A NEW ACCREDITED CONTINUING EDUCATION SERIES WITH THE EXPERTS

Addressing Disparities in Cancer Care and Incorporating Precision Medicine for Minority Populations

RESOURCE GUIDE

TABLE OF CONTENTS

LINK TO RECORDED WEBINAR

DOWNLOADABLE SLIDES

Introduction to Health Equity and Racial Disparities in Cancer Care

COURSE DIRECTOR AND MODERATOR

Edith Mitchell, MD, MACP, FCPP, FRCP

Clinical Professor of Medicine and Medical Oncology
Department of Medical Oncology
Director, Center to Eliminate Cancer Disparities
Associate Director, Diversity Affairs
Sidney Kimmel Cancer Center at Jefferson Health
116th President of the National Medical Association

FEATURED FACULTY

Robert Winn, MD

Director, VCU Massey Cancer Center
Richmond, Virginia

Karen Winkfield, MD, PhD

Executive Director, Meharry-Vanderbilt Alliance
Nashville, Tennessee

Cancer incidence and outcomes vary considerably between racial and ethnic groups. Inequalities in wealth that lead to differential exposure to risk factor and structural barriers to high-quality cancer prevention, early detection, and treatment; and differences in death rates between non-Hispanic (NH) Black and NH White men and women are well documented.[1]

- NH Black women remain 80% more likely to die from cervical cancer than NH White women[1]
- Lung cancer is the second leading cause of death for men and women, with death rates for NH Black men being 20% higher than NH White men[1]
- Black men have the highest prostate cancer death rate compared with other racial or ethnic groups, and the death rate for Black men is 2.2 times higher than the death rate for White men[1]
- Colorectal cancer death rates are 47% higher in NH Black men and 34% higher in NH Black women compared with NH White men and women[1]
- Breast cancer mortality is 40% higher for Black women compared with White women in every US state, with some states as much as 60% higher, including Louisiana and Mississippi[1]
- Cancer death rates are also higher in cancers of the stomach, uterine corpus (endometrial) for NH Blacks compared with NH Whites[1]

Introduction to Health Equity and Racial Disparities in Cancer Care

- In December 2020, a collaboration between NCCN, ACS-CAN, and NMQF conducted a survey of 600 patients/family caregivers and 200 oncologists to investigate perceptions, experience, and practices regarding racial bias in cancer care. The survey found that 63% of Black and 67% of Latinx patients, survivors, and caregivers said they had a negative experience with their oncology care team, such as having assumptions made about them or their financial situation, or trouble getting questions answered compared with 43% of White respondents who reported such experiences[2]

- As for oncologists, 62% of those surveyed believed that non-White patients experienced worse outcomes from cancer care but only 36% felt those patient populations were receiving worse care or poorer communication during care, which highlights the disconnect between awareness of the problem and a deeper understanding of the source of disparities in outcomes[2]

62%

of physicians believe that non-White cancer patients have worse **health outcomes** compared with White cancer patients

But ONLY

36%

felt those patient populations were receiving worse care or poorer communication during care

Studies have documented that physicians spend **less time** per appointment with Black patients and are **less likely to offer procedures and services** that can detect cancer at early stages.[3]

Sources of Disparities

Racial disparities in cancer occurrence and outcomes arise from inequities across the cancer care continuum. Below are examples of how racial inequities affect cancer outcomes.

Exposure to Risk Factors

Structural racism leads to higher exposure to risk factors. Due to banking policies such as "redlining", minority communities are more likely to be located near waste sites and less likely to have access to resources like fresh foods, which can contribute to higher rates of cancer.[4]

Prevention

Vaccination against human papillomavirus (HPV) can prevent cervical cancer; however, vaccination rates among Black patients are lower compared with White patients even when adjusted for socioeconomic status.[5]

Early Diagnosis

Disparities in outcomes for cervical cancer, lung cancer, colorectal cancer, and breast cancer can be attributed in part to lower screening rates and more advanced disease at diagnosis.[3,4]

Access to Treatment

Access to novel multiple myeloma (MM) treatments: the magnitude of survival improvement among Black patients after the introduction of novel MM therapies was <50% of the benefit seen in White patients. Black patients are also less likely to receive the standard of care, and when treatment is equalized, the disparities in outcomes disappear.[6]

Addressing Disparities

- Community outreach and engagement is essential. Engaging individuals, families, and communities with the goal of learning from them helps to inform clinical practice, research questions, and research strategy
- Representation in clinical trials. Black patients represent 20% of the MM population, but only 5% of the clinical trial population. Providers can work to ensure clinical trials are more inclusive, engaging patients in the research process, and reevaluating inclusion criteria to ensure therapies are effective and safe in all populations

BLACK PATIENTS

20%

MM POPULATION

5%

CLINICAL TRIAL POPULATION

Effect of COVID-19 on Disparities in Cancer Care

- The effects of the pandemic have highlighted disparities in access to care, and one major effect is delayed screening for cancer. It is estimated that over the next 10 years, delays in cancer screening will result in up to 10,000 excess deaths from breast and colorectal cancer.[7] Lessons learned from the COVID pandemic related to the impact of structural racism and social determinants of health must be leveraged to create sustainable change in cancer care.[8] This actionable framework provides real-world examples of how to improve access and create an inclusive environment for patients from all backgrounds[9]

References

1. American Cancer Society. *Cancer Facts & Figures for African Americans* 2019-2021. Atlanta: American Cancer Society, 2019. Accessed April 22, 2021. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-african-americans/cancer-facts-and-figures-for-african-americans-2019-2021.pdf
2. Leading Health and Cancer Advocacy Groups Unite to Reduce Racial Disparities in Cancer Care – The National Minority Quality Forum. Accessed April 22, 2021. https://www.nmqf.org/nmqf-media/reduce-racial-disparities-in-cancer-care
3. Franks P, Fiscella K, Meldrum S. Racial disparities in the content of primary care office visits. *J Gen Intern Med*. 2005;20(7):599-603. doi:10.1111/j.1525-1497.2005.0109.x
4. Sauer AG, Siegel RL, Jemal A, Fedewa SA. Current prevalence of major cancer risk factors and screening test use in the united states: disparities by education and race/ethnicity. Cancer Epidemiol Biomarkers Prev. 2019;28(4):629-642. doi:10.1158/1055-9965.EPI-18-1169
5. Gelman A, Miller E, Schwarz EB, Akers AY, Jeong K, Borrero S. Racial disparities in human papillomavirus vaccination: does access matter? *J Adolesc Health*. 2013;53(6):756-762. doi:10.1016/j.jadohealth.2013.07.002
6. Marinac CR, Ghobrial IM, Birmann BM, Soiffer J, Rebbeck TR. Dissecting racial disparities in multiple myeloma. *Blood Cancer J*. 2020;10(2):1-8. doi:10.1038/s41408-020-0284-7
7. Sharpless NE. COVID-19 and cancer. *Science*. 2020;368(6497):1290. doi:10.1126/science.abd3377
8. Siker ML, Deville C Jr, Suneja G, Winkfield K. Lessons from COVID-19: addressing health equity in cancer care. *Int J Radiat Oncol Biol Phys*. 2020;108(2):475-478. doi: 10.1016/j.ijrobp.2020.06.042.
9. Winkfield KM, Regnante JM, Miller-Sonet E, González ET, Freund KM, Doykos PM. Development of an actionable framework to address cancer care disparities in medically underserved populations in the United States: expert roundtable recommendations. *JCO Oncol Pract*. 2021;17(3):e278-e293. doi: 10.1200/OP.20.00630.