# Organizational Partnership to Enhance Programmatic Reach



**Report Prepared for:**

**South Dakota Department of Health**

*All Women Count!*, Breast and Cervical Cancer Early Detection Program

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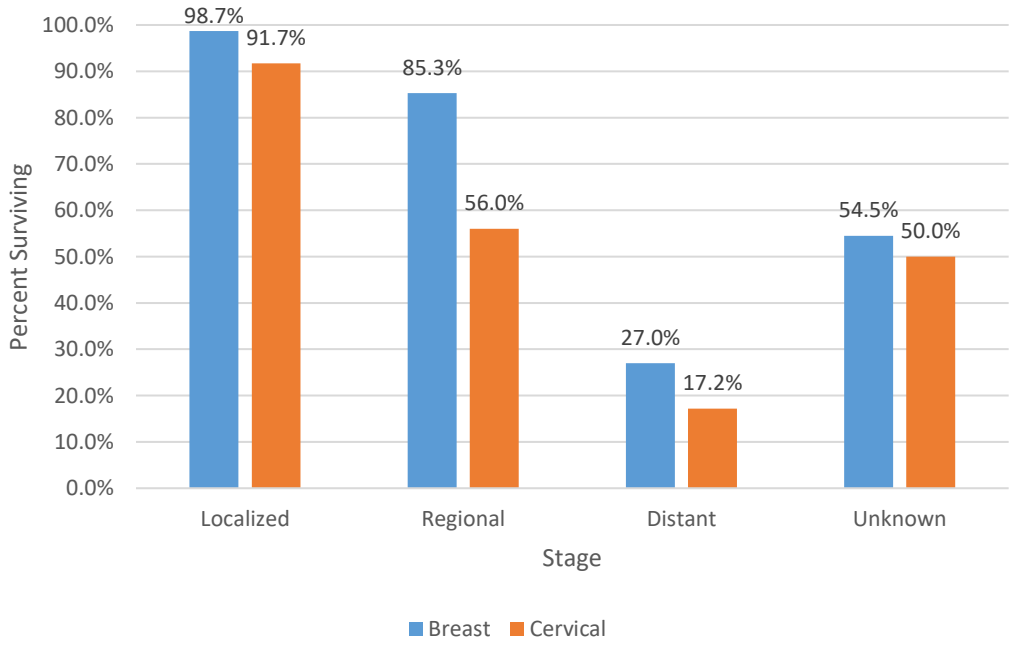
# Organizational Partnership to Enhance Programmatic Reach:

How the 211 Helpline and South Dakota's Breast and Cervical Cancer Early Detection Program Partnered to Enhance the Reach of *All Women Count!*

## Background

Breast and cervical cancers make up a significant portion of all new cancer cases annually in the United States at 15.3% and 0.8%, respectively.[1-2] Approximately 12.4% of women will be diagnosed with female breast cancer and 0.6% of women will be diagnosed with cervical cancer at some point during their lifetime.[1-2] Cancer stage at diagnosis has a strong influence on the woman's length of survival. For both breast and cervical cancer, a cancer diagnosis at the localized stage (or confined to the primary site) results in higher 5-year relative survival rates than a diagnosis at a distant (metastasized) stage, as depicted in Figure 1.

**Figure 1.** 5-Year Relative Survival by Stage at Diagnosis, Breast & Cervical
(SEER 18 2008-2014, All Races, Females by SEER Summary Stage 2000)[1-2]




Screening, therefore, plays a pivotal role in survival for all women susceptible to breast and cervical cancer. For cervical cancer, a simple Pap test may find abnormal cells, which can then be removed before they become cancer. For breast cancer, screening by mammogram or clinical

breast exam is recommended to find cancer at an early stage when it is most treatable and may be cured.

Despite the prevention and early detection benefits of screening, 25.1% of South Dakota (SD) women aged 40+ have not had a mammogram within the last two years, and 18.9% of SD women aged 21-65 have not had a Pap test in the past three years.[3]

**South Dakota Breast and Cervical Cancer Early Detection Program: *All Women Count!***

To encourage screening for breast and cervical cancer, the SD Department of Health (DOH) utilized funding from the Centers for Disease Control and Prevention to develop *All Women Count! (AWC!)*, South Dakota's Breast and Cervical Cancer Early Detection Program.

*AWC!* provides breast and cervical cancer early detection screening to low-income, underserved, underinsured, and uninsured women in SD who meet basic eligibility requirements, including:[4]

- Income: At or below the income guidelines (see appendix A)
- Uninsured or underinsured: defined as those who cannot afford the copayments or deductibles or whose insurance does not cover breast or cervical cancer screening services
- Age:
    - Age 30 to 64 for cervical cancer screening
    - Age 40 to 64 for breast cancer screening
    - Women 30 to 39 are also eligible for a diagnostic mammogram if they have documented breast signs or symptoms suspicious for cancer

SD women may enroll in *AWC!* services at participating *AWC!* screening sites, which include 250 clinics, hospitals, and family planning facilities throughout the state.[5]

As the statewide infrastructure is in place to support SD women with breast and cervical cancer screening services, a primary interest of the *AWC!* program is now to enhance the reach and exposure of the available services to eligible women.

The following report explores how an organizational partnership between the SD Breast and Cervical Cancer Early Detection Program (SD BCCEDP) and the Helpline Center in SD was developed and deployed to enhance the reach of *AWC!* through a dedicated Health Navigator focused on breast and cervical cancer navigation for women aged 30-64.

## Methods

This project used an observational qualitative design. Key personnel at the Helpline Center were interviewed, using a structured guide.

*Participants*

Two Helpline Center personnel agreed to share about their experience partnering with the *AWC!* program. Participant roles were Vice President of Program Development and Health Navigator.

*Interview Questions*

A structured interview guide was developed to gather information describing how the SD BCCEDP supported the Helpline Center in developing processes to enhance the reach of *AWC!* through a dedicated Health Navigator, focused on breast and cervical cancer navigation for women aged 30-64 calling into the 211 Helpline. To explore the processes, challenges, and successes of collaboration, this paper assessed the following questions among the interviewed partner organization:

1. Tell us a little about the South Dakota 211 Helpline.
2. How does breast and cervical cancer screening fit into the mission of the Helpline Center?
3. Would you describe for us the factors or the context that led you to reach out to the population potentially eligible for *AWC!* services?
4. When did you begin your collaboration with the SD Department of Health *AWC!* program?
5. Tell us a little about the Health Navigator's role.
6. How is the Health Navigator position funded?
7. What training did the Health Navigator receive? Were any specialized trainings provided?
8. How are callers identified for eligibility for health navigation services?
9. Once identified as eligible, how is the health navigation service presented to a caller?
10. Tell us about the timing and method(s) of delivery for the outlined health navigation services.

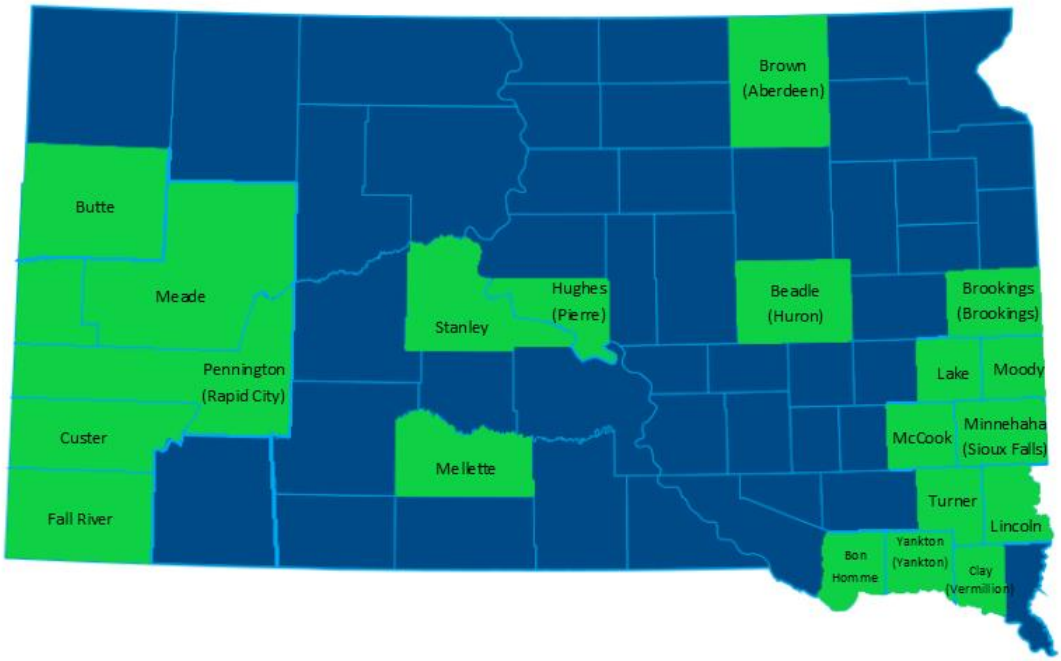
11. Are callers receptive to learning more about the offered health navigation services?
12. What challenges or barriers have you faced in providing health navigation services?
13. Are there tracking mechanisms in place to measure outcomes of the navigation service provision?
14. Describe the outcomes to date. What success has been achieved through this intervention? Benefits?
15. What has the burden of adding this screening eligibility assessment been?
16. What resources are provided to support this role? This service overall?
17. What support has been provided by the SD DOH?
18. Are there additional training needs that have not yet been met?
19. What would be needed to expand this to counties that are not yet served by 211?
20. Are there other ways to expand upon this intervention?
21. What has been most surprising about this process?
22. What else do you think would be important for us to know about this process?

**Partnership Overview: The Helpline Center (211 Helpline)**

In July 2000, the Federal Communications Commission reserved the 211 dialing code for community information and referral services. The 211 code was intended as an easy-to-remember and universally recognizable number that would enable a critical connection between individuals and families in need with the appropriate community-based organizations and government agencies. Active 211 systems cover all or part of 50 states, serving over 94% of the entire U.S. population.[6]

Since 2001, the Helpline Center has been the 211 provider in SD. Currently, 70% of the SD population has access to 211. Active 211 counties in SD are indicated in Figure 2, representing 21 of 60 SD counties.[6]

**Figure 2.** Active 211 Counties in South Dakota (2019)




The mission of the Helpline Center is to connect individuals with resources and hope all day, every day. 211 Helpline Specialists are cross trained to handle crisis and information/referral phone calls. 211 provides individuals with information about and referrals to social services for every day needs and in times of crisis. 211 can offer access to a variety of service types, including:

- **Basic Human Needs Resources** including food and clothing, shelters, housing, and utility assistance.
- **Mental Health and Health Resources** including counseling, support groups, drug and alcohol treatment, health insurance programs, Medicaid and Medicare, maternal health resources, health insurance programs for children, medical information lines, clinics, hospitals and crisis intervention services.
- **Employment Supports** including job training, employment services, transportation assistance and education programs.
- **Older Adults and Persons with Disabilities** including adult day care, community meals, respite care, home health care, transportation and homemaker services.
- **Children, Youth and Family Support** including child care, after school programs, educational programs for low-income families,

family resource centers, recreation programs, mentoring, tutoring and protective services.

- **Volunteer Opportunities and Donations** – Individuals who wish to donate time, goods or money to community organizations can find this information by dialing 211.
- **Disaster Support** – 211 works with local emergency management teams to assist in the response and recovery efforts based on the disaster.

Every day, individuals across SD turn to 211 for information and support. Trained Helpline Specialists assess the individual's needs, access a database of available resources, and link or refer them directly to an agency or organization that can help.

The Helpline Center realized that, because of the personal and human connection that they develop with callers on an everyday basis, they may be uniquely poised to suggest service connections beyond the caller's immediate need. The Helpline Center began to identify innovative ways of delivering additional value-added services to their core of connecting people to services and resources through the 211 Helpline.

In March of 2016, while attending a conference, staff of the Helpline Center learned about a unique partnership in Texas between the 211 Texas telephone Helpline and the University of Texas School of Public Health. Researchers at the University of Texas School of Public Health were investigating cancer among individuals with low socioeconomic status when they realized that many of these individuals may be calling 211 for referral services or other support. In this partnership, the programs developed a telephone navigation intervention with a goal to screen, educate, motivate and link 211 Texas callers to local cancer control and prevention services.[7]

The unique partnership sparked the SD Helpline Center's desire to provide value-added services to their callers by proactively assessing callers' needs for preventative services. They realized that they may be a unique access point to reach a population that is likely not receiving preventative cancer screenings as recommended. With this realization and service idea in mind, the Helpline Center reached out to the SD DOH to identify how they may be able to partner in order to offer a similar telephone navigation intervention for callers of the SD 211 Helpline.

## Partnership Development

The SD DOH was in full support of partnering with the Helpline Center to trial this intervention. In January 2017, the SD DOH Breast and Cervical Cancer Early Detection Program, *AWC!,* entered into a contract with the Helpline Center to begin providing breast and cervical cancer screening navigation services to women aged 30-64 through the 211 Helpline.

In March 2017, the Helpline Center utilized funds from the SD DOH to hire a Health Navigator with a background as a registered nurse to implement the intervention. The overall goal of the intervention was to increase preventative breast and cervical cancer screenings by educating and connecting women to recommended services. Prior to working with callers, the Health Navigator completed training as a Helpline Specialist as well as training about the *AWC!* Program.

The Health Navigator began by implementing a new process for the handling of female 211 callers between the ages of 30-64. As individuals call or text into the 211 Helpline, trained Helpline Specialists assist with the caller's immediate need. Once the immediate need is sufficiently addressed, the Helpline Specialists are then encouraged to offer female callers between the ages of 30-64 the opportunity to speak with the Health Navigator by asking, "*Would you be interested in speaking with a Health Navigator regarding health information?*" The Helpline Specialist may choose to refrain from asking this question if they feel that it isn't appropriate following the situation they have just addressed (i.e., crisis calls). If the caller is interested in speaking with the Health Navigator, the Helpline Specialist will transfer the caller directly to the Health Navigator, when available, or will send a referral to the Health Navigator on behalf of the caller with the caller's contact information for future follow-up.

Once the Health Navigator is connected with the caller, an intake questionnaire (Appendix B) is completed to gather information about the caller's demographic information (age, marital status, education, race, ethnicity, employment and insurance), healthcare provider information, past medical history and chronic conditions. If the woman is due or past due for preventative screenings, the Health Navigator determines if the individual meets the income eligibility requirements to receive breast and cervical cancer screening through the *AWC!* Program. The Health Navigator works with all women, whether eligible or ineligible for *AWC!*, to find a local provider, schedule an appointment, and provide appointment reminders. For *AWC!* eligible women, the Health Navigator will also

complete the enrollment forms for the *AWC!* program and submit them to the selected service provider when scheduling the appointment. A copy of the completed *AWC!* enrollment form is also provided to the caller so that they may take it along to the appointment.

The Health Navigator completes a reminder call the day before the scheduled appointment. The Health Navigator also attempts to follow-up with these women a week after their scheduled appointments to make sure the caller attended the appointment, see if the caller wants to share and review results, as well as to record the next recommended screening date in order to send future screening reminders.

## Partnership Outcomes

Data gathered from June 1, 2017 – December 31, 2018 identified 7,282 women between the ages of 30-64 who called the SD 211 Helpline. Of those women, approximately 12% (N=871) agreed to be connected with the Health Navigator. Due to difficulty reaching callers that could not be directly transferred to the navigator, only 46% (N=403) of the women who agreed to speak with the Health Navigator were able to be contacted for follow-up health navigation services.

Outcomes for the 403 navigated women were positive. Of the women who were up-to-date with breast and/or cervical cancer screenings, 92 still requested a follow-up reminder for screening at a future timepoint. For women who were not up-to-date with the recommended breast and/or cervical cancer screenings, 129 were referred to a provider or directly scheduled for a screening appointment with their preferred provider. Of the 129 women referred for screening, 44% (N=57) met the eligibility requirements for the *AWC!* program and were appropriately enrolled for program services. Additionally, the Health Navigator was able to confirm that 81 of the total 129 women referred for screening services attended their appointments and received all recommended screenings. The Health Navigator documented screening completion dates for these women and will be able to follow-up with future screening reminders at appropriate timepoints.

*Program Expansion*

While the initial intervention was focused on assessment of breast and/or cervical cancer screening needs among women aged 30-64, navigation services are now offered to a broader population of callers. The Helpline Center started piloting an expansion of the Health Navigation program to those 18-64, male or female, who may need further assistance with a variety of healthcare concerns. The Helpline Specialists now may ask, "*Would you be interested in speaking with a Health Navigator regarding health information?*" to this broader population of callers. If the individual expresses interest or states a specific health concern, the Helpline Specialist makes a referral to the Health Navigator for follow-up. With this expansion in place, the Health Navigator assisted an additional 108 callers with various health concerns from July 1-December 31, 2018. To date, many health topics have been discussed with an appropriate referral or follow-up made, including: smoking cessation, medical transportation, prescription assistance, appointment management, obstetrics care, vasectomy, medical expense assistance, insurance, diabetes management, and establishing care with a primary care physician.

The expanded navigation program has allowed the Helpline Center to take a more wholistic approach with callers, meeting all immediate needs as well as preventative health care needs.

*Challenges*

Challenges and barriers were noted throughout the implementation of this intervention. In the first year, data collection was a challenge for the program. The Helpline Center was able to integrate program tracking into their case management software system that allows for easier client follow-up, client referrals, and reporting. Additionally, with any new program, there is the initial challenge of integrating the program within current processes. Specifically, the Health Navigation program relies heavily on the frontline Helpline Specialists to ask callers if they would be interested in health navigation. To encourage staff to assess callers' interest in the service, the Health Navigator provides monthly challenges and goals for staff to meet. The challenges and referral goals have shown great success in terms of increasing referrals by Helpline Specialists.

One of the largest barriers facing the Health Navigation program is the inability to reach callers who had expressed interest in speaking with the Health Navigator. Ideally, during normal business hours, Helpline Specialists try to warm transfer an interested caller directly to the Health Navigator to secure the connection. However, the 211 Helpline serves numerous callers outside of normal business hours. Helpline Specialists schedule follow-up times for the Health Navigator to contact interested callers who were not able to be directly transferred for the service, though numerous contact attempts are often unsuccessful in reaching the client for follow-up.

The client contact barrier remains even after a screening referral or appointment has been made. Often, a client will work with the Health Navigator all the way through scheduling the recommended screening appointment(s), but will then cancel prior to the appointment or simply not show up for the scheduled screenings. The Health Navigator works to follow-up with these clients, but often, the client will not answer or return the Health Navigator's calls, making it difficult to understand the reason for cancellation or no-show.

To reduce the client contact barrier, in July 2018 the Helpline Center integrated a text message contact attempt following each failed phone contact attempt. Through texting, the Health Navigator is able to contact the client for their initial outreach, send appointment reminders and follow-up after their appointments. While the texting option appears favorable for many clients, it can be difficult and time consuming to conduct assessments and schedule screening appointments via text. Many clients stop responding before they are connected to services due to the length of a text conversation. Despite challenges with texting, the Helpline Center views the texting option as an opportunity to connect with more clients. Every client that the Health Navigator is able to connect with is considered a success when connecting women with important cancer screening services.

Another challenge identified through the Health Navigation program is that clients' income is often above the required guidelines for *AWC!,* despite the client's need for services. In most of these cases, the client shares more immediate needs that create a situation where she is unable to afford medical bills. For the client, scheduling a screening appointment is secondary to covering daily expenses. Although the client may be above income guidelines, the costs of screening services are a prohibitive burden. If the client is not eligible for free cancer screening services, the Health Navigator will try to get them scheduled with a community clinic on a sliding scale fee basis. In doing so, the system allows the Health Navigator to follow-up with the client and keep them informed and educated about their health needs.

Transportation has proven to be another barrier to screening. The Helpline Center Health Navigation program received funding through a Susan G. Komen Foundation grant to resolve this specific barrier to screening by providing a ride through public transportation or a gas card. The Health Navigator has worked to partner with health clinics to promote the available funds. To date, usage of funds has not been significant; however, promotion and outreach continues with local clinics to educate staff on the availability of transportation funds.

*Success Stories*

Despite the challenges and barriers that have surfaced throughout program implementation, the Health Navigation program has identified screening needs and provided screening services to numerous women in need throughout SD. Here are a few examples of how the Health Navigation program has impacted SD lives:

> A caller mentioned that she had been in the emergency room for abdominal pain. She ended up with an abnormal Pap smear and needed further testing. Her emergency room bill was over $12,000 and, while she needed further testing, she did not know how she could afford it. The Health Navigator was able to enroll the women in *AWC!* prior to her appointment for further testing. She was very thankful for the service.

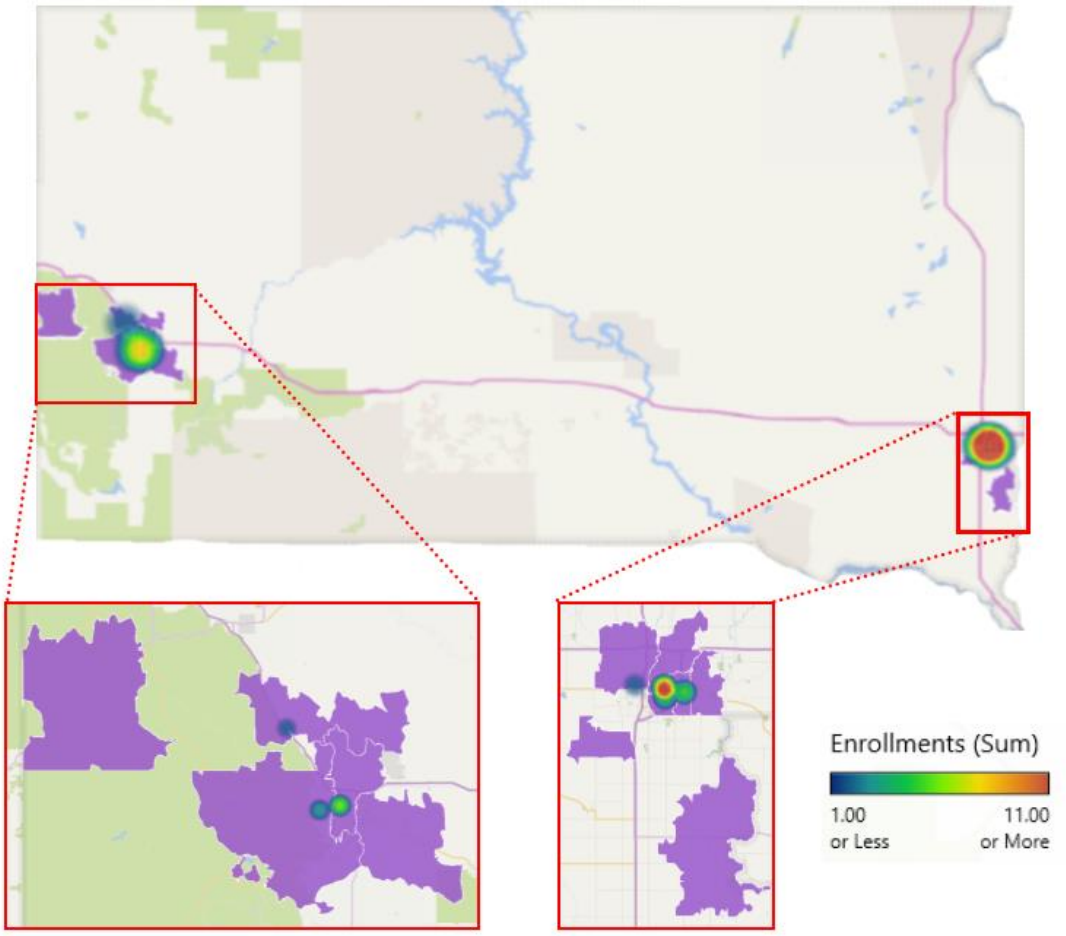
The Helpline Center received a text from a 30-year-old women requesting resources for rent assistance. The Helpline Specialist offered a referral to the Health Navigation program. The Health Navigator was able to follow-up in an additional text to connect with the woman. The client had a significant family history of breast cancer. Due to the client's age, she required a prior authorization from the *AWC!* program to complete her appointment. In addition, she had an abnormal Pap that she did not follow-up on due to finances. The Health Navigator was able to quickly work with *AWC!* staff to authorize the client's eligibility and an appointment was scheduled for a mammogram and Pap smear.

The Health Navigator was able to help a client schedule a free cancer screening appointment and also get her established with a primary care physician. Additionally, the client was given a referral to the South Dakota QuitLine. She agreed to follow-up calls to encourage her new, nicotine-free lifestyle and to check in with her overall health goals. We are happy to share that she was still nicotine free during her last phone call. Her next follow-up call is scheduled when her next health care screening is due.

*Future Growth*

The Helpline Center would like to continue to expand the Health Navigation program. From January 1-December 31, 2018, women connected to *AWC!* services through the 211 Helpline Health Navigator were concentrated to five counties, including Lincoln and Minnehaha counties on the east side of the state and Lawrence, Meade, and Pennington counties on the west side of the state (Figure 3). North-central and south-central regions of the state do not currently have any active 211 counties (Figure 2). The Helpline Center hopes to see 211 Helpline coverage expand across the state, one county at a time. Expansion of 211 services to more SD counties would ultimately enhance reach of the Health Navigation program.

**Figure 3.** Geographical distribution of callers referred to AWC! program through the 211 Helpline, January 1 – December 31, 2018




Continued expansion of services is also planned for the Health Navigation program in content areas of identified high needs. Since expanding the Health Navigation to male and female callers, ages 18-64, the Health Navigator has identified diabetes management and prescription assistance as areas of high need. Due to the increasing demand, the Helpline Center is researching further resources and assistance for clients in these areas.

The Helpline Center is also hoping to integrate more closely with the medical field. Other states have piloted a dual navigation approach, working directly with health system navigators for specific clients. This type of partnership treats the patient as a whole, allowing for social determinants of health to be considered and addressed as part of treatment with hopes of closing the gap in health equity.

## Summary

The organizational partnership between the Helpline Center and the SD DOH resulted in favorable outcomes, as described in this report. The partnership connects the existing breast and cervical cancer screening services of *AWC!* with a target population of underserved women aged 30-64 who are commonly due or overdue for preventative cancer screenings, ultimately expanding the reach of the *AWC!* program.

Funds provided by the SD DOH allowed the Helpline Center to hire a dedicated Health Navigator to implement the intervention. The dedicated role is essential, considering the numerous case management tasks involved in the intervention including follow-up calls, client reminders, and appointment scheduling.

The 211 Helpline not only serves as a unique connector to reach the identified target population for *AWC!* services, but it also offers the human connection and empathy that can bridge the divide between patients and services. Staff of the 211 Helpline identified that there is typically more going on in a person's life than just the immediate need that they called to address. Attentive listening allows the 211 staff to understand the caller's circumstances and offer appropriate services and resources. Once the immediate needs are resolved and trust is established with the caller, 211 staff are able to discuss additional services, such as the Health Navigation program, that could benefit or improve the caller's well-being. The human connection and relational approach from the 211 Helpline incline the callers to be more receptive to the referral for further services.

With the partnership and program intervention proving to be a success, the next step for program establishment is promotion of the partnership among healthcare providers in SD. Knowledge and awareness of the partnership within the medical community would assist the Health Navigator in scheduling screening appointments on behalf of 211 callers, supporting a coordinated approach to patient care.

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**APPENDIX A**

# 2018 Cancer Screening Programs
# South Dakota Department of Health

All Women Count! Program

## Income Guidelines for Screening Eligibility

| Family Size | Annual Income | Monthly Income | Weekly Income |
|---|---|---|---|
| 1 | $24,280 | $2,023 | $467 |
| 2 | $32,920 | $2,743 | $633 |
| 3 | $41,560 | $3,463 | $799 |
| 4 | $50,200 | $4,183 | $965 |
| 5 | $58,840 | $4,903 | $1,132 |
| 6 | $67,480 | $5,623 | $1,298 |
| 7 | $76,120 | $6,343 | $1,464 |
| 8 | $84,760 | $7,063 | $1,630 |
| 9 | $93,400 | $7,783 | $1,796 |
| 10 | $102,040 | $8,503 | $1,962 |
| 11 | $110,680 | $9,223 | $2,128 |
| 12 | $119,320 | $9,943 | $2,295 |
| 13 | $127,960 | $10,663 | $2,461 |
| 14 | $136,660 | $11,383 | $2,628 |
| 15 | $145,240 | $12,103 | $2,793 |

- **Husband-wife combined income before taxes should be at or below levels listed for family size.**
- **Single income before taxes should be at or below levels listed for family size.**
- **For further clarification, call the South Dakota Department of Health, All Women Count! Program at 1-800-738-2301.** February 1, 2018

# APPENDIX B

**HEALTH NAVIGATION INTAKE FORM**

| | | | | |
|---|---|---|---|---|
| **DATE:** | **RECEIVED: F/U** | **DIRECT TRANSFER** | **TRANSFER TO VM** | **CS:** |
| **SENC:** | Entered | SENC # | Need to enter | Na |

**INTRO**

Do you have an established health care provider?

Yes No

Name of Provider: Location of Provider:

Last appointment with Provider:

Can I help to schedule an appointment to establish care with a provider? Yes No

**DEMOGRAPHICS**

First Name: Last Name: MI:

Age: DOB:

Address: County:

City: State: Zip Code:

Phone Number: Email Address:

Best Contact: PHONE, TEXT, PHONE/TEXT, EMAIL, LETTER BEST TIME TO CONTACT:

**STATISTICS**

**MARITAL STATUS**

Never married, Married, Single, Widow, Live in, Divorced, Separated

**EDUCATION**

Less than HS, Some HS, HS grad, GED, Some Tech School, Tech School Grad, Some College, College grad

**RACE**

White, Black or African American, Asian, Native Hawaiian or Pacific Islander, American Indian, Alaska Native, Unknown

**ETHNICITY**

Non-Hispanic, Hispanic, Puerto Rican, Cuban

**INCOME/EMPLOYMENT**

**EMPLOYMENT:** Yes No

Full time, Part time, Retired, SSDI, Seasonal

**INSURANCE:** Yes No

Private, Medicaid, Medicare, SSDI

Total household income: #Supported

AWC Eligible: Yes No Na

**PAST MEDICAL HISTORY**

**PAP** Yes No Na
Last Pape: (within 5 years) Yes No Unknown Na

Date of last pap:

Results of last pap: Normal Abnormal

History of abnormal pap: Yes No Unknown Na

Date of abnormal pap:

HPV: Yes No Unknown Na

Hysterectomy: Yes No Unknown Na

Date of hysterectomy:

Reason for hysterectomy: Cancer Dysplasia Other

Family history of cervical cancer: Yes No Unknown Na

Relatives affected by:

Age dx:

Physician recommendations: Yearly 3 years 5 years Unknown NA

**Mammogram** Yes No Na

Last mammogram: (within 2 years) Yes No Unknown Na

Date of last mammogram:

Results of last mammogram: Normal Abnormal

History of abnormal mammogram: Yes No Unknown Na

Date of abnormal mammogram:

CBE: Yes No Unknown Na

Date of last CBE:

SBE: Yes No Unknown Na

Family history of breast cancer: Yes No Unknown Na

Relatives affected by:

Age dx:

Physician recommendations:

**Colon**

IFOBT Yes No Unknown Na

Date of last IFOBT:

Results of Ifobt: Normal Abnormal Na

Physician recommendations:

Colonoscopy: Yes No Unknown Na

Date of last colonoscopy:

Results of last colonoscopy: Normal Abnormal Na

Pathology of last colonoscopy:

Family history of colon cancer: Yes No Unknown Na

Relative affected by:

Physician recommendations:

**CHRONIC DISEASE**

**DIABETES** Yes No Unknown No data
Medications:

Last A1C: Last eye exam: Last Foot exam:

Next appointment to see physician:

**HEART DISEASE** Yes No Unknown No data

**HYPERTENSION** Yes No Unknown No data
Medications:

**VARIOUS HEALTH CONCERNS**

**SMOKING** Never Everyday Some days Former
Years/Amount per day:

Previous attempt to quit: Yes No Unknown Na

Date:

Referral to the QuitLine: Yes No Refused Na

**PRESCRIPTION ASSISTANCE** Yes No Na

**OBESITY**

**MEDICATIONS** Yes No Unknown Na

Medication List on hand Yes No Unknown Na

Medications:

**OUTCOMES**

Screening up to date: Yes No Unknown Na
Needs appointment: Yes No Unknown Na
Appointments needed: Pap Mammogram Pre-appt Both Scope iFOBT PCP