American Hospital Association™
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CARE DELIVERY TRANSFORMATION FRAMEWORK

Care Navigation and Coordination

Hospitals and health systems already provide excellent patient care, but navigating the complex healthcare ecosystem can be incredibly challenging for patients. Sixty-five percent of patients say coordinating and managing healthcare is overwhelming and time consuming for many reasons, including:

- Having to coordinate across multiple providers.
- A lack of accessible providers.
- Not fully comprehending recommended treatment or diagnoses.
- Dealing with long appointment wait times.
- Insurance coverage and the cost of treatment.

This complexity can be discouraging and lead to missed or delayed care, which could negatively impact health outcomes.[1]

Care navigation and coordination are mechanisms that can help support patients by reducing barriers to care and increasing understanding of their diagnosis. Patients supported through care navigation may have a better care experience. A navigator keeps patients on the highest-value care pathway, resulting in cost savings and transparency for the patient and the healthcare organization. They can also help support in treatment management, sometimes reducing emergency admissions.[2] University of Alabama at Birmingham Health System assigned care navigators to patients with active cancer diagnoses and saw a decline in emergency department visits, hospitalizations and intensive care unit readmissions. Care navigation programs can also alleviate common barriers that may perpetuate disparities in health outcomes, such as language, technology, health literacy and transportation.[3] Such support can lead to a boost in hospital satisfaction scores.

Hospitals and health systems across the United States are transforming care delivery to better meet the evolving needs of patients and communities.

Through the Care Delivery Transformation Framework, the AHA is supporting hospitals and health systems as they explore strategies to improve care. The framework represents how components of the healthcare ecosystem can facilitate the development and implementation of innovative care delivery models in three core areas: clinical settings, community settings and linking care to community.

Learn more at www.aha.org/CDT.

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Key Aspects of Care Navigation and Coordination

Care navigation and coordination, fathered by Harold P. Freeman, M.D., in 1990, involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective outcomes.[4] Care navigators can help facilitate transitions as patients — particularly those with chronic or complex diseases — move from acute care to a home setting, helping maintain connections to needed outpatient services.

While similar, care navigation and care coordination have some differences.

Care navigation focuses heavily on the clinical pathway, with navigators acting as guides through the medical system and treatment plan. The navigators offer clinical guidance and support to keep patients on the best path for their unique needs. They may:[5]

- Help patients understand their diagnosis and treatment plan by interpreting and translating test results or medical terminology.
- Identify gaps in care or direct patients on the path that offers the highest value care.
- Monitor side effects and symptoms in between provider visits and work with physicians to adjust treatment based on those observations.
- Provide emotional support.

Care coordination focuses more specifically on administrative and logistical parts of care. Common parts of a coordinator's work may include: [5]

- Coordinating care across multiple providers and settings, including managing the transition of care and sharing health records and plans to deliver integrated care focused on the patient.
- Educating the patient and family on self-care.
- Connecting patients with community resources.

Use Cases

Care navigation and coordination can be used in multiple care settings, including but not limited to:

Oncology

- Because of the complex and often long duration of cancer treatment, oncology is the original area where care navigation was identified as a need.
- In a recent study of breast cancer patients, those who received more coordinated care, with patient navigation support, started treatment sooner, were more likely to complete it and had significantly higher survival rates (over 90%).[6]

Care Navigation and Coordination

Complex medical needs

- When a patient has a diagnosis where treatment requires several different medications, machines and providers, care navigation can be extremely helpful in educating the patient and family.
- Lurie Children's Hospital of Chicago's Almost Home Kids program provides a bridge between hospital and home. This community-based program responds to family needs and trains caregivers on complex equipment and offers respite care. Families live in a space where medical professionals help them adjust to their new life before heading home.

Addressing social needs

- In some situations, patients who may have complex social needs can benefit from the extra support a care navigator brings. A care navigator can help patients understand and adhere to their treatment plan.
- The NYC Health + Hospitals has a care navigator program specifically for hepatitis C patients. The program works to improve screening and treatment adherence rates, pairing a navigator with a patient when they test positive. They stay in contact with patients — who often have substance use disorders, are incarcerated or recently released or have HIV — until the disease is ultimately cured.

In one randomized clinical trial, a post-discharge patient navigation intervention for patients with comorbid substance use disorder reduced emergency department visits and hospital utilization, resulting in approximately **$17,780** in cost savings per participant **over a 12-month period**.

Implementation Considerations

The Care Delivery Transformation Framework incorporates several operational infrastructure elements and foundational principles that, when strategically aligned, can support hospital and health system leaders as they design, implement or scale care navigation and coordination programs. Below are some strategic considerations to keep in mind when building a care navigation program.

Workforce

- **Stakeholder involvement**
  - **Board and C-suite leadership.** Investment from decision makers is crucial for moving a program forward and encouraging use.
  - **Clinicians.** Gather insights on what they hear from patients and the gaps they observe to help shape the program. Include a range of positions who interface with patients — doctors, nurses and administration staff.
- **Identifying workforce**
  - Care navigators come from a variety of roles, such as social work, nursing or patient care. They are trained professionals who may have a background in medicine and healthcare or have previous experience with the disease.[7] Navigators with less formal education may assist with basic navigation like arrangements and referrals, where those with formal training and education may provide treatment or peer support.[8]

Care Navigation and Coordination

Person-centered

- **Cultural congruence.** Care navigator training should focus on patient-centered care. Care navigators should be able to navigate a range of treatment needs with respect and appreciation. Training should include cultural awareness, knowledge, skills, encounters and desires. This can increase patient satisfaction and provide a feeling of belonging.[9]
- **Patients.** Obtain patient voices through a continuous feedback loop such as surveys or focus groups. Use this information to design and iterate the care navigation program. The barriers patients face will likely vary by service line, so ensure specific feedback is gathered.
- **Community.** Use existing community organizations and available population-level data to design care navigation and coordination and inform a more comprehensive understanding of community needs.

Payment Models

Care and patient navigation programs are often funded through a blended structure.

- **Operational Budget.** Consider funding care navigation programs through an operational budget, given their demonstrated ability to drive downstream value, including improved clinical outcomes, enhanced patient experience and total cost of care reduction.
- **Reimbursement.** Principal Illness Navigation (PIN) services (G0023/G0024) provide care navigation, coordination, patient education and resource connection services for Medicare beneficiaries with serious, high-risk medical conditions. Principal Illness Navigation-Peer Support (PIN-PS) services (G0140/G0146) include these same core functions but additionally incorporate peer support from trained personnel, including certified peer specialists, and are primarily intended for patients with qualifying high-risk behavioral health conditions.
- **Philanthropy.** Explore grant and philanthropic opportunities to bolster support and sustainable funding for care navigation programs. Nonprofits, foundations and institutes, like the American Cancer Society and local and state government grants, are initial areas to explore funding.

Policies & Procedures

- **Privacy & confidentiality.** Care navigation is grounded in the HIPAA Privacy Rule, and can help guide when you use or disclose protected health information (PHI). HIPAA Rules for Patient Navigators: What You Can Share, When, and With Whom offers this guidance:[10]
  - **With the care team for treatment:** Coordinate appointments, referrals, transportation and social support using only the PHI needed for the task.
  - **With health plans for payment:** Provide identifiers and service details required for eligibility checks, authorizations and claims.
  - **With family or caregivers:** Share information relevant to involvement in care when the patient agrees, is present and does not object, or when professional judgment supports acting in the patient's best interest.
  - **With community resources:** Disclose only the minimum data necessary; obtain a Data Disclosure Authorization if the sharing is not permitted under treatment, payment and healthcare operations.

Conclusion

Support for patients trying to navigate a complex healthcare ecosystem is a critical part of improving clinical quality, patient outcomes and patient experience and lowering the total cost of care. A care navigator or coordinator can provide guidance around potential barriers, help set appointments and referrals, translate medical language, decode insurance information and provide an emotional respite.

Explore the different resources mentioned in this brief and linked below to learn more about implementing a care coordination and navigation program in your organization.

AHA Resources

Care Delivery Transformation Framework

- **Infographic:** Visual representation of transformational care delivery models across clinical and community settings and how they are linked together.
- **Discussion Guide:** Foster conversations with hospital leaders and their teams to identify opportunities to transform care delivery.
- **Issue Brief:** Dig deeper into the framework with this issue brief.

PODCAST: When Health Care Is Hard to Navigate: Designing Patient Care Navigation

Even the most experienced health care leaders can feel lost when they become patients. In this conversation, Ji Im, system senior director of community and population health at CommonSpirit Health, explores why seamless navigation, community partnerships and human connection are essential to reducing friction and improving the health care experience. Ji also shares how her personal health story has reshaped her understanding of care navigation and patient-centered design.

WEBINAR: Bridging the Gap: Strategies for Better Patient Transitions

This webinar replay highlights Harvard Medical School and California's Community Memorial Healthcare's successful, real-world strategies that bridge hospital and community care.

Citations

1. https://www.aapa.org/research/patient-experience/
2. https://www.rightwayhealthcare.co/blog/importance-of-healthcare-navigators-in-2021
3. Ibid.
4. https://www.ahrq.gov/ncepcr/care/coordination.html
5. https://preveta.com/blog/understanding-the-distinction-between-care-navigation-and-care-coordination/
6. https://pmc.ncbi.nlm.nih.gov/articles/PMC13160784/#abstract1
7. https://www.care-navigators.com/services/healthcare-advocacy/
8. https://pmc.ncbi.nlm.nih.gov/articles/PMC5808907/#abstract1
9. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/cultural-competence-training-for-health-care-professionals
10. https://www.accountablehq.com/post/hipaa-rules-for-patient-navigators-what-you-can-share-when-and-with-whom

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