



Washington, D.C. 20201

SEP 03 2015

The Honorable Joseph R. Biden, Jr.
President of the Senate
Washington, DC 20510

Dear Mr. President:

I am pleased to provide you with the report on the Patient Navigator Outreach and Chronic Disease Prevention Program. This report was prepared by the Health Resources and Services Administration.

In 2005, Congress passed the Patient Navigator Outreach and Chronic Disease Prevention Act (P.L. 109-18) that created Section 340A of the Public Health Service Act, which was later amended by the Affordable Care Act (P.L. 111-148). Section 340A authorizes a demonstration grant program to develop and implement patient navigator services to improve health outcomes for individuals with cancer or other chronic diseases, with a specific emphasis on health disparities populations.

This report provides information on how the program was implemented and outcomes related to the statutorily-defined patient navigator duties, as well as options that can inform future patient navigator program development.

I hope you find this information useful.

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Enclosure



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

The Honorable Patty Murray
Ranking Member
Committee on Health, Education, Labor
and Pensions
United States Senate
Washington, DC 20510

SEP 03 2015

Dear Senator Murray:

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The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

SEP 03 2015

Dear Representative Pallone:

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The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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The Honorable John Boehner
Speaker of the House of Representatives
Washington, DC 20510

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Washington, D.C. 20201

SEP 03 2015

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor
and Pensions
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

I am pleased to provide you with the report on the Patient Navigator Outreach and Chronic Disease Prevention Program. This report was prepared by the Health Resources and Services Administration.

In 2005, Congress passed the Patient Navigator Outreach and Chronic Disease Prevention Act (P.L. 109-18) that created Section 340A of the Public Health Service Act, which was later amended by the Affordable Care Act (P.L. 111-148). Section 340A authorizes a demonstration grant program to develop and implement patient navigator services to improve health outcomes for individuals with cancer or other chronic diseases, with a specific emphasis on health disparities populations.

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**Department of Health and Human Services
Health Resources and Services Administration**

**REPORT TO CONGRESS
Patient Navigator Outreach and Chronic Disease
Prevention Program
Fiscal Years 2008-2012**

Executive Summary

Introduction

In 2005, Congress passed the Patient Navigator Outreach and Chronic Disease Prevention Act, Public Law 109-18, creating Section 340A of the Public Health Service Act (42 U.S.C. 256a), which was amended by the Affordable Care Act, Public Law 111-148, Section 3510. Section 340A authorized a demonstration grant program to develop and implement patient navigator services to improve health care outcomes for individuals with cancer or other chronic diseases, with a specific emphasis on serving health disparity populations. Patient navigators assist patients in identifying and overcoming barriers to care, and they typically live in the communities they serve.

Initial funding for the Patient Navigator Outreach and Chronic Disease Prevention Program (PNDP) began in fiscal year (FY) 2008. The Affordable Care Act reauthorized the program through FY 2015 and revised the statutory authority by requiring core proficiencies for patient navigators and a 4-year time limit on grants. New 3-year awards for PNDP grantees were made in FY 2010. Grantees received their second year of funds in August 2011 (FY 2011). However, no funding was appropriated for the program in FY 2012, so the program ended in August 2012 after the second year of the grants was completed.

Purpose of this Report

This report includes descriptive quantitative information on navigator activities, information on populations served by the funded grantee projects, characteristics of the grantee projects, and a discussion of findings and implications that can inform the development of future patient navigator programs.

Statutorily Mandated Navigator Duties

The statutory authority requires that patient navigators perform the following six duties:

- 1) Act as contacts, including assisting in the coordination of health care services;
- 2) Facilitate the involvement of community organizations;
- 3) Notify individuals of clinical trials;
- 4) Anticipate, identify, and help patients overcome barriers within the health care system;
- 5) Coordinate with relevant health insurance ombudsman programs; and
- 6) Conduct ongoing outreach to health disparity populations and individuals who are at risk for, or who have cancer, or other chronic diseases.

Implementation

In FY 2008, the Health Resources and Services Administration (HRSA) awarded six PNDP grants with 2-year project periods, providing a total of \$4.8 million over FY 2008 and FY 2009.¹ In FY 2010, HRSA awarded 10 PNDP grants with 3-year project periods, providing a total of \$7.8 million over FY 2010 and FY 2011. However, funding for the PNDP was not appropriated in FY 2012, and the program implementation and evaluation ended in August 2012, after the second year of the grants was completed.

The PNDP provided grants to local organizations to recruit and train patient navigators, and to provide navigation services. The patient navigators provided navigation services to at least 11,574 patients and provided health education and screening to more than 26,000 people. The grantees implemented the six statutorily-prescribed navigator duties, with most actions involving coordinating health care (52 percent) and/or assisting with removal of barriers to care (34 percent).² Most grantees identified and implemented an additional key navigation duty of “proactive navigation,” which involved encouraging patient self-management and helping the patient work with the health care system generally, rather than focusing on a specific barrier to medical care. The patient navigators belonged to different ethnic, racial, cultural, and linguistic groups, but all were experienced in working with members of their local communities. Of the 104 navigators, 89 percent were female, 67 percent were multilingual, and 52 percent had no college degree.

The patients who received navigation services meet the criteria of a health disparity population, as required by the statute.³ For the PNDP, a health disparity population was defined not solely by race or ethnicity but by socioeconomic factors that limited their access to quality preventive and ongoing health care. For example, a high proportion of navigated patients had no health care coverage because they did not qualify for Medicaid and had no access to other affordable health care coverage. For the patients receiving services through the PNDP – 56 percent had not graduated from high school, 73 percent were Black or African-American or Hispanic or Latino, 53 percent spoke English as a second language, 46 percent had no health care coverage, and 83 percent had annual household incomes under \$20,000. In addition, 59 percent of patients had at least one comorbid⁴ condition in addition to the condition for which they were receiving navigator services.

¹ In FY 2009, HRSA funded two additional 1-year grants from the FY 2008 competition with a total of \$656,000. These grantees were not included in the data reporting program and are therefore not included in this report.

² Based on data from grantees in the initial funding period.

³ For this program, the term health disparity population is defined in statute to be “a population that, as determined by the Secretary, has a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates as compared to the health status of the general population.”

⁴ Comorbidity is the presence of one or more additional disorders (or diseases) co-occurring with a primary disease or disorder; or the effect of such additional disorders or diseases.

Findings

Findings of this demonstration program suggest that patient navigator programs are a promising intervention for improving prevention and treatment of a range of chronic conditions for patients in underserved populations. By enhancing patients' health literacy, coordinating logistics of care, and providing patient-centered input to health care providers, navigator programs may improve access to health care and the continuity and effectiveness of health care. As a result, successful patient navigator demonstration programs and partnership arrangements such as the PNDP could be expanded to improve patient outcomes in other public health areas across the nation. To be most effective, new navigator interventions will need to be tailored to the needs of specific patient populations. Further investigation is needed to identify these effective strategies, to estimate the benefits of patient navigators, and to determine patient navigator core competencies.

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Acronym List

FQHC	Federally Qualified Health Center
FY	Fiscal Year
HbA1c	Hemoglobin A1c
HRSA	Health Resources and Services Administration
PCP	Primary Care Provider
PHS	Public Health Service
PNDP	Patient Navigator Outreach and Chronic Disease Prevention Program

I. Legislative Language

This report is being provided to Congress as required by Section 340A(j) of the Public Health Service (PHS) Act (42 U.S.C. 256a), which was amended by the Affordable Care Act, Public Law 111-148, Section 3510. The legislation required that the Report to Congress include an evaluation of program outcomes; analysis of measures; aggregate information about patients served and program activities; and recommendations on whether patient navigator programs could be used to improve patient outcomes in other public health areas.

II. Introduction

The Health Resources and Services Administration's (HRSA) Patient Navigator Outreach and Chronic Disease Prevention Program (PNDP) provided grants to local organizations to recruit and train patient navigators, and to provide navigation services in an effort to improve health care outcomes for individuals with cancer or other chronic diseases. The following examples are just two of the program's many successes.

A 76-year old married man diagnosed with cancer had 80/20 insurance coverage. When he received the bill for his 20 percent co-pay, he knew that he and his wife would be unable to pay. He decided that he had lived a long life and would stop treatment immediately. The navigator visited the family and asked about supplemental insurance coverage. The wife had a supplemental policy that stated on page 5 that "this policy may be applied to the spouse." The navigator contacted the insurance company and confirmed the coverage. Two weeks later, the family received a check for \$6000 and the man decided to continue treatment for his cancer.

An elderly woman was referred for diabetes education because her blood sugar was poorly controlled with insulin. The patient navigator evaluated the patient's skill at administering insulin and observed that she drew the dose incorrectly on 2 out of 2 trials. The navigator contacted the physician who prescribed an insulin "pen" and the navigator instructed the patient on its use. The patient "dialed the pen" correctly on 3 out of 3 trials and self-delivered the correct dose of insulin.

Patient navigators may be known by several different names including Community Health Workers or *Promotore(a)s*, peer educators, and lay health advisors. Navigators are trained front-line health care workers who come from, and therefore have a detailed knowledge of, the communities they serve. They act as educators, advocates, and as an intermediary between health care systems and the community and facilitate access to care, increase the quality of care, and improve health outcomes. Navigators build community self-sufficiency through outreach,

advocacy, and other supportive activities that build on their existing ties with community networks.⁵

By coordinating health care services and patient education, navigators assist patients in identifying and overcoming barriers to health care. These barriers are pronounced for individuals from health disparity populations. Patient navigators assist vulnerable individuals in accessing timely high-quality care. If the practice of navigation is more widely adopted, these benefits could improve community and public health outcomes.

This report fulfills a requirement of section 340A of the PHS Act. Section III of the report provides an overview of the PNDP. Section IV of the report describes program implementation by HRSA, including program activities, navigator characteristics, and training. Section V of the report describes outcomes and impacts of the program including the six statutorily-defined patient navigator duties. Section VI describes some factors that could support the future use of patient navigator programs to improve patient outcomes in other public health areas.

III. Overview

Section 340A of the PHS Act authorizes a demonstration grant program to develop and implement patient navigator services to improve health care outcomes for individuals with cancer or other chronic diseases with a specific emphasis on serving health disparity populations. The statute defines a health disparity population as one that has a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates as compared to the health status of the general population.

The statute requires that the PNDP grantees recruit, assign, train, and employ patient navigators who have direct knowledge of the communities they serve. The patient navigators were required to facilitate the care of individuals by performing the following six duties:

- 1) **Act as contacts, including assisting in the coordination of health care services** (such as screening clinics, diagnosis centers, treatment facilities, and clinical trials) and provider referrals 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 or who have cancer or other chronic diseases to receive better access to high-quality health care services (such as by creating partnerships with patient advocacy groups, charities, health care centers, community hospice centers, other health care providers, or other organizations in the targeted community).

⁵ Community Health Workers Toolkit, updated April 2014, Accessed September 23, 2014.
<http://www.raconline.org/communityhealth/chw/files/community-health-workers-toolkit.pdf>

- 3) **Notify individuals of clinical trials** and, on request, facilitate enrollment of eligible individuals in these trials.
- 4) **Anticipate, identify, and help patients overcome barriers within the health care system** to ensure prompt diagnostic and treatment resolution of an abnormal finding of cancer or other chronic disease.
- 5) **Coordinate with relevant health insurance ombudsman programs** to provide information to individuals who are at risk for or who have cancer or other chronic diseases. Information topics include health care coverage, including private insurance; health care savings accounts; and other publicly funded programs such as Medicare, Medicaid, health programs operated by the Department of Veterans Affairs or the Department of Defense, the State Children's Health Insurance Program, and any private or governmental prescription assistance programs.
- 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.

IV. Implementation of the Patient Navigator Program

The PNDP provided grants to local organizations to recruit and train patient navigators, and to provide navigator services to reduce barriers to care and improve health care outcomes. Patient navigators have beneficial effects on health status and psychological well-being by improving patient-provider communication and encouraging specific behaviors, such as exercise, healthy eating, follow-up care, and social engagement.⁶

The PNDP was implemented as part of these nationwide efforts. In Fiscal Year (FY) 2008, HRSA awarded six PNDP grants with 2-year project periods, providing a total of \$4.8 million over FY 2008 and FY 2009.⁷ In FY 2010, HRSA awarded 10 PNDP grants with 3-year project periods, providing a total of \$7.8 million over FY 2010 and FY 2011. However, no funding was appropriated for the PNDP in FY 2012, and the program implementation and evaluation ended on August 31, 2012, after the second year of the grants was completed.

In this report, initial funding of the PNDP in FY 2008 is referred to as the first funding period and funding in FY 2010 is referred to as the second funding period. Two grantees from the first

⁶ See the Stanford Patient Education Research Center's Chronic Disease Self-Management Program's compendium of evidence. Accessed June 20, 2014. Available at: http://patienteducation.stanford.edu/research/Review_Findings_CDSMP_Outcomes1%208%2008.pdf.

⁷ In FY 2009, HRSA funded two additional 1-year grants from the FY 2008 competition with a total of \$656,000. These grantees were not included in the data reporting program and are therefore not included in this report.

funding period also were awarded funding for the second funding period. Thus, a total of 14 unique PNDP grants were implemented and evaluated.

Navigator Characteristics

The program included 104 patient navigators who provided navigation services across the 14 grantees. The grantees recruited navigators from varied ethnic, racial, cultural, and linguistic backgrounds who were experienced in working with members of their local communities. Interviewed grantees agreed that having a health education or community health worker background and being a member of the community in which the program is implemented are essential characteristics of the successful navigator. As shown in Table 1, most navigators were female, Hispanic or Latino, and fluent in more than one language.

Table 1 - Select Navigator Characteristics

	Average Age	Female %	Hispanic/Latino %	Black/African-American %	No College Degree %	Nursing Degree %	Medical Asst./Nurse's Aide %	Multilingual %
Overall	40	89	50	17	52	9	29	67

Source: PNDP grantee performance reporting systems (Retrieved 2012). Includes data from the first and second funding period.

Navigator Training

Initial navigator training lasted from 1 to 7 weeks and focused on education about the population-relevant disease(s) and the procedures that were relevant to the process of navigation. The training programs commonly involved four components: (1) communication, (2) health systems, (3) community resources, and (4) disease management. Navigators also received weekly group or personal supervision, and many grantee organizations also provided additional training as needs were identified. For 12 of the 14 grantees, navigators received formal training in motivational interviewing, which is a directive patient-centered counseling technique that helps patients identify health-related choices and examine related consequences.

Some grantees trained navigators in providing pharmacy and health care coverage assistance, while other grantees trained navigators on where to refer patients who required these services. In addition, navigators received training about the health care system that they would be working in and the availability of community resources. Typically, navigators were also introduced to key contacts across the organization in order to establish the relationships necessary for effective navigation. For some grantees, specialty services were provided internally (e.g., family counseling, nutrition, or health care coverage assistance), whereas for other grantees, these services were provided externally in the community. Consequently, relationships across community-based organizations were more fully developed for some grantees than for others. Navigators also were oriented to information systems and administrative procedures and trained to document key aspects of each interaction related to patient services.

Navigator Project Activities

Grantee organizations varied according to the characteristics of the physical environment, populations served, services provided, and organizational resources available to support navigation. The structures of the navigator programs also reflected local characteristics, including needs of the population, disease focus of the program, available community resources, and the type of health care system in which the project was implemented. Table 2 describes the characteristics of the 14 PNDP grantees.

Table 2 - PNDP Grantee Site Characteristics

Location ⁸	# of Navigators	Organization Structure	Patient Population Characteristics	Number of Patients Served Site-wide per Year (approx.)	Number of Patients Receiving Navigation	Navigation Focus
California	8	Twelve primary care clinics, Federally Qualified Health Center (FQHC)	Low-income, underinsured, Hispanic or Latino, Spanish-speaking, 2.1 million in catchment area	52,000	2,809	Cancer
Florida mostly metropolitan	4	Public health care system providing all aspects of care; FQHC	Underinsured, Black or African-American and Hispanic or Latino; 650,000 in catchment area	362,000	1,503	Cancer Congestive heart failure Diabetes Hypertension
Georgia partially rural	13	Two free primary care clinics	Low-income, underinsured, 151,880 in three-county catchment area	2,000	267	Diabetes Hypertension Hyperlipidemia
New York metropolitan	7	Network including primary and specialty care; FQHC	Ethnically diverse, medically underserved; 315,000 in catchment area	90,000	926	Diabetes
Texas urban	11	Academic health center with affiliated primary, specialty, and hospital care, FQHC	Low-income, underinsured, Hispanic or Latino and Black or African-American; 56,339 in catchment area	2,500	306	Diabetes Hypertension

⁸ HRSA agreed not to identify grantees in the final report and to report aggregate participant and performance data in order to ensure confidentiality of patients and staff, and to achieve greater participation during focus groups, site visits, and other evaluation interactions.

Location ^a	# of Navigators	Organization Structure	Patient Population Characteristics	Number of Patients Served Site-wide per Year (approx.)	Number of Patients Receiving Navigation	Navigation Focus
South Carolina rural	6	Network of educators/clinics providing outreach and primary care to underserved populations; FQHC	Underinsured, low-income, minority; 700,000 in catchment area	3,000	1,030	Cardiovascular disease Diabetes
California rural	18	Large health care system; FQHC	Underinsured, low-income, Hispanic or Latino, large migrant farm worker population, 2.5 million in catchment area	134,000	1,927	Asthma Diabetes Cervical cancer Breast cancer
West Virginia rural/ Appalachian	10	Network of three primary care clinics; FQHC	Low-income, six counties; 200,000 in catchment area	21,000	771	Diabetes Hypertension Hyperlipidemia
California border area rural	3	Community organization with close ties to referral network of clinics	Low-income, immigrant communities, 60,000 in catchment area	Not Available ^a	165	Cancer Diabetes Obesity Hypertension
Hawaii rural/ isolated	3	Cancer care center partnering with three rural community hospitals	Filipino, other Pacific Islander; 330,396 in catchment area	21,000	382	Cancer
California metropolitan	7	Primary health care clinic	Minority, low-income, medically underserved, Hispanic or Latino, Black or African-American, and Pacific Islander, 40,000 in catchment area	9,500	890	Diabetes Hypertension Obesity Asthma
Utah rural/ reservation isolated	5	Cancer institute with three primary care clinical partners	low-income, minority; American Indian/Native American; 6,500 in catchment area	1,800	55	Cancer Hypertension Diabetes

^a This information was not provided in the grant application.

Location ⁸	# of Navigators	Organization Structure	Patient Population Characteristics	Number of Patients Served Site-wide per Year (approx.)	Number of Patients Receiving Navigation	Navigation Focus
California rural	5	Five primary care clinics, migrant health center, FQHC	Underinsured, large migrant farm worker population, Hispanic or Latino, 826,985 in catchment area	100,000	479	Diabetes Asthma Cardiovascular disease Cancer
New York metropolitan	4	Three primary care clinics; FQHC	Ethnically diverse, low-income, uninsured, medically underserved; 403,002 in catchment area	43,000	64	Diabetes Hypertension Heart disease Pediatric asthma

Source: PNDP grantee performance reporting systems and grantee applications (Retrieved 2012). Includes data from the first and second funding period.

Data Collection

Grantees collected data about patients and the encounters that each navigator had with patients. For each of these encounters, the navigators documented one or more actions that they took to support these patients. Grantees from both funding periods of the PNDP collected information on a series of common data elements related to patient characteristics, navigator characteristics, navigator actions, and outcomes of navigator actions. Navigators classified the characteristics of each of their actions according to categories that reflected the statutorily-mandated duties.

For the first funding period, some grantees stored their data in a Microsoft Access database that was provided to them by HRSA, and others were able to use their own data collection systems. Data were uploaded on a monthly basis. A data manager reviewed the data for errors and inconsistencies and returned reports to the grantees for local data quality assurance. In the second funding period, grantees used an online data collection system provided by HRSA. Data were updated regularly, and error reports were provided to the grantees on a monthly basis.

Baseline and Benchmark Measures

HRSA's funding opportunity announcement required applicant organizations to describe specific baseline measures and evaluation methods for each project. While navigator projects varied in terms of the characteristics of the program implementation site, the targeted disease(s), and the stage of disease at which intervention occurred, benchmark measures commonly focused on measures related to coordination of medical appointment attendance and improvements in health care services administration. Navigator programs collected quantitative and qualitative data including outcomes-oriented measures (health and health services related) and process-oriented measures (recruiting, assigning, training, and employing patient navigators).

Data was collected from three main sources: (1) quantitative data collected in accordance with cross-site data elements; (2) site-specific data provided by grantees in their final project reports; and (3) qualitative data from discussions with grantees, site visits, and grantees' quarterly reports.

Quantitative Data Collection

Data collected across grantees included those related to the characteristics of patients served, performance of the six statutorily-mandated navigator duties, and efforts by patient navigators to address barriers within the health care system to ensure prompt diagnostic and treatment resolution of an abnormal finding of cancer or other chronic disease. These data elements provide the basis for the evaluation of program outcomes.

Qualitative Data Collection

HRSA program staff gathered qualitative data about the grantee activities through monthly telephone calls with each grantee individually, as well as monthly group conference calls with all grantee organizations. These calls gave the grantees an opportunity to update HRSA regarding their progress and for HRSA to provide technical assistance, as needed. In addition, HRSA conducted site visits in January and February 2010 which provided a large qualitative data set. Each visit lasted 1.5 days, and during this time unstructured discussions were conducted with key informants, including program and administrative staff, health care providers, and community partners. Additionally, grantee organizations submitted quarterly reports. Lastly, from March to July 2012, qualitative data were collected during videoconference focus groups with HRSA, grantee staff, and patient navigators; as well as via telephone interviews with PNDP partners.

V. Outcomes and Impact

This section describes outcomes from the PNDP, including the modes of communication used and efforts to address barriers to quality care in the health disparities populations served.

Patients Served

The PNDP grantees provided navigation services to 11,574 patients through the efforts of 104 navigators across the 14 grantees. Navigators also reached more than 26,000 individuals through community outreach efforts.¹⁰ These efforts included health fairs, presentations, and educational encounters within various community locations that provided screening and education about cancer and chronic diseases. Ninety percent of patients who had received navigation services through the PNDP were recruited from within clinical settings.

The patients who received navigation services meet the criteria of a health disparity population, as required by the statute. For the PNDP, a health disparity population was defined not solely by

¹⁰ As of the final performance reports from grantees - June 30, 2012

race or ethnicity but by socioeconomic factors that limited their access to quality preventive and ongoing health care. For example, a high proportion of navigated patients had no health care coverage because they did not qualify for Medicaid and had no access to other affordable health care coverage. As shown in Table 3, 73 percent of patients were female, 29 percent of patients lived alone, and 56 percent of the patients in the program had never completed high school. While race, ethnicity, and primary language varied by site, overall, 17 percent of patients were Black or African-American and 56 percent were Hispanic or Latino. Lastly, 53 percent of patients spoke English as a secondary language.

Table 3 - Select Demographics of Patients Receiving Services through the PNDP

	Female %	<High School %	Race: Black or African- American* %	Ethnicity: Hispanic or Latino* %	Single Person Household %	English as 2nd Language %
Overall	73	56	17	56	29	53

Source: PNDP grantee performance reporting systems (Retrieved 2012). Includes data from the first and second funding period. Note: Not all information was available for all patients receiving navigation services.

* Race and ethnicity responses are not mutually exclusive.

As shown in Table 4, 83 percent of patients had household incomes of less than \$20,000 per year. In the year prior to receiving navigation services, an average of 23 percent of patients reported having had an emergency department visit, though this proportion varied across projects. In addition, 46 percent of patients reported having no health care coverage upon enrollment for navigation services. For most grantees, an important goal of navigation was coordinating with health insurance ombudsmen and helping people applying for and obtaining insurance coverage or reduced-fee care.

Table 4 - Select Income and Health Care Characteristics of Patients Receiving Services through the PNDP

	Household Income <\$20Kyr %	No Health Care Coverage* %	Medicaid %	ER Visit in Prior Year %	Hospital Stay Year Prior to Enrollment %
Overall	83	46	19	23	18

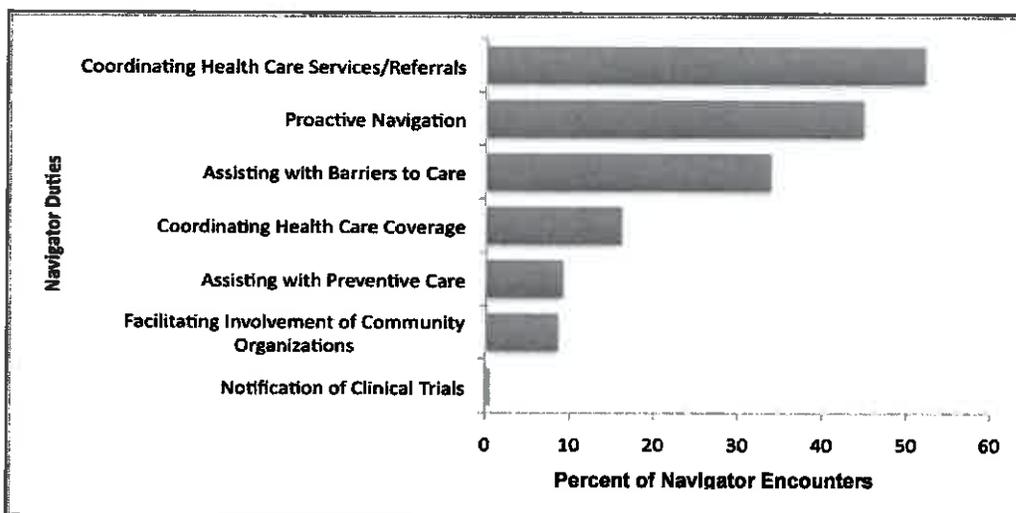
Source: PNDP grantee performance reporting systems (Retrieved 2012). Includes data from the first and second funding period.

*No coverage also includes those for whom the only sources of funding for health care services were reduced-fee options (e.g., provided by the clinic) and/or single service programs (e.g., programs providing free mammograms for low-income women).

Navigator Encounters

In Figure 1, navigator encounters are categorized according to the six duties specified in the authorizing legislation. A seventh category identified by navigators - proactive navigation - was added to the list of duties specified in the legislation. Proactive navigation is related to following up with patients in anticipation of the recommended next steps in care.

Figure 1 - Navigator Encounters Categorized According to the Six Navigator Duties



Source: PNDP grantee performance reporting systems (Retrieved 2012). Data included in this chart are from the first funding period only. Since each encounter could be associated with multiple duties, percentages in Figure 1 add to more than 100 percent.

Coordinating health care services happened in over half of all navigator encounters (52 percent). This coordination typically consisted of assisting patients with scheduling services and connecting patients with providers. Examples include:

- Assisting patients to obtain mental health services, which improved self-management of medical conditions;
- Making follow-up appointments and completing paperwork; and
- Identifying emergent health issues and facilitating access to that care and care options to help people shift from using emergency care to using primary care.

Proactive navigation was also very common (45 percent of encounters) and involved following-up with patients and educating them to ensure that they understood the next steps in getting necessary health care, as well as providing reminders and psychosocial support for following-up. For example, a navigator intervened when they observed that a patient's preconceived beliefs or lack of understanding of medical recommendations can reduce access to cancer screening and treatment:

“...few African-Americans, say, go to have a biopsy or something, because African-Americans believe when you start cutting on whatever the problem is, it spreads like grass. So they have this fear of [not] having procedures done, so we do a lot of escorting and we go with them to different doctors’ appointments and we sit with them and assure them that everything is going to be okay. We do that if they don’t have a family member that can do it for them. We do a lot of supporting.”

Coordination of health care coverage, that is, helping patients submit applications for Medicaid or site-specific health system sponsored free or reduced-fee care, was involved in 16 percent of navigator encounters. Navigators reported that nine percent of encounters were related to assisting with preventive care, such as scheduling recommended cancer screening appointments or ensuring diabetic patients received annual foot exams. Another nine percent of encounters were related to facilitating involvement of community organizations; for example, navigators helped patients by offering culturally and linguistically competent services by helping with paperwork to link patients to social services, including mental health, pharmacy, and financial assistance.

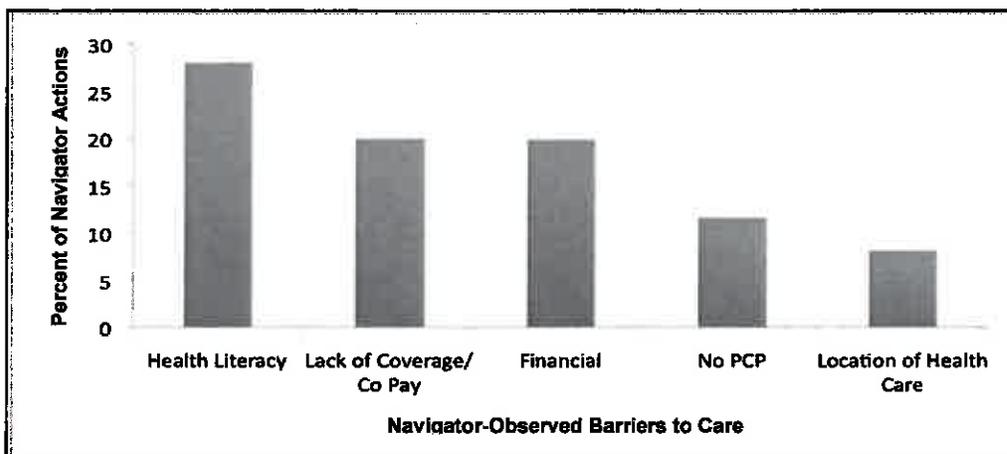
Although notifying individuals of clinical trials, and on request, facilitating enrollment of eligible individuals was among the navigator duties, less than one percent of navigator encounters were associated with these tasks. Grantees universally reported difficulty in finding relevant clinical trials and they expressed concern about the ethical implications of clinical trial referrals given the vulnerability of the populations served, the appropriateness of such referrals given the intended role of the navigator, and the nature of the clinical trials themselves.

Addressing Barriers in the Health Care System

Navigators were asked to report on barriers identified and addressed for each action undertaken during the navigation encounter. Just over a third of all navigator actions (34 percent) involved assisting patients to overcome barriers within the health care system. Figure 2 shows the top five barriers encountered during direct contact with individuals (i.e., telephone or face-to-face contact). The most commonly reported barriers were low health literacy, financial issues, lack of health care coverage, no primary care provider (PCP), and inability to locate and travel to a health care provider location. One example included:

A navigator noted that a patient had to drive 47 miles from her house once each week for cancer treatment that lasted 10-15 minutes. The navigator looked for care locations near the patient’s home that would accept her insurance. The navigator contacted a local hospital and its navigation program. The primary patient navigator worked with both programs to ensure that the treatment clinic would accept the patient’s insurance and contacted the treatment program and coordinated care to ensure that all of the patient’s medical records were transferred to the treatment clinic. The patient’s drive decreased to 1.6 miles on a weekly basis for her radiation treatment.

Figure 2 - Barrier Identification



Source: PNDP grantee performance reporting systems (Retrieved 2012). Data included in this chart are from the first funding period only. N=24,340 navigator actions involving direct contact via telephone or face-to-face meeting.

Navigators reported that low health literacy, associated with 28 percent of actions involving direct contact, was a major barrier to patient access and participation in health care. Navigators addressed health literacy through a range of activities, including helping patients to complete forms, explaining the meaning of test results, and providing instructions about next steps in diagnosis or treatment. Thus, navigators converted medical information into language that was understandable and culturally relevant. Navigators also translated for patients with limited comprehension of written and/or spoken English.

Lack of insurance coverage or inability to make co-payments was noted in 20 percent of navigator actions involving direct contact. Applications for reduced-fee services or Medicaid coverage required filling out forms and obtaining documents to verify income. A related barrier, financial problems, was identified in 20 percent of navigator actions involving direct contact. Navigators reported that patients lacking resources for food, shelter, and clothing were less willing to seek medical care, medicines, or medical equipment, even if fees were reduced. Navigators provided information about sources of financial assistance and assisted with related applications. According to one navigator:

"If somebody can't afford the roof over their heads or food on their table, you can talk all you want about checking, getting your hemoglobin and being seen and following your diet, but if they have no money for food or the electricity is being turned off tomorrow, they're way more concerned about that."

Navigators reported that when patients had too much income to qualify for Medicaid, grantees often provided reduced-fee services through FQHC funding or other sources. But, at times, a patient's inability to pay even these reduced fees deterred them from obtaining care in a timely manner, or led them to abandon health care appointments and treatment regimens.

Navigators reported that not having an established PCP was a barrier in 12 percent of navigator actions involving direct contact. This barrier was common when patients came from outside clinic populations, which was 10 percent of the people receiving navigation services. Navigators helped to relieve this barrier for patients by offering PCP application assistance, administrative guidance, and assignment of providers to create initial and follow-up appointments.

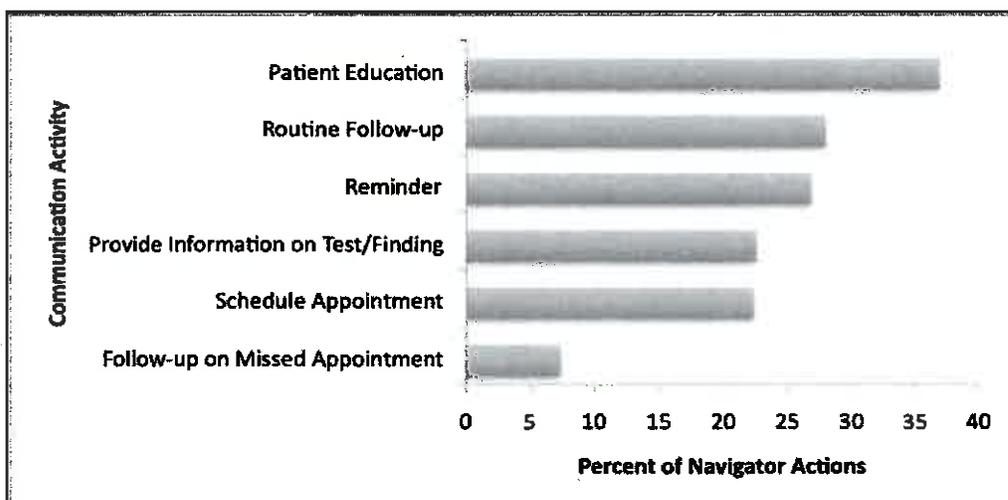
Navigators reported that the location of the health care provider was a barrier in eight percent of navigator actions involving direct contact. In these instances, navigators provided information about provider location and travel resources.

Less frequent barriers included conflicts with employment, disability, scheduling, childcare and family issues, lifestyle habits, housing, memory problems, lack of access to specialists, and patient’s attitudes toward providers.

Types of Navigator Actions

Navigators often addressed these barriers through actions involving patient education and care coordination, by educating patients proactively about what to expect. Figure 3 shows the percentage of navigator actions categorized according to the type of action.

Figure 3 - Type of Navigator Actions



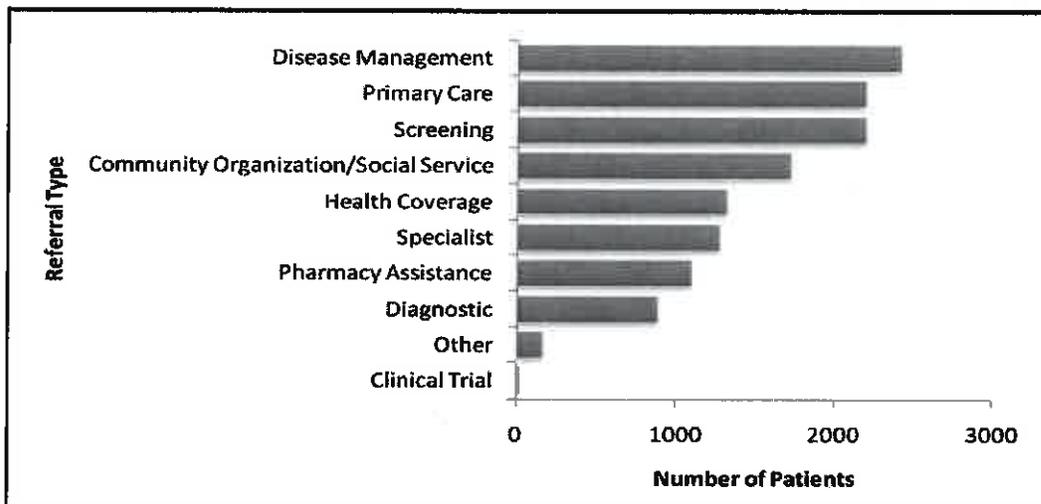
Source: PNDP grantee performance reporting systems (Retrieved 2012). Data included in this chart are from the first funding period only. N=30,925 navigator actions (includes messages, letters, and attempted calls without contact).

Making Referrals and Facilitating Community Services

Patient navigators supported two kinds of referrals for patients: 1) referrals including health care services identified by providers as critical to successful disease treatment or prevention and 2) referral for services identified by navigators to address barriers to care. As shown in Figure 4, most navigators referred patients to a wide range of services or providers, with primary care and

disease management most central to the navigation effort. Navigators referred more than 41 percent of patients to more than one referral target.

Figure 4 - Patient Referral Targets



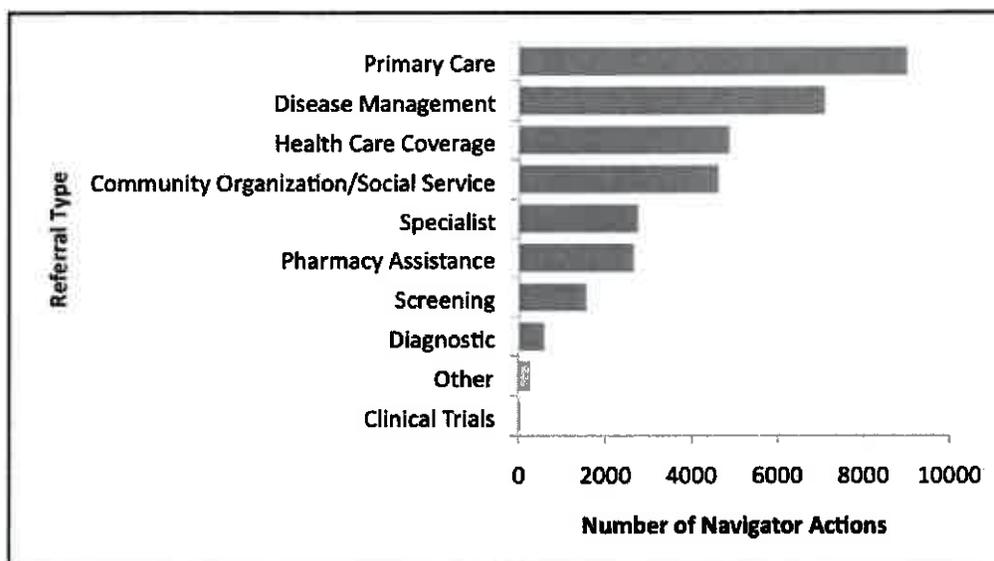
Source: PNDP grantee performance reporting systems (Retrieved 2012). Data included in this chart are from the first funding period only. N=6,567 patients; because overlapping referral actions were common, numbers of patients with reported referral types add to more than the total number of patients.

The level of effort associated with navigating patients varied by referral target. Referrals to primary care, disease management, and community organizations/social services were associated with the highest number of navigator actions. One physician described how navigator involvement aided in the transfer of care between the hospital and follow-up primary care saying that:

“...before the navigation program started, the [hospital] discharge planner would have...given patients maybe a piece of paper that would say here’s all the documents you’re going to need; here are directions. [Now, the navigator] will go in and say, ‘Okay, you got the list of what you need. Do you have any of these documents today?’ Sometimes she starts collecting the documents for them...Sometimes she’ll go and say to their spouse or family member, ‘When you go home, I need this paystub,’ or whatever... And in some cases, if they have everything already, ... before they’ve even left the hospital... she’s collected everything and brought it to the eligibility worker to get that card started, so when they go for that [clinic] appointment they just get their card [for health care coverage]...So it’s the extra step of actually helping them start that process [in the hospital] as opposed to hoping that when they leave they’ll show up at the primary care and start that process on their own.”

Figure 5 shows the number of actions associated with each type of referral. The number of actions recorded for each referral was determined by three factors: (1) difficulty involved in helping the patient gain access to the service, (2) level of intervention required for the specific disease, and (3) project protocol which provided guidance regarding the level of navigator effort per patient.

Figure 5 - Referral Effort



Source: PNDP grantee performance reporting systems (Retrieved 2012). Data included in this chart are from the first funding period only. N=33,921 navigator actions involving referrals. Note that each navigator encounter can include multiple referral actions and that each referral action is counted separately.

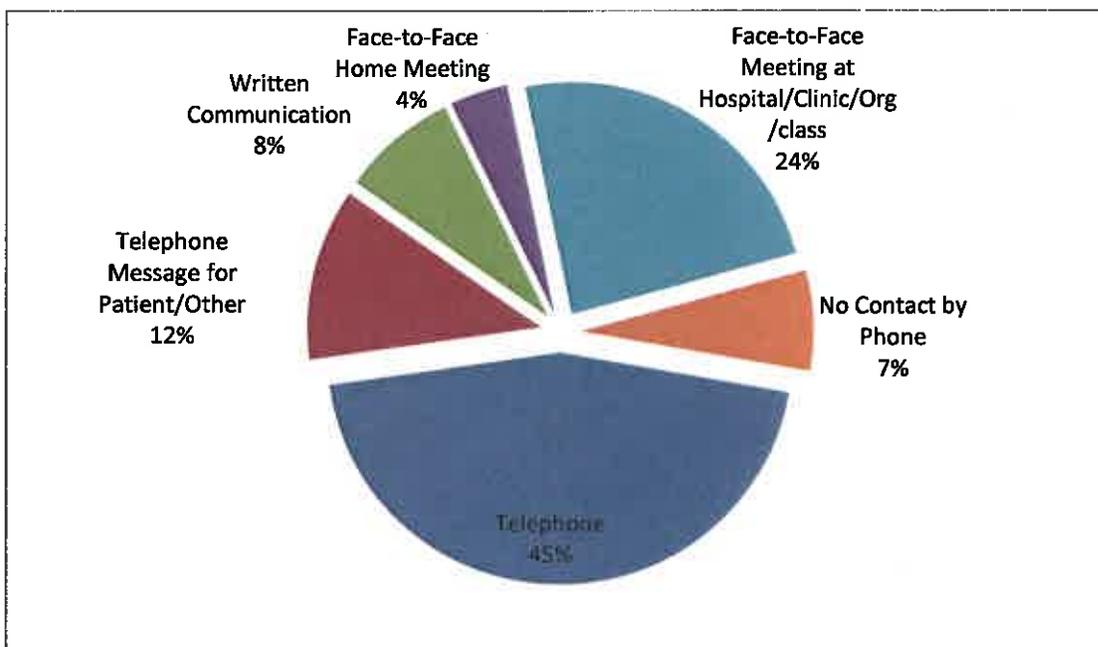
Figure 4 and Figure 5 demonstrate that navigators frequently made referrals to organizations in the community that provided supportive services. Cooperation with these organizations was critical to ensuring that barriers to care were addressed in a timely manner. A health care administrator said:

“Health education classes this year increased 64 percent, from 153 to 251, because [the navigator] is out in the community. Our mammogram and prostate screening examinations and lab reports that we do for people who get medication increased from 100 to 266, and that’s what ... [a] 166 percent increase. So I guess that tells you a lot.”

Navigator Communication

As shown in Figure 6, navigators used multiple modes of communication to achieve their goals. The telephone call was the most common vehicle for communication (64 percent). Navigators talked with people 45 percent of the time, left messages 12 percent of the time, and could not contact people by phone 7 percent of the time. Navigators noted that reminder calls and messages left for patients were crucial to the success of the program and were an effective tool for increasing appointment adherence. Written notes, accounting for about eight percent of navigator actions, were the best method for reaching people who had no telephone. Navigators reported that a face-to-face meeting at either the patient’s home or the clinic was critical to establishing initial rapport with the patient, particularly in navigation for diseases that required long-term lifestyle changes. These meetings accounted for 28 percent of navigator actions, with most meetings happening at the hospital, clinic, in a class, or at a community organization (24 percent).

Figure 6 - Modes of Navigator Communication/Contact



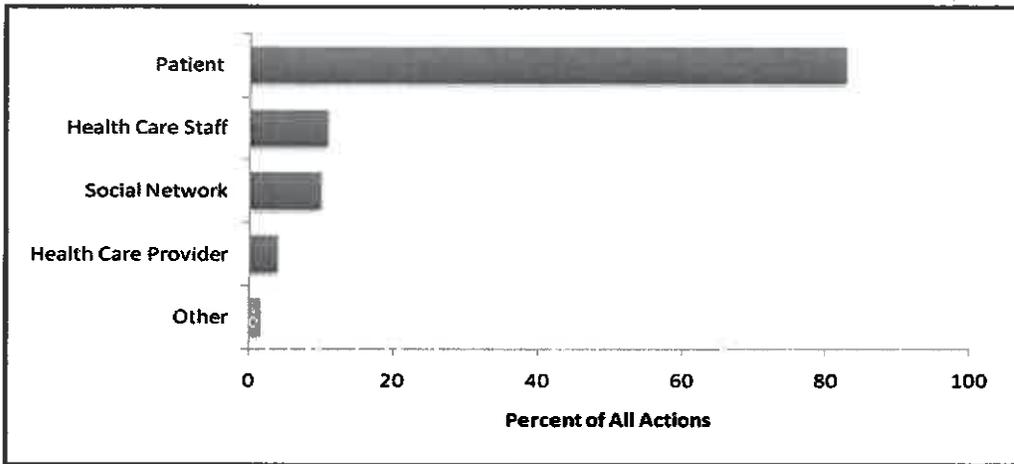
Source: PNDP grantee performance reporting systems (Retrieved 2012). Data included in this chart are from the first funding period only. N=33,388 navigator actions.

Coordination of Care

One of the required navigator duties was assisting in the coordination of care, including screening and referrals. Figure 7 displays information about persons involved in navigator actions. The navigator projects were patient-centered, with education of the patient central to project success. As a result, most navigator contacts involved patient interaction, instead of navigators mainly working with doctors or hospital staff. Interactions with health care providers and staff were less frequent than expected based on discussions between HRSA and PNDP grantees.¹¹

¹¹ The data collection system may have undercounted these interactions because actions related to project-wide meetings, documentation in medical records, email communications, and scheduling via remote access to appointment databases were not recorded among navigator actions.

Figure 7 - Persons Involved in Navigation

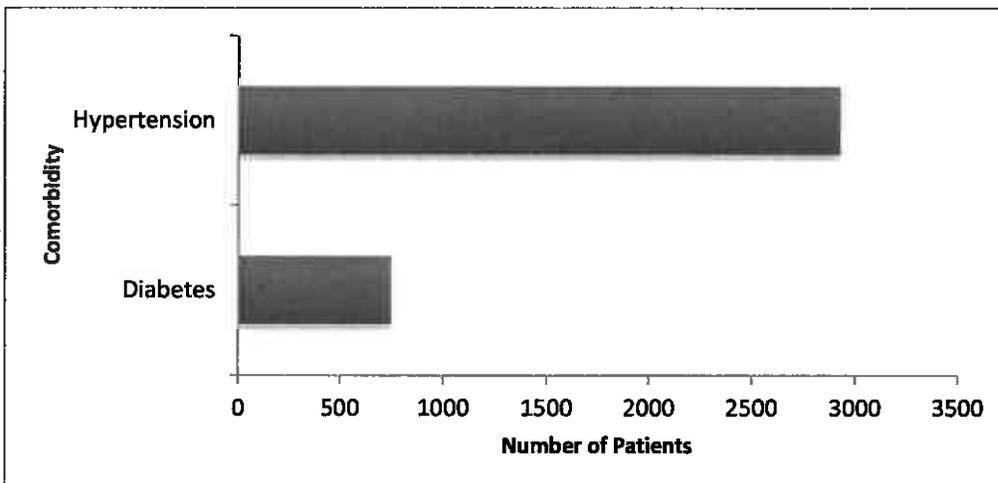


Source: PNDP grantee performance reporting systems (Retrieved 2012). Data included in this chart are from the first funding period only. N=30,929 navigator actions. Note that each navigator encounter can include multiple referral actions and that each referral action is counted separately.

Physiological Outcomes

Of the 11,574 patients who received navigation services across both funding periods, 55 percent entered navigation services with a diagnosed disease. Preliminary data on physiologic outcomes associated was available for a small cross-site sample of patients with diabetes and/or hypertension from the second funding period (362 patients) and physiologic outcomes on indicators for these patients showed significant improvements.

Figure 8 - Total Number of Patients with Select Comorbidities



Source: PNDP grantee performance reporting systems (Retrieved 2012). Data included in this chart are from first and second funding period only. N=10,218 patients.

Hemoglobin A1c (HbA1c) is a measure that reflects blood glucose levels over time. Levels above seven percent are considered unhealthy and have been linked to diabetic complications such as blindness and neuropathy. Measurements prior to or within 30 days of enrollment into navigation services were compared to readings taken after navigation (at least 31 days after enrollment; if multiple results were available, the most recent result was used). Readings around the time of enrollment showed that, on average, diabetic patients had levels of 10.2 percent, with more than 9 in 10 patients (91 percent) showing readings of 7 percent or higher. After enrollment into navigation, patients showed average glucose levels of 8.9 percent. The proportion of patients with HbA1c levels below seven percent more than doubled after receiving navigation services. In summary, navigation was associated with reductions in average HbA1c levels and more patients with readings below seven percent.

Hypertension was assessed through the average systolic and diastolic readings, or the number of patients above the norm of 140/90. Readings above the norm can cause serious damage to the heart, blood vessels, eyes, and kidneys. The proportion of patients with blood pressure readings above the norm decreased from 55 percent to 46 percent from around the time of enrollment to the time after navigation.

Program Impact

Through the PNDP, patient navigators were able to facilitate increased access to care, improved coordination of care, and improved efficiency and effectiveness of care through several important strategies. Navigators provided culturally and linguistically competent support services to help patients better understand the importance of preventative care and their treatment options. They also provided social and psychosocial support to patients in order to encourage the kinds of behavior change that can lead to improved care and outcomes for many chronic conditions. This focus on cultural competency and community knowledge was critical to the success of the PNDP.

The three main health-related benefits provided by the PNDP are:

- 1) Navigators increased access to care by:
 - Addressing barriers to care, including lack of transportation, low health literacy, and urgent priorities such as lack of food and shelter;
 - Assisting patients in obtaining mental health services, which improved self-management of medical conditions;
 - Making appointments and facilitating completion of paperwork;
 - Helping patients to complete applications for health care coverage and pharmacy assistance; and
 - Implementing community outreach and education programs.
- 2) Navigators improved coordination of care by:
 - Improving patient understanding of and adherence to prescribed care;
 - Supporting patients' health-related behavioral and lifestyle change; and

- Helping integrate care across primary, specialty, and social services arenas by communicating information to patients about the availability of these services within organizations, departments, or buildings.
- 3) Navigators improved efficiency and effectiveness of care by:
- Offering culturally and linguistically competent services, including help with paper work, following up on health education, and linking patients to social services;
 - Introducing patients' points of view in administrative and clinical proceedings;
 - Identifying emergent health issues and facilitating access to that care and care options to help people shift from using emergency care to using primary care;
 - Identifying processes and procedures to improve patient outcomes (e.g., finding resources for reduced-fee medications while patients were waiting for pharmacy assistance approval);
 - Increasing patients' ability to self-manage chronic disease through education and support;
 - Improving patient-provider communication by documenting patient needs and coaching patients on communicating with providers; and
 - Advocating for individuals receiving inadequate or suboptimal care due to administrative error or patient misunderstanding.

In particular, navigation was related to improved follow-up and/or attendance rates under most circumstances. For example:

- At one site, the percentage of patients who kept scheduled medical appointments was 76 percent clinic-wide prior to navigator program implementation. After program implementation, 100 percent of patients who received navigation services kept scheduled medical appointments.
- At another site, the percentage of gestational diabetic women returning for postpartum visits prior to navigator program implementation was 77 percent clinic-wide. After navigation, it was 95 percent for patients in the navigation program.
- Reminder calls from navigators at a different site led to a missed-appointment rate of 20 percent for diagnostic appointments of patients with navigators. Prior to the program the clinic-wide missed appointment rate was 33 percent.
- Several grantees reported a decrease in the percentage of patients who cancelled appointments without notice because navigators were in touch with patients who needed to cancel. Informing the office of cancellations in advance allowed staff to reschedule other patients for free or reduced-fee service appointments that are in high demand.

Many PNDP grantees set navigator project goals according to quality-of-care benchmarks established under best practice guidelines, for example:

- The percentage of patients receiving pharmacy assistance improved with navigation. One site reported that 76 percent of all clinic patients obtained pharmacy assistance to get adequate medications before navigation; 100 percent of patients in the navigation program obtained adequate medications.
- Establishing a patient in a primary care practice is considered to be critical to quality health care and disease prevention, and this was a quality-of-care goal for several grantees. One site reported that of 1,450 patients who initially had no primary care home,

73 percent had a PCP by the end of the project. Of 655 patients discharged from a county hospital with no established care, 63 percent received navigation services and had a PCP by the end of the project.

- Grantees were able to improve patient participation in care. One site reported that 83 percent of patients in the program maintained compliance with an individual treatment plan, and another reported that 71 percent of patients documented and achieved self-management goals associated with diabetes treatment.
- Many grantees reported increased compliance with case management and disease prevention algorithms, including meeting best practice targets for foot exams, eye exams, HbA1c levels, lipid profiles, and clinician referrals for needed services—all necessary components of diabetes care. Patients engaged in navigation were more likely than comparable patients in the clinic populations to receive these services.
- Many grantees reported that they met or exceeded contact targets for community outreach, including health fairs, group health screenings, and education sessions.

Data Limitations

Funding for the PNDP was discontinued in FY 2012. At that time, the contract was ended with the research company tasked with data collection and analysis. Consequently, the sample size that can be used to report on the outcomes of this program is smaller than anticipated. In some sections, data presented are based on the first funding period of the program only and are reported accordingly. As mandated by the statute, the grantees maintained a focus on cancer and other chronic diseases. The PNDP grantees tailored their navigation programs to meet the needs of their local population. There was not a single implementation of the program focused only on one defined patient population. As a result, this analysis provides a description of the program as implemented and presents some options that could affect how patient navigator programs can be used to improve patient outcomes in other public health areas but should not be interpreted as a rigorous scientific evaluation.

The impact of navigation on physiologic measures can be attributed to multiple factors related to the short time period of the study. First, many of the interventions were revised and improved over the period of study, so relatively few patients were exposed to a fully developed program for a long enough period of time. Second, there were multiple instances of small sample sizes that may be too small to detect changes created by navigation. Third, the influence of outliers could not be assessed based on the information reported. Fourth, the sample itself was diverse, in which patients with different lengths of time in navigation, different illness severity, and different comorbidities were pooled.

VI. Summary and Conclusions

The information in this report was provided by health care administrators, providers, navigators, and other PNDP grantee staff. Based on the data and program experience, navigator programs improve coordination of care and lead to better health outcomes across a range of disease and patient populations. By working to improve patients' health literacy, coordinating logistical aspects of care, and ensuring patient-centered care, navigator programs improve access,

continuity, and effectiveness of care. As a result, patient navigator programs and partnership arrangements such as the PNDP can be used to improve patient outcomes in other public health areas across the nation. To be effective, navigator interventions need to be tailored to the needs of specific patient populations.

Patient navigator programs hold promise as interventions to improve quality and cost-effectiveness of health care for people from health disparities populations; however, research is needed to focus patient navigator programs and quantify their effects, including estimating the cost-effectiveness of such programs.^{12,13}

Navigation also appears to be a promising approach to improve at least some physiologic outcomes. In order to fairly assess the impact of navigation on physiologic outcomes, a larger number of patients need to receive this service according to a fully developed, mature program, and the patients should be stratified to identify those likely to need more assistance (e.g., patients with a greater number of comorbidities, greater severity of illness, or mental health issues).

Specifically, further investigation is needed to:

- Determine the most effective strategies for navigating different sub-populations, including people new to care, patients with multiple comorbidities, patients with mental and behavioral health disorders, patients with identified risk factors but no diagnosable disease, and patients with diagnosed disease at high risk for emergency room visits or hospitalization;
- Accurately estimate the effects of navigation based on baseline and comparison group data and of specific models of navigation;
- Investigate the role of navigation in transitional care, including coordination of outpatient care with area hospitals, rates of re-hospitalization, and potential health care cost savings;
- Determine core competencies of navigators for primary and specialty care and how these will need to be adjusted to meet characteristics of target groups;
- Optimize navigation practices for:
 - Patients with multiple diagnosed comorbid diseases, who are thought to receive sub-optimal care in spite of high expenditures and who have high need for care coordination among multiple specialists;
 - Patients with a diagnosed disease who are established in medical clinics and who are non-adherent to medical recommendations;

¹² Naylor M, Brooten D, Jones R, Lavizzo-Mourey R, Mezey M, Pauley M. Comprehensive discharge planning for the hospitalized elderly. *Annals of Internal Medicine*. 1994; 120: 999-1006. Available at http://www.commonwealthfund.org/usr_doc/Annals_of_Internal_Medicine_1994.pdf. Accessed February 3, 2014.

¹³ Friedman B, Basu J. The rate and cost of hospital readmission for preventable conditions. *Medical Care Research and Review*. 2004; 61(2): 225-240. Available at <http://www.ncbi.nlm.nih.gov/pubmed/15155053>. Accessed February 3, 2014.

- Patients with mental and behavioral health disorders as a primary medical condition or co-morbidity with other illnesses, who may neglect their physical health and the follow-up on provider's instructions;
- People without regular, recent medical care who are overwhelmed by socioeconomic stressors and have been diagnosed with or are at high risk for disease and people in crisis due to having inadequate food, shelter, and clothing who are not able to reliably keep medical appointments; and
- Patients with an average risk for disease in established medical clinics that will benefit from preventive care visits.

VII. Appendix A: Full-Text Copy of Statute

**TITLE 42 - THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A - PUBLIC HEALTH SERVICE
SUBCHAPTER II - GENERAL POWERS AND DUTIES
Part D - Primary Health Care
Subpart v - healthy communities access program**

§ 256a. Patient navigator grants

(a) Grants

The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to eligible entities for the development and operation of demonstration programs to provide patient navigator services to improve health care outcomes. The Secretary shall coordinate with, and ensure the participation of, the Indian Health Service, the National Cancer Institute, the Office of Rural Health Policy, and such other offices and agencies as deemed appropriate by the Secretary, regarding the design and evaluation of the demonstration programs.

(b) Use of funds

The Secretary shall require each recipient of a grant under this section to use the grant to recruit, assign, train, and employ patient navigators who have direct knowledge of the communities they serve to facilitate the care of individuals, including by performing each of the following duties:

- (1)** Acting as contacts, including by assisting in the coordination of health care services and provider referrals, for individuals who are seeking prevention or early detection services for, 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)** 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 health care services (such as by creating partnerships with patient advocacy groups, charities, health care centers, community hospice centers, other health care providers, or other organizations in the targeted community).
- (3)** Notifying individuals of clinical trials and, on request, facilitating enrollment of eligible individuals in these trials.
- (4)** Anticipating, identifying, and helping patients to overcome barriers within the health care system to ensure prompt diagnostic and treatment resolution of an abnormal finding of cancer or other chronic disease.
- (5)** Coordinating 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 publicly funded programs (such as Medicare, Medicaid, health programs operated by the Department of Veterans Affairs or the Department of Defense, the State children's health insurance program, and any private or governmental prescription assistance programs).
- (6)** Conducting 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.

(c) Prohibitions

(1) Referral fees

The Secretary shall require each recipient of a grant under this section to prohibit any patient navigator providing services under the grant from accepting any referral fee, kickback, or other thing of value in return for referring an individual to a particular health care provider.

(2) Legal fees and costs

The Secretary shall prohibit the use of any grant funds received under this section to pay any fees or costs resulting from any litigation, arbitration, mediation, or other proceeding to resolve a legal dispute.

(d) Grant period

(1) In general

Subject to paragraphs (2) and (3), the Secretary may award grants under this section for periods of not more than 3 years.

(2) Extensions

Subject to paragraph (3), the Secretary may extend the period of a grant under this section. Each such extension shall be for a period of not more than 1 year.

(3) Limitations on grant period

In carrying out this section, the Secretary shall ensure that the total period of a grant does not exceed 4 years.

(e) Application

(1) In general

To seek a grant under this section, an eligible entity shall submit an application to the Secretary in such form, in such manner, and containing such information as the Secretary may require.

(2) Contents

At a minimum, the Secretary shall require each such application to outline how the eligible entity will establish baseline measures and benchmarks that meet the Secretary's requirements to evaluate program outcomes.

(3) Minimum core proficiencies

The Secretary shall not award a grant to an entity under this section unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies, as defined by the entity that submits the application, that are tailored for the main focus or intervention of the navigator involved.

(f) Uniform baseline measures

The Secretary shall establish uniform baseline measures in order to properly evaluate the impact of the demonstration projects under this section.

(g) Preference

In making grants under this section, the Secretary shall give preference to eligible entities that demonstrate in their applications plans to utilize patient navigator services to overcome significant barriers in order to improve health care outcomes in their respective communities.

(h) Duplication of services

An eligible entity that is receiving Federal funds for activities described in subsection (b) of this section on the date on which the entity submits an application under subsection (e) of this section may not receive a grant under this section unless the entity can demonstrate that amounts received under the grant will be utilized to expand services or provide new services to individuals who would not otherwise be served.

(i) Coordination with other programs

The Secretary shall ensure coordination of the demonstration grant program under this section with existing authorized programs in order to facilitate access to high-quality health care services.

(j) Study reports

(1) Final report by Secretary

Not later than 6 months after the completion of the demonstration grant program under this section, the Secretary shall conduct a study of the results of the program and submit to the Congress a report on such results that includes the following:

(A) An evaluation of the program outcomes, including—

(i) quantitative analysis of baseline and benchmark measures; and

(ii) aggregate information about the patients served and program activities.

(B) Recommendations on whether patient navigator programs could be used to improve patient outcomes in other public health areas.

(2) Interim reports by Secretary

The Secretary may provide interim reports to the Congress on the demonstration grant program under this section at such intervals as the Secretary determines to be appropriate.

(3) Reports by grantees

The Secretary may require grant recipients under this section to submit interim and final reports on grant program outcomes.

(k) Rule of construction

This section shall not be construed to authorize funding for the delivery of health care services (other than the patient navigator duties listed in subsection (b) of this section).

(l) Definitions

In this section:

(1) The term “eligible entity” means a public or nonprofit private health center (including a Federally qualified health center (as that term is defined in section 1395x (aa)(4) of this title)), a health facility operated by or pursuant to a contract with the Indian Health Service, a hospital, a cancer center, a rural health clinic, an academic health center, or a nonprofit entity that enters into a partnership or coordinates referrals with such a center, clinic, facility, or hospital to provide patient navigator services.

(2) The term “health disparity population” means a population that, as determined by the Secretary, has a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates as compared to the health status of the general population.

(3) The term “patient navigator” means an individual who has completed a training program approved by the Secretary to perform the duties listed in subsection (b) of this section.

(m) Authorization of appropriations

(1) In general

To carry out this section, there are authorized to be appropriated \$2,000,000 for fiscal year 2006, \$5,000,000 for fiscal year 2007, \$8,000,000 for fiscal year 2008, \$6,500,000 for fiscal year 2009, \$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.

(2) Availability

The amounts appropriated pursuant to paragraph (1) shall remain available for obligation through the end of fiscal year 2015.