

Assessing the Value of Patient Navigation for Completing Cancer Screening

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In 1974, after finishing medical training in an acute care hospital, my view of health care was largely that of doctors and nurses treating people in bed. Then I joined the Indian Health Service and quickly learned the value of community health workers such as the Community Health Representatives (CHR), who are lay health workers navigating Native Americans and Alaska Natives through their health care system. Without the many efforts of CHRs at the often-complex interface between providers and patients, I am sure our health outcomes would have fallen far short for many patients.

Although similar patient navigation positions have developed in other clinical settings, lay workers serving at the interface between health care providers and patients are not yet an integral part of the U.S. health care system. One reason, of course, is that our health care system is not particularly systematic, but another is that we have not yet achieved consensus about the value of patient navigators. Both of these barriers seem to be giving way. The Affordable Care Act defines a future health care system that is more patient centered, that delivers evidence-based interventions more effectively, and that is more accountable for population health outcomes; and research such as that published in this issue of *CEBP* will help to define the value of patient navigators within our health care system (1, 2).

What do we know about the value of patient navigators and what do we need to learn? A substantial body of research has shown that patient navigators improve participation in cancer screening, particularly in communities of color (3). The question addressed by 6 of the Patient Navigator Research Program studies published in this issue of *CEBP* is whether patient navigators can improve the timeliness and completion of the work-up of abnormal findings of breast, cervix, colorectal, and/or prostate cancer screening tests. (4–9) The qualitative answer to that question seems to be "yes," but the heterogeneity in design and analysis across this set of studies makes it difficult to clearly answer that question quantitatively using a pooled or meta-analytic approach.

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The difference in average time to resolution of abnormal results among those who achieved resolution was pretty small, being only about 2 to 4 weeks (5–8). Although this modest shortening of time would offer only a marginal clinical benefit, the effects of navigation on completing a resolution after one year would be more meaningful. Navigation seems to have had an absolute impact of between 10% and 20% after 1 year (4–7), although one of the studies showed quicker resolution in the first month but no cumulative difference after 60 days (8), and another observed an absolute benefit of only 6% (ns) (9). The Kaplan–Meier curves displayed in some of these papers are informative about the latency of effects of patient navigation. In the Boston study, benefits seemed to emerge as soon as 6 weeks after screening (7), but in the Ohio, Denver, San Antonio, and Tampa studies, benefits from navigation emerged only after about 6 months (4–6, 9).

The net benefits of patient navigation for cancer screening will be the sum of the benefits of increased participation in screening, which are already established by considerable previous research, plus the benefits of more timely and complete resolution of abnormal screening test findings, which are only now being fully assessed. That sum of net benefits seems to be considerable. The modest direct costs of navigation may be easily offset by savings from avoidance of the high costs of treating regionally advanced cancer because of the cancer stage shifts that will result from more complete follow-up from patient navigation.

When ocean-going ships enter busy and complex harbors they are often navigated by pilots who are based in those harbors, but such hands-on navigation is not required for most ships or for most harbors. Likewise, personal navigation can be useful and effective for some patients in some circumstances, but it is not needed for most patients or most circumstances. The set of Patient Navigator Research Program papers published in this issue of *CEBP* shows that the proportion of patients who already achieve a final resolution of abnormal cancer screening tests can be quite high in many health care systems even without navigation, and that the benefits of navigation tend to emerge only after several weeks or months. Therefore, the enactment of navigation services linked to cancer screening would seem to be best timed and focused for those patients who are at high risk for noncompliance or for those who show early indications of noncompliance with follow-up.

Community health workers will likely play increasingly important roles in the future U.S. health care

system, but as we develop the profession of patient navigation it is important that we define specific competencies for each of the wide range of roles patient navigators can play. Recruiting community members to get screened requires one set of skills, steering patients through the process of diagnostic testing to the resolution of abnormal screening tests requires additional knowledge, and supporting patients who are undergoing complex cancer treatments requires yet more advanced clinical competencies. Lay workers and health care professionals will both have roles to play in patient navigation across such a wide spectrum. To better enable the integration of patient navigators into

the U.S. health care system, we now need to define the requisite competencies and set standards for patient navigator training and certification. As we begin to professionalize this field, however, we need to remember that the effectiveness of community health workers such as patient navigators requires that they be culturally credible in 2 different worlds: both in the clinic and in the community.

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