Published in final edited form as:
J Cancer Educ. 2011 September ; 26(3): 427–435. doi:10.1007/s13187-011-0229-8.

Qualitative Evaluation of a New Tobacco Cessation Training Curriculum for Patient Navigators

Jamie S. Ostroff,
Department of Psychiatry and Behavioral Sciences, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10021, USA

Elyse Shuk,
Department of Psychiatry and Behavioral Sciences, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10021, USA

Paul Krebs,
Division of General Internal Medicine, New York University School of Medicine, New York, NY, USA

Wei-Hsin Lu,
Stony Brook University Medical Center, School of Medicine, Stony Brook, NY, USA

Jack Burkhalter,
Department of Psychiatry and Behavioral Sciences, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10021, USA

Jeralyn Cortez-Weir,
Department of Psychiatry and Behavioral Sciences, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10021, USA

Rian Rodriguez,
Ralph Lauren Center for Cancer Care and Prevention, 1919 Madison Avenue, New York, NY, USA

Vanessa N. Burnside, and
Department of Psychiatry and Behavioral Sciences, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10021, USA

Erica I. Lubetkin
Department of Community Health and Social Medicine, Sophie Davis School of Biomedical Education at The City College of New York, New York, NY, USA

Abstract

Treatments for tobacco dependence exist but are underutilized, particularly among low-income and minority smokers. Patient navigation has been shown to help patients overcome barriers to quality care. In preparation for testing the feasibility of integrating tobacco cessation patient navigation into primary care, this paper describes the development and qualitative evaluation of a new curriculum for training patient navigators to address cessation treatment barriers faced by low-income, minority smokers who are advised to quit by their physicians. Thematic text analysis of transcripts obtained from focus groups with experienced patient navigators ($n = 19$) was conducted. Participants endorsed patient navigation as a relevant strategy for addressing tobacco

Correspondence to: Jamie S. Ostroff.
ostroffj@mskcc.org.

cessation treatment barriers and made several recommendations regarding the knowledge, core competencies, and skills needed to conduct tobacco cessation patient navigation. This curriculum could be used by existing patient navigation training centers or made available as a self-guided continuing education program for experienced navigators who wish to expand their navigation interventions to include a tobacco cessation focus.

Keywords

Smoking; Tobacco cessation; Patient navigation; Tobacco dependence; Disparities

Although smoking rates have declined among US adults, individuals who experience poverty are more likely to smoke [1]. Safe and effective treatments for tobacco dependence exist [2]; however, evidence-based treatments are underutilized, particularly among low-income and minority smokers [3, 4]. Hispanics are 57%, and African Americans are 13% less likely than non-Hispanic White smokers to receive quitting advice from their physicians [5]. African American and Hispanic smokers are less likely to use tobacco cessation medications [6]. Despite the widespread promotion of free quitlines, use among Medicaid recipients remains low. For instance, only 16% of New York State Quitline callers identified as Medicaid participants [7].

Given that tobacco-related morbidity and mortality disproportionately burden vulnerable populations [8, 9], innovative approaches are urgently needed to eliminate tobacco-related health disparities [10]. Widespread adoption of tobacco control policies (tobacco taxation, clean indoor air laws) coupled with dissemination of clinical practice guidelines for treating tobacco dependence and greater availability of safe and effective tobacco cessation treatments represent strong push strategies for reducing tobacco-related health disparities. Nonetheless, complementary pull strategies must be developed to address barriers and improve linkage of high-risk smokers to available quitting resources [11].

In cancer care, patient navigation (PN) has increasingly been adopted to reduce health disparities by helping patients overcome barriers to receiving timely, quality care [12, 13]. First developed by Dr. Harold Freeman while working with breast cancer patients in Harlem, New York [14], the National Cancer Institute's Center to Reduce Cancer Health Disparities describes PN as the support and guidance offered to vulnerable persons with abnormal cancer screening or a new cancer diagnosis so as to enhance access to the cancer care system [15]. Patient navigators are typically health care professionals or highly trained lay community health workers who coordinate health care for patients and assist them in managing complex health care systems. The goal is to facilitate access to quality cancer care that meets cultural needs for all patients [16]. Growing evidence suggests that PN can be effective in addressing disparities in breast cancer screening and access to cancer treatment [17, 18].

More recently, the PN approach has been used in the primary care setting where patient navigators may extend a primary care provider's (PCP) efforts to promote adherence to preventive health recommendations. Although patient navigators have typically not focused on assisting smokers to access evidence-based cessation interventions, PN represents a promising bridge between the PCP, the smoker, and the existing community-based cessation support services [19–21]. Patient navigators may receive referrals from PCPs and provide more in-depth assistance than PCPs traditionally have been able and willing to provide [22]. PCPs serving a largely low-income, urban minority population have expressed interest in the potential system-level benefit of having a patient navigator affiliated with their medical practice to assist in linking smokers to community-based cessation services [23].

This paper describes the initial development and qualitative evaluation of a new curriculum for training patient navigators to identify and address the treatment access barriers faced by smokers who are advised to quit by their PCPs.[1] This curriculum was developed in preparation for a planned field study to test the feasibility and promise of integrating tobacco cessation patient navigation (TCPN) into primary care clinics that serve a low-income, minority population. Curriculum development was guided by prior work using participatory research methods [24] drawing upon the expertise of experienced patient navigators who evaluated the curriculum content and suggested recommendations for its improvement in a series of three focus groups.

Methods

Development of the Tobacco Cessation Patient Navigation Training Curriculum

The overall educational objective was to develop a didactic curriculum to provide the core knowledge, skills, and competencies that patient navigators need to identify and address barriers faced by smokers advised to quit by their PCPs. Experienced navigators who had little or no prior formal training in tobacco cessation treatment are the target audience. The curriculum was guided by prior efforts to standardize PN training [25], and the tobacco treatment content was consistent with the Clinical Practice Guidelines [2] and similar efforts to train tobacco treatment specialists [26].

Guided by the social cognitive theory [27], the training philosophy emphasized the development of positive outcome expectancies and self-efficacy in order to empower patient navigators to promote the use of evidence-based cessation support services. Content experts with experience in training health care providers to treat tobacco dependence (JO, PK, JB), addressing health disparities in primary medical care (EL), patient navigation (JC, RR), and adult education (WL) developed the TCPN curriculum through a collaborative iterative process (See Table 1 for an outline of topics addressed in the curriculum.) The TCPN training curriculum has four modules: (1) overview of patient navigation, (2) overview of tobacco use and disparities, (3) how to navigate patients towards usage of evidence-based cessation treatments, and (4) tobacco cessation patient navigation documentation and data management.

Recruitment of Focus Group Participants

The project was approved by the Institutional Review Boards at Memorial Sloan-Kettering Cancer Center and The City College of New York. Patient navigators with experience in working with racial and ethnic minority patients in urban, medical care settings were recruited. Patient navigators were eligible if they had completed navigation training at the Harold P. Freeman Patient Navigation Institute (HPFPNI) in New York City (NYC) and worked as a navigator for at least 6 months in the NYC metropolitan area. Study collaborators at Ralph Lauren Center for Cancer Care and Prevention and HPFPNI identified an eligible pool of 148 patient navigators, randomly selected a group of 50 patient navigators and sent them an invitation letter. A research study assistant contacted patient navigators via follow-up phone calls to assess their interest. Nineteen patient navigators (38%) were recruited to participate in a total of three focus groups. Thematic saturation can be attained when conducting focus groups with this number of participants when the sample is homogeneous and the subject of inquiry is fairly defined [28, 29]. The primary reason for non-participation was scheduling conflicts. Each participant was given an incentive of $100 to cover his/her time and travel expenses.

[1]This tobacco cessation patient navigation training module is available from the authors upon request.

Data Collection and Focus Group Guide

Consistent with well-established focus group moderation strategies [28, 29], two health psychologists (JO, PK) co-moderated the focus groups, which each lasted approximately 90 min. The overall objective was to seek feedback from experienced patient navigators regarding the utility and the relevance of the proposed tobacco cessation patient navigation curriculum. A focus group guide (see Table 2), developed by the research team and pretested with an experienced patient navigator (JC), was used to moderate the discussions while allowing for unstructured time for participants to discuss other relevant issues.

Participants were presented with three modules of the curriculum: a review of PN principles, information regarding tobacco use and disparities, and strategies for providing TCPN. Following the presentation of each module, participants' reactions regarding the utility of the content were explored. Given the target population of low-income, racial and ethnic minority smokers, there was much attention given to the content's socioeconomic and cultural relevance. Finally, participants' overall thoughts about the curriculum and implementation of TCPN within a primary care practice setting were elicited. All discussions were audio-recorded and transcribed for subsequent thematic content analysis.

Qualitative Analysis

Participants' narrative comments were reviewed using inductive thematic text analysis, in which conceptual findings were identified directly from the data through an iterative process of transcript review, interpretation, and consensus discussions [30–34]. The analysis team consisted of three study investigators (JO, EL, WL) and a qualitative method specialist (ES). In the first phase of analysis, each member of the analysis team read the same transcript, independently highlighted the content they regarded as important, and noted their reflections in the transcript's margins, a process known as margin coding [35]. Each team member subsequently synthesized their thoughts regarding the transcript's key findings, and selected participant quotes supporting each observation, into an analysis template. The team then held a consensus meeting to share their independent reflections and collectively generate a set of findings for the transcript. The team repeated this iterative process until transcripts of all three focus groups had been coded and synthesized. The final analytic phase entailed generating higher-order descriptive and interpretive themes that represented prominent findings observed across all three transcripts.

The salience of thematic findings was assessed using two methods [36–38]. First, there was consideration of whether multiple analysis team members had reached similar conclusions regarding participant feedback about the curriculum. Consensus meetings revealed concurrence in their interpretations. Second, the degree to which findings recurred across the three focus groups was considered and the themes identified were evident in each focus group.

Results

The sample included 19 patient navigators who worked in hospitals or community health centers in the NYC metropolitan area. Most participants (95% female; 68% aged between 30 and 49 years; 68% with college degrees) were experienced navigators with eight participants having between 1 and 5 years of experience (42%); only six had less than 1 year of navigation experience (32%; Table 3). Only one navigator had received prior formal tobacco cessation training. The participants reported that they served a racially and ethnically diverse patient population, including a high proportion of African American and Hispanic patients. Analysis of the focus group transcripts revealed one overarching theme and four sub-themes

representing specific recommendations intended to improve the TCPN curriculum for future training use.

Overarching Theme: Proof of Concept for Tobacco Cessation Navigation

The overarching theme, “Proof of concept for tobacco cessation navigation” delineates participants’ endorsement that tobacco cessation navigation fits well with the philosophy, roles, and responsibilities of patient navigation. Participants generally endorsed the idea of providing tobacco cessation navigation to smokers advised to quit by their physicians, acknowledging both the challenges associated with quitting tobacco and the need to support smokers throughout the process. In some instances, the curriculum raised the navigators’ awareness of the importance of assessing tobacco use. One participant shared, “I have a patient navigation intake sheet and this (curriculum) gave me the idea that I'm actually going to put in a check box to see if a patient I'm working with is a smoker.” Some participants felt that tobacco cessation navigation should be incorporated within their broad early detection and cancer treatment navigation goals whereas other participants felt it would be better to have a dedicated PN whose sole expertise was tobacco cessation. Participants described the curriculum as informative and practical, presenting a valuable set of skills for tobacco cessation navigation. Additionally, participants regarded the curriculum to be customizable and easily adaptable to the parameters of their own work settings and patients served.

Subtheme 1: Clarify the Patient Navigator Role

The first subtheme, “Clarify the patient navigator role,” provides suggestions as to how to better define the role and function of a tobacco cessation patient navigator. Several participants felt the curriculum should more specifically emphasize how the navigator should relate to the smoker and the referring health care provider. For example, participants stated that the curriculum should reflect that a patient navigator's central role is to be attentive to a patient's needs, to become “expert” on the patient's concerns, and to serve as an able intermediary between the patient and the PCP. One participant said that “a key word that should be included (in the description of the navigator role) is that patient navigators are liaisons between provider and patient.”

Other participants indicated that the curriculum must better reflect the boundaries of a navigator's job responsibilities. Specifically, the curriculum should emphasize that the navigator is not a mental health counselor or therapist but rather a liaison between the health care team, the patient and his/her community. Additionally, some participants wanted the curriculum to better describe how navigators should work with and build effective, collegial relationships with other allied health care providers, such as social workers or nurses.

Subtheme 2: Make the Case to the Patient

The second subtheme, “Make the case to the patient,” highlights recommendations for including resources that navigators could use to educate patients regarding tobacco use and cessation, making the curriculum content more culturally sensitive, and displaying tobacco use statistics in a simple, easy-to-digest format. Many participants suggested making tobacco use information more persuasive by depicting broad, negative outcomes from tobacco use and second-hand smoke beyond health hazards, and using quitting testimonials from former smokers to enhance patients’ quitting motivation. Participants identified the importance of emphasizing some of the lesser known health hazards and risks associated with tobacco use, including increased susceptibility to infections and the addictive nature of nicotine. Some participants endorsed the use of graphic visual depictions of tobacco-related health hazards and changes in appearance (skin wrinkling, stained teeth), believing that these can powerfully convey smoking's long-term health and cosmetic consequences. Another strategy noted was accentuating the physical health hazards for second-hand

smokers, such as including data about asthma incidence among nonsmokers who live with smokers, especially children. Several participants also suggested highlighting the negative financial impact of tobacco use.

Participants recommended making the curriculum more culturally sensitive in order to guide how navigators would work with patients from diverse racial/ethnic groups and with patients who have comorbid conditions, such as mental illness or substance abuse. These participants emphasized that patient navigation involves tailoring a culturally relevant, patient-centered, communication message. One participant stated, “Navigators know that they must tailor to the person, not just as an individual, but also their cultural belief system and values.” As a result, participants requested adding content providing direction on how to tailor cessation guidance based on a patient's racial/ethnic and health background. Specific recommendations included placing greater emphasis on assessing a patient's unique health concerns and cultural beliefs about tobacco use, describing how a navigator can customize cessation information according to cultural and health needs, and instruction on how to tailor evidence-based cessation approaches to specific racial/ethnic communities.

Participants’ third “make the case” suggestion was to make data presenting tobacco use prevalence more user-friendly for navigators and to provide suggestions for helping them make the data relevant to patients. Their foremost suggestion was to present tobacco use data by age, race/ethnicity, income level, NYC neighborhood, and overall use in the USA, in “more simplified” terms so that it can be easily understood by those with less experience interpreting public health data. Specific recommendations included replacing percentages with phrases like, “one out of x people smoke,” and inserting percentage figures onto bar graphs so that the viewer could quickly absorb the prevalence data.

Subtheme 3: Better Engage the Patient to Seek Cessation Treatment or Consider Quitting

The third subtheme, “Better engage the patient to seek cessation treatment or consider quitting,” presents guidance about how navigators can use communication skills to encourage patients to follow through on quitting advice made by their PCP. Several participants believed that the curriculum should include additional training to help navigators motivate smokers to quit or seek cessation treatment. Participants felt that the curriculum should emphasize strategies for eliciting a patient's perceptions and beliefs surrounding tobacco use and quitting. For example, several participants advocated that navigators need to convey an understanding that tobacco use may serve functional purposes (e.g., stress reducing, cultural, spiritual) for the patient. Additionally, participants cited a need to acknowledge the patient's beliefs about quitting methods and to provide accurate information about effective quitting strategies along with a supportive message that quitting is a process that can require multiple attempts. Several participants spoke about the importance of imparting knowledge about what a patient can expect to experience when quitting, such as withdrawal symptoms and their duration. Others stated that the curriculum should emphasize the importance of identifying and addressing a patient's barriers to quitting. One participant shared, “...although everybody knows that smoking is bad, I think you have to tackle the reasons why they smoke.”

Participants made several recommendations for modifying the curriculum's communication skills content. Several participants found the presentation of motivational interviewing skills and communication techniques to identify patients’ barriers to using tobacco cessation services as especially helpful. Participants discussed the utility of presenting in-depth examples of specific communication strategies while others felt that such detail is unnecessary because most navigators already have excellent communication skills. Participants agreed that any description of communication skills should be presented in a practical, down-to-earth, nonjudgmental style. Moreover, participants felt that the

curriculum should explain the importance of using effective communication skills so as to establish a trusting and an empathic rapport.

Participants' last engagement recommendation was that the curriculum should instruct a navigator on how to walk the patient through the cessation process, such as describing specifically what a patient may experience when calling the Quitline and emphasizing the benefit of both counseling and cessation medication such as nicotine replacement therapy. Several navigators suggested that smokers may have misgivings about using cessation medications and seeking help outside their communities. Navigators should be well equipped to address the specific concerns of their patient populations and to help demystify the quitting process and the available community resources.

Subtheme 4: Broaden Education Regarding Cessation Resources

Finally, the fourth subtheme "Broaden education regarding cessation resources," refers to the need to provide additional information about cessation treatment options. Specifically, participants requested that current information about cessation resources within the patient's local community should be made available, including specific locations and contact information. One participant stated, "When you speak to the smoker, you tell them, 'At XYZ Hospital they have a smoking cessation program. Call this person directly and they can help you,' and giving them the information on how to get to this place and...about the entire process...." Participants were mindful of working with economically disadvantaged individuals, and they recommended that the curriculum describe low-cost cessation treatment options that would be affordable for patients with limited financial resources. For example, participants desired education regarding out-of-pocket costs for cessation medications and treatment options that are available for those without health insurance and undocumented persons.

Discussion

This paper describes the development and the qualitative evaluation of a new curriculum for training patient navigators to identify and to address the barriers faced by low-income, racial and ethnic minority smokers who are advised to quit by their PCPs. Focus groups were conducted with experienced patient navigators who provided constructive feedback on the overall premise and specific training needs necessary to integrate TCPN into routine medical care at inner-city community health centers. Overall, focus group participants endorsed the utility of patient navigation in helping address gaps in the delivery of tobacco cessation treatment to low-income and minority smokers. Participants emphasized the importance of clarifying the specific roles and the responsibilities of tobacco cessation patient navigators, providing adequate background information about the risks of tobacco use and cessation resources available within their communities, and providing additional communication skills training to handle smokers' discomfort in speaking about their tobacco use and to address smokers' ambivalence about quitting and using tobacco cessation treatments.

The next step in developing a TCPN program will be to train patient navigators using the new curriculum and to conduct a pilot field study to examine the feasibility and the promise of integrating tobacco cessation navigation within a primary care setting serving low-income, urban smokers. The TCPN training module will be implemented as an intensive, 12-h training session over 2 days. An interactive teaching model will be used in which trainees will be asked to identify smokers' barriers in seeking tobacco cessation treatment that they may have encountered and discuss ways to overcome these obstacles. Vignettes of typical patient barriers (e.g., financial concerns, low English literacy, lack of quitting knowledge) will be explored to determine how a navigator might assist. Facilitative communication skills, such as building rapport and active listening, will be demonstrated

and reinforced with role-playing exercises. As accurate tracking and documentation of the patient navigation process and cessation outcomes are important to demonstrate its utility, recordkeeping will be demonstrated in detail using an electronic database resource created specifically for TCPN.

This study's limitations include the small sample size of patient navigators recruited from a single institute for patient navigator training. Most participants were experienced navigators from an urban area serving predominantly African American and Hispanic, low-income communities. Lay navigators with less expertise and those working with rural smokers may have additional TCPN training needs. Further, formative and summative evaluation is needed in order to assess the feasibility, generalizability, and promise of TCPN.

Despite these limitations, these data support the goodness of fit for expanding the role of patient navigation as a strategy for improving the link between low-income, minority smokers and community-based cessation support services. Participants strongly endorsed the applicability of using patient navigation to address tobacco cessation treatment barriers and made several recommendations regarding the knowledge, core competencies, and skills needed to conduct TCPN. Ultimately, this new curriculum module could be used by existing patient navigation training centers or made available as a self-guided continuing education program for experienced navigators who wish to expand their range of navigation services to include a tobacco cessation focus.

Acknowledgments

This research was supported by grants from the National Cancer Institute #U54CA137788/U54CA132378 CCNY/MSKCC Partnership and T32CA009461 Institutional Training Grant, and partial support from P30 CA008748.

References

1. Fagan P, Moolchan ET, Lawrence D, Fernander A, Ponder PK. Identifying health disparities across the tobacco continuum. Addiction. 2007; 102:5–29. doi:10.1111/j.1360-0443.2007.01952.x. [PubMed: 17850611]
2. Fiore, MC.; Jaén, CR.; Baker, TB.; Bailey, WC.; Benowitz, NL.; Curry, SJ. Clinical practice guideline. U.S. Dept. of Health and Human Services, Public Health Service; Rockville, Md.: 2008. Treating tobacco use and dependence: 2008 update..
3. Houston TK, Scarinci IC, Person SD, Greene PG. Patient smoking cessation advice by health care providers: the role of ethnicity, socioeconomic status, and health. American Journal of Public Health. 2005; 95(6):1056–1061. doi:10.2105/ajph.2004.039909. [PubMed: 15914833]
4. Fu SS, Kodl MM, Joseph AM, Hatsukami DK, Johnson EO, Breslau N, Baolin Wu, Bierut L. Racial/ethnic disparities in the use of nicotine replacement therapy and quit ratios in lifetime smokers ages 25 to 44 years. Cancer Epidemiology, Biomarkers & Prevention. 2008; 17(7):1640–1647. doi:10.1158/1055-9965.epi-07-2726.
5. Lopez-Quintero C, Crum RM, Neumark YD. Racial/ethnic disparities in report of physician-provided smoking cessation advice: analysis of the 2000 national health interview survey. American Journal of Public Health. 2006; 96(12):2235–2239. doi:10.2105/ajph.2005.071035. [PubMed: 16809587]
6. Cokkinides VE, Halpern MT, Barbeau EM, Ward E, Thun MJ. Racial and ethnic disparities in smoking-cessation interventions: analysis of the 2005 national health interview survey. American Journal of Preventive Medicine. 2008; 34(5):404–412. [PubMed: 18407007]
7. Brecher, C.; Lynam, E.; Spiezio, S. Medicaid in New York: why is New York's program the most expensive in the nation and what to do about it. Citizens Budget Commission; Albany, NY: 2006.
8. Vallejo-Torres L, Morris S. Factors associated with the use of primary care services: the role of practice nurses. The European Journal of Health Economics. 2010:1–9. doi:10.1007/s10198-010-0251-5. [PubMed: 20087626]

9. Franks P, Jerant AF, Paul Leigh J, Lee D, Chiem A, Lewis I, Lee S. Cigarette prices, smoking, and the poor: implications of recent trends. American Journal of Public Health. 2007; 97(10):1873–1877. [PubMed: 17761576]
10. Vidrine J, Reitzel L, Wetter D. The role of tobacco in cancer health disparities. Current Oncology Reports. 2009; 11(6):475–481. doi:10.1007/s11912-009-0064-9. [PubMed: 19840525]
11. Orleans, Tracy C. Increasing the demand for and use of effective smoking-cessation treatments: reaping the full health benefits of tobacco-control science and policy gains-in our lifetime. American Journal of Preventive Medicine. 2007; 33(6, Supplement 1):S340–S348. doi:10.1016/j.amepre.2007.09.003. [PubMed: 18021909]
12. National Cancer Institute. [28 January 2011] NCI's patient navigator research program: fact sheet. 2008. http://www.cancer.gov/cancertopics/factsheet/PatientNavigator
13. Dohan D, Schrag D. Using navigators to improve care of underserved patients: current practices and approaches. Cancer. 2005; 104(4):848–855. doi:10.1002/cncr.21214. [PubMed: 16010658]
14. Vargas RB, Ryan GW, Jackson CA, Rodriguez R, Freeman HP. Characteristics of the original patient navigation programs to reduce disparities in the diagnosis and treatment of breast cancer. Cancer. 2008; 113(2):426–433. doi:10.1002/cncr.23547. [PubMed: 18470906]
15. National Cancer Institute. [28 January 2011] What are patient navigators?. 2009. http://crchd.cancer.gov/pnp/what-are.html
16. Freund KM, Battaglia TA, Calhoun E, Dudley DJ, Fiscella K, Paskett E, Raich PC, Roetzheim RG. National cancer institute patient navigation research program. Cancer. 2008; 113(12):3391–3399. doi:10.1002/cncr.23960. [PubMed: 18951521]
17. Phillips CE, Rothstein JD, Beaver K, Sherman BJ, Freund KM, Battaglia TA. Patient navigation to increase mammography screening among inner city women. Journal of General Internal Medicine. 2011; 26(2):123–129. [PubMed: 20931294]
18. Donelan K, Mailhot J, Dutwin D, Barnicle K, Oo S, Hobrecker K, Percac-Lima S, Chabner B. Patient perspectives of clinical care and patient navigation in follow-up of abnormal mammography. Journal of General Internal Medicine. 2011; 26(2):116–122. doi:10.1007/s11606-010-1436-4. [PubMed: 20607432]
19. Andrews JO, Felton G, Wewers ME, Waller J, Tingen M. The effect of a multi-component smoking cessation intervention in African American women residing in public housing. Research in Nursing & Health. 2007; 30(1):45–60. doi:10.1002/nur.20174. [PubMed: 17243107]
20. Martinez-Bristow Z, Sias JJ, Urquidi UJ, Feng C. Tobacco cessation services through community health workers for Spanish-speaking populations. American Journal of Public Health. 2006; 96(2):211–213. doi:10.2105/ajph.2005.063388. [PubMed: 16380561]
21. Ferrante JM, Cohen DJ, Crosson JC. Translating the patient navigator approach to meet the needs of primary care. Journal of the American Board of Family Medicine. 2010; 23(6):736–744. [PubMed: 21057069]
22. Chase E, McMenamin S, Halpin HA. Medicaid provider delivery of the 5A's for smoking cessation counseling. Nicotine & Tobacco Research. 2007; 9(11):1095–1101. [PubMed: 17978983]
23. Lubetkin E, Wei-Hsin Lu, Krebs P, Yeung H, Ostroff J. Exploring primary care providers' interest in using patient navigators to assist in the delivery of tobacco cessation treatment to low income, ethnic/racial minority patients. Journal of Community Health. 2010; 35(6):618–624. doi:10.1007/s10900-010-9251-8. [PubMed: 20336355]
24. Braun KL, Allison A, Tsark JoAnn U. Using community-based research methods to design cancer patient navigation training. Progress in Community Health Partnerships: Research, Education, and Action. 2008; 2(4):329–340.
25. Calhoun EA, Whitley EM, Esparza A, Ness E, Greene A, Garcia R, Valverde PA. A national patient navigator training program. Health Promotion Practice. 2010; 11(2):205–215. [PubMed: 19116415]
26. Pberta L, Ockenea JK, Ewya BM, Leicherb ES, Warnerc D. Development of a state wide tobacco treatment specialist training and certification programme for Massachusetts. Tobacco Control. 2000; 9:372–381. doi:10.1136/tc.9.4.372. [PubMed: 11106706]
27. Bandura A. Health promotion by social cognitive means. Health Education & Behavior. 2004; 31(2):143–164. [PubMed: 15090118]

28. Krueger, RA.; Casey, MA. Focus groups: a practical guide for applied research. Sage; Los Angeles: 2008.

29. Morgan, DL. Focus groups as qualitative research. Sage; Thousand Oaks; London; New Delhi; 1997.

30. Bernard, HR. Research methods in anthropology: qualitative and quantitative approaches. AltaMira; Lanham, MD: 2005.

31. Boyatzis; Richard, E. Transforming qualitative information: thematic analysis and code development. Sage; Thousand Oaks, Calif; London: 1998.

32. Creswell, JW. Qualitative inquiry and research design choosing among five traditions. Sage; Thousand Oaks, Calif: 1998.

33. Judith, Green; Thorogood, Nicki. Qualitative methods for health research. Sage; London; Thousand Oaks, CA: 2004.

34. Patton, MQ. Qualitative evaluation and research methods. Sage; Thousand Oaks, CA: 2002.

35. Miles, MB.; Michael Huberman, A. Qualitative data analysis. Sage; Thousand Oaks, CA: 1994.

36. Warren, CAB.; Karner, TX. Discovering qualitative methods: field research, interviews, and analysis. Roxbury Pub. Co.; Los Angeles, Calif: 2005.

37. Patton MQ. Enhancing the quality and credibility of qualitative analysis. Health Services Research. 1999; 34(5 Pt. 2):1189–1208. [PubMed: 10591279]

38. Guba, EG. Toward a methodology of naturalistic inquiry in educational evaluation. Center for the Study of Evaluation, UCLA Graduate School of Education, University of California; Los Angeles: 1978.

Table 1

Key topics for tobacco cessation patient navigation training curriculum

Rationale for Using PN to Address Tobacco-Related Health Disparities
PN roles, responsibilities, and core competencies
Review common barriers to accessing tobacco cessation treatment
Overview of Tobacco Dependence and Treatment
Tobacco-related hazards
Prevalence of tobacco use in the United States
Tobacco-related health disparities
Nature of nicotine addiction and psychological dependence
Overview of the most common treatments for tobacco dependence
Culture and Diversity
Cultural competency
Culturally specific functional benefits of tobacco use
Communication/Counseling Skills
Understanding the role of patient-centered communication in the assessment of smoker's needs
Communication techniques to facilitate engagement and reduction of resistance to change (empathic, non-judgmental)
Motivational enhancement
Mapping Resources
Heath systems and community assessment
Pathways for accessing tobacco treatment
Implementation and Monitoring Outcomes
Documentation
Tracking process and outcomes
Provider feedback and liaison with referring PCP

Table 2

Focus group guide

Evaluation of Tobacco Cessation Patient Navigation Curriculum Focus Group Guide for Patient Navigators

We will first show you three modules from an educational presentation we are developing to train patient navigators to encourage tobacco cessation among smokers. Here is a hard copy of the presentation—feel free to jot down your reactions to the material presented on the handout as we walk through the presentation.

Module 1: Overview of Patient Navigation (18 slides)

We would like to hear your opinions regarding the usefulness of the module for setting the stage and reviewing the patient navigation (PN) model of improving access and quality of care.

• In what specific ways is the content presented in the module important to include when training patient navigators to address tobacco cessation?

• Did we do justice in describing the PN model?

• What content is less important to include or should be deleted? Please explain why.

• What topic/issues should be added to the module? Why?

Module 2: Overview of Tobacco Use and Disparities (47 slides)

We would like to hear your opinions regarding the usefulness of the module for providing information regarding the nature of tobacco use.

• In what specific ways do you feel the information in this module provides good coverage of the issues that you would need to understand to address smoking cessation with smokers?

• What parts of this module do you feel are useful? Please explain why.

• What parts of this module are less useful? Why?

• Does this module provide adequate information about the risks of tobacco use? If not, what is missing?

• Does this module provide adequate information about the nature of tobacco addiction and psychological dependence? If not, what is missing?

Module 3: How to Be a Tobacco Cessation Patient Navigator (49 slides)

We would like to hear your opinions regarding the usefulness of the presentation, the comprehensiveness of the presentation, and whether we have neglected to include any information that would be useful for you in navigating smokers to access existing community services and to understand to address smoking cessation with your clients.

• Does this module provide adequate information about recommended strategies and community services available to help smokers quit?

• Does this module provide adequate information about how navigators can use communication skills to help smokers link up with these community services?

• Does this module provide adequate information about common barriers and possible solutions to helping smokers access recommended cessation services?

• In your opinion, what are some other potential barriers for quitting not described in the curriculum and how would a patient navigator address these barriers?

Evaluating Presentation as a Whole

We would like your overall feedback about the presentation in its entirety.

• Now thinking about the training presentation as a whole, based on your own work as patient navigators working with individuals from minority groups, what information or content is not currently in the presentation that would be important to include if you were to address smoking cessation with minority smokers?

• What do you think about the length of the presentation? How can the length of the presentation be improved, if at all?

• What do you think about the level of detail in the information provided? How can the level of detail be improved, it at all?

• Overall, how comfortable do you feel you would be in applying your navigation skills to addressing tobacco use with smokers, after having seen the training curriculum?

How a PN May Work in a Primary Care Setting

Now we'd like for you to step back and think about how a PN might work within a primary care practice setting and help smokers referred by a primary care provider (PCP).

• In what specific ways do you feel PCPs could effectively hand-off/refer smokers to a PN?

• In what specific ways do you feel a PN could effectively communicate with a PCP about their progress in linking smokers to appropriate cessation services?

Table 3

Participant characteristics

	n	(%)
Patient navigators (n = 19)		
Gender		
Male	1	(5.3)
Female	18	(94.7)
Age (years)		
20–29	3	(15.8)
30–39	7	(36.8)
40–49	6	(31.6)
50–59	2	(10.5)
60–69	1	(5.3)
Race[a]		
African American	7	(36.8)
Asian	1	(5.3)
Hispanic/Latino	7	(36.8)
Native American	1	(5.3)
White, non-Hispanic	2	(10.5)
Education Level		
Some College (No degree)	6	(31.6)
Bachelor's or Associate Degree	3	(15.8)
Some Graduate school (No degree)	1	(5.3)
Graduate Degree	9	(47.4)
Years of Patient Navigation Experience[a]		
<6 months	2	(10.5)
6 months–1 year	4	(21.1)
1–2 years	4	(21.1)
2–5 years	4	(21.1)
5–10 years	2	(10.5)
10+years	2	(10.5)
Formal Cessation Treatment Training[a]		
No	17	(89.5)
Yes	1	(5.3)
Ethnic/Racial Composition of Patients Served	(mean %)	(min, max %)
Latino/Hispanic	37	(0–80)
African American	28	(10–50)
White	10	(0–60)
Asian/Pacific Islander	8	(0–65)
Native American	5	(0–90)
Other	1	(0–10)

[a] Sum totals <19 due to missing data