Previous studies have shown that African Americans may experience more barriers to quality cancer care than Caucasian Americans (Gornick, 2000). Those barriers include issues related to the high cost burden of cancer treatment and lack of support resources for patients, families, and caregivers (Chang et al., 2004; Halbert et al., 2002). The risk for poor outcomes is additive in the presence of comorbidities and decreased economic, psychological, and social resources (Aday, Begley, Lairson, & Slater, 1998), in addition to aging (Schneider, Zaslavsky, & Epstein, 2002). In fact, cancer-related disparities are projected to notably worsen among ethnic minorities and older adults (Smith, Smith, Hurria, Hortobagyi, & Buchholz, 2009).

Cancer outcomes are unequally distributed across racial and ethnic groups, with minorities experiencing worse outcomes, particularly in overall survival (American Cancer Society, 2010; Hayes & Smedley, 2004; Ries et al., 2005). Cancer generally occurs later in life, with more than half of cancer diagnoses occurring among individuals aged 55 years or older (American Cancer Society, 2010), thus increasing the vulnerability of older African Americans. African American older adults enrolled in Medicare are more likely to report poor health than their Caucasian counterparts (42% versus 25%) and are much less likely to have supplemental insurance (Chang et al., 2004).

Several groups (Brandeis University, 2003; Institute of Medicine, 2002) have recommended employing community health workers (CHWs) to help eliminate disparities. CHWs have been described as serving in areas of community outreach and follow-up by helping patients to access health-related services. They also have provided informal counseling, social support, health education, screening, detection, and basic emergency care (Rosenthal et al., 1998; Witmer, Seifer, Finocchio, Leslie, &