Commentary: Team Approach to Patient Navigation

By Barbara McAneny, MD

I appreciate the opportunity to continue the dialog about patient navigators and the viewpoint of Mukkamala et al.¹ I recognize that the original function of patient navigators was to help people suffering from health disparities navigate our highly complex medical delivery system. I also recognize that Michigan suffers from an extremely high unemployment rate and that the circumstances and poverty of the patient population add to health disparity issues. I will not dwell on which state has more cultural or economic barriers but will instead focus on the use of scarce resources to best serve these populations.

Mukkamala et al¹ comment that the navigator knows the patient from the time an abnormal screening occurs or a lump is found. Unlike family or friends, the navigator is a stranger at that moment and must establish a relationship of trust. Thus, part of the navigator's time must be spent on call for the mammography center. I assume that their navigator is only for breast patients and is not available for people with abnormalities on screening colonoscopies or people found in their primary care office with elevated prostate-specific antigen, painless jaundice, masses on chest x-rays, and so on. My point is that it is not possible to introduce another allied health professional at the moment of diagnosis or suspicion of cancer for all patients in all locations.

In addition, there is a trusted health professional who has an existing relationship in most of those situations: the physician. That person is the health professional who is known and trusted by the patient, has the medical expertise to give appropriate advice and emotional support, and is present at the time of the suspicious event or diagnosis. Perhaps in radiology suites, the radiologist is a stranger and should not be put in the position of counseling a patient but should instead allow the physician who ordered the test to inform the patient of the abnormal result and develop the plan for therapy. In my office, we encourage relatives or friends to attend visits, take notes (we often write down the important points ourselves), or tape visits. We encourage and schedule follow-ups as testing is completed to ensure that the patients have the information they need and the time to ask questions. We have found that satisfaction is high, and there are no delays in the treatment process.

Clearly, the information given to a patient must be accurate. What training and certification are necessary to ensure that the

navigator will deliver the appropriate and accurate information to the patient? To my knowledge, there are no training programs for navigators, although many of them are nurses. However, some nurses have specialized in oncology, and some have not. We face a nursing shortage: Is navigation the best use of these highly trained personnel?

If you pay a nurse at \$20 per hour plus benefits to be a navigator, and the nurse sees 150 patients per year, his or her salary adds the expense of \$360 per patient to provide this unreimbursed service. We often do not have a profit margin that can withstand another \$360-per-patient expense. Compliance with regimens can be ensured by incorporating the navigation function into the job of other personnel. In my office, the person who checks the patient out after the visit schedules the follow-up appointments and all the tests, obtains prior authorizations, and gives the patient a card with a direct line to call with questions. That person—who is not a nurse—does not answer medical questions but develops a first-name relationship with the patient. This person is an important part of the health care team, along with the nurses, social workers, and physicians. Not having a specific person labeled as navigator does not negate the value of the team approach to care.

In summary, I feel a well-functioning practice that incorporates the functions of patient navigator into the job of every person who interacts with the patient; has an efficient system of scheduling tests and obtaining and sharing results with the patient; and is sensitive to the cultural, psychologic, and economic barriers to care does not need to incur the expense of hiring patient navigators.

Accepted for publication on May 19, 2010.

Author's Disclosure of Potential Conflicts of Interest

The author has indicated no potential conflicts of interest.

Barbara McAneny, MD, is chief executive officer of New Mexico Oncology Hematology Consultants in Albuquerque, NM. Contact her at mcaneny@nmohc.com.

DOI: 10.1200/JOP.777009

Reference

1. Mukkamala A, Schmit M: Patient navigators: Experience in a community hospital. *J Oncol Pract* 6:224, 2010