

Chapter 7

Consensus Support for the Role of Patient Navigation in the Nation's Healthcare System

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Purpose of the Patient Navigation Consensus Paper

Patient Navigation was developed as an intervention to improve outcomes among medically underserved populations by addressing barriers to completing a health care goal [1]. As Patient Navigation underwent widespread implementation, both its definition and practice evolved to address diverse patient populations and needs, by various workforce members, in numerous settings. This chapter is intended to create a common understanding of Patient Navigation and the role it can play in the healthcare system. It is aimed mainly at supporting recommendations for healthcare policy changes (e.g., staffing) and also provides a framework for building broad support for support for Patient Navigators across the healthcare delivery system.

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The History of Patient Navigation

All people, regardless of socioeconomic level, education, race, or diagnosed disease, experience significant difficulties utilizing our complex systems of health care, thus Patient Navigation has the potential to benefit all. However, these difficulties are exacerbated among individuals facing complex chronic diseases as well as among vulnerable populations, making Patient Navigation even more important for those who experience numerous and challenging barriers [2]. In fact, research has demonstrated that Patient Navigation is most effective, and in many cases only effective, when targeted to populations with the largest barriers to care.

Patient Navigation can also serve to overcome barriers to health care and poor health outcomes that are exemplified among medically underserved populations. The Institute of Medicine issued a report entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, calling attention to disparities in quality care and access for racial and ethnic minorities and the uninsured [3]. The National Cancer Institute (NCI) defines “cancer health disparities” as “adverse differences in cancer incidence (new cases), cancer prevalence (all existing cases), cancer death (mortality), cancer survivorship, and burden of cancer or related health conditions that exist among specific population groups,” [4] which may be characterized by age, disability, education, ethnicity, gender, geographic location, income, or race.

To address such health disparities, Dr. Harold Freeman created the first Patient Navigation program in 1990 in Harlem, New York. Navigators were recruited from the local community and trained to help to get women into the health system early to eliminate barriers between the point of suspicious finding and diagnostic resolution and treatment [1]. The results of the program in Harlem were remarkable. Before Patient Navigation was introduced in Harlem, in a 22-year period ending in 1986, 708 patients (94% black) with breast cancer were treated at Harlem Hospital Center. All of these patients were low income and half were uninsured. Women were offered free and low-cost examinations/mammograms as well as Patient Navigation services to remove barriers to ensure timely diagnostic resolution and the start of treatment. During the project from 1990 to 1992, 1034 females and 102 males were screened, of whom 7 breast cancers and 1 cervical cancer were found and 87.5% of those navigated with suspicious findings completed the breast biopsy process and only 56.6% of non-navigated group [1]. After the Patient Navigation intervention, the results were dramatically different in a positive way for the Harlem patients. Of 325 breast cancer patients, 41% of the patients had early stage breast cancer (0 and 1), 21% of the patients had stage 3 and 4; and the 5-year survival rate was 70% compared to 54 and 56% for stage 1 and 2, respectively, before program implementation [1].

The federal government took notice of the marked improvement with the work of Patient Navigators in Harlem and passed the Patient Navigation and Chronic Disease Prevention Act (H.R. 1812) (“Patient Navigation Act”), which was signed into law by President Bush in 2005 [5]. This landmark legislation helped to put a

national reach to Patient Navigation by authorizing grant programs and by outlining six required responsibilities of nonmedical navigators including:

- Acting as liaisons by assisting in the coordination of healthcare services and provider referrals.
- Facilitating the involvement of community organizations in assisting individuals who are at risk for or who have cancer or other chronic diseases to receive better access to high-quality healthcare services.
- Notifying individuals of clinical trials and, on request, facilitating enrollment of eligible individuals in these trials.
- Anticipating, identifying, and helping patients to overcome barriers within the healthcare system.
- Coordinating with the relevant health insurance programs to provide information to individuals without health coverage.
- Conducting ongoing outreach to health disparity populations.

The goal of this effort was to design, implement, and evaluate replicable Patient Navigation programs targeting valuable populations. The Act defined Patient Navigation as “support and guidance offered to vulnerable populations with abnormal cancer screening or a cancer diagnosis with the goal of overcoming barriers to timely, quality care [6].” This Act authorized appropriations beginning in fiscal year 2006 and extending through the end of fiscal year 2010 [7]. Following this, in 2008, a U.S. Surgeons General collective issued a *National Call to Action on Cancer Prevention and Survivorship* and listed Patient Navigation one of the four priority areas the nation must embrace to make progress in the War on Cancer [8]. Lastly, with the passage of the Patient Protection and Affordable Care Act of 2010, the funding authorization for the Patient Navigation Act was extended through fiscal year 2015 as deemed necessary [9]. The Affordable Care Act (ACA) was a major step for Patient Navigation, reauthorizing Section 340a of the Public Health Service Act (Patient Navigator and Chronic Disease Prevention Act). The ACA mandates that insurance navigators help consumers navigate the health insurance marketplace. In addition, the ACA adds a requirement to ensure that all Patient Navigators meet minimum core proficiencies, to be defined by the Secretary of HHS [9].

Patient Navigation is explicitly mentioned in only one section of the ACA; however, the principles upon which the foundations of Patient Navigation are built can be seen throughout the act. The ACA provisions address four key issues imperative in reducing health disparities, all of which are amenable to increased implementation of Patient Navigation: prevention and early detection; healthcare access and coordination; insurance coverage and continuity; and diversity and cultural competency [10]. In 2012, the American College of Surgeons Commission on Cancer mandated that Patient Navigation is a standard of care that must be met by cancer programs seeking accreditation beginning in 2015 [11]. This requirement has led to a sharp increase in the number of cancer navigation programs in the country and, consequently, should increase the population of patients who will benefit from the proven ameliorative powers of Patient Navigation.

Research and Interest in Patient Navigation

In addition to the Harlem Hospital program, there have been other programs that have had demonstrable success with implementing Patient Navigation such as the Lincoln Medical and Mental Health Center, which saw a reduction in their colorectal cancer patient “no shows” from 67 to 10%, a decrease in time from initial appointment to treatment from 10 weeks to two weeks, and an increase in early detection by 50% [12]. This particular example also suggests that Patient Navigation holds potential for improving healthcare system efficiency and reducing costs (mitigating the negative time management and financial challenges associated with “no show” rates). Other successful Patient Navigation programs around the country are helping patients overcome financial, communication and systematic barriers [12]. “Overall, Patient Navigation programs are bringing about increases in screening, and adherence to diagnostic follow-up care after the detection of an abnormality [12].”

The National Cancer Institute Center to Reduce Health Disparities (NCI/CHCRD), the Health Resources and Services Administration (HRSA), the Centers for Medicare and Medicaid Services (CMS), the American Cancer Society (ACS), additional cancer advocacy organizations and even the pharmaceutical industry have all invested significant resources to fund Patient Navigation research and service delivery programs. This type of support has led to the growth of the field, and with continued support, the role of the navigator can become solidified as a permanent fixture in the health care professional space. As one example and as a result of the 2005 Patient Navigation Act, the NCI received \$20 million to launch the Patient Navigation Research Program (PNRP) [13]. With additional support by the ACS, nine trial sites around the country were competitively selected to test the efficacy of a Patient Navigation intervention, specifically whether Patient Navigation decreases the delay between suspicious findings on screening to diagnostic resolution, and from diagnosis to the beginning of treatment. Analysis of research data from the nine sites demonstrated enhanced quality of life for cancer patients, greater satisfaction with the healthcare system, and increased rates of treatment commencement among other findings supporting the efficacy of Patient Navigation. More than 25 peer-reviewed papers have been published since this multi-center national trial was initiated: the majority of reports show consistent positive effects of Patient Navigation on minimizing diagnostic and treatment delays and maximizing diagnostic resolution.

In October 2008, the Health Resources and Services Administration awarded \$4.8 million in total funding for six two-year projects with the intent to further investigate how Patient Navigators could improve health outcomes of patients battling chronic diseases [14]. HRSA awarded an additional ten Patient Navigation demonstration projects grants totaling \$7.8 million in 2010. The Patient Navigator Outreach and Chronic Disease Prevention Program (PNDP) grantees provided navigation services to 11,574 patients mainly recruited in clinical settings through the work of 104 navigators and reached over 26,000 people through community

outreach efforts such as health fairs, presentations, and educational sessions within various community settings that provided screenings and education about cancer and chronic diseases [14]. Navigators reported 52% of encounters involved coordinating healthcare services including scheduling and connecting patients to providers. Proactive navigation was also very common and a reported 45% of encounters dealt with follow-up and educating patients to ensure understanding of next steps in necessary health care [14]. Prior to the implementation of this program, at one site only 76% of patients clinic-wide kept scheduled appointments and patients who received navigation services increased to 100% attendance of scheduled medical appointments. By working to improve patients' health literacy and coordinating logistical aspects of care, navigators successfully delivered patient-centered care, proving Patient Navigator programs improve access, continuity, and effectiveness of care [14].

CMS already has a handful of community-based Patient Navigation programs through their Health Care Innovation Challenge Awards aimed at delivering better health, improved care, increased patient engagement, and lower healthcare costs [15]. Funded programs include the \$15 million grant for a cancer-specific Patient Navigation program, Patient Care Connect Program (PCCP), through the University of Alabama at Birmingham's Comprehensive Cancer Center. The results of the study indicate a dramatic trend toward a clinically significant reduction in healthcare utilization and Medicare costs, with substantial impact during initial phase, survivorship and the last six months of life [16]. Specific results during the PCCP implementation include a drop in hospitalization rates of 19.7% and ICU admission rates were dramatically reduced by 6% compared to 0.8% in the non-navigated group [16]. In terms of Medicare claims, there was a considerable reduction of overall cost in the navigated patient population from \$15,091 to \$8269 per patient per quarter, which is a Medicare savings of \$6822 per navigated patient; cost in the last six months of life decreased from \$23,735 to \$16,764 per patient for the navigated patient population, in comparison to the non-navigated group that increased from \$13,418 to \$15,544 [16]. CMS also funded a four-year \$5.4 million national Cancer Prevention and Treatment Demonstration Project to determine if Patient Navigation can reduce cost and mortality of Medicare beneficiaries by decreasing barriers to cancer screening, promoting early detection and timely diagnosis, and enhancing access to treatment of cancer to the clinical core of the University of Texas, M.D. Anderson Cancer Center [17]. Project Facilitated Assistance, Research, and Outreach Services (FAROS) targets older Latino Medicare beneficiaries where participants are enrolled and randomized into either the intervention group of facilitated screening or treatment services by a trained Patient Navigator, or the comparison group of usual cancer prevention or treatment care [17]. As of 2010, over 1100 patients have enrolled in Project FAROS and of 821 baseline surveys, 36% of the navigated group reported never having a colorectal cancer screening (CRCS) [18]. The findings from Project FAROS will provide a tailored Patient Navigation intervention, inform public policy makers to decrease barriers to CRCS specific to older Latinos, as well as examine the economic impacts of Patient Navigation services.

There continues to be national interest in research around the field of Patient Navigation. The Patient-Centered Outcomes Research Institute (PCORI), an independent organization authorized by Congress as a result of the ACA, has funded research on health disparities and funds projects that utilize Patient Navigation. This nonprofit, nongovernmental entity is established to promote comparative effectiveness research by identifying research priorities, establishing a research agenda, and providing funding to conduct research that targets outcome differences in racial ethnic, and sex subpopulations [19]. In 2012, PCORI established addressing health disparities as a research priority. In releasing its funding guidelines, it stated that one example of a fundable research project that intends to answer “How does the availability of a Patient Navigator for patients and/or caregivers improve patients’ health outcomes compared to usual strategies? Under what circumstances, or for what conditions, are Patient Navigators most effective [20]?” Currently, almost half of the projects funded by PCORI’s Addressing Disparities program include interventions containing a CHW-Patient Navigator component, and almost all of those projects target racial and ethnic minority groups [20]. There is already evidence to support Patient Navigation as a method to improve outcomes related to the screening and diagnosis of cancer [1, 6, 10, 12, 13, 16, 17].

Recognizing the value in the services of Patient Navigators, the American College of Surgeon’s Commission on Cancer (COC) and the Association of Community Cancer Centers have both placed an emphasis on the creation of Patient Navigation services [11, 21]. The COC guidelines actually require accredited cancer treatment facilities to have a Patient Navigation program by January 2015 or risk losing that status. There are currently over 1500 COC accredited facilities responsible for treating approximately 70% of the newly diagnosed cancer cases [22].

Moving Patient Navigation Forward

Patient Navigation has evolved over the years. It is being used in other chronic disease fields and now covers the entire cancer continuum from outreach (screening navigation) through diagnosis into treatment and through survivorship or end of life. Originating as trained lay community health workers helping patients overcome access to care barriers, the Patient Navigation field has grown into positions for health care professionals, including nurses and social workers, as well as highly trained outreach workers that help coordinate care for patients and to serve on a multidisciplinary team [23]. In fact, the Oncology Nursing Society, the Association of Oncology Social Work, and the National Association of Social Work have issued a joint position statement about Patient Navigation and its role as an essential component of cancer care services [24]. They agree that the navigation processes are “fundamental in nursing and social work” and that they both “enhance their professional knowledge and competencies with preparation in Patient Navigation

processes [24].” Additionally, there is support for including lay navigators (defined as a trained nonprofessional) with nursing and social work navigators as part of a multidisciplinary team. Patient Navigators, both professional and lay, enhance the healthcare team, as their primary role is to help the patient through the labyrinthine healthcare system and reduce or eliminate barriers to care. Some of the most common barriers patients face are geographic access to the clinic or hospital, identification and access to financial services, transportation and child care issues, fear and anxiety, medical mistrust, lost wages and language and cultural issues [23] (Fig. 7.1).

The evolution of Patient Navigation over the past 20 years has allowed for diverse patient needs to be addressed by varied workforce members across several diseases and settings and has led to improved outcomes for patients, which is also a benefit to the healthcare system. Notwithstanding, the presence of Patient Navigation is fragmented in the healthcare system and its contribution is consistently misunderstood. One example of this is in the discussion around the requirements for establishing the state health insurance exchanges under the ACA. The Department of Health and Human Services has set the requirement that states creating a state run exchange “must establish or have a process in place to establish and operate a Navigator program [25].” Most recently, in September 2015 CMS awarded \$67 million in Navigator Cooperative Agreement Awards to individuals and organizations to serve as navigators in federally facilitated partnership exchanges/marketplaces [26]. The goals of the program are to support the staffing of navigators who serve as insurance eligibility and enrollment specialists; provide information in a fair and impartial manner; facilitate the selection of a qualified health plan; provide referrals to the health insurance consumer assistance or state ombudsman; and provide culturally and linguistically appropriate information [27]. With the federal government’s continued support of cancer and chronic disease

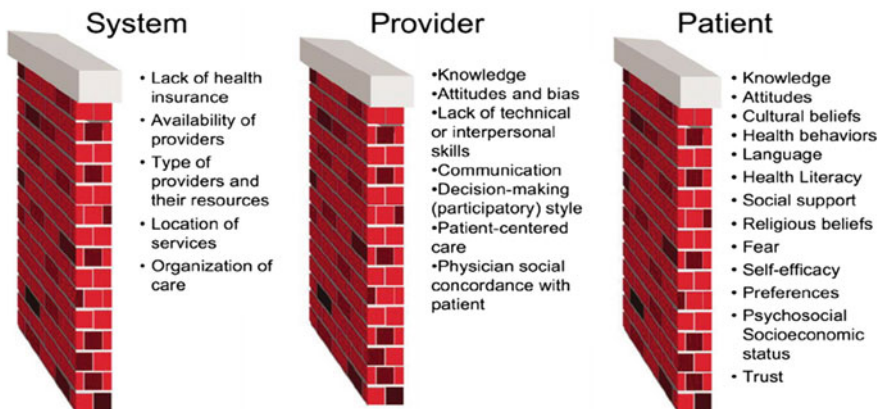


Fig. 7.1 Common barriers to care. Reprinted from *Seminars in Nephrology*, Vol. 33(5), Nicholas SB, Kalantar-Zadeh K, Norris KC. Racial disparities in kidney disease outcomes, Pages 409–15, Copyright 2013, with permission from Elsevier

Patient Navigation programs, it is uncertain why, in the creation of the state exchange guidelines, the term navigator was used for an insurance enrollment specialist. This inconsistent use of the term highlights the need for a clearly defined role of Patient Navigators.

Recommendation #1: Establish a Job Description and Recognized Job Code for Patient Navigators

Patient Navigation was established in 1990 and despite the growth of the field and several federally funded programs, the Department of Labor Standard Occupational Classification does not recognize the job title of ‘Patient Navigator’. This classification is used by Federal statistical agencies to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data [28]. One of the key challenges in Patient Navigation is the need to clearly define terms and roles to distinguish it from other health professions. Patient Navigation can be described as an intervention that assists individuals in overcoming barriers to timely access to the full continuum of quality healthcare. Although all individuals would benefit from Patient Navigation, it is a particularly effective intervention to reduce health disparities in cancer care when aimed at vulnerable or medically underserved populations and functions as a system [29]. Patient Navigation can include not only patients but also providers, families, and caregivers, and extend throughout the cancer continuum from prevention and screening through post-treatment and survivorship.

Given that the Patient Navigator role was born from using women in the community to help steer their peers into screening and care along the continuum, there still seems to be some confusion between the role of a Patient Navigator and a community health worker (CHW). While the term ‘Community Health Worker’ is often an umbrella phrase that includes among other roles, Patient Navigation, it was recently recognized with a Standard Occupational Classification after a recommendation by the Department of Labor, and it was also included in the ACA [9, 30]. A CHW is defined as one that “assists individuals and communities to adopt healthy behaviors, conducts outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health, provides information on available resources, provide social support and informal counseling, advocates for individuals and community health needs, provides services such as first aid and blood pressure screening, may collect data to help identify community health needs” [30]. Thus, at present it is widely recognized that the roles of Patient Navigators and CHWs are not identical, but are synergistic and complementary. To use a common metaphor, CHWs raise health awareness and focus more on moving people “to the front door” of needed health care, whereas Patient Navigators help people get “through the door” and through the labyrinthine healthcare system behind the door (Fig. 7.2). Patient

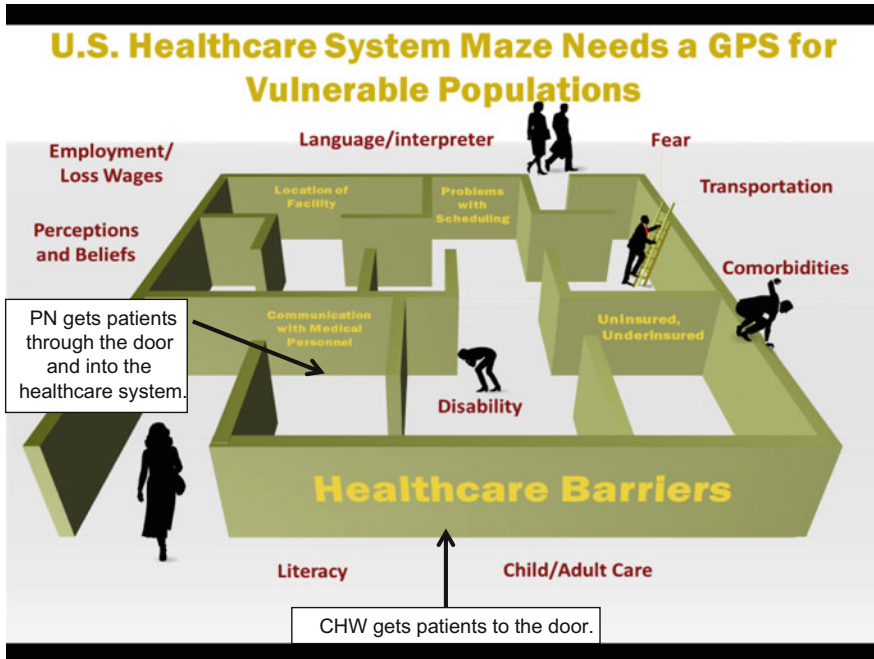


Fig. 7.2 The role of delineation between Patient Navigators and Community Health Workers. Reprinted from U.S. Department of Health and Human Services. Patient Navigation Research Program (PNRP). March 8, 2010. 45th Regular Meeting of the Board of Scientific Advisors Center to Reduce Cancer Health Disparities. U.S. Healthcare System Maze Needs a GPS for Vulnerable Populations. Available from: http://deainfo.nci.nih.gov/advisory/bsa/archive/bsa0310/presentations/915%20Chu%20Paskett%20Howerton%20%20BSA%20PNRP%20Presentation_3%205%2010_FINAL.pdf

Navigation is focused on helping people overcome barriers to health care, whether the barriers are structural (such as lack of insurance or transportation) or psychosocial (such as fear or medical mistrust).

While this lack of clarity in the healthcare system is not an uncommon occurrence because of some overlap in these roles, there are distinct differences that need to be made in order to move the field of Patient Navigation forward (Fig. 7.3). CHWs promote positive health behaviors in the community, use evidence-based interventions to educate community members, encourage appropriate health screenings, and can help people enroll in health insurance programs, among other tasks [31, 32]. The ACA of 2010 supports this definition of the role of the CHW as it provided grant opportunities from the CDC over 4 years to enhance programming efforts across the nation [31].

The role of Patient Navigation is different but complementary, as further delineated in another section of health reform legislation, supporting for Patient Navigation programs through HRSA demonstration projects [14]. There the role of Patient Navigation is explicit and in affirming that Navigators must: 1. Serve as a

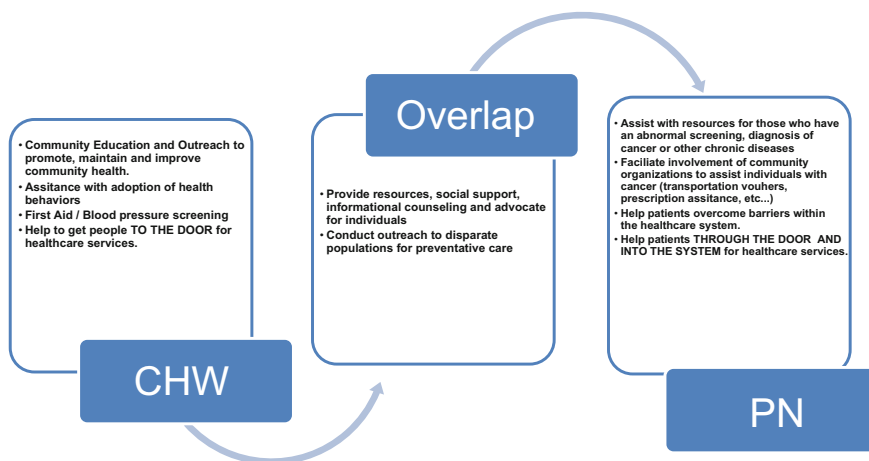


Fig. 7.3 Patient Navigation and Community Health Workers

contact for individuals who are seeking prevention or early detection services, or who following a screening or early detection service are found to have a symptom, abnormal finding, or diagnosis of cancer, or other chronic disease; 2. Facilitate the involvement of community organizations in assisting individuals who are at risk for cancer or other chronic diseases to receive better access to high-quality health services; 3. Notify individuals of clinical trials, and on request, facilitate enrollment of eligible individuals in these trials; 4. Anticipate, identify, and help patients to overcome barriers within the healthcare system to ensure prompt diagnostic resolution of an abnormal finding or cancer or other chronic disease; 5. Coordinate with the relevant health insurance ombudsman programs to provide information to individuals who are at risk for or who have cancer or other chronic diseases about health coverage, including private insurance, health care savings accounts, and other publically funded programs; and 6. Conduct ongoing outreach to health disparity populations, including the uninsured, rural populations, and other medically underserved populations, in addition to assisting other individuals who are at risk for or who have cancer or other chronic diseases to seek preventative care [33]. Implicit in this description of Patient Navigator functions compared to CHW's is that most Patient Navigators are employed by the health systems that they function within, whereas most CHWs are employed by municipal, county, or state agencies. It bears repeating: CHW's focus on getting people "to" the front door of a health system, whereas Patient Navigators focus on getting them "through" the complex healthcare delivery system.

The health care system continues to struggle with how to address health disparities, including access to care, quality of care, and high healthcare costs. Patient Navigation is one way to systematically address the fragmented healthcare system. However, although there are several highly effective training programs spread across the country, there are currently no standardized professional trainings with a

defined minimum core curriculum. Given that these positions often rely on grant funding, there can be high turnover and low job security. Since Patient Navigation services are not recognized as reimbursable, there is often little incentive to create a sustainable role in the community or healthcare institution they serve.

Recommendation #2: Create National Standards for Training and Certification of Patient Navigation

Currently there is an array of Patient Navigation programs across the country; however, there is also a lack of national standards for training. The existing navigation training programs include a range of interactive classroom instruction while others are online or use a mixed-method approach. The length can range from 160 classroom hours to six weeks to three days of instruction. These training programs vary in length, target audience, attendee requirement/pre-requisite, content focus, and mode of delivery. Along with these differences, Patient Navigators vary with educational and healthcare experience and it is imperative to establish an adequate preparation regardless of job title, patient population, disease condition, or practice setting that enables Patient Navigators to teach patients the individualized steps to take for successful navigation in the health system; patients can then gain the skills to take ownership of their health. This diversity has implications for the intricacy of curricula materials and methods of delivery for an accepted, definitive training program.

Although there is a lack of agreement on development and maintenance of effective Patient Navigator training programs, the dissemination of core competencies of training topics necessary to excel as a Patient Navigator can be derived from the NCI's PNRP, CMS, and ACS standardized programs [23]. All three programs employ Patient Navigators who are trained, culturally competent healthcare workers who help patients to subjugate barriers to access quality care and negotiate through the health system. Cumulatively, the programs developed the standardized curriculum of training topics based upon core competencies from current navigators and training experts at the nine PNRP sites, the NCI and the ACS in July 2006 [23]. These include an overview of health and cancer disparities and thus the inception of Patient Navigation; the varying roles, responsibilities, and programs for Patient Navigation; cancer overview with a focus on screening and treatment; culture and diversity; effective communication and client interaction skills; introduction to clinical research; health system mapping and community assessment; and resource management [23]. The training was delivered using interactive formats to target different learning styles through the use of traditional lecture, small group discussion, and roleplay with case scenarios.

Following this precedence, The Harold P. Freeman Patient Navigation Institute (HPFPNI) was established in 2007 to support the growth in Patient Navigation programs by offering standards and best practices of navigator training that are customizable for each program. The Institute, located in New York City, serves as a

gold standard of Patient Navigation and offers a certification upon completion of the two-day in-person training, which ensures programs uphold best practices and adhere to the peer-reviewed, recognized definition of Patient Navigation set forth by PNRP [34]. HPFPNI has trained over a thousand people the skills of successful Patient Navigators through the core principles such as informing the timely necessity of certain examinations, eliminating barriers to timely care across the healthcare continuum, and the critical function of overcoming barriers to timely diagnosis and treatment in patients with abnormal findings [34].

A training program that focuses on competencies enables individuals to be well prepared to perform their job duties in a real-world setting. Further, competency-based approaches facilitate multidisciplinary teams and programs that effectively work together to address the complexity of cross-cutting problems that are often experienced in a setting such as health care (Chapter 20). The previously described standardized Patient Navigator training program (ACS, CMS, NCI-PNRP) utilized the core competencies as a guide to develop a performance checklist, taking the first step toward an accepted definition of core competencies for navigators [23]. This checklist was adapted from Denver Health's CHW Competency Assessment Tool, which was designed to test proficiency as a CHW through skills-testing prior to graduating the program and earning the certificate [35]. The core curriculum for this CHW training program is performance based and addresses three areas of emphasis: workplace/academic core, vocational core, and cooperative education core/CHW field experience. The assessment tool contains elements of competencies and application of skills and knowledge presented during the training in real-world situations like basic interviewing skills, familiarizing the client with the agency, basic health needs assessment, health promotion and education, resource referral, and follow-up [35]. From the CHW assessment tool, the four broad areas adapted for the Patient Navigator checklist include client interaction; care management (health assessment and advising); intervention (referrals); and documentation [23]. The tool is given at the beginning of the CHW program and used as a reference throughout the training to develop and support effective competencies.

Established competencies for similar fields to Patient Navigation are currently the foundation for accreditation or certification at either state or national levels (Chapter 20). As of October 2014, Illinois House bill 5412 defines CHW's core competencies and roles and focuses on developing a certification process; in Texas and Indiana, the state health departments are the accrediting body for the CHW training programs [31]. Texas, Ohio, and Minnesota require a certification of CHWs to cover services. Additionally in Indiana and Alaska, only programs that provide standardized CHW training are allowed to pay for CHW professionals. However, the New Mexico Senate bill 58 allows for voluntary CHW certification [31]. Minnesota and Massachusetts have both taken comprehensive approaches to implement systems of policy change to build capacity for an integrated and sustainable CHW workforce; Patient Navigation can use CHWs as a model to determine the necessity of credentialing or State certification [31].

By ensuring the stewardship of scarce resources, training in core competencies (Chapter xx), and acquisition of basic skills and knowledge [23], a national training and certification program using established national standards can propel the field of Patient Navigation to the next level by establishing and securing the importance of this role in the health care system.

Recommendation #3: Demonstrate the Usefulness of Patient Navigation on Improving Healthcare Quality

The ACA called for a national strategy to improve the delivery of healthcare services, patient health outcomes and population health [9]. The National Strategy for Quality Improvement in Health Care (the National Quality Strategy) established three aims and six priorities for quality improvement [36]. The aims of the Strategy are to (1) improve the overall quality of care by making care more patient-centered, reliable, accessible, and safe; (2) improve the health of the US population by supporting proven interventions to address behavioral, social, and environmental determinants of health; and (3) reduce the cost of quality healthcare [36]. To advance the aims, six priorities were set through a participatory process of national stakeholders: (1) making care safer by reducing harm caused in the delivery of care; (2) ensuring that each person and family are engaged as partners in their care; (3) promoting effective communication and coordination of care; (4) promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; (5) working with communities to promote wide use of best practices to enable healthy living; and (6) making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models [36] (Fig. 7.4). Five out of six of these priorities clearly align with the goals of Patient Navigation with synergistic efforts of CHWs, as outlined in priority five, to work within communities to enable healthy living and assist people to needed and available health care.

In the 2012 Annual Report to Congress, the National Quality Strategy provided long-term goals for each of its established priorities. One of these goals for engaging patients and families is to enable patients and their families and caregivers to navigate, coordinate, and manage their care appropriately and effectively [36]. Two of the long-term goals for promoting effective communication and coordination of care include: improving the quality of care transitions and communications across care settings and establishing shared accountability and integration of communities and healthcare systems to improve quality care and reduce health disparities [36]. Clearly, the role of a Patient Navigator can help achieve these important goals.

In terms of the priority for promoting the best prevention and treatment practices for the leading cause of mortality, the strategy is choosing to first focus on cardiovascular disease; it may be beneficial for Patient Navigators to play a role in achieving the goals for this chronic disease. Following a cardiac event or procedure,



Fig. 7.4 Roles of Patient Navigators

awareness of and enrollment in outpatient cardiac rehabilitation (OCR) remains suboptimal and the use of a Patient Navigation is a proven practice and intervention to improve these outcomes. Minority women receive 12% fewer referrals than white women for OCR following hospital discharge for a cardiac event, illustrating a major health disparity that can be eliminated through Patient Navigation [37]. Compared to usual care, participants receiving navigation were six times more likely to have an awareness of OCR and of those patients proved nine times more likely to enroll in OCR following hospital discharge [38].

Lastly, with the priority of making quality care more affordable, the goal is to ensure affordable and accessible quality healthcare for all. Clearly it is important to look into payment reforms and establishing common measures to assess the costs impacts of new programs and payment systems. There is an opportunity here to build on the work of the PNRP and CMS programs, which have begun to address the question of cost-effectiveness of Patient Navigation, as well as the success of the CHW model as guidance in moving this goal forward.

In addition to coalition building among service providers, local and state governments, professionals and the community, CHWs have made significant advancements in several states by integrating their work into the healthcare system through the use of empirical evidence. In Minnesota, the Community Health Worker Alliance successfully lobbied the state legislature by demonstrating the Return on Investment (ROI) of paying for training and education of CHW's relative

to the benefit to the community [39]. In Massachusetts, CHWs helped more than 200,000 uninsured people enroll in health insurance programs, when the state health law reform took effect [39]. A study of CHWs found that they increased access to primary care through culturally competent outreach and enrollment and improved quality and cost-effectiveness of care by assisting patients with self-management of chronic diseases [40]. However, the financing of these workers can be diverse. In Alaska, CHWs are funded by the corporations that employ them. In Massachusetts, funding comes from the state budget; while in Minnesota and Indiana, the work of the CHW is reimbursable under the state Medicaid programs [39]. Patient Navigation programs can learn from these models of engaging stakeholders, developing national standards for training programs and accreditation in order to enhance their role on a multidisciplinary team and solidify their presence in the healthcare delivery system.

With a national priority on quality improvement in healthcare, Patient Navigation is poised to promote a more patient-centric health care service delivery model, integrate a fragmented health care system for the benefit of the patients, and eliminate barriers to timely and appropriate care and thus reduce the cost of quality care. As we move to value-based care, the payment mechanisms will allow for Patient Navigators to be part of the team in the bundled payment models.

Recommendation #4: Support Research in Patient Navigation

With the current national focus on patient-centered care, it is important to consider developing additional research and validated patient-reported outcome metrics since patients have stated that Patient Navigators are effective because they provide emotional support, as well as information and assistance with problem-solving. Now there is an opportunity to evaluate the impact of Patient Navigation in improving cancer outcomes beyond the detection and diagnosis phase of care.

The National Cancer Institute (NCI) Community Cancer Centers Program is a network of hospital cancer centers that serves as a community-based platform to support basic, clinical, and population-based research initiatives across the cancer care continuum—from prevention, screening, diagnosis, treatment, and survivorship through end-of-life care [41]. In 2007, the NCI provided funding to 16 community cancer centers at hospitals around the country for a pilot program called the NCI Community Cancer Centers Program (NCCCP). The pilot was designed to build a community-based research platform to support a wide range of basic, clinical, and population-based research on cancer prevention, screening, diagnosis, treatment, survivorship, and palliative care at community hospitals—contributing to enhanced quality of care for patients and advancing cancer research. On August 12, 2009, the NCCCP received funding through the NIH Evaluation Office to conduct a comparative analysis of NCCCP sites with comparable community cancer centers external to the NCCCP [42]. Increased quality of care among NCCCP sites was significantly greater than that among comparison-group hospitals for radiation

therapy after breast-conserving surgery and hormonal therapy for women with hormone receptor-positive breast cancer. In multivariate regressions, increases in hormonal therapy among NCCCP-site patients were significantly greater than those among comparison-group hospitals [43]. As a result of funding from the American Recovery and Reinvestment Act (ARRA) in 2010, the NCCCP expanded the original pilot network from 16 to 30 hospitals in 22 states. A new evaluation is planned for the 14 additional sites [43]. This analysis will build on the ongoing evaluation by understanding how the NCCCP has enhanced cancer care delivery to patients. NCCCP cancer centers promote multidisciplinary cancer care that is patient-centered, data-driven, evidence-based, and delivered through coordinated teams of physicians, Patient Navigators, and staff in a community setting.

Although Patient Navigation has mostly been used in oncology, it does not need to be limited to cancer. In response to CMS's quality improvements initiatives (QI) such as imposed financial penalties to hospitals with high 30-day readmission rates, PCORI awarded \$2 million for their project PArTNER, Patient Navigator to Reduce Readmissions, to African American and minority-serving institutions, who provide care for patients with limited social support, health literacy and contribute most to readmission rates [44]. Tailoring to the needs of the patients they serve, navigators personally visit during hospitalization and at home post-discharge to provide social support and self-management skills training, followed by ongoing patient/caregiver-led telephone support, which timely has great potential to impact QI [44]. In 2014, PCORI awarded over \$1.8 million to address chronic hepatitis B virus (HBV) infection (CHB) rates in Asian Americans, the highest in the US and the largest health gap compared to white Americans. Using Patient Navigators plus mobile phone text messaging intervention compared to usual care, this study hopes to improve timely testing every 6–12 months for patients at high risk for complications and early signs of liver problems [45].

Recommendation #5: Explore Reimbursement Models for Patient Navigation

Given the growth of the field of Patient Navigation and its potential impact on the health system for not only cancer, but other chronic diseases as well, it is important to explore reimbursement models for the services provided by Patient Navigators. The goal for Patient Navigation would be permanent integration into the healthcare delivery system and recognition as a covered service for both public and private payers. There are two important models to consider as guidance for pursuing reimbursement models: diabetes educators and CHWs.

In 1997, the federal government made some important changes to Medicare in the Balanced Budget Act of 1997. Not only was coverage for some clinical cancer screening services expanded, but it also extended coverage to include diabetes self-management [46]. This expansion covered diabetes self-management education and training when provided to an individual with diabetes by a certified provider in

an outpatient setting [46]. Physicians providing care to the patient must certify that the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide the patient with diabetes self-management skills and knowledge [46]. The training must be completed by a “certified provider” defined by Medicare as “a physician, other individual or entity paid under Medicare’s physician fee schedules who meets the National Diabetes Advisory Board (NDAB) standards [47].” Medicare must actually receive a copy of the certified provider’s Education Recognition Program (ERP) certificate from the American Diabetes Associate (ADA) before any claims can be submitted for this service.

Given the evolution of the research, standardized training and the impact on patient outcomes, diabetes education, and training is now a reimbursable expense for both public and private payors. As of mid-2016, 46 states and the District of Columbia have some law that requires health insurance policy coverage for diabetes treatment. Laws in Mississippi and Missouri require only that insurers offer coverage, but not necessarily include the coverage in all active policies. Most states require coverage for both direct treatment and for diabetes equipment and supplies that are often used by the patient at home [48]. Both private insurance and public insurance offer billing codes for the services of the diabetes educator in increments of 30–60 min [47].

Congress also created the CMS Innovation Center under the ACA, giving the Center the authority and direction to “test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care” for those who get Medicare, Medicaid, or CHIP benefits [9]. The Center’s mandate gives it great flexibility in selecting and testing innovative payment and service delivery models, enables the Center to work with Medicare, State Medicaid, and CHIP programs to better serve beneficiaries, and provides \$10 billion in direct funding in fiscal years 2011 through 2019 to support this mission. It also allows the Secretary of Health and Human Services to expand, through rulemaking, the scope and duration of models proven effective after evaluation, including implementation on a nationwide basis to cover the entire Medicare, Medicaid, or CHIP populations.

In September 2012, H.R. 6521 was introduced at the federal level to “provide payment for Patient Navigator services under title XIX of the Social Security Act” [49]. The Bill, which called for reimbursement of “any Patient Navigator service” as specified by the Patient Navigation Act, provided to a Medicaid beneficiary, however, did not pass [49], as well as the more recently proposed Patient Navigation Assistance Act of 2014 that amended title XIX of the Social Security Act—otherwise known as Medicaid—to require that state Medicaid plans provide reimbursement for Patient Navigation services [17]. As Medicaid provides coverage to minority and low-income individuals this would be a particularly innovative way to target the population most in need of Patient Navigation services in the context of a complex, changing healthcare environment. Patient Navigators can not only facilitate improved healthcare access and quality for underserved populations through advocacy and care coordination, but they can also address deep-rooted issues related to distrust in providers and the health system that often lead to avoidance of health problems and non-compliance with treatment recommendations [50].

Similar to the evolution for the reimbursement of diabetes educators, CHWs are starting to follow suit with reimbursement efforts for the services. Leading the way is the state of Minnesota. However, before the state legislature took action, Minnesota committed to a statewide initiative whose mission was to reduce cultural and linguistic barriers to health care, improve quality and cost-effectiveness of care, and increase the number of healthcare workers who come from diverse backgrounds or underserved communities [51]. The project of the initiative developed a standardized curriculum to educate CHWs in Minnesota; developed professional standards for CHWs that define their role in the healthcare delivery system; created a sustainable employment market, incorporating CHW's into the healthcare workforce; and demonstrated that trained CHWs are effective, and that a CHW's time with a patient is a billable/reimbursable valued service [51]. As a result of advocacy efforts to the state legislature, the service of CHWs became eligible for reimbursement [52]. The work being done in Minnesota is also groundbreaking in that the state Medicaid program covers reimbursement for the work being done by CHWs. In order to qualify for reimbursement, the CHW must complete the state's fourteen-credit certificate program and at that point, are eligible to enroll in the Minnesota Health Care Plan as a Medicaid provider authorized to serve under supervision of approved billing providers [39].

Patient Navigation can also learn from both the diabetes educator and CHW paths towards reimbursement. In recent years, several states have bundled payments for CHWs as part of non-clinician members in care teams. The same can be extended to Patient Navigators depending on the care delivery model used and the risk appetite of the physicians and healthcare organizations. Patient-centered medical homes and ACA Section 2703 Health Homes are two popular care delivery models pursued by state Medicaid programs for reimbursing community health workers [9]. Under these models, physician practices and healthcare organizations develop care teams by recruiting new staff or training existing staff such as nurses and medical assistants for patient education, care coordination, and population health monitoring. The care teams are typically reimbursed on a per-member-per-month basis by Medicaid, Medicare, and state's commercial insurers. Health Homes established under Section 2703 of the ACA, which serve Medicaid beneficiaries with two or more chronic conditions or persistent mental health condition are also eligible to receive an enhanced federal match for the services delivered in the first 8 quarters of implementation [53]. As of March 2014, 47 states had implemented medical homes or health homes. Patient Navigation services can be delivered as part of these medical homes to help enrollees navigate the healthcare system. Other care delivery models in which CHWs and Patient Navigators can be incorporated and reimbursed include accountable care organizations (ACO) and shared community-based resources. Under shared resources programs, state Medicaid reimburses for resources shared by multiple practices and organizations to coordinate care. Size of these shared resource teams range from single care managers to large inter-disciplinary teams, and they are often reimbursed using a per-member-per-month rate. Accountable care organizations (ACO) are typically responsible for providing care across a variety of settings

including primary care and acute care. Since ACOs need to provide culturally appropriate support to members for navigating the healthcare system, they typically include community health workers and potentially Patient Navigators. Payments for non-clinician members such as CHWs and Patient Navigators can be bundled into payment strategies for ACOs which includes one of the following [54]:

- One-Sided Shared Savings—Modified fee-for-service model in which care teams share a portion of the savings, but not the losses.
- Two-Sided Shared Savings—Modified fee-for-service model in which care teams share both benefits (portion of savings) and losses.
- Bundled payments—Care teams are reimbursed single payment for one episode of care for a patient, which might include multiple services.
- Partial capitation/global payments—Care teams receive partial capitation payment for certain services
- Global payments—Care teams receive fixed monthly or annual payment per patients (per-member-per-month) regardless of services provided.

Implications/Conclusion

The momentum in health care is to improve quality and access to care as well as empower patients to have a leading role in their care. Given the decades of experience and data collected in Patient Navigation programs, it is clear that this role is critical in addressing the healthcare disparities that plague our society.

With policy initiatives in job classification, certification and training, quality and research, Patient Navigation can continue to grow as an integral part of the healthcare delivery system. The ACA reauthorizes Section 340a of the PHSA, the Patient Navigator and Chronic Disease Prevention grants for five more years through 2015 [9]. There was an additional important requirement added to this revision, which states that in order for an entity to receive a grant, it must ensure the navigators meet minimum core proficiencies tailored to the specific intervention [9]. While authorization levels beyond fiscal year 2015 were not specified, it is imperative that the advocates integrate Patient Navigation into the fabric of the healthcare delivery system across the country.

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