

# research highlights

## Dramatic Racial/Ethnic Differences in State Cancer Screening Rates Point to Hundreds of Thousands at Risk

USE OF POTENTIALLY LIFE-SAVING cancer screening procedures among California adults varies dramatically depending on race and ethnicity, according to a new study by the UCLA Center for Health Policy Research, based in the School of Public Health.

The differences — attributed to cultural, education, language and other barriers — persist even when comparing like income levels or health insurance status across racial and ethnic groups. Lower screening rates reduce the odds of early detection for hundreds of thousands of Californians and survival rates for those who develop cancer.

The report is based on data from the 2001 California Health Interview Survey (CHIS 2001) and funded by The California Endowment. Researchers examined screening rates for cervical, breast, colorectal and prostate cancer among whites, Latinos, Asians, blacks, American Indian/Alaska Natives, and Native Hawaiian and other Pacific Islanders.

“Our findings underscore the reality that racial and ethnic disparities in cancer screening and other important health services can be found even within similar socioeconomic groups, such as low-income families and Medi-Cal beneficiaries,” says Dr. Ninez A. Ponce, a center researcher and author

on the study who is assistant professor of health services at the school.

Screening saves lives by detecting cancer or pre-malignancies at a time when treatment typically is most successful. Five-year relative survival rates for breast, prostate, colorectal and cervical cancer rise above 90 percent if the tumor is discovered before it spreads to other parts of the body. Once a tumor has metastasized, survival rates drop to 34 percent for prostate cancer, 23 percent for breast cancer, 15 percent for cervical cancer and 9 percent for colorectal cancer.

The report includes detailed screening rates for the four cancers by 1) race/ethnicity alone, 2) income and race/ethnicity, and 3) Medi-Cal coverage and race/ethnicity. Among the key findings:

- Asians report lower rates of screening than whites for all four cancers.
- Latinos report lower screening rates than whites for breast, colorectal and prostate cancer.
- Native Hawaiians and other Pacific Islanders consistently report some of the lowest screening rates in the state.
- American Indian and Alaska Natives are less likely to have been screened for breast or prostate cancer than whites.

The UCLA research team focused on the use of cancer screening tests among adults who have not been diagnosed with the site-specific cancer: Pap testing for cervical cancer; mammography for breast cancer; fecal occult blood test, colonoscopy or sigmoidoscopy for colorectal cancer; and the PSA (prostate specific antigen) test for prostate cancer.

### Percent with Recent Cancer Screening Test by Race/Ethnicity, Adults Under Age 65 Covered by Medi-Cal, California, 2001

	PAP Test	Mammogram	Colorectal Cancer Screening	PSA Test
Race/Ethnicity	%	%	%	%
White	85.8	72.0	51.1	31.5
Latino	92.2	70.4	35.8	30.1
Asian	54.3	70.4	49.1	*
African American	90.3	74.8	44.2	45.3
American Indian/Alaska Native	91.4	71.1	58.7	*
Native Hawaiian & Other Pacific Islander	76.0	*	*	*
Other/Multiracial	87.3	72.1	53.3	*
All With Medi-Cal	86.2	71.6	46.2	28.8

## Coordination of Services More Important to the Success of Medical Practice than Physician Continuity

NEITHER PHYSICIAN CONTINUITY – patients seeing the same doctor for most of their visits – nor part-time practice was associated with outcomes measures of cost, patient satisfaction or important health care services, according to the results of a large study of patients in a managed care plan. The study, led by Dr. Patricia Parkerton, assistant professor of health services at the UCLA School of Public Health, concluded that the presence of specific practice structures that coordinated care was more important.

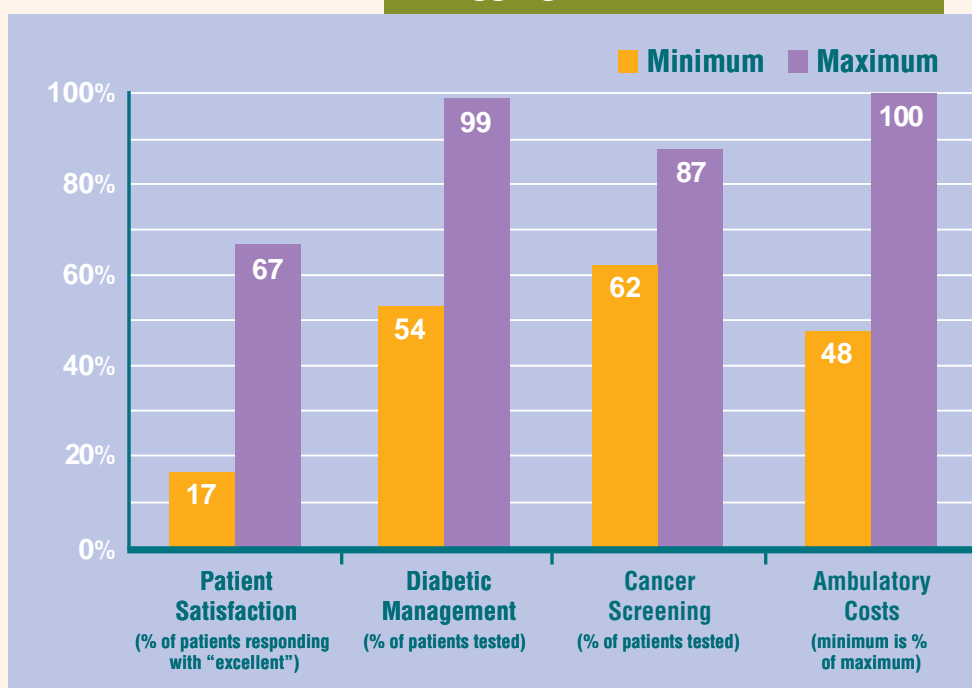
Parkerton's group examined the practices of nearly 200 primary care physicians responsible for 320,000 adult patients who were members of Group Health Cooperative, a health plan in the Puget Sound region of Washington. Physician performance was measured as it pertained to four areas: cancer screening, diabetic management, outpatient costs, and patient satisfaction. Results have been published in *Medical Care* and *The Journal of General Internal Medicine*, and will be published in January's *Family Practice*.

"Analyzing physician performance data can identify effective primary care practice structures and processes, ultimately benefiting patient care," Parkerton says. The variability in physician performance within one system of care was striking, as was the performance variability of individual physicians. A physician's good performance in one area (e.g., cancer screening) was not likely to be mirrored in other areas (e.g., patient satisfaction); only one doctor – less than 1 percent – performed in the top third on all four measures.

Parkerton's group found that structural aspects of physician practices were significantly associated with better patient outcomes. The level of coordination within a practice was improved by the length of time a clinical team worked together, a larger clinical center, and formal practice sharing. On the other hand, factors related to continuity were not associated with better physician performance. Part-time physicians did not achieve poorer outcomes on any of the measures, including patient satisfaction; indeed, practices that had part-time physicians and those with reduced appointment hours fared better on performance measures of cancer screening and diabetic management. Parkerton's research team suggests this may be the result of effective communication methods on the part of these practices – including telephone and e-mail contact with patients and strong coordination among members of the patient's health care team.

"This study demonstrates the advantages of working within a delivery system to understand its operational issues, and highlights our need to develop organizational supports to increase physician effectiveness," Parkerton concludes.

### Physician Performance Range on Aggregate Measures



From Parkerton PH, et al., Physician Performance Assessment: Nonequivalence of Primary Care Measures. *Medical Care* 41(9):1034-47, 2003. Reprinted with permission.

## Report Indicates Disparities in Children's Health Status That Can Significantly Affect Ability to Learn and Grow

A UCLA CENTER FOR HEALTH POLICY RESEARCH STUDY based on data from the 2001 California Health Interview Survey (CHIS 2001) has found wide gaps in the health and access to care among California's children under 6 years of age.

"The Health of Young Children in California: Findings from the 2001 California Health Interview Survey" examines the health, access to health care and well-being of young children, all of which affect children's ability to reach their greatest potential in school and in life. The report notes that the lack of access to health care and quality childcare for many young Californians may have long-term consequences for their development and ability to grow and learn. Hardest hit are low-income and minority children, particularly Latino children, who represent 50 percent of California's youngest children.

According to the report, there is room for improvement in conditions affecting all children. "CHIS shows that health and dental care as well as parent activities at home are falling short of what is needed for young Californians of all incomes and ethnicities," says report lead author Moira Inkelas, adjunct assistant professor in the UCLA School of Public Health and assistant director of the UCLA Center for Healthier Children, Families and Communities.

The report also provides the first statewide data on California's potential to close the gap for children who are eligible for health insurance but not enrolled. Approximately 202,000 children under the age of 6 are uninsured. According to CHIS 2001, about 80 percent of those children are uninsured despite being eligible for the public programs Healthy Families or Medi-Cal. In particular, Latino children and those in low-income families are four times less likely to have health insurance. The report states that targeted outreach, enrollment and retention efforts are needed to extend health insurance to more children and develop policies and programs to fill existing gaps.

The study also found that many preschool-age children spend no time in structured preschool settings. There are large disparities in preschool attendance among California's ethnic populations. CHIS 2001 shows that, overall, approximately 22 percent of children ages 3–5 years are in a preschool program such as Head Start, preschool or nursery school. Of children ages 3–5 years, only 13 percent of Latino children are enrolled compared to 36 percent African American, 32 percent American Indian/Alaska Native, 29 percent non-Hispanic white and 23 percent of Asian/Pacific Islander children.

CHIS 2001, the largest health survey ever conducted in any state and one of the largest in the nation, is the first health survey to provide detailed information on the health of young children in California, both statewide and for many counties.



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## Survey of Firearm Dealers in 20 U.S. Cities Shows Some Are Willing to Make Illegal Handgun Sales

SOME GUN DEALERS ARE WILLING TO SELL HANDGUNS even when the buyer indicates the end user is prohibited from purchasing a firearm, according to a unique UCLA School of Public Health survey of dealers in 20 of the nation's largest cities. The findings appeared in the June 2003 edition of the journal *Injury Prevention*.

The survey results demonstrate the need for changes in laws about gun sales and transfers, and for more resources to conduct gun sale compliance checks, according to Dr. Susan B. Sorenson, professor of community health sciences and the study's lead author.

"In the absence of federal handgun registration, firearm dealers carry the primary burden in the United States for ensuring guns are not sold to individuals who are prohibited from buying one," Sorenson says. "While dealers are in a

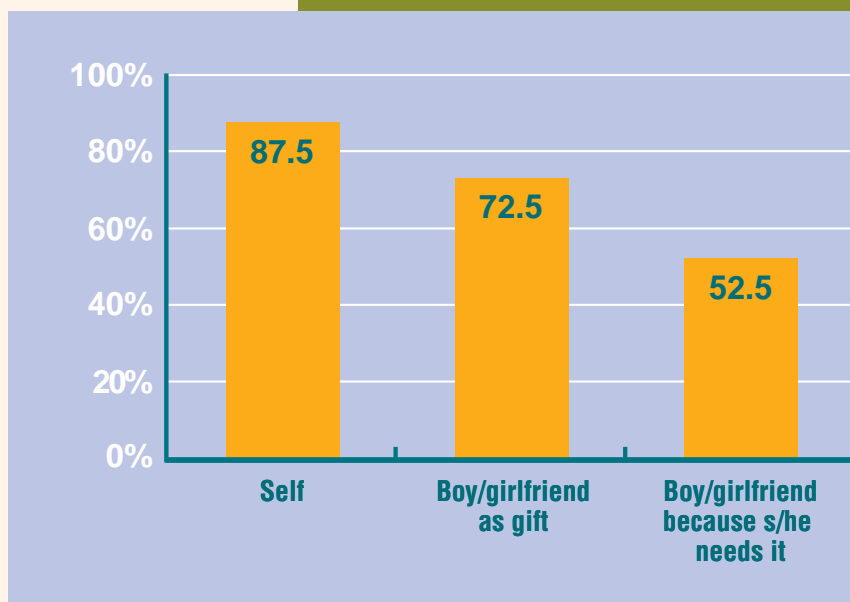
position to exercise judgment when a customer is explicit about buying a firearm for someone else, some dealers appear willing to ignore or sidestep relevant information to a sale — even when told that the end user was prohibited from purchasing a firearm.”

Sorenson’s team conducted telephone interviews with 120 handgun dealers, six from each of the 20 largest U.S. cities with 10 or more dealers. Those cities included Baltimore; New York City; Philadelphia; Memphis, Tenn.; Nashville, Tenn.; Jacksonville, Fla.; Oklahoma City; Houston; Dallas; San Antonio, Texas; El Paso, Texas; Austin, Texas; Forth Worth, Texas; Cleveland; Indianapolis; Denver; Seattle; Phoenix, Ariz.; Los Angeles; and San Diego. Dealers within each city were randomly assigned to a male or female interviewer and then randomly assigned to one of three purchase conditions: 1) the handgun was for the caller, 2) the handgun was a gift for a girl or boyfriend, 3) the handgun was for a girl or boyfriend “because she/he needs it.” Dealers were told, “I’ve never done this before. What do I need to know?” Federal law allows licensed firearm dealers to sell a firearm to any person who is not a prohibited purchaser, such as a convicted felon. Guns may also be purchased as gifts. But selling a handgun would be illegal under the “need” condition.

The findings showed most dealers were willing to sell a handgun regardless of the end user. When the handgun was identified as for the caller, 88 percent of dealers would make the sale; as a gift, 71 percent; and as a gift for someone who “needs it,” 53 percent.

A follow-up survey of 20 additional telephone calls was made after the study was complete. The caller told the dealer, “My girl/boyfriend needs me to buy her/him a handgun because she/he isn’t allowed to.” In 16 of the 20 calls, the dealer responded with an unequivocal “no,” while four agreed to sell a handgun.

### Dealer Willingness to Sell a Handgun When Caller Indicates it Is for:



## Teens at Substantially Higher Risk for Injury Crashes When Driving at Night, Carrying Other Young Passengers

WHEN TEENAGERS DRIVE AT NIGHT or in the presence of other young passengers, their risk of having a crash resulting in injury is dramatically raised, according to findings from a study by members of the Southern California Injury Prevention Research Center, based in the School of Public Health, which also found that the presence of an adult passenger older than 30 significantly lowers the injury crash risk for teen drivers.

It has long been known that teenage drivers have higher crash rates than adult drivers. “Because young drivers lack maturity and driving experience, they are less able to identify hazards and are more likely to exhibit risky driving behaviors, such as speeding and following too closely,” notes Thomas M. Rice, a Ph.D. candidate who conducted the study, published in the journal *Injury Prevention*, with Dr. Jess Kraus, the center’s director, and Corinne Peek-Asa. But this study, Rice notes, was the first to estimate the independent effects of both nighttime driving and passenger transport on the risk of injury crash occurrence among the young drivers.

The researchers analyzed data from crashes involving 16- and 17-year-old drivers in California during a five-and-a-half year period before implementation of the state’s graduated driver licensing system, designed to reduce the problem of high crash rates among young drivers by introducing adolescents into the driving environment in several stages, with the early stages intended to keep them out of high-risk driving situations. They found that teenagers driving alone are

more than three times as likely to cause crashes as those driving in the presence of an adult 30 or older – and that those carrying teenage passengers are notably more likely to cause crashes than those driving alone.

The likelihood of causing an injury crash increases with advancing late night hours for both male and female teens, rising to as much as tenfold during the later time periods. The hours of 10 p.m. to midnight are particularly dangerous for teen drivers, given that more are on the road at that time. More drivers are critically injured between 10 p.m. and midnight than during any other two-hour late-night time interval, according to the study.

“Several other studies have identified this time period as risky for teenage drivers, yet a majority of graduated licensing systems in the United States ignore this time period,” says Rice. “States with nighttime driving restrictions could reduce the number of critical injuries to drivers by expanding the restrictions to include these hours. The incorporation of passenger restrictions into existing graduated systems should also result in fewer severe and fatal injuries.”

## SPH Researchers Develop Measures of Performance for Use in L.A. County Health Department Programs

MEASURABLE PERFORMANCE INDICATORS addressing the delivery of services by a local health department have been developed by a team of UCLA and RAND researchers.

The effort took place at the behest of Dr. Jonathan Fielding, who serves in the dual role as professor of health services at the school and director of public health for the county. Fielding asked Drs. Mark Schuster, Steven Asch and Stephen Derose to assist him in setting clear goals and quantifiable performance metrics for the county’s 40-plus public health programs. “While there has been a huge effort to define and measure quality in medical care, this effort has not been matched in the public health sphere,” Fielding explains.

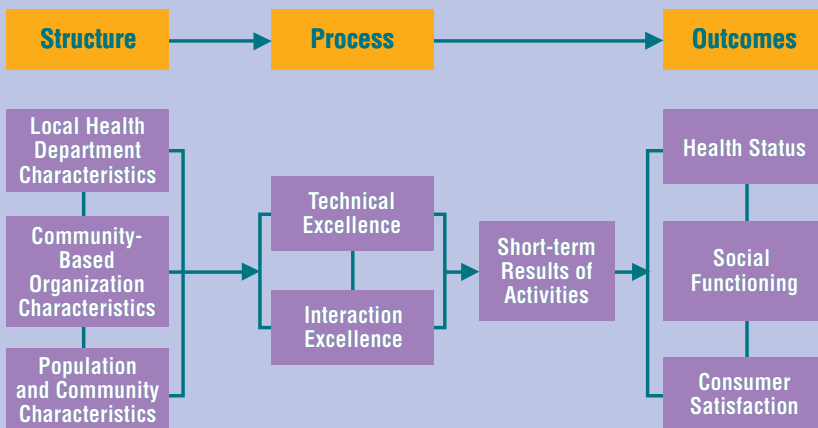
Fielding and the team of research consultants worked with program directors and senior members of their staffs to define quality with respect to their programs – asking questions such as what the programs were trying to achieve and how the directors would know if they were successful. “This is part of our efforts in Los Angeles County to make sure we are using the best evidence to develop effective public health programs and policies,” says Fielding.

The result was a set of specific program goals and related performance indicators, summarized in two articles – one published last year in the *Annual Review of Public Health*, and one in press at the *American Journal of Preventive Medicine*. All told, the researchers developed 61 indicators, with an emphasis on measuring the quality of process in services delivery.

“This was a great example of a productive partnership between a university, a think tank, and a local health department,” says Schuster, associate professor of health services and pediatrics at UCLA and senior natural scientist at RAND. “We had the opportunity to work on an applied issue of importance to the department, and also to publish articles in public health journals so that others could learn from the experience.”

“We have learned in the health department that focusing on quality, measurable goals and quantifiable program indicators requires a considerable ongoing investment,” says Fielding. “One of the major problems is the lack of data collection systems for many of the key indicators. Continued emphasis on these issues is essential in building a set of interventions for improving the health of the population that are thoroughly grounded in the best evidence.”

### Components of Quality Measurement for a Local Health Department



Reprinted with permission from *The American Journal of Preventive Medicine*, DeRose SF et al., Developing Quality Indicators for Local Health Departments: Experience in Los Angeles, in press.