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Addressing Cancer Disparities in a Family Setting

[This study uses medical record reviews, patient surveys, and participant observers to examine patient health disparities across family practice settings]

Cancers such as breast, cervical, colorectal, and prostate disproportionately affect racial and ethnic minority populations. Cervical cancer is a disease that disproportionately affects women of color. Latinos develop cervical cancer almost twice as often as women in other racial groups. Disease and death rates for colorectal, and prostate cancers for African Americans are higher than for all other racial and ethnic groups in the US. In addition, breast cancer death rates are much higher for African American women than for all other groups.

Early detection is an important weapon in the fight against cancer. The Centers for Disease Control and Prevention warn that many deaths from breast and cervical cancers can be avoided by increasing cancer-screening rates through the use of mammography and pap testing for all women at risk. Similarly, colorectal cancer, a second leading cause of cancer-related death in the US, can be detected using a combination of screening tests including fecal occult blood test (FOBT), flexible sigmoidoscopy, colonoscopy, and double-contrast barium enema. While there is controversy about prostate cancer screening, there is research to suggest that digital rectal examinations (DRE) in conjunction with prostate-specific antigen (PSA) testing may result in better outcomes for “at risk” populations such as African American men who have historically experienced poor prostate cancer outcomes.

Even though increased access is an important first step to decreasing barriers to screening and early detection, cancer screening and health disparities still persist for racial and ethnic minorities who have access to medical care. Studies of patients with near universal insurance coverage have found race, gender, and socioeconomic disparities in the use of colorectal screening technologies. They have also found race and socioeconomic disparities for breast cancer screenings.

There is some research that suggests that primary care providers who are often ill prepared to communicate effectively with their diverse patient populations serve as barriers to screening. This study will attempt to identify if this is the case in New Jersey primary care settings. Specifically, the study aims to: (1) describe cancer screening disparities in New Jersey primary care practices; (2) examine differences in cancer screening disparities across different types of practices, and (3) identify characteristics of practices that have greater or fewer screening disparities using a qualitative comparative case study. These aims will be addressed using data from a group randomized clinical trial of family practices in New Jersey. Half of practices will be randomized to an immediate Participatory Quality Improvement (PQI) intervention. The control group will receive a delayed intervention. Information collected from the first twenty intervention practices serve as the data for this study. Participating practices include health care

system-affiliated and independent practices with variation in ownership (e.g., minority versus non minority owned practices), patient catchments (e.g., practices with racially and ethnically diverse versus non diverse clientele), and managed care penetration. Screening outcomes for 2000 patients will be examined by medical record review and by patient report of provision of guideline-specified prevention and care. A qualitative, observational study will be used to discern characteristics of practices with greater or fewer screening disparities. Data gathered from this pilot study will be used in grant applications to national funding agencies which will seek to further insight on the best ways to intervene to promote “best practices” in primary care settings around cancer screening for all patients and minority patients specifically.