

Strategies to Eliminate Racial/Ethnic Disparities in Breast and Cervical Cancer Detection

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While the struggle to eliminate the pro-male bias in medical research and treatment continues, health care professionals must recognize that some women comprise an especially neglected subset in this regard—underserved both as women with female cancers and as patients who are racial/ethnic minorities.

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Breast cancer is one of the most frequently diagnosed cancers, with an estimated 182,460 new cases in 2007. It is the most common cancer among women in the United States, and is second to lung cancer as the most common cause of cancer death in women. In women aged 45 to 55 years, breast cancer is the leading cause of cancer death.^{1,2} Cervical cancer is less common than breast cancer, with an estimated 11,150 US cases anticipated for 2007, but has decreased dramatically in incidence and mortality over the past few years.³

However, despite concerted medical and public health efforts, racial/ethnic disparities in breast and cervical cancer still prevail, especially for black and Hispanic women. Both breast and cervical cancer are more likely to be diagnosed in black women at later stages of the

CONTINUING MEDICAL EDUCATION

Goal

To explore racial/ethnic gaps in the detection of breast and cervical cancer and methods for promoting equitable care in women.

Learning Objectives

1. To quantify disparities in breast and cervical cancer rates and effects between white and minority women.
2. To examine the reasons for these disparities.
3. To propose ways for eliminating these disparities in the clinical setting.

Accreditation

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Albert Einstein College of Medicine and Quadrant HealthCom Inc. Albert Einstein College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

This activity has been peer reviewed and approved by Brian Cohen, MD, Professor of Clinical ObGyn, Albert Einstein College of Medicine. Review date: November 2008. It is designed for ObGyns, primary care physicians, and nurse practitioners.

Albert Einstein College of Medicine designates this educational activity for a

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Participants who answer 70% or more of the questions correctly will obtain credit. To earn credit, see the instructions on page 00 and mail your answers according to the instructions on page 00.

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FOCUSPOINT

Even after controlling for insurance status, income, age, and disease severity, minorities receive lower-quality care due to discrimination, cultural insensitivity, and poor provider relationships.

disease, although their incidence of breast and cervical cancer is relatively low.⁴ Additionally, death rates from cervical cancer among black women are more than double that among white women.^{1,2} Rates of cervical cancer are also higher among Hispanic women compared with white women.⁴

These disparities are multifactorial, comprising genetic, sociocultural, and environmental variables. Socioeconomic status, lack of health insurance, geography, and cultural and language barriers play a role as

well.^{4,5} There are also barriers to receiving timely, high-quality cancer prevention measures, screening, and ongoing treatment. Even after controlling for insurance status, income, age, and disease severity, racial/ethnic minorities still receive lower-quality health care, a dynamic attributed to racial discrimination, cultural insensitivity, and poor provider-patient relationships.^{3,6} The resulting insufficient access and substandard quality of care for minority women pose numerous health and medical challenges.

Regular screening and timely diagnosis are major determinants of breast and cervical cancer incidence and mortality.^{1,2} Because ObGyns and primary care physicians (PCPs) are largely responsible for providing these services to women, they can serve as first-line advocates in ensuring equality of care.⁷

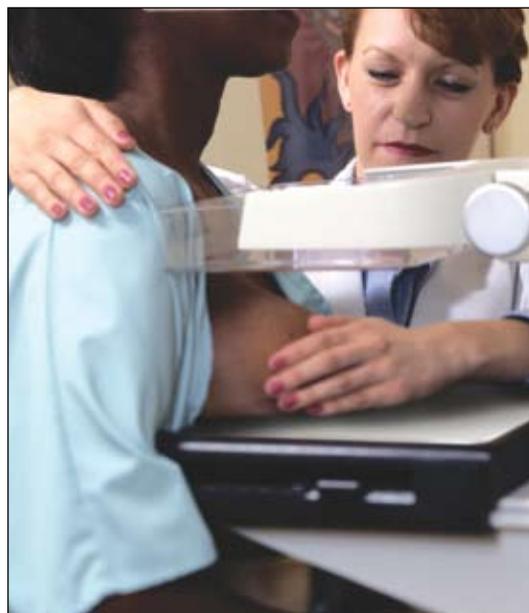


Photo courtesy of Hologic.

BREAST CANCER

Racial/ethnic disparities in breast cancer incidence and mortality are most pronounced among black women. Although white women have a higher incidence of breast cancer after age 40 than black women, the latter have higher rates before age 40 and are more likely to die from breast cancer at any age. Breast cancer incidence and mortality are lower among women of other racial/ethnic groups (Asian-American/Pacific Islander, Hispanic/Latina, American Indian/Alaskan Native) than among white and black women.⁶ Mortality for all women decreased by 2.2% between 1990 and 2004, but the decline was larger for white and Hispanic women than for black women. Between 1995 and 2004, mortality decreased by 2.4% per year in white and Hispanic/Latina women and 1.6% per year in black women, and was unchanged in Asian-American/Pacific Islanders and American Indians/Alaskan Natives (Figure 1).⁶

Breast cancer survival for all women is currently 89% at 5 years postdiagnosis.⁶ This rate is lower in women with more advanced disease and larger tumor size at diagnosis, lower socioeconomic status, and onset before age 40 (more likely in black women). When breast cancer survival data are stratified by race/ethnicity, black women are less likely to survive than white women, with 5-year survival rates of 77% and 90%, respectively.⁶ This discrepancy has been attributed to later stage at detection and poorer stage-specific survival rates, emphasizing the

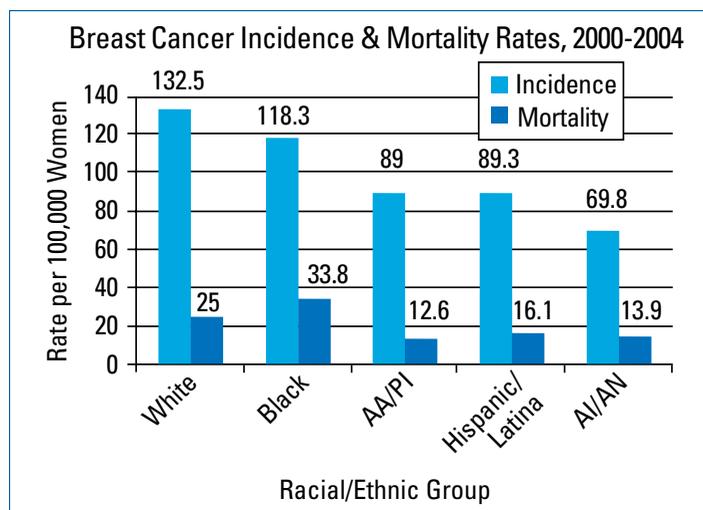


FIGURE 1. Breast cancer incidence and mortality by race/ethnicity.

AA/PI = Asian American/Pacific Islander. AI/AN = American Indian/Alaskan Native.

importance of early detection and screening. Also, black women are more likely than white women to have aggressive tumors that are associated with a poorer prognosis overall.⁶

CERVICAL CANCER

Both black and Hispanic women face racial/ethnic disparities in cervical cancer, primarily in diagnosis and incidence.^{1,2} The incidence of cervical cancer is 50% higher in black women than white women, and 66% higher in Hispanic women compared with non-Hispanic women.⁸ Again, black women have lower survival rates than white women. Rates of squamous cell carcinomas, the most common histologic type of cervical cancer, are significantly higher among black and Hispanic women than white women. Hispanic women have significantly higher rates of cervical adenocarcinoma and adenosquamous carcinoma, which is more often associated with poorer outcomes.⁸

A 2007 analysis of cervical cancer incidence by geography, race/ethnicity, and histology found that rates of invasive cervical cancer per 100,000 women declined between 1998 to 2002 from 10.2 to 8.5. However, black and Hispanic women still maintained higher rates than white women. Rates were noticeably higher among Hispanic women aged 40 years and older (26.5), black women aged 50 years and older (23.5), and Asian-American/Pacific Islanders aged 50 years and older (18.9) compared with white women older than 40 (15.7) and 50 (14.1) years of age (Figure 2).⁸ Cervical cancer is also diagnosed at an earlier stage more often in white than in black women, with rates of 53% and 44%, respectively.⁹ These figures likewise illustrate the need for improved screening and early detection.

STRATEGIES FOR CLINICIANS

Even when minority patients have access to the health care system, organizational, structural, and clinical barriers may prevent them from capitalizing on advances in disease prevention.¹⁰ Because breast and cervical cancer survival depends on early detection and prevention, disparities in health care delivery and quality, institutional and provider bias, and cultural beliefs may contribute to the disproportionate burden of these cancers in racial/ethnic minority women. ObGyns and PCPs can help overcome these barriers in the clinical setting and reduce the health disparities in these populations by implementing four concepts: the medical home,

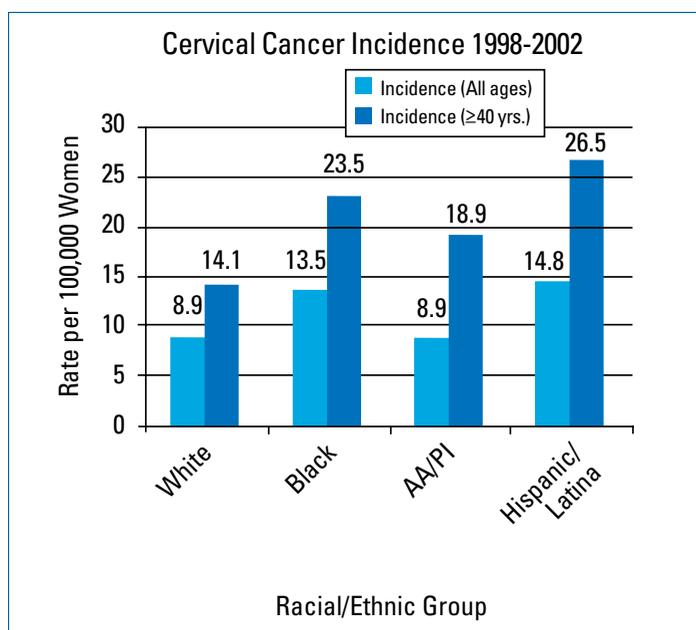


FIGURE 2. Cervical cancer mortality by race/ethnicity.

AA/PI = Asian American/Pacific Islander.

planned/chronic care, cultural competency, and health literacy.

Medical Homes

A “medical home” is a health care setting that promotes systematic care and increased access to health care professionals. Within a medical home, health care professionals can incorporate planned care, cultural competency, and health literacy into daily practice and clinical encounters as part of a comprehensive strategy to address the disparities in breast and cervical cancer. A medical home provides patients with timely, well organized care and enhanced access to health care professionals. It includes four indicators: a designated physician or source of care, easy access to that professional by phone, access to medical care/advice after office hours, and minimal waiting during office visits.⁷ Medical homes improve health care access and quality among vulnerable populations, including uninsured, low-income, and racial/ethnic minorities. When minorities have a medical home, disparities in access and prevention disappear, and preventive screenings

FOCUSPOINT

There are four concepts that health care professionals can implement to help reduce barriers: the medical home, planned/chronic care, cultural competency, and health literacy.

increase.⁷ For example, one study showed that use of reminders for preventive care by medical homes increased breast cancer screening rates, and that disparities in receipt of preventive care reminders were nonexistent among patients with medical homes.⁷ ObGyns and PCPs should create a practice environment that promotes the medical-home concept and facilitates prevention. This can be accomplished by redesigning the practice, establishing standards of care, public reporting of performance, and rewarding excellence.

FOCUSPOINT

Planned care involves making prevention and screening an automatic part of the system, so that even if the patient does not initiate it, the system does.

Planned Care and the Chronic Care Model

Although the creation of high-quality medical homes is an important step in eliminating disparities, establishing these environments may be challenging, due to time constraints and limited training in prevention. Planned care, which stems from the chronic care model, is a systematic scheme that encourages process changes such as team-based care coordination, recall registries, and tracking systems to promote prevention and chronic disease manage-

ment.¹¹ Through planned care, routine preventive services and screening are incorporated into acute and other visits, and depend on collaborative efforts of care team members.

Between 2001 and 2004, there was a decline in both screening via mammography and Papanicolaou (Pap) tests and provider-patient counseling about health risks and health promotion.¹² The planned care approach provides an opportunity to improve these findings. Data show that women will participate in cancer screenings if their health care professional recommends it.¹³ Planned care involves making prevention and screening an automatic part of the system, so that even if the patient does not initiate it, the system does. For example, if a 50-year-old woman presents with cold symptoms, a planned care system would ensure that the medical assistant or nurse schedules mammography, inquires about her most recent Pap test, and provides colon cancer screening information—all before the provider assesses the cold symptoms. Computerized or manual tracking

systems, patient and clinician reminders, and patient information materials can also help to improve delivery of high-quality preventive care in the planned care model.

Cultural Competency

ObGyns and PCPs are in a unique position to provide information about medical risks to their patients. To accomplish this, however, cultural competence is essential to the provider-patient interaction. As the demography of the United States changes, health care professionals are engaging patients with a broad range of health perspectives. Positive provider-patient communication is linked to patient satisfaction, adherence to instructions, and improved health outcomes. Patient-centered and culturally competent care can improve quality and decrease disparities.¹⁴ This requires competence and excellence in understanding patients' culture, language preferences, and gender and social values.

Health care professionals should respect cultural differences and incorporate them into the patient care and program planning processes. This involves understanding the critical position of women as health care "leaders" in their families, their cultural roles, and the barriers and constraints they encounter within the health care system.¹² Cultural competence training can be incorporated into orientation and ongoing instruction for health care professionals and staff. Many states and residency programs currently require such training and licensure, and many professional organizations offer curricula for this purpose.¹⁴

Health Literacy

A final recommendation for eliminating racial/ethnic disparities in breast and cervical cancer is a focus on health literacy. Health literacy includes ensuring that the patient understands instructions, medical education materials, the consent process, and the health care system—ie, the degree to which women obtain, process, and understand instructions in order to apply them to actual scenarios. More than 50% of women cite health care professionals as their primary source of health information. However, many women are dealing with time constraints and multitasking, which limits their ability to absorb complicated health education materials.¹²

Moreover, poor health literacy is common among minority populations, and has an adverse impact on cancer incidence and mortality and

quality of life.¹⁵ For example, cancer screening information that is poorly understood will be ineffective, leading to later diagnosis. Furthermore, minority women may make suboptimal decisions about interventions because informed-consent documents and treatment plans are too complicated to understand.

Patients with poor literacy skills approach communication differently than those with good literacy skills.¹⁶ For example, they may “guess” their way through instructions, or read and comprehend so slowly that they miss the meaning of the material or cannot make a timely decision. This may cause them to reach an unwarranted conclusion when receiving advice.

ObGyns and PCPs should be aware of patients’ literacy levels and provide appropriately readable instructions and information. Breast and cervical cancer education materials distributed to patients should be aimed at the 4th to 6th grade level, given the average literacy level of the US population.^{17,18} For example, the Patient Handout (What You Should Know About Breast Cancer Screening) on page 00 of this issue is written at a 5th grade reading level. By providing patients with short, concise instructional materials written at the appropriate reading level, ObGyns and PCPs can eliminate much of the disparity in services for minority women.

CONCLUSION

Efforts to reduce health care disparities with regard to breast and cervical cancer in minority women must focus not only on the diagnostic and treatment process, but also on cultural and socioeconomic factors that have an impact on these women. ObGyns and PCPs are well-positioned to address such disparities by modifying practice and care systems. Because women rely heavily on their providers as a source of health information, professionals who recognize and understand existing inequities have an opportunity to help ensure high-quality, well organized, and culturally competent health care to minority women and eliminate racial/ethnic bias. This can be accomplished by creating medical homes that provide access and quality care by incorporating the elements of planned care, cultural competency, and health literacy into daily practice and patient encounters.

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