Capsule Commentary on Balaban et al., Impact of a Patient Navigator Program on Hospital-Based and Outpatient Utilization Over 180 Days in a Safety-Net Health System

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Complex case management offers an intuitive strategy for improving care for high-risk populations, particularly during hospital-to-home care transitions.[1] Unfortunately, however, complex case management has shown only modest benefits in rigorous evaluations.[1]

Nevertheless, research has begun to shed light on which approaches to complex case management offer the most promise. Specifically, the most effective programs seem to involve close, interpersonal interaction among care coordinators, patients, and primary care clinicians; a focus on care transitions; a component of medication management; and the targeting of patients amenable to intervention, such as the frail elderly.[2]

The study by Balaban et al.[3] in this week's *JGIM* adds important insights to this burgeoning literature.

In their study, Balaban et al. report 180-day outcomes of a randomized evaluation of a care transition intervention provided by unlicensed community health workers (referred to as "patient navigators"). These navigators identified hospitalized patients at risk for readmission, visited them prior to discharge, provided post-discharge phone calls, and offered support with medications, appointments, transportation, communication, and self-care. Among patients 60 years of age and older, there was a modest but significant reduction of 0.21 hospital-based encounters per patient, which was accompanied by an increase in ambulatory utilization in the first 30 days following discharge (presumably ambulatory visits substituted for avoidable re-hospitalizations). Paradoxically, however, among patients younger than 60, there was an *increase* of 0.79 hospital-based encounters per patient. The authors acknowledge that the explanation for this finding among patients <60—which was also observed in a previously published short-term analysis[4]—is not clear.

What can we learn from these results? First, this study supports the notion that unlicensed staff can provide meaningful support for high-risk patients, at least in certain settings. Other studies have also demonstrated this finding.[5]

Second, the contradictory results among patients ≥60 vs. those <60 underscore the differential impact of complex case management in different populations. Increasingly it seems that these programs are most effective among frail, older adults.[2]

Finally, it is clear that we are only beginning to understand the nuances of complex case management. This is a ripe area for future research!

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