# Health Disparities Related Literature

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ACCESS TO CARE:


Studies suggest that proximity to a safety net clinic (SNC) promotes access to care among the uninsured. Distance-based barriers to care may be greater for people with limited English proficiency (LEP), compared to those who are English proficient (EP), but this has not been explored. We assessed the relationship between distance to the nearest SNC and access in non-rural uninsured adults in California, and examined whether this relationship differs by language proficiency. Using the 2005 California Health Interview Survey and a list we compiled of California's SNCs, we calculated distance between uninsured interviewee residence and the exact address of the nearest SNC. Using multivariate regression to adjust for other relevant characteristics, we examined associations between this distance and interviewee's probability of having a usual source of health care (USOC) and having visited a physician in the prior 12 months. To examine differences by language proficiency, we included interactions between distance and language proficiency. Uninsured LEP adults living within 2 miles of a SNC were 9.3% less likely than their EP counterparts to have a USOC (P = 0.046). Further, distance to the nearest SNC was inversely associated with the probability of having a USOC among LEP, but not among EP; consequently, the difference between LEP and EP in the probability of having a USOC widened with increasing distance to the nearest SNC. There was no difference between LEP and EP adults living within 2 miles of a SNC in likelihood of having a physician visit; however, as with USOC, distance to the nearest SNC was inversely associated with the probability of having a physician visit among LEP but not EP. The effect sizes diminished, but remained significant, when we included county fixed effects in the models. Having LEP is a barrier to health care access, which compounds when combined with increased distance to the nearest SNC, among uninsured adults. Future studies should explore potential mechanisms so that appropriate interventions can be implemented.


Objective: To develop a conceptual framework for investigating the role of racial/ethnic residential segregation on health care disparities.

Data Sources and Settings: Review of the MEDLINE and the Web of Science databases for articles published from 1998 to 2011. Study Design: The extant research was evaluated to describe mechanisms that shape health care access, utilization, and quality of preventive, diagnostic, therapeutic, and end-of-life services across the life course. Principal Findings: The framework describes the influence of racial/ethnic segregation operating through neighborhood-, health care system-, provider-, and individual-level factors. Conceptual and methodological
issues arising from limitations of the research and complex relationships between various levels were identified.

**ACCULTURATION:**


Objective To describe the relationship between acculturation and human papillomavirus (HPV) infection among diverse US Latinas, a group at high risk for cervical cancer.

Methods Using survey and medical testing data from the 2003-2004 National Health and Nutrition Examination Survey (NHANES), we examined the relationship between acculturation level and HPV infection among diverse Latinas (n = 503) and Mexican American women (n = 442). Multivariable logistic regression was performed using infection with any type of HPV and with high-risk oncogenic genotypes as outcome variables.

Results More acculturated Mexican American women were more likely to be infected with high-risk HPV than less acculturated women. In multivariate analyses, Mexican Americans with higher levels of self-rated English language ability (2.48 OR, 95% CI: 1.42-4.33); with birth in the US (2.07 OR, 95% CI: 1.03-4.16); and with US born parents (2.98 OR, 95% CI: 1.45-3.72) were more likely to be infected with high-risk HPV genotypes. Mexican American women with higher levels of acculturation were more likely to test positive for other sexually transmitted infections.

Conclusion Higher acculturation levels related to more frequent infection with high-risk HPV genotypes and other STIs among US Mexican American women. This association may in part be due to engagement in sexual behaviors.


Hispanic and Spanish-speaking patients experience lower satisfaction with their health care when compared to whites and English speakers. We attempt to clarify the relationship between language preference and patient satisfaction in Hispanics. Study participants were Hispanic patients recruited from two clinics that serve an exclusively Hispanic population. We compared baseline levels of patient satisfaction among English-speaking, Spanish-speaking, and bilingual participants. Multivariate linear regression was used to model the effect of language preference on patient satisfaction. Baseline comparisons revealed that bilingual patients experienced higher satisfaction with doctor–patient communication and the office staff than Spanish-speaking patients. Multivariate analysis demonstrated that language preference was not significantly associated with patient satisfaction. Patient language preference was not a consistent predictor of satisfaction in this cohort of Hispanic patients receiving linguistically competent primary care. The analysis of local data in this study provides a crude adjustment for healthcare quality that is missing from previous research.
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This cross-sectional study assessed: (a) awareness and knowledge of federal dietary tools (MyPyramid, Food Guide Pyramid (FGP), and food labels (FL)), and (b) the influence of acculturation and state of residence on FGP knowledge (FGPK) indicators among low-income Latina WIC participants (N = 479) living in Connecticut, Ohio, Texas, and California. Participants were familiar with FGP but only 37% recognized MyPyramid. FGPK was highest for fruits (71%) and lowest for the ‘breads and cereals’ group (12%). Less than half (47%) used FL’s when grocery shopping. Living in OH, was associated with the lowest FGPK. Multivariate analyses showed that more acculturated individuals living in CT/CA had better FGPK than participants living in TX and their less acculturated counterparts in CT/CA. The forthcoming revised federal dietary tools need to be adequately disseminated among Latinos, with special emphasis on those with lower acculturation levels, living in rapid emerging Latino communities or in the US–Mexico border.


The purpose of this study is to determine if English language use is associated with smoking, diabetes, hypertension, limitations in Activities of Daily Living (ADL), and 12-year mortality in older Mexican Americans. Using data from a cohort of 3,050 Mexican Americans aged 65 years and older, we examined prevalence of 4 health indicators and survival over 12 years of follow-up by English language use. English language use is associated with increased odds of hypertension in men, independent of nativity and sociodemographic control variables. Among women, English language use is associated with lower odds of ADL limitations and increased odds of smoking. The associations for women were partially explained by occupational status and nativity. After adjusting for health conditions, sociodemographics, and nativity, English language use was associated with increased mortality among men. Interaction terms revealed that for both men and women, higher English language use was associated with mortality for respondents with the highest level of income only. English language use is a predictor of health and mortality in older Mexican Americans separate from country of birth.
Racial and ethnic minorities have disproportionately higher cancer incidence and mortality than their White counterparts. In response to this inequity in cancer prevention and care, community-based lay health advisors (LHAs) may be suited to deliver effective, culturally relevant, quality cancer education, prevention/screening, and early detection services for underserved populations.

**Approach and Strategies:** Consistent with key tenets of community-based participatory research (CBPR), this project engaged community partners to develop and implement a unique LHA training curriculum to address cancer health disparities among medically underserved communities in a tricounty area. Seven phases of curriculum development went into designing a final seven-module LHA curriculum. In keeping with principles of CBPR and community engagement, academic-community partners and LHAs themselves were involved at all phases to ensure the needs of academic and community partners were mutually addressed in development and implementation of the LHA program. Discussion and Conclusions: Community-based LHA programs for outreach, education, and promotion of cancer screening and early detection, are ideal for addressing cancer health disparities in access and quality care. When community-based LHAs are appropriately recruited, trained, and located in communities, they provide unique opportunities to link, bridge, and facilitate quality cancer education, services, and research.


Objective: To examine the effectiveness of current community-based participatory research (CBPR) clinical trials involving racial and ethnic minorities. Data Source: All published peer-reviewed CBPR intervention articles in PubMed and CINAHL databases from January 2003 to May 2010. Study Design: We performed a systematic literature review. Data Collection/Extraction Methods: Data were extracted on each study’s characteristics, community involvement in research, subject recruitment and retention, and intervention effects. Principle Findings: We found 19 articles meeting inclusion criteria. Of these, 14 were published from 2007 to 2010. Articles described some measures of community participation in research with great variability. Although CBPR trials examined a wide range of behavioral and clinical outcomes, such trials had very high success rates in recruiting and retaining minority participants and achieving significant intervention effects.


Community-based participatory research (CBPR) is a paradigm to study and reduce disparities in health outcomes related to chronic disease. Community advisory boards (CABs) commonly formalize the academic–community partnerships that guide CBPR by providing a mechanism for community members to have representation in research activities. Researchers and funding agencies increasingly recognize the value of the community’s contribution to research and acknowledge that community advisory boards are a key component of successful CBPR projects. In this article, we describe the best processes for forming, operating, and maintaining CABs for CBPR. We synthesize the literature and offer our professional experiences to guide formation, operation, and maintenance of CABs.

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CROSS CULTURAL CONSIDERATIONS:


Physicians and other health care professionals practicing in today's culturally diverse society face significant challenges when they treat patients with different beliefs, values and views of health care. These differences are often exacerbated at the end of life, and may include different attitudes towards suffering, how death is addressed and discussed and the expression of pain. This monograph presents practical strategies for the provision of culturally and linguistically competent end-of-life care.


Under the auspices of a partnership grant to reduce cancer health disparities, Moffitt Cancer Center (MCC) partnered with the Ponce School of Medicine to identify the perceived cultural communication needs of MCC healthcare providers regarding Hispanic patients with limited or no English skills. Oncologists (N = 72) at MCC were surveyed to identify the specific areas of cultural communication techniques for which they desired to receive additional training. The majority of participants (66%) endorsed an interest in obtaining training to communicate difficult issues (terminal illness, controversial diagnosis) in a manner respectful to Hispanic culture. A workshop was conducted with providers (N = 55) to improve cultural communication between Hispanic patients and families focusing on culture, terminal illness, and communication strategies. Findings from a pre-post test indicate an overall positive response to the workshop. Results from this study can help inform future efforts to enhance cultural competency among health providers.


Objective: To illustrate the complex patterns that emerge when race/ethnicity, socioeconomic status (SES), and gender are considered simultaneously in health care disparities research and to outline the needed research to understand them by using disparities in lung cancer risks, treatment, and outcomes as an example.

Principal Findings:

SES, gender, and race/ethnicity are social categories that are robust predictors of variations in health and health services utilization. These are usually considered separately, but intersectionality theory indicates that the impact of each depends on the others. Each reflects historically and culturally contingent variations in social, economic, and political status. Distinct patterns of risk and resilience emerge at the intersections of multiple social categories and shape the experience of health, health care access, utilization, quality, and outcomes where these categories intersect. Intersectional approaches call for greater attention to understand social processes
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at multiple levels of society and require the collection of relevant data and utilization of appropriate analytic approaches to understand how multiple risk factors and resources combine to affect the distribution of disease and its management. Conclusions: Understanding how race/ethnicity, gender, and SES are interactive, interdependent, and social identities can provide new knowledge to enhance our efforts to effectively address health disparities.


Objective: To assess the validity of race/ethnicity in Medicare databases for studies of racial/ethnic disparities. Data Sources: The 2010 Medicare Consumer Assessments of Healthcare Providers and Systems (CAHPS®) survey was linked to Medicare enrollment data and local area characteristics from the 2000 Census. Study Design: Race/ethnicity was cross-tabulated for CAHPS and Medicare data. Within each self-reported category, demographic, geographic, health, and healthcare variables were compared between those that were and were not similarly identified in Medicare data. Data Collection Methods: The Medicare CAHPS survey included 343,658 responses from elderly participants (60 percent response rate). Data were weighted for sampling and nonresponse to be representative of the national population of elderly Medicare beneficiaries. Principal Findings: Self-reported Hispanics, Asians, Pacific Islanders, and American Indians were underidentified in Medicare enrollment data. Individuals in these groups who were identified in Medicare data tended to be more strongly identified with their group, poorer, and in worse health and to report worse health care experiences than those who were not so identified.
IMMIGRANTS:


Research on the incidence of cancer among the immigrant population has tended to be of quite a limited scope. We investigate whether immigrant women in the US are less likely to have been recently diagnosed with cancer, and what factors might help to explain any differences identified. We estimate multivariate Logistic regression models to identify the determinants of a diagnosis within the last 3 years of any cancer, of breast cancer and of cervical cancer as well as the use of cancer screening by US women, using self-reported information on cancer diagnosis from consecutive waves of the US National Health Interview Survey over the years 1998-2007. Immigrant women of different ethnic groups are less likely to have been diagnosed with cancer, breast cancer and cervical cancer compared to US-born women. The use of basic health services, including cancer screening, is also lower for immigrant women for each main ethnic group. More research is required to determine whether immigrants may face delays in timely diagnosis of cancer by health care professionals.
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INTERVENTIONS FOR DISPARITIES:


Screening tests for colon, cervical and breast cancer remain underutilized despite their proven effectiveness in reducing morbidity and mortality. Stone et al. concluded that cancer screening is most likely to improve when a health organization supports performance through organizational changes (OC) in staffing and clinical procedures. OC interventions include the use of separate clinics devoted to prevention, use of a planned care visit, designation of non-physician staff for specific prevention activities and continuous quality improvement interventions.

Objectives To identify specific elements of OC interventions that increases the selected cancer screening rates. To determine to which extent practices bought into the interventions.

Methods Eleven randomized controlled trials from January 1990 to June 2010 that instituted OC to increase cancer screening completion were included. Qualitative data was analyzed by using a framework to facilitate abstraction of information. For quantitative data, an outcome of measure was determined by the change in the proportion of eligible individuals receiving cancer screening services between intervention and control practices. The health prevention clinic intervention demonstrated a large increase (47%) in the proportion of completed fecal occult blood test; having a non-physician staff demonstrated an increase in mammography (18.4%); and clinical breast examination (13.7%); the planned care visit for prevention intervention increased mammography (8.8%); continuous quality improvement interventions showed mixed results, from an increase in performance of mammography 19%, clinical breast examination (13%); Pap smear (15%) and fecal occult blood test (13%), to none or negative change in the proportion of cancer screening rates. Conclusions To increase cancer screening completion goals, OC interventions should be implemented tailored to the primary care practice style. Interventions that circumvent the physicians were more effective. We could not conclude whether or not continuous quality techniques were effective. Further research is needed to evaluate cost-effectiveness of these interventions.


BACKGROUND: Community outreach programs are important vehicles for reducing the discovery-delivery disconnect by bringing cancer education and screening services directly to community members. Such programs are consistent with the priority areas of the Department of Health and Human Services’ initiatives for reducing health disparities by 2010, and they support the use of culturally, linguistically, and literacy-specific approaches for eliminating cancer health disparities. METHODS: This article reviews the important tenets of culture and literacy when developing community outreach programs for medically underserved
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populations, examines a health education empowerment model for community program planning, and describes the use of the CLEAN Look Checklist (in which CLEAN is an easy-to-remember mnemonic of culture, literacy, education, assessment, and networking) for identifying cues and strategies to achieve relevant outreach. RESULTS: This article illustrates the application of this approach with an example of outreach strategies for reaching at-risk Haitian American women in our community. CONCLUSIONS: Meeting the challenge of a strong health disparities agenda requires integration of cultural and literacy considerations in outreach program, message, and intervention development. The use of a checklist may help clinicians, educators, and researchers create a sustainable model of community outreach guided by a paradigm that incorporates a multilevel approach to address cancer outcomes for disenfranchised populations.


To describe the participatory approach used to develop Good For The Neighborhood (GFTN), a community program to improve the health of four underserved communities. A core program was developed involving a park and stay approach to impact four underserved predominately minority communities (two predominately African American, 1 predominately Latino, and the Seneca Nation of Indians). The core program includes health screenings, risk assessments, health education, and exposure to health services. An extensive tracking and evaluation system was developed to determine participation and impact on the community. Multi-methods (key informant interviews, focus groups, surveys) were implemented to gain feedback from community partners and participants as to how to adopt the program to meet the needs of the community. GFTN has been sustained for over 3 years and has reached over 3,500 predominately minority individuals in four communities with 1/3 of participants engaging regularly in the program. The program has evolved in the four communities to meet specific needs. A park and stay approach in partnership with the community has led to a strong program that community partners and residents embrace. Community ownership and social networking, including word-of-mouth from residents is essential to establishing a successful program.


Cancer-related disparities are the significant differences in cancer incidence, cancer prevalence, cancer death, cancer survivorship, and burden of cancer or related health conditions that exist disproportionately in certain populations compared with the general population with respect to variables like race, ethnicity, and geography. The emergence of comprehensive cancer control efforts provides a framework to address the unequal disease burden felt by these groups. This article illustrates four distinct programs uniquely designed to fit at-risk populations. Specific examples are given that demonstrate a significant impact on the full range of the cancer care continuum. Although measureable progress has been made to
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improve prevention, detection, and treatment of cancer throughout the United States, many populations remain underserved, impeding our ability to achieve national healthcare goals. Here, we reemphasize the need to sustain this progress through use of partnerships, technology, and policy.
MEASURES OF DISPARITIES:


Health disparities are a major concern in the United States. Research suggests that inequitable distribution of money, power, and resources shape the circumstances for daily life and create and exacerbate health disparities. In rural communities, inequitable distribution of these structural factors seems to limit employment opportunities. The Sustainable Livelihoods framework, an economic development model, provides a conceptual framework to understand how distribution of these social, economic, and political structural factors affect employment opportunities and community health in rural America. This study uses photo-elicitation interviews, a qualitative, participatory method, to understand community members' perceptions of how distribution of structural factors through creation and maintenance of institutional practices and policies influence employment opportunities and, ultimately, community health for African Americans living in rural Missouri.


INTRODUCTION: Recent initiatives aim to improve public awareness of health disparities. However, little research has actually documented the US public's awareness of racial/ethnic and socioeconomic health disparities. We sought to determine 1) whether the US public is aware of racial, educational, and income disparities in health, 2) whether awareness differs across these disparity domains, and 3) what respondent characteristics are associated with awareness of racial, educational, and income disparities in health. METHODS: We conducted the National Opinion Survey on Health and Health Disparities with 2,791 US adults. We asked respondents to answer questions about disparities in health between 1 of several pairs of population subgroups: African Americans versus whites, non-high school graduates versus high school graduates, high school graduates versus college graduates, the poor versus the middle class, or the middle class versus the rich. We used chi(2) tests and logistic regression to compare correlates of respondents' awareness of disparities across the different pairs of population subgroups. RESULTS: Most respondents were aware of health disparities between the poor and middle class (73%); fewer were aware of health disparities between African Americans and whites (46%). Although respondents recognized that education is associated with many positive life outcomes, they were less aware of the link between education and health. Respondents who were younger, less educated, lower-income, healthier, or politically conservative were less likely to be aware of health disparities. CONCLUSION: Public awareness of disparities in health differs
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depending on both the type of disparity and the characteristics of the individual respondent.


Objective: To review methods of measuring racial/ethnic health care disparities.

Study Design: Identification and tracking of racial/ethnic disparities in health care will be advanced by application of a consistent definition and reliable empirical methods. We have proposed a definition of racial/ethnic health care disparities based in the Institute of Medicine’s (IOM) Unequal Treatment report, which defines disparities as all differences except those due to clinical need and preferences. After briefly summarizing the strengths and critiques of this definition, we review methods that have been used to implement it. We discuss practical issues that arise during implementation and expand these methods to identify sources of disparities. We also situate the focus on methods to measure racial/ethnic health care disparities (an endeavor predominant in the United States) within a larger international literature in health outcomes and health care inequality.

Empirical Application: We compare different methods of implementing the IOM definition on measurement of disparities in any use of mental health care and mental health care expenditures using the 2004–2008 Medical Expenditure Panel Survey. Conclusion: Disparities analysts should be aware of multiple methods available to measure disparities and their differing assumptions. We prefer a method concordant with the IOM definition.


Each year, the American Cancer Society estimates the numbers of new cancer cases and deaths expected in the United States in the current year and compiles the most recent data on cancer incidence, mortality, and survival based on incidence data from the National Cancer Institute, the Centers for Disease Control and Prevention, and the North American Association of Central Cancer Registries and mortality data from the National Center for Health Statistics. A total of 1,596,670 new cancer cases and 571,950 deaths from cancer are projected to occur in the United States in 2011. Overall cancer incidence rates were stable in men in the most recent time period after decreasing by 1.9% per year from 2001 to 2005; in women, incidence rates have been declining by 0.6% annually since 1998. Overall cancer death rates decreased in all racial/ethnic groups in both men and women from 1998 through 2007, with the exception of American Indian/Alaska Native women, in whom rates were stable. African American and Hispanic men showed the largest annual decreases in cancer death rates during this time period (2.6% and 2.5%, respectively). Lung cancer death rates showed a significant decline in women after continuously increasing since the 1930s. The reduction in the overall cancer death rates since 1990 in men and 1991 in women translates to the avoidance of about 898,000 deaths from cancer. However, this progress has not benefitted all segments of the population equally; cancer death rates for individuals with the least education are more than twice those of the most educated. The elimination of educational and
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Racial disparities could potentially have avoided about 37% (60,370) of the premature cancer deaths among individuals aged 25 to 64 years in 2007 alone. Further progress can be accelerated by applying existing cancer control knowledge across all segments of the population with an emphasis on those groups in the lowest socioeconomic bracket.

Webb, B. C., S. L. Simpson, et al. (2011). "From politics to parity: using a health disparities index to guide legislative efforts for health equity." Am J Public Health 101(3): 554-560. OBJECTIVES: We created an index quantifying the longitudinal burden of racial health disparities by state and compared this index to variables to guide the construction of, and validate support for, legislative efforts aimed at eliminating health disparities. METHODS: We evaluated 5 focus areas of greatest racial disparities in health from 1999 to 2005 and compiled state health disparities index (HDI) scores. We compared these scores with variables representing the purported social determinants of health. RESULTS: Massachusetts (0.35), Oklahoma (0.35), and Washington (0.39) averaged the fewest disparities. Michigan (1.22), Wisconsin (1.32), and Illinois (1.50) averaged the greatest disparities. The statistical reference point for nationwide average racial disparities was 1.00. The longitudinal mixed model procedure yielded statistically significant correlations between HDI scores and Black state population percentage as well as with the racial gap in uninsured percentages. We noted a trend for HDI correlations with median household income ratios. CONCLUSIONS: On the basis of the HDI-established trends in the extent and distribution of racial health disparities, and their correlated social determinants of health, policymakers should consider incorporating this tool to advise future efforts in minority health legislation.
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PATIENT NAVIGATION:


**BACKGROUND:** Patient satisfaction is an important outcome measure of quality of cancer care and 1 of the 4 core study outcomes of the National Cancer Institute (NCI)-sponsored Patient Navigation Research Program to reduce race/ethnicity-based disparities in cancer care. There is no existing patient satisfaction measure that spans the spectrum of cancer-related care. The objective of this study was to develop a Patient Satisfaction With Cancer Care measure that is relevant to patients receiving diagnostic/therapeutic cancer-related care. **METHODS:** The authors developed a conceptual framework, an operational definition of Patient Satisfaction With Cancer Care, and an item pool based on literature review, expert feedback, group discussion, and consensus. The 35-item Patient Satisfaction With Cancer Care measure was administered to 891 participants from the multisite NCI-sponsored Patient Navigation Research Program. Principal components analysis (PCA) was conducted for latent structure analysis. Internal consistency was assessed using Cronbach coefficient alpha (alpha). Divergent analysis was performed using correlation analyses between the Patient Satisfaction With Cancer Care, the Communication and Attitudinal Self-Efficacy-Cancer, and demographic variables. **RESULTS:** The PCA revealed a 1-dimensional measure with items forming a coherent set explaining 62% of the variance in patient satisfaction. Reliability assessment revealed high internal consistency (alpha ranging from 0.95 to 0.96). The Patient Satisfaction With Cancer Care demonstrated good face validity, convergent validity, and divergent validity, as indicated by moderate correlations with subscales of the Communication and Attitudinal Self-Efficacy-Cancer (all P < .01) and nonsignificant correlations with age, primary language, marital status, and scores on the Rapid Estimate of Adult Literacy in Medicine Long Form (all P > .05). **CONCLUSIONS:** The Patient Satisfaction With Cancer Care is a valid tool for assessing satisfaction with cancer-related care for this sample.


Patient navigation (PN) programs are being widely implemented to reduce disparities in cancer care for racial/ethnic minorities and the poor. However, few systematic studies cogently describe the processes of PN. We qualitatively analyzed 21 transcripts of semistructured exit interviews with three navigators about their experiences with patients who completed a randomized trial of PN. We iteratively discussed codes/categories, reflective remarks, and ways to focus/organize data and developed rules for summarizing data. We followed a three-stage analysis model: reduction, display, and conclusion drawing/verification. We used ATLAS.ti_5.2 for text segmentation, coding, and retrieval. Four categories of factors affecting cancer care outcomes emerged: patients, navigators, navigation processes,
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and external factors. These categories formed a preliminary conceptual framework describing ways in which PN processes influenced outcomes. Relationships between processes and outcomes were influenced by patient, navigator, and external factors. The process of PN has at its core relationship-building and instrumental assistance. An enhanced understanding of the process of PN derived from our analyses will facilitate improvement in navigators’ training and rational design of new PN programs to reduce disparities in cancer-related care.

BACKGROUND: Patient navigators may increase colorectal cancer (CRC) screening rates among adults in underserved communities, but prior randomized trials have been small or conducted at single sites and have not included substantial numbers of Haitian Creole-speaking or Portuguese-speaking patients. METHODS: We identified 465 primary care patients from 4 community health centers and 2 public hospital-based clinics who were not up-to-date with CRC screening and spoke English, Haitian Creole, Portuguese, or Spanish as their primary language. We enrolled participants from September 1, 2008, through March 31, 2009, and followed them up for 1 year after enrollment. We randomly allocated patients to receive a patient navigation-based intervention or usual care. Intervention patients received an introductory letter from their primary care provider with educational material, followed by telephone calls from a language-concordant navigator. The navigators offered patients the option of being screened by fecal occult blood testing or colonoscopy. The primary outcome was completion of any CRC screening within 1 year. Secondary outcomes included the proportions of patients screened by colonoscopy who had adenomas or cancer detected. RESULTS: During a 1-year period, intervention patients were more likely to undergo CRC screening than control patients (33.6% vs 20.0%; P < .001), to be screened by colonoscopy (26.4% vs 13.0%; P < .001), and to have adenomas detected (8.1% vs 3.9%; P = .06). In prespecified subgroup analyses, the navigator intervention was particularly beneficial for patients whose primary language was other than English (39.8% vs 18.6%; P < .001) and black patients (39.7% vs 16.7%; P = .004). CONCLUSIONS: Patient navigation increased completion of CRC screening among ethnically diverse patients. Targeting patient navigation to black and non-English-speaking patients may be a useful approach to reducing disparities in CRC screening. Trial Registration clinicaltrials.gov Identifier: NCT01141114.

Although patient navigation was introduced 2 decades ago, there remains a lack of consensus regarding its definition, the necessary qualifications of patient navigators, and its impact on the continuum of cancer care. This review provides an update to the 2008 review by Wells et al on patient navigation. Since then, there has been a significant increase in the number of published studies dealing with cancer patient navigation. The authors of the current review conducted a search by using the keywords "navigation" or "navigator" and "cancer." Thirty-three articles
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published from November 2007 through July 2010 met the search criteria. Consistent with the prior review, there is building evidence of some degree of efficacy of patient navigation in terms of increasing cancer screening rates. However, there is less recent evidence concerning the benefit of patient navigation with regard to diagnostic follow-up and in the treatment setting, and a paucity of research focusing on patient navigation in cancer survivorship remains. Methodological limitations were noted in many studies, including small sample sizes and a lack of control groups. As patient navigation programs continue to develop across North America and beyond, further research will be required to determine the efficacy of cancer patient navigation across all aspects of the cancer care continuum. CA Cancer J Clin 2011. (c) 2011 American Cancer Society, Inc.


Patient navigation (PN) is increasingly used in cancer care, but little is known about the identification and training of patient navigators. PN may be implemented by professional health care providers, paraprofessionals, or lay health workers and, therefore, presents an opportunity to compare professional and lay interventionist experiences. The goal of the current report is to compare the training experiences of four professional (Pro) and five lay (LHW) patient navigators enlisted to increase colonoscopy adherence among African American primary care patients. The results of early assessments showed that LHWs’ intervention-related knowledge was significantly lower than that of Pros. However, there were no significant differences in knowledge scores between LHWs and Pros for most subsets of knowledge items in later assessments. Furthermore, there were no significant differences in LHWs’ and Pros’ reported self-efficacy and satisfaction with training. Findings support the use of diverse strategies to train and prepare LHWs as patient navigators.
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REPORTS


