

Current and Classic Resources, July/August 2011

Current Resources

Burgess D J, vanRyn, M, Grill J, et al. Presence and correlates of racial disparities in adherence to colorectal cancer screening guidelines. J Gen Intern Med, 2010; 26(3):251–8.

Aims: “In this study, we tested the hypothesis that: 1) Blacks would be less likely to be adherent to CRCS than Whites; 2) race differences would persist even after controlling for demographic and health-related factors; and 3) any significant association between Black race and CRCS would be explained by: a) less favorable cognitions about screening; and b) less social and medical environmental support for screening.”

Sample: “The study population included male and female veterans, age 50–75, with one or more primary care visits between January 2005 and December 2006, at one of 124 VA medical centers participating in a 2003 organizational survey on CRCS and diagnostic practices.”

Methodology: Self-reported survey data, along with some administrative data, which included information on colorectal cancer screening, demographic, environmental and cognitive factors.

Results: Less health disparities in VA populations between races in CRCS screening than national average, and both groups had higher CRCS screening rates than the national average:

Discussion: This attenuation of disparities in CRCS rates may be due to the VA’s systematic efforts to increase screening including the use of reminders as a part of the Electronic Medical Records.

Joynt KE, Orav EJ, Jha AK. Thirty-day readmission rates for Medicare beneficiaries by race and site of care. JAMA. 2011;305(7):675-681.

Aims: Examined three issues, disparity rates in readmission rates for MI, CHF and pneumonia; if disparities were found, were they due to race or the site of care; and characteristics of hospitals if disparities based on site of care.

Sample: “Medicare Provider Analysis review (MedPAR) 100% files to examine all hospitalizations with the primary discharge diagnoses of acute MI, CHF, or pneumonia occurring between January 1, 2006, and November 30, 2008 (International Classification of Diseases, Ninth Revision, Clinical Modification [ICD-9] codes for acute MI, 410.xx, excluding 410.x2; for CHF, 398.91, 404.x1, 404.x3, and 428.0-428.9; and for pneumonia, 480-486), for Medicare fee-for-service beneficiaries aged 65 years or older.”

Methodology: “Risk adjusted odds for all-cause 30-day readmission”

Results: 3,163, 011 discharges, 8.7% black, 91.3% white. “Overall, when we considered our entire group of patients with acute MI, CHF, and pneumonia in a single sample, black patients had 13% higher odds of all-cause 30-day readmission than white patients (odds ratio [OR], 1.13; 95% confidence interval [CI], 1.11-1.14; P<.001); patients discharged from minority-serving hospitals had 23% higher odds of readmission than patients from non-minority serving hospitals (OR, 1.23; 95% CI, 1.20-1.27; P<.001).”

Discussion: This study confirms the disparities in thirty-day readmission rates based on race and type of facility.

Suurmond J, Uiters E, de Bruijne MC, Stronks K, Essink-Bot ML. Explaining ethnic disparities in patient safety; a qualitative analysis. Am J Public Health, 2010;100:S113-S117.

Aims: Examined processes underlying ethnic disparities in patient safety

Sample: Health providers in various hospitals in the Netherlands

Methodology: Semi structured interviews over a 5 month period from 2008-2009 of unintended patient safety event in an immigrant patient.

Results: Twelve health care providers described 30 cases. Three key patterns emerged: (1) inappropriate responses and practices by health care providers in relation to objective characteristics of immigrant patients, such as lack of Dutch language proficiency, lack of health insurance or genetic conditions; (2) misunderstandings between patient and health care professionals as a result of differences in illness perceptions and expectations about treatment and care; and (3) inappropriate treatment and care because of providers’ prejudices against or stereotypical ideas about immigrant patients.

Discussion: This qualitative study provides key patterns that may result in patient safety health disparities. Further study of these patterns should be conducted to validate the incidence and suggest preventive measures.

If you would like to contribute an annotated reference contact: [Timothy P. Hickman, MD, MEd, MPH](#) or [Fariha Shafi, MD](#)