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Training Experiences of Lay and Professional Patient Navigators for Colorectal Cancer Screening

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Introduction

Patient navigation (PN) is increasingly used in cancer care. In this context, PN has been defined as “assistance offered to patients, survivors, families, and caregivers to help them access and chart a course through the healthcare system” and overcome barriers to healthcare [1]. A recent report indicates that over 200 cancer programs nationwide provide some type of PN [2]. Despite the widespread use of PN and the movement to increase its implementation, relatively little is known about processes and best practices for the selection and training of patient navigators with diverse backgrounds. By describing the training-related experiences of both lay and professional patient navigators, this report provides useful data that can inform future cancer-related patient navigation programs.

Although the profile of a patient navigator varies, navigators are often categorized as professional or paraprofessional (e.g. social workers, nurses, nurse practitioners, health educators) or lay health workers [3]. A lay health worker (LHW) has been defined as someone, paid or voluntary, who carries out functions related to health care delivery; is trained in the context of an intervention; and has no formal professional or paraprofessional

certificated or degreed tertiary education in a health-related field or in the specific focus of the intervention [4]. Additionally, LHWs are often peers: individuals who come from a similar social context and are ethnically, culturally, linguistically, and/or socioeconomically similar to the population that is the focus of intervention [5]. There are several reports of individuals being trained to serve as LHWs among Latino [6], Asian American [7,8], and African American communities [9,10]. In most of these interventions, LHWs are central to the dissemination and implementation of these programs. What is often critical to the development and implementation of these programs is the LHW's experience as a representative community member and his or her familiarity with and acceptance within a local community. By comparison, PN is distinct from most of the LHW interventions described above because either a professional *or* a LHW may conduct PN. When both professionals and LHWs serve as patient navigators, PN offers a unique opportunity to compare the aspects of both the professional and lay interventionist experience. A comparison of the training experiences of professional and lay patient navigators helps provide insight into: 1) the relative benefits and disadvantages of working with navigators of different backgrounds; 2) the learning needs of different types of navigators; and 3) effective training strategies for different types of navigators.

PN is a promising approach for addressing existing health disparities in cancer prevention and control. There are marked racial disparities in rates of colorectal (CRC) incidence, stage of diagnosis, mortality, and survival [11], with worse outcomes among African Americans compared to Caucasians. While a number of CRC screening modalities have been recommended, colonoscopy serves as a preventive measure as well as a screening modality used to detect cancer and polyps [12]. However, overall rates of participation in CRC screening are low, and racial differences in CRC screening are apparent. According to recent Behavioral Risk Factor Surveillance System (BRFSS) data, 41% of Whites age 50 and older reported no previous endoscopic screening (colonoscopy or sigmoidoscopy) compared to 46% of Blacks age 50 or older (Centers for Disease Control and Prevention, CDC) [13], with similar patterns found in New York State. While several studies suggest that PN appears to be a promising strategy for increasing CRC screening, particularly in patient populations of color [14,15], there is still much to understand regarding its implementation, including the identification, recruitment, and training of navigators. The current report compares the training experiences of professional and lay navigators who are part of an ongoing patient navigation program to increase colonoscopy screening in African American primary care patients, specifically differences in training-related knowledge, self-efficacy as a navigator, satisfaction with training, and completion of role play-based training encounters.

Strategies

Recruitment of Navigators

Lay navigators—African American adults were recruited as lay health workers (LHWs), in order to serve as volunteer lay navigators. LHWs were recruited via flyers posted in *[omitted for blind submission]*'s primary care clinic and endoscopy suite, as well as through a previous study in which some participants expressed interest in becoming navigators. An individual was considered eligible for this position if he or she was 50 years of age or older (the typical age recommendation for CRC screening), and had obtained a recent screening colonoscopy. There was no educational requirement for LHWs. Following a telephone screening, an application was mailed to the individual, and he or she was invited to the first core training session (see below). After training, LHWs who were appointed as navigators received a stipend of \$15 per hour of work (with a commitment to work an average of 4–6 hours per week).

Professional navigators—Potential professional navigators (Pros) were recruited via advertisements on internet employment boards and listing services. About half of the Pros were already working at [omitted for blind submission] in full-time positions. For new professional navigators, job requirements listed in the advertisement included a Bachelor's degree or higher in health education, psychology, related health and social service disciplines; previous experience working with ethnic and racial minorities and/or inner city communities; experience in research, including recruitment and consenting; knowledge of various aspects of community health (e.g., program development, urban public health issues, community outreach); and strong interpersonal, written, and oral communication skills. To ensure ethnic congruency, all professional navigators were African American. The starting full-time salary was in the mid-\$30K range, comparable to similar positions at [omitted for blind submission]. Job descriptions for both Pros and LHWs are briefly summarized in Table 2.

Description of Navigator Training Curriculum

Both LHWs and Pros underwent extensive training, each based on a curriculum with five primary components: 1) a core, two-part training session (six hours per session) that reviewed a wide range of topics related to CRC and navigator responsibilities (see Table 1); 2) a 4-hour training on CRC facts conducted by regional staff of the Cancer Information Service (CIS) of the National Cancer Institute; 3) a 1-hour information session with a gastroenterologist who provided a clinical perspective on CRC and colonoscopy, including a tour of the patient exam rooms and equipment; 4) a 2-hour telephone communications training provided by Human Resources at the [omitted for blind submission]; and 5) a series of one-on-one structured role plays simulating a navigation encounter with a trainer in the role of the patient. All navigators also received manuals that detailed all of the material covered in training sessions that were based, in part, on a navigator training manual developed by the Bureau of Cancer Prevention and Control of the New York City Department of Health and Mental Hygiene.

The largest component of the training curriculum was the two-part Core Sessions, which were held separately for LHWs and Pros. A substantial part of the Core Sessions for both types of navigators was training in strategies to enhance the cultural relevance of the PN through the CEDIP/CEEP Model. CEDIP (clarify, empathize, disclose, inform, and plan) was taught to LHWs and CEEP (clarify, empathize, educate, and plan) was taught to Pros. CEDIP/CEEP is a semi-structured directive and anticipatory approach to PN that trains navigators to probe about barriers to colonoscopy and prepares them to respond to a range of participant responses. This approach is largely based on motivational interviewing techniques [16, 17], as well as on concepts central to telephone-based education described by Brouse and Basch, in order to increase informed choices about CRC screening [18]. As part of CEDIP/CEEP, navigators were trained to systematically address a range of financial, structural, psychological, and sociocultural barriers to colonoscopy screening, such as fear of the procedure, fear of cancer, beliefs that CRC screening is embarrassing, belief that screening is unnecessary (especially in the absence of symptoms), medical mistrust, and concerns about discrimination [19–22].

A key component of the CEDIP model taught to LHWs but not the Pros was the disclosure component. Consistent with the aims of the funded study, only LHW training focused on appropriate use of a personal narrative to disclose their own colonoscopy screening experience. LHWs were guided in developing a 3–5 minute narrative that focused on various aspects of that experience, including the concerns they had about colonoscopy and the personal benefits of having a colonoscopy. The Core Sessions of both LHWs and Pros also included the use of non-traditional learning strategies as described by Hurd et al. [9]

and National Cancer Institute [23]. These included educational contracts and interactive “games” such as phrase-matching exercises and “fill-in-the-blanks.” All trainings were led by study investigators and staff. All LHW trainees received a certificate of completion following the Core Sessions, as well as two store gift certificates. As noted above, all navigators completed a series of structured role play exercises that simulated navigation encounters. In these role plays, a study investigator or staff member played the role of a patient with a colonoscopy referral. These patient roles were semi-scripted and navigators were evaluated on their performance during these encounters.

Implementation of the entire curriculum was completed over the course of approximately three months. For LHWs, all trainings took place over a two-month period, with a one-week interval between Core Session 1 and Core Session 2, followed by the CIS training, gastroenterologist session, and telephone training occurring in the same week one month later. Training of the Pros took place over a two-week period, with Core Sessions 1 and 2 conducted after the other training components. Role play exercises were conducted last.

Assessment

All measures were developed by study investigators, because of: 1) the absence of validated and published measures that assess the training experiences of patient navigators; and 2) the need to assess training experiences and outcomes specific to the navigation intervention’s unique content.

Intervention-related knowledge—Navigator knowledge of intervention-related content, as taught in the Core Sessions of the training curriculum, was assessed with a 23-item, multiple-choice questionnaire composed of two subsections. The first subsection included 9 items related to general knowledge about CRC (e.g., incidence, racial disparities, disease progression) and colonoscopy. The second subsection included 14 items related to the process of navigation and systems of care within the specific health care setting. The knowledge questionnaire was administered to the Pros at four timepoints: as pre- and post-tests at Core Session 1 (Times 1 and 2) and as pre- and post-tests at Core Session 2 (Times 3 and 4). The questionnaire was administered to the LHWs at these timepoints, as well as a fifth time following the CIS training described above (Time 5).

Navigator self-efficacy—The perceived self-efficacy of each navigator was assessed with a 10-item scale created by study investigators that asked about a navigator’s confidence in his or her ability to conduct specific tasks central to the navigator role (i.e., describing the problem of CRC in the African American community, completing program forms, maintaining confidentiality). Response options ranged from 1 (not at all confident) to 4 (very confident). The self-efficacy data presented here was collected at 2 timepoints: following Core Session 1 (Time 2), following Core Session 2 (Time 4).

Satisfaction with training—Navigators were asked to provide anonymous evaluations of the quality of the training received. Satisfaction was assessed with an 11-item scale. Response options ranged from 1 (strongly disagree) to 4 (strongly agree). The satisfaction questionnaire was administered at 2 timepoints: following Core Session 1 (Time 2), following Core Session 2 (Time 4).

Role play exercises—Navigators were required to complete a series of structured role plays in order to demonstrate proficiency in navigator-related tasks. The number of role plays completed by each navigator during the training varied; study investigators/staff made subjective determinations based on the perceived proficiency of the navigators about

whether or not each navigator needed to complete additional role play exercises. Staff provided extra assistance, in the form of practice, to those navigators who required it.

Results

Nine navigators completed all components of the training curriculum: 5 LHWs and 4 Pros, all of whom were African American. Additional characteristics of both LHWs and Pros are presented in Table 2. Among LHWs, 60% were younger than 65 years of age, 80% were female, and the majority completed at least 12 years of education. Sixty percent reported being unemployed. Also, 80% reported having previous public speaking experience, as well as telephone-based work experience. Among the Pros, all were female and between the ages of 25 and 34, and the majority (3 out of 4 Pros) had Master's degrees. In terms of communication skills, all of the lay navigators reported feeling comfortable talking with and engaging people that they did not know.

Table 3 presents mean total knowledge scores at each timepoint. The mean score of the Pros was very high at Time 1 (> 90% correct) and remained high in subsequent administrations. In contrast, the mean score for the LHWs was considerably lower at Time 1 (< 60% correct). Student's t-tests revealed that at Times 1, 2, and 3, the mean total knowledge scores of LHWs were significantly lower than those of the Pros. However, the mean LHW score increased at each time point such that by Time 4, it remained lower than that of Pros but this difference was not statistically significant. Results were similar for the subset of items related to CRC/colonoscopy knowledge. At Times 1, 2, and 3, the mean CRC/colonoscopy knowledge scores for LHWs were significantly lower than those of Pros (see Table 3). However, by Time 4, the difference was no longer significant. In fact, there was little difference between the LHW scores at their final Time 5 assessment (completed only by LHWs) and Pros' final scores at Time 4 (88.9% versus 91.7%, respectively). A similar trend emerged in comparisons of mean navigation/systems scores (see Table 3). However, at Time 5, the mean score among lay navigators decreased and this Time 5 score was significantly lower than professional navigators scores at Time 4 (67.9% versus 92.6%; $p < .05$).

Results also showed that the self-efficacy scores of LHWs and Pros were not significantly different at Time 2 or Time 4 (see Table 3). There were also no significant differences between LHWs and Pros in terms of satisfaction with the core training session, at either Time 2 or Time 4 (see Table 3). Finally, LHWs and Pros differed somewhat in the number of role play exercises in which they participated before entering the field as navigators. LHWs completed a mean of 5.2 role play exercises while Pros completed a mean of 4 such exercises.

Discussion

The current report compared the training experiences and outcomes of lay and professional patient navigators enlisted to increase CRC screening via colonoscopy among African American primary care patients. Results revealed that among Pros, knowledge was consistently high across assessment timepoints. Among LHWs, there was a gradual improvement in knowledge over time. Only at the final time of assessment were there no significant differences observed in total knowledge and general CRC/colonoscopy knowledge between the two groups of navigators. However, for the subset of knowledge items related to the navigation process and systems of care, the final score among LHWs was significantly lower than that of the Pros. These findings suggest that the navigator training strategies were largely effective in preparing LHWs to serve as navigators, but LHWs may require extended training, time and support in mastering knowledge related to hospital systems (e.g. computerized scheduling systems), as well as administrative tasks

related to navigation (e.g. preparing forms). As suggested by the difference between LHWs and Pros in the number of role plays conducted, the study investigators did provide some extra time and support in helping navigators achieve mastery before they went into the field. Findings also suggest that Pros required less support in achieving mastery of knowledge and tasks related to navigation. This finding is not surprising given the educational backgrounds of the Pros, with all Pros having Bachelor's degrees and the majority (75%) also having Master's degrees in health-related disciplines. Another important factor in the Pros' performance is their status as employees of the funded study. As such, they had greater ongoing access to training materials and as well as the other study staff members who served as trainers, giving them an advantage in terms of their preparation and readiness to navigate.

Results revealed no further differences in LHWs' and Pros' reported self-efficacy. Self-efficacy tended to be high among both LHWs and professionals across multiple timepoints. Also, there was no difference in satisfaction with the core training between the two groups. Furthermore, there was only a small difference in the mean number of role play exercises completed by each group. This finding suggests that while intervention-related knowledge components may be mastered more quickly and thoroughly by Pros, LHWs and Pros are more similar in terms of how well they are able to master experiential components. This finding also attests to the attention and support given to the LHWs by staff; as suggested here, it is possible that they will require more coaching and practice to reach the point of mastery.

The current results offer some insight into effective preparation of LHWs for the navigator role compared to individuals with more formal health-related training (Pros). However, it is important to note that navigators in the current study were trained to facilitate routine colonoscopy screening among primary care patients who received referrals from their primary care physicians for the procedure. It is unclear whether outcomes between LHWs and professionals would be similar when trained for other types of navigation. Much of the PN described in the literature focuses on decreasing treatment delays once a screening test result is abnormal and additional diagnostic tests are required, or when cancer is diagnosed [24,25]. It is possible that PN conducted post-diagnosis may require a more sophisticated knowledge base and skill set compared to screening navigation targeting asymptomatic primary care patients. While the current study did not investigate whether LHWs or Pros would be better suited to navigate post-colonoscopy to help patients with abnormal findings, it is possible that Pros would be better prepared given their more advanced educational background (as was the case with our sample). Future research should explore the appropriateness and effectiveness of LHWs and Pros in conducting navigation post-colonoscopy.

Conclusions

PN has gained wide acceptance as a clinical and public health intervention. Its use has expanded rapidly in recent years, and given racial disparities in CRC and related screening [11,13], it is likely to be increasingly utilized as a method of supporting adherence to colonoscopy referral and other types of recommended CRC screening. The findings reported here suggest that, at least in the context of colonoscopy-specific navigation, laypeople can achieve training outcomes comparable to professionals or paraprofessionals who have specialized educational backgrounds and different motivations for serving in this role (e.g., meeting requirements to maintain formal employment). Though more research is needed on the minimum educational requirements needed, our findings indicate that Master's degrees may not be a necessary educational requirement for screening navigators given the competencies that navigators in both groups were able to achieve. Similar outcomes are possible when LHWs are provided with adequate support over time, though our findings

suggest that the successful training of LHWs is a more time-intensive process when compared to training those with more formal education relevant to patient navigation.

Although training LHWs may be a greater investment in terms of time, this investment is supported by the Patient Navigator Outreach and Chronic Disease Prevention Act (“Patient Navigator Act”) of 2005. This national legislation provides funding “to recruit, assign, train, and employ patient navigators who have direct knowledge of the communities [that] they serve [in order] to facilitate the care of individuals.” The wording of this legislation speaks directly to the advantages of having LHWs serve in these roles. Based on the data reported here, it is recommended that training of LHWs for colonoscopy-specific navigation should include the following efforts: 1) coordination of multiple training sessions, both group and individual, with sessions divided into several shorter periods of instruction; 2) inclusion of interactive instructional techniques as well as more traditional didactic strategies; 3) assessment of trainees at multiple timepoints for close monitoring of mastery; and 4) assessment of diverse outcomes (i.e., comprehension, satisfaction and self-assessment of ability) in order to determine trainees’ perspectives of training, an area that is particularly important for programs that rely on ongoing recruitment of LHWs. As more PN programs are developed and implemented, further data is needed to guide practitioners and administrators in their efforts to include LHWs in these programs, including data on sustainability and cost-effectiveness. These data will contribute to the growth of a PN training and implementation knowledge base that is critical to the development of standards and best practices in this emergent area of cancer care.

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Table 1**Curriculum Content for Core Sessions 1 & 2.****Background**

What are Cancer and Colorectal Cancer (CRC)?
 Colorectal Cancer (CRC) as a Public Health Issue
 CRC in Black Americans
 What is Colonoscopy?
 Open-access Colonoscopy
 Referral of Patients for Colonoscopy

What is Patient Navigation & Why Do We Need It?

Barriers to Colonoscopy
 Description of the Study
 Why use the Patient Navigation Model?
 Patient Navigation in New York City

Role and Responsibilities of Peer Patient Navigators

Overview of Peer Patient Navigation
 Training of Peer Patient Navigator Training
 General Responsibilities of the Peer Patient Navigator
 Cultural Targeting

Navigation Sessions

First Contact between Peer Patient Navigator & Participant
 Scheduling
 Immediately After the First Call
 Reminder Calls and “No Shows”
 Follow-up
 Culturally-targeted Components

Communicating about Barriers to Colonoscopy

Introduction and Goals
 Provide Information
 Telling Your Story
 Strategies for Exploring and Addressing Patient Concerns about Colonoscopy
 Talking about Common Colonoscopy Concerns
 Special Issues
 General Guidelines to Remember
 Telephone Techniques
 Confidentiality
 Voice
 Listening

Glossary

Table 2

Characteristics of Lay and Professional Navigators

	Peer Navigators (LHWs) (n=5)	Professional Navigators (n=4)
Age		
25–34	0	4
35–44	0	0
45–54	1	0
55–64	2	0
65+	2	0
Gender		
Female	4	4
Male	1	0
Years of School Completed		
<12 years	1	0
12 years	2	0
More than 12 years	1	4
Missing	1	0
Employed		
Yes	2	4
No	3	0
Previous public speaking experience		
Yes	4	4
No	1	0
Previous telephone work experience		
Yes	4	4
No	1	0
Enjoy and feel comfortable talking with people		
Yes	5	4
No	0	0
Job Description	<p>A Peer Patient Navigator is someone who has a similar cultural background as the person that they will navigate, and has already had a screening colonoscopy, so that he/she will be able to share their colonoscopy experience with the person that they navigate. The Peer PN should be able to identify with, understand, and advise patients with challenges they may face in obtaining cancer screening. A Peer PN provides colorectal cancer screening education to the patient, provides informal counseling and support, assists with scheduling appointments, provides telephone reminders, assists with transportation needs, arranges for escort services (as needed) during screening appointments, and follows-up on whether patients have completed the screening test.</p>	<p>Health Educators/Research Interviewers are being hired for a new research program examining colorectal cancer screening among minority patients. Using a Patient Navigator model, this project seeks to increase the rate of colonoscopy adherence among primary care patients. Responsibilities include the recruitment of study participants from primary care settings, consenting and HIPAA of participants, conducting study interviews, patient navigation for colonoscopy screening, conducting follow up interviews, and maintaining a tracking database and assisting in data entry.</p>

Table 3

Intervention-related knowledge items: mean percent correct.

Total knowledge	LHWs	Pros	p
Time 1	56.5%	92.4%	.0006
Time 2	69.6%	93.5%	.01
Time 3	75.7%	92.4%	.04
Time 4	75.7%	92.4%	.14
Time 5	76.1%		
CRC/colonoscopy knowledge			
Time 1	60.0%	94.5%	.007
Time 2	78.8%	94.5%	.01
Time 3	80.0%	97.2%	.01
Time 4	75.6%	91.7%	.24
Time 5	88.9%		
Navigation/systems knowledge			
Time 1	54.3%	91.1%	.0004
Time 2	64.3%	92.7%	.02
Time 3	72.9%	89.3%	.13
Time 4	75.7%	92.6%	.10
Time 5	67.9%		
Mean navigator self-efficacy			
Time 2	3.56 (.25)	3.15 (.21)	.79
Time 4	3.62 (.37)	3.30 (.28)	.69
Satisfaction with navigator training			
Time 2	3.27 (.93)	4.0 (0)	.28
Time 4	3.49 (.71)	3.86 (.17)	.25