The Use of Patient Navigators to Increase Breast and Cervical Cancer Screening to Medically Underserved Women in the Alabama Black Belt

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Introduction

- Healthcare disparities play a prominent role in producing social inequalities in cancer mortality.
- Residents in medically underserved communities have been shown to have a significantly higher rate of late-stage cancer diagnosis and significantly lower rates of cancer survival than residents in more urban communities.
- Breast cancer mortality was 39% higher in underserved communities than in non-underserved communities.
- Also women in underserved communities have 2.2 times higher mortality than women in non-underserved communities.
- Limited access to care, lack of health insurance, and lower rates of screening such as mammography and pap smear among residents of rural and more disadvantaged areas may account for their higher rates of a late-stage cancer diagnosis.
Alabama “Black Belt”

- In Alabama, the Black Belt communities are among some of the poorest counties in the nation.
- These counties have a high rate of poverty, declining population, lack of public transportation, high unemployment, and poor access to medical care.
- The Black Belt counties have few nurses, physicians, and hospital beds.
- In these counties, 64% of the population is African American, the per capita income is $13,540, and 27% of the population lives below the poverty level.
Alabama “Black Belt”

- African American women have lower incidence rates than white females for all cancers combined, but they have a 20% higher mortality rate.

- For most cancers, African American women are less likely, then white women, to be diagnosed with localized cancer and more likely to be diagnosed with cancer that has metastasized.

- Also, African American women have lower 5 year relative survival rates than do white at each stage of diagnosis, suggesting influence by disparities in access to quality care and comorbid conditions.
Patients per Primary Care Physician

<table>
<thead>
<tr>
<th>County</th>
<th>PCPs</th>
<th>Patients per PCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>5</td>
<td>1,045</td>
</tr>
<tr>
<td>Alabama</td>
<td>2</td>
<td>1,594</td>
</tr>
<tr>
<td>Sumter</td>
<td>8</td>
<td>2,685</td>
</tr>
<tr>
<td>Perry</td>
<td>660</td>
<td>5,091</td>
</tr>
<tr>
<td>Marengo</td>
<td>2</td>
<td>2,550</td>
</tr>
<tr>
<td>Jefferson</td>
<td>3</td>
<td>1,000</td>
</tr>
<tr>
<td>Hale</td>
<td>12</td>
<td>7,694</td>
</tr>
<tr>
<td>Greene</td>
<td>5</td>
<td>2,959</td>
</tr>
<tr>
<td>Clarke</td>
<td>1</td>
<td>2,097</td>
</tr>
<tr>
<td>Choctaw</td>
<td>5</td>
<td>2,727</td>
</tr>
</tbody>
</table>
What Others Have Done
Community Health Advisors in Action Program (CHAAP)

- Lay volunteers from the community were recruited and trained to serve as patient navigators.
- The patient navigators were trained to help breast cancer patients in the Black Belt overcome barriers to diagnostic follow-up and treatment.
- They followed the patients through their entire cycle of care, to reduce the time between diagnosis and treatment and increase adherence to treatment.
- This study found that the use of community patient navigators helps improve adherence to diagnostic follow-up and treatment.
- It also suggested that patient navigators can close the gap between development and delivery of cancer treatments to medically underserved patients.
Needs Assessment

- Access/Transportation: 47%
- Financial/Insurance Issues: 71%
- Lack of Information/Education: 71%
- Fear/Emotional Issues: 64%
- Hospital navigation: 53%
- Social Support Issues: 49%
- Cultural Beliefs/Attitudes: 86%
Healthcare Utilization After CHAPP Program Implementation

![Graph showing healthcare utilization costs per patient over quarters after program implementation. The graph compares costs between navigated and non-navigated cases, with a general trend of increasing costs over time.](image-url)
# Outcomes

<table>
<thead>
<tr>
<th>County</th>
<th>Number of patients</th>
<th>Scheduled</th>
<th>Attended</th>
<th>Not attended</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dallas and surrounds</td>
<td>21</td>
<td>181</td>
<td>179</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Jefferson and surrounds</td>
<td>81</td>
<td>514</td>
<td>444</td>
<td>24</td>
<td>46</td>
</tr>
<tr>
<td>Montgomery and surrounds</td>
<td>31</td>
<td>438</td>
<td>424</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Sumter and surrounds</td>
<td>14</td>
<td>251</td>
<td>239</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>147</strong></td>
<td><strong>1,384</strong></td>
<td><strong>1,286</strong></td>
<td><strong>43</strong></td>
<td><strong>55</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Scheduled</th>
<th>Attended</th>
<th>Not attended</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage</strong></td>
<td><strong>98.9%</strong></td>
<td><strong>96.8%</strong></td>
<td><strong>2.3%</strong></td>
<td><strong>0.9%</strong></td>
</tr>
</tbody>
</table>

- Table shows the number of appointments scheduled, attended, not attended, and unknown for different counties.
- Dallas and surrounds have the highest number of patients (21) with 98.9% of scheduled appointments attended.
- Jefferson and surrounds have the highest number of scheduled appointments (514) with 86.4% of attended appointments.
- Montgomery and surrounds have the highest number of not attended appointments (10) and unknown appointments (4).
- Sumter and surrounds have the highest percentage of scheduled appointments attended (95.2%).
The Alabama Breast and Cervical Cancer Early Detection Program

- Established by the Centers for Disease Control and Prevention
- Provides Free Breast and Cervical Cancer Screening to Underserved Women
  - Age 40-64
  - At or below 250% of Poverty Level
  - No insurance or Underinsured
Project Goals

COMMUNITY HEALTH ADVISORS & NAVIGATION

A Partnership between the UAB Comprehensive Cancer Center and the Alabama Breast and Cervical Cancer Early Detection Program
Project Design

- **Target Population:** Low-income women, primarily African-American, in the Alabama Black Belt who have not had recommended breast and cervical cancer screenings that meet the qualifications for The Alabama Breast and Cervical Cancer Early Detection Program.

- **Goal:** Recruit patient navigators who are demographically similar to patients in target communities and reside in the community.

- **Curriculum Development:** Develop training manual to help train patient navigators to deal with physiological, communication, social issues, and other barriers that impact access to health care.
Patient Navigator Training

- Training: Patient navigators will attend a training session provided by the UAB Comprehensive Cancer Canter and The Alabama Breast and Cervical Cancer Early Detection Program to learn how to increase breast and cervical cancer screening in their communities using the following methods:
  - Assessment of individual patient barriers to cancer screening
  - Patient education and support
  - Resolution of patient barriers (e.g. transportation, translation services)
    - Provide patient with list of providers and facilities that are in partnership with The Alabama Breast and Cervical Cancer Early Detection Program
  - Client tracking and follow-up to monitor client progress in completing screening
Patient Navigator Training

- Patient Navigators will:
  - Review a woman’s medical benefits to determine her eligibility for available resources
  - Assist women in identifying appropriate sources of care by providing them with information about services and health resources
  - Provide information about community resources to overcome social, economic, and personal barriers (transportation, child care, financial assistance, etc.)
  - Help women complete the necessary paperwork (insurance forms, medical history forms, etc.) to link them with appropriate resources
  - Accompany women to their appointments and provide transportation if needed
Patient Navigator Intervention Flow Chart

ASK
Do you currently get the recommended cancer screenings? Do you see your doctor regularly for your mammogram and Pap test?

If Patient says yes, then she is in:
- Stage 4: Getting screened
- Stage 5: Making screening a habit
- Stage 6: Always getting the recommended screenings

If Patient says no, then ADVISE her about the need for screening, including risk and benefits

Stage 1
Not thinking about getting screened
Patient has little or no intention of getting screened
Reinforce personally relevant information to the patient, such as an increased risk due to family history or increased age; increased options for treatment and increased chances for survival or cure due to early detection; the need to stay healthy to be able to work and care for family; the availability of low or no cost screening. ARRANGE to follow up.

Stage 2
Thinking about getting screened
The patient has heard about the risks of cancer, realizes it is relevant to him/her, and is seeking more information
Repeat the key messages about the risks and benefits. Also discuss the recommended screening guidelines for each cancer. Provide specific information about low and no cost screening resources, locations, times, eligibility criteria for services, etc. Help the client work through barriers such as fear. ARRANGE to follow up.

Stage 3
Ready to get screened
Client is actively planning to get screened
ASSIST client to problem-solve about practical barriers. If needed, help the client get a screening appointment, or accompany the client to the clinic/hospital. Help the client ANTICIPATE and address potential difficulties. ARRANGE to follow up.
Patient Navigator Activities

- Patient navigators were able to reach women in their communities by hosting cancer awareness activities.
- These activities included:
  - Church events
  - Health fairs
  - Parades
  - Relay for Life
  - Susan G Kolmen events
Navigator Meetings

- We held monthly meetings with the Patient Navigators in order to address any problems they may have
  - We rotated the meeting throughout the different counties involved

- Example of Problems and Solutions:
  - One patient kept cancelling at the last minute
    - Navigator offered to transport patient to the appointment
  - One patient would show up to appointments but leave before filling out the paperwork in the office
    - Patient was leaving because she did not understand some of the questions asked and was unsure how to answer them
    - Navigator accompanied patient to appointment to help her fill out paperwork
  - Negative feedback from the Hale County Housing Authority
    - Still working to resolve this issue so more health fair can be set up in those neighborhoods
Cookbook handed out to all women who completed assessment forms at Navigator events

Cookbook includes:

- Healthy substitutions for common recipes
- How to reduce salt intake
- Tips for using herbs and spices instead of salt
- Low calorie dessert recipes
- Community resources and contact information for:
  - Local health department
  - Local Family Practice offices, Dentist, and Optometrist
  - Discount pharmacies
  - Food pantries and Farmer’s Markets
  - Housing authority
Results
Barriers:
- Invalid phone numbers
Clarke

Barriers:
• Invalid phone numbers
Barriers:
- Invalid phone numbers
Hale

Barriers:
- Negative feedback from housing authority
- Invalid phone numbers
Jefferson

Barriers:
- Invalid phone numbers
- Patients calling at last minute to cancel
- Work schedule/ no vacation time

- Clinical Appointments Not Made: 24%
- Clinical Appointments Made: 61%
- Clinical Appointments Kept: 39%
- Clinical Appointments Not Kept: 76%

- Mammogram Appointments Not Made: 11%
- Mammogram Appointments Made: 69%
- Mammogram Appointments Kept: 31%
- Mammogram Appointments Not Kept: 89%
Marengo

Barriers:
- Invalid phone numbers
- Transportation
Perry

Barriers:
- Trouble getting the word out
- Invalid phone numbers
Sumter

Barriers:
- Invalid phone numbers
Total

- 4,372 women contacted
- 583 women eligible
- 154 clinical appointments made
  - 93 clinical appointments kept
- 78 mammogram appointments made
  - 58 mammogram appointments kept
- Barriers
  - Invalid phone numbers
  - Patients calling at last minute to cancel
  - Work schedule/ no vacation time
  - Transportation
  - Trouble getting the word out
Future Goals

- Continue the CHAN program and train more navigators in order to incorporate more ”Black Belt” counties in the future

- Partner with UAB School of Medicine free health clinic (Equal Access Birmingham) to help patients in the clinic get connected with a Patient Navigator and get preventative screening

Addressing Barriers

- Include a 2nd line on the form for additional contact information

- Send out letters to women who were not reached via phone, including additional information such as how to get in touch with the patient navigators

- Continue providing transportation to women who need it
References

- 2016 County Health Rankings from http://www.countyhealthrankings.org/app/alabama/2015/measure/outcomes/2/map