

## EDITORIALS AND COMMENTARIES

---

### **Patient Navigation: A Community Based Strategy to Reduce Cancer Disparities**

Harold Freeman

Poor people experience substantial barriers when seeking timely screening, diagnosis, and treatment of cancer. This was a major conclusion of the American Cancer Society (ACS) based on the findings of the ACS National Hearings on Cancer in the Poor in 1989. As national President of the Society that year, I had the privilege of chairing these hearings in seven American cities with testimony from poor people from all 50 states. The poor people who testified came from all racial and ethnic groups—whites, blacks, Hispanics, Asians, and Native Americans.

The key findings of the hearings were as follows: 1) Poor people face substantial barriers in seeking screening, diagnosis, and treatment of cancer. 2) Poor people experience more pain, suffering, and death due to cancer because of late diagnosis and treatment. 3) Poor people make sacrifices in order to obtain care and often do not seek care because they cannot afford it. 4) Poor people often indicate that the educational system related to health care is frequently insensitive and even irrelevant to them. 5) Poor people often become fatalistic and give up hope when in need of health care. Based on these findings coupled with my personal experience in providing cancer care to poor black patients in Harlem, I established the nation's first Patient Navigation Program beginning in 1990 at Harlem Hospital Center in New York City.<sup>1</sup> Since the introduction of Patient Navigation in 1990, hundreds of Patient Navigator programs of various varieties have been established throughout the nation. Of significance, too, is the fact that the Harlem Patient Navigator Program served as the model for the "Patient Navigator Outreach and Chronic Disease Prevention Act," which was signed into law by the President in June 2005.

#### **BACKGROUND**

Some Americans suffer a higher cancer incidence and mortality than the mainstream of American society and, in general, do not enjoy the same health status. Since the early 1970s the scientific community, focusing mainly on black and white differences, has documented racial disparities in cancer incidence, mortality and survival. Data from the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute (NCI) have consistently shown that black Americans experience higher cancer incidence and mortality rates and lower 5-year survival. Furthermore, studies have shown that the disproportionate distribution of blacks at lower socioeconomic levels accounts for most of the excess cancer burden among blacks. Moreover, evidence indicates that poor Americans, black and white, have a 10 to 15% lower 5-year survival rate. Poverty is associated with low edu-

---

Correspondence: (E-mail: hfreeman@mail.nih.gov)

cational level, substandard living conditions, risk promoting life style and diminished access to health care. Diminished access is often manifested by low quality and inadequate continuity of health care as well as insufficient access to methods of disease detection, diagnosis and treatment.<sup>2</sup> In addition there are currently an estimated 45 million medically uninsured Americans. About half of the nation's poor have incomes considered too high to qualify for Medicaid.

### **PATIENT NAVIGATION: THE HARLEM EXPERIENCE**

In recent years there has been progress in increasing screening rates for breast cancer. However, the closing of the screening gap in breast cancer has not been reflected in closing the racial gap in mortality rates. The gap between white and black breast cancer rates is, in fact, still widening. Early detection does not reduce mortality unless such screening is followed by timely treatment. We have determined that one way to promote increased screening and timely treatment is through patient navigation. Patient navigators, who are most often lay people selected from the community, assure that any barrier a patient encounters in seeking screening, diagnosis and treatment is eliminated. Patients most frequently encounter financial, communication, medical system and emotional/fear barriers. The patient navigator identifies, anticipates, and helps to alleviate barriers that patients encounter.<sup>3</sup>

### **HARLEM HOSPITAL BREAST CANCER STUDIES**

In a 22 year period ending in 1986, 606 patients (94% black) with breast cancer were treated at Harlem Hospital Center. Almost all patients were of low socioeconomic status, and almost 50% had no medical coverage. About half were incurable at the time of diagnosis (stages 3 and 4), and only 6% had early breast cancer. The 5 year survival of these patients was 39%.<sup>4</sup> In a separate study at the same hospital 324 patients with breast cancer were treated between 1995 and 2000. Of these patients, 70% were black and 26% were Hispanic. The patients were all poor and half were uninsured. However, there were dramatic improvements in stage of disease at the time of treatment and in 5-year survival rates. The results indicated that 41% had stages 0 and 1 disease, and 21% had late stage disease (stages 3 and 4). The 5-year survival was 70%, compared to 39% in the earlier Harlem Hospital study.<sup>5</sup> Three factors accounted for the dramatically improved results demonstrated in the recent Harlem experience. First, the program offered free or low cost screening mammography. Second, the patient navigator program eliminated any barriers to screening and timely resolution of suspicious findings including treatment. Third, improved outreach and culturally sensitive public education were believed to have played an important role in promoting screening. Patient Navigation is believed to have been a critical determinant of the improved outcome in the Harlem patients.

### **COLON CANCER**

In this issue of the *Journal of Urban Health* an analysis of a Patient Navigator program conducted in an urban public hospital in New York City is reported by

Nash et al.<sup>6</sup> Nash et al. conclude that there are health care system barriers to patients receiving screening colonoscopy that, when addressed, can result in substantial improvements in providing screening colonoscopy. Specifically, Nash indicates that the introduction of Patient Navigators resulted in a dramatic and sustained decline in broken appointment rates for colonoscopy (67 to 5%).

## FINAL THOUGHTS

Three major factors to improve cancer outcome are: 1) provide screening to patients regardless of ability to pay. 2) Establish patient navigation program to eliminate any barrier to screening and timely diagnosis and treatment. 3) Increase outreach and public education. We face a particular challenge in promoting and applying screening for colon cancer. In communities of low socioeconomic status, patient navigation has proved to be an effective intervention in promoting screening, timely diagnosis and treatment of cancer, and we suggest that the same approach that has had positive results in breast cancer can be successfully applied to screening, diagnosis and treatment of colon cancer.

## REFERENCES

1. Freeman HP, Muth BJ, Kerner JF. Expanding access to cancer screening and clinical follow up among the medically underserved. *Cancer Practice*. 1995;3:19–30.
2. Freeman HP. Race, poverty, and cancer. *J Natl Cancer Inst*. 1991;83:526–527.
3. Freeman HP. A model patient navigator program. *Oncol Issues*. 2004;19:44–47.
4. Freeman HP, Wasfie TJ. Cancer of the breast in poor black women. *Cancer*. June 1989;63(12):2562–2569.
5. Oluwole SF, Ali Ao, Adu A, et al. Impact of cancer screening program on breast cancer stage at diagnosis in a medically underserved urban community. *J Am Coll Surg*. February 2003;196(2): 180–188.
6. Nash D, Sulaiman A, Vlahov D, Schori M. Evaluation of an intervention to increase screening colonoscopy in an urban public hospital setting. *J Urban Health*. 2005;83(2).