Health Policy
NEWSLETTER

Vol. 22, No. 2 | **JUNE 2009**

The Patient Navigator Outreach and Chronic Disease Prevention Act of 2005: A bipartisan approach to improving access to care and addressing health disparities

Too frequently, patients with the greatest health care needs have the least ability to comprehend, access, and navigate the U.S. health care system. A variety of factors, including: low educational levels (and resultant issues regarding literacy in general and health literacy in particular); limited English proficiency (LEP); poverty; and a lack of knowledge on the part of the practitioner towards patients' cultural beliefs and practices, can exacerbate this chasm between the healthcare consumer and the provider. It can be difficult and time-consuming for providers to help some patients to understand how best to participate in their own care. *Patient navigators* were created to provide appropriate support to this patient population in an effort to improve their health outcomes.

Patient navigators may be community health workers, lay health educators, peer health promoters, medical assistants or nurses who serve as liaison between patients and providers to promote health among groups that may lack access to adequate health care. The purpose of a Patient Navigator is to help reduce health care disparities; facilitate communication between patients and providers; assist patients in overcoming barriers to care; shape perceptions individuals may have about disease and specific health-related behaviors; provide outreach services and educational support; and offer culturally and linguistically competent assistance.

In 1989 Dr. Harold Freeman, a surgical oncologist at Harlem Hospital, became concerned over the large numbers of women from the local community presenting with late-stage breast cancer, despite the availability of routine screening for the disease. As the National President of the American Cancer Society, he conducted a series of hearings throughout the US to get feedback from community members about the impact of cancer on their lives. After hearing common accounts of significant barriers to care, he determined that the obstacles for cancer prevention, early detection, treatment and support were surmountable. In 1990, Dr. Freeman created the first "patient navigation" program at Harlem Hospital Center in New York City, funded by a grant from the American Cancer Society[1].

In 2005, policymakers came together to support the Patient Navigator Outreach and Chronic Disease Prevention Act of 2005 (Public Law 109-18). With unanimous support in Congress, and under the leadership of Senator Robert Menendez (D-NJ), the Act amended the Public Health Service Act and became Public Law, authorizing the Secretary of Health and Human Services to make grants through 2010 for the development of patient navigator programs. A total of $25 million was awarded over five years for patient navigator programs through the Community Health Centers at Health Resources and Services Administration (HRSA), the Office of Rural Health Policy, the National Cancer Institute (NCI), and the Indian Health Service.[2] The overall purpose of the funding is to determine if patient navigators help reduce barriers to access to care and improve health care outcomes in underserved patient populations.

Research has shown that patient navigator interventions produce greater rates of screening and follow-up on diagnosis, resulting in better health outcomes. For example, in a study on colorectal cancer screening within a large urban hospital, two patient navigators were hired for a study period. Broken appointment rates went from 67% to 5% in one month, with the likelihood of keeping the appointment for the colonoscopy increasing by nearly three times[3]. Another colorectal cancer screening study within a minority community health setting compared two groups of patients with similar demographic characteristics who were recommended colonoscopy services by their physicians. The patients from the navigator-assisted group had a 15.8% compliance rate, compared with only 5% in the non-navigator-assisted group. The navigator-assisted group also achieved higher rates of fecal occult blood test completion than the non-navigator-assisted group (42.1% vs. 25%).[4] Ronald Myers, PhD, DSW, Professor in the Department of Medical Oncology at Jefferson Medical College, is currently leading a patient navigation project funded by the NCI Center for Reducing Cancer Health Disparities. Dr. Myers' study, *Increasing Colon Cancer Screening in Primary Care Among African Americans*, seeks to determine the impact of preference-based message tailoring navigation on colorectal cancer screening in primary care at a population level. Einstein is a participating site for the study, with investigators from the Center for Urban Health Policy and Research serving as part of the research team.

In the studies mentioned, Patient Navigator Programs helped reduce health care disparities by facilitating communication between patients and providers; assisting patients in overcoming barriers to care; providing outreach services and educational support; and offering culturally and linguistically competent assistance. Patient navigator programs that yield sustained long-term clinical benefits and improve health outcomes and compliance are likely to also provide economic benefits to our health system. By funding programs that target underserved patient populations, the Patient Navigator Act of 2005 has the potential to contribute to improved access and efficiency of care and engage patients into taking a more active and informed role in their own health care. ■

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