CANCER SCREENING IN MINORITY AND UNDERSERVED POPULATIONS

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CEO and Medical Director
Disparities in Cancer Care

The National Cancer Institute (NCI) defines "cancer health disparities" as adverse differences in cancer incidence (new cases), cancer prevalence (all existing cases), cancer death (mortality), cancer survivorship, and burden of cancer or related health conditions that exist among specific population groups in the United States.
African American women have a lower incidence, but a higher mortality, from breast cancer than White women.

<table>
<thead>
<tr>
<th>Racial/Ethnic Group</th>
<th>Incidence</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>127.8</td>
<td>25.5</td>
</tr>
<tr>
<td>African American/Black</td>
<td>118.3</td>
<td>33.8</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>89.0</td>
<td>12.6</td>
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<tr>
<td>Hispanic/Latino</td>
<td>89.3</td>
<td>16.1</td>
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<tr>
<td>American Indian/Alaska Native</td>
<td>69.8</td>
<td>16.1</td>
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<tr>
<td>White</td>
<td>132.5</td>
<td>25.0</td>
</tr>
</tbody>
</table>
Colorectal Cancer

Colorectal Cancer
Incidence Rates* by Race and Ethnicity,† Male, United States, 1999–2013‡§

Rate per 100,000

Year of Diagnosis


All Races White Black A/PI AI/AN Hispanic
Lung and Bronchus Cancer

Lung and Bronchus Cancer
Incidence Rates* by Race and Ethnicity,† Male, United States, 1999–2013‡§

<table>
<thead>
<tr>
<th>Year of Diagnosis</th>
<th>All Races</th>
<th>White</th>
<th>Black</th>
<th>A/PI</th>
<th>AI/AN</th>
<th>Hispanic</th>
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<tbody>
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<td>1999</td>
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</table>

*Rate per 100,000
†Male
‡§United States

Graph showing the incidence rates of lung and bronchus cancer by race and ethnicity from 1999 to 2013.
HPV-Associated Cervical Cancer

Rates by Race and Ethnicity, United States, 2008–2012

<table>
<thead>
<tr>
<th>Race</th>
<th>Rate (per 100,000 women)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>7.1</td>
</tr>
<tr>
<td>Black</td>
<td>9.2</td>
</tr>
<tr>
<td>AI/AN</td>
<td>6.3</td>
</tr>
<tr>
<td>A/PI</td>
<td>6.1</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>7.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.7</td>
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</tbody>
</table>
PREVENTATIVE CARE
Cancer Screening

The USPSTF recommends:

• **Breast** – screening mammography, with or without clinical breast , every 1-2 years for women age 40 years and older

• **Lung** – annual screening with low-dose tomography in adults ages 55-80 who have a 30 pack a year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

• **Colorectal** – screening starting at age 50 and continuing until age 75

• **Cervical** - screening in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years
## Mammography Screening Rates in the U.S.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian (non-Hispanic)</td>
<td>67%</td>
</tr>
<tr>
<td>Black (non-Hispanic)</td>
<td>66%</td>
</tr>
<tr>
<td>White (non-Hispanic)</td>
<td>66%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>63%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>62%</td>
</tr>
</tbody>
</table>

Adapted from American Cancer Society materials
Common Patient Barriers to Colorectal Screening

<table>
<thead>
<tr>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logistics: not understanding what to do</td>
</tr>
<tr>
<td>Lack of time, inconvenience, and lack of transportation</td>
</tr>
<tr>
<td>Distasteful, prolonged bowel preparation (&quot;prep&quot;)</td>
</tr>
<tr>
<td>Embarrassing/humiliating</td>
</tr>
<tr>
<td>Invasive</td>
</tr>
<tr>
<td>Painful/uncomfortable/discomfort</td>
</tr>
<tr>
<td>Cost (e.g., unaffordable copayment/deductible)/lack of insurance coverage</td>
</tr>
<tr>
<td>Taboo topic, uncomfortable to discuss, not discussed openly in public like prostate and breast cancer screening</td>
</tr>
</tbody>
</table>
COMMON PHYSICIAN BARRIERS TO COLORECTAL SCREENING

- Dealing with other urgent medical problems
- Language issues,
- Prior patient refusal of screening
- Physician forgetfulness
- Lack of time,
- No reminders
- Inadequate patient tracking systems.
Motivators to Physicians Recommending Screening

- Patient request
- Patient age between 50 and 59 years
- Physicians' positive attitudes toward screening
- Preventive health visits
- Reminders
- Incentives
Percent of Lung Screening Ordered by PCPs
Risk Assessment/Counseling/Intervention

The USPSTF recommends:

- **BRCA risk assessment and genetic counseling/testing** - primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2).
  - Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

- **Tobacco use counseling and interventions: non-pregnant adults** - clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.
Preventative Medications

The USPSTF recommends the following:

- **Breast Cancer** - clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.

- **Cardiovascular Disease/Colorectal Cancer** - initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.
RALPH LAUREN CENTER
FOR CANCER CARE
Who We Are

- Ralph Lauren Center for Cancer Care (RLCCC)
- Founded in Harlem in 2003 to fight inequity in the American health care system
- Provide compassionate cancer prevention, diagnosis and treatment
Our Patient Population

- Low-income minorities
- 85% African American or Hispanic
- 70% immigrants
- Average household income: $28,000
- High prevalence of obesity, diabetes and HIV
- Drug, alcohol, and tobacco use are common
Services We Provide

- Cancer Screening:
  - Breast
  - Colon
  - Prostate
  - Lung
- Genetic testing
- Individual smoking cessation counseling sessions
- Nutrition counseling and education

*RLLCC is the only community health center in our catchment area of Upper Manhattan providing cancer screening and treatment.*
Additional Patient Services

- Patient care navigation model
- Financial support and counseling
- Psychosocial services
- Food pantry
- Legal services
- Free haircuts for patients
Smoking Cessation Program

- Bristol-Meyers Squibb Foundation
  - 2-year grant starting August 2015 for smoking cessation and lung screening programs

- Program Goals:
  - Provide minority and underserved individuals smoking cessation-related education and counseling
  - Provide access to safe and effective smoking cessation medications

- Benefits of Quitting:
  - After 1 year: reduced risk of heart attack
  - After 2-5 years: risk of stroke may equal that of a nonsmoker’s
  - Within 5 years: risk of certain cancers reduced by half
  - After 10 years: lung cancer risk reduced by half
Lung Screening Program

Goals
• Engage our population with screenings
• Ensure high risk patients are evaluated
• Immediately address abnormal screening results
• Make smoking cessation counseling readily available

Qualifying Criteria
• Individuals between 55-74 years old
• Currently smoke or quit within the last 15 years
• Have smoked 30 or more pack years

Recruitment
• Advertisements
• In-Reach
• Outreach
• Physician Liaison
Pathway to Screening

Patient meets with RLCCC

Patients receives referral for CT scan

Referral made by RLCCC

Referral made by PC

Radiology

Radiology

Results sent to RLCCC

Results sent to PC

Results sent to RLCCC

Results sent to PC
Contact Information

For more information, contact:
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