Cancer Related Services in Memphis and Shelby County:

Availability, Affordability, and Utilization

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PURPOSE, SCOPE, AND ORGANIZATION OF THIS REPORT

The Center for Research on Women at The University of Memphis conducted research on the range of cancer related services in Memphis and Shelby County during December 1996 and January 1997. Our purpose was to document and analyze 1) the range of service providers; 2) the types of services available; 3) who utilizes particular types of services; 4) how services are paid for; and 5) gaps in the service network and/or underutilized services. Our analysis addresses availability and quality of services, affordability to consumers, and factors that influence actual utilization of services.

Toward these ends, we conducted a survey of health care providers and other organizations involved in the service network. The survey was supplemented by telephone interviews with a number of health care professionals and program coordinators.

Complementing the survey and interviews was 1) a review of the literature on the demographics and epidemiology of cancer; outreach strategies for underserved populations; and the changing landscape of health care delivery and financing; and 2) archival research of Commercial Appeal files for coverage of local issues, especially TennCare.

A well established body of research documents continuing socioeconomic, racial/ethnic, and gender differences for morbidity and mortality rates, as well as in availability, affordability, and utilization of health care services. This research reveals that lower income, lesser educated, and/or racial/ethnic minorities are "underserved" populations.
(The research on gender is more complex and differs somewhat from the more general analysis of underserved populations.) Underserved populations are less likely to experience early detection and treatment. Since early detection and treatment are major factors in cancer patient survival, underserved populations pose a special challenge. This reality informs our analysis and emerges as a theme in our findings for Shelby County.

We organize our discussion based on four components of the cancer related health care system: 1) preventive and early detection education, and screening for early diagnosis; 2) clinical care; 3) assisted living support services; and 4) psychosocial support services for patients, cancer survivors and families. Because early detection and treatment are critical factors in survivability, our discussion of education and screening is the centerpiece of our report.

Analysis of each of the four components is organized in terms of three criteria: general availability and quality of services; affordability of services; and issues that influence consumer utilization of services.

Our discussion of the four components is prefaced by an overview of the health care environment in Shelby County, a brief introduction to local and national cancer statistics, and most importantly, an overview of the research on underserved groups. Our discussion of underserved groups includes a model that undergirds our analysis and identification of key issues. The model reflects the research on underserved groups and should be taken into account when programs for underserved populations are designed and evaluated.
INTRODUCTION: THE HEALTH CARE ENVIRONMENT, CANCER STATISTICS AND UNDERSERVED POPULATIONS

The Shelby County Health Care Environment

Healthcare technology, delivery, and financing are becoming increasingly complex and comprehensive in scope. Tennessee is in the forefront of managed care for otherwise uninsured (and usually low income) people. The ambiguities and pitfalls of the new system, TennCare, as well as the potential opportunities, are particularly evident in Shelby County, where more than one in four residents is enrolled in TennCare. When the number of Medicare recipients is taken into account, it is clear that Medicare/TennCare policy has a profound impact on the health care environment in Shelby County.

TennCare’s enrollment of over 220,000 still leaves many of the working poor uninsured, with estimates of the uninsured working poor (those making $7.50 an hour or less) in the range of another 80,000 households. This group presents a special challenge, since public funds for “indigent care” have been shifted to TennCare. In addition to the uninsured, there are the “underinsured” (those who have limited coverage and for whom deductibles and co-payments may be prohibitive), many of whom will be unable to fully pay their medical bills.

TennCare operates through a network of managed care organizations (MCO’s) that contract with primary care providers, specialists, and hospitals to provide services to the plan’s enrollees. Patient co-payments and/or deductibles are typically waived for preventive care services, including cancer screening. Several primary care clinics are heavily involved with TennCare and/or the uninsured and underinsured working poor in Shelby County. Memphis Health Center, Mid-South Family Health Center, Memphis Family Care Centers (The Med),
Brannon-McCullough Clinic, the Church Health Center, and the neighborhood health centers operated by the Shelby County Health Department target low-income populations. The concentration of low-income patients in several primary care centers presents an opportunity to target this traditionally underserved population for cancer education and screening.

The Church Health Center targets the working poor who are ineligible for TennCare and has developed its own insurance plan and provider network, the "Memphis Plan." The Memphis Plan enrolls low income employees and offers a group plan to small employers who would otherwise be unable to afford group insurance.

Employer-provided health insurance has increasingly gravitated to managed care, with state employees and the larger private employers offering managed care options. Many employers are heavily involved in preventive health, promoting education and screening opportunities offered by their MCO's and preferred providers. In this environment, public awareness campaigns about cancer risk factors and early detection, as well as opportunities for screening, have expanded. Since preventive care is associated with holistic health approaches, the managed care environment has also stimulated psychosocial support programs, including support groups for both patients and families.

With managed care, hospitalization is de-emphasized in favor of home-based rehabilitation or hospice care. Several hospitals offer comprehensive cancer care, from inpatient treatment to home health care to hospice services. Financed in part by insurance, home care options nevertheless present significant out-of-pocket expenses for some families. While demand for home care is growing, providers report that there is an underserved market, and that hospice care is underutilized.
With the growing market for home-based care, a new market for "assisted living" services has emerged. Dominated by commercial providers, assisted living services are rarely covered by insurance. Assisted living services range from $12.00 to $20 per hour, with some agencies requiring a three hour minimum. Amidst growing demand on the part of those who can afford such services, the "de-hospitalization" movement may be accompanied by unmet needs on the part of less affluent populations. The "two-tiered" market for home care (those who can afford to pay and those who cannot) introduces the broader issue of "underserved" populations. The concept of underserved populations is developed in the next section.

What Cancer Statistics Tell Us

Mirroring national patterns, cancer was the second leading cause of death (after heart disease) in Shelby County in 1995. There was a total of 1,173 cancer-related deaths, accounting for 22.5% of all deaths. Lung and other respiratory cancers claimed the most lives for men and women, followed by prostate and breast cancer respectively. The prevalence of breast and prostate cancer often receives special attention because both of these cancers can be detected early with appropriate screening.

African Americans are over-represented among cancer deaths in Shelby County for virtually every type of cancer except lymphatic and blood-related cancers. African Americans also tend to die from cancer at a younger age than "white" residents. In Shelby County, for example, among white women, 7% of breast cancer deaths are among women under the age of 45; for black women 19% of deaths are among women under the age of 45. Similarly, 44% of white breast cancer deaths are under 65, while 53% of black women are under 65.
African Americans are also less likely to survive a bout with cancer. National figures reveal that black men diagnosed with prostate cancer are twice as likely to die from the disease as white men; black women diagnosed with breast cancer have a five year survival rate of only 69% compared to a survival rate for white women of 84%. (See health department/vital records data for more detailed analysis of Memphis-Shelby County.)

Racial/ethnic differences for cancer remain, but become less distinct, when socioeconomic status and education are taken into account. This suggests an independent race-related effect associated with institutional, environmental and/or behavioral factors, (with some evidence for genetic/population factors in particular cases.)

Much of the disparity between African Americans’ and whites’ experience with cancer, like that associated with socioeconomic and educational disparities, is attributable to early detection and treatment. Even when financial barriers are minimized, early detection and treatment are associated with being white, middle class, and comparatively well educated. For example, among the age group of women for whom mammography is recommended, only about 40% follow through. The 40% is skewed toward whites, the middle class, and better educated women. Women who have had a mammogram have a 30% higher survival rate for breast cancer than women who have never had a mammogram. With this evidence for the efficacy of early detection, why would any woman not have a mammogram?

A Model for Thinking About Underserved Populations
Research has begun to focus on behavioral factors, rooted in both sociocultural norms and past experience with health care providers, that dissuade underserved groups from taking advantage of education and screening opportunities for early detection and treatment. Some factors have to do with socioeconomic status and education; others
have more to do with minority status vis a vis a largely “white” health care “establishment.” We present the model below as a way of thinking about these factors.

I. Individuals tend toward a “wellness orientation” or “symptom orientation.” Underserved groups are more likely to include individuals who are “symptom” rather than “wellness” oriented.

   A. Wellness oriented individuals demonstrate a high level of interest and initiative with regard to learning about risk factors, the effects of diet and lifestyle, self-examination, and routine “check ups.” (High awareness, motivation, and follow-through.) Wellness orientation is usually associated with good past experience with health care providers.

   B. Symptom oriented individuals respond to identifiable symptoms associated with “feeling sick,” sometimes ignoring minor symptoms in the belief that they will “go away.” (Lower awareness, motivation and follow-through.) Symptom orientation is usually associated with poor past experience with health care providers.

II. Wellness oriented and symptom oriented individuals tend to differ in terms of one or more of the following:

   A. Being “in control” and feeling in control of their time and circumstances. “I was going to go for that mammogram but something came up and I couldn’t make it.”

   B. The relative salience of health concerns related to other concerns or priorities such as money, work, and family issues. “Worrying about whether I might have something is the least of my worries right now.”
C. Concern, fear, and/or confusion about the financial and personal costs of being sick (e.g. the ability to pay for health care, losing work, child care issues.) “I can’t afford to be sick, and it’s probably nothing anyway.”

D. Confidence/trust in health care providers and confidence in their ability to communicate with providers. “They’ll just say that it’s stress.”

III. Traditional “outreach” programs for underserved groups tend to emphasize “public” awareness, reduced cost, and geographic convenience of services. (E.g. free or reduced services from a mobile mammography unit at a neighborhood health clinic.) Providers of these services often report that “they built it and nobody came.” These programs depend on a high degree of initiative from consumers and do not adequately confront the factors that predispose groups to “wellness” or “symptom” orientation.

IV. New approaches to outreach are based on “grassroots” strategies, meaning that they are both more “indigenous” and more “intrusive.” Grassroots strategies take advantage of existing institutions and networks to change expectations, confront concerns and confusion, neutralize the problems of competing priorities, and deliver services in a non-threatening environment.

V. The long term success of outreach for education, early detection and treatment depends not only on the quality of the outreach program itself, but on what happens to people who are diagnosed with cancer. This means that the quality and affordability of clinical care, and the support systems for rehabilitation or terminal care (both assisted living support services and psychosocial support), must reinforce patients’ confidence in health care providers and continue to deal with their ongoing concerns.
EDUCATION AND SCREENING: MAJOR FINDINGS

INTRODUCTION: Cancer related epidemiological research has resulted in a major emphasis on preventive or “wellness” education among health care professionals. Preventive education includes identification of risk factors and promotion of healthy lifestyles. Education also extends to identification of “early warning signs,” encouraging patient involvement in detection (e.g. breast self-examination), and promoting the efficacy and availability of screening.

Screening involves routine tests that are capable of diagnosing presymptomatic cancers. Self-examination and mammography for breast cancer, digital examination and blood testing for prostate cancer, pap smear/biopsy for cervical cancer, colo-rectal examination, and examination/biopsy for skin and oral cancers are the most common forms of screening.

It is useful to think of education and screening efforts in terms of two approaches.

1) Generic approaches promote general public awareness of risk factors, healthy lifestyles, early warning signs, and the availability of routine screening. Generic programs depend on individual initiative to follow through with recommendations, such as taking advantage of screening. Generic programs are well developed in Shelby County.

2) Targeted approaches identify underserved groups and attempt to design specialized educational materials (e.g. the Cancer Information Service’s “low literacy” literature) and remove barriers that discourage screening. Targeting has traditionally meant distributing brochures and giving talks in communities with high concentrations of target population areas, and minimizing cost and maximizing convenience of screening programs (e.g. sponsoring a mobile mammography unit at a
public health clinic.) Targeting in Shelby County usually means low-income African Americans, reflecting their status as an underserved population. Several new targeted programs for education and screening are in the design or implementation stage. Two of these programs -- "Sisters Sharing the FACS" and "Neighbors for Life" embrace elements of "grassroots" outreach discussed in our "model for thinking about underserved populations."

AVAILABILITY

• Numerous health care providers, primarily those affiliated with the major cancer care hospitals (St. Francis, Baptist, and Methodist) and major MCO's, along with specialized organizations such as American Cancer Society and the American Lung Association are involved in generic programs. Efforts include distribution of printed materials in health care centers and at public events, newsletters, public service announcements, lectures, workshops, health fairs, and other special programs targeting both health care professionals and the public. Except for special promotional campaigns (see below), however, much of this activity occurs in conjunction with groups -- such as employers -- that have contractual affiliation through contracts with the hospitals and MCO's.

• Public awareness campaigns center around Cancer Awareness Month in October (including Race for the Cure), Prostate Cancer Awareness Week in September, and the local Jesse Harris Cancer Awareness Week in April. The ACS supplies literature and literature is also available directly from the national Cancer Information Service (1-800-Cancer.)
• Screening for breast, cervical, prostate and colo-rectal cancer is widely available through primary care providers and hospitals for individuals who seek these services. Special work-site screening opportunities are offered by a growing number of employers in conjunction with preferred provider hospitals. On-site screening offers added convenience.

AFFORDABILITY

• Literature and special events that are open to the public (especially during the awareness campaigns) are usually free.

• TennCare waives deductibles and co-payment for preventive care, which includes recommended screening.

• Free or reduced cost screening is periodically available at participating sites. The Health Department’s six neighborhood clinics offer free or reduced cost mobile mammography for two days annually at each clinic. St. Francis, Baptist and Methodist all have programs for free or reduced cost screening.

• The American Cancer Society operates a Patient Services Unit which attempts to make arrangements for free or reduced price screening on request.

• The Church Health Center reports that it is able to make arrangements for free mammography through a variety of mechanisms.
UTILIZATION

• Screening programs offering free or reduced cost services to target underserved populations report underutilization. (St. Francis discontinued its grant-funded outreach screening for low income neighborhoods because of poor participation.)

• Public health neighborhood clinics and TennCare affiliates include education and routine recommended screening in their operating protocol. High volume practice and continuity of care providers poses a challenge to fulfilling this commitment; compliance is monitored through “chart audits.” Audits are mandated for TennCare contractors and public health clinics, but the TennCare system is still evolving and the “report card” is not yet in.

• Primary care providers report that they are most successful in persuading symptom-oriented patients to be screened when clinics are in a position to do on-site and on-demand screening. When patients come in with acute complaints, they are treated then diverted for appropriate screening. This is a form of “intrusive” outreach.

• Outreach to underserved populations is becoming more aggressive. The Shelby County Health Department will assume a leadership role in the “West Tennessee Coalition,” a statewide breast and cervical cancer initiative. The Coalition targets uninsured women (i.e. not covered by private insurance or TennCare) between the ages of 18 and 50. Supported by state funding, the Coalition is to involve the YWCA, churches, clinics, and other service organizations. The five year initiative will be launched in June of this year. The strategy is still in the planning stages.
• The American Cancer Society has a standing committee, the "Socioeconomically Disadvantaged" committee, to monitor the status of cancer care for underserved populations. This committee, along with the West Tennessee Coalition, offers another point of entry for collaborative efforts.

• The YWCA is coordinating two new targeted programs. "Encore" targets African American women over 50 and uninsured or underinsured women. Encore offers education and free screening through YWCA locations, and for incarcerated women. Encore also responds to requests for programs at other sites. A companion program, "Encore Plus" targets lesbian women who are less likely to visit a doctor for routine gynecological services such as birth control and pre-natal care. It is not clear how either program will evaluate its effectiveness.

• The American Cancer Society’s “Neighbors for Life” trains volunteers to work in their neighborhoods and churches to promote education and screening. While the theory is sound, it is not clear from our information how the effectiveness of this program will be evaluated.

• Methodist Hospital coordinates "Sisters Sharing the FAC’s (Fight Against Cancer.) Using hospital employees who live in the neighborhoods, “Sisters” targets 32,000 women over 40 who live in White Haven and South Memphis. Volunteers speak and do workshops in the community, and participants who respond to screening opportunities are given a special number to call. The special number enables Methodist to monitor the extent to which callers are responding to “Sisters” outreach.
SPECIALIZED CANCER CARE: MAJOR FINDINGS

INTRODUCTION: Advanced technologies for the treatment of cancer are widely available in Shelby County, as are rehabilitative home health care services and hospice services for the terminally ill. The emergence of this “continuum of care” introduces new alternatives with varying financial considerations, and makes new demands on patients and their families to make informed and appropriate choices. Substantial out-of-pocket expenses remain not only for uninsured and underinsured cancer patients, but for insured patients by virtue of deductibles and co-payments. The implications for quality of care of TennCare and the changing character of indigent care are still unclear.

AVAILABILITY

- As a regional medical center, Shelby County offers progressive cancer care at a number of hospitals. St. Francis, Baptist/Trinity, and Methodist Alliance offer specialized cancer care units (with social work and educational services), as well as home health services and hospice care for cancer patients among others.

- In addition to the hospital affiliated home health services, independent commercial providers have entered the home health care market. There are 56 listings in the current “yellow pages” for home health care. Some, but not all, promote their services as Medicare certified or TennCare affiliated. Providers appear to be keeping up with demand, but affordability may limit demand.

- In addition to hospital and physician affiliated hospice care, some commercial home health agencies advertise hospice care. Non-profit providers, usually churches, offer non-clinical aspects of hospice care, which are discussed in the context of assisted living and psychosocial support services.
AFFORDABILITY

- All local TennCare MCO’s are affiliated with hospitals that offer cancer care. However, there are few oncolgical specialists affiliated with the MCO’s; MCO’s claim that they will make provisions for specialized care by going beyond their affiliates if necessary. Given that the “report cards” on TennCare MCO’s are still in process, it is too soon to assess how well TennCare is functioning to make cancer care affordable to participants. TennCare primary care providers are perceived to vary in terms of responsiveness to symptoms.

- The high cost of treatment and ambiguities of state and local support for uninsured/underinsured care (the TennCare “eligibility gap”) introduce uncertainty for the uninsured and underinsured. Although hospitals report that some funds are available for indigent care, there is at least the perception of an affordability/access problem. Evidence of treatment being denied is anecdotal, but is likely to fuel patients’ fears.

- For the insured, including Medicare participants, there may be substantial out-of-pocket expenses in the form of co-payments and deductibles. Physician care and other specialized services delivered in the hospital setting are billed separately and often involve a co-payment on the order of 10% to 30%. Caps on total co-payment vary by insurance provider, so that co-payment can be a significant factor in affordability.

- Home health/hospice care insurance coverage is typically less comprehensive than inpatient care, involving co-payments and time limitations, both of which limit affordability.
UTILIZATION

- Consumers are confused and apprehensive about TennCare coverage, which may encourage denial of symptoms and/or delay in seeking diagnosis and treatment.

- Co-payments and deductibles create apprehension about the cost of treatment even among those with Medicare and private insurance, which may also delay treatment.

- Consumers appear to lack full understanding of hospice care, which may result in their reported underutilization of these services. Some hospice services require patients to have a 24-hour caregiver, which may exclude needy patients. For reasons that remain speculative, African Americans are less likely to take advantage of hospice care.
ASSISTED LIVING SUPPORT SERVICES: MAJOR FINDINGS

INTRODUCTION: Assisted living support services include assistance with meals and/or grocery shopping, housekeeping, running errands, delivery services, transportation, "companion" care, and telephone check-in. Hospice patients may require such assistance, as do patients who are recuperating from surgery or being treated on an outpatient basis. With shorter hospitalizations the trend, demand for assisted living support services is growing.

Support services are sometimes part of a home health care package, complementing nursing services, but the support services themselves are typically not covered by insurance. Personal assistance for non-ambulatory patients, such as help with bathing, are in a grey area between nursing services and daily living support services. As such they may are may not be covered by insurance. Even with insurance coverage, there are typically time and dollar limitations. Commercial providers are the norm, with the average cost for support services from twelve to fifteen dollars an hour. Some agencies require a three hour minimum.

Apart from commercial providers, churches and other charitable organizations provide formal and informal support. Informal support means church members keeping track of "shut-ins" and providing meals, telephone check-in, and other services. Formal support from charitable organizations is usually in the form of free or reduced cost meals (e.g. MIFA) and transportation services (available from a number of sources, especially for doctor's visits.)

Public policy and charitable organizations have failed to think in terms of comprehensive daily living support services. This suggests that our vision of family and neighborhood may be rooted in a past where family and friends were more readily available as caregivers.
AVAILABILITY

- Assisted living support services are available to those who are able to pay.

- Free or reduced cost services are limited, most often including meals, transportation (and sometimes financial assistance with medical supplies or medications.)

AFFORDABILITY

- Restrictions on insurance coverage limit affordability of assisted living services, which cost at least $12.00 per hour.

UTILIZATION

- If cost barriers were removed, demand for assisted living support services would very likely increase. "Friends for Life," a comprehensive case-management service for HIV and AIDS patients, provides assisted living services through grant support. There does not appear to be a parallel approach for cancer patients, but reported demand for assisted living services among cancer patients suggests that the Friends for Life model merits further investigation.
PSYCHOSOCIAL SUPPORT SERVICES: MAJOR FINDINGS

INTRODUCTION: Psychosocial support includes social work services for inpatients in cancer care units, individual/family counseling, support groups for outpatients and their families (often related to particular medical outcomes such as mastectomy or ostomy,) psychosocial aspects of hospice care, and bereavement counseling/support groups for families and friends of cancer victims.

AVAILABILITY

- Psychosocial support services often originate with hospital social workers who organize and/or facilitate peer support groups.
- The other primary sponsor of psychosocial support services is churches.
- Mental health practitioners offer more specialized services.
- Hospitals and the American Cancer Society can typically refer inquiries to an appropriate support group coordinator.
- Most support groups are fairly informal, but there is movement toward more professional facilitated group experiences. "Carpe Diem" offers professionally facilitated weekend retreats on a fee for service basis, with some "scholarships" available for those whose with limited ability to pay.

AFFORDABILITY

- With the exception of services offered private mental health practitioners, most opportunities are free of charge.
UTILIZATION

• The more formal the support group, the more likely it is to be white and middle class.

• Church-sponsored support groups tend to come and go as needed. African Americans are more likely to use church-based support groups.

• The underserved population is probably the working class and low-income "unchurched," both black and white. This is the same group for whom access to assisted living support services is most limited. The Friends for Life "case management" approach combines both practical and psychosocial support, and again suggests a model for underserved cancer patients.
Appendix
AVAILABILITY OF SURVEYED SERVICES:

QUICK SUMMARY

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<th>SERVICES</th>
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<th>Utilization Limited/As Needed</th>
<th>Limitations</th>
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Note: Inpatient care is “available as needed” because hospitals report that indigent patients will not be refused. Perceptions and/or individual experiences may differ, discouraging some from seeking or following through with treatment.
The following institutions and organizations are key providers of cancer related services and resources and/or target traditionally underserved populations in Memphis and Shelby County:

**Hospitals and Primary Care Providers**

- Baptist Memorial Hospital (Cancer Institute/ Community Clinical Oncology Program, Hospice, Women’s Health Center)
- Brannon-McCullough Primary Health Clinic
- Chamberlin Clinic
- Church Health Center
- Health Care Center
- Memphis Cancer Center
- Memphis Family Care Centers (The Med)
- Memphis Health Center
- Memphis and Shelby County Health Department and Neighborhood Clinics
- Methodist Hospital (Cancer Care Center, Home Health Services, Hospice)
- Mid-South Family Health Center
- St. Frances Hospital and Hospice
- St. Jude Children’s Research Hospital*
- Tennessee Managed Care Network (TENNCare)
  - Access Med Plus
  - Blue Care
  - Omni Care Health Plan
  - Phoenix Health Care of Tennessee
  - Prudential Community Care
  - TLC Family Care
- Trinity Health Care Services (Baptist Hospital)
- University of Tennessee College of Dentistry
- Women’s Health Clinic

*While St. Jude’s services are available to residents of Memphis and Shelby County, local residents are not the target population for St. Jude’s and the Ronald McDonald House.
The following organizations provide cancer related services or education and were identified through our survey. This is not a comprehensive list of commercial service providers (assisted living) or informal community-based and church sponsored psycho-social support groups.

Other Organizations

Aloysius Home, Inc.
American Cancer Society
  Living Today
  Look Good...Feel Better
  Lost Chord Club
  Road to Recovery
American Lung Association
American Red Cross
Associated Catholic Charities of Tennessee
Ave Maria Home
Carpe Diemof the Mid-South (West Clinic)
Companion Care by Service Master
Corporate Angel Network
Flying Colors (Memphis Cancer Center)
Friends for Life
Germantown United Methodist Church
Goodwill Homes Community Services, Inc.
HOPE House
House Call Home Health and Hospice
Kelly Assisted Living
Susan G. Komen Foundation (sponsors the "Race for the Cure" fund raiser, provides grants to other local cancer related programs)
Josephine K. Lewis Center for Senior Citizens
Medicaid Transportation
Medox Plus
Memphis Area Legal Services
Memphis Area Transportation Authority (MATA Plus)
Memphis Housing Authority
Memphis InterFaith Association
Neighbors for Life (American Cancer Society)
Ronald McDonald House
Second Presbyterian Church
Senior Citizens Services
Sisters Sharing the FACs (Methodist Hospital)
St. Ann's Catholic Church
Tennessee Department of Human Services
Trinity Bereavement Support
West Tennessee ECHO
WINGS (The West Clinic)
YWCA Encore/Encore Plus