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Health care reform: Continuing the prostate screening debate; Where does patient navigation belong?

Michael Preston, *University of Arkansas for Medical Sciences*



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Health care reform: Continuing the prostate screening debate; Where does patient navigation belong?

Michael A. Preston, Ph.D., M.P.H.
University of Arkansas for Medical Sciences

mapreston@uams.edu

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Presenter Disclosures

Michael Preston

- (1) The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:**

“No relationships to disclose”

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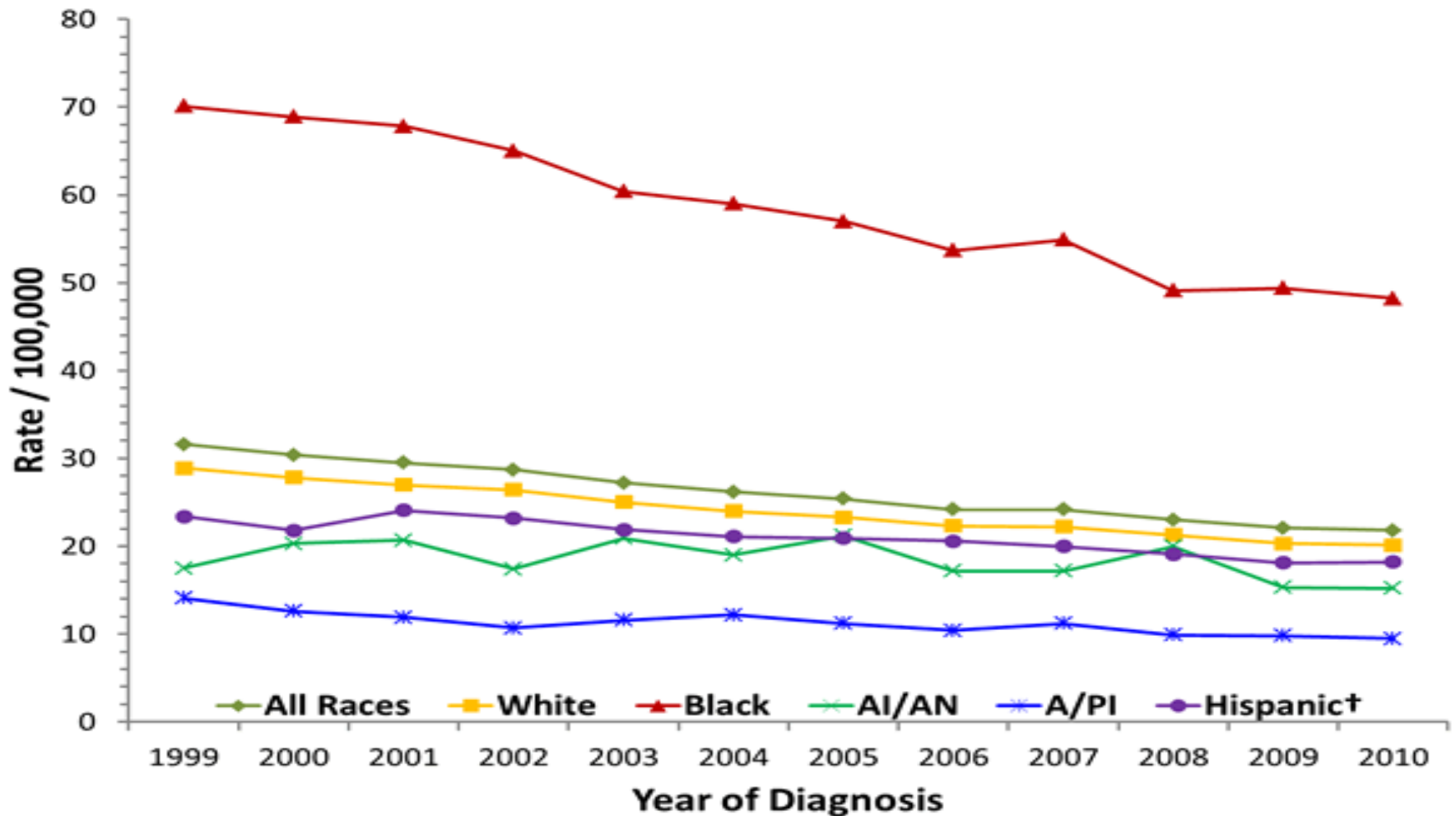
Prostate Cancer

- * Most commonly diagnosed cancer among men
- * Second leading cause of cancer deaths among men
- * 238K+ new cases (1:6 men will get prostate cancer)
- * 29K+ deaths (1:36 men will die of prostate cancer)
- * 2.5 million men are survivors
- * Overall death rate has declined
- * Disparities remain among racial/ethnic groups and disadvantaged populations

Prostate Screening

- * PSA (prostate-specific antigen) blood test
- * DRE (digital rectal exam)
- * Uncertainty or false test results
 - * Confusion
 - * Worry
- * Expectant management (watchful waiting)
- * Current recommendations (No screening with PSA)
- * Early detection: 5-year survival rate
 - * 99% (local) vs 28% (distant)

Prostate Cancer Death Rates* by Race and Ethnicity, U.S., 1999–2010



Source: Mortality Files, National Center for Health Statistics, CDC.

Patient Navigation

- * Strategies to reduce disparities in cancer detection, treatment, and outcomes among racial/ethnic minorities and low-income patients have been gathering momentum with the introduction of PN initiatives
- * African American males rely on their physicians to recommend all needed tests/screenings
- * PN: designed to help patients overcome obstacles to timely screening, diagnosis, and treatment
 - * PN services significantly decreased time to receive f/u services
 - * Improved diagnosis and 5-year survival rates (breast)

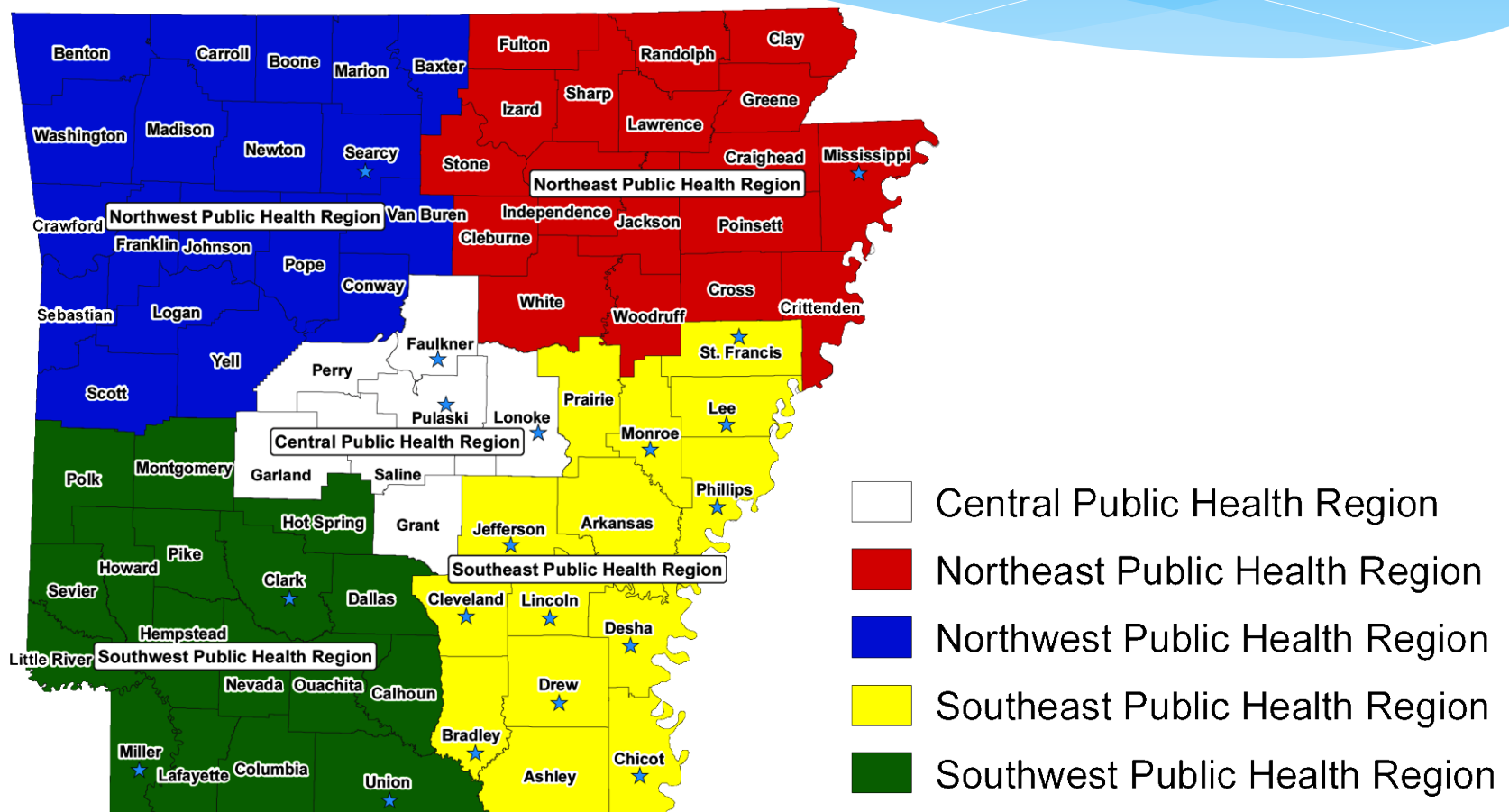
Objective

- * To examine the current and potential roles of PN in the improvement of prostate screenings among disadvantaged populations

Population Studied

- Low-income (less than 200% FPL)
- Uninsured or under-insured patients
- Disadvantaged populations
- 19 counties in Arkansas
- March 2008 to February 2012

Arkansas Prostate Counties



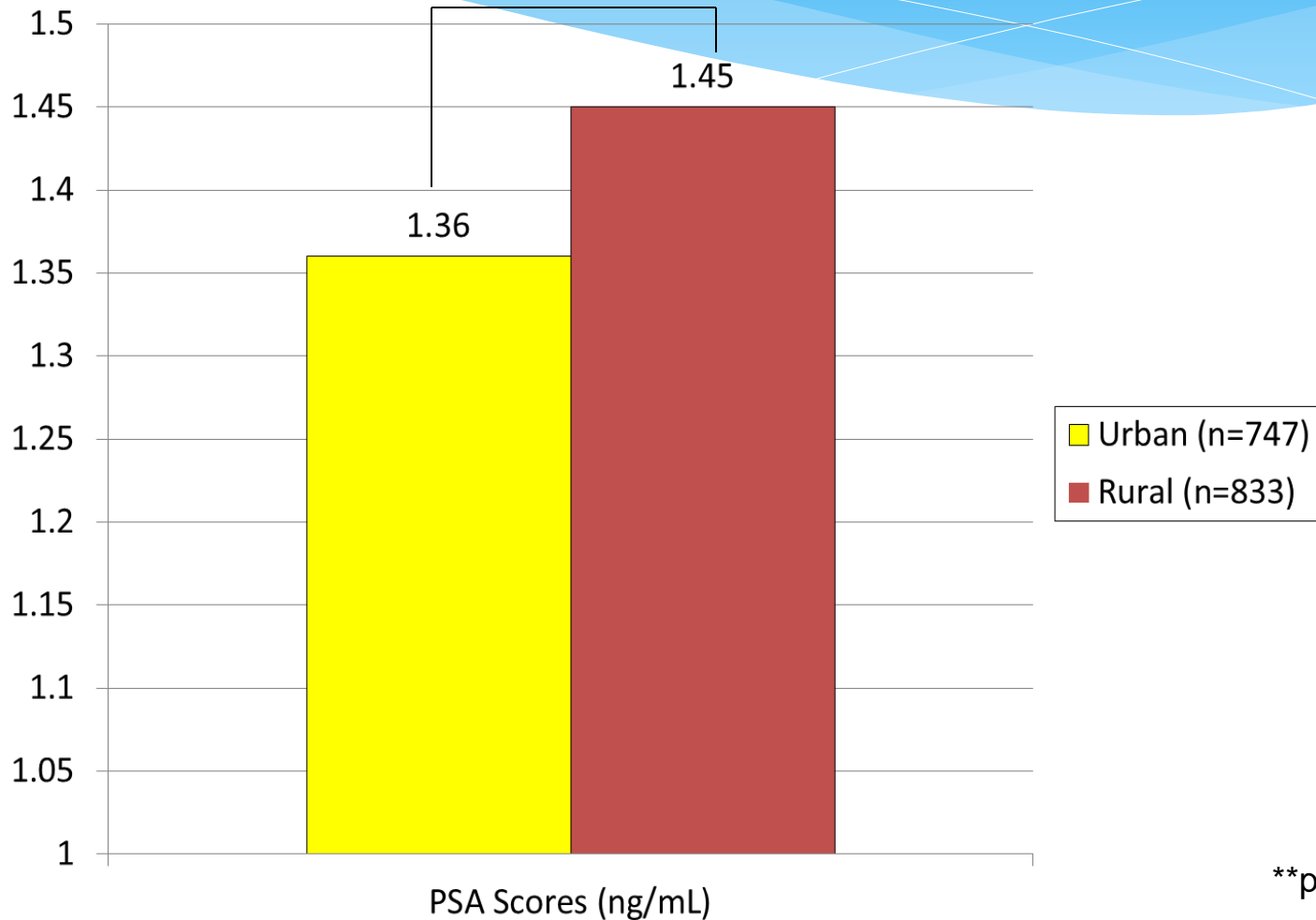
Methods

- * Longitudinal study design was conducted on males over 35 years of age presenting to PN since 2008 (n=1602)
- * Information included patient's demographics, geographical location, PSA scores, DRE scores, and the array of event types in which community engagement occurred
- * Data analyzed using comparison analyses

Principal Findings

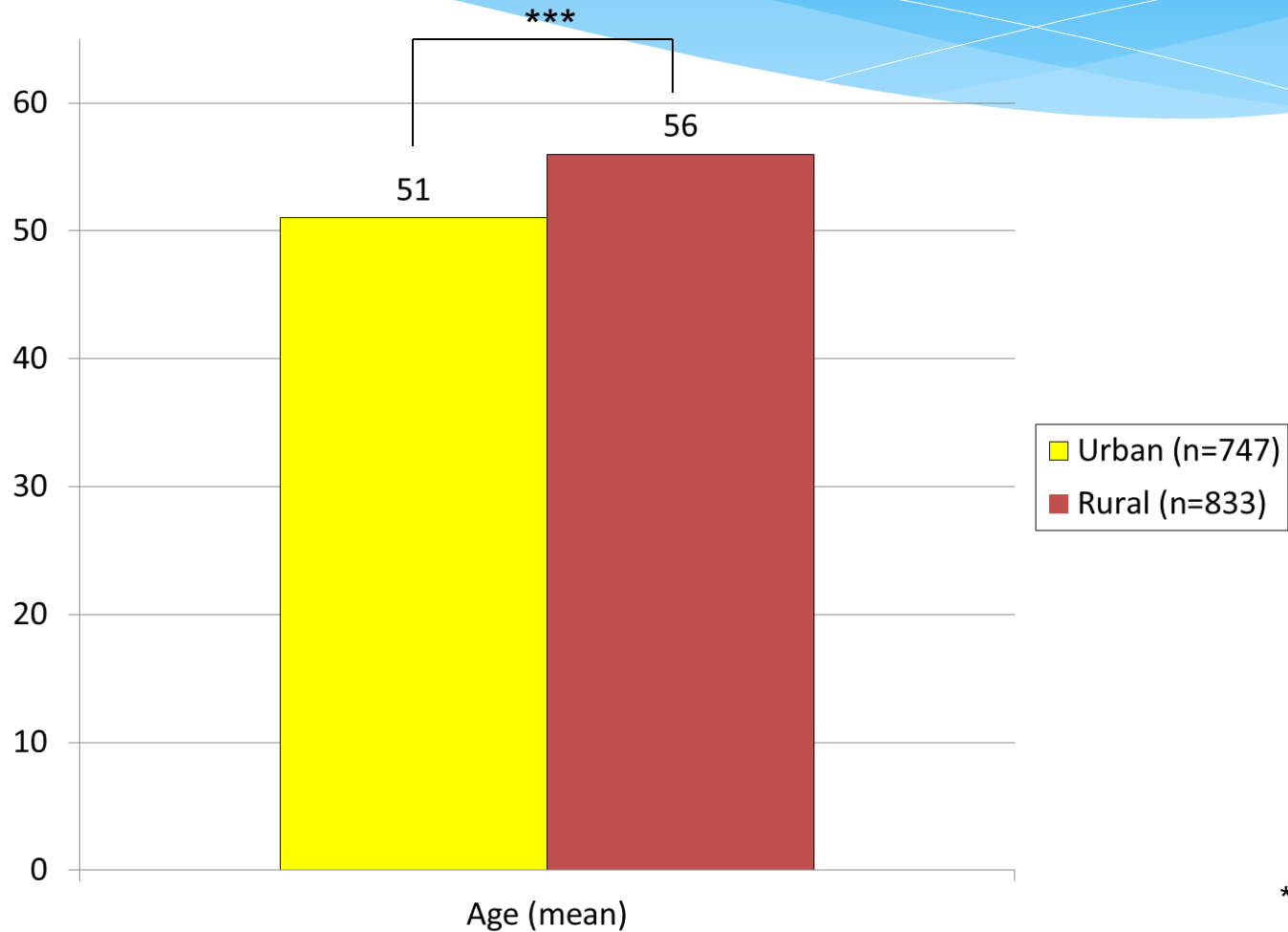
- * PN allowed for greater utilization of health services among populations of rural origins
 - * (Urban: n=747, Rural: n=833)
- * Mean PSA scores were within normal range
 - * 4.0 ng/mL and lower
- * No significant differences among racial/ethnic groups

PSA Score Urban vs Rural



**p<0.05

Mean Age Urban vs Rural



Conclusions

- * Equity of access to cancer screenings among DP can be achieved with the utilization of PN programs
- * Access to the health care system is a strong barrier which fosters disparities among DP
- * PN allows rural DP entry into the health care system at earlier stages, considering PSA as a proxy for disease
- * PN programs may prove useful in reducing racial/ethnic disparities in prostate screening and mortality

Policy Implications

- * Health care reform lays the foundation for preventative programs such as PN
- * This study provides additional evidence suggesting such strategies are worthy of testing and evaluation on a larger scale
- * Identify best ways to design health systems for preventive services that target medically underserved populations
- * Potentially missed opportunities to get physicians and patients to make informed-decisions for prostate screening