

INTRODUCTION

- Lung cancer is the leading cause of cancer death, and Black Americans face disproportionate incidence, late-stage diagnosis, and mortality.¹
- Low-dose computed tomography (LDCT) screening reduces lung cancer mortality, yet uptake remains low in Black communities due to medical mistrust, logistical barriers, and outreach that overlooks social determinants of health.²
- This study tested a community-based navigation model, using pharmacies and a mobile health unit, to close that gap through a structured screening pathway.

METHODS

Study Setting and Population

Eligible adults were identified at independent community pharmacies (Washington, DC) and a mobile health unit (Baton Rouge, LA) using USPSTF screening criteria.



Data Collection

Navigators collected sociodemographic characteristics, smoking history, health status, prior cancer screening history, and primary screening motivation using REDCap.



Navigation Process

GO2 confirmed interest, completed needs assessment, arranged transportation, and paid for screening where needed.

Partner screening facility conducted shared decision-making visit and scheduled LDCT appointment.

GO2 administered exit survey, documented results, confirmed annual follow-up



Data Analysis

Descriptive statistics were calculated using SPSS to summarize participant characteristics and outcomes across the screening navigation cascade.



DISCUSSION AND CONCLUSION

Actionable Take Away Message

- Despite reduced financial and logistical barriers, 74% of interested participants did not complete screening, suggesting non-access factors, possibly behavioral, may also play a role.
- Eligibility rates were nearly identical across sites (20% DC vs. 18% Baton Rouge) despite differing care settings and assessment volumes, suggesting the navigation model performs consistently across diverse community settings.
- Screening completion was higher in DC (38.5%) than Baton Rouge (19%), possibly because DC's virtual shared decision-making avoided an extra in-person step, suggesting virtual SDM may be a low-cost way to reduce drop-off.

Future Direction for Research

- Embedding behavioral health specialists at intake may help catch hesitation before it becomes disengagement.
- Future studies should apply a stages-of-change framework (e.g., the Transtheoretical Model) to identify where participants drop off between expressing interest and completing screening.
- Offering on-site or mobile screening at the point of interest, rather than requiring a separate follow-up visit, may reduce drop-off by allowing participants to act while motivated.

REFERENCES & ACKNOWLEDGEMENTS

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- Dwyer LL, Vadagam P, Vanderpoel J, et al. Disparities in lung cancer: a targeted literature review examining screening, diagnosis, treatment, and survival outcomes in the United States. J Racial Ethn Health Disparities. 2023;11(3):1489. <https://doi.org/10.1007/S40615-023-01625-2>

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RESULTS

Table 1. Sociodemographic characteristics of eligible participants (n=80)

Characteristic	n (%)
Age	
50-59	23 (28)
60-69	51 (64)
70-80	6 (8)
Sex	
Female	45 (56)
Male	35 (44)
Race	
Black/African American	71 (89)
White	5 (6)
Other/Multiracial	4 (5)
Education	
High school or less	55 (69)
Some college or higher	25 (31)
Health Insurance	
Medicare/Medicaid	62 (77)
Other/Uninsured	18 (23)
Prior PCP	
Yes	68 (85)
No	12 (15)

Key Findings

- 85% of respondents had an established primary care provider, yet had not received lung cancer screening.
- Prior screening for other cancers ranged from 58%-78%, yet 74% of participants enrolled in navigation did not complete LCS.
- Appointment scheduling was the largest bottleneck: 70% (56/80) of participants enrolled in navigation did not successfully schedule a LCS appointment.

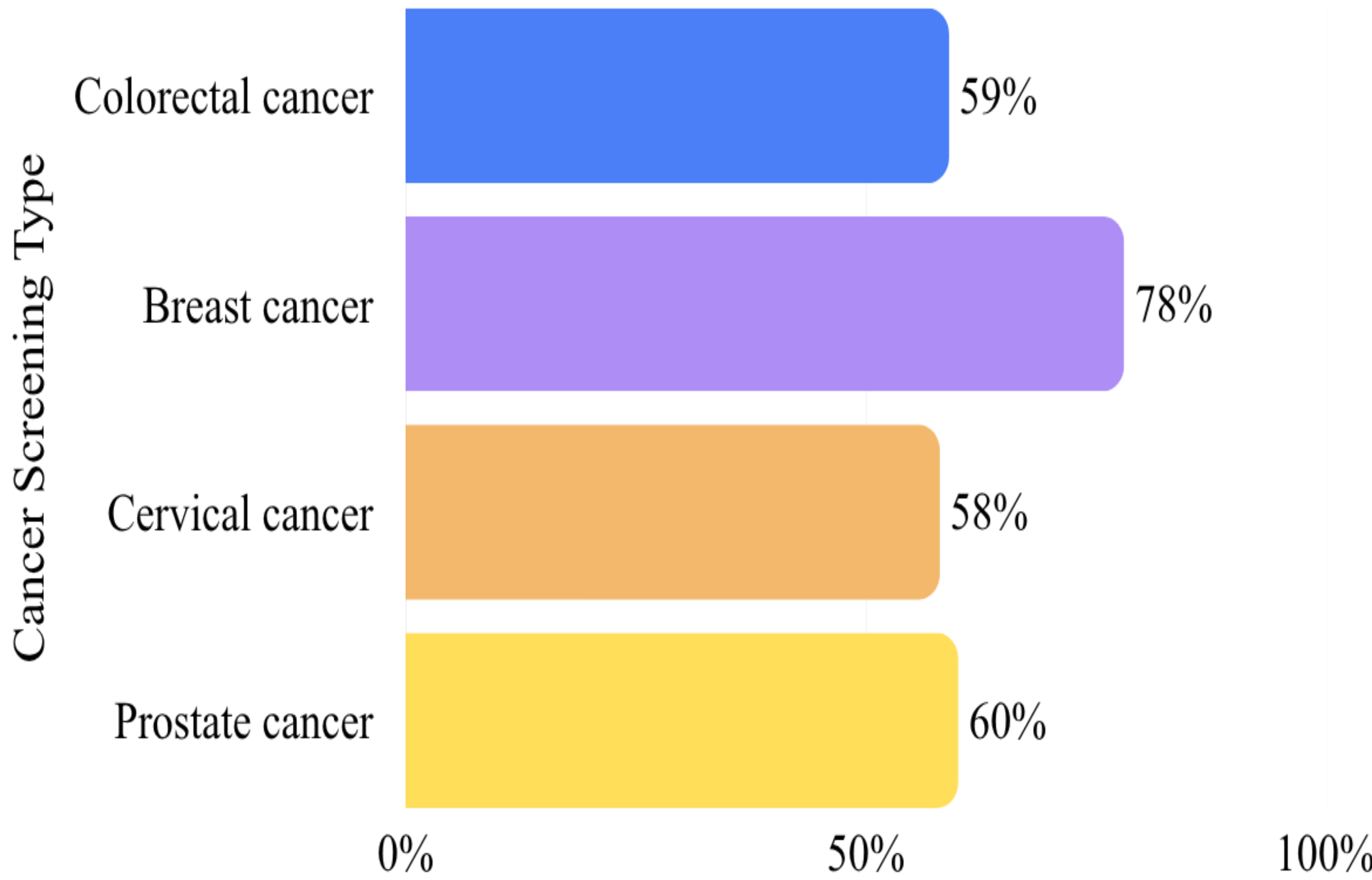


Figure 1. Prior cancer screening history among eligible participants (N=80)

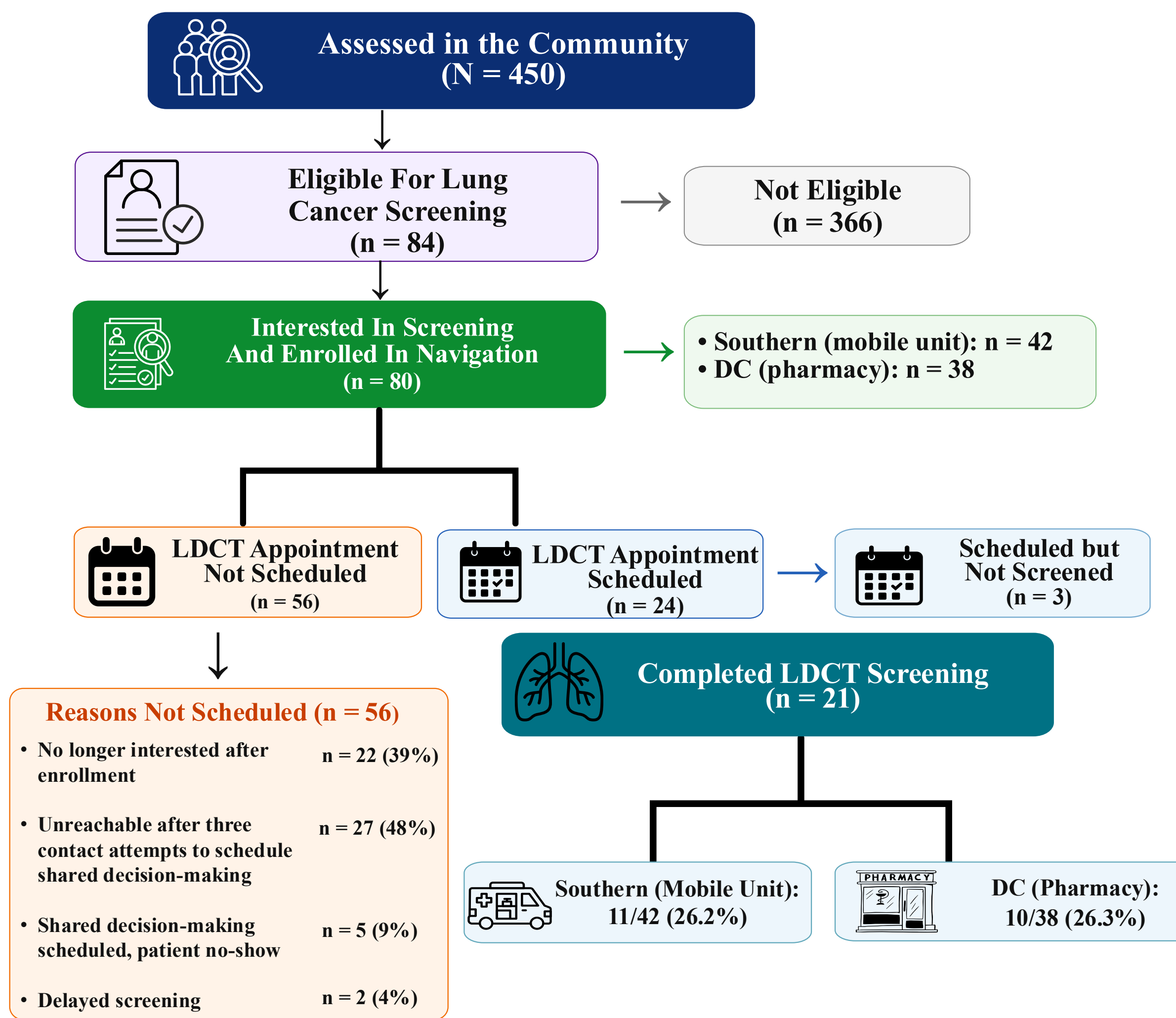


Figure 2. Screening navigation flow chart

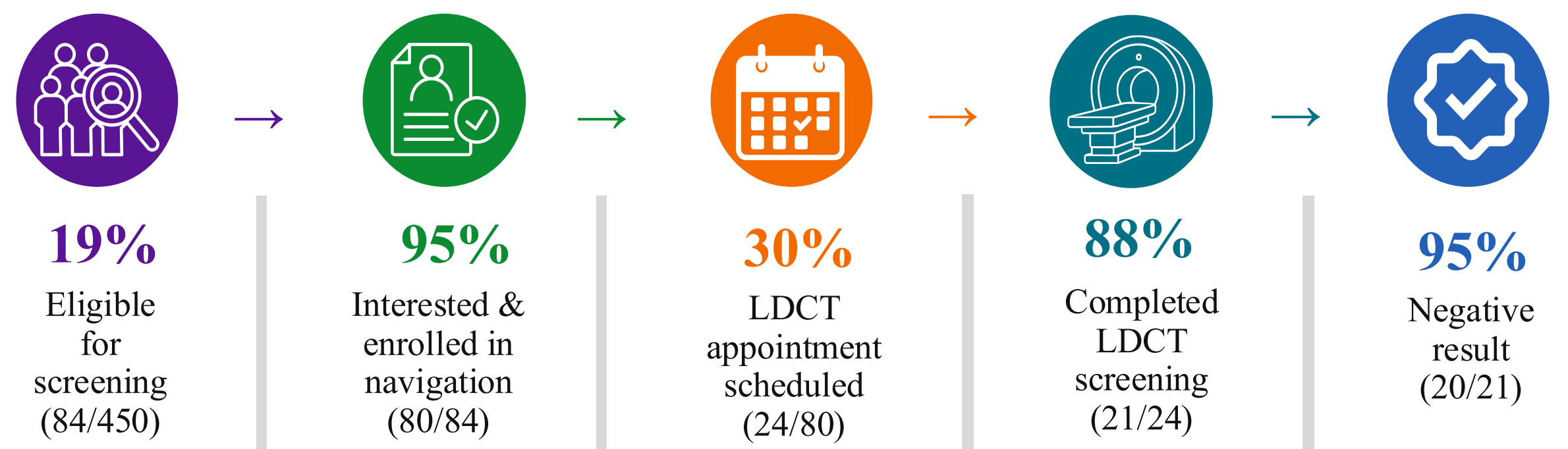


Figure 3. Lung cancer screening navigation outcomes