IIPNN CMS (Medicare) Reimbursement for PN Services

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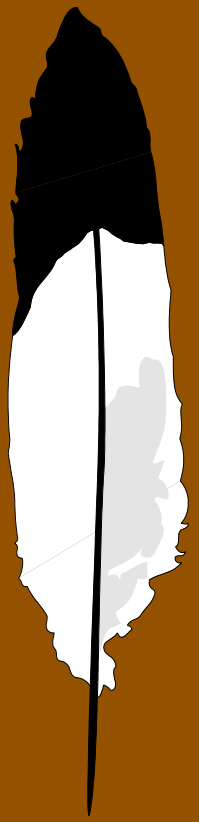
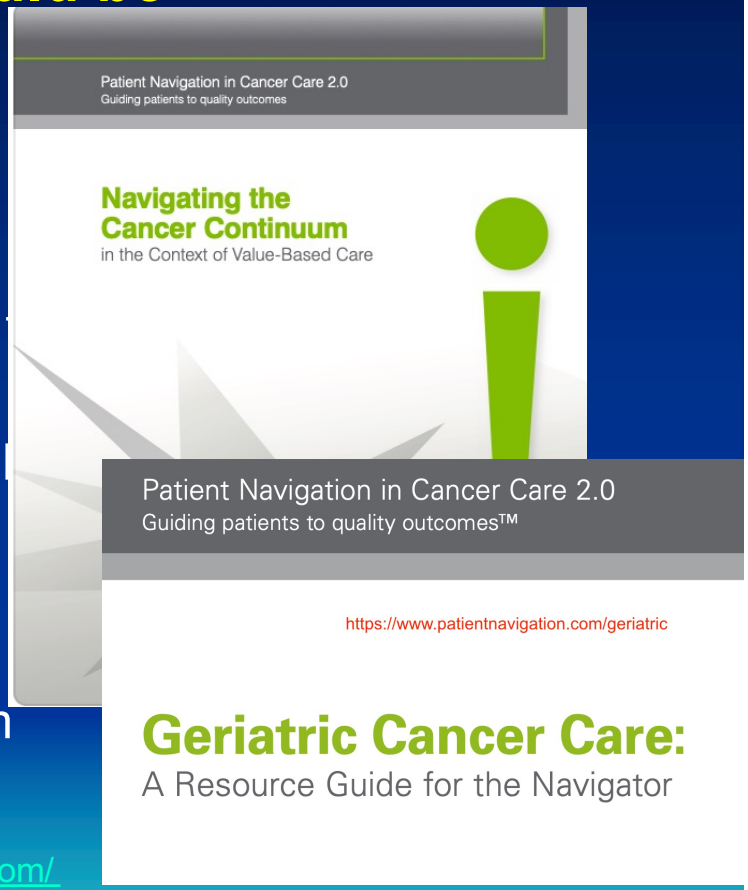


Nationally recommended PN metrics and PIN code reimbursement are related in most successful programs

Navigation programs should be

- Assessed annually to evaluate successes
- Identified areas of unmet need, new barriers, and ongoing challenges
- Establish objectives for expanding and advancing program
- Using the metrics and outcome measures establis for the navigation program
- Data collected can be compared with the baseline analyzed to determine areas needing additional attention, further development to promote program viability and evolution



Patient Navigation in Cancer Care 2.0 (Pfizer) p. 49 https://www.patientnavigation.com/
2022 Pfizer Geriatric Tool Kit https://www.patientnavigation.com/geriatric

Examples of National Organizations & recommendations for metrics and reports

- Commission on Cancer
- The National Accreditation Program for Breast Centers
- The American Society of Clinical Oncology (ASCO)'s Quality Oncology Practice Initiative Merit-based Incentive Payment System / Alternative Payment Models
- Center for Medicare and Medicaid's Oncology Care Model
- Academy Of Oncology Nurse & Patient Navigators
- Oncology Nursing Society

NOTE: uniformity in PN data metrics

3 areas of measurement:
- Patient Experience (PE)
- Clinical outcomes (CO)
- Return on investment (ROI)

Categories	Metric	Meas	Interval	Data Type
Coordination of Care / Care Transitions	1. Treatment Compliance: Percentage of navigated patients that adhere to institutional treatment pathways per quarter	CO ROI	Quarter	Number Percent
	2. Barriers to care: Number and list of specific barriers to care identify by navigator per month	CO ROI	Month	Number
	3. Interventions: Number and specific referrals / interventions offered to navigated patients per month	PE CO	Month	Number
	4. Clinical Trial Education: Number of patients educated on clinical trials by the navigator per month	PE CO	Month	Number
	5. Clinical Trial Referrals: Number of navigated patients per month referred to clinical trial department	PE CO	Month	Number
	6. Patient Education: Number of patient education encounters by navigator per month	PE CO ROI	Month	Number
	7. Multidisciplinary Communication: number of patients who are referred to revenue generating services	ROI	Month	Number
	8. Diagnosis to initial treatment: Number of business days from diagnosis to iniitial treatment modality	PE CO	Business days	Number
	9. Diagnosis to First Oncology Consult: Number of business days from diagnosis to initial oncology consult	ROI	Business days	Number
Research, Quality, Performance Improvement	10. Patient Experience / Patient Satisfiaction with Care: Patient experience or patient satisfaction survey results per month	PE	Month	Number Percent
	11. Patient Experience / Patient Satisfaction with Care: Monitor one major goal of current navigation program annually as defined by cancer committee	PE CO ROI	Annual	Text
	12. Patient Transition from Point of Entry: Percentage of navigated analytic cases per month transitioned from institutional point of entry to initial treatment modality	PE CO	Month	Number Percent
	13. Diagnostic Workup to Diagnosis: Number of business days from date of abnormal finding to pathology report for navigated patients	CO	Business days	Number
Operations management, Organizational Develop, Health Economics	14. 30-, 60-, 90-Day Readmission Rate: Number of navigated patients readmitted to the hospital at 30, 60, 90 days. Report	ROI	Quarterly	Number
	15. Navigation Operational Budget: Monthly operating expenses by line item	ROI	NA	NA
	16. Navigation Caseload: Number of new cases, open cases, and closed cased navigated	ROI	Month	Number
	17. Referrals to Revenue-Generating Services: Number of referrals to revenue-generating services per month by navigator	ROI	Month	Number
	18. Inpatient Oncology Unit Length of Stay	ROI	Days	Number
	19. No show rate. Number of navigated patients who do not complete a scheduled appointment	ROI	Month	Number
	20. Patient Retention through Navigation: Number of analytic cases per month or quarter that remained in your institution due to	ROI	Month	Number
	21. Emergency Department Utilization: Number of navigated patient visits to the emergency department per month	ROI	Month	Number
	22. Emergency admissions per Number of Chemotherapy Patients: Number of navigated patient visits per 1000 chemotherapy patients that had an emergency department visit per month	ROI	Month	Number

Categories	Metric	Meas	Interval	Data Type
Community Outreach, Prevention	23. Cancer Screening Follow-Up to Diagnostic Workup: Number of navigated patients per quarter with abnormal screening referred for follow-up diagnostic workup	PE CO ROI	Quarter	Number
	24. Cancer Screening: Number of participants at cancer screening event and/or percentage increase of cancer screening	PE CO	Month / Quarter	Number
	25. Completion of Diagnostic Workup: Number of navigated individuals with abnormal screening that completed diagnostic workup per month/quarter	CO ROI	Month / Quarter	Number
	26. Disparate Population at Screening Event: Number of individuals per quarter at community screening events by Office of Management and Budget (OMB) Standards.	PE CO	Quarter	Number
Professional Roles and Responsibilities	27. Navigation Knowledge at the Time of Orientation: Percentage of new hires that have completed institutionally accepted developed navigator core competencies	CO	Annual	Number Percent
	28. Oncology Navigator Annual Core Competencies Review: Percentage of staff that have completed institutionally accepted developed navigator core competencies annually to validate core knowledge of oncology navigation	CO	Month	Number Percent
Psychosocial Support, Assessment	29. Psychosocial Distress Screening: Number of navigated patients per month that received psychosocial distress screening at a pivotal medical visit with a validated tool	PE CO	Month	Number
	30. Social Support Referrals: Number of navigated patients referred to support network per month	PE CO ROI	Month	Number
Patient Empowerment, Patient Advocacy	31. Patient goals: Percentage of analytic cases per month that patient goals identified and discussed with the navigator	PE CO ROI	Month	Number Percent
	32. Caregiver Support: Number of caregiver needs / preferences discussed with navigator per month	CO	Month	Number
	33. Identify Learning Style Preference: Number of navigated patients per month that preferred learning style was discussed during the intake process	PE CO	Month	Number
Survivorship and End of Life	34. Survivorship Care Plan: Number of navigated patients per month that received a survivorship care plan and treatment summary	PE CO	Month	Number
	35. Transition from Treatment to Survivorship: Percentage of navigated analytic cases per month transitioned from completed cancer treatment to survivorship.	PE CO	Month	Number Percent
	36. Referrals to Support Services at the Survivorship Visit: Number of navigated patients per month referred to appropriate support service at the survivorship visit	PE CO ROI	Month	Number
	37a. Palliative Care Referral: Number of navigated patients per month referred for palliative care services	PE CO ROI	Month	Number
	37b. Hospice / End-of-life Care Referral: Number of navigated patients per month referred for hospice / end-of-life care services	PE CO ROI	Month	Number

Navigation Metrics Toolkit (August 2020)

- The American Cancer Society, the Academy of Oncology Nurse and Patient Navigators (AONN+) and the Merck Foundation collaborated
- on a toolkit to facilitate patient navigation programs
- in the integration of ~35 metrics identified and documented by AONN+ in 2015.
- The 2020 Toolkit delineated 10 of the metrics

https://aonnonline.org/images/resources/navigation_tools/2020-AONN-Navigation-Metrics-Toolkit.pdf

Clarified how 10 of the 35 metrics could be measured and evaluated

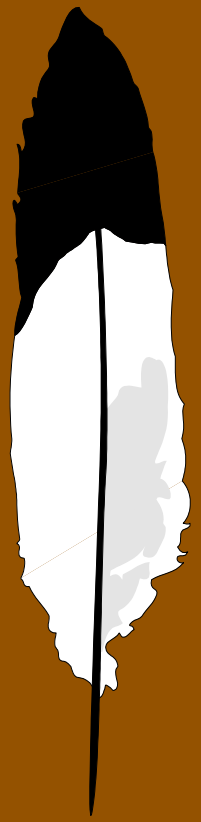
- Concurrently, process for obtaining national accreditation for PN exam
- American National Standards Institute (ANSI) National Accreditation Board (ANAB)
- National Certification for Oncology Nurse and Patient Navigator Generalists Available in US (August 5, 2020)

https://aonnonline.org/press/3068-anab-awards-national-accreditation-to-aonn-foundations-for-learning-inc

NavPoint Health

Detailed Study Metrics with Measurement Information

1	BARRIERS TO CARE
Measure description	Number and list of specific barriers to care identified by navigator per month (obstacles that prevent a cancer patient from accessing care, services, resources and/or support)
Initial population	Number of cancer patients, regardless of age, who were receiving navigation services during the 6-month measurement period
Denominator	Total number of barriers identified per patient during the measurement period
Numerator	Number of barriers identified per patient per month
Exclusion and exception	None
Data sources	▪ EHR ▪ NAVmetrics™ ▪ Institutional navigation software
Key terms, data elements, codes	▪ Financial [insurance, transportation, communication, language, knowledge deficits, work/disability, need help at psychological (fear, anxiety, distress)] ▪ Practical [children, etc.] ▪ Physical [pain, anorexia, mobility] ▪ Complex care coordination ▪ Other [home, cultural, spiritual]
Unit of measurement or analysis	Number of barriers
Sampling	Care settings will be compared.
Risk adjustment	None per patient (outer data will be analyzed and omitted if necessary)
Data period	October 15, 2018, through April 15, 2019
Measure results	Monthly metric data will be compared between each study site and an aggregate benchmark for all participating sites; the benchmark will use rolling 12-month data and display 25th, 50th, and 75th percentiles.
Calculation/Measure algorithm	Data will be reported in percentiles.



Introduction to CMS PIN Codes

Centers for Medicare & Medicaid Services (CMS) PIN Codes

- Change to Medicare payments effective January 1, 2024
- Examples of Services that qualify
  - Person-centered assessments which involve assessing how SDS 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

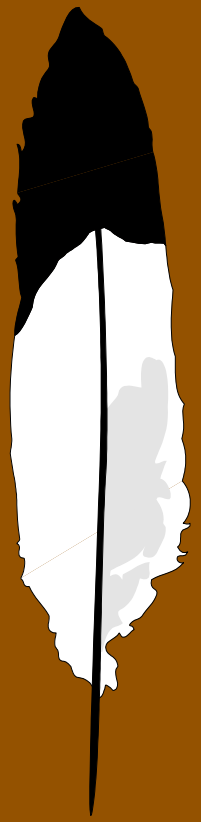
The Centers for Medicare & Medicaid Services Will Pay for Patient Navigation—Now What? By Mandi L. Pratt-Chapman, PhD, MA, OPN-CG; Gabriel Rocque, MD; Julie McMahon, MPH; Manali Patel, MD, MPH, MS, FASCO; Taneal Carter, MS, MPA; Nancy Pena, OPN-CG, MI, BS; Poorna Kushalnagar, PhD; Lexi Boyd, BSN, NR; Reesa J. Sherin, MSN, RN; Jessica Quiring, BS, CN-BA, OPN-CG, CDP; Zarek Mena, OPN-CG; Linda Burhansstipanov, MSPH, DrPH; Don S. Dizon, MD; Clara Lambert, CPH, BBA, OPN-CG; Samuel Cykert, MD; and Julie E. Bauman, MD, MPH. Released Association of Cancer Care Centers, March 2024

Principle Illness Navigation (PIN) Code Reimbursement

- CMS Codes and reimbursement contribute to *sustainable* navigation programs
- PIN Codes do NOT cover outreach or screening …. But,
  - If get reimbursed for patients diagnosed with at least one of 17 conditions that last at least 3 months, provides sufficient funds for MOST Indigenous programs to cover the costs of outreach and screening tasks
  - Code G0023 pays $78.92 an hour; G0024 pays $49.45
- Both Community (non-clinical) and clinic-based programs are eligible
- Both licensed (RNs, SW) and non-licensed auxiliary staff are eligible
- Many large clinical settings are integrating PIN "return on investment" metrics into EHR systems (e.g., EPIC)
  - EHRs do not collect many metrics essential for PN programs; IT has to add
  - Challenging to get reports generated in a timely manner

Issues with 2024 Requirements

- Patient asked to pay portion of auxiliary staff fee
  - Requirement is to ask, but does not mean have to collect the fee
- Codes do not include services prior to diagnosis (e.g., screening)
- Codes do not address long-term or late effects from condition
  - AI cancer survivors more likely to experience both effects 3 to 15 years after initial cancer treatment completed
- Various contradictions in training requirements to be “certified”
  - ACS ~5 hours
  - Both ONS and AONN+ requires equivalent to years of experience as a pre-requisite to taking the accredited exams
- Need a checklist for oncology patient navigators based in non-clinical community based organizations



What are the 17 conditions?
What are the codes?

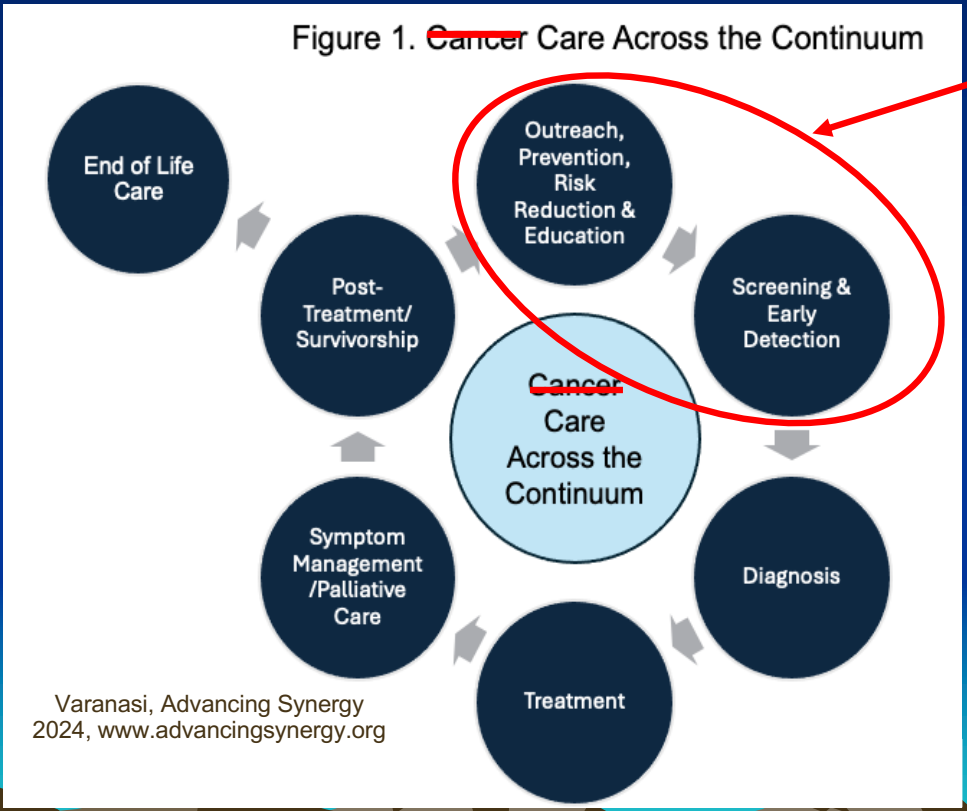
17 Chronic Conditions Eligible for PIN Code Reimbursement

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Dementia
- Diabetes
- Heart failure
- HIV/AIDS
- Hypertension
- Ischemic heart disease
- Osteoporosis
- Severe Mental Illness
- Substance Use Disorder (SUD)

https://codingintel.com/principal-illness-navigation-pin-services/#:~:text=Examples%20of%20serious%2C%20high%2Drisk,clinical%20integration%20with%20the%20practice. accessed July 2025

Cancer Care Continuum can be adapted to conditions other than cancer

Remove “cancer” from the phases and note that some public health programs will not include specific phases, e.g., end-of-life



PIN codes exclude

Abbreviations relevant to CMS & Navigation Reimbursement

- CHI: Community Health Integration
- CMS: Centers for Medicare and Medicaid Services
- CPT: Current Procedural Terminology; Reimbursement for anything that patient steps *within hospital*
- G codes: used to report patient functional data to Medicare; Reimbursement codes for clinical or educ *events not in hospital*
- PIN: Principal Illness Navigation
- ~~SDOH: Social Determinants of Health~~

Pratt-Chapman, Mandi L., PhD, MA, OPN-CG; Gabriel Rocque, MD: Julie McMahon, MPH; Manali Patel, MD, MPH, MS, FASCO; Taneal Carter, MS, MPA; Nancy Pena, OPN-CG, MI, BS; Poorna Kushalnagar, PhD; Lexi Boyd, BSN, NR; Reesa J. Sherin, MSN, RN; Jessica Quiring, BS, CN-BA, OPN-CG, CDP; Zarek Mena, OPN-CG; Linda Burhansstipanov, MSPH, DrPH; Don S. Dizon, MD; Clara Lambert, CPH, BBA, OPN-CG; Samuel Cykert, MD; and Julie E. Bauman, MD, MPH, The Centers for Medicare & Medicaid Services, Will Pay for Patient Navigation—Now What? Association of Cancer Care Centers, October 2024

NavPoint Health

NavPoint Health (NPH) & Native American Ca
https://www.navpointhealth.com/ and https:

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

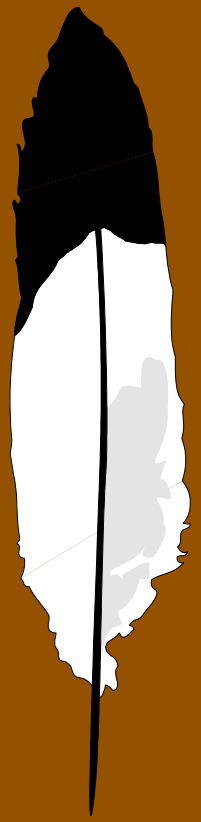
Code	How to Use	2024 Rate[a]	Minimum Time to Bill	Training Required
G0136	Risk Assessment based on a practitioner's reason to believe there are unmet SDOH needs, not intended for routine screening for patients at every visit or for every patient. Typically not administered in advance of the visit. If 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 HealthCommunities Tool and Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) as appropriate tools. This code is permanently added to telehealth visits, as well.	$28.67	5-15 minutes not more than every 6 months per practitioner per beneficiary	State-based requirements OR documentation of key competency domains
G0019	Community Health Integration (CHI) initiating visit with assessment by a clinical health worker under the direction of a billing practitioner to document and address SDOH needs that significantly interfere with a patient's 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/month)	State-based requirements OR documentation of key competency domains
G0022	CHI services to address SDOH needs that are significantly interfering with a patient's 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: should assess SDOH, facilitate patient-driven goal setting, and establish an action plan for tailored support. 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, facilitating behavior change, providing social and emotional support, mentorship, and inspiration to help patients meet treatment goals.	$78.92	First 60 minutes per calendar month (once/month)	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, but also 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—intended for mental and substance abuse support based on training from SAMHSA.	$78.92	First 60 minutes per calendar month (once/month)	SAMHSA standards[b]
G0146	PIN services by peers - intended for mental and substance abuse support based on training from SAMHSA.	$49.45	Additional 30-minute increments per calendar month (unlimited)	SAMHSA standards[b]

HCPCS Code	G0023	G0024	G0141	G0146
Code Description	Provides personalized and supportive services to patients with a high-risk condition for up to 60 minutes of services per calendar month	Provides personalized and supportive services to patients with a high-risk condition for up to 30 minutes of services per calendar month	Provides peer support for patients with behavioral health conditions for up to 60 minutes of services per calendar month	Provides peer support for patients with behavioral health conditions for 30 additional minutes of services per calendar month
Provider	Certified or trained auxiliary personnel/ patient navigator		Certified or trained auxiliary personnel/ peer support specialist	
Condition	1 Chronic Condition (Cancer qualifies)		Behavioral Health Focus	
Service Desc (Non- Exhaustive List)	• Person-centered interviews to understand the patient's life story, strengths, needs, goals, and preferences • Facilitating patient-driven goal setting and establishing an action plan • Developing and proposing strategies to help meet treatment goals • Providing social and emotional support		• Patient-centered interviews • Health education • Helping patients develop self-advocacy skills G0024 and G0146 are 30 minute increments (sometimes referred to as "Kicker codes")	
How Often Can you Bill?	Can be billed once a month (can be billed with G0140/146))		Can be billed once a month (can be billed with G0023/024)	
Payors	Medicare FFS, Dual Eligibles (Medi/ Medi), Medicare Advantage			
Requirements	• Patient must have at least on E&M visit by overseeing physician prior to billing of the PIN Code • Patient must be referred and consent given for navigation services (can be verbal or written, but will require documentation)			

Evaluation and Management (E&M) services are medical services that physicians and other qualified healthcare professionals provide to assess and manage a patient's health condition

Payment for PIN Services

- Auxiliary healthcare staff working under a qualifying billing practitioner (Medicare Part B)
- Specific to “serious, high-risk disease” (e.g., chronic conditions) expected to last at least 3 months and require ongoing monitoring of a treatment plan
- Auxiliary staff must meet qualifications (individual state requirements or documentation of sufficient knowledge (e.g., certification from GW online training)
- NOTE: US federal government removed the code for SDOH



Getting Ready for PIN code reimbursement

Prep / background specific to your organization

- System and Referral
  - If integrating within EHR
    - Need to comply with compliance regulations / guidance
    - Need to understand how your organization bills and get billing department on board
  - Regardless of whether within or external to EHR:
    - Need an “automated standing order” from the qualified healthcare provider that saw the patient
      - Evaluation and Management (E&M) services are medical services that physicians and other qualified healthcare professionals provide to assess and manage a patient's health condition

Process of Getting Started with PIN Code Reimbursement

- System (continued)
  - The Supervising / billing Evaluation and Management (E & M) practitioner that performed the initial assessment & referred to the navigation program
- Billing
  - G-0023 and G-0141 is one hour each month to be eligible for reimbursement
    - Can bill for clinic and non-clinic auxiliary staff (cultural, non-licensed PN)
  - Multiple 30-minute increments of service for codes G-0024 and G-0146 AFTER the G-0023 or G-0141 hour is completed (each month)
  - End of the month invoice to CMS by *one practitioner*

Pratt-Chapman, Mandi L., PhD, MA, OPN-CG; Gabriel Rocque, MD: Julie McMahon, MPH; Manali Patel, MD, MPH, MS, FASCO; Taneal Carter, MS, MPA; Nancy Pena, OPN-CG, MI, BS; Poorna Kushalnagar, PhD; Lexi Boyd, BSN, NR; Reesa J. Sherin, MSN, RN; Jessica Quiring, BS, CN-BA, OPN-CG, CDP; Zarek Mena, OPN-CG; Linda Burhansstipanov, MSPH, DrPH; Don S. Dizon, MD; Clara Lambert, CPH, BBA, OPN-CG; Samuel Cykert, MD; and Julie E. Bauman, MD, MPH, The Centers for Medicare & Medicaid Services, Will Pay for Patient Navigation—Now What? Association of Cancer Care Centers, October 2024.

Getting Ready for PIN code reimbursement

- Patient Eligibility:
  - Patient has Medicare Part B
  - "New" Patient has at least one of the 17 conditions
    - Not an existing patient unless new condition
  - CMS requires cost sharing (20%)
    - Patient is asked to pay for navigation services
    - Requirement is to ask, NOT collect monies
  - PN obtains informed consent
    - Can be verbal
    - Collected annually
    - PN documents date consent conversation occurred

Example of Verbal consent and protocol

- Draft script for CMS co-pay
  - These are the services I'm providing...
  - There services are the same as other Medicare benefits and they are subject to a 20% co-pay under your Medicare benefits.
  - If you have hardship with the copay, we have access to other resources
    - The Patient Advocacy Foundation (PAF) has a special fund that will pay the patient's co-pay
    - The program can submit the claim and PAF pays the co-pay. The claim is not based on income level or any other criteria
  - What questions do you have?

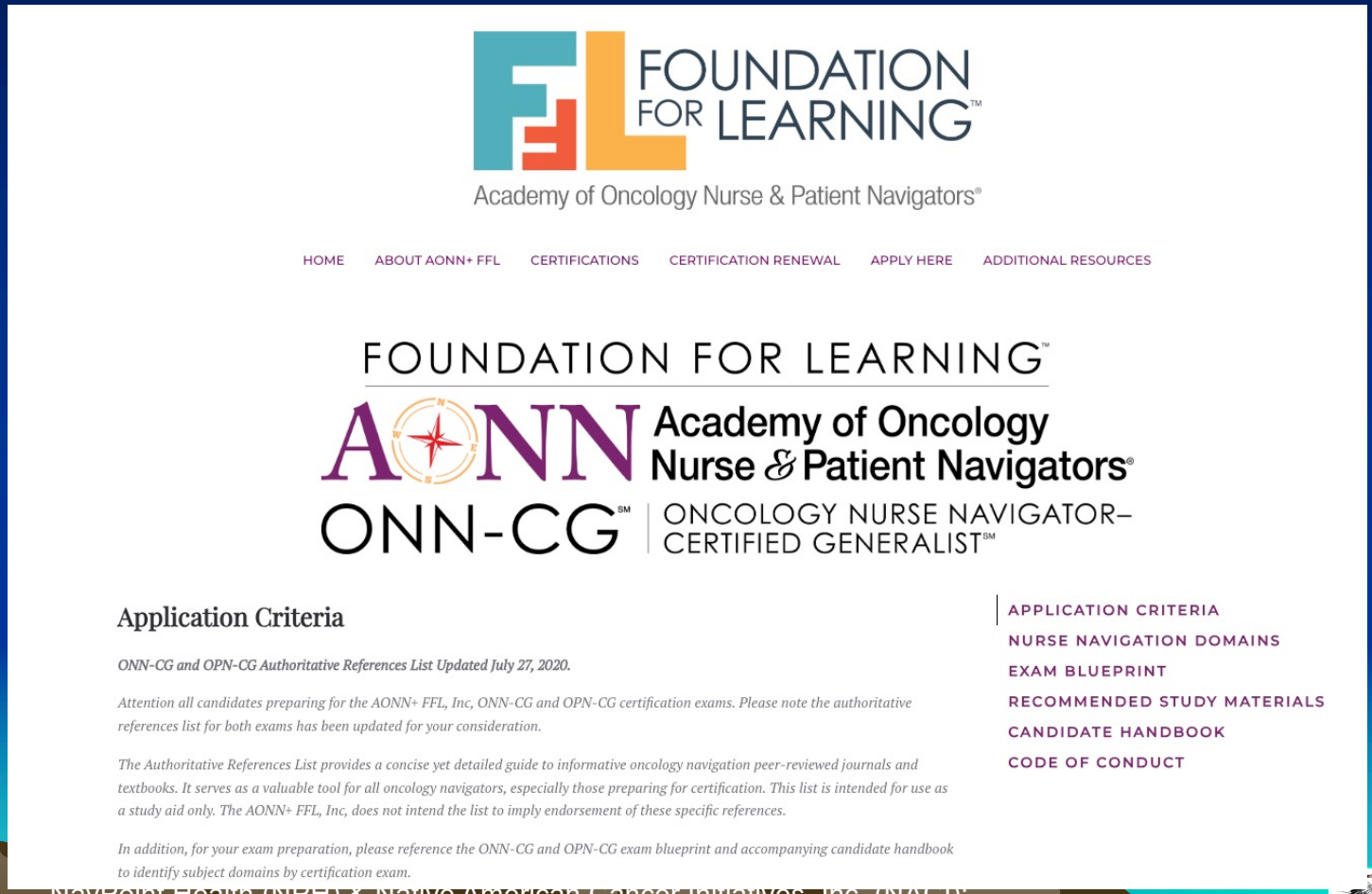
Getting Ready for PIN code reimbursement

- Patient Navigator Eligibility:
  - Both licensed and non-licensed are considered “auxiliary staff”
  - Completed recommended training to be “credential, accredited” (e.g., state-specific requirements)
    - GW website (free and solid foundation, 14-17 hours self-instruction); https://cme.smhs.gwu.edu/gw-cancer-center-/content/new-oncology-patient-navigator-training-fundamentals
    - AONN+ ~~Accreditation~~ exam (OPN-CG); https://aonnffl.org/nurse-navigator-certification
    - American Cancer Society Leadership in Oncology Navigation (**ACS LION**™) https://www.cancer.org/health-care-professionals/resources-for-professionals/patient-navigator-training.html
    - Susan G. Komen (for breast cancer specifically) https://navigationnation.learnupon.com/users/sign_in?next=%2Fcourses&utm_source=sfmc&utm_medium=email&utm_campaign=25Apr8_PatientNav&utm_term=aware&utm_id=56045&sfmc_id=129400617
    - NACR’s trainings for cultural competence; https://natamcancer.org/Training

GW Oncology Patient Navigation Training: The Fundamentals (updated 2025)

- https://cme.smhs.gwu.edu/gw-cancer-center-/content/new-oncology-patient-navigator-training-fundamentals#group-tabs-node-course-default3

Academy of Oncology Nurse and Patient Navigators (AONN+)



Example of Academy of Oncology Nurse and Patient Navigators (AONN+) OPN-CG Oncology Patient Navigator – Certified Generalist

CHRs are NOT trained in these competency domains to be called "PN"

- Application criteria
  - Provide a copy of your curriculum vitae demonstrating 1 year or 2000 hours of direct patient navigation in practice at time of application
  - Provide your job description reflecting your roles and responsibilities
  - Provide a reference letter signed by your employer verifying navigation experience

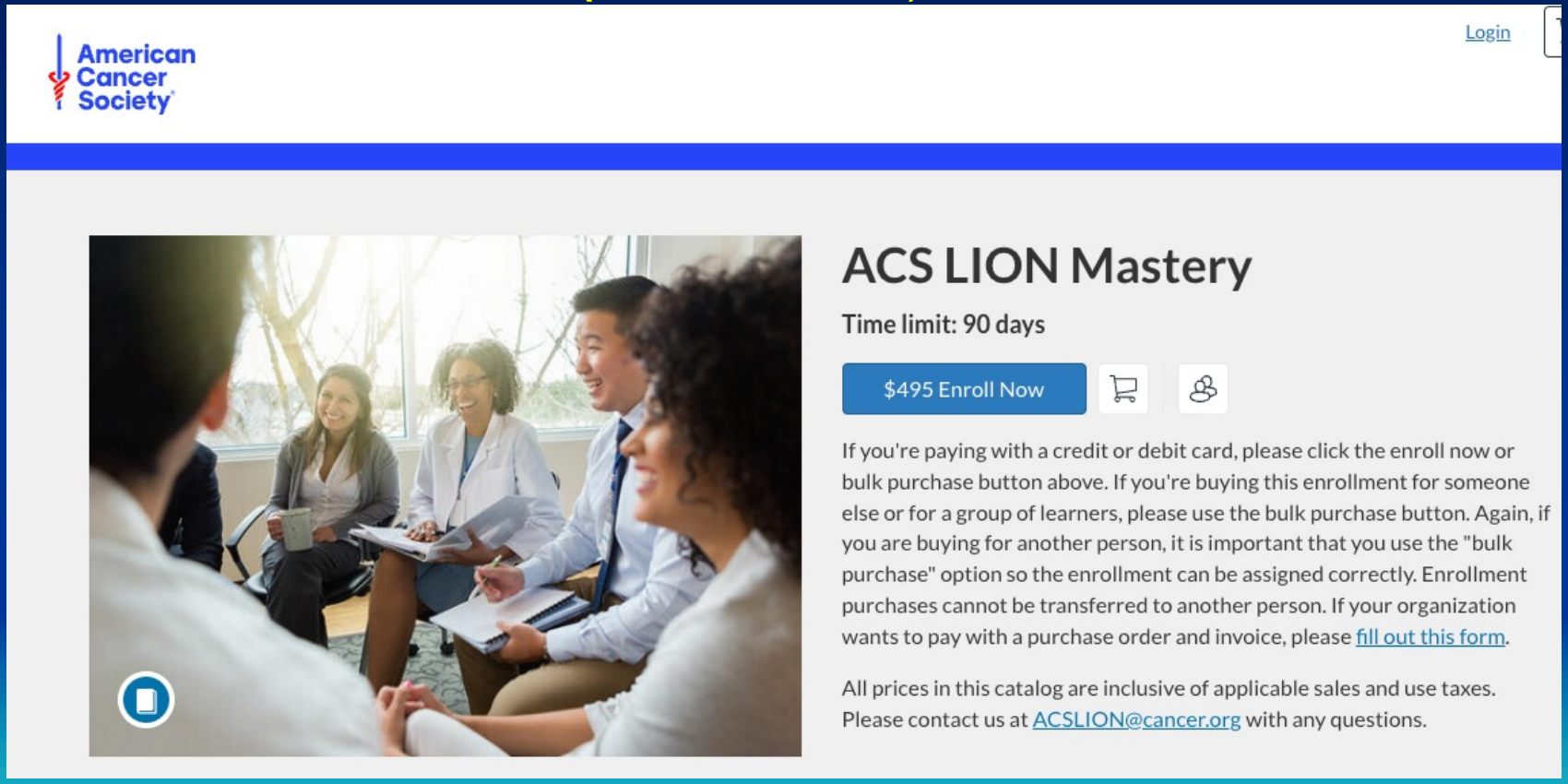
https://www.aonnffl.org/patient-navigator-certification

Exam Blueprint

Click the + to expand.

- \+ 1. Patient Care – 20%
- \+ 2. Knowledge for Practice – 24%
- \+ 3. Practice-Based Learning and Improvement – 10%
- \+ 4. Interpersonal and Communication Skills – 14%
- \+ 5. Professionalism – 14%
- \+ 6. Systems-Based Practice – 3%
- \+ 7. Interprofessional Collaboration – 8%
- \+ 8. Personal and Professional Development – 7%

American Cancer Society Leadership in Oncology Navigation (ACS LION™)



https://cancer.catalog.instructure.com/courses/2025-lion

Susan G. Komen Foundation

New Course Announcement: Navigating Professional Oncology Navigation Taskforce (PONT) Standards

Enhance your impact with our new course, "Navigating Professional Oncology Navigation Taskforce (PONT) Standards." Learn about the PONT standards, how to apply them and identify opportunities for professional growth. Our course will be available on April ~~24~~ on our learning platform.

April 30th, not 24th

LEARN MORE

https://navigationnation.learnupon.com/users/sign_in?next=%2Fcourses&utm_source=sfmc&utm_medium=email&utm_campaign=25Apr8_PatientNav&utm_term=aware&utm_id=56045&sfmc_id=129400617

Native American Cancer Research Corporation (NACR)

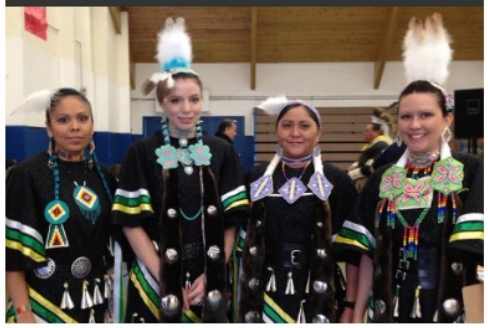
Overview of Native Patient Navigator (NPN)

- PN Definitions & Roles in and out of Indian Country (45mins) 🟣
  - Describe the origins and rationale for patient navigation
  - Identify other positions than may include patient navigation roles or tasks
  - Identify PN roles
- PN Navigating HC system in and out of Indian Country (45mins) 🟣
  - Understand why it is important to survey local healthcare providers and also to go to the facility and meet people.
  - Demonstrate understanding of why a data base of resources is critical to meeting patients' needs.
  - Demonstrate diverse protocols for establishing relationships with the cancer care professionals and facilities.
  - Develop strategies to address cases that do not fit the protocols.
  - Practice assessing and matching facilities/services to local AI cancer patients.
- PN & Cancer Continuum in Indian Country (45mins) 🟣
  - Identify what occurs during each phase of the cancer continuum
  - Identify Patient Navigator (PN) roles relevant to each phase of the cancer continuum
- PN Collaborating with HC Team in and out of Indian Country (30mins) 🟣
  - Understand why it is important to build relationships with the Cancer Center's staff
  - Demonstrate knowledge of diverse protocols for establishing relationships with the cancer care professionals and facilities.
  - Be prepared to collaborate with others.
- Safety for Native Patient Navigators (90mins) 🔴
  - Identify at least 3 strategies to improve personal safety for the PN
  - Identify settings that increase likelihood of patient's private information remaining confidential

Legend of PN Competency Domains:

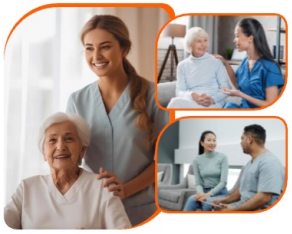
(Click to view each full PN competency statement)

- **I. Domain:** Ethical, cultural, legal, and professional issues
- **II. Domain:** Client and care team interaction and communication skills
- **III. Domain:** Health Knowledge
- **IV. Domain:** Patient care coordination
- **V. Domain:** Practice-based learning
- **VI. Domain:** Systems-based learning
- **VII. Domain:** Communication / interpersonal skills



NavPoint Health and NACI Care

NavPoint Health™
Driving Patient Navigation Forward



Abou

- Patient Navigation Record System (commercial product)

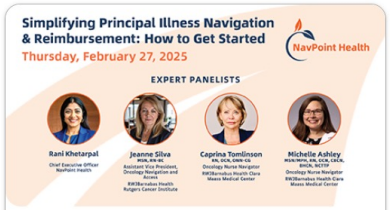
NavPoint Health (NPH) & N
https://www.navpointheal

NavPoint Health

Latest News, Events, and Resources from NavPoint Health™

The Patient Navigation Record System

Learn how PNRS address EMR gaps, enabling documentation, reimbursement, and measurable ROI in



Simplifying Principal Illness Navigation & Reimbursement

Patient navigation is evolving, and practices & providers need the right strategy to build, optimize, and maximize

Operationalizing the PIN Codes in Cancer Navigation

Patient navigation is complex and the introduction of the PIN Codes has added a new layer of both

What is NACI Care™ ?

NACI Care™ is a comprehensive patient navigation tool designed to support data entry, tracking, and evaluation across multiple therapeutic areas. It streamlines patient navigation by gathering and analyzing visit data efficiently while standardizing processes against nationally recommended metrics.

Benefits of NACI Care™

Creating Standards
Enhances your ability to provide navigation services aligned to nationally recognized quality standards.

Data & Insights
Measures and tracks the impact of your navigators to gain valuable insights in addressing disparities in patient care, driving efficiencies and balancing navigator workload.

Effective Reporting
Creates reporting documentation required to submit for reimbursable navigation services.

Patient Outcomes
Maximizes the effectiveness of your navigation program to ensure timely, high-quality medical and psychosocial services to improve patient outcomes.

- Thank you for inviting me and allowing me to discuss strategies to help Indigenous navigation programs become sustainable via CMS PIN Code Reimbursements