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Latina and Black/African American Women's Perspectives on Cancer Screening and Cancer Screening Reminders

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Abstract

Introduction—Racial and ethnic disparities continue to exist in cancer screening rates, especially among U.S. Latina and Black/African American populations. We conducted six focus groups among 41 women from these communities in order to better understand their preferences about cancer screening reminders and the motivators and deterrents they face in obtaining recommended breast, cervical and colon cancer screening.

Methods—Using self-reported patient race/ethnicity from electronic medical records of a large, integrated health care system in Seattle, we recruited women ages 30–60 to participate in one of five two-hour focus groups. Using verbatim transcripts from these discussions, we conducted a qualitative analysis to identify common themes.

Results—The focus group participants were primarily strong endorsers and utilizers of recommended breast, cervical and colon cancer screening services. Insurance and belief in preventive care were the most common motivators that they cited in obtaining cancer screening. However, they still reported multiple barriers to getting recommended cancer screening for themselves and community members, including lack of time, conflicting information about screening intervals, distrust in the health care system, and a lack of understanding of the benefits of preventive care.

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COMPLIANCE WITH ETHICAL STANDARDS

Conflicts of interest: All authors declare they have no conflicts of interest.

Ethical approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This article does not contain any studies with animals performed by any of the authors.

Informed consent: Informed consent was obtained from all individual participants included in the study.

Conclusions—Efforts to improve understanding about the benefits of cancer screening, clarify cancer screening guideline recommendations, increase cultural competency among health care professionals, and expand the times and locations where cancer screening is available are all options that may improve cancer screening rates among Latinas and Black/African American women.

Keywords

Cancer screening; Reminders; Latina; Black/African American; Disparities

INTRODUCTION

Cancer mortality rates for some of the most common cancers, such as breast and colorectal, have significantly declined in the past decade [1]. This marked progress is attributable to improvements in early detection and treatment [2, 3]. However, despite such headway, a number of racial and ethnic groups continue to experience higher cancer mortality rates compared with Whites [4, 5]. The most common explanations for this disparity are poorer socioeconomic, cultural, environmental and health system factors, the most common being poverty, smoking, lack of access to care and insufficient knowledge about the risk factors for developing cancer [6–8].

Cancer screening for breast, cervical and colon cancers, has been shown to reduce mortality from these diseases [9]. And yet, a number of barriers to cancer screening have been identified, including cost, fear, trust, time and lack of knowledge [10–13]. These barriers have been highlighted as a major contributor to the lower cancer screening rates for Latinas and Black/African American women [14–16], and higher mortality rates for certain cancers, including breast and colon, among Black/African American women [17] and cervical among Latinas [18].

One of the main strategies used to encourage individuals to obtain recommended cancer screening is through personalized reminders including e-mails, text messages, letters and telephone calls from providers. Each method has shown some success [19–21]; and each has drawbacks, such as privacy limitations [22], cost, logistics or patient perception [23–25]. To our knowledge, evaluations of reminder letters have focused on one screening event and one health condition at a time; for example, mammography and breast cancer [26, 27], pap smear and cervical cancer [28, 29], or immunizations and influenza [29, 30]. There is significant research demonstrating how to increase adherence to preventive services when considering a single needed service [26–31], but there is scant research has been published on screening adherence when considering multiple indicated services.

Group Health Cooperative, an integrated health care system based in Washington State, has been a longtime maverick in preventive health care [32]. Group Health systematically reminds its health plan members to obtain recommended preventive health services based on evidence-based guidelines tailored to age, gender and personal risk factors. Between 2007 and 2009, Group Health gradually adopted a different strategy to prompt individuals to participate in preventive health services using person-centered reminder letters in a single, consolidated, annual reminder sent around the time of their birthday. Person-centered care is

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an approach to health care that places the person at the center of a clinical interaction and explicitly views the whole person, rather than a diagnosis or specific clinical need. Health care systems throughout the U.S. have been closely evaluating the concept of a Person-Centered Medical Home [33, 34]. As part of the transition to the Person-Centered Medical Home, physician practices are adopting new approaches to address health care needs comprehensively and to provide integrated, evidence-based care. Meeting these goals can, in part, be facilitated by person-centered reminders, such as birthday-timed letter reminders.

It was unclear what impact this consolidated annual reminder would have on the uptake of recommended services. One recent analysis of this administrative change showed an unexpected and significant decline in cervical cancer screening utilization among eligible female Group Health patients [35] after the reminder letter shifted from Pap smear reminders to the consolidated annual preventive services reminder. Given these findings, and in light of ongoing national disparities in cancer screening uptake among Black/African American and Latina populations, we opted to concentrate on these populations, in order to understand what role the consolidated reminder was playing in their choices to obtain recommended cancer screening and to better understand specific barriers women from these communities may face in getting these services.

We conducted five focus groups; three with Black/African American women and two with Latinas, in order to obtain their perspectives on Group Health’s prevention reminder letter as well as their personal and cultural perceptions of cancer risk, cancer screening and general health care seeking. We subsequently conducted a qualitative analysis to identify themes and feedback that may help make cancer screening reminders more effective and to better understand other factors that affect women’s decisions to obtain recommended cancer screening.

METHODS

Using Group Health’s administrative data, we drew a purposive sample of women who met the following eligibility criteria: 1) self-identified as either African American/Black or Latina, 2) had been enrolled as a Group Health patient for at least one year, 3) did not have a previous history of cancer, 4) had not had a hysterectomy before age 40 and 5) who had not requested translation services for their health care. We recruited women between the ages of 30 and 60 years old, since some of these women would be eligible for cervical, breast and/or colon cancer screening. These exclusions were based on the fact that 1) Women enrolled at Group Health for less than a year may not have received a Birthday Letter yet and therefore would not have been familiar with it; 2) Women with a previous history of cancer may be a more activated population to seek cancer screening and therefore not considered “typical” in the larger population; 3) Women who had a hysterectomy before age 40 would likely not be getting cervical, breast or colon cancer screening; and 4) Women who were not conversant in English would not have been able to fully and comfortably participate in these discussions without a translator, which would have been a significant disruption to conversational flow.

We mailed letters inviting women to participant in a one-time, facilitated, two-hour focus group in which they would be asked to share their opinions and experiences about cancer

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screening and about the format and style of Group Health's annual prevention services reminder letter. Letter recipients were asked to respond, if interested, to a toll-free voice mail and told they would be called back within a week to determine their eligibility and availability for one of the schedule focus group times. We chose a variety of meeting days and times of the day and evening, in order to make the groups as accessible as possible. A research assistant screened potential participants over the phone for eligibility in the two weeks following the mailing of the recruitment letters. We aimed to have 8–10 women per focus group. The recruitment flow is depicted below in Figure 1.

We held separate Black/African American and Latina discussions to focus better on group-specific issues. While we recognized that language could be an important barrier for some women, for logistical and budgetary reasons, we only recruited women who were comfortable speaking in English.

Focus groups were held at a well-known and easily accessible location in Seattle, WA. Each participant was mailed a discussion reminder letter and a map guiding them to the location of the meeting. We also called participants to confirm their plans to attend. Participants were reimbursed $60 for their time. We also provided them with free parking, snacks and beverages. All procedures described were reviewed and approved by Group Health Research Institute's Institutional Review Board.

Trained focus group facilitators were from the same racial/ethnic group as the women of a given discussion. This choice was made with the goal of making participants as comfortable as possible. Facilitators described the purpose of the study and obtained written informed consent from each participant. Using a semi-structured guide with probes, the facilitators orchestrated the discussions. A professional stenographer recorded verbatim transcripts. Facilitators made sure that all participants shared their input for each question.

The 18-question structured study guide was used for all five groups. Discussions were opened with questions about participants' cancer screening history and experiences and general perceptions about cancer. We elicited participants' cultural beliefs and attitudes about what motivates them and their peers from their same race/ethnicity to get or not get cancer screening. Additionally, as part of the discussion, participants were provided with a current mock sample of the birthday letter that included a sample sheet outlining an individual's recommended screening services, and accompanying brochure that furnished the current prevention services guidelines for Group Health women by age to get their opinions on its format and content. They were subsequently provided with a revised mock sample of the letter and accompanying documentation that had been modified based on preliminary patient feedback (prior to the focus groups) in order to obtain feedback on previously-suggested changes that had been made to the materials. Participants were asked to give their opinions about the format and content of the prevention services letter and accompanying materials, in order to help improve patient-centeredness and motivating messaging.

Three analysts (S.B., E.C. and L.T.) independently read an initial set of two focus group transcripts, and noted distinct comments to develop a coding scheme and further refined the

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codes until they reached consensus. One analyst used the coding scheme to code all of the transcripts using Atlas.ti qualitative software Version 7.2. A second analyst reviewed and validated the coded transcripts. Once all transcripts were coded, two analysts used thematic and contextual analysis techniques and reviewed the coded output to develop a list of primary and secondary themes.

RESULTS

A total of 39 women participated in these focus groups, 24 (62%) who self-identified as Black/African American and 15 (37%) who self-identified as Latina. Fifty-eight percent of the women were aged 50–60, 27% were 40–49, and 15% were 30–39. Although we did not formally collect information on each participant's country of birth, some participants indicated that they were born and raised in either in Africa or in Central or South America.

All women in the focus groups reported having received at least one type of cancer screening -- either cervical, breast and/or colon, depending on their age. Some reported having had a Pap smear but were unaware that this was a cancer screening procedures, citing that they thought it was a test for sexually transmitted infections. Many indicated that they did not always get screened on the schedule that was recommended to them.

By design, the results from these focus groups fell into two areas: 1) personal and cultural experiences and opinions about prevention, health care, cancer screening and cancer screening reminders; and 2) reaction to the consolidated annual reminder letters from Group Health. Within these areas, main themes were identified as listed and described below.

1. Personal and cultural experiences and opinions about prevention, health care, cancer screening and cancer screening reminders.

    - **Unknown Family History** - Although there was a variety of opinions and experiences among participants, one prominent theme was that cancer was a hidden or forbidden topic in their families. While some participants indicated that they knew some members of their family had cancer, they were not made aware of what type. Not knowing familial cancer history concerned some of them, since they knew that some cancers can have a genetic susceptibility component to them. Without specific diagnosis information from their relatives, these participants could not determine whether they themselves had an elevated risk for a certain cancer.

        > "The older generation they don't say much and they keep it hush, hush." [Black/African American]
        >
        > "My mom is 74. She will not tell us anything that is going on with her. If we go to the doctor and we're like, mom, well, the doctor said this. Does this run in our family? And ask her questions like that. She won't tell us anything -- if anything is going on with us. If the doctor asks about our history, well, we

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> can't ask my mom about our history because she won't tell us." [Black/African-American]

> "My family is from Latin America and…they don't talk about anything in the past -- which means I have no family history -- which means I have no idea who died of cancer -- who died of this, who died of that. So when I am asked, I can only think of my immediate -- to my, say, paternal grandmothers or my aunts and uncles that I know of. Other than that, I have no clue who has what or has anything. So I'm flying blind." [Latina]

- **Beliefs about Cancer Screening and Preventive Care** – There were mixed experiences, perceptions and beliefs about preventive care within the focus groups. There were no discernable patterns among Black/African American or Latina participants. Some expressed that they devoutly believed in preventive health care services. Others expressed that preventive care was not a cultural norm for them, or they needed reminders or external motivation to seek preventive services. Many participants who were raised outside the U.S. explained that prevention was not common in their country or part of the belief model with which they were raised.

> "Culturally we tend to not be proactive with our health and wait till something is hurting or something is looking weird and not normal, and then we go and get checked." [Latina]

> "For me it was having that preventive measure. I live pretty healthy. I want to stay that way." [Latina]

> "I think a lot of the community is misinformed about the education about preventive care, before you actually get the entire cancer or whatever. So I think education is the most important thing." [Black/African American]

> "So I'm trying to make sure I take an interest in me and my health; do the tests that are recommended for the times in my life to take them. If they're there -- I have a health plan -- I need to utilize all angles to keep myself healthy, so I can be around for others to help others." [Black/African American]

> "In Africa where I come from people go to the doctor when they are dying, then so by the time they get to hospital it's already spread over the body." [Black/African American]

Additionally, one Black/African American participant reported that, having been raised in a low-income family that only sought health care in the case of an emergency because of cost, she was still acclimating to the concept of preventive care for her and her family's healthcare utilization.

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> "I have to say with this type of stuff it's been a shift for me. When I was younger, my mom didn't have insurance. For us going to the doctor was completely out of the water. We never went unless we had to go for an emergency extraction or having a cavity." [Black/African American]

- **Varying Trust in the Health Care System –** Participants reported varied levels of trust in the health care system. Many described offensive health care experiences that were racist or culturally insensitive. Some distrusted the intentions of health care providers because they didn't feel that providers understood patient values and priorities. Culturally-insensitive communication was also mentioned as a barrier to trusting the system and clinicians.

> "I remember having surgery also a few years back, and I remember they couldn't find my vein. And the nurse tells me my skin is too dark. I said, don't touch me. My skin is not too dark." [Black/African American]

> "You hear down south, especially with the African American men, and they did the experiment and how they ended up with a venereal disease. When the woman went in for one thing, you would become sterilized. And for a long time I would keep going, but I was always afraid to go. We need more doctors of color to talk to us to be more sensitive." [Black/African American]

> "I will not go with a male doctor. It's my kind of heritage. I kind of don't want a man poking around." [Latina]

> "There are a lot of Hispanics out there that are not – going to the doctor, period, is something intimidating. Specifically if they don't think they're going to be understood or what the doctor is telling them… Going to the doctor and not being able to communicate is scary." [Latina]

Despite multiple participants in all focus groups feeling distrustful of or disrespected by the health care system, some women reported having a strong and positive connection to a provider, which they attribute to their willingness to get recommended cancer screening.

> "My doctor and I are partners in my health care and I follow her instructions." [Latina]

> "I love my doctor. I keep him because he's going to fix my problem. Trust, you know, people helping you." [Latina]

> "I love my doctor. And I just dread -- oh, lord, don't retire any time soon." [Black/African American]

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> "I appreciate that my doctor goes through every -- what I've done and what's coming up. It's just a conversation. I know in the summer I'm getting all my exams taken for -- eyes, body, everything." [Black/African American]

- **Cost of Screening Procedure** – Despite the fact that everyone who participated in the focus groups had health insurance, multiple women indicated that cost or worry about cost likely played a role in whether they or their peers sought cancer screening. Additionally, some Latina participants explained that many people from their community did not understand the value of insurance. Both perspectives reflected a deep general concern about health care expenses.

> "Then the other part of it is money…cost. There's cost associated -- people that are in disparity --there's the gap where people are, you know, poor, middle class, rich." [Black/African American]

> "Most people are living paycheck to paycheck, and $25 [for a mammogram] is the difference between eating the next week or not". [Black/African American]

> "I think it's the cost. With Group Health we don't pay for the mammogram screening. I don't think people are aware what their medical [insurance] provides." [Black/African American]

> "I think we all need to be reminded it costs the system a lot less if we do preventive care. That is the key to the outrageous cost. But I didn't realize that. I didn't understand that until a few years ago. I still was thinking that way. I'm not going to do that exam. It's going to cost a fortune. So that needs to be reminded." [Latina]

> "Health insurance is so different in our country than it is here. I think cost factors into it for a lot of us…when you are trying to explain the idea of insurance to Hispanics, we just don't get [it]. We don't use it the same way." [Latina]

> "I think cost factors into it for a lot of us. My husband sells insurance. We know that a lot of times it's when you are trying to explain the idea of insurance to Hispanics, we just don't get. We don't use it the same way. And I think that might be a barrier too. Thinking of the cost." [Latina]

- **Spanish Language Issues** – In the Latina focus groups, participants had many opinions and concerns about the use of Spanish in cancer screening reminders as well as within the health care system as a whole. Many of them expressed a wish for Group Health to make a more concerted effort to provide cancer screening reminders in Spanish, and

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to have sufficient Spanish-speaking health care staff available at each care level.

> "I have no respect to organizations who don't translate to Spanish. You got to." [Latina]
>
> "Language might be a part of it. There are a lot of Hispanics out there that are not – going to the doctor period if something is intimidating. Specifically if they don't think they're going to be understood or what the doctor is telling them." [Latina]
>
> "Sometimes I get so much strain -- appointment the lady say to me, what? Can you explain? I already talk loud because I want to know if somebody can help me with this. And then I tried to say, okay, you can make an appointment for me and explain to the doctor face-to-face." [Latina]
>
> "It would be good to send information in Spanish: This is what's going to happen; this is what's not going to happen. So they feel more comfortable and safe making appointments." [Latina]

- **Personal Availability and Clinic Accessibility** – Many participants expressed that they do not always feel they have the time to go to the doctor for cancer screening, either because of work or family obligations. Others also explained that the locations of the mammography clinics are not convenient for them. Still others expressed a desire for clinic hours for cancer screening services to be more flexible, such as into the evening or weekends.

> "The reason why I didn't make the appointment has been my schedule, because I work a pretty rigid schedule where I work." [Black/African American]
>
> "A lot of these places for the cancer screenings are it's not where the black people are." [Black/African American]
>
> "I know if they could have a Saturday clinic for mammograms -- open it up for people that work or people that have no vacation time, started their job, or just have different reasons why they cannot take off work. I think if they had more choices of when, they might come in. That might help." [Black/African American]
>
> "It seems like most of us mothers dealing with kids' schools and stuff like that. You know, there's the sort of image of the doctor taking 45 minutes to get you in -- time-consuming." [Latina]
>
> "If I can just go down the road close to my house to the clinic and get a Pap test and that's great. It's on the way to work or I

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> can get it on their way back without taking time off from work. If I have to go to the mammogram all the way up here, I have to take time off. I got to rearrange a day. The stool test is great because I can do it at home. It really depends with the test." [Latina]

2. Reactions to and Feedback on the Prevention Services Reminder Letter

In the second part of the focus groups, facilitators asked participants to give feedback on the content and design of the reminder letter. Each participant received a mock letter in an envelope, together with supplemental materials for their review and subsequent feedback. The most prominent input they gave is represented by the following themes and quotes:

- **Conflicting Screening Recommendation Information** – When the focus group participants were shown a sample of the Group Health Birthday Letter, most recognized it and remembered receiving it. Some women reported having taken action to schedule the recommended visits right away, or posted it in a prominent place such as a bulletin board or the refrigerator door, so that it would serve as a reminder for them to make their appointments. However, many women expressed confusion about the recommendations made in the letter, especially regarding the intervals between their cancer screenings. A number of women reported that they tracked their screening tests closely and that the recommendations in the mailing either did not match their perceived schedule or did not align with their health care provider's recommendations. Some women reported frustration from the misalignment. Others reported incurring costs for preventive services they thought were supposed to be covered by their insurance except that the interval between two like tests was too short for coverage.

> "I get confused what I'm supposed to be doing when -- if it's every two years or five years. And you hear stuff on the news." [Latina]
>
> "The reminders, they get confusing. I know I've got some schedule for a Pap smear or something and I called and scheduled it. And later I've gotten a bill -- well, you owe this -- and I thought that was part of our insurance. And they say, oh, you came in at the wrong time." [Black/African American]
>
> "I just went to the doctor for… like a Pap smear… and the doctor was like… It's too early to come now, but you're due in December. It is confusing. I just know she said that. She kind of understood it better than me. It's not very clear cut." [Black/African American]

- **Timing of and Number of Tests Included in Reminder**

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There were a variety of preferences about when women wanted to receive reminders and whether the letter should include one reminder per test or if the letter should consolidate all upcoming tests that would be due in the future. Some liked receiving them around the time of their birthdays, despite the recommended tests potentially being well into the future. Others preferred to be reminded closer to the time that a specific test was due.

> "I would rather have it when it is due." [Black/African American]

> "It's nice to have advance notice so you set it up." [Black/African American]

> "I would prefer a reminder per test just because women multitask all the time, and so I can't think that far ahead. If it's six months and I need to know to remind myself to schedule six months from now, I prefer additional reminder." [Latina]

- **Reminder Format and Distribution Method**

  Part of the discussion was concentrated on participant preferences about prevention services and cancer screening reminders. There was a variety of perspectives and opinions, including those about the mailed letter, secure messaging via Group Health's e-mail based electronic system, electronic text messages or personalized phone reminders. In one of the Black/African American discussions, women suggested that the reminders should come from community-based advocates, not just from health care providers.

  > "For me if I got a text message. If on the text message it had a phone number, I could click and dial. That I would pay attention to." [Latina]

  > "A phone call -- it's a better reminder than a letter. A letter you misplace it. It gets lost." [Latina]

  > "I think getting some brochures or information about cancer screening to some of those churches or conventions where there is a mass population of African American women who meet once a year on some type of national or state level where this information can be distributed out to them." [Black/African American]

DISCUSSION

While there is a myriad of research pointing to sub-optimal cancer screening and cancer-related mortality rates in Latinas and Black/African American women [7, 14, 18], there is very little qualitative data available on what could be done to improve cancer screening uptake and perhaps ultimately improve mortality rates in these populations. The voices heard

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from these focus groups do not generate easy answers for the amelioration of these disparities. Nonetheless, they point to areas for health care systems to consider improvement or modification, in order to increase knowledgeable decision-making about cancer screening and to enhance the delivery of these services in order to make them more accessible and palatable to the affected populations.

This research highlights ongoing perceived and actual barriers to cancer screening services. Despite all participants in these focus groups having health insurance, they still encountered significant worry about incurring costs for cancer screening procedures. Many participants wanted to be able to obtain reliable quotes for these procedures based on their individual insurance policy, so that they are able to make an informed financial decision about obtaining cancer screening. Group Health Customer Service provides estimated costs to patients based on their individual insurance policies. Although the reminder letters do provide statements about calling Customer Service for coverage questions, our focus groups indicate that not everyone is seeing this information. Clearer messaging and better navigational support is needed.

Multiple participants from both Black/African American and Latina focus groups indicated that they had postponed or skipped recommended cancer screening either because their jobs precluded them from being able to take time off or because some cancer screening services, such as mammography, are available at a limited number of clinics, some of which are far from where they live or work. Questions remain as to whether prevention services clinic hours should be extended to evenings and/or weekends or whether it would help to make preventive services available at more facilities.

There are ample data that Latinas have the highest rates of smartphone ownership compared to any other racial/ethnic group in the U.S. [36]. Most Latinas in our focus groups indicated they preferred to receive communication through their smartphones. Implementing text-based reminders might also be one way to improve some of the language barriers that were identified in the Latina focus groups. While there remain some privacy concerns and restrictions regarding the use of text messaging for health care information, this channel for screening reminders warrants further research and testing (while still protecting privacy) to determine whether they increase preventive services utilization.

The women experienced various levels of trust in the health care system regarding the recommendations they receive about cancer screening. Those who either felt skeptical, or had engaged in conversations with others who experience similar hesitancy, advocated for better education within their communities about the values of cancer screening and preventive health care. Some women also indicated that they wanted a more visual presence of providers and role models from their racial/ethnic group, in order to increase their trust in cancer screening and in the health care system in general. There have been many programs in other parts of the country that have implemented such community based education and advocacy [37, 38].

It is important to note the following limitations to these focus groups: All women who participated had received at least one form of recommended cancer screening, which

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suggests we may have enrolled particularly activated/motivated women who may not be representative of all women in these racial/ethnic groups. Secondly, we were only able to include individuals who spoke English, due to limited resources for this project, which precluded having a series of translators. Some English-speaking Latinas spoke anecdotally about the experiences of their Spanish-speaking family and/or community members. We believe different or additional perspectives might have been gained had we been able to include Latinas and other individuals who were not proficient in English. Third, we had limited information about socio-demographic characteristics such as birth origin, immigrant and primary language; all of which could have been useful to explore how these factors were associated with reported perceptions. The reason for these limited demographic data was that we obtained age, gender and race/ethnicity via medical records with a waiver of consent and we did not collect additional demographic information at the time of the focus groups. Last, we did not focus our analyses on a comparison between the racial/ethnic groups that participated. Doing so could have provided even more refined elucidation of barriers and solutions to cancer screening.

Despite these limitations, our focus groups elucidated the complexity of cancer screening beliefs and reminders among Latinas and Black/African Americans as well as the variety of experiences and barriers they face in obtaining recommended screening. Simply the number of preferences related to timing and format of cancer screening reminders alone was of important note. Additionally, participants resoundingly agreed that a health care system recognizes and values the different race and ethnicities of its patient population may increase the trust these patients place in their providers. Health care systems may benefit from devoting resources and innovation to reminding patients about recommended cancer screening through multiple channels, rather than a singular system in order to increase screening rates.

Even more pivotal is the remaining gaps in health care education and trust that were expressed. Health care systems must continue to recognize these ongoing short comings and enhance written and verbal communication, staff sensitivity and engage racially diverse staff and providers in order to build understanding and trust among Latina and Black/African American populations. By understanding that it may be difficult for some populations to know their family history, or discuss topics such as cancer, providers could approach cancer screening discussions and recommendations more effectively. Health care systems also need to increase their transparency regarding the costs associated with cancer screening, so that patients can make informed decisions and get recommended care. Navigational support for patients who might be unsure of how to get desired cancer screening services or to get their questions answered about them may be of great benefit to the populations studied through these focus groups. These enhancements could potentially improve uptake of recommended cancer screening and, ultimately, the wellbeing of many Latinas and Black/African American women.

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African American/Black	Latina
602 Letters Mailed ⬇	598 Letters Mailed ⬇
47 Responded ⬇	25 Responded ⬇
37 Scheduled ⬇	23 Scheduled ⬇
24 Attended	15 Attended

Figure 1.

Focus Group Recruitment Flow