a cancer center can create a flow chart depicting a timeline from access to care through delivery of care through follow-up and survivorship care. For example, using this process, the author’s institution found that it could adjust how medical oncology consultation appointments were made, enabling the practice to reduce the amount of time before the start of chemotherapy by two weeks. The flow chart also may depict some specific delays where patient navigation could facilitate the process, increase efficiency of care delivery, and improve communication among healthcare providers. In some facilities, oncology nurses have formed task forces to work on system-wide improvements.
- Measuring the success of patient navigation programs is critical in demonstrating the value of such programs. New software is available for tracking the information electronically (for example, Priority Consult, www.priorityconsult.com). Specific outcome indicators of successful navigation may include the following.
  - Tracking patients along the continuum
  - Recording steps to reduce barriers
  - Ensuring that cancer care meets National Comprehensive Cancer Network guidelines
  - Documenting overall improvements in efficiency
  - Advocating for the value of patient navigator programs

**Conclusion**

Understanding the evolution of patient navigation provides direction for the development and future of such roles. Although navigation arose because of pressures from third-party payors, patient navigation in cancer care has evolved into a collaborative relationship among oncologists, nurse navigators, and patients and families with a goal of patient-centered care. The opportunity to improve communication, expedite care, and ensure that patients receive appropriate, efficient, and high-quality interventions exists throughout the spectrum of cancer care, from screening through survivorship and palliative care.

The future of patient navigation will focus on comparing various navigation models and measuring their impact on outcomes, particularly clinical outcomes such as participation in cancer screening, adherence to diagnostic follow-up care, reductions in late-stage diagnoses, fewer delays initiating treatment, improvements in survivorship, and patient satisfaction with cancer care (Wells et al., 2008). The role of patient navigator is a rewarding one for oncology nurses and provides a new level of involvement and responsibilities for nurses in cancer care.

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