

The role of patient navigators: Case studies in Singapore

**Nur Zarifah Binte Mustapha, Xu Yi,
Mas Rizalynda Binte Mohd Razali,
Nasrifudin Bin Najumudin
and Haslinda Binte Barman**

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Abstract

In 2014, a patient navigator (PN) program was initiated in a healthcare cluster in Singapore. The program was set up to improve care coordination and facilitate continuity of care of patients. PNs are trained nurses who act as a clinical liaison between the patients, family, staff and the healthcare system to coordinate patients' treatment plans and ensure continuity of care provision from the acute to the community setting. PNs care for patients with chronic diseases and their role includes resolving caregiver disputes, eliminating barriers to treatment, exploring financial assistance options, facilitating terminal discharge and providing end-of-life counseling. This article describes the activities performed by PNs in the acute care setting. The case studies demonstrate the depth and breadth of navigation activities and illustrate how hospital-based navigators help patients seek treatment earlier, access resources and receive care at the appropriate healthcare setting.

Keywords

Patient navigator, care coordination, discharge planning, continuity of care

Introduction

A patient navigator (PN) is an individual whose primary role is to provide personalized guidance to patients as they interact with and move through healthcare systems.¹ The concept was founded by Dr Harold Freeman in 1990. It was initially designed to eliminate barriers to timely cancer screening, diagnosis, treatment and supportive care.² Since then, PN programs have been established across the United States to help people seek complete cancer screening and/or treatment.³

Patient navigators in Singapore

In 2014, a PN program was initiated in a healthcare cluster in Singapore. Made up of trained nurses, the overarching goal of the program is to help patients overcome modifiable barriers to care in order to achieve optimal outcomes, and receive care in the appropriate setting. The trained nurse must have at least five years of nursing experience and completed four months of the PN structured training course at Singapore General Hospital. The program recruits patients across a range of chronic diseases as well as patients who face end-of-life care issues.

The purpose of this article is to describe through case studies how hospital-based navigators can help patients seek

treatment earlier, access resources and receive care at the appropriate healthcare setting. The case series is approved with waiver of informed consent by the ethics review board.

Case 1

Mr A was a 75-year-old Malay male who was admitted for aspiration pneumonia with stage 4 sacral sore and re-feeding syndromes. He presented with fever, shortness of breath and a cough productive of greenish sputum for two days. According to Mr A's third daughter, Mr A had been coughing after swallowing and had difficulty swallowing his medications. Therefore, Mr A had not been taking his medications prescribed during his previous hospitalization. Upon auscultation, bilateral basal crepitation was also heard in both lungs.

Division of Nursing, Singapore General Hospital, Singapore

Corresponding author:

Nur Zarifah Binte Mustapha, Singapore General Hospital, 31 Third Hospital Avenue, Bowyer Block B Level 2, 168753, Singapore.
Email: nur.zarifah.mustapha@sgh.com.sg



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He had a medical history of Alzheimer's dementia, diabetes mellitus and hyperlipidemia and was followed-up by the hospital's geriatrician and outpatient practitioner. Premorbid, he was bedridden and dependent on his children for his daily living activities. Mr A married twice and had six children from his first marriage and no children in the second marriage. All his children were very concerned and committed to the care of their father. However, they had disagreements over deciding who should be the main caregiver.

Mr A's eldest daughter requested for Mr A to be discharged under her care. She claimed that she had been the main caregiver for Mr A over the past 10 years but was not informed of her father's current admission. She expressed concern about the incident as there were previous court proceedings over his guardianship.

Upon a comprehensive assessment, the PN identified the following care issues:

1. Infection related to the sacral pressure ulcer and aspiration pneumonia.
2. Malnourishment related to dysphagia (Mr A was commenced on enteral feeding).
3. No main caregiver for continuity of care.

The interventions included the following:

1. Coordinated family conference to identify the main caregiver. Mr A's children consented that the eldest daughter will be the main caregiver.
2. Trained the main caregiver on wound care and tube feeding.
3. Referred Mr A to a transitional home care team for home visits to ease transition from hospital to home.
4. Referred the patient to a home nursing team for care such as change of nasogastric tube and wound management in the home setting.

For a month after Mr A was discharged, the PN continued to follow-up with his daughter to check if she was coping well with her father's care at home. The daughter verbalized that the maid managed the wound dressing well and the home nursing team visited Mr A within a week after discharge. Mr A's sacral sore and his nutritional status had improved.

Case 2

Mrs B was admitted for an infection of her second-right toe. Medical records had shown a history of hypertension and diabetes mellitus. During the first interview, she appeared withdrawn. The PN continued to visit her daily during her hospitalization and subsequently, Mrs B felt comfortable enough to share her concerns.

Mrs B voiced that the infection was due to her diabetes getting out of control. She had financial difficulties and could not attend the regular medical checkups in the primary care clinics. She also stopped her insulin injections because she could not afford it. Mrs B was taken care of by her husband who had mobility problems and was undergoing medical treatment for his heart problems. The sole breadwinner in

the family was her 22-year-old son who earned about SGD \$700 a month as a part-time delivery man.

After the PN assessed Mrs B's situation, prompt referral to the medical social worker was made so that application for financial assistance could be initiated. However, during hospitalization, scan results revealed that she suffered from calcification of the arteries in the right leg, whereby surgery is the main line of treatment. The news was traumatic for Mrs B and she chose not to undergo surgery.

A few days later, Mrs B was readmitted and agreed to proceed with the surgery. After the surgery, the PN suggested that Mrs B should receive further rehabilitation at a community step-down institution, but the plan was rejected by Mrs B's husband for fear of incurring additional costs.

To ensure that Mrs B would be well cared for at home, the PN performed the following interventions:

1. Educated Mrs B and husband on the treatment and management of diabetes mellitus, including diet control, medication compliance, exercise, monitoring blood glucose level and recognition of hypoglycemia/hyperglycemia events.
2. Arranged for a home assessment by an occupational therapist. This was done to educate Mrs B's husband on home safety and to tailor subsequent education according to Mrs B's daily routine and home set-up.
3. Engaged the Department of Family Medicine (FMCC) for home consultation.
4. Arranged for home-based physiotherapy services. Mrs B had difficulty in mobilizing after the amputation and her husband was not physically strong enough to provide assistance.
5. Worked with the medical social worker to apply for funding support for home nursing services and the purchase of equipment such as a commode and wheelchair.

After Mrs B was discharged, the PN called Mrs B to enquire about her condition. Mrs B verbalized that she was visited by the medical team from FMCC and received a free commode and wheelchair from the hospital. However, she had discontinued her consultation with the Home Nursing Foundation in view of additional consultation charges. She chose to go to the polyclinic instead for wound dressing, which was subsidized under the Community Health Assist Scheme. Mrs B has since regained her physical functioning and is able to move around in a wheelchair independently at home and in the community.

Case 3

The oncology PN was called by a ward nurse to review an urgent case: "Please see this terminally ill patient who is not keen for hospice placement. The patient wants to go home, but he requires 100% oxygen." Mr C was a 52-year-old man with metastatic hepatocellular carcinoma admitted two weeks ago due to shortness of breath.

He was treated with intravenous antibiotics for pneumonia and assessed by the cardiovascular doctor with the

impression of congestive heart failure. His condition further deteriorated. The Palliative Medical Team reviewed him and asked to plan for discharge on the following day as Mr C wished to pass away at home.

The PN immediately arranged a meeting with Mr C's sister, the main spokesperson, to assess his family's psychosocial support. Mr C's wife was the main caregiver. He had a two-year-old son who was looked after by his parents. His wife had no experience in caregiving and would need additional help if Mr C wished to spend his last days at home.

The family was overwhelmed given the limited time to arrange for his care at home.

To ensure that Mr C received good end-of-life care at home, the PN performed the following interventions:

1. Arranged for home oxygen supply. Mr C required an oxygen supply from two combined oxygen concentrators.
2. Arranged the earliest available interim caregiver service to provide basic nursing care to the patient for a short period of time.
3. Referred Mr C to hospice home care service for symptom management and terminal care.
4. Trained Mr C's wife in the application of the fentanyl patch and the administration of subcutaneous injections for pain control.

Mr C's wife was calm and committed during the discharge preparation. The PN went through the important aspects of terminal care with the emphasis on observing breathing pattern, oral care and monitoring for possible terminal restlessness and chest rattle sound. The indications, doses and frequency of discharge medication were also taught to Mr C's wife. The hospice home care team was notified to provide care continuity at home. One hour after discharge, the PN was informed that Mr C had passed away peacefully at home. Although the family was sad about his demise, his wife thanked the nurses for coordinating the discharge and fulfilling his final wish.

Discussion

In Singapore, the PN is trained to coordinate care for patients in order to ensure their smooth transition from hospital to home. Depending on the targeted barriers, the specific tasks of the PN may include disease and health system education, assisting in financial assistance options, facilitating terminal discharge, referral to community resources, conducting family conferences to identify patients' and family's immediate concerns, monitoring of patients after discharge to evaluate the progress of recovery and facilitate access to the right level of care.

Literature suggests that the deployment of PNs can improve patient outcomes and can result in healthcare savings. In a community stroke navigation program, stroke

survivors reported improvement in community integration.⁴ Another recent study found that a PN intervention (hospital-based) among high risk, safety-net patients decreases readmission among older patients.⁵ Lakewood Hospital's pilot project, in which the PN worked with at-risk patients to reduce readmission and self-pay visits, resulted in savings of \$156,000 for the hospital in just 6 months.⁶

This case series is believed to be the first to illustrate the PN's work since its introduction into our healthcare system. Little is known about the outcome of the PN program and continued research is recommended to evaluate the PN's impact in Singapore.

Conclusions

The three case studies illustrated how PNs can help to better coordinate care with the aim of providing better, quicker and more convenient healthcare in the most appropriate setting.

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Conflict of interest

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