

EDITORIAL

Isn't there enough evidence on the benefits of patient navigation?

In this issue of *CA: A Cancer Journal for Clinicians*, Chan and colleagues¹ describe an umbrella review of 61 systematic reviews published between 2012 and 2022, along with a review of 53 primary studies published globally since 2021. Patient navigation (PN) has many definitions, and, in this, review PN was defined according to the definition of Wells et al.² combined with that of Dalton et al.,³ which expanded the definition of PN to also include care coordination. Their primary research question focused on evaluating the effectiveness and cost-effectiveness of different cancer navigation models and programs. Multiple databases were searched to find quantitative PN intervention studies with any comparator as well as qualitative, mixed-methods, and systematic reviews. The Joanna Briggs Institute's JBI Critical Appraisal Checklist for Systematic Review and Research Syntheses was used to examine the risk of bias for each of the systematic reviews. Findings of this umbrella review indicated that the risk of bias of the included systematic reviews seemed low; however, fewer than one half of the included reviews reported the likelihood of publication bias. The review concluded that PN is effective in increasing uptake or adherence to cancer screening, reducing the time from screening abnormality to diagnosis, increasing rates of diagnostic resolution, reducing the time from diagnostic resolution to treatment initiation, increasing treatment completion, increasing treatment adherence, increasing survivorship surveillance appointments for breast or cervical cancer, increasing quality of life, and increasing satisfaction with care. Furthermore, the review pointed to a lack of evidence regarding PN in palliative care and end-of-life phases. The review also concluded that most effectiveness and cost-effectiveness data for PN interventions were collected in the United States; therefore, Chan and colleagues call for additional research to evaluate the effectiveness and cost-effectiveness of PN outside of the United States, in survivorship and palliative care phases of the cancer continuum, for indigenous populations, and for individuals affected by rare cancers, hematologic malignancies, as well as advanced or metastatic cancer.¹

Although this review has many important contributions to the literature, there are points that need to be addressed. First, although Chan and colleagues updated the more recent literature, their conclusions do not differ from those of the myriad of other reviews. Now is the time for the implementation of PN in health care because the

amount and consistency of evidence is sufficient demonstrating the impact of PN across the cancer continuum. This report solidifies the evidence—when can we all agree that enough evidence is enough and that PN needs to be an integral part of usual clinical care with reimbursement? The next phase of studies should collect and report on the implementation of PN in usual care.

Second, Chan and colleagues correctly point out the need for a consistent definition of PN. In our view, researchers and practitioners do PN a disservice when they do not use the definition of PN established and vetted by leading organizations like the American Cancer Society (ACS) National Navigation Roundtable (NNRT).⁴ The use of inconsistent PN definitions and lumping together patient navigators with other categories of health care providers are important barriers to acceptance of PN as a billable service.

Third, on the same theme, including others who provide PN-like services in care and research studies of PN does not strengthen the evidence for PN but, instead, weakens it. Patient navigators have defined competencies, with formal training, certification, and the potential for accreditation: The Academy of Oncology Nurse and Patient Navigators (AONN) certification examinations are led by the AONN+ Foundation for Learning (<https://aonnfl.org/>); and certifications for Oncology Nurse Navigator–Certified Generalists and Oncology Patient Navigator–Certified Generalists are accredited through the ANSI National Accreditation Board (<https://anabpd.ansi.org/>). If other individuals who are not trained, certified, or accredited are performing this role, then (1) it weakens evidence of the effectiveness of the patient navigator's role in those individuals without adequate training who are performing this role, and (2) it weakens the case for reimbursement for a specific PN job code.

With the wide-ranging and successful research and evaluation efforts that have been conducted over the last few decades, the evidence supporting the impact of oncology navigation on a range of patient-related outcomes across the cancer continuum is extensive. Now, these efforts must shift to strategies and research focused on implementation, adaptation, scaling up, and sustainability. Implementation is complex and requires attention to the context for adaptation to local and institutional needs, assessing readiness for implementation, and understanding the enablers of implementation, planning for sustainability, and scaling of interventions.⁵ These

are dynamic processes that require ongoing evaluation and dissemination of lessons learned. We need to build on emerging efforts, such as the recent Centers for Disease Control and Prevention's Community Guide recommendations for breast, cervical, and colorectal cancer screening based on a systematic review of the evidence,⁶ the Centers for Medicare & Medicaid Services Enhanced Oncology Model,⁷ and the ACS capacity-building navigation grants and learning community.⁸ Now, the need is to build evidence about successful implementation strategies at multiple levels and within different contexts to reach the goal of ensuring that this evidence-based intervention is integrated into all oncology care.

Key components to measuring the effectiveness and replicability of evidence-based interventions in PN are standard measures and approaches, such as those outlined in the AONN Standardized Metrics and Certifications.⁹ These metrics provide a common framework for assessing program quality across the domains of patient satisfaction, clinical outcomes, and return on investment. Ongoing investment in assessing the scalability of navigation through the reporting of standard measures must be prioritized by institutions, health systems, and national organizations.

With the consistent evidence in favor of PN in oncology care further solidified by this comprehensive review of systematic reviews, it is our opinion that now is the time to turn our resources and attention to ensuring the adoption of evidence-based PN practices across our complex, multilayered health care system. Figure 3 in the review by Chan and colleagues clearly summarizes the barriers and facilitators across these multiple levels that must be addressed to support best-practice implementation and crystallizes the complexity of realizing the promise of oncology navigation. In other words, the health system needs to be ready to accept, adopt, and scale evidence-based PN.

The ACS NNRT was established in 2017 and is a national coalition of 80 member organizations to advance navigation efforts that eliminate barriers to quality care, reduce disparities, and foster ongoing health equity across the cancer continuum. In 2021, the NNRT established a 5-year aim to pursue the development of a sustainable model for oncology PN that would achieve health equity across the continuum of cancer care.¹⁰ The NNRT has long recognized the importance of patient navigator role definitions, a competent PN workforce, and reimbursement of patient navigators as vital to the sustainability of PN. This new 5-year sustainability aim also recognizes that our complex health care systems and the oncology provider community must embrace a collective approach to successfully integrate navigation evidence into our everyday practice. Reimbursement of navigation services alone, without parallel efforts to eliminate barriers to the adoption of evidence-based practices, will not advance cancer equity. Indeed, it may well perpetuate existing inequities. The sustainability of PN will require collaboration across leaders from every level of the health care system, from policy makers to payors and, most importantly, health system administrators and oncology providers. Together, these stakeholders must hold each other accountable to adopt the unmistakable evidence before us. The time is now, the patient cancer care experience depends upon it.

CONFLICT OF INTEREST STATEMENT

Electra D. Paskett reports grants/contracts from Guardant Health, Genentech, the Merck Company Foundation, and Pfizer Canada, Inc., and personal fees from GlaxoSmithKline outside the submitted work. Tracy Battaglia reports grants/contracts from the American Cancer Society, the Merck Company Foundation, and the National Institutes of Health Clinical Center outside the submitted work. The remaining authors disclosed no conflicts of interest. The authors are the Steering Committee for the National Navigation Roundtable of the American Cancer Society. The views here are those of the authors and not of the National Navigation Roundtable or the American Cancer Society.

Electra D. Paskett PhD¹ 

Tracy Battaglia MD, MPH²

Elizabeth A. Calhoun PhD, MEd³

Michelle C. Chappell MS⁴

Andrea Dwyer BS⁵

Linda G. Fleisher PhD, MPH⁶

Jennifer Greenwald MPH⁷

Kristen J. Wells PhD, MPH⁸

¹Department of Medicine, The Ohio State University, Columbus, Ohio, USA

²Boston University Chobanian and Avedisian School of Medicine and Boston Medical Center, Boston, Massachusetts, USA

³School of Public Health, University of Illinois at Chicago, Chicago, Illinois, USA

⁴American Cancer Society National Navigation Roundtable, Atlanta, Georgia, USA

⁵University of Colorado Cancer Center, Aurora, Colorado, USA

⁶Fox Chase Cancer Center, Philadelphia, Pennsylvania, USA

⁷American Cancer Society, Inc., Atlanta, Georgia, USA

⁸Department of Psychology, San Diego State University, San Diego, California, USA

Correspondence

Electra D. Paskett,

Department of Internal Medicine, The Ohio State University, 1590 North High Street, Suite 525, Columbus, OH 43201.

Email: electra.paskett@osumc.edu

See referenced original article on pages 000-000, this issue.

ORCID

Electra D. Paskett  <https://orcid.org/0000-0002-8247-8299>

REFERENCES

- Chan R, Milch V, Crawford-Williams F, et al. Patient navigation across the cancer care continuum: an overview of systematic reviews and emerging literature. *CA Cancer J Clin*. 2023. doi:10.3322/caac.21788
- Wells KJ, Battaglia TA, Dudley DJ, et al. Patient Navigation Research Program. Patient navigation: state of the art or is it science? *Cancer*. 2008;113(8):1999-2010. doi:10.1002/cncr.23815

3. Dalton M, Holzman E, Erwin E, et al. Patient navigation services for cancer care in low-and middle-income countries: a scoping review. *PLoS One*. 2019;14(10):e0223537. doi:10.1371/journal.pone.0223537
4. American Cancer Society. National Navigation Roundtable. Accessed May 15, 2023, <https://navigationroundtable.org>
5. Greenhalgh T, Papoutsi C. Spreading and scaling up innovation and improvement. *BMJ*. 2019;365:l2068. doi:10.1136/bmj.l2068
6. Guide to Community Preventive Services. *Using The Community Guide*. Community Preventive Services Task Force; 2023. <https://www.thecommunityguide.org/pages/using-community-guide.html>
7. U.S. Centers for Medicare & Medicaid Services (CMS). *Oncology Care Model*. CMS; 2022. Accessed May 15, 2023, <https://innovation.cms.gov/innovation-models/oncology-care>
8. American Cancer Society. MySocietySource News Story. <https://www.mysocietysource.org/Pages/newsdetails.aspx?ItemID=2181>
9. Academy of Oncology Nurse and Patient Navigators (AONN). AONN+ Evidence-Based Navigation Metrics. <https://aonnonline.org/navigation-metrics>
10. American Cancer Society (ACS). *National Navigation Roundtable 2020–21 Report*. ACS; 2021. <https://navigationroundtable.org/wp-content/uploads/FINAL-Navigation-RT-Report.pdf>