Cancer Health Disparities; Challenges and solutions through SDoH assessment and actions

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- CEO, Carolina Blood and Cancer Care
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AACR Cancer Disparities Progress Report 2020

34% of cancer deaths among all U.S. adults ages 25 to 74 could be **prevented if socioeconomic disparities were eliminated** (45).

U.S. Cancer Health Disparities at a Glance

Adverse differences in numerous measures of cancer burden exist among certain population groups in the United States. Examples of such disparities include:

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).

Eliminating health disparities for racial and ethnic minorities from 2003 to 2006 would have reduced

Direct medical costs by:
$230 BILLION

Indirect costs associated with illness and premature death by:
>$1 TRILLION

As of 2018, nearly **80 percent** of individuals included in genome-wide association studies—the most common type of research that detects genetic alterations that are associated with disease risk—**were of European descent; 10% were Asian, 2% African, 1% Hispanic, and less than 1% other population groups** (92).

DEATH RATES*

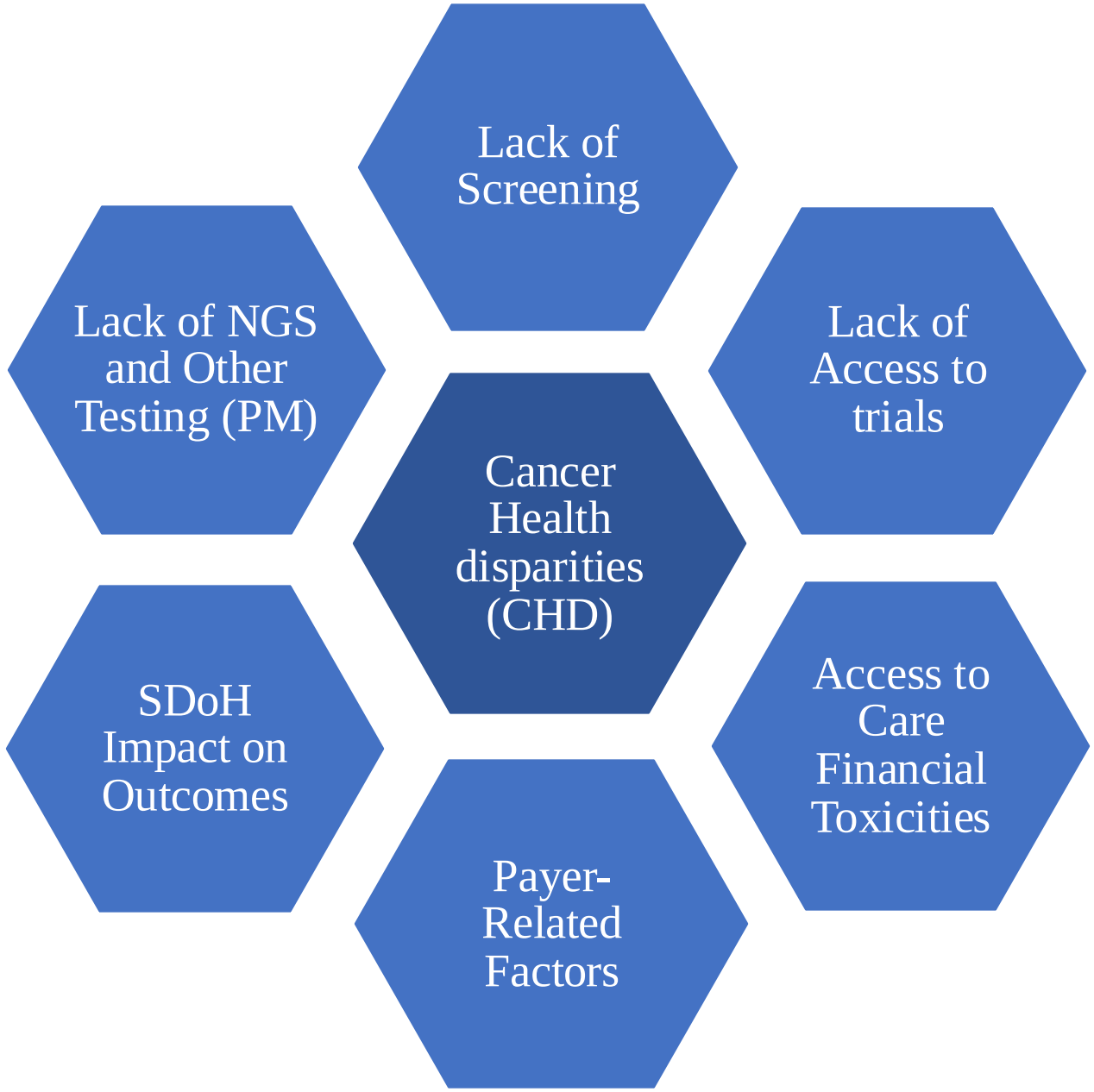
Cancer Type	African Americans	Whites	Rate Ratio
Prostate, males	38.4	18.2	2.11
Stomach	5.3	2.6	2.04
Multiple myeloma	6.0	3.0	2.00
Cervix uteri, females	3.1	2.2	1.41
Breast, females	27.3	19.6	1.39
Colorectal	18.3	13.4	1.37
Liver and intrahepatic bile duct	8.5	6.3	1.35
Pancreas	13.3	11.0	1.21
Lung and bronchus	40.2	39.3	1.02
Kidney and renal pelvis	3.4	3.7	0.92

*Both sexes unless otherwise specified

Data from: SEER Cancer Statistics Review 1975-2016 (Howlader N, Noone AM, Krapcho M, Miller D, Brest A, Yu M, Ruhl J, Tatalovich Z, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA (eds). SEER Cancer Statistics Review, 1975-2016, National Cancer Institute. Bethesda, MD, https://seer.cancer.gov/csr/1975_2016/, based on November 2018 SEER data submission, posted to the SEER website, April 2019.

Our limited knowledge of cancer biology in racial and ethnic minorities diminishes the potential of precision medicine in these populations.

Summary of Factors Leading to Disparities



NOLA PATIENT INTAKE FORM/Cancer screening/SDOH/Cognitive assessment needs

TODAYS DATE	Chart No.	
FIRST NAME	LAST NAME DOB:	

1.	What is your country of birth: USA, including Puerto Rico / Other			
2.	How many years have you lived in the United States			
3.	WHAT IS YOUR RACE?			
4.	What is your Gender/sexual orientation: Male / Female/ Transgender /Prefer not to identify			
5.	Sexual orientation: heterosexual/bisexual/LGBT/prefer not to identify			
6.	EDUCATION status	Less than High school/high school/Undergraduate/Graduate/Doctorate		
7.	WHAT IS YOUR MARITAL STATUS?	Married/living as married/Widowed/ Divorced/ Separated/ Never married/ Other		
8.	ANNUAL INCOME? (household)	< than $25,000/ $25,000-$49,999/ $50,000-$74,999/ $75,000-$100,000/$100,000-149,999/$150k-$199,999/ $200,000 or more How many members live on this income		
9.	HOW OFTEN DO YOU FEEL THIS	I DON'T HAVE ENOUGH MONEY TO PAY MY BILLS NEVER / RARELY/ SOMETIMES/OFTEN/ALWAYS		
10.	EMPLOYMENT	FULL TIME/PARTIME/ UN EMPLOYED/RETIRED/SELF EMPLOYED/STUDENT		
11.	IF SELF- EMPLOYED (OR EMPLOYED-FIELDS	Sales/ IT/Hardware Software/Transportation/Homemaker/education/ clergy/ healthcare /hospitality		

Access to healthcare/Transportation

	Do you have a doctor or clinic for your regular care? ***If no where do you get your care***	Yes	No	FQHC/ER/Urgent care
	In the past year, was there a time when you needed health care but could not get	Yes	No	If not why
	Do you have any problems with transportation to your health care visits?	Yes	No	

Language/literacy/Mental Health

	Are you able to communicate with your doctor in your language?	Yes	No	Preferred language
	Do you have cell phone/ access to the internet, if yes, do you use for visit	Yes	No	
	Do you often feel anxious, depressed, or worried? Are you experiencing any memory lapses or forgetfulness? Do you ever feel confused?	Yes	No	If yes, cognitive assessment
	Are you under care from a psychologist and/or mental health counselor	Yes	No	
	Are you on any medications like anti anxiety, sleep or opioids	Yes	No	

Food insecurity

	In the past 12 months has there been a point where the food you bought just didn't last and you didn't have money to get more?			If yes, is it often or sometimes
	Within the past 12 months, have you worried that your food would run out before you got money to buy more			If yes, is it often or sometimes

Family responsibilities for family members/friends/social support/community activity

	Are you responsible for child/elder care in your family? Do problems getting childcare make it difficult for you to work/study	Yes	No	
	Do problems getting childcare make it difficult for you to get healthcare?			
	Do you have friends or neighbors support	Yes	No	

Housing: access, utility services, household density

	Do you have any of these problems with your housing? Pest infestation/Mold/ Lead paint or pipes/ Inadequate heat/ Oven or Stove not working/ Water Leaks/ No or non-function smoke detector/ None of the above	Yes	No	If yes, how often
	How many people live in your house/apartment?			
	Do you exercise	Yes	No	
	Do you drink alcohol	yes	No	If yes; daily or a social drinker
	Do you smoke	yes	No	Pack years
	Do you take any recreational drugs	yes	No	

PERSONAL AND FAMILY HISTORY OF CANCER

12. FAMILY H/O	CANCER	(WRITE IN) TYPE OF CANCER?	AGE/YEAR AT DIAGNOSIS
a. SELF	Yes/ No	_____	_____ or Don't know
b. Sibling	Yes/ No	_____ or Don't know	_____ or Don't know
c. Birth mother	Yes/ No	_____ or Don't know	_____ or Don't know
d. Her Parents	Yes/No	_____ or Don't know	_____ or Don't know
e. Her Siblings	Yes/No	_____ or Don't know	_____ or Don't know
f. Father	Yes/No	_____ or Don't know	_____ or Don't know
g. His Parents	Yes/No	_____ or Don't know	_____ or Don't know
h. His Siblings	Yes /No	_____ or Don't know	_____ or Don't know

Principal Illness Navigation (PIN)

Documentation requirements
Informed consent; verbal should suffice
Care plan:
Include cancer, stage and co-morbidity
Mention specific HrSN and SDOH
Any findings from ROS
Assessment and plan to include cancer, stage and co-morbidity, Any findings from ROS
Assessment and plan to include patient-driven goals aiming for remission and/or palliation, reducing symptoms burden
Maintain quality of life, care coordination, monitoring labs and medication side effects on regular basis, care coordination with other providers. Patient and/or family input was considered in preparation of comprehensive care plan.
Use CPT code G0023 for initial visit 60-minute time (care plan) and plan for monthly follow up (increment of 30-minute CPT code: G0024). For elaborate information PIN algorithm

Where services can be used

Providing tailored support as needed to accomplish the practitioner's treatment plan—post-chemotherapy or post-office visit follow up for side effects management;
Providing the patient with information/resources to consider participation in clinical trials/research

Identifying or referring patient (and caregiver or family) to appropriate supporting services including community resources for SDOH

Helping the patient contextualize health education, patient's treatment team with the patient's individual needs, goals, preferences and SDOH need(s)

Calling patients to act on abnormal labs, schedule follow-up appointments or additional tests as well as appointment to see another MD
Follow up after an emergency department visit; or discharges from hospitals and/or other healthcare facilities

Health care access/health system navigation: coordinating receipt of needed services as well as scheduling appointment with other healthcare practitioners, providers and facilities; home and community-based service providers and caregiver education

Code	Minimum time per Calendar Month	CY24 Fee Schedule
G0023	60 minutes	Non-Facility(Office) $80.56 Facility $49.60
G0024	Each additional 30 minutes	Non-Facility (Office) $50.26 Facility: $34.62

Community resource health integration

Documentation requirements
Informed consent; verbal should suffice
Care plan:
include cancer, stage and co-morbidity
Mention specific HrSN and SDOH
Any findings from ROS
Assessment and plan to include Assessment and plan to include what resources are provided and which entity; Plan to call monthly
Maintain quality of life, care coordination, care coordination with other providers
Patient and/or family input was considered in preparation of comprehensive care plan.
Use CPT code G0136 once for SDoH ; G0019 for initial visit 60-minute time (care plan) and plan for monthly follow up (increment of 30-minute CPT code: G0020); For elaborate information see CHI algorithm
Even if patient does not need any help, please use G0136 for SDoH assessment once every six months

Zcodes:

Z55 education and literacy: coordinate appropriate health education. Follow common algorithm per central box

Z59 housing and economics: financial assistance, shelter and other OOP costs

Z60 social environment: problems related to social environment. Connect patient to support groups

Z62 upbringing

Z63 primary support group, including family circumstances: coordinate support groups

Z56 employment: connect patient to local resources

Z57: occupational exposure to risk factors: connect patient to local county resources

Code	Minimum time per Calendar Month	CY24 Fee Schedule
G0019	60 minutes	Non-Facility(Office) $80.56 Facility $49.60
G0022	Each additional 30 minutes	Non-Facility (Office) $50.26 Facility: $34.62