Understanding the Impact of Disparities and Social Determinants of Health on Cancer Care

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Disclosure of Conflicts of Interest

- Alti Rahman, MHA/MBA, CSSBB, has no relevant financial relationships to disclose.
- Susan Sabo-Wagner, MSN, RN, OCN, has no relevant financial relationships to disclose.

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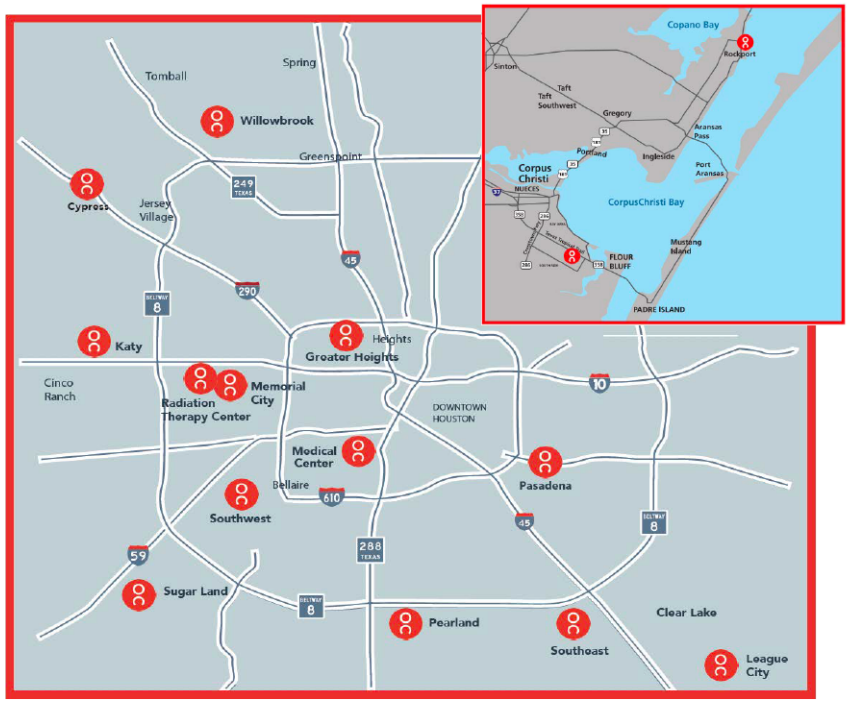
THE FULL PICTURE

LOCATIONS



18 Medical Oncologist:

2 Radiation Oncologist:

12 Nurse Practitioners &
1 Physician Assistant:

15 Medical Clinics + Infusion:

3 Retail Pharmacies:

3 Imaging Centers:

2 Radiation Clinics:

2 Research Locations:
*Over 34 Clinical Trials

Awards:

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CLIA Clinical Laboratory Improvement Amendments

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Agenda Overview

- Terminology Level Set
- Data, Data, Data (there's more…)
- Why Social Determinants of Health are important

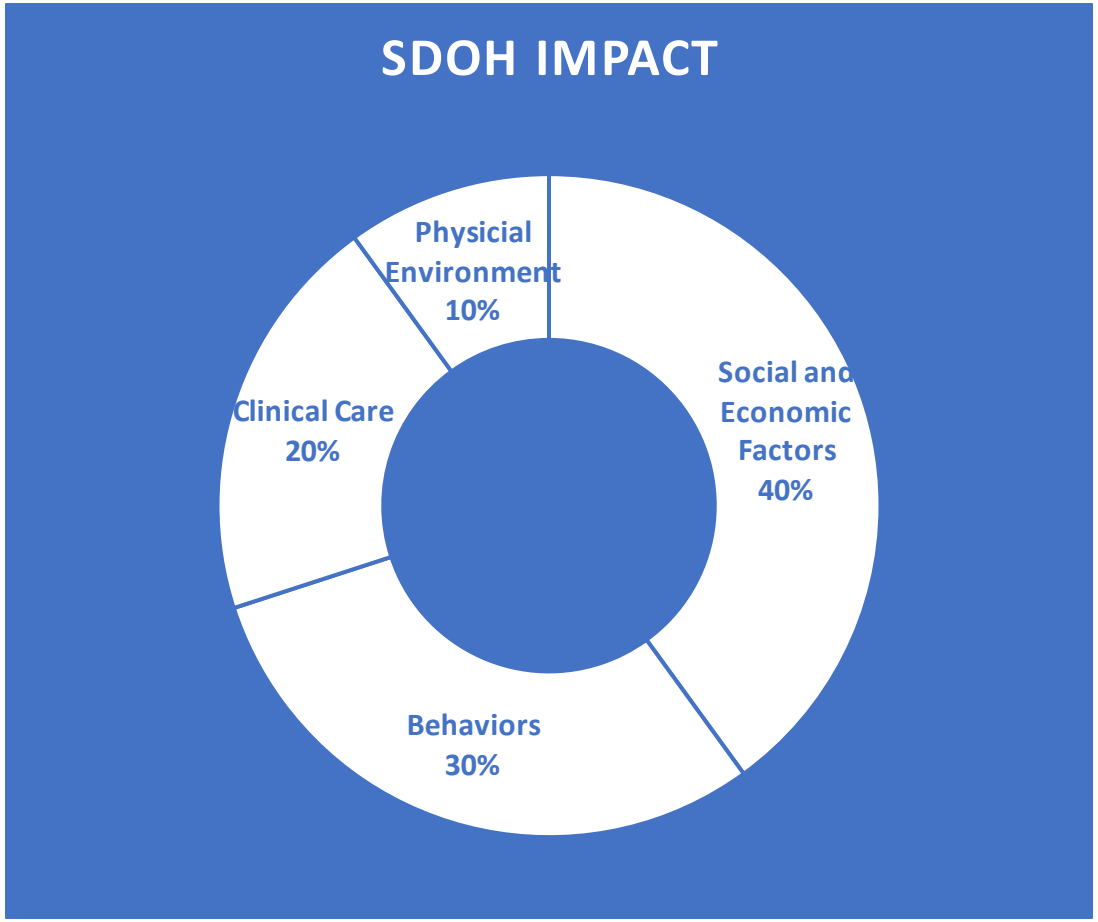
Key Definitions

Health Equity vs Health Equality

- **Health equity** means that everyone has a fair and just opportunity to be as healthy as possible….removing obstacles to health such as poverty and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care [9]
- **Health disparities** are differences in health or in the key determinants of health, such as education, safe housing, and discrimination, which adversely affect marginalized or excluded groups [9]
- CDC…when everyone has the opportunity to be as healthy as possible.” As such, equity is a process and equality is an outcome of that process. [3]

Social Determinants of Health (SDOH)

- SDOH are conditions and environments in which people are born, grow, live, learn, work, play, worship, and age that affect a wide range of health risks and outcomes.
- They help us to understand the factors affecting an individual's health that contribute to health inequalities.
- 80% of a person's health is determined by factors outside of clinical care…Behaviors and Environment



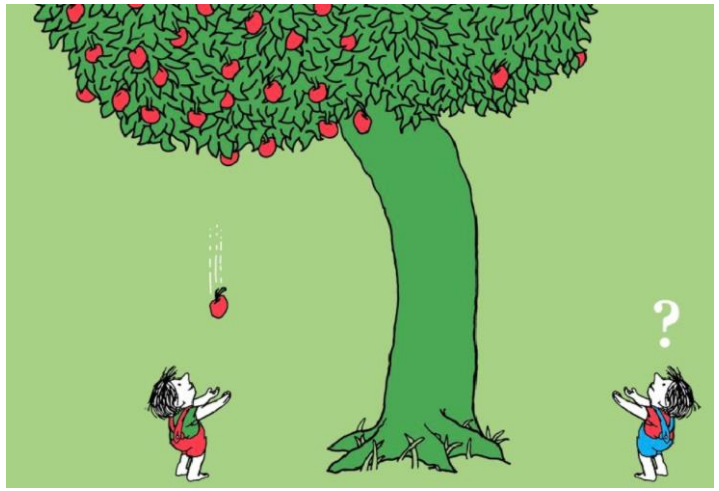
Examples of Social Determinants of Health

- Neighborhood
- Food
- Healthcare
- Education
- Economic
- Community

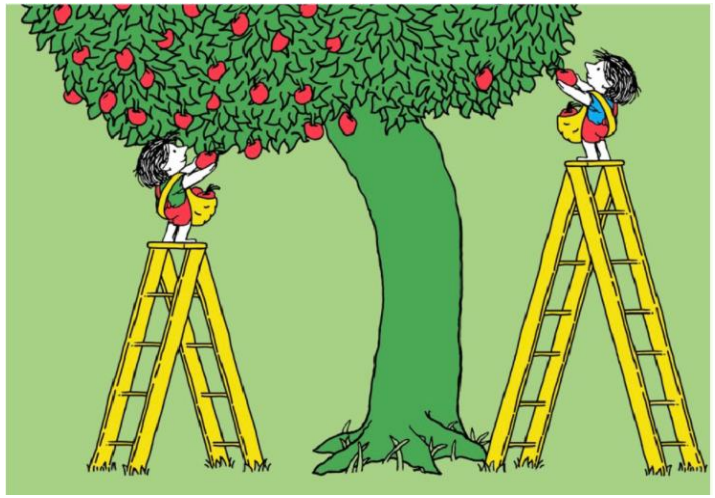
Cultural Competency

- **Cultural Competence** is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.(1) A culturally competent health care system can help improve health outcomes and quality of care, and can contribute to the elimination of racial and ethnic health disparities

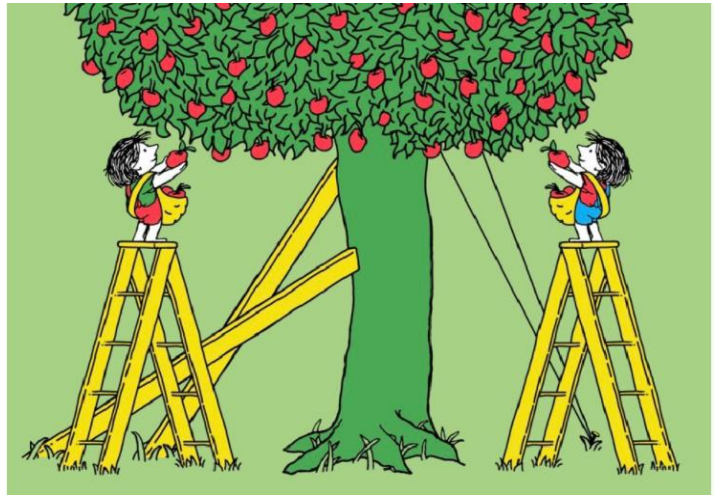
Equality vs Equity



Inequality



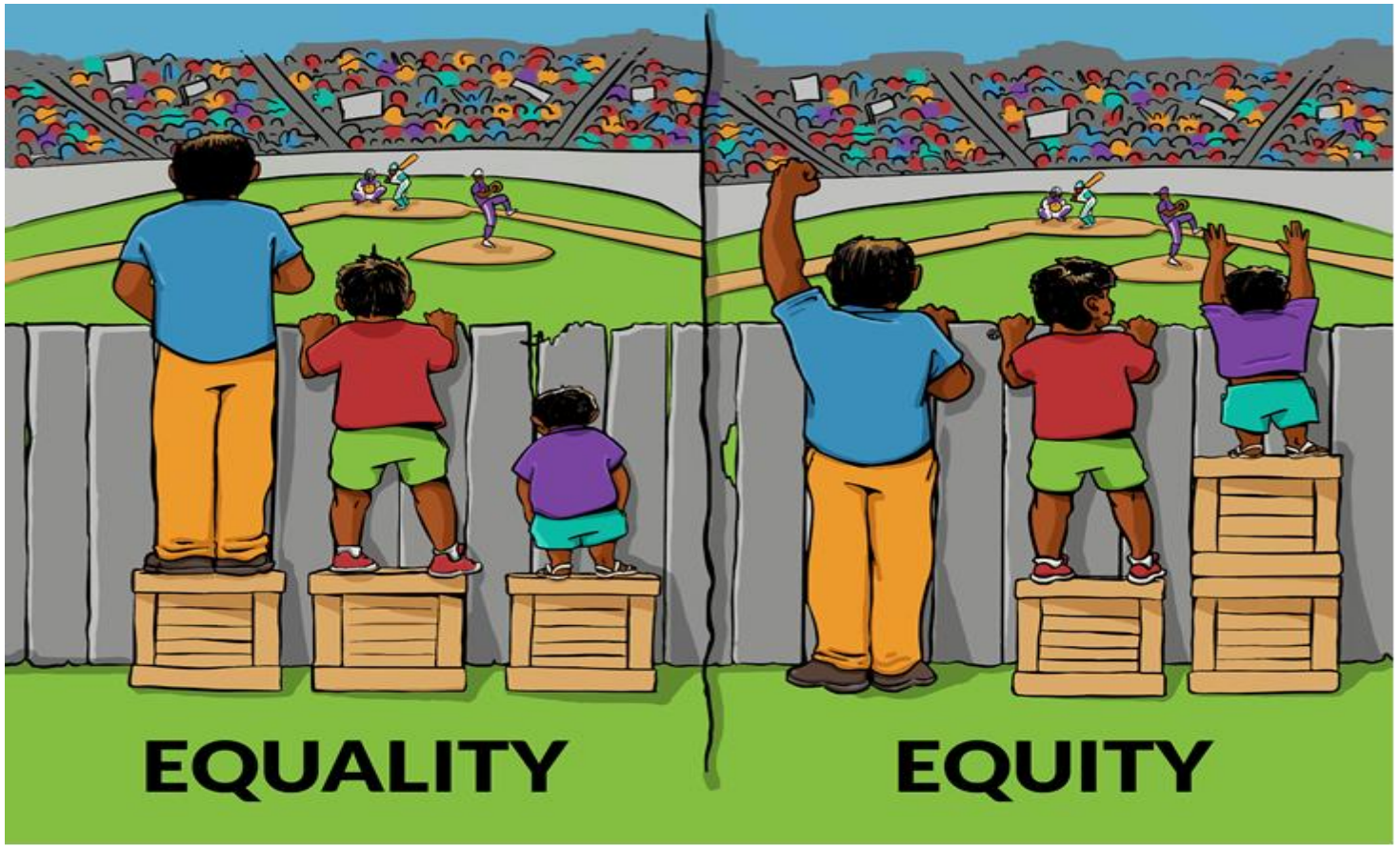
Equity



Justice

https://onlinepublichealth.gwu.edu/resources/equity-vs-equality/

Equality vs Equity



Importance of Health Equity

- Disparities in access, outcomes and cultural awareness continue to plague the healthcare system
  - Disproportionate impact of COVID-19 on minority communities.
- Understanding Health Equity Involves understanding the racial, ethnic, and language composition of a population.
- This means a system where a person's clinician and health plan understand their cultural and linguistic needs and provide appropriate services to meet those needs.

https://www.ncqa.org/wp-content/uploads/2021/01/HealthEquity_NCQA-Recommendations-to-Biden-Transition_Web.pdf

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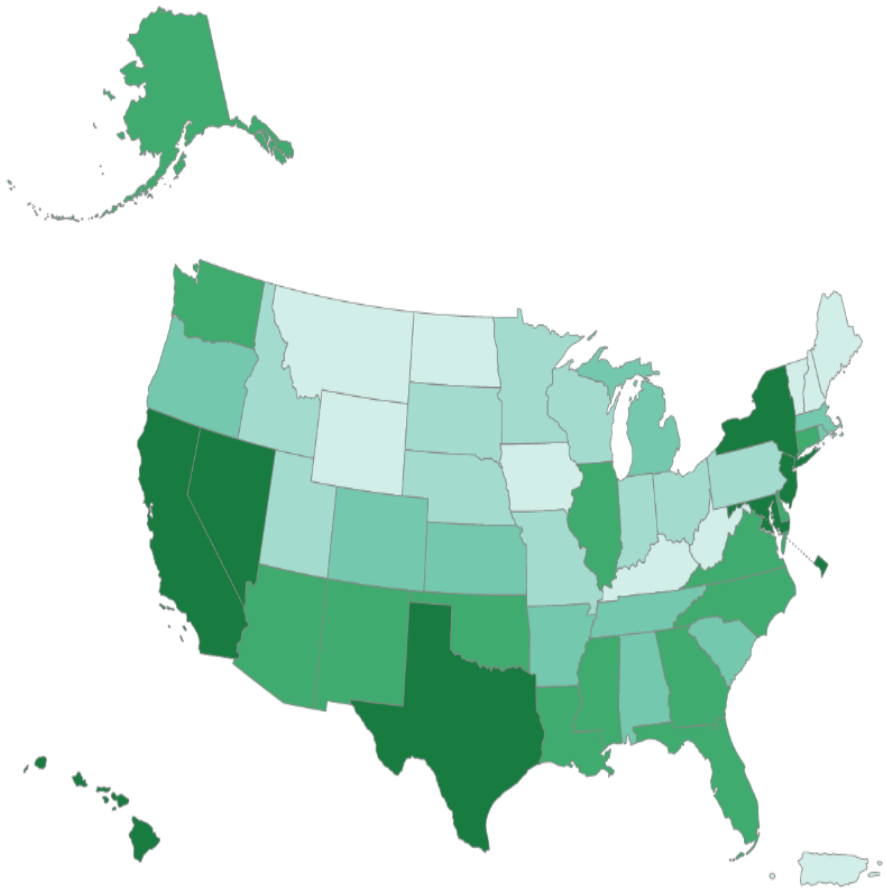
Diversity Index by State: 2020

United States: 61.1%



Interested in viewing counties?
Use the filter to select a state then click the arrow to view counties.

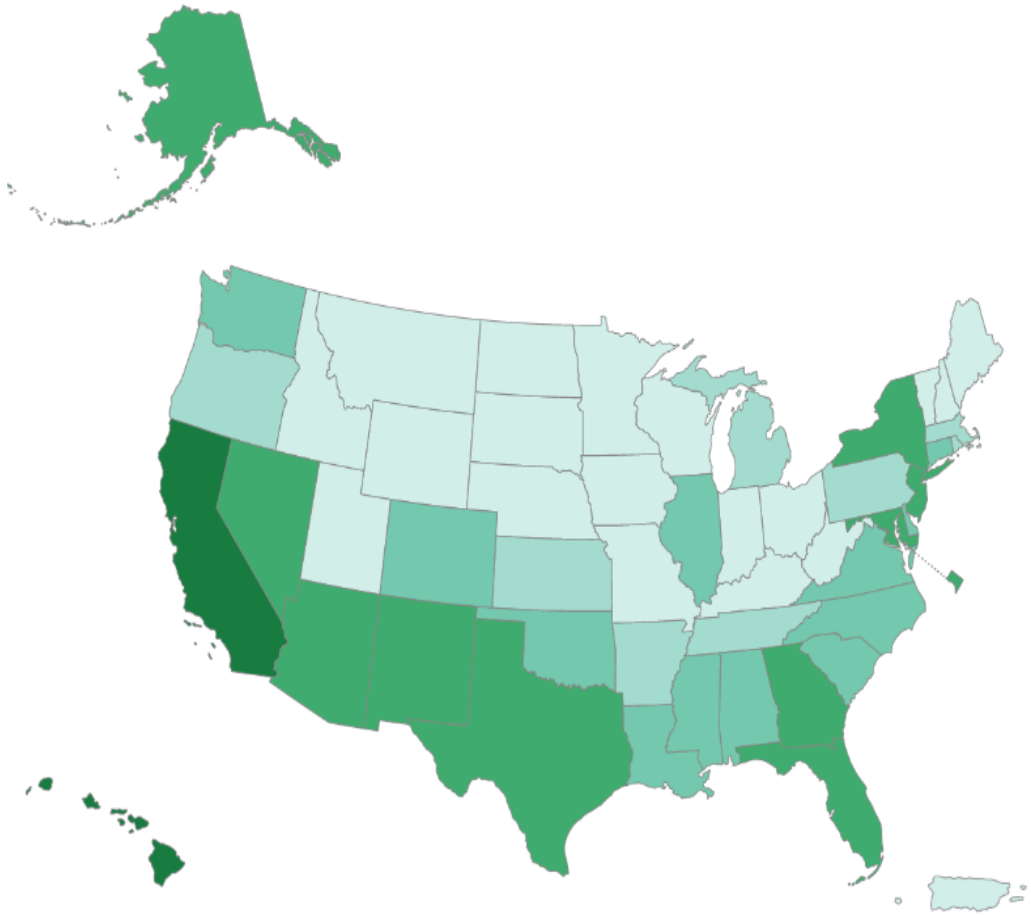
Alabama

Change the year
- 2020
- 2010

Diversity Index
- 65.0% or more
- 55.0% to 64.9%
- 45.0% to 54.9%
- 35.0% to 44.9%
- Less than 35.0%

Diversity Index by State: 2010

United States: 54.9%



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Equality vs Equity Examples

Equality	Equity
Cutting the budget and operating hours for all clinics in the same amount	Assessing utilization of the clinics and cutting budget and hours based on need
Conducting patient education at all clinic locations using printed materials in English and having speakers who only speak English where as the primary language in various communities speaks other languages	Conducting patient education at all clinic locations using printed materials that are tailored to multiple languages based on community needs

Measuring Health Disparity [4]

- Race
- Ethnicity
- Education
- Income level
- Language
- Age
- Sexual orientation
- Gender identity
- Address
- Culture

Which U.S. Population Groups Experience Cancer Health Disparities?

According to the National Cancer Institute cancer health disparities in the United States are adverse differences in cancer measures such as number of new cases, number of deaths, cancer-related health complications, survivorship and quality of life after cancer treatment, screening rates, and stage at diagnosis that exist among certain population groups including:

racial and ethnic minority groups;

individuals of different ancestry;

individuals of low socioeconomic status;

individuals with disabilities;

individuals who lack or have limited health insurance coverage;

residents in certain geographic locations, including rural areas;

members of the lesbian, gay, bisexual, and transgender community;

immigrants;

refugees or asylum seekers;

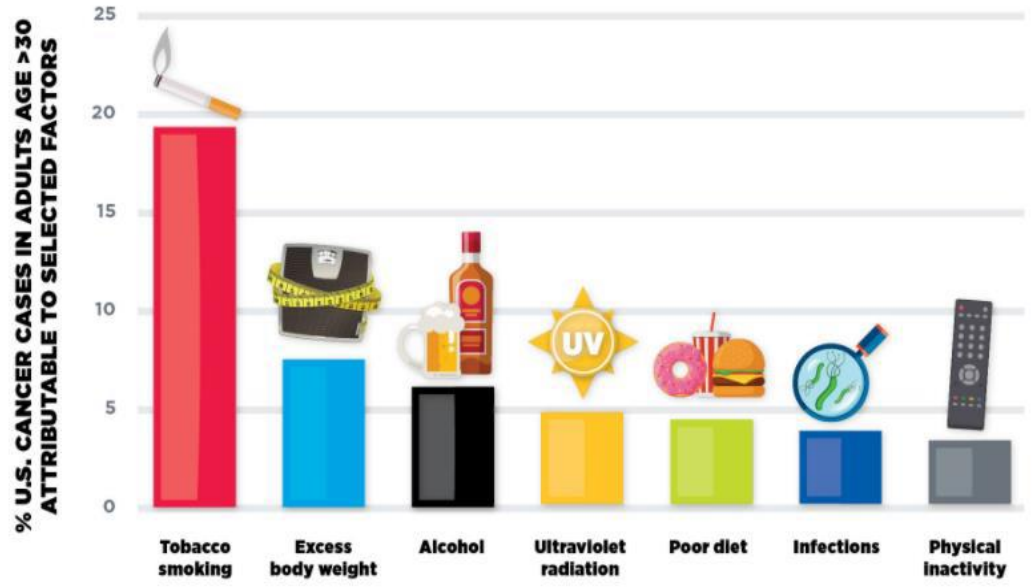
adolescents and young adults; and

the elderly.

American Association for Cancer Research (AACR) Cancer Disparities Progress Report 2020

Avoidable Cancer Risk Factors

FIGURE 6 INCREASING CANCER RISK



Research has identified numerous factors that increase an individual's risk for developing cancer. By modifying behavior, individuals can eliminate or reduce many of these risks and thereby reduce their risk of cancer. Developing and implementing additional public education and policy initiatives could help further reduce the burden of cancers related to preventable cancer risk factors.

American Association for Cancer Research (AACR) Cancer Progress Report 2020

DISPARITIES IN THE BURDEN OF AVOIDABLE CANCER RISK FACTORS

There are considerable disparities in the exposure to avoidable cancer risk factors among certain segments of the U.S. population, such as:

5 TIMES LESS LIKELY	Individuals with a graduate degree are more than **5 times less likely** to smoke cigarettes than those with a high school education or less.
1.5 TIMES LESS LIKELY	Heterosexual individuals are **1.5 times less likely** to smoke cigarettes compared to LGBT individuals.
57% vs **40%**	Prevalence of obesity is higher among Black women (57%) compared with white women (40%).
31% vs **23%**	Hispanics (31.7%) have the highest prevalence of physical inactivity, followed by non-Hispanic Blacks (30.3%) and non-Hispanic whites (23.4%).
HIGHEST DEATH RATES	Non-Hispanic American Indian/Alaska Natives have the highest alcohol-related death rates among all racial and ethnic groups.
SUNSCREEN USE	Only 6% of non-Hispanic Black and 24% of Hispanic fifth-graders reported using sunscreens compared with 45% of non-Hispanic whites.
57% vs **47%**	Adolescents living in metropolitan areas are more likely to be up to date with HPV vaccination (57%) compared with those in nonmetropolitan areas (47%).

American Association for Cancer Research (AACR) Cancer Progress Report 2020

U.S. Cancer Disparities at a glance

111% and 39% HIGHER RISK	African American men and women have a **111 percent and 39 percent higher risk of dying from prostate cancer and breast cancer**, respectively, compared with their white counterparts (4).
20% and 38% MORE LIKELY	Hispanic children and adolescents are **20 percent and 38 percent more likely to develop leukemia** than non-Hispanic white children and adolescents, respectively (5).
TWICE AS LIKELY	Asian/Pacific Islander adults are **twice as likely to die from stomach cancer** as white adults (6).
TWICE AS LIKELY	American Indian/Alaska Native adults are **twice as likely to develop liver and bile duct cancer** as white adults (6).
3.5X HIGHER	Men living in Kentucky have **lung cancer incidence and death rates that are about 3.5 times higher** than those for men living in Utah (7).
<HALF AS LONG	Patients with localized hepatocellular carcinoma, the most common type of liver cancer, who have no health insurance have **overall survival that is less than half as long** as those who have private health insurance (8 months versus 18 months) (8).
35% HIGHER	Men living in the poorest counties in the United States have a **colorectal cancer death rate that is 35 percent higher** than that for men living in the most affluent counties (6).
70% MORE LIKELY	Bisexual women are **70 percent more likely to be diagnosed with cancer** than heterosexual women (9).

Social Determinants of Health

Integrating SDOH in to the Cancer Experience

Overview

- Current Problems
- How does SDoH fit in?
- Purpose and Goal
- Objectives
- Assumptions/Barriers
- Current workflow
- Screening Tools/Comparisons
- Selection of SDoH Questions/Resources
- New Workflow
- Next Steps

Current Problems

- Retrospective identification of socioeconomic issues with patients
- Patients are losing employer-sponsored health insurance, source of income, unable to afford co-pays and medication.
- Patients with socioeconomic needs are not always identified or addressed due to not having a more standardized and prospective screening process
- Lack of Identification and Interventions results in:
  - Treatment delays and complicated health outcomes
  - Medication Adherence/Adverse events/Appointment Compliance
  - Decreased ability to access care
  - Decreased ability to satisfy patient financial obligations

What are Social Determinants of Health

- **<u>Social Determinants of Health</u>**: are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes.(1)
  - …"Recent estimates attribute 10 to 20 percent of health outcomes to medical care, 30 percent to genetics, 40 to 50 percent to behavior, and 20 percent to the social and physical environment"….(2)
  - …" Other developed countries spend about seven percentage points less of their gross domestic product (GDP) on health care, but they have better health outcomes, on average, including a higher life expectancy, lower infant mortality rate, and a lower chronic disease burden."…(3)
  - …"What determines someone's health is a combination of genetic predisposition, behaviors, the medical services received, and the social and physical environment."…(4)

How does SDoH fit in?

- Patients may not know to discuss non-medical issues with their physician
- Prospective SDoH questionnaires will prompt patients to discuss their needs.
- SDOH status of a patient can change.
  - Example: job loss, housing instability, food security, access to reliable transportation
- Peer Reviewed/Validated questionnaires exist for aligning identification of SDoH with locally available resources
- Statistically Model SDoH Identifications and Interventions against Outcomes (Support Predictability studies)
- Statistical Correlations for At Risk (Total Cost of Care/Episode/Bundled/ Capitation) contracts against SDoH data and initiatives

SDOH Screening Tools

PRAPARE Tool: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences. [5]

AHC Health-Related Social Needs Screening Tool [6]

Social Needs Screening Tool: The EveryONE Project [7]

Comparison of SDoH Screening Tools

	PRAPARE Tool	AHC Health-Related Social Needs Screening Tool	EveryOne Project Social Needs Screening Tool
Organization	National Association of Community Health Centers	CMC Accountable Health Communities	American Academy of Family Physicians
Number of Questions	20	26	15
Housing. Finances Education. Child Care Employment. Food Transportation. Utilities Personal Safety. Stress	X	X	X
Family/Community Support Physical Activity Substance Use Disabilities		X	
Personal Characteristics Veteran Status Language Insurance Status	X		
Website	https://www.nachc.org/wp-content/uploads/2018/05/PRAPARE_One_Pager_Sept_2016.pdf	https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf	https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf

Selected Social Determinants

- Housing
- Utilities
- Transportation
- Food & Nutrition
- Family & Community Support
- Physical Activity
- Substance Use
- Personal Safety
- Child Care
- Finances
- Stress
- Education
- Employment
- Disabilities
- Language Barrier

Example of Resources Provided by Nurse Navigators/Care Coordinators

Housing	Transportation	Stress

• Ballard House – we fill out paperwork
• Hilton Hotel Medical Center
• Residence Inn Marriott
• Latitude Medical Center
• CarePatrol assisted living, personal care homes
• Liaisons for placement and temporary housing
  • Personal care homes
  • Nursing homes
  • LTAC
  • SNF
  • Assisted living facilities
  • Local realtors – low cost options
• Local charities
	• COA/CancerCare Patient Assistance Transportation Program
	• ACS
	• Red Cross
	• MTM (Medicaid) - Texas Non-Emergency Medical Transportation
	• Tean Pus
	• Texas Health Spring
	• Work with FINCO
	• Ambulatory transport/WC transportation services
	• List of online Organizations
		• Flyer Packet
		• Individualized list based on location (online/in-person)
		  • Support groups
		  • Church groups and religious organizations
		  • Breast cancer support groups
		• Local organizations and support groups
		  • American Cancer Society, Leukemia Lymphoma Society, Livestrong, Reel Recovery, Susan B Komen Foundation, Leukemia Texas

- Important to compile resources at the national, regional, and local levels
  - Non-Profit Foundations
  - Payor Resources – Acceleration of SDOH resources due to COVID
  - Employer sponsored benefits

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The Cancer Patient Journey

Upstream Factors Affect Downstream Factors

Pre-Diagnosis → Early Diagnosis → Cancer Diagnosis Confirmed → Treatment Plan → Survivorship Surveillance → Back to Work Hospice

Peri-Diagnostic Period

- Wellness
- Behavioral health
- Pre Screening
- Social determinants of health
- Genetic counseling
- Health Disparities

Post Diagnosis

- Treatment pathways
- Surgery, imaging, pathology, genetic testing
- Management of inpatient, ER admissions

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Oncology Consultants HOPE Initiative

Purpose

- 100% screening rate for new and current patients in identifying social determinants of health and socioeconomic needs.
- Prospectively identify patients with unmet social needs or a change in financial stability.
- Screen for social determinants for **which we can provide resources**
- If a need is identified and the patient wants it to be addressed, practice will:

1) Provide resources, referrals, assistance programs

2) Follow up with the patient to see if that need was successfully addressed.

Goals (Measurable)

Increase % of patients screened for SDOH and financial need

Increase % of patients screened positive and are referred to resources

% of patients that have successfully addressed an identified SDOH challenge.

Turnaround time to address social needs.

Increase in financial assistance granted to patients

Increase ability for patient to satisfy financial obligations

Assumptions and Barriers

- Assumptions
  - Less turbulent patient experience
  - Increase patient access to care
  - Increase patient satisfaction
- Barriers
  - Implicit bias
  - Not having a follow-up process
  - Ensuring patients use these resources and are satisfied with resources provided

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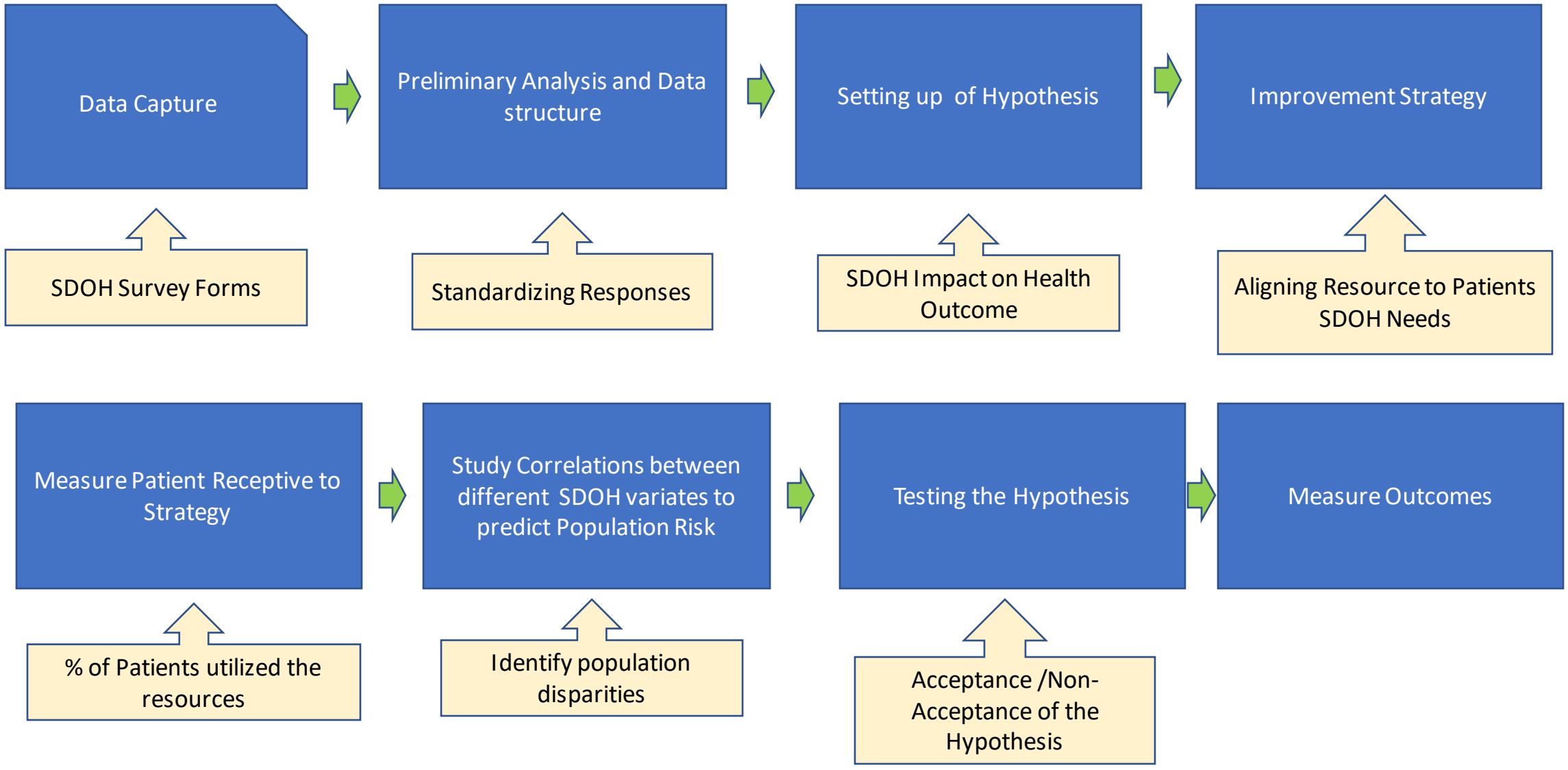
STUDY - SDOH IMPACT on HEALTH OUTCOME and Identify Population Disparities based on location



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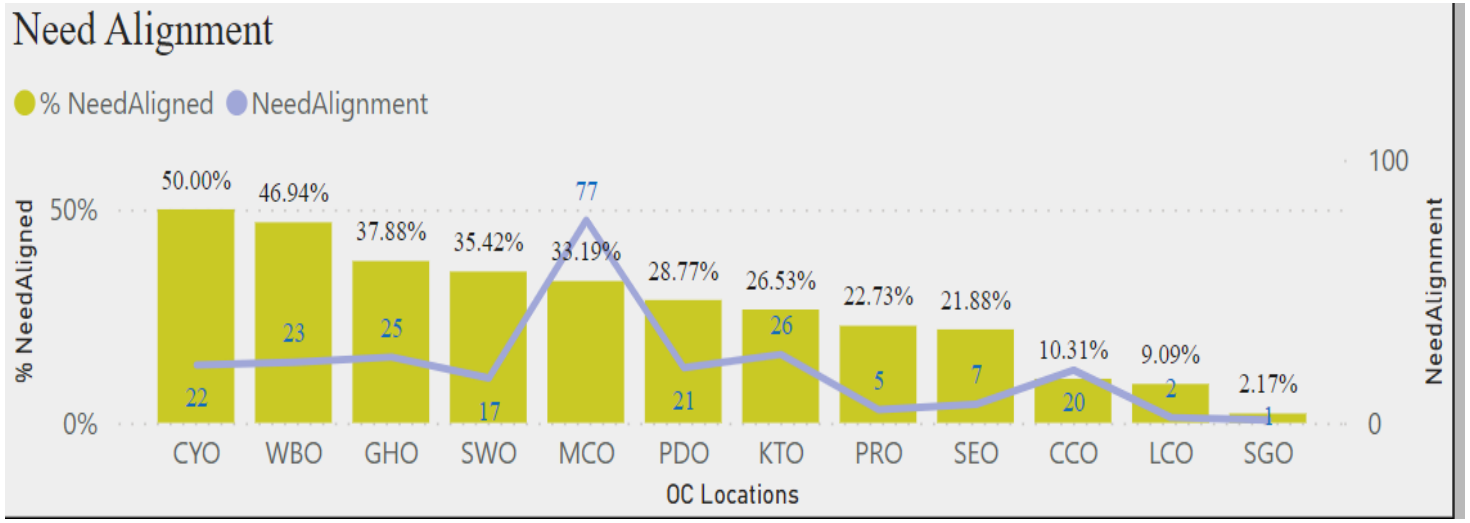
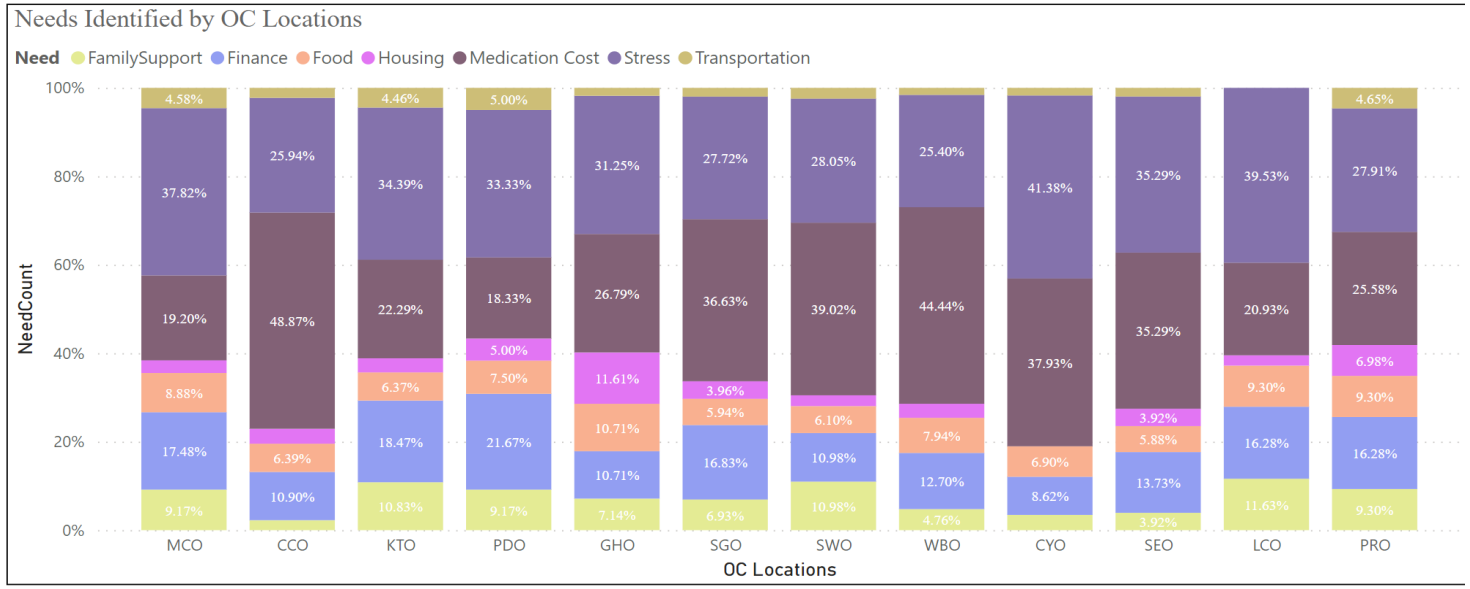
PowerBI Dashboard Initial Results





Thank You!

Questions?

References

1. https://www.cdc.gov/socialdeterminants/index.htm)
2. https://www.americanactionforum.org/research/understanding-the-social-determinants-of-health/#:~:text=Recent%20estimates%20attribute%2010%20to,the%20social%20and%20physical%20environment.
3. White et al. Health Cost Primer: Explaining Medical Cost Trend. Council for Affordable Health Coverage Papanicolas et al. Health Care Spending in the United States and Other High-Income Countries.
4. http://www.ncsl.org/portals/1/documents/health/HealthDisparities1213.pdf
5. PRAPARE Tool: Protocol for Responding to and Assessing Patient Assets, Risks, and Experienceshttps://www.nachc.org/wp-content/uploads/2018/05/PRAPARE_One_Pager_Sept_2016.pdf
6. The AHC Health-Related Social Needs Screening Toolhttps://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
7. Social Needs Screening Tool (AAFP) https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf