

Low uptake of colorectal cancer screening among African Americans in an integrated Veterans Affairs health care network

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Background: African Americans have the highest incidence and mortality from colorectal cancer (CRC). Despite guidelines to initiate screening with colonoscopy at age 45 in African Americans, the CRC incidence remains high in this group.

Objective: To examine the rates and predictors of CRC screening uptake as well as time to screening in a population of African Americans and non-African Americans in a health care system that minimizes variations in insurance and access.

Design: Retrospective cohort study.

Setting: Greater Los Angeles Veterans Affairs (VA) Healthcare System.

Patients: Random sample (N = 357) of patients eligible for initial CRC screening.

Main Outcome Measurements: Uptake of any screening method; uptake of colonoscopy, in particular; predictors of screening; and time to screening in African Americans and non-African Americans.

Results: The overall screening rate by any method was 50%. Adjusted rates for any screening were lower among African Americans than non-African Americans (42% vs 58%; odds ratio [OR] 0.49; 95% confidence interval [CI], 0.31–0.77). Colonoscopic screening was also lower in African Americans (11% vs 23%; adjusted OR 0.43; 95% CI, 0.24–0.77). In addition to race, homelessness, lower service connectedness, taking more prescription drugs, and not seeing a primary care provider within 2 years of screening eligibility predicted lower uptake of screening. Time to screening colonoscopy was longer in African Americans (adjusted hazard ratio 0.43; 95% CI, 0.25–0.75).

Limitations: The sample may not be generalizable.

Conclusions: We found marked disparities in CRC screening despite similar access to care across races. Despite current guidelines aimed at increasing CRC screening in African Americans, participation in screening remained low, and use of colonoscopy was infrequent. (*Gastrointest Endosc* 2014;80:291-8.)

Abbreviations: ACG, American College of Gastroenterology; CI, confidence interval; CPRS, Computerized Patient Record System; CRC, colorectal cancer; HR, hazard ratio; OR, odds ratio; SES, socioeconomic status; VA, Veterans Affairs.

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Colorectal cancer (CRC) is the second leading cause of cancer-related mortality in the United States.¹ Although CRC affects all racial and ethnic groups, African Americans carry an excessive burden of disease with the highest overall incidence, highest incidence of advanced stage at disease presentation, highest attributable mortality, and lowest survival rates after diagnosis compared to any other ethnic or racial group.^{1,2} Further, although CRC incidence has decreased by 10% in whites in the past 30 years, rates have remained stable in African Americans over the same period.³

The specific causes of CRC outcome inequalities in African Americans are not fully characterized. Biological susceptibility, a dietary proclivity to fats and red meats, increased smoking, social and economic disparities, and low use of screening methods have been implicated.^{2,4,5} Particular attention has been paid to low adherence to screening guidelines among African Americans, and multiple studies demonstrate that African Americans are less likely to engage in CRC screening than non-African Americans.^{2,6} In 2009, in response to evidence supporting a younger age at presentation and a high prevalence of proximal tumors in African Americans, the American College of Gastroenterology (ACG) updated CRC screening guidelines, suggesting initiation of CRC screening at age 45 and use of colonoscopy as the preferred screening modality in African Americans.⁷

The 2002 Institute of Medicine report *Unequal Treatment: Confounding Racial and Ethnic Disparities in Health Care* attributed health care disparities to the interplay between patient characteristics, provider practices, and attributes of the health care system.⁸ Patient-level characteristics are the demographic and health characteristics unique to an individual that may predict or act as barriers to screening. Provider-related factors include specific practices or preferences that may determine whether screening is recommended by a clinician. System-level attributes are the aspects of the health care system that affect a patient's ability to obtain CRC screening.

The Veterans Affairs (VA) health system presents an ideal model to test whether patient and provider factors affect CRC screening after controlling for system-level factors. Because access inequalities are minimized in the VA setting and given recent studies indicating fewer disparities in CRC treatment in VA settings, it is possible that CRC screening rates are equal among races in the VA population. However, the extent to which disparities in screening adherence currently exist in the VA population is unknown.⁹

We aimed to determine the rates of screening uptake and time to screening uptake in African American and non-African-American veterans in a large VA health care system database. In addition, we sought to identify modifiable predictors of CRC screening in non-African-American and African-American veterans by using a conceptual framework accounting for a wide range of clinical and demographic characteristics.

Take-home Message

- African Americans have the highest incidence of and mortality from colorectal cancer (CRC). In a patient population where variations in access to insurance and a usual place of care are minimized, we found marked disparities in CRC screening among African Americans compared with non-African Americans. These disparities exist despite American College of Gastroenterology guidelines recommending initiation of CRC screening at age 45 in African Americans with colonoscopy as the preferred method.
- The findings confirm that there is still a need for targeted efforts to identify and address barriers to CRC screening and screening colonoscopy in African Americans.

METHODS

Study population and data collection

This study was reviewed and approved by the institutional review board of the VA Greater Los Angeles Healthcare System. We sought patients seeking care in the VA Greater Los Angeles Healthcare System, an integrated network of 12 sites serving a racially- and ethnically-diverse population in Southern California. We used a random number generator to identify African American patients older than 45 years of age and non-African Americans older than 50 years of age. We then extracted data from the VA electronic medical records, the Computerized Patient Record System (CPRS). Included subjects were eligible for CRC screening between January 1996 and October 2012. Before January 2009, all subjects were considered screening-eligible after their 50th birthday. Because of new screening recommendations for African Americans in the 2009 ACG CRC screening guidelines, we also included African Americans who turned 45 years of age after 2009.

We excluded subjects with 1 or more of the following: (1) no VA CPRS chart notes within 2 years of his/her age of CRC screening eligibility; (2) a history of colon or rectal cancer diagnosed before his/her age of eligibility; (3) a colectomy performed before the age of eligibility; (4) a recorded family history of colon or rectal cancer; (5) a history of ulcerative colitis or Crohn's disease; or (6) CRC screening at any time before his/her age of screening eligibility (colonoscopy, flexible sigmoidoscopy, colonography, barium enema, fecal immunochemical testing, or fecal occult blood test).

Outcome variables

The primary outcome was uptake of any CRC screening procedure after the age of screening eligibility (50 years of age or older for non-African Americans and African Americans before 2009 and 45 years of age or older for African Americans after 2009). Included screening methods were those listed in the 2009 ACG guidelines: colonoscopy,

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