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intramuscular antineoplastics, other agents might have more favorable pharmacy benefit approval processes. The patient's insurance status should be an important future consideration. Out-of-pocket costs vary greatly by primary payer, secondary insurance status and coverage, retail pharmacy coverage, and whether deductibles or out-of-pocket caps have been met. We observed wide variability in copayments. In addition, though ideal from a clinical safety profile, many eligible patients (38%) chose not to participate. Interestingly, as reflected in the patient testimonials, our urban location might have precluded some patients from participating given the small size of many New York City apartments, where personal space is prized. A larger catchment area where patients faced more time constraints and financial toxicity to a face-to-face encounter may have benefited the pilot.

Conclusion

As oncologic therapeutics evolve from intravenous to oral and subcutaneous formulations (eg, immunotherapies) the need for untethered oncology care will broaden.[8] Patients prefer subcutaneous therapies, and these formulations reduce resource utilization and improve tolerability and health-related quality-of-life outcomes. We found high patient satisfaction with home administration, but regulatory barriers impaired our ability to realize these benefits and deliver on the goals of the National Cancer Plan.

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INSTITUTE FOR COMPREHENSIVE CANCER CARE SERVICES

The Centers for Medicare & Medicaid Services Will Pay for Patient Navigation—Now What?

INSTITUTE FOR COMPREHENSIVE CANCER CARE SERVICES

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The Centers for Medicare & Medicaid Services Will Pay for Patient Navigation—Now What?

In Brief

Following decades of research demonstrating the efficacy of patient navigation on clinical and patient-reported outcomes, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that pays for patient navigation and navigation-related services effective January 1, 2024. This article reviews the new codes to reimburse for principal illness navigation (PIN) services, social determinants of health (SDOH) assessment, community health integration, and PIN-Peer Support (PIN-PS). A description of the codes, how to use them, who can perform services, and next steps for the field are reviewed.

The evidence is overwhelming that patient navigation improves access to care and health outcomes for patients with cancer. Following decades of research demonstrating the efficacy of patient navigation on clinical and patient-reported outcomes,[1-4] on November 2, 2023, CMS issued a final rule announcing a change to Medicare payments effective January 1, 2024.[5] Published on November 16, 2023, the calendar year (CY) 2024 payment policies under the Medicare Physician Fee Schedule (MPFS)[5] allow for payment for PIN services under Medicare Part B that were provided by auxiliary health care staff working under a qualifying billing practitioner to help those affected by cancer and other serious illnesses.

Under the new rule, health care support staff, such as community health workers, patient navigators, and peer navigators, can now be reimbursed for their time supporting patients with "serious, high-risk disease"[5] that is expected to last at least 3 months and require ongoing monitoring of a treatment plan. Examples of qualifying conditions include but are not limited to cancer, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder.

What Are the New Billable Services?

CMS created new codes to reimburse for support services to assist patients with health-related social barriers that interfere with treatment adherence for cancer and other serious illnesses. The rule includes several types of reimbursement under the supervision of a qualifying billing practitioner. These include:

- SDOH risk assessment
- Community health integration (CHI) service coordination responsive to SDOH assessment
- PIN services to help patients complete a treatment plan for a serious condition expected to last at least 3 months
- PIN-PS that aligns with rigorous training, primarily for behavioral health support, such as peer-led mental health and substance use programs under the Substance Abuse and Mental Health Services Administration.[6,7]

Services that are necessary to help improve adherence to treatment plans that are typically provided by oncology patient navigators and community health workers are now reimbursable as PIN services. The rule provides a number of examples of qualifying activities, including provision and facilitation of: [5,8]

- Person-centered assessments, which involve assessing how SDOH might affect a person's health care adherence and outcomes
- Patient-driven goals of care
- Care planning
- Care coordination
- Communication, including in-system navigation and coordination of community-based care
- Health education
- Coaching and mentoring to support patient self-advocacy
- Collection of health outcomes data.

Who Can Provide Services?

CMS uses various codes for billing, including *Current Procedural Terminology (CPT)* codes for medical procedures and services and G codes for functional limitation reporting. The new G codes for PIN may be used by anyone performing these services, provided they are appropriately trained. However, CMS does not endorse any specific organization, certification process, or credential, deferring to state-based credentialing requirements where they exist.[5]

The rule defines patient navigation, "[i]n the context of healthcare," as "individualized help to the patient (and caregiver, if applicable) to identify appropriate practitioners and providers for care needs and support, and access necessary care timely…and includes identifying or referring to appropriate supportive services."[5, p. 361] While advance care planning, chronic care management, behavioral health, psychiatric care, transitional care, and home health and hospice supervision were already reimbursable services, the new codes effective January 1, 2024, are specifically for patient navigation services not previously covered.

These codes can be used by any staff performing eligible services (SDOH assessment, CHI, PIN, PIN-PS), including nurses or social workers as well as oncology patient navigators who are based in clinic or in community settings, community health workers, and other auxiliary personnel.[5-8] The codes do not specify any particular role or profession. Recognizing that social needs have a major influence on access to and completion of cancer care, the new rule provides 2 new G codes for CHI services that can be performed by appropriately trained personnel, including community health workers and navigators, to assess and address patient SDOH affecting a practitioner's ability to diagnose or treat a major illness. An initial CHI assessment by the billing practitioner (**G0023**) is required before nonclinical auxiliary staff performing follow-up CHI services can use code **G0024** as "incident to" billing under the practitioner who performed the initial assessment.[5]

How Do I Bill for Navigation Services?

To bill for PIN services, the person being navigated must have a health condition that the practitioner expects to require management for at least 3 months. PIN services can be performed by a patient navigator, community health worker, or other auxiliary staff member working on a health care team or under an agreement with a health care practice if there is a supervising practitioner. Besides physicians, clinicians that qualify as supervising practitioners vary based on state scope of practice laws for advanced practice registered nurses (APRNs) and physician assistants (PAs).[9,10] In addition to PIN services, codes for CHI services, PIN-PS, and SDOH assessment are also new (Table 1).

Documentation for CHI, PIN, and SDOH risk assessment must include time spent providing services, documentation of patient consent (which can be verbal), description of services performed, and inclusion of associated *International Classification of Diseases, 10th Revision (ICD-10) codes; ICD-10, Clinical Modification Z codes* (ie, reasons for encounters); and G codes. The initiating visit can be an office visit or an annual wellness visit.[5]

Importantly, patient consent is required for CHI and PIN services, as there is cost-sharing associated with all Medicare billing. Standard cost-sharing for Medicare is 20% after the deductible has been met. Medicare Advantage beneficiaries are responsible for coinsurance after the deductible has been met. Consent may be obtained by auxiliary personnel, including a navigator, nurse, or social worker. Only 1 practitioner a month may bill. If this provider changes, another consent must occur.[5]

CMS requires institutions to document credentialing first based on existing individual state requirements. CMS also requires documentation of sufficient knowledge for practice, which state requirements would not necessarily demonstrate.

It is important to note that these new CPT codes do *not* replace *CPT* codes for chronic care management (**99437, 99439, 99490, 99491**), complex chronic care management (**99487, 99489**), and principal care management (**99424-99427**).[5-11] These codes also do not replace health behavior assessment and intervention services that can be provided by clinical social workers and other trained mental health professionals (**96156, 96158, 96159, 96164, 96159, 06167, 96168**).

In addition to the new CHI, PIN, PIN-PS, and SDOH codes, the 2024 MPFS rule also includes *CPT* codes for group behavior training (96202, 96203), caregiver training to facilitate in-home and community-based supports (97550, 97551), and group caregiver training (975552).[5] In addition, while G0511 previously could be used for general care management from federally qualified health centers, remote patient monitoring is also acceptable as of January 1, 2024.[12]

Finally, the 2024 MPFS rule delayed any permanent decision about virtual supervision (telehealth) established under the Consolidated Appropriations Act of 2023, extending approval for telehealth services through December 31, 2024.[13]

How Much is Reimbursement?

CY 2024 rates for select codes are included in Table 1. The American Society of Clinical Oncology (ASCO) also publishes a reimbursement breakdown by for various services.[12] Given that these rates will change each CY, we refer readers to the ASCO annual updates for guidance on future reimbursement rates.[11]

Navigator Credentialing

Credentialing can be confusing. Regardless of the auxiliary health personnel title or professional role, CMS requires institutions to document credentialing first based on existing individual state requirements.[14,15]

For example, New Mexico has existing state requirements for community health worker training and practice with oversight from the New Mexico Department of Health, Office of Community Health Workers.[16,17] Community health worker certification costs about $100 and requires either: 1) completion of a specific training provided by the New Mexico Department of Health or from an approved Department of Health training partner along with field experience, or 2) 2000 hours of experience in the last 2 years plus 2 letters of reference. Although CMS does not require field experience, the State

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TABLE 1. PATIENT NAVIGATION-RELATED G CODES AND 2024 MEDICARE RATES FOR SELECT SERVICES

Code	How to Use	2024 Rate[12]	Minimum Time to Bill	Training Required
G0136	Risk assessment is based on a practitioner's reason to believe there are unmet SDOH needs; it is not intended for routine screening for patients at every visit or for every patient. It typically is not administered in advance of the visit. If conducted during an annual wellness visit, cost-sharing does not apply. If conducted at a visit for any other reason, cost-sharing applies. CMS does not require a particular tool but cites the CMS Accountable Health Communities Tool and Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) as appropriate tools. This code is permanently added to telehealth visits as well.	$18.67	5-15 minutes not more than every 6 months per practitioner per beneficiary	State-based requirements OR documentation of key competency domains
G0019	CHI staff make an initial visit with assessment by a clinical health worker under the direction of a billing practitioner to document and address SDOH needs that significantly limit the ability to complete diagnosis or treatment of the chronic health condition. Examples of CHI services include person-centered care planning, health system navigation, referral and coordination to community-based resources, care coordination, and patient self-advocacy promotion.	$78.92	60 minutes (once monthly)	State-based requirements OR documentation of key competency domains
G0022	CHI staff address SDOH needs that are significantly limiting the ability to complete diagnosis or treatment of the chronic health condition after an initial assessment under supervision of a billing practitioner.	$49.45	Additional 30-minute increments (unlimited)	State-based requirements OR documentation of key competency domains
G0023	Initial person-centered assessment for PIN services; staff should assess SDOH, facilitate patient-driven goal setting, and establish an action plan for tailored support. Such support can include coordination of community-based services and care transitions, health education, patient self-advocacy skill coaching, active navigation of the health care system, facilitation of behavior change, provision of social and emotional support, mentorship, and inspiration to help patients meet treatment goals.	$78.92	First 60 minutes per calendar month (once monthly)	State-based requirements OR documentation of key competency domains
G0024	PIN services after the initial assessment is billed using G0023. Note that "incident to" billing can used for services provided by navigators working within the cancer care setting and for navigation conducted external to the cancer care setting with appropriate agreements with trained staff at community-based organizations. Clear integration of community-based services with the supervising practitioner are required for billing.	$49.45	Additional 30-minute increments per calendar month (unlimited)	State-based requirements OR documentation of key competency domains
G0140	PIN services by peers are intended for mental and substance abuse support based on training from SAMHSA.	$78.92	First 60 minutes per calendar month (once monthly)	SAMHSA standards[6]
G0146	PIN services by peers are intended for mental and substance abuse support based on training from SAMHSA.	$49.45	Additional 30-minute increments per calendar month (unlimited)	SAMHSA standards[6]

CHI, community health integration; CMS, Centers for Medicare & Medicaid Services; PIN, principal illness navigation; SAMHSA, Substance Abuse and Mental Health Services Administration; SDOH, social determinants of health.

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of New Mexico Community Health Worker Certification does require field experience within the structure of approved training programs. University- and community college-based, approved trainings have required practicums or clinical agency components.[16,17]

It is unclear whether navigators seeking to be newly credentialed in New Mexico would need field hours in addition to training if that training is obtained outside of the approved list of New Mexico Department of Health, Office of Community Health Workers, programs. Certification regulations for community health workers imply that navigators seeking to be credentialed in New Mexico must look to satisfy the state's requirement and have some field-based experience.[17,18] While a patient navigator completing the community health worker certification in New Mexico would be satisfying the minimum requirement credentialing, CMS also requires documentation of sufficient knowledge for practice, which state requirements would not necessarily demonstrate.[18,19]

Effective, consistent navigation services elevate the reputation of a cancer program or practice and can potentially save institutions money. Navigation is optimal when its delivery is cost-effective, time-efficient, and compassionate.

In another example from the state of California, Medi-Cal covers community health worker services to help control and prevent chronic, infectious, mental health, perinatal, sexual, reproductive, and other conditions with a written recommendation from a supervising practitioner.[20] California requires community health workers to share lived experience with the population being served and complete an approved curriculum that comes with a certificate of completion. Community health workers may practice for a maximum of 18 months under a supervising practitioner without a certificate of training if the community health worker can demonstrate appropriate skills and document 2000 hours of work, including paid or volunteer roles, within the previous 3 years. All community health workers must complete 6 hours of continued education training annually.[20] Unlike many other states, California also specifies that "health navigators, health coaches, community outreach workers, recovery specialists, and family support workers" fall under the same credentialing requirements as do community health workers.[21]

In states that do not specifically include "navigators" within the definition of community health workers for payment credentialing, it is currently unclear whether navigators with a more focused scope of practice are required to fulfill state-specific community health worker requirements.[22] We do know, however, that obtaining community health worker credentialing based on state requirements and documenting training in appropriate competencies for the oncology navigator role should be sufficient. Specific competencies that must be met include "patient and family communication, interpersonal and relationship-building, patient and family capacity building, service coordination and systems navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including specific certification or training on the serious, high-risk condition/illness/disease addressed in the initiating visit."[5, p. 389] Cancer programs and practices can comply with the rule by documenting that navigators have successfully completed training that meets these competencies (Table 2).

The GW Oncology Patient Navigation Training: The Fundamentals (Principal Investigator: Pratt-Chapman) was created and maintained with support from the Centers for Disease Control and Prevention (CDC) (cooperative agreements #NU38DP004972, #5NU58DP006461, and #NU58DP007539 and has been available since 2015 at bit.ly/PNTraining. Other excellent state-based or national trainings—with or without a fee—also meet CMS training requirements.[21] Additionally, the Gallaudet University Center for Deaf Health Equity has a patient navigation curriculum for speakers of American Sign Language adapted from the GW Cancer Center Oncology Patient Navigator Training: The Fundamentals. This curriculum is currently in use for a clinical trial, but it is not yet publicly accessible.

Training to Provide Affirming Care to Priority Populations

CMS acknowledges that navigation is most effective when focused on populations that have the greatest need for support. In addition to navigation basics, CMS requires that navigators have content-specific knowledge relevant to the type of navigation services they will perform. In the ACCURE Trial,[23] for example, navigators also had critical racial health equity training. Myriad of health equity resources are available, including from the CDC's funded National Networks.[24] In addition to having a strong foundation of cancer patient navigation knowledge, a deep understanding of the community being served is critical to effectively navigating patients and families. See Table 3 for training resources on priority populations.

Training is not the only way to demonstrate appropriate expertise for a navigator's knowledge for practice. In 2008, the National Consortium of Breast Centers began providing certification for certain types of breast cancer navigation. In 2020, the Academy of Oncology Nurse & Patient Navigators (AONN+) inaugurated the Oncology Patient Navigator-Certified Generalist (OPN-CG) credential. Both credentials are helpful to document appropriate knowledge for practice in serving a specific patient population. Supplemental knowledge resources specific to cancer basics are offered from the National Cancer Institute (cancer.gov), the American Society of Clinical Oncology (cancer.net), and the American Cancer Society (cancer.org). For licensed clinical professionals, the authors anticipate that social work licensure and nurse licensure should be sufficient documentation of training given the heightened rigor of these credentials. We will collectively benefit from lessons learned and shared across navigating roles as institutions begin to pilot and roll out billing for PIN services.

Beyond Training: Navigator Professional Development, Program Implementation, and Evaluation

Training is the start, not the end, of strong navigation. Expertise in navigation requires ongoing personal and professional development from navigators eager to learn and seek out reliable information such as core competencies for community health workers[25] and oncology patient navigators,[18] as well as the Oncology Navigation Standards of Professional Practice.[19] Navigators should understand

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TABLE 2. TRAININGS OR CREDENTIALS THAT MEET CMS REQUIREMENTS FOR REIMBURSEMENT OF SERVICES

Training	Scope	Costs	How to Access	Considerations
Academy of Oncology Nurse and Patient Navigators (AONN+) – OPN-CG certification	National certification that requires successful completion of an examination and a number of years of experience.	$150	Online at aonnffl.org/renew	Currently on hold, but still valid to document appropriate training for those with the credential. Requires renewal after 3 years
American Cancer Society Leadership in Oncology Navigation (LION)	National training and certification.	$495	Online at cancer.org/health-care-professionals/resources-for-professionals/patient-navigator-training.html	Cost associated. Requires renewal every 3 years. Approximately 10 hours.
GW Cancer Center Oncology Patient Navigator Training: The Fundamentals	National training for those supporting patients of all cancer types. Certificate provided. Prepares learners for AONN+ OPN-CG certification.	Free	Online at bit.ly/PNTraining	Funded by the Centers for Disease Control and Prevention, this training aims to level set navigator knowledge. Institutions should provide supplemental context-specific and cancer-specific training tailored to the specific duties of the navigator following this foundational training. 10 hours of core requirements plus supplemental reading (estimated 17 hours total).
Patient Navigation and Community Health Worker Training	A full curriculum for patient navigators, care coordinators, and community health workers.	Varies	Sign up at Patientnavigatortraining.org (course is hybrid: in-person and online)	Requests for financial aid considered on a case-by-case basis. May not cover all required competencies for CMS billing with level 1 training only. Hours vary based on level and degree of tailoring.
Susan G. Komen Patient Navigation Training Program	National training for those affected by all cancers with additional breast cancer focused content.	Free	Online at komen.org/about-komen/our-impact/breast-cancer/navigation-nation-training-program	Originally adapted from GW Cancer Center Oncology Patient Navigator Training: The Fundamentals with additional unique content developed by Komen. Features virtual ongoing educational events and peer networking. 10 hours of core requirements plus special topics.

CMS, Centers for Medicare & Medicaid Services; GW, George Washington; OPN-CG, oncology patient navigator–certified generalist.

TABLE 3. TRAINING FOR SPECIFIC PATIENT POPULATIONS

Focused Content	Resources	Type of Resource	Scope	Additional Information
State-based requirements	ASTHO overview of state requirements	Online brief	Review of state requirements for community health worker credentialing as of June 2022.	Accessible at astho.org/topic/brief/state-approaches-to-community-health-worker-certification
Breast cancer patients	National Consortium of Breast Centers	Certification	Credential to affirm core knowledge for breast cancer for navigation.	Cost associated. Accessible at navigatorcertifications.org
	Susan G. Komen	Online training	Training aligned with CMS requirements plus additional breast cancer-specific lessons.	Free, self-paced, online. Accessible at komen.org/about-komen/our-impact/breast-cancer/navigation-nation-training -program
Black, Latino, LGBTQI people	GW Cancer Center Together, Equitable, Accessible, Meaningful (TEAM) Training	Online training	Training to assist health care teams in identifying and implementing changes to advance health equity in Black, Latino, Latina, Latinx, and LGBTQI populations.	Free, self-paced, online Accessible at bit.ly/GWCCTEAMtraining
People who use American Sign Language (eg, those who are deaf, deaf-blind, or hard of hearing)	Gallaudet University Center for Deaf Health Equity	Online training	Training specifically focused on health disparities of people who are deaf, deaf-blind, or hard of hearing.	In development; will be made available for continuing education.
Elderly persons from 13 diverse ethnic backgrounds	Stanford Internet-Based Successful Aging (iSAGE)	Online training	Training to improve quality of life and care for older persons of diverse backgrounds.	Free, but limited capacity. Includes community of practice with secure interaction forum and dialogue. Accessible at geriatrics.stanford.edu/about.html
LGBTQI persons	National LGBT Cancer Network Welcoming Spaces Training	Online training	Training to elevate cultural humility to serve LGBTQI populations.	Free, self-paced, online. Accessible at cancer-network.org/welcoming-spaces
Native American and Alaska Native persons	Native American Cancer Research Corporation	Virtual and in-person training	Education to address cultural and political issues that impact navigation across the cancer continuum for Indigenous populations.	Cost associated. Competency-based modules; include personal skills assessment. Ranges from 80-200 hours based on number of modules and tailoring. Accessible at natamcancer.org/Patient-Navigator-Training

ASTHO, Association of State and Territorial Health Officials; CMS, Centers for Medicare & Medicaid Services; GW, George Washington; LGBTQI, lesbian, gay, bisexual, transgender, queer/questioning (one's sexual or gender identity), and intersex.

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the complexities of the health sequelae and social conditions faced by their patients. Effective navigators have strong relationship- and team-building skills, assess community resources to ensure responsiveness and credibility of services, and consistently deliver navigation services to build trust with patients, caregivers, and clinicians. Effective, consistent navigation services elevate the reputation of a cancer program or practice and can potentially save institutions money. Navigation is optimal when its delivery is cost-effective, time-efficient, and compassionate. Professional development, continuing education, and mentorship are critical to supporting the health and growth of the patient navigation workforce. Finally, the scope of navigator practice should be appropriate to licensure, training, and experience.[25-27]

Successful navigation programs require strategic integration of key stakeholders and information technology (IT) support. Focused implementation of risk-stratified patient navigation responsive to specific patient populations and care contexts—as well as IT support to chart, track, and evaluate navigation—is key for optimal program impact.[28-32] Successful planning before implementation includes these 4 key steps:

- Convening IT and administrative leaders to build new G codes into the electronic health record (EHR)
- Tracking navigation activities either within or outside of the EHR
- Optimizing patient demographic data to stratify outcomes
- Piloting the billing of new codes prior to full implementation.

Early engagement of key stakeholders will improve the incorporation of patient navigation data, streamlining workflows and enhancing reporting capabilities. Recommended key stakeholders to engage include billing specialists, the compliance team, data analysts, and informatics specialists. A practical guide published by the Association of Community Cancer Centers (ACCC) that was cited by CMS in the 2024 MPFS rule provides guidance on refining the focus, models, and workflows of a navigation program.[30]

A critical part of patient navigation implementation is outcomes tracking. In the ACCURE Trial, which eliminated health outcome disparities between White and Black patients with breast and lung cancer, the navigation intervention was matched with rapid data reporting through clinical quality dashboards that allowed practitioners to see disparities in real time.[24] The GW Patient Navigation Barriers and Outcomes Tool (PN-BOT) is a free resource for case management and data tracking.[27] While this tool is limited to 1 user and is not integrated into EHRs, the software can be adapted to customize an EHR, and EHR vendors may have examples of templates that have worked to document navigation in various settings. Investments in commercial software and/or tailored EHR fields that support case management and data tracking may help navigators be most efficient and accurate with documentation critical for billing.

Next Steps for the Field

First, future research should include analyses of which states include navigators under the community health worker terminology for purposes of payment credentialing as well as the degree to which state-level requirements for community health worker credentialing fit with oncology patient navigators' scope of practice. Studies on implementing the payment codes—including barriers, facilitators, and lessons learned—will also be valuable.

Second, the workforce of community health workers and navigators cannot be sustained without skills-based pay that reflects the experience, knowledge, and expertise of those performing navigation services. Additionally, skills-based pay is essential to avoid the common paradox of an inequitably paid community health worker or health navigator who struggles to pay for basic life expenses while helping patients access much-needed resources. It also should be emphasized that the degree to which current reimbursement rates are sufficient to cover the salary and programmatic costs of providing community health worker and patient navigation services is yet to be determined. More research is needed to optimize appropriate reimbursement rates for patient support that optimally advances health equity based on patient need, navigator training and experience, and costs of providing services.

Third, while these new codes are an important step forward for navigation sustainability, cost-sharing is a real and serious limitation for patients. Based on current CMS policy, patients will need to consent to PIN services, since there will be a 20% cost-share. There is a real risk that those individuals most in need of services could decline assistance due to inability to pay. Additionally, cost-sharing will likely come as a surprise to patients who previously received navigation services free of charge. The field will benefit from research describing reasons for and extent of patient nonconsent for services and the amounts patients pay due to cost sharing. Advocacy to close the cost-share gap as well as proactive philanthropy to cover costs for needy patients should be pursued and lessons learned should be shared with the field.

Fourth, feasibility of effective caseload management that supports the health of patients and the navigation workforce should be further studied to ensure appropriate expectations.[33-36] Appropriate caseload management can be achieved using an acuity-based case weight system.[32] This system provides for equitable distribution of community health worker and patient navigator caseloads considering the navigator's time allocation based on individual patient needs, severity of illness, and social determinants. Smaller caseloads are needed for more complex navigation—such as support for patients who have been historically excluded, marginalized, stigmatized, and/or traumatized. These individuals are more likely to have significant and numerous barriers to care, necessitating more time and resources from the auxiliary health professional to find culturally-, economically-, legally-, and socially-affirming supports.

Fifth, ongoing training, support, mentorship, and counseling for navigation roles on the front line of care should be prioritized, and best practices to accommodate navigators with disabilities should

be shared and implemented. As the navigation workforce continues to professionalize, ongoing training and education should support deepening the proficiency of navigators beyond the baseline required by CMS.[27] Institutions should also seek to model supports that allow navigators to actualize their own optimal health while assisting those in need.

Finally, while payment for patient navigation is a thoughtful and laudable start to support much-needed and health-related social needs support to people affected by cancer and other serious illnesses, future research on barriers and facilitators to implementation of the new G codes for SDOH, CHI, PIN, and PIN-PS will be needed to share lessons learned for cancer programs and practices in the years to come. ■

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Additional Resources

GW School of Medicine & Health Sciences. 2021 Updates to the Oncology Patient Navigator Training.

GW School of Medicine & Health Sciences. Financial Navigation Lesson for Oncology Patient Navigators.

GW School of Medicine & Health Sciences. Patient Navigation Guide (English and Spanish) and Companion Resources.

GW School of Medicine & Health Sciences. Reducing Financial Toxicity: Tips for Patient Navigators.

GW School of Medicine & Health Sciences. Advancing the Field of Cancer Patient Navigation: A Toolkit for Comprehensive Cancer Control Professionals.

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Native American Cancer Initiatives. NACI Care™.: A Patient Navigation Data Entry, Tracking, and Evaluation Tool.

National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Distress management, version 1.2024.

National Comprehensive Cancer Network. Evidence-based Resources for Patients and Navigators.

National Comprehensive Cancer Network. Measuring and Addressing Health Related Social Needs in Cancer: Working Group Recommendations.

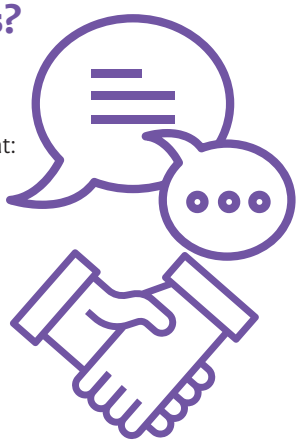
fast facts

4 Community Engagement Recommendations to Reduce Racial Disparities in Access to Cancer Care

- Reflect community demographics in practice leadership
- Use culturally and linguistically appropriate wording
- Partner formally and equitably with community-based organizations
- Develop programs based on community health needs assessments

Source. National Comprehensive Cancer Network. Health Equity Report Card.

Do Providers Need More Honest Dialogue with Patients?



A City of Hope study of patients with advanced neuroendocrine tumors found that:

- Only **30%** of patients say their top goal for treatment is living longer; **70%** of patients selected other treatment goals as most important, including maintaining the ability to do daily activities, reducing or eliminating pain, or reducing or eliminating symptoms like fatigue.
- **67%** of those surveyed agreed with the statement, "I would rather live a shorter life than lose my ability to take care of myself."
- Respondents felt that their providers were more singularly focused on extending overall survival, even if it impacted other outcomes; only **52%** of patients perceived that they had the same treatment goals as their physician.

Source. Li D, Can-Lan S, Kim H, et al. Patient-defined goals and preferences among adults with advanced neuroendocrine tumors. JNCCN. 2022;20(12):1330. doi:10.6004/jnccn.2022.7059

Nearly Half of American Women Forgo Preventive Care Services

A survey of more than 3,000 American women found nearly half (**45%**) are forgoing preventive care services like check-ups, screenings, and vaccines; the inability to afford out-of-pocket costs is the most common reason women cite for skipping this critical care. Other survey findings include:

- 3 out of 4 women (**76%**) have received a cervical cancer screening at some point in their lifetime
- White women are more likely to have received a cervical cancer screening (**81%**) than Black women (**65%**), Asian women (**66%**), and Hispanic women (**68%**)
- Women who are insured (**79%**) are more likely to have received a screening than uninsured women (**51%**)
- **72%** of women are likely to get a cervical cancer screening if it is recommended by their provider
- Only **34%** are likely to get a cervical cancer screening if it is not covered by their insurance.

Source. Alliance for Women's Health and Prevention Poll conducted online from Nov. 18-Dec. 8, 2022 by Ipsos. womenshealthandprevention.org/wp-content/uploads/2023/01/AWHP-Ipsos-Survey_Topline-Results.pdf.

5 Negative Effects of Prior Authorizations

1. ***Delayed Care***. More than 9 in 10 physicians (**94%**) reported that prior authorization delayed access to necessary care.
2. ***Bad Outcomes***. Nearly nine in 10 physicians (**89%**) reported that prior authorization had a negative impact on patient clinical outcomes.
3. ***Disrupted Care***. 4 in 5 physicians (**80%**) said patients abandoned treatment due to authorization struggles with health insurers.
4. ***Lost Workforce Productivity***. More than half of physicians (**58%**) who cared for patients in the workforce reported that prior authorizations had impeded a patient's job performance.
5. ***Patient Harm.*** 1/3 of physicians (**33%**) reported that prior authorization led to a serious adverse event for a patient in their care, including hospitalization, permanent impairment, or death.

Source. American Medical Association. 2022 AMA Prior Authorization Physician Survey. ama-assn.org/system/files/prior-authorization-survey.pdf.

What Frustrates Patients the Most About Medical Bills

- Being able to understand what they're being billed for—**29%**
- Uncertainty if they can pay the bill—**27%**
- Not getting a bill until weeks after they received service—**24%**
- Uncertainty if the final bill will be consistent with the estimate of responsibility—**20%**

Source. An AKASA survey conducted by You.Gov. prnewswire.com/news-releases/nearly-40-of-americans-confused-by-medical-bills-301705347.html.

more online @ accc-cancer.org

TOOL | Guideline-Based Care Plans for Providers and Patients

ACCC, in partnership with the Center for Business Models in Healthcare, is making 4R Care Sequences® available at no cost to ACCC members. These guideline-based care plans are personalized for specific patient populations at each point in care, for example, at diagnosis and during transitions between treatments. The 1-page templates are available in hard copy or electronically.

PODCAST | Beyond the Brush: Navigating Dental Care in Head & Neck Cancer

While advancements in oral medicine are improving the treatment landscape for head and neck cancer, routine dental care and preventative oral cancer screenings can help identify head and neck cancers early. This CANCER BUZZ podcast explains the proactive role dentists can play in early identification of cancer—as well as the need for equitable access to dental care—and explores how a cross-disciplinary cancer care team and patient education work in tandem to better manage complications from head and neck treatment.

PUBLICATION | Multidisciplinary Approaches to Addressing the Needs of Patients with Gynecologic Cancers

This executive summary of ACCC's September Gynecologic Oncology Summit addresses issues like care equity, gynecologic cancer awareness, social drivers of health, workforce challenges, and patient advocacy. Explore discussions held during the summit regarding barriers in the management of gynecologic cancers and potential next steps to further improve treatment of this patient population.

BLOG | Unite for HER's Vision for Equitable Cancer Care

This national nonprofit organization has spent the last 14 years enriching the health and well-being of those affected by breast and ovarian cancers. In this blog, learn how collaboration lies at the heart of its efforts. By forming strategic partnerships with hospitals, nonprofits, and advocacy groups, Unite for HER works collectively to ensure that underserved communities receive equitable access to integrative services, education, and support.