Best Practices and Innovations

Caring for New Yorkers with Cancer

Friday, June 17, 2022

Virtual Conference

healthfirst®
Health Insurance for New Yorkers

AGENDA

	Friday, June 17, 2022
9:00am–9:10am	**Welcome and Introduction** Jay Schechtman, MD, MBA *Chief Clinical Officer, Healthfirst* Susan J. Beane, MD, FACP *Executive Medical Director, Healthfirst*
	Keynote
9:10am–9:40am	Harold P. Freeman, MD *Professor of Surgery, Emeritus* *Columbia University College of Physicians and Surgeons* **The Role of Patient Navigation in Reducing Health Disparities**
	Panel 1
9:40am–10:20am	Kevin R. Jain, MD *Director, BronxCare,* *Mount Sinai Comprehensive Cancer Care* **Cancer Screening: A Review of Prostate Cancer Screening in the Bronx** Ridwan Shabsigh, MD, FACS *Chairman, Department of Surgery, SBH Health System* **Update on Prostate Cancer with Focus on the Role of the PCP**
10:20am–10:35am	Question and Answer Session
10:35am–10:45am	Break

AGENDA

Panel 2	
10:45am–11:45am	Bradley Pua, MD *Associate Professor of Radiology in Cardiothoracic Surgery* *Chief, Interventional Radiology* *Director, Lung Cancer Screening Weill Cornell Medicine* **Screening On Wheels** Francesca Gany, MD, MS *Chief, Immigrant Health and Cancer Disparities Service, Memorial Sloan Kettering Cancer Center* ***FOOD: Food Insecurity Interventions to Improve Cancer Outcomes** ***Food to Overcome Outcome Disparities** Joseph Ravenell, MD *Associate Professor, Departments of Medicine and Population Health and Medicine* *Associate Dean for Diversity Affairs and Inclusion, NYU Grossman School of Medicine* **Community-Based Approaches to Address Cancer Health Inequities**
11:45am–12:00pm	Question and Answer Session
12:00pm	Final Remarks and Adjournment
Dismiss Session	

Jay Schechtman, MD, MBA

Chief Clinical Officer, Healthfirst

Jay Schechtman, MD, has been with Healthfirst since 1999 and is responsible for all aspects of members' care and quality, encompassing medical and care management, clinical performance outcomes, and pharmacy.

Dr. Schechtman is an industry expert in population health, accountable care, high-risk populations, and integrated products. Dr. Schechtman also serves as the Assistant Clinical Professor in Community and Preventive Medicine at the Icahn School of Medicine at Mount Sinai.

Prior to working at Healthfirst, Dr. Schechtman was a National Medical Director for Magellan Specialty Health and a full-time academic physician at the Mount Sinai Medical Center in New York. He obtained a medical degree from Mount Sinai School of Medicine and an MBA from the combined healthcare management program of Mount Sinai and Baruch College.
Dr. Schechtman is board-certified in rehabilitation medicine and was chief resident at Mount Sinai.

Susan J. Beane, MD, FACP

Executive Medical Director, Healthfirst

Susan J. Beane, MD, FACP, joined Healthfirst in 2009, bringing with her extensive professional experience in managed care. As Executive Medical Director at Healthfirst, Dr. Beane focuses on transforming the delivery of care and optimization of medical outcomes through provider and community partnerships. Her interest and passion is collaboration across the healthcare delivery system to design and implement programs that improve access and equity for Healthfirst members and their communities.

Dr. Beane is a graduate of Princeton University and Columbia University Vagelos College of Physicians and Surgeons.

Harold P. Freeman, MD

Professor of Surgery Emeritus, Columbia University, Past National President of the American Cancer Society, Founder of the Harold P. Freeman Patient Navigation Institute

Harold P. Freeman, M.D., is Founder and President of the Harold P. Freeman Patient Navigation Institute in New York City. He is Professor of Surgery Emeritus, Columbia University. Dr. Freeman previously served as Director of Surgery at Harlem Hospital and Professor of Clinical Surgery at Columbia University College of Physicians and Surgeons. He is a diplomat of the American Board of Surgery and a Fellow of the American College of Surgeons. He is a member of the Institute of Medicine of the National Academy of Sciences. Dr. Freeman is Founder and Chairman Emeritus of the Ralph Lauren Center for Cancer Care and Prevention, and Founder and of the Breast Examination Center of Harlem. Both are programs of Memorial Sloan Kettering Cancer Center. Dr. Freeman was the first Director of the National Cancer Institute, Center to Reduce Cancer Health Disparities, and is a past Associate Director of the National Cancer Institute. Dr. Freeman is a past national president of the American Cancer Society. He was the chief architect of the American Cancer Society's initiative on Cancer in the Poor. The American Cancer Society established the "Harold P. Freeman Award" in 1990 to recognize his work in this area. Dr. Freeman pioneered the Patient Navigation concept and model which addresses disparities in access to timely diagnosis and treatment, particularly among poor and uninsured people. Based on this model, the Patient Navigator and Chronic Disease Prevention Act was signed into law by President Bush in 2005. The American College of Surgeons Commission on Cancer mandated that patient navigation is a standard of care required for cancer center approval beginning in 2015. Dr. Freeman was appointed by Presidents George Bush and Clinton to serve as Chairman of the United States President's Cancer Panel for an 11-year period. Dr Freeman is a Lasker Laureate. He received the Lasker Award for Public Service in 2000 for "enlightening scientists and the public about the relationship between race, poverty and cancer". Dr Freeman was named a "Giant of Cancer Care" in 2015 by OncLive. In 2017 Dr Freeman received the Cura Personalis Award at Georgetown University. This is Georgetown University Medical Center's highest honor which "recognizes a health professional who has made outstanding contributions to human health guided by compassion and service."

Kevin R. Jain, MD

Chief, Medical Oncology/Hematology, BronxCare

Dr. Kevin R. Jain is the Director of the BronxCare Mount Sinai Comprehensive Cancer Care and Section Chief of BronxCare's Medical Oncology and Hematology. Dr. Jain is a highly renowned and experienced specialist in the treatment of gynecologic malignancies, gastrointestinal oncology, lung cancer and lymphoma, among other oncology areas. Prior to joining BronxCare, he served on the faculty of Yale Medical Group at Yale New Haven Hospital.

Bradley Pua, MD,

Associate Professor of Radiology in Cardiothoracic Surgery; Chief, Interventional Radiology; Director, Lung Cancer Screening Program

Dr. Pua obtained a B.S. degree in Chemistry from New York University (NYU) and continued at NYU School of Medicine, where he was awarded his M.D. degree. He completed three years of surgical residency at New York University Medical Center prior to deciding to pursue a career in Interventional Radiology and subsequently completed a fellowship in Interventional Radiology at New York-Presbyterian Hospital-Weill Cornell Campus and Memorial Sloan Kettering Cancer Center. Dr. Pua remained at Cornell to complete his diagnostic radiology residency and was elected to serve as Chief Resident in his final year.

Dr. Pua's clinical expertise is in Interventional Radiology, and he performs a variety of interventional procedures including, but not limited to, arterial embolizations, stent placements, tumor ablations, biopsies, and vascular access. His interests include both pediatric interventions and minimally invasive cancer therapy, with a particular focus on thoracic tumors. He firmly believes in holistic care for disease, beginning with screening and prevention, navigation, and various minimally invasive treatment options.

Ridwan Shabsigh, MD, FACS

Chairman, Department of Surgery, SBH Health System; Professor of Clinical Urology, Weill Cornell Medical School

Dr. Ridwan Shabsigh received his medical degree from Damascus University Medical School in Syria and did his urology residency training in Germany and the USA. He completed a residency in urology and a fellowship in sexual medicine, urinary incontinence, and urologic prostheses at Baylor College of Medicine in Houston, Texas. Prior to joining St. Barnabas Hospital, he worked as a urologist and a faculty member at the department of urology of Columbia University and subsequently as director of urology at Maimonides Medical Center in Brooklyn, New York.

Dr. Ridwan Shabsigh is a Diplomate of the American Board of Urology and a Fellow of the American College of Surgeons. He is an active member of several professional societies. Currently he is the president of the International Society of Men's Health www.ismh.org, the co-chairman of the International Consultation of Men's Health and Infertility www.ICUD-MHI.org, and the vice president of the Foundation for Men's Health www.foundationformenshealth.org.

As a leader in sexual medicine, urology, and men's health, Dr. Ridwan Shabsigh has focused his practice on men's health issues, offering services in comprehensive men's health maintenance, counselling of patients newly diagnosed with prostate cancer, penile prosthesis surgery, medical and surgical treatments for Peyronie's disease, treatments for urinary incontinence including the artificial urinary sphincter and the male sling, and surgical treatments for urethral strictures. In addition to his New York practice, he offers telemedicine consultations (website coming soon).

In research, he has participated in numerous clinical trials on new drugs and devices for the treatment of sexual dysfunctions, Peyronie's disease, testosterone therapy, and benign prostatic hyperplasia. He is a frequent contributor to the medical press and has authored numerous original papers, review articles, book chapters, and editorials in journals such as the New England Journal of Medicine, Lancet, British Medical Journal, Journal of Urology, and the Journal of Men's Health. He published a comprehensive patient education book on the link of sexual health with overall health: Sensational Sex in 7 Easy Steps: The Proven Plan for Enhancing Your Sexual Function and Achieving Optimum Health. His website includes a web-TV health show, the "Dr Ridwan Show, Health Information You Can Use" at www.DrRidwan.com.

Francesca M. Gany, MD, MS

Chief, Immigrant Health and Cancer Disparities Service, Memorial Sloan Kettering Cancer Center

Dr. Francesca Gany is the founding Chief of the Immigrant Health and Cancer Disparities Service at Memorial Sloan Kettering Cancer Center, Co-leader of the Population Sciences Research Program, and Associate Director at MSK for Community Outreach and Engagement. She has served as the PI on several pioneering immigrant health studies and programs in the areas of cancer prevention, treatment adherence and quality of life, social determinants of health, language access, cultural responsiveness, technology and immigrant health, and healthcare access. Her work has led to the development of long-term policy and programmatic changes.

Dr. Gany has a strong interest in cultural and linguistic responsiveness in healthcare. She spearheaded the development of the community-based participatory African Health, Latino Health, and South Asian Health Initiatives. She has led several studies to develop capacity around disease risk reduction through innovative multi-level interventions, disseminated through faith- and community-based organizations, and through Consulates.

She worked with the community to develop the NCI-funded Cancer Awareness Network for Immigrant and Minority Populations (CANIMP), which responds to the disparities in the use of, and participation of immigrants in, cancer prevention, detection, and treatment services, and research. CANIMP works with the West African, Latino, Indian, Pakistani, Bangladeshi, Haitian, Chinese, Korean, and English-speaking Caribbean immigrant communities.

Dr. Gany is a PI on the NCI-funded U54 City College of New York / MSK Partnership for Cancer Research, Training, and Community Outreach, which implements translational research, outreach, and training to address cancer health disparities. She is also PI on the NY Mexican Consulate's Ventanilla de Salud-MSK research program, as well as the NCI-funded Food to Overcome Outcomes Disparities (FOOD) study, which examines the impact of interventions to address food insecurity on treatment completion, quality of life, and depression symptoms in people with cancer. The FOOD program grew out of the Integrated Cancer Care Access Network, a cancer patient navigation program Dr. Gany co-developed.

Prior to joining MSK, Dr. Gany was the founder and Director of the Center for Immigrant Health at the New York University School of Medicine, the NYU Cancer Institute CORE Center (Cancer Outreach, Outcomes and Research for Equity), and of the Health Promotion, Disease Prevention, and Human Migration concentration in the NYU Global Masters of Public Health program.

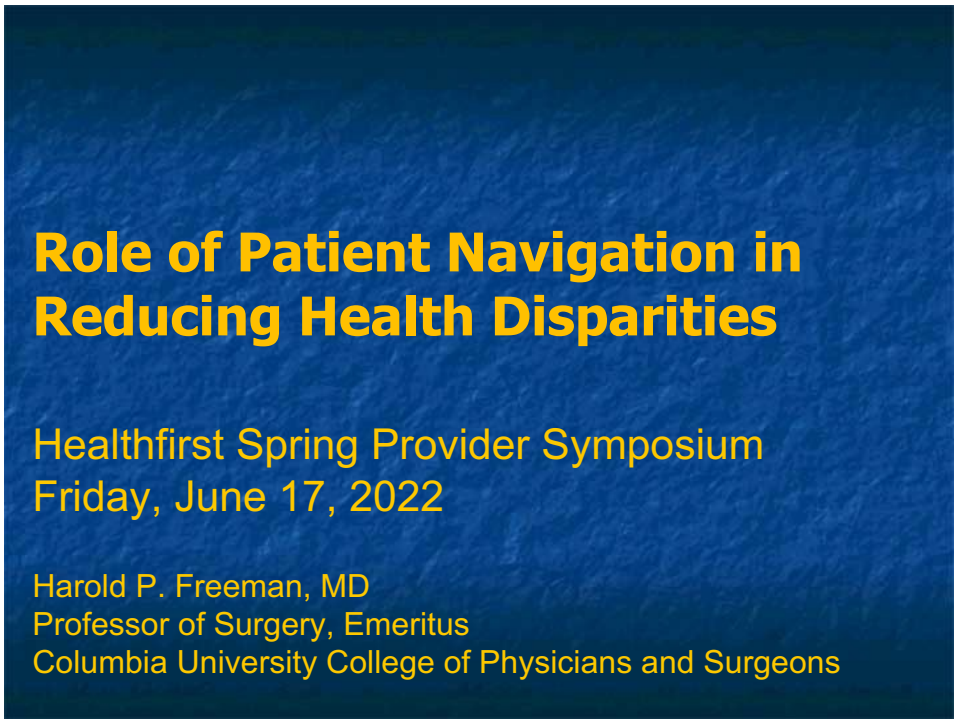
Joseph E. Ravenell, MD

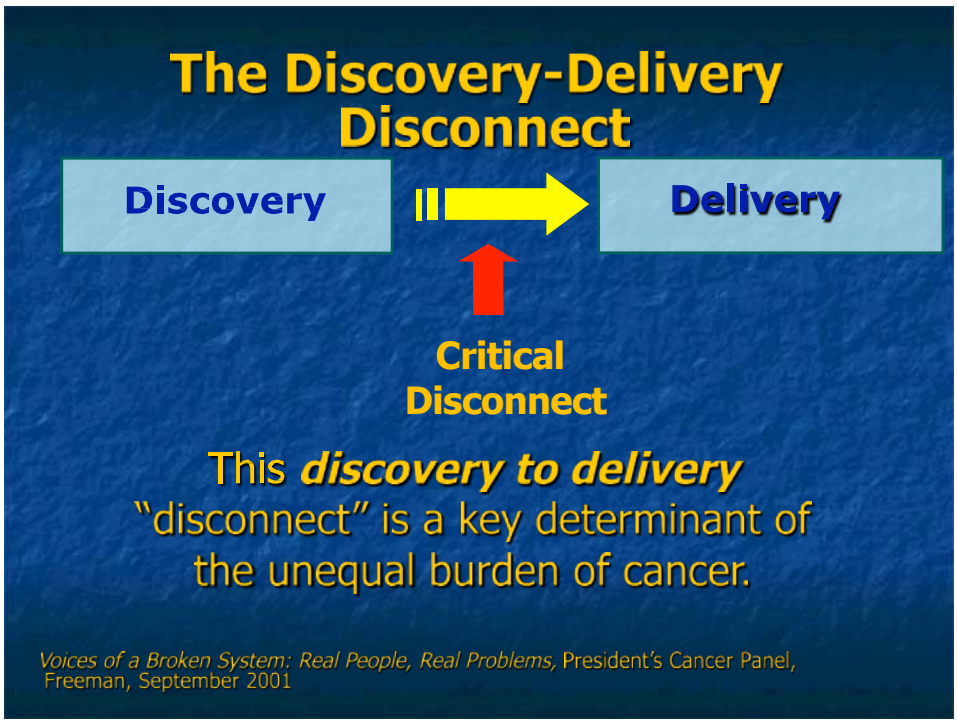
Associate Professor, Departments of Medicine and Population Health, and Associate Dean for Diversity Affairs and Inclusion, NYU Grossman School of Medicine

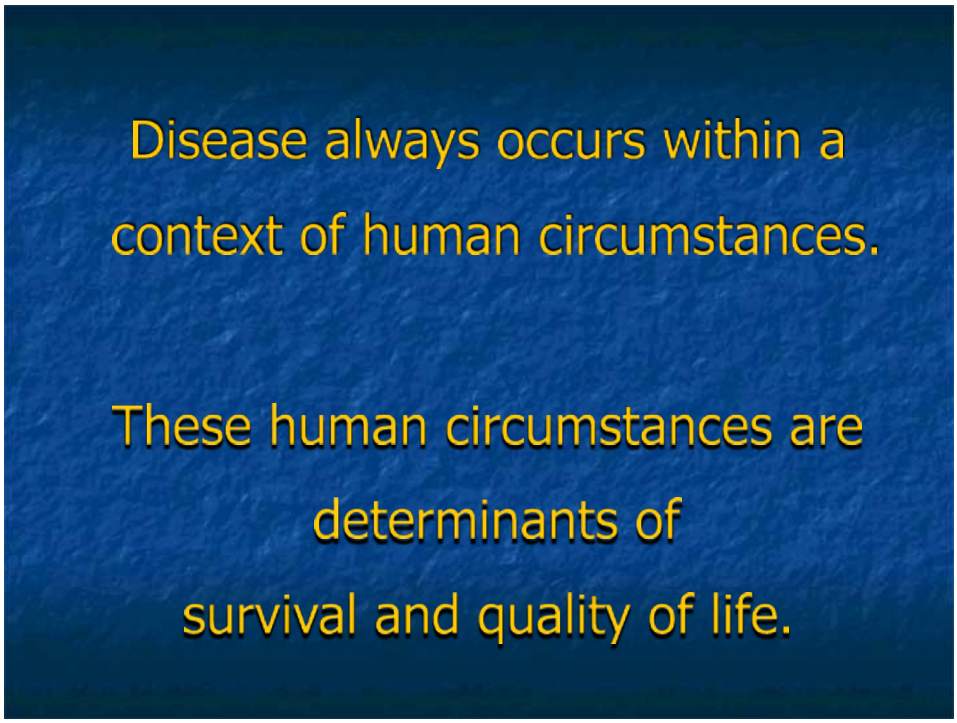
Dr. Ravenell is an associate professor in NYU Langone's Departments of Population Health and Medicine. He obtained his medical degree from the University of Chicago Pritzker School of Medicine, completed his internal medicine residency training at the Hospital of the University of Pennsylvania, and finished a Clinical Epidemiology and Health Services Research Fellowship at Weill Cornell Medical College.

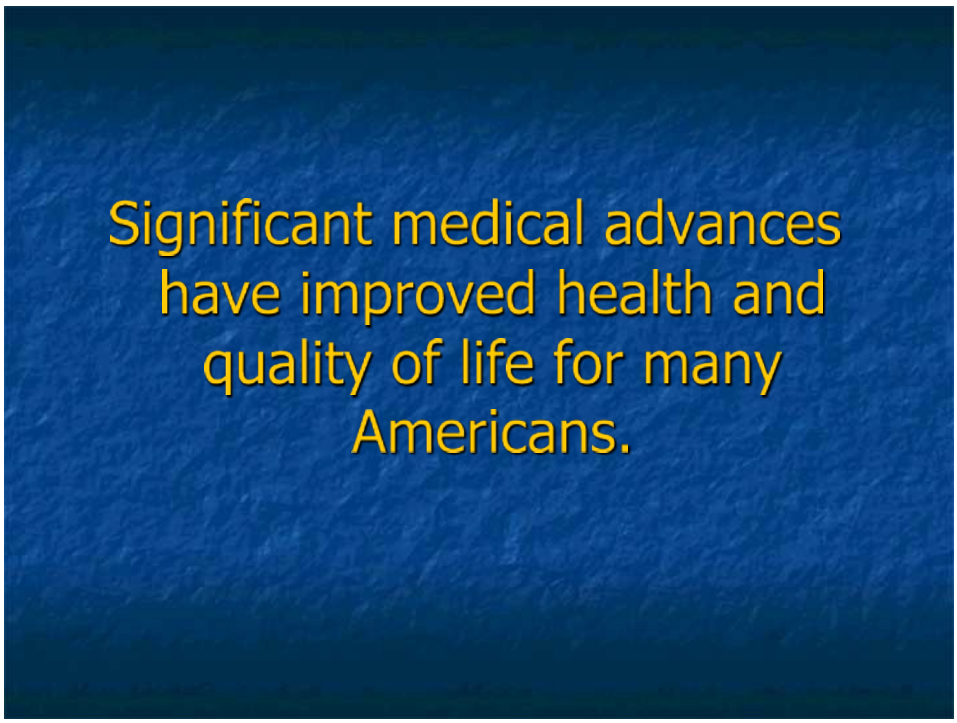
Dr. Ravenell has been a principal investigator of multiple National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) grant–funded clinical trials to test community-based strategies to improve colon cancer screening and cardiovascular disease prevention among Black men in urban settings. This work has led to a research network of more than 200 community-based sites including churches, barbershops, mosques, and social service agencies. Dr. Ravenell's community-based research was the subject of an invited TED talk he delivered in Vancouver, BC, in February 2016, which has received more than a million views. Dr. Ravenell is also an established mentor for students, trainees, and junior faculty seeking careers in academic medicine and health disparities research. He continually cultivates a holistic approach to promoting health equity through research, scholarship, and mentorship.

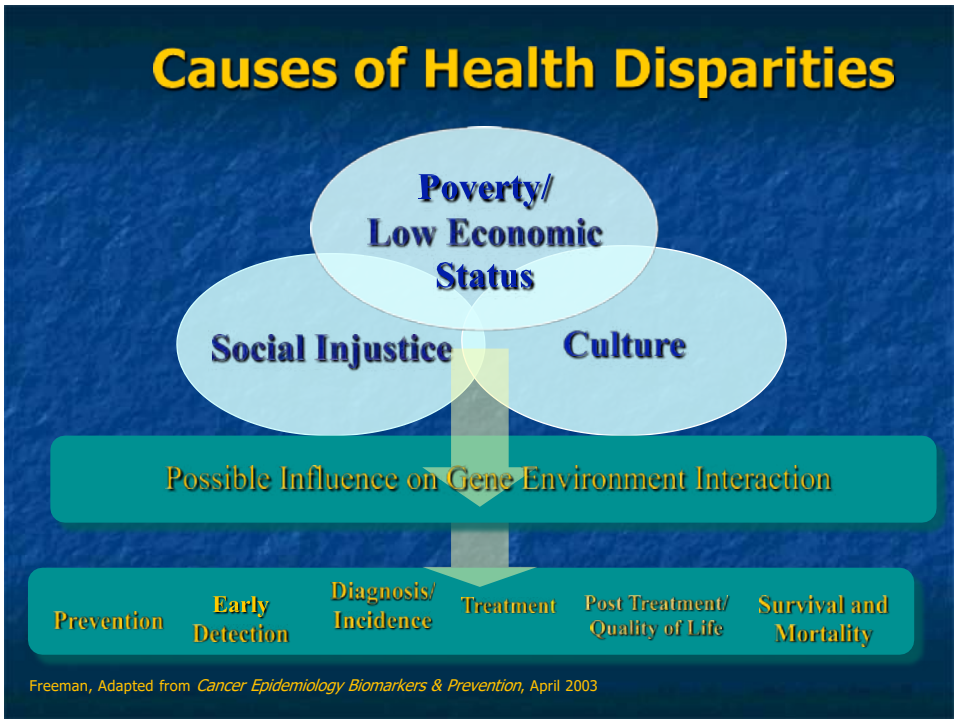
PRESENTATIONS

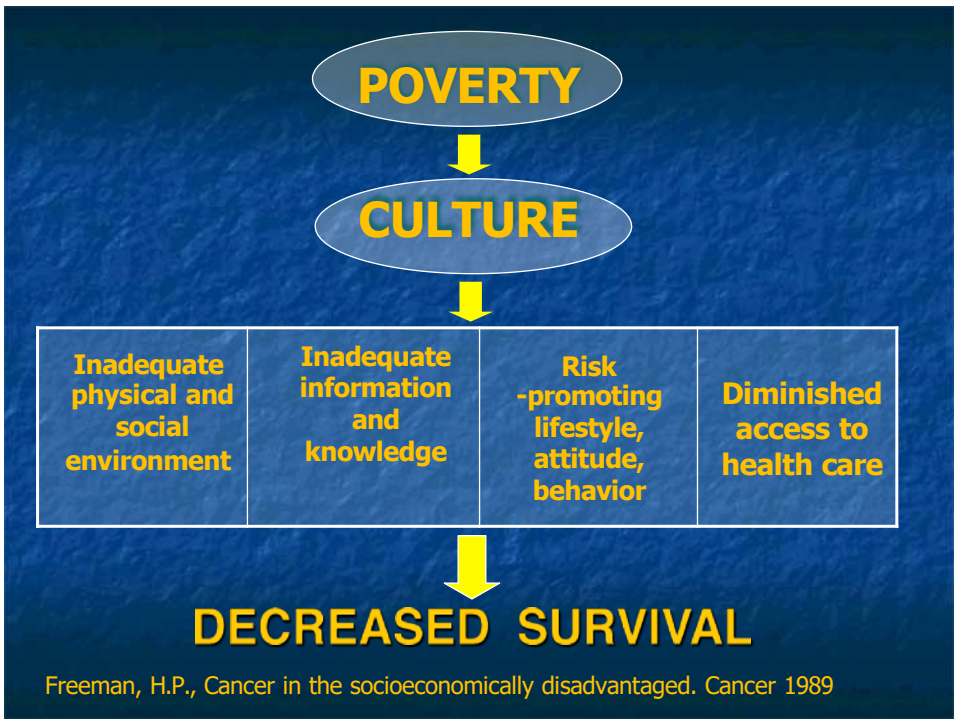




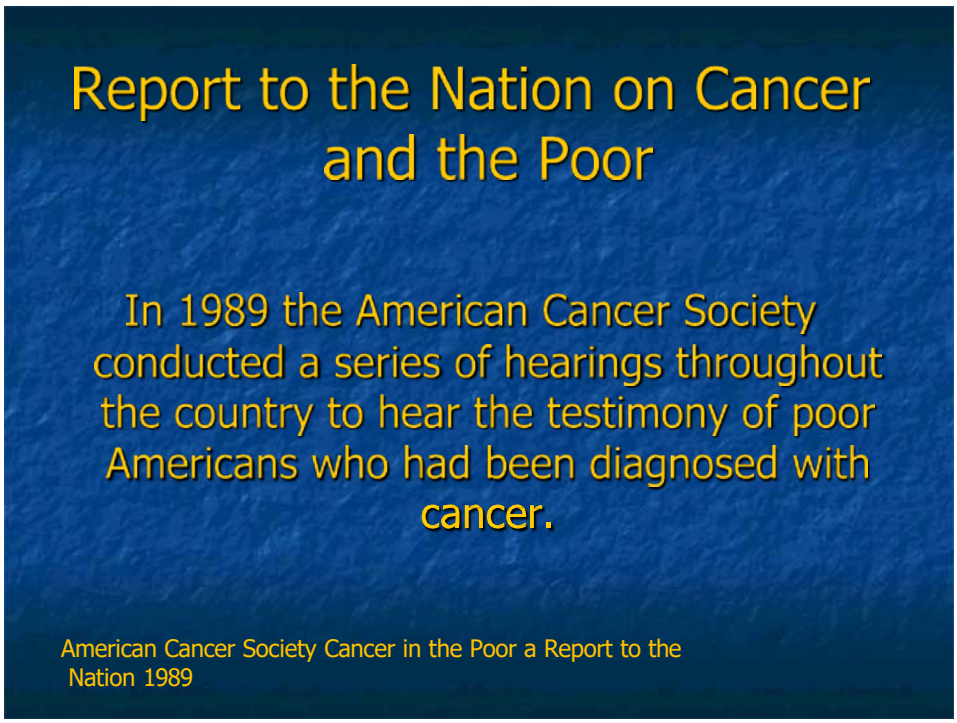

Disease always occurs within a context of human circumstances.
These human circumstances are determinants of survival and quality of life.


Significant medical advances have improved health and quality of life for many Americans.


Causes of Health Disparities
Poverty/ Low Economic Status
Social Injustice
Culture
Possible Influence on Gene Environment Interaction
Prevention
Early Detection
Diagnosis/ Incidence
Treatment
Post Treatment/ Quality of Life
Survival and Mortality
Freeman, Adapted from Cancer Epidemiology Biomarkers & Prevention, April 2003


POVERTY
CULTURE
Inadequate physical and social environment
Inadequate information and knowledge
Risk -promoting lifestyle, attitude, behavior
Diminished access to health care
DECREASED SURVIVAL
Freeman, H.P., Cancer in the socioeconomically disadvantaged. Cancer 1989


Patient Navigation


Report to the Nation on Cancer and the Poor
In 1989 the American Cancer Society conducted a series of hearings throughout the country to hear the testimony of poor Americans who had been diagnosed with cancer.
American Cancer Society Cancer in the Poor a Report to the Nation 1989

Report to the Nation on Cancer and the Poor

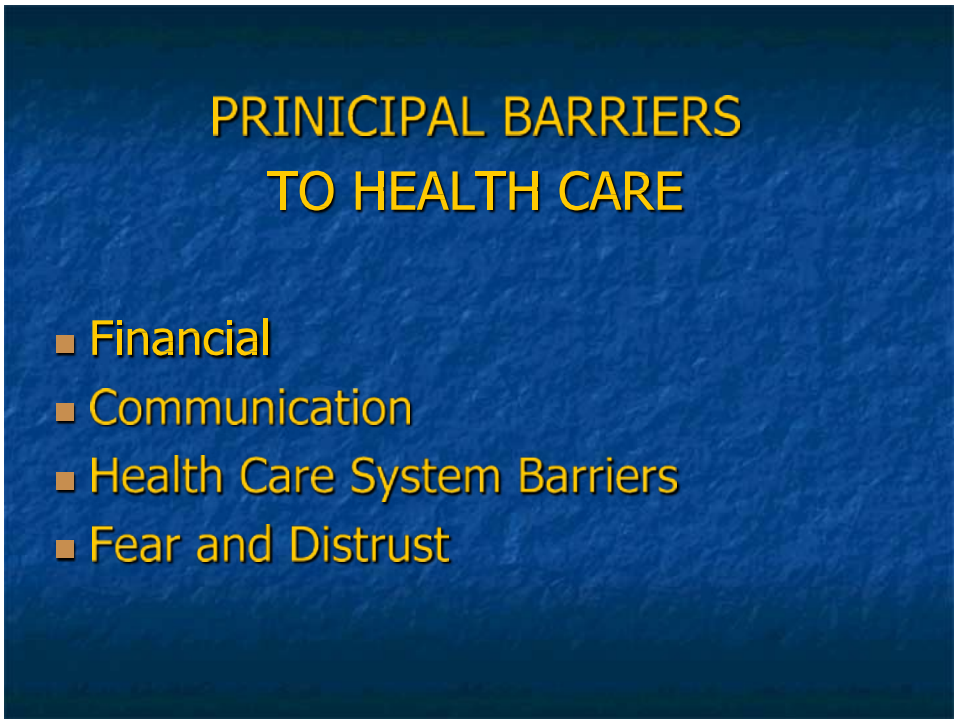
Findings

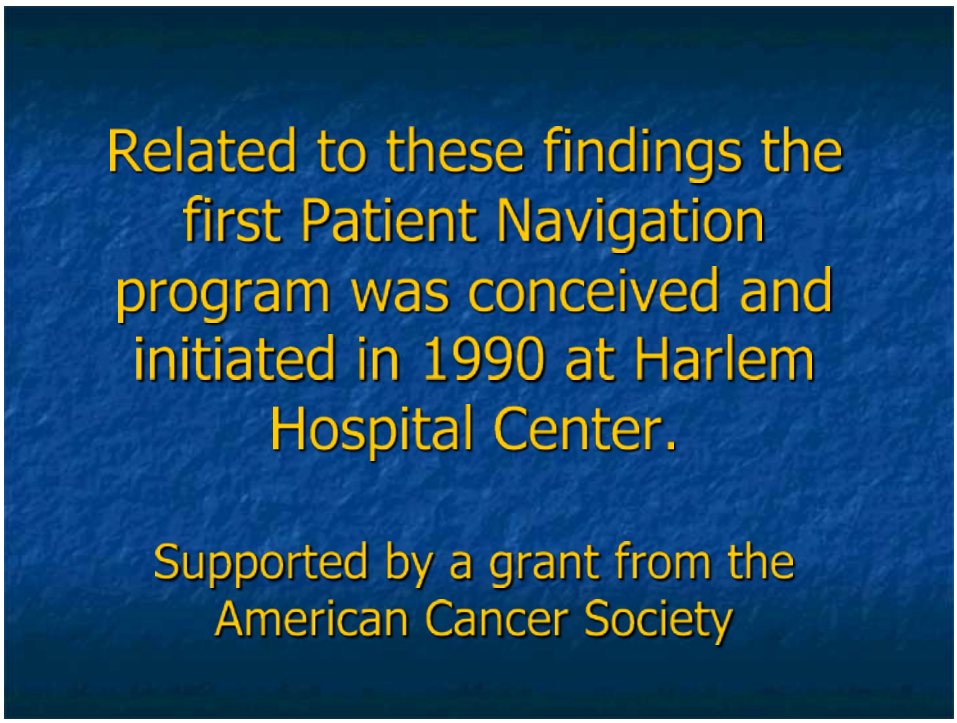
- Poor people meet significant barriers when they attempt to seek diagnosis and treatment of cancer.
- Poor people often do not even seek care if they cannot pay for it.
- Poor people experience more pain and suffering because of late stage disease.

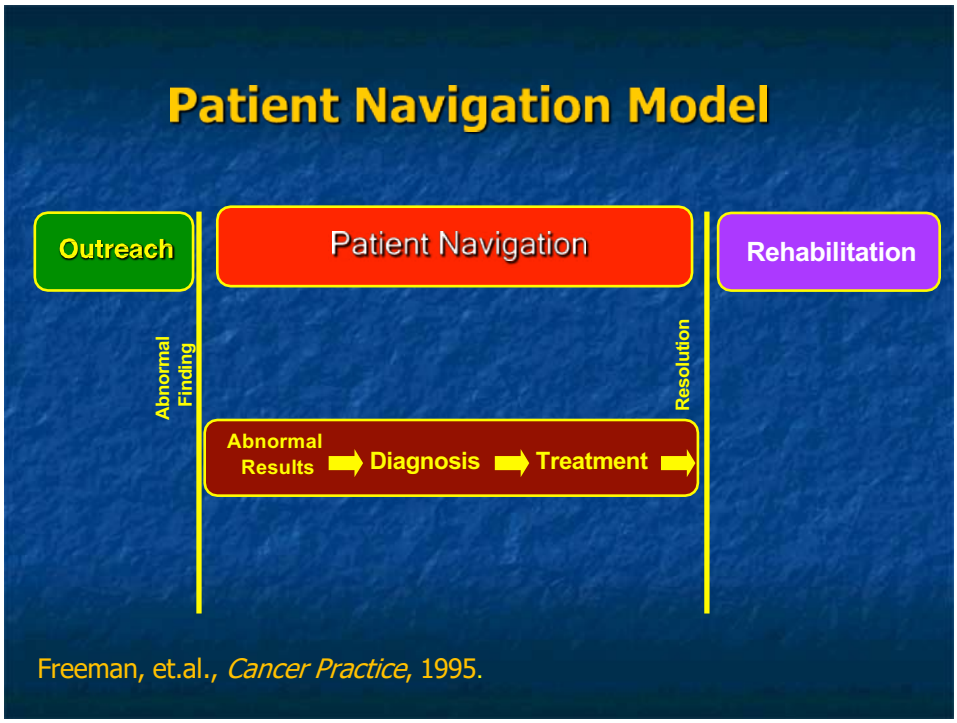
Report to the Nation on Cancer and the Poor, 1989

Findings

- Fatalism about cancer is prevalent among the poor and prevents them from seeking care.
- Poor people and their families must make extraordinary and personal sacrifices to obtain and pay for care.
- Current cancer education programs are culturally insensitive and irrelevant to many poor people.


PRINICIPAL BARRIERS
TO HEALTH CARE
Financial
Communication
Health Care System Barriers
Fear and Distrust


Related to these findings the first Patient Navigation program was conceived and initiated in 1990 at Harlem Hospital Center.
Supported by a grant from the American Cancer Society

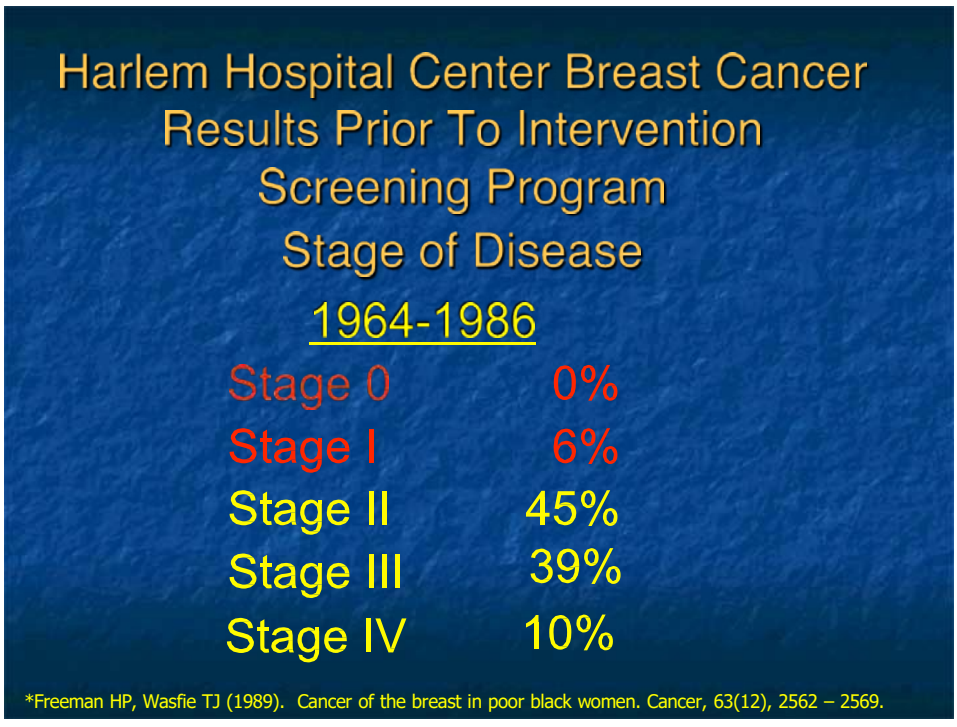


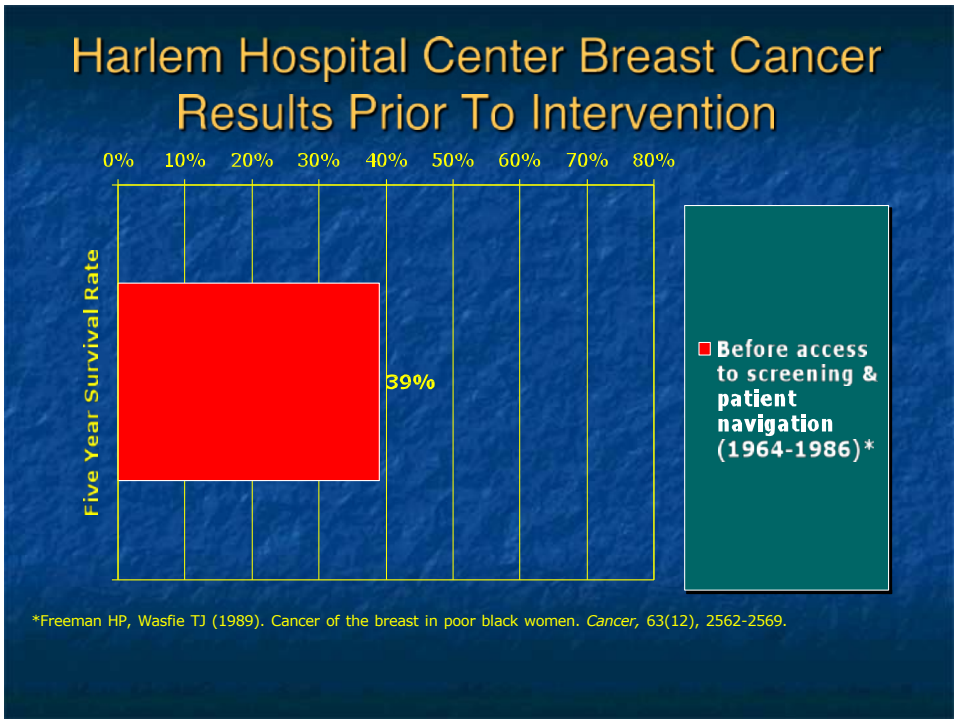
Patient Navigator Model

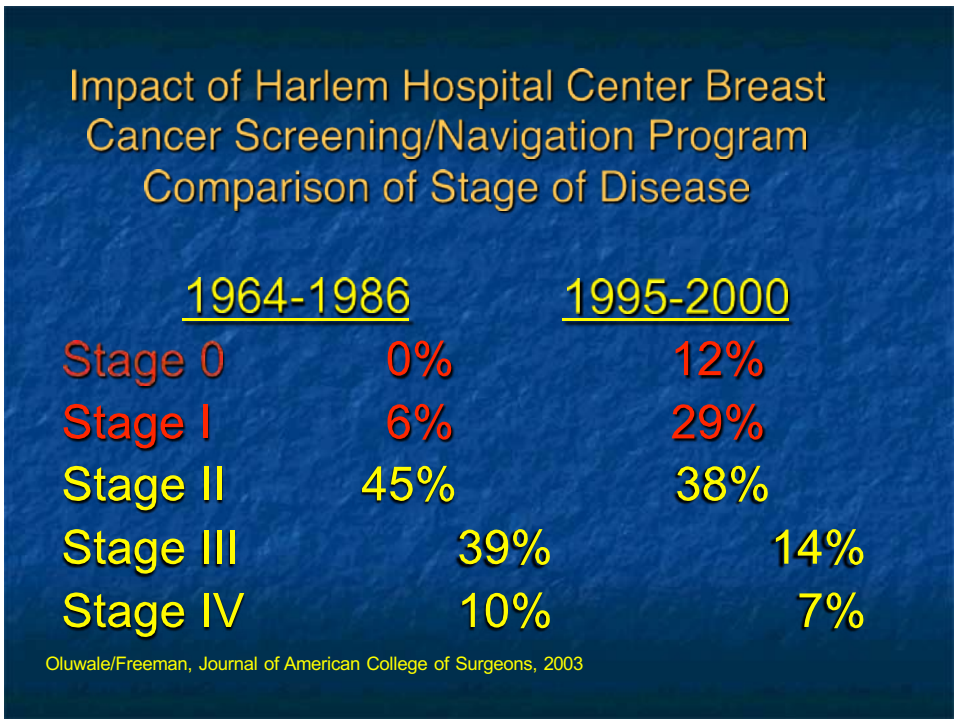
The Patient Navigator Model promotes timely diagnosis and treatment and aims to ensure seamless, coordinated care and services.

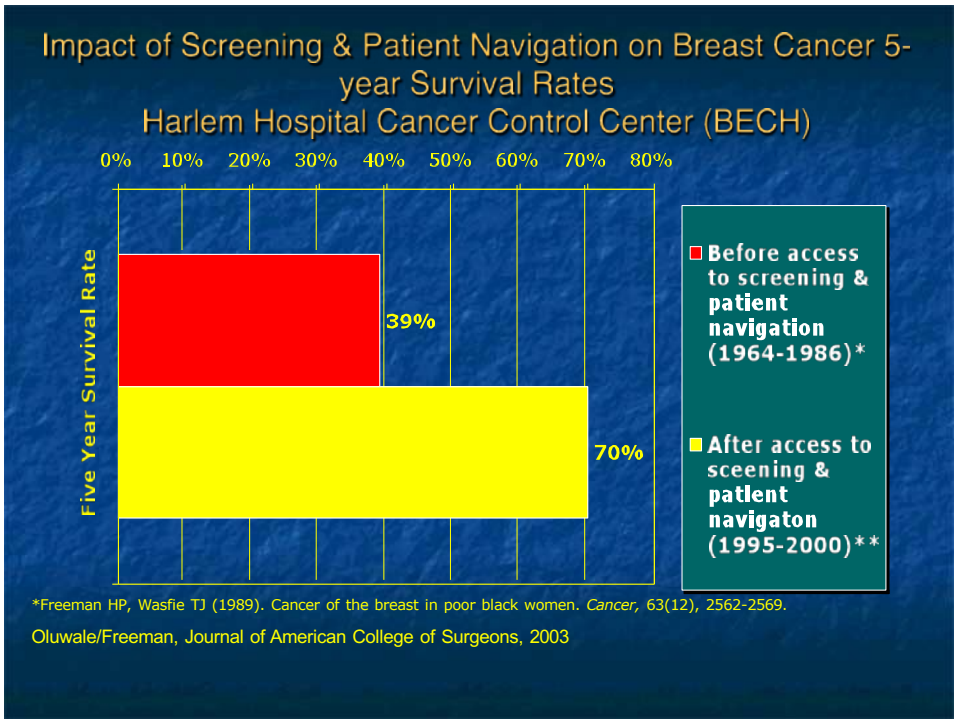
Patient navigators provide assistance to patients and families to "negotiate" the health care delivery system.


The Harlem Breast Cancer Experience

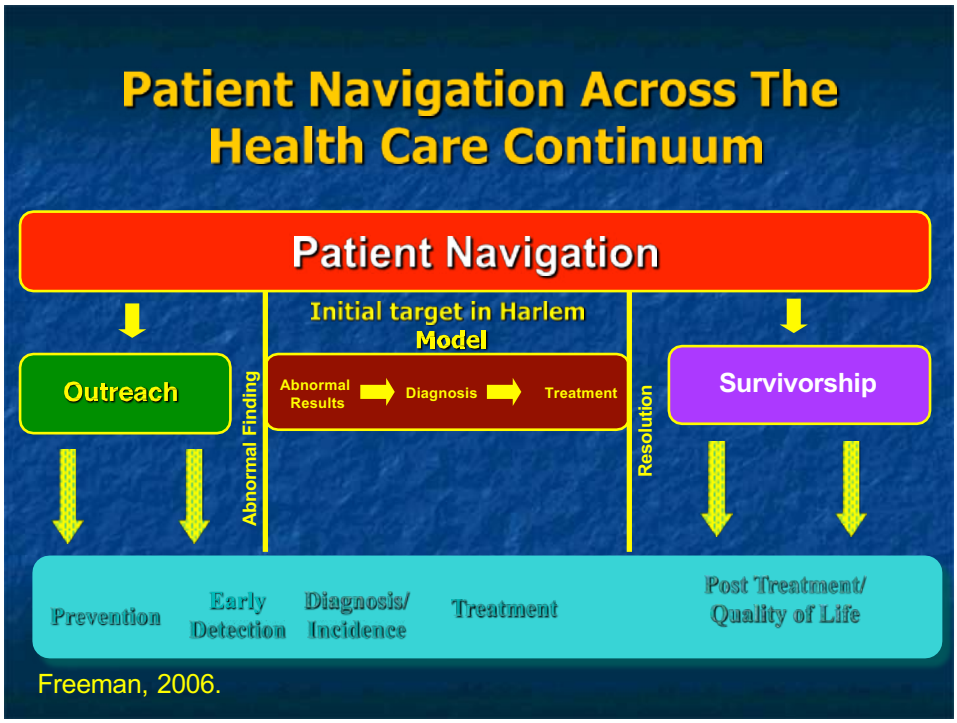

Harlem Hospital Center Breast Cancer
Results Prior To Intervention
Screening Program
Stage of Disease
1964-1986
Stage 0 0%
Stage I 6%
Stage II 45%
Stage III 39%
Stage IV 10%
*Freeman HP, Wasfie TJ (1989). Cancer of the breast in poor black women. Cancer, 63(12), 2562 – 2569.

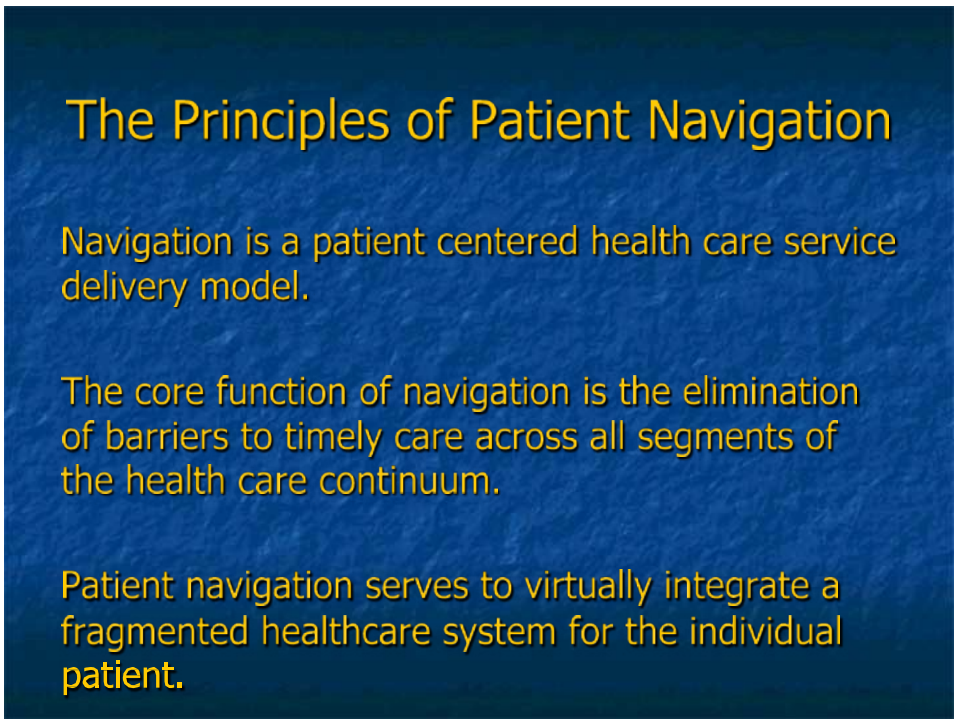

Harlem Hospital Center Breast Cancer Results Prior To Intervention
0%
10%
20%
30%
40%
50%
60%
70%
80%
Five Year Survival Rate
39%
Before access to screening & patient navigation (1964-1986)*
*Freeman HP, Wasfie TJ (1989). Cancer of the breast in poor black women. Cancer, 63(12), 2562-2569.

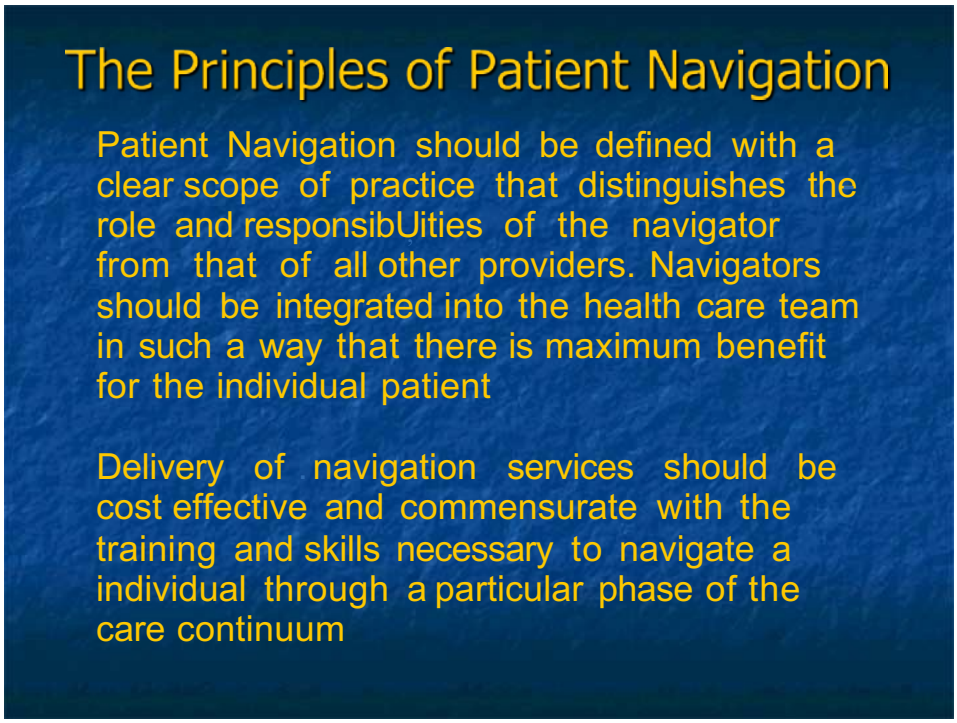

Impact of Harlem Hospital Center Breast Cancer Screening/Navigation Program Comparison of Stage of Disease
1964-1986
1995-2000
Stage 0 0% 12%
Stage I 6% 29%
Stage II 45% 38%
Stage III 39% 14%
Stage IV 10% 7%
Oluwale/Freeman, Journal of American College of Surgeons, 2003

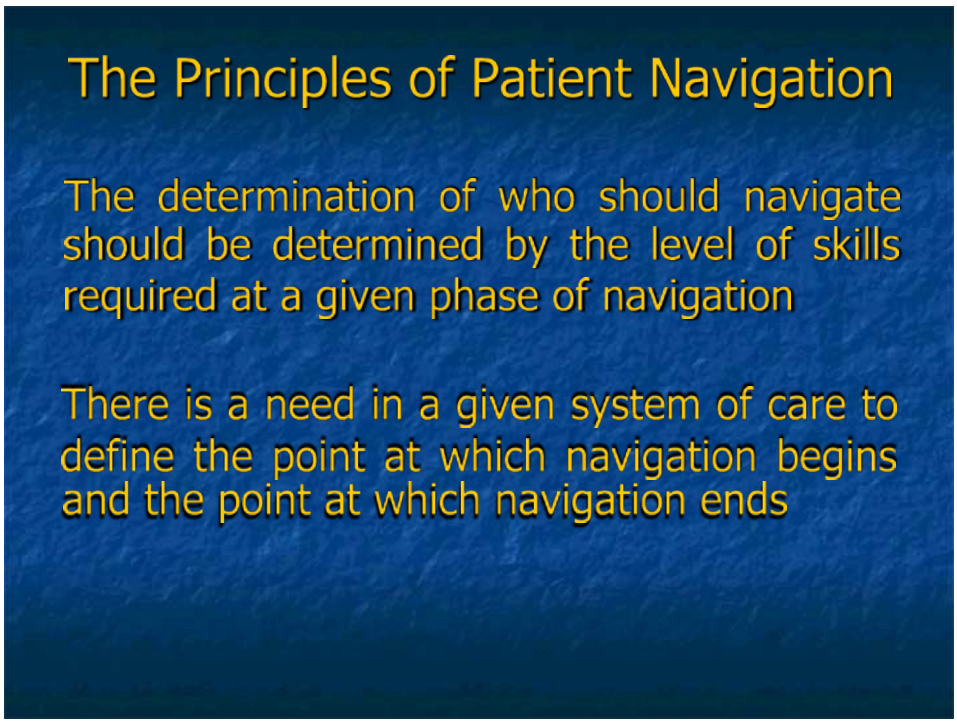

Impact of Screening & Patient Navigation on Breast Cancer 5-year Survival Rates
Harlem Hospital Cancer Control Center (BECH)
0% 10% 20% 30% 40% 50% 60% 70% 80%
Five Year Survival Rate
39%
70%
Before access to screening & patient navigation (1964-1986)*
After access to sceening & patient navigaton (1995-2000)**
*Freeman HP, Wasfie TJ (1989). Cancer of the breast in poor black women. Cancer, 63(12), 2562-2569.
Oluwale/Freeman, Journal of American College of Surgeons, 2003


National Legislation authorizing Patient Navigation Program
Signed into law
June 29, 2005
"Patient Navigator Outreach and Chronic Disease Prevention Act of 2005"
P.L. 109-18


Patient Navigation Across The Health Care Continuum
Patient Navigation
Initial target in Harlem Model
Outreach
Abnormal Finding
Abnormal Results
Diagnosis
Treatment
Resolution
Survivorship
Prevention
Early Detection
Diagnosis/ Incidence
Treatment
Post Treatment/ Quality of Life
Freeman, 2006.


The Principles of Patient Navigation
Navigation is a patient centered health care service delivery model.
The core function of navigation is the elimination of barriers to timely care across all segments of the health care continuum.
Patient navigation serves to virtually integrate a fragmented healthcare system for the individual patient.


The Principles of Patient Navigation
Patient Navigation should be defined with a clear scope of practice that distinguishes the role and responsibUities of the navigator from that of all other providers. Navigators should be integrated into the health care team in such a way that there is maximum benefit for the individual patient
Delivery of navigation services should be cost effective and commensurate with the training and skills necessary to navigate a individual through a particular phase of the care continuum


The Principles of Patient Navigation
The determination of who should navigate should be determined by the level of skills required at a given phase of navigation
There is a need in a given system of care to define the point at which navigation begins and the point at which navigation ends

The Principles of Patient Navigation

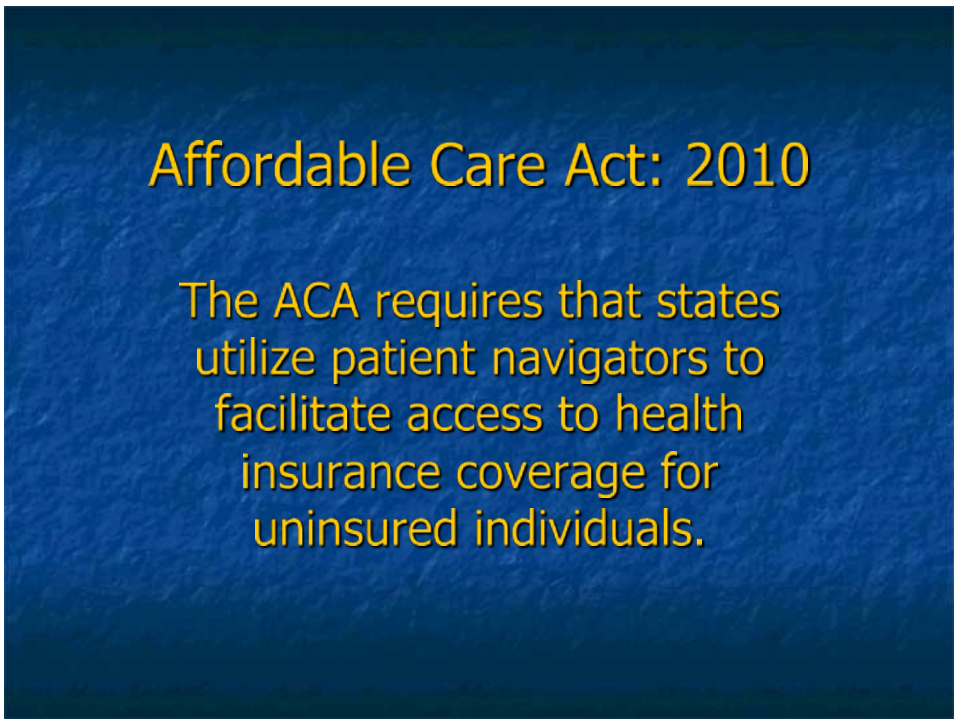
There is a need to navigate patients across disconnected systems of care such as primary care sites and tertiary care sites. Patient navigation can serve as the process that connects disconnected health care systems.

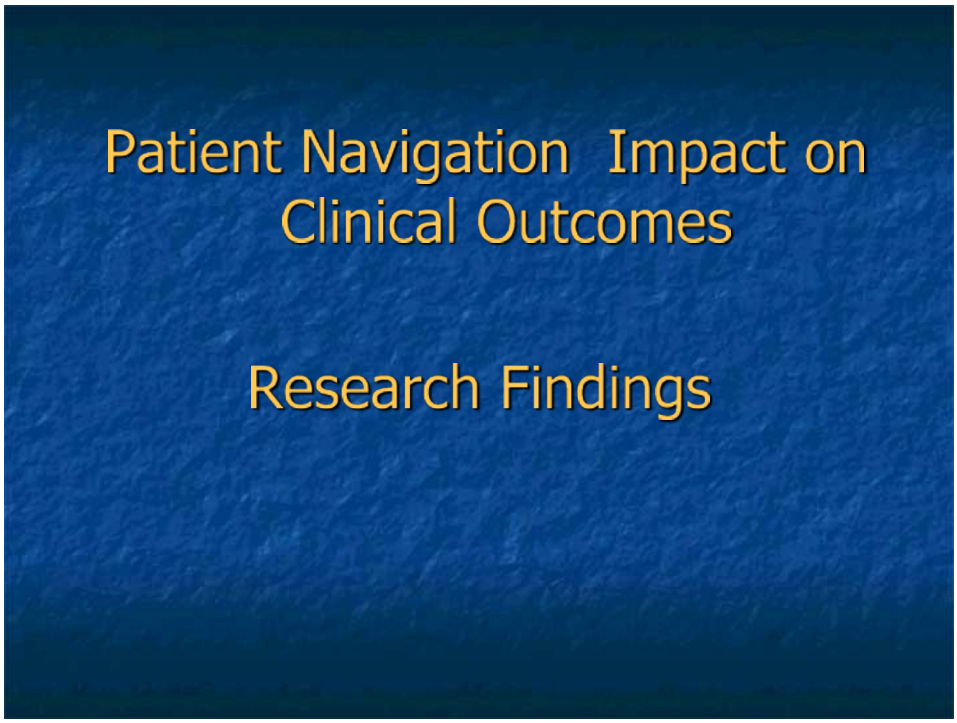
Navigation systems require coordination. In larger systems of patient care, this coordination is best carries out by assigning a navigation coordinator or champion who is responsible for overseeing all phases of navigation activity within a given health care site.

Three Major Factors to Improve Results

- Provide screening to patients regardless of ability to pay
- Establish patient navigation program
- Increase outreach and public education

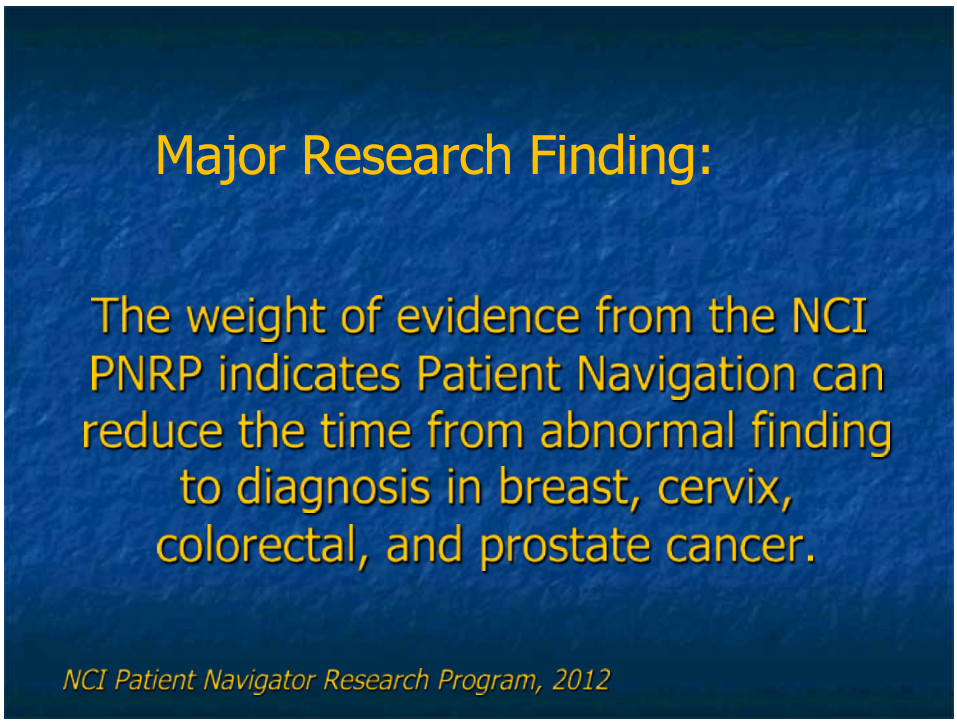

American College of Surgeons
Commission on Cancer
Cancer Program Standards 2012:
Standard 3.1
American College of Surgeons
Commission on Cancer mandated that
Patient Navigation is to be a standard
of care to be met by cancer programs
seeking approval beginning 2015

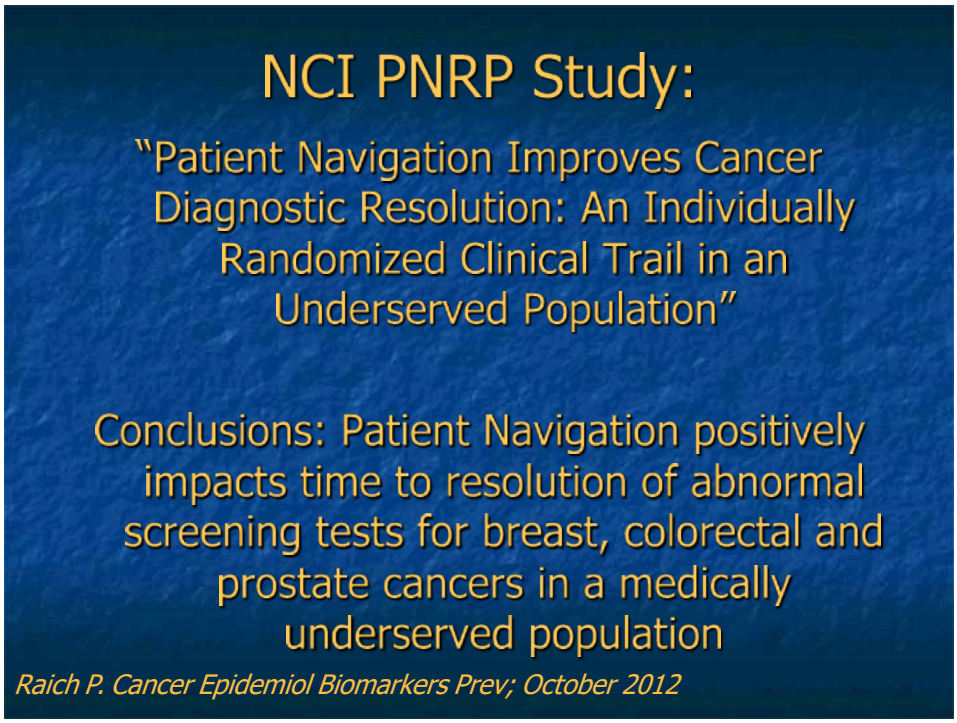

Affordable Care Act: 2010
The ACA requires that states
utilize patient navigators to
facilitate access to health
insurance coverage for
uninsured individuals.

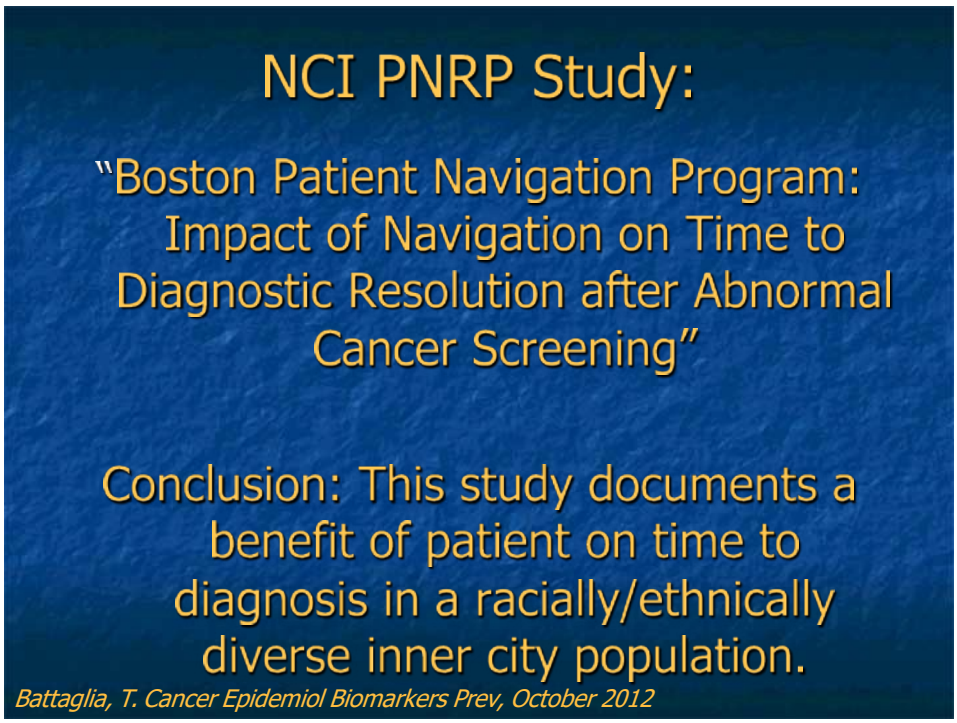

Patient Navigation Impact on Clinical Outcomes
Research Findings

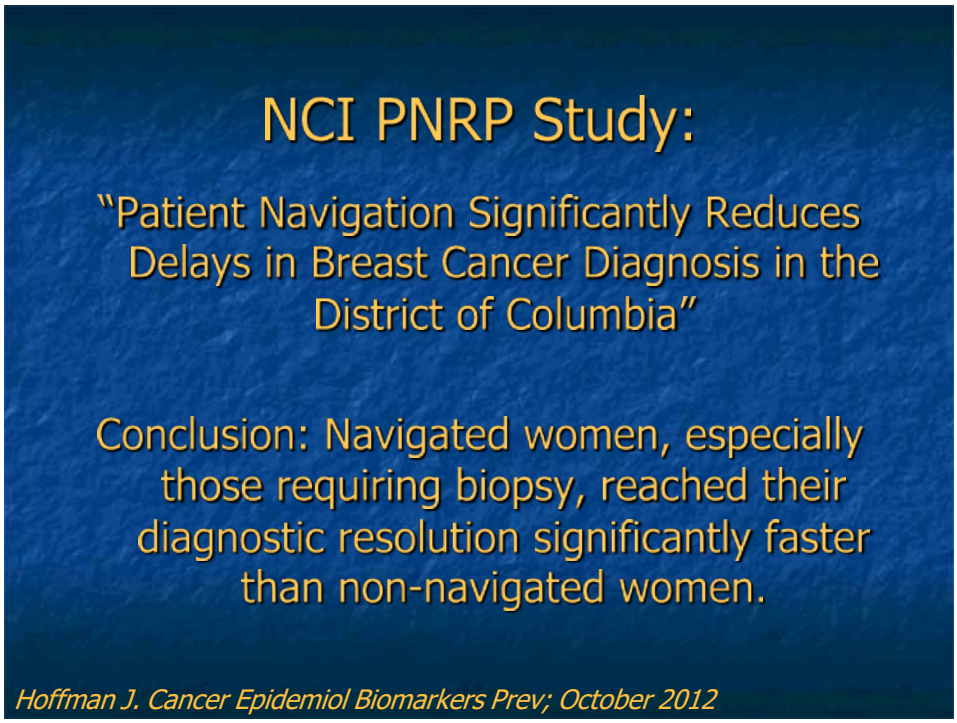

Major Research Finding:
A 2011 review of the literature on patient navigation showed that patient navigation improves participation in cancer screening particularly in vulnerable populations
Paskett E, CA Cancer J Clin 2011

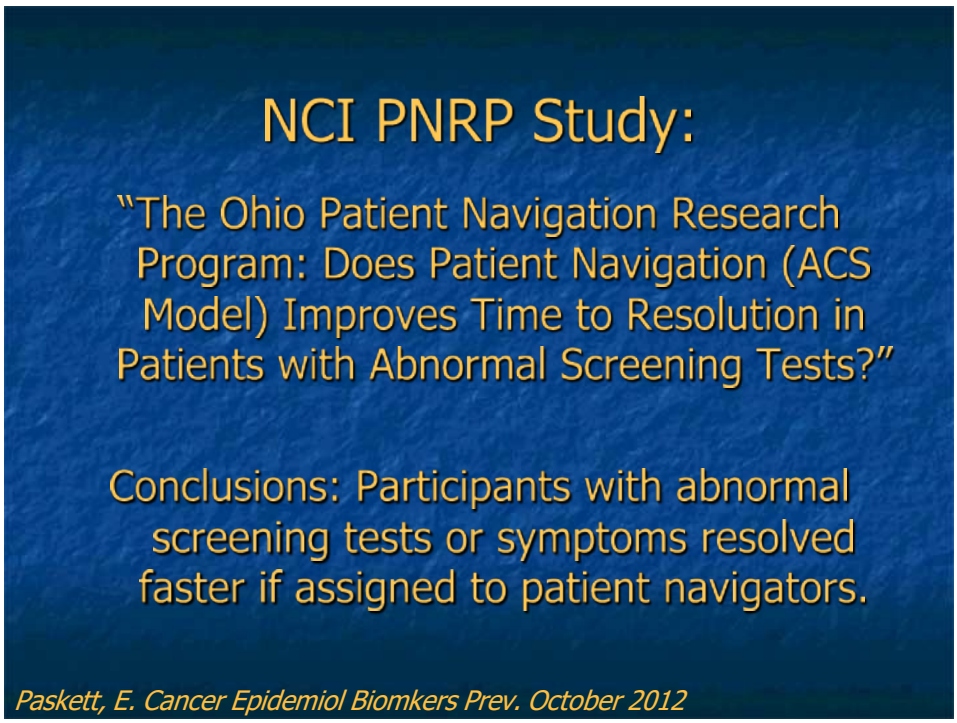

National Cancer Institute
Patient Navigation
Research Program (PNRP)
Research Findings

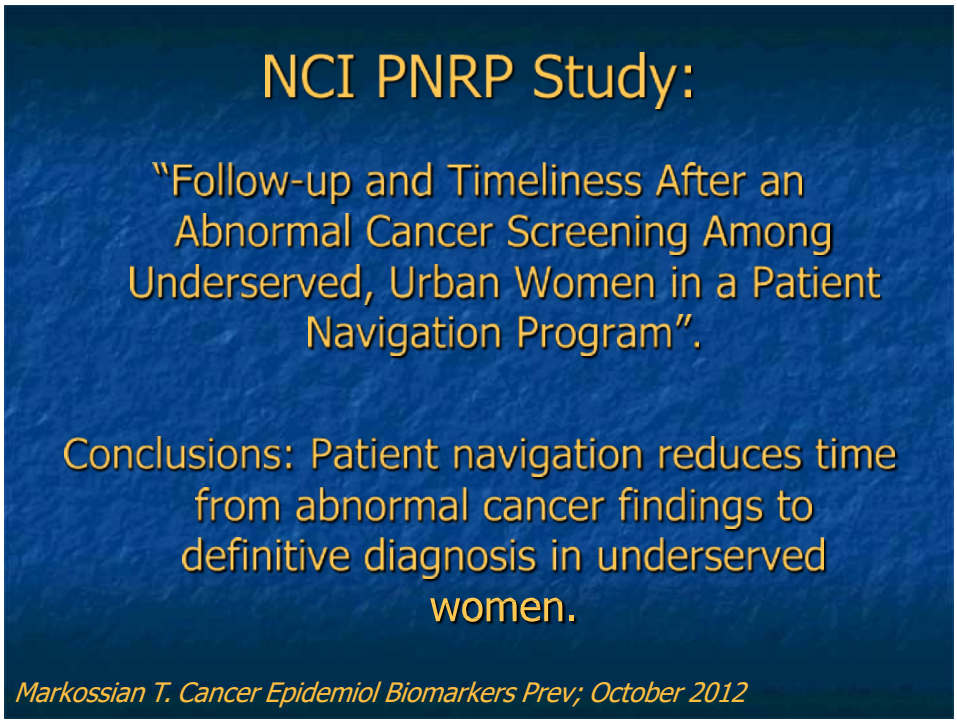

Major Research Finding:
The weight of evidence from the NCI PNRP indicates Patient Navigation can reduce the time from abnormal finding to diagnosis in breast, cervix, colorectal, and prostate cancer.
NCI Patient Navigator Research Program, 2012


NCI PNRP Study:
"Patient Navigation Improves Cancer Diagnostic Resolution: An Individually Randomized Clinical Trail in an Underserved Population"
Conclusions: Patient Navigation positively impacts time to resolution of abnormal screening tests for breast, colorectal and prostate cancers in a medically underserved population
Raich P. Cancer Epidemiol Biomarkers Prev; October 2012

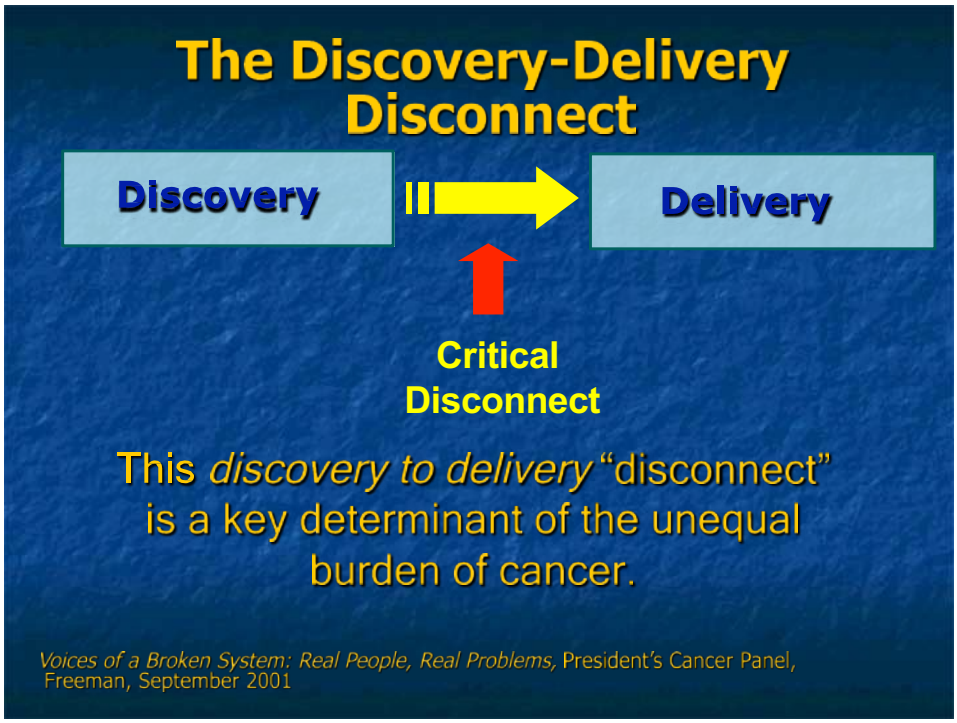

NCI PNRP Study:
"Boston Patient Navigation Program: Impact of Navigation on Time to Diagnostic Resolution after Abnormal Cancer Screening"
Conclusion: This study documents a benefit of patient on time to diagnosis in a racially/ethnically diverse inner city population.
Battaglia, T. Cancer Epidemiol Biomarkers Prev, October 2012


NCI PNRP Study:
"Patient Navigation Significantly Reduces Delays in Breast Cancer Diagnosis in the District of Columbia"
Conclusion: Navigated women, especially those requiring biopsy, reached their diagnostic resolution significantly faster than non-navigated women.
Hoffman J. Cancer Epidemiol Biomarkers Prev; October 2012


NCI PNRP Study:
"The Ohio Patient Navigation Research Program: Does Patient Navigation (ACS Model) Improves Time to Resolution in Patients with Abnormal Screening Tests?"
Conclusions: Participants with abnormal screening tests or symptoms resolved faster if assigned to patient navigators.
Paskett, E. Cancer Epidemiol Biomkers Prev. October 2012


NCI PNRP Study:
"Follow-up and Timeliness After an Abnormal Cancer Screening Among Underserved, Urban Women in a Patient Navigation Program".
Conclusions: Patient navigation reduces time from abnormal cancer findings to definitive diagnosis in underserved women.
Markossian T. Cancer Epidemiol Biomarkers Prev; October 2012


Final Thoughts


The Discovery-Delivery Disconnect
Discovery
Delivery
Critical Disconnect
This *discovery to delivery* "disconnect" is a key determinant of the unequal burden of cancer.
Voices of a Broken System: Real People, Real Problems, President's Cancer Panel, Freeman, September 2001


Patient Navigation Historical Time Table
1986 Report on Cancer is Economically Disadvantaged, Freeman, American Cancer Society
1989 National Hearings on Cancer in the Poor
1989 "Cancer in the Socioeconomically Disadvantaged", J. Cancer. 1989 Freeman HP
1990 Patient Navigator Program initiated at Harlem Hospital
1995 "Expanding Access to Cancer Screening and Clinical Follow-up Among the Medically Underserved", J. Cancer Practice. 1995 Freeman HP
2004 National Cancer Institute funded 9 demonstration sites

Patient Navigation Historical Time Table

2005 Patient Navigator Outreach and Chronic Disease Prevention Act

2006 Center for Medicare and Medicaid funded 6 demonstration sites

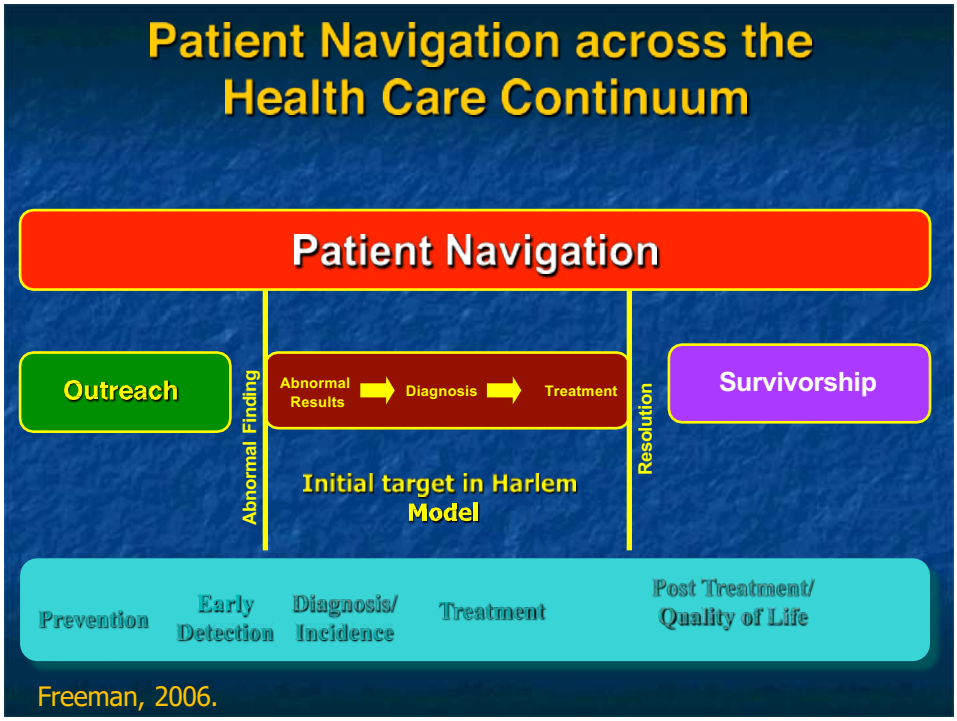
2008 Health Resources and Services Administration funded 6 demonstration sites (under the Patient Navigation Act)

2012 American College of Surgeons, Commission on Cancer mandates that patient navigation is a standard of care for cancer center approval

2012 Patient Navigation Assistance Act introduced into Congress

- **No person in America with cancer should go untreated.**
- **No person in America should experience delays in diagnosis and treatment that jeopardize survival.**
- **No person in America should be bankrupted by a diagnosis of cancer.**

The unequal burden of disease in our society is a challenge to science and a moral dilemma for our nation.



CANCER SCREENING: A REVIEW OF PROSTATE CANCER SCREENING IN THE BRONX

Kevin R. Jain, M.D.

Director

BronxCare Mount Sinai Comprehensive Cancer Care

June 17, 2022

SCREENING DEFINITIONS AND GOALS

- Secondary Prevention method in which earlier therapeutic intervention is possible through screening an asymptomatic population to identify cancer at an earlier stage than it would have been diagnosed otherwise
- Reduce mortality and severity of the disease

SCREENING METHOD CRITERIA

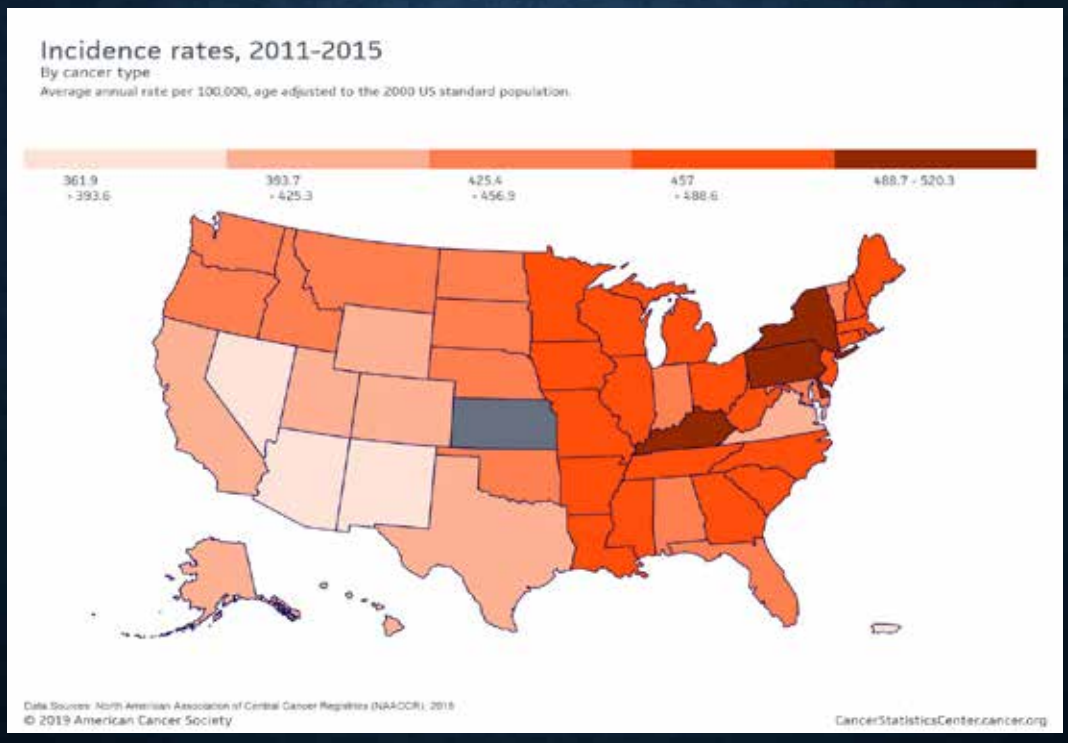
- Cost effective
- Accessible
- Sensitive
- Specific
- Safe
- Acceptable

CANCER PREVENTION

- Tobacco cessation
- Healthy diet
- Decrease alcohol intake
- Limit sun exposure
- Avoid tanning salons
- Weight loss/exercise
- Family History
- Cancer screening
- HPV vaccination
- Chemoprevention

SCREENING GOALS

- Streamline access for patients and physicians
- Standardize education and outreach
- Increase "screened" population
- Address population needs



AMERICAN CANCER SOCIETY CANCER REPORT 2019

- New ACS CAN report takes an in-depth look at the state of cancer in New York City.
- 40,126 New York City residents were diagnosed with cancer annually between 2011-15

COULD FILL MADISON SQUARE GARDEN, TWICE

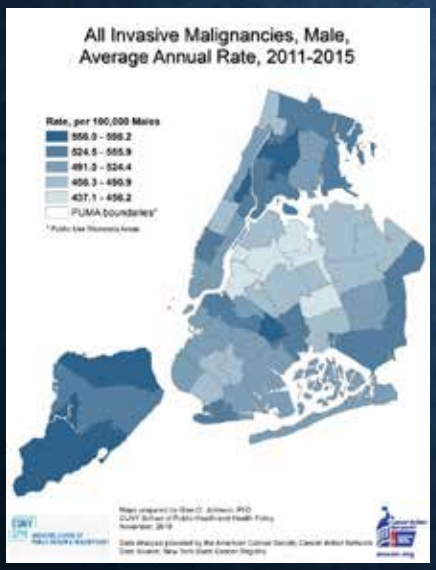
ACS CAN REPORT FINDINGS

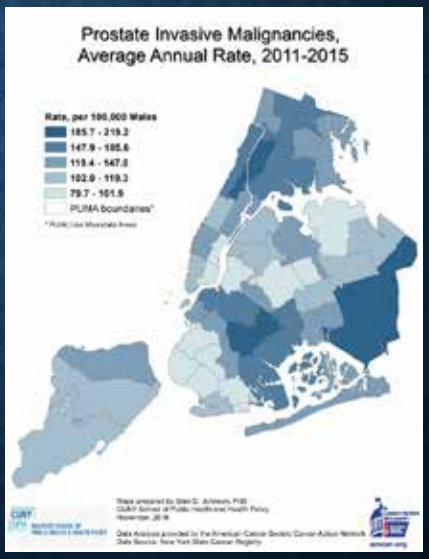
- Cancer cases and cancer deaths differ greatly among boroughs and the neighborhoods making up New York City
- Result of diverse socioeconomic and demographic characteristics of New York City

ACS CAN REPORT FINDINGS

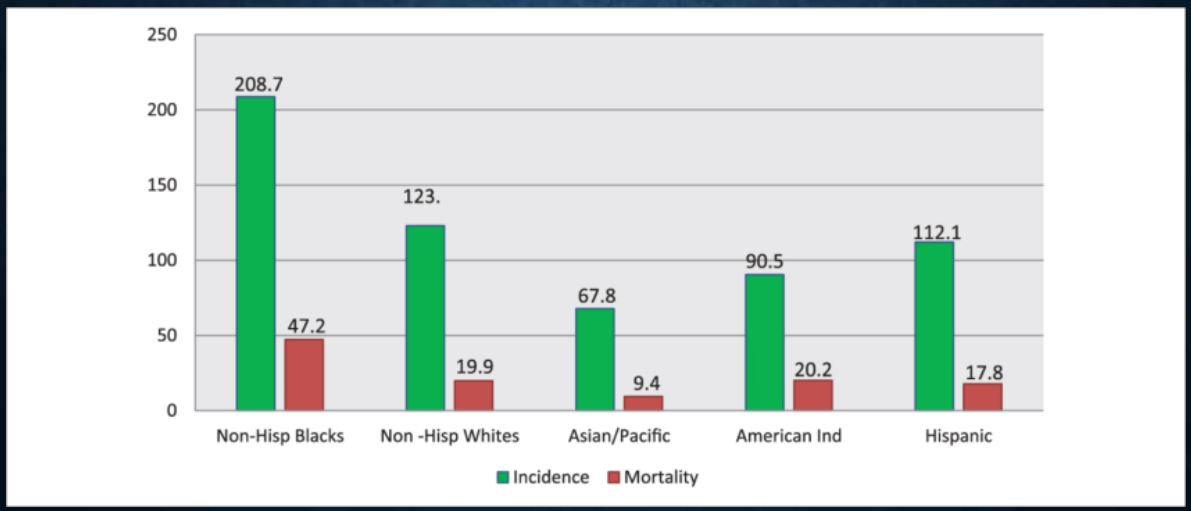
- Men in the Bronx have the highest rates of prostate cancer respectively on average annually between 2011-2015.
- Men living in Morris Heights, Fordham South and Mount Hope, Brownsville & Ocean Hill, and Tottenville, Great Kills and Annadale have the approximate highest cancer incidence rate overall among men

ACS CAN NEW YORK CITY REPORT

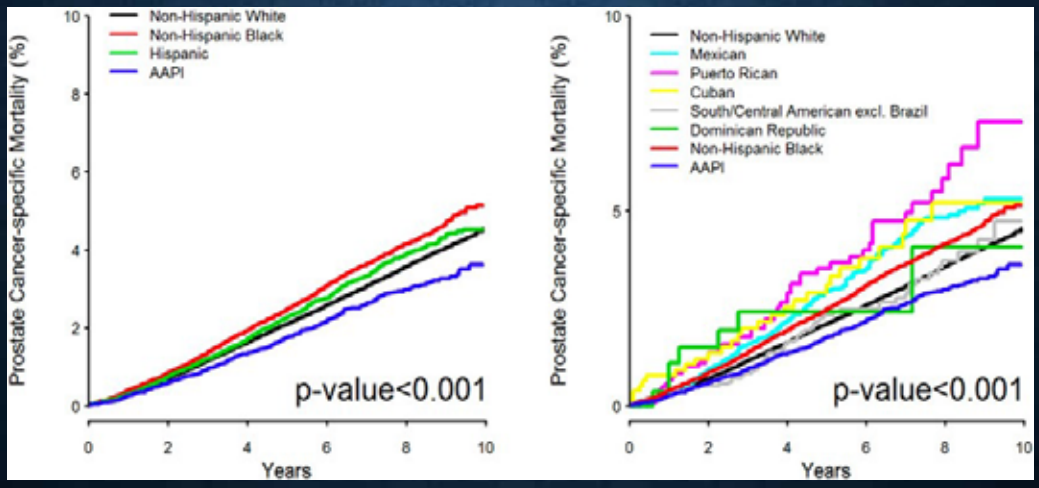




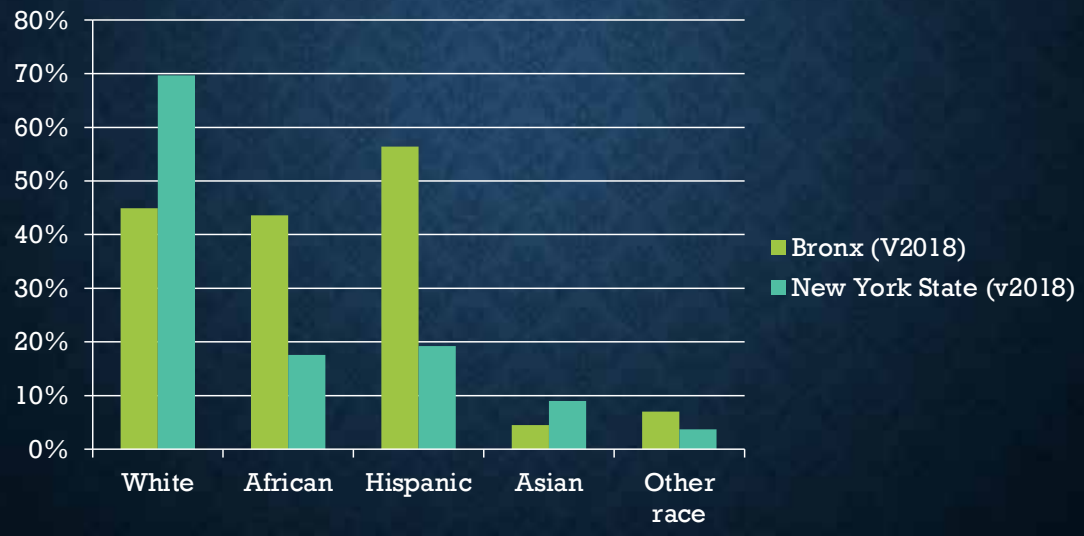
PROSTATE CANCER INCIDENCE AND DEATH RATES IN AMERICAN BY RACE 2008-2012



PROSTATE CANCER MORTALITY 2000-2013

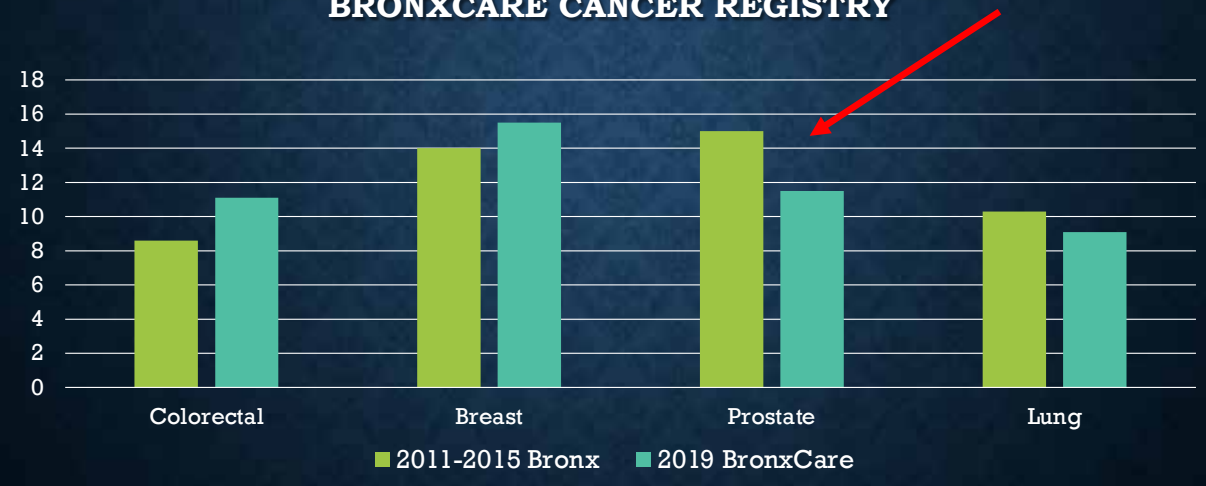


BRONX CATCHMENT AREA



PERCENTAGE OF CANCER CASES

SOURCE: NEW YORK STATE CANCER REGISTRY
BRONXCARE CANCER REGISTRY



2019

- Preliminary Radiation Oncology resident Dr. Asona Lui started a small project surveying the primary care providers at BronxCare to better understand screening practices and feelings about PSA testing.

FINDINGS

- Despite high rates of prostate cancer and prostate cancer related mortality in the Bronx our institution has relatively low rates of prostate cancer screening.
- To better understand the barriers to appropriate prostate cancer screening in our primary care clinics, Dr. Lui worked on a research project with the Division of Urology and the Cancer Center, for which she won an award at Hospital Day.
- Her results suggested that our practitioners would benefit from the addition of a flag for "prostate cancer screening discussion" to action list of eligible patients

EFFECTS OF SCREENING ON PROSTATE CANCER MORTALITY IN ERSPC/PLCO TRIALS

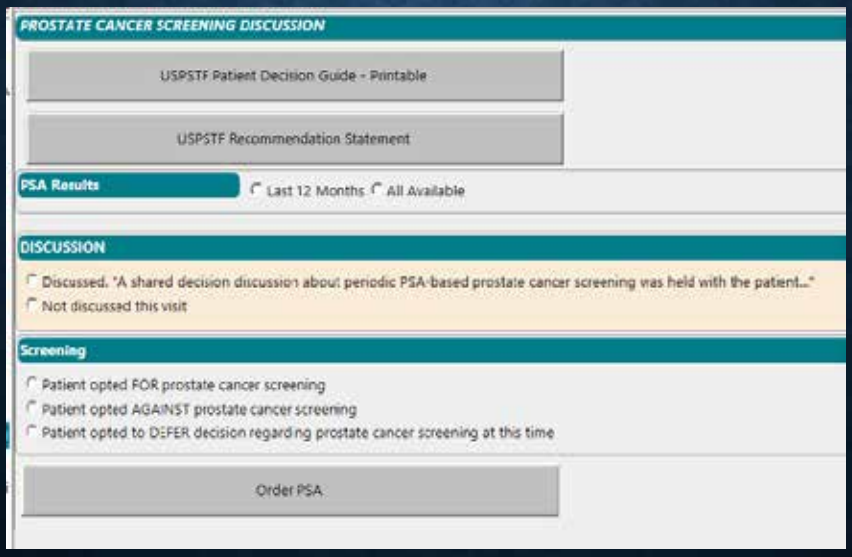
- Re-analysis of Clinical Trial Data (October 2017)
- Conclusion:

  After accounting for differences in implementation and settings, ERSPC and PLCO (European and United States clinical trials) provide evidence that screening reduces prostate cancer mortality

PROSTATE CANCER SCREENING

- 2012-2017
  - USPSTF recommended NO prostate screening
- May 2017
  - Recommends that men ages 55-69 be informed about potential benefits and harms of PSA screening (Grade C)
  - Recommends against screening age 70+
  - Emphasis on shared decision making
  - Consideration of harms of screening/over treatment
- Specific mention of high risk men (AA, FHx, known BRCA1 or BRCA2 mutation)

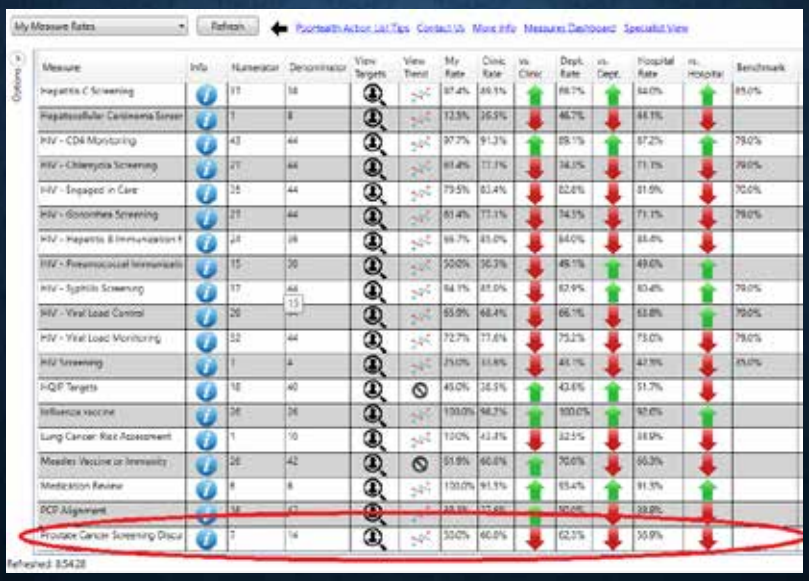
EMR EMBEDDED DECISION SUPPORT



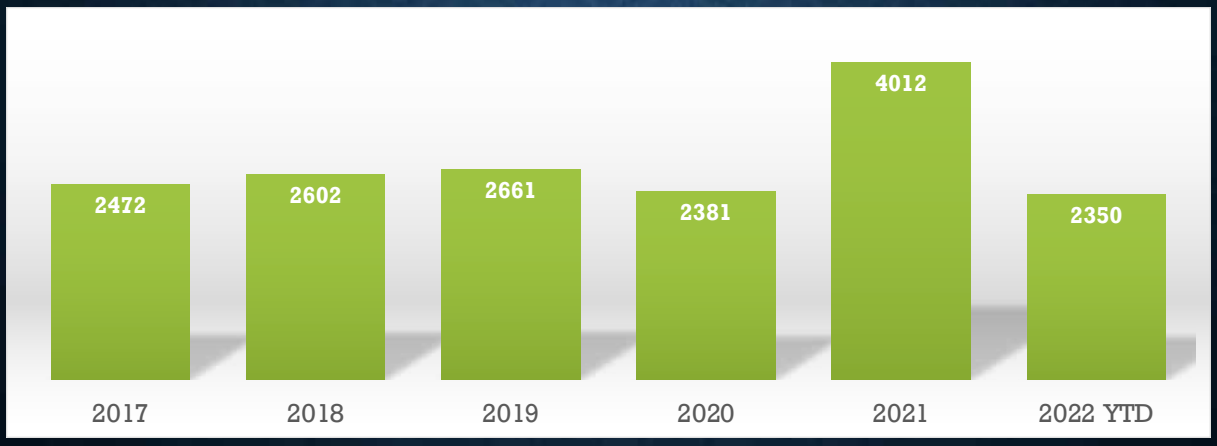
PERFORMANCE MEASURE ADDED 1/1/21

	HIV - Engaged in Care		Compliant		25-Nov-2022	25-May-2022
	HIV - CD4 Monitoring		Compliant		17-Dec-2022	17-Dec-2021
	HIV - Syphilis Screening		Compliant		17-Dec-2022	17-Dec-2021
	Prostate Cancer Screening		Compliant		18-Mar-2023	18-Mar-2022
	Adult Access (45-64) to Pre		Compliant		25-May-2023	25-May-2022
	HIV - Hepatitis B Immuniza		Compliant			29-Apr-2009
	Hepatitis C Screening		Compliant			22-Aug-2017
	HIV Screening		Exclusion			
	Add a measure...					

POPULATION HEALTH: BENCHMARKING



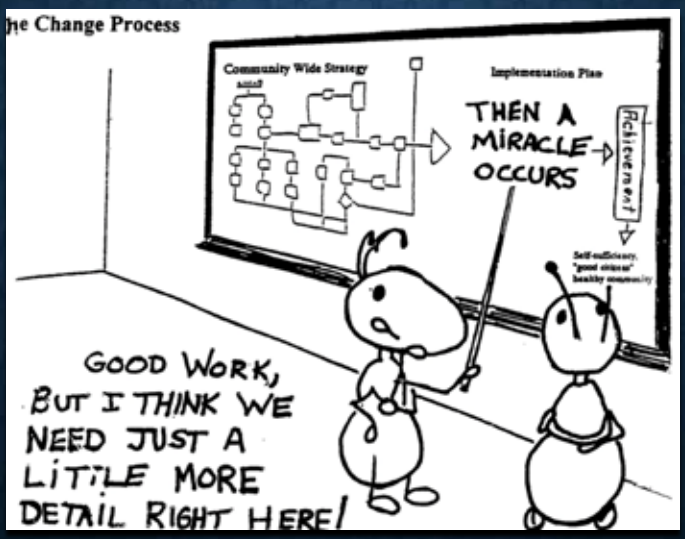
BRONXCARE OUTPATIENT PROSTATE CANCER SCREENING ANNUALLY (PSA)



SUMMARY/NEXT STEPS

- Screening the major cancers is a critical cancer control tool
- Consider our population in promotion and implementation of effective mechanisms
- Personalized counseling based on patient characteristics and provider biases
- A population health approach with embedded EMR decision support doubled screening rates

QUESTIONS?


he Change Process
Community Wide Strategy
Implementation Plan
THEN A MIRACLE OCCURS
Achievement
GOOD WORK, BUT I THINK WE NEED JUST A LITTLE MORE DETAIL RIGHT HERE!

Update On Prostate Cancer
With Focus on the Role of the PCP

Ridwan Shabsigh, MD, FACS
Chairman, Department of Surgery, SBH Health System
Professor of Clinical Urology, Weill Cornell Medical College

Incidence of Cancer

Estimated New Cases

Males				Females		
Prostate	180,890	21%		Breast	246,660	29%
Lung & bronchus	117,920	14%		Lung & bronchus	106,470	13%
Colon & rectum	70,820	8%		Colon & rectum	63,670	8%
Urinary bladder	58,950	7%		Uterine corpus	60,050	7%
Melanoma of the skin	46,870	6%		Thyroid	49,350	6%
Non-Hodgkin lymphoma	40,170	5%		Non-Hodgkin lymphoma	32,410	4%
Kidney & renal pelvis	39,650	5%		Melanoma of the skin	29,510	3%
Oral cavity & pharynx	34,780	4%		Leukemia	26,050	3%
Leukemia	34,090	4%		Pancreas	25,400	3%
Liver & intrahepatic bile duct	28,410	3%		Kidney & renal pelvis	23,050	3%
All Sites	**841,390**	**100%**		**All Sites**	**843,820**	**100%**

Siegel, R.L., Miller, K.D., MPH2; Jemal, A. CA CANCER J CLIN 2016

Mortality of Cancer

Estimated Deaths

Males				Females		
Lung & bronchus	85,920	27%		Lung & bronchus	72,160	26%
Prostate	26,120	8%		Breast	40,450	14%
Colon & rectum	26,020	8%		Colon & rectum	23,170	8%
Pancreas	21,450	7%		Pancreas	20,330	7%
Liver & intrahepatic bile duct	18,280	6%		Ovary	14,240	5%
Leukemia	14,130	4%		Uterine corpus	10,470	4%
Esophagus	12,720	4%		Leukemia	10,270	4%
Urinary bladder	11,820	4%		Liver & intrahepatic bile duct	8,890	3%
Non-Hodgkin lymphoma	11,520	4%		Non-Hodgkin lymphoma	8,630	3%
Brain & other nervous system	9,440	3%		Brain & other nervous system	6,610	2%
All Sites	**314,290**	**100%**		**All Sites**	**281,400**	**100%**

Siegel, R.L., Miller, K.D., MPH2; Jemal, A. CA CANCER J CLIN 2016

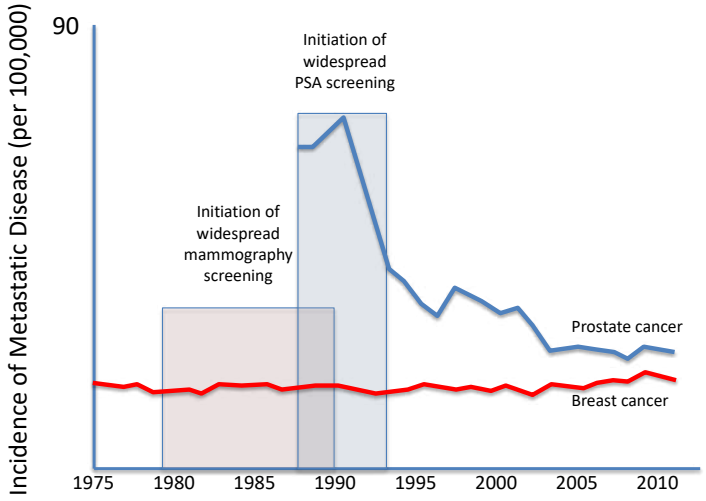
Lifetime Risk of Dying from Prostate Cancer

- Risk of dying from prostate cancer is ~3%
- Once metastatic disease develops there is no cure
- Prior to PSA screening only 25% of CaP were confined to prostate vs. 91% since
- 5 year cancer specific survival rates increased from ~70% to 100% (from 1980s to early 2000s)

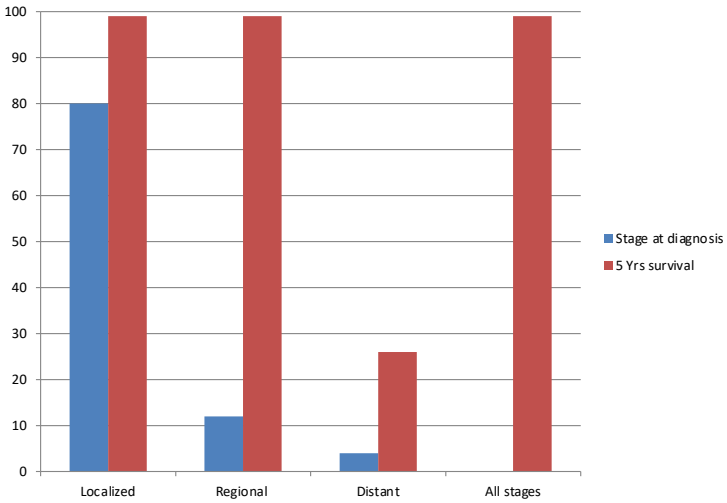
Lifetime Risk of Dying from Prostate Cancer

- The majority of patients with prostate cancer die with the cancer, not from it!
- However, prostate cancer can have significant morbidity, mortality and impact
- Nowadays with the development of multiple successful treatments, the majority of patients with metastatic prostate cancer can live for long times …

Trends in Metastatic Breast and Prostate Cancer: Lessons in Cancer Dynamics



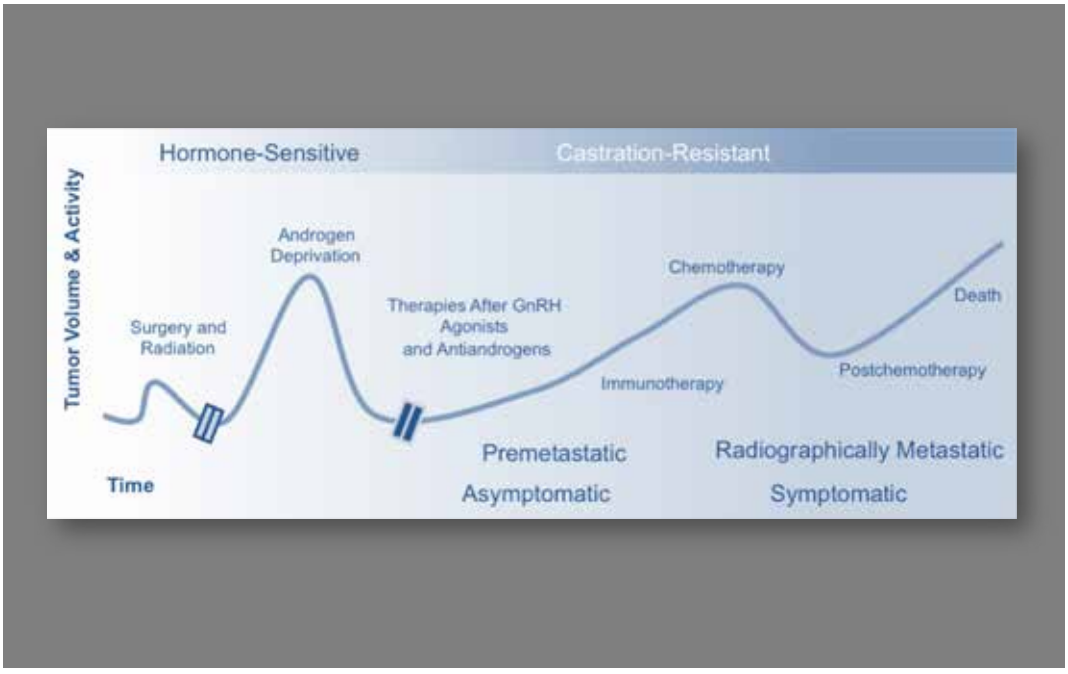
N ENGL J MED 373;18 NEJM.ORG OCTOBER 29, 2015



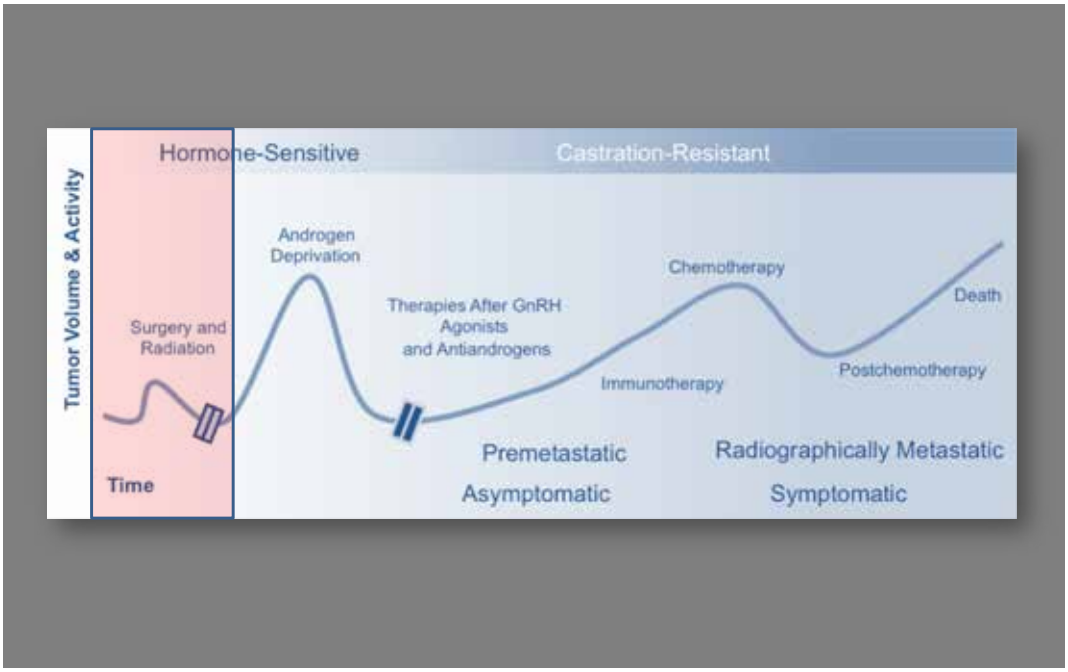
Stages at Diagnosis

Siegel, R.L., Miller, K.D., MPH2; Jemal, A. CA CANCER J CLIN 2016

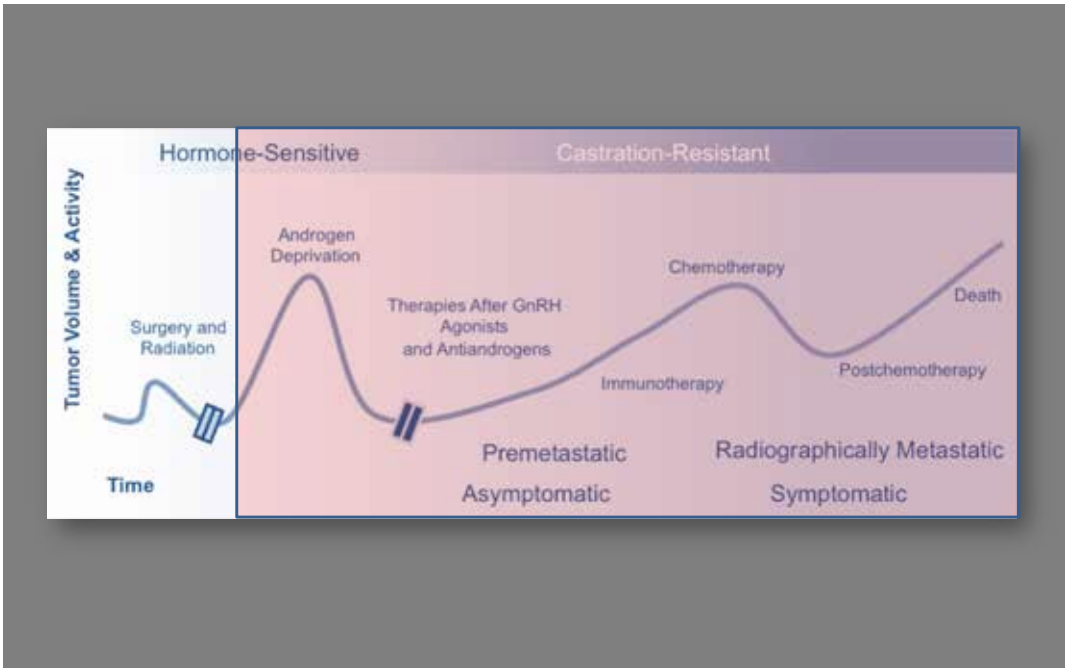
Natural History of Prostate Cancer



Natural History of Prostate Cancer



Natural History of Prostate Cancer



Management of prostate cancer

- Early PSA era: screen and treat everyone
- Selective screening and treatment:
  - Patients' health and life expectancy
  - Cancer risk stratification
  - Biological potential
  - Patients and family wishes

Prostate Cancer—Indolent vs. Aggressive

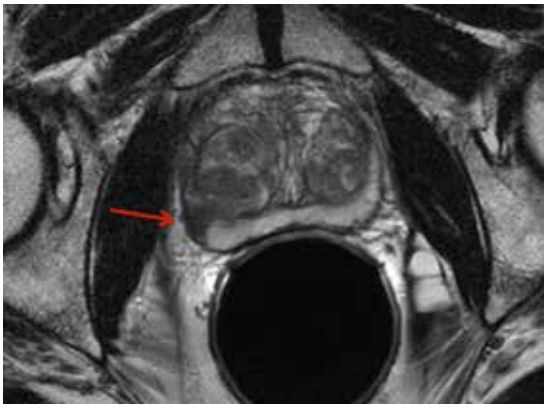
	Very Low Risk	Low Risk	Intermediate Risk	High Risk
PSA (ng/ml)	< 10	< 10	10-20	>20
Stage	T1c	T1c, T2a	T2b-T2c	T3-T4
GS	≤ 6	≤ 6	7	8-10
# of cores	< 3			
% of cancer in any core	≤ 50%			
PSA density (ng/mL/g)	<0.15			

Biomarkers

Who to biopsy	Who to rebiopsy	Who to treat
PSA Free PSA PCA3 PHI TMPRSS-ERG 4K score EcoDx	PCA3 Confirm DX	Polaris OncotypeDx Decipher Promark

Test	Platform	Tissue	Population studied	Outcome
Ki-67	IHC	Biopsy	Intermediate and high risk, EBRT	Mets
			Active surveillance	CSS
PTEN	FISH, IHC	TURP, biopsy	Active surveillance	CSS
Decipher	1.4M RNA expression oligonucleotide Microarray	RP tissue	adverse pathology	CSS
			BCF	Mets, BCF
			adjuvant EBRT	Mets
Oncotype DX	Quant-RT-PCR, 12 CaP genes and 5 controls	Biopsy	low- to interm-risk RP	pT3 or GG 4 on RP
Prolaris	Quantitative RT-PCR for 31 cell cycle-related genes and 15 housekeeping controls	TURP, Biopsy	Active surveillance	CSS
		Biopsy	Localized CaP	BCF
		Biopsy	Interm-risk EBRT	BCF
		RP, N0	Localized Cap	BCF
ProMark	Multiplex immunofluorescent staining of 8 proteins	Biopsy	GS 3+3 or 3+4	pT3 or GG4 on RP

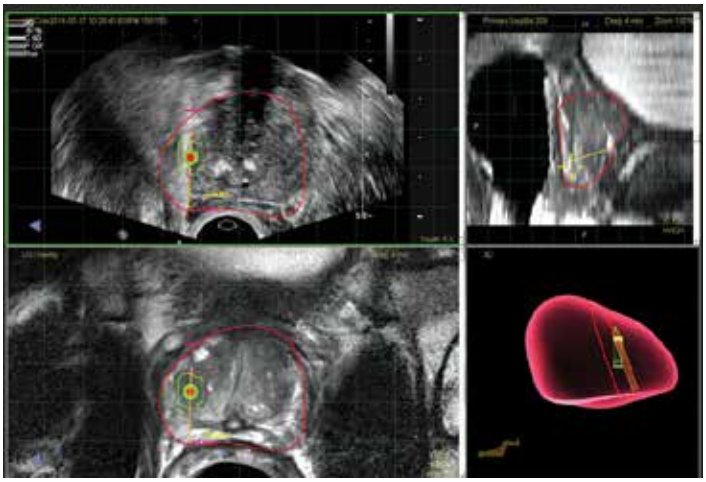
Better Imaging



Multipartametric Prostate MRI

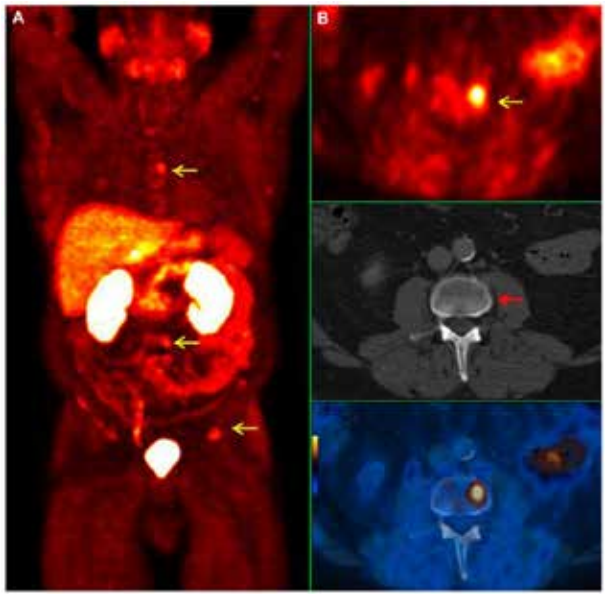
Better Imaging

mpMRI guided biopsy



Better Imaging

PSMA
PET CT



Treatment Options for Localized CaP

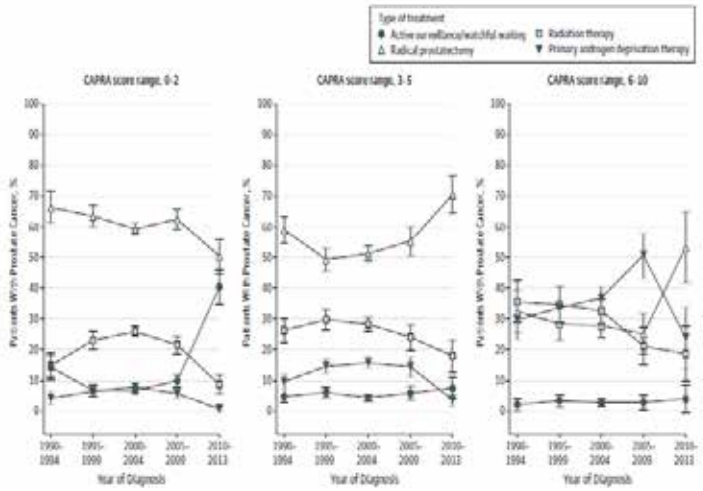
- Watchful waiting
- Active surveillance
- Ablation (Cryotherapy, HIFU, Laser…)
- Brachytherapy
- EBRT ± ADT
- Surgery

Active Surveillance

10,471 patients from 45 urologic practice (CaPSURE)

AS increased to 40.4% for low risk patients

76.2% of men >75 with low risk



JAMA July 7, 2015 Volume 314, Number 1

Active Surveillance (AS)

- Recommended for most patients with low risk (GS≤6) prostate cancer
- Younger age, high volume, AA, family history should be taken into account
- Patients <55 with high volume low risk disease may need to be treated
- Patients with short life expectancy may be well with WW

ASCO

- PSA 3-6 months, annual DRE, confirmatory biopsy within 6-12 months and then every 2-5 years depending on results
- Genetic tests and MRI may be indicated in discordant clinical and pathologic findings
- MRI alone is not enough for follow up
- Patient who has higher grade or higher volume should consider therapy

Chen JCO 2016

Complications of prostate biopsy in Men on AS

- PRIAS protocol:, biopsy at 1,4,7,10 and every 5 years their after
- 2184 biopsies on 1164 men
- Infection: 2.7% transrectal and 201% transperinteal
- Hematuria 10.8%, hematospermia 10%, pain 5.6%
- Number of repeat biopsy is not associated with infection
- Men who had a complication at first biopsy were less compliant

Bokhors LP, BJUI 2016

AS long term results

- 1298 men 71% very low risk and 29% low risk
- PSA and DRE every 6 months and annual biopsy
- 15 years OS: 68%, CCS: 99.9%, metastasis free survival 99.4%
- 31% had grade reclassification and 57% received therapy
- Mean time on AS 8,5 years

Tosonian JJ. JCO 2015

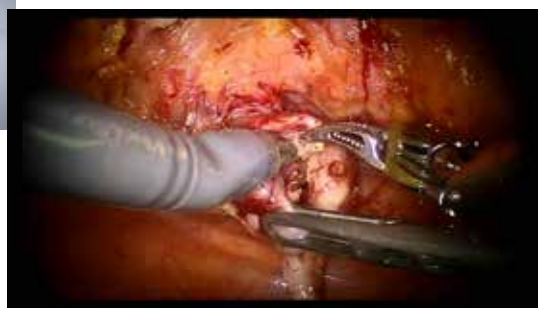
Metastatic Prostate Cancer in Men Initially Treated with AS

- 14% of intermediate risk
- Median time to mets 8.9 years, median age 70 years, median PSA = 6.2 ng/ml
- PSA doubling time < 3 years, more than 3 cores and GS 7
- Presence of GS 5 is associated with 3-4 times increase in risk of mets development

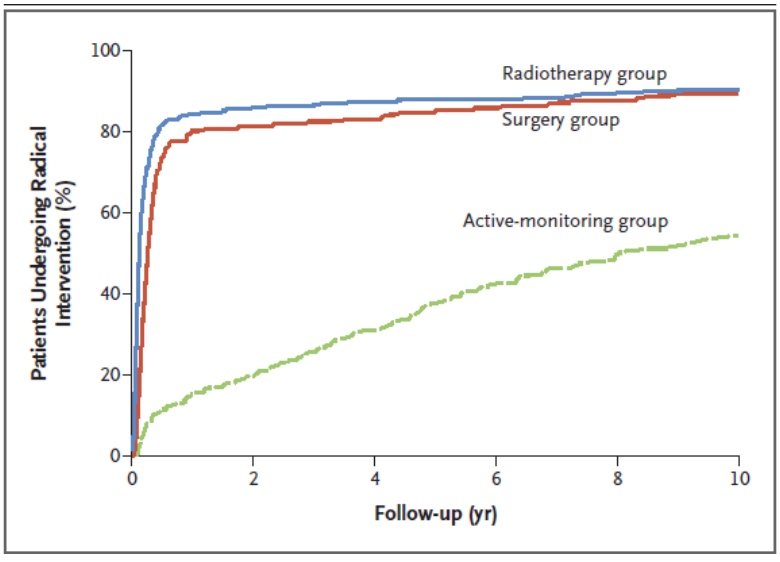
Yamamato et al, J Urol 2016

Surgery

Robotic Radical Prostatectomy



10-Year Outcomes after Monitoring, Surgery, or Radiotherapy for Localized Prostate Cancer



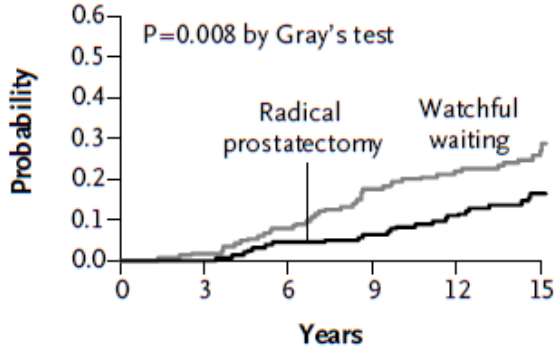
Radical Prostatectomy or Watchful Waiting in Early Prostate Cancer

- Swedish RTC of prostatectomy versus watchful waiting in disease detected mainly clinically (before PSA screening) continues to show a benefit for early prostatectomy.
- The number of men younger than 65 needed to treat to prevent one death is now four.
- Follow-up of 24 years

N ENGL J MED 370;10 NEJM.ORG MARCH 6, 2014

Radical Prostatectomy or Watchful Waiting in Early Prostate Cancer

H Death from Prostate Cancer, Men <65 Yr of Age



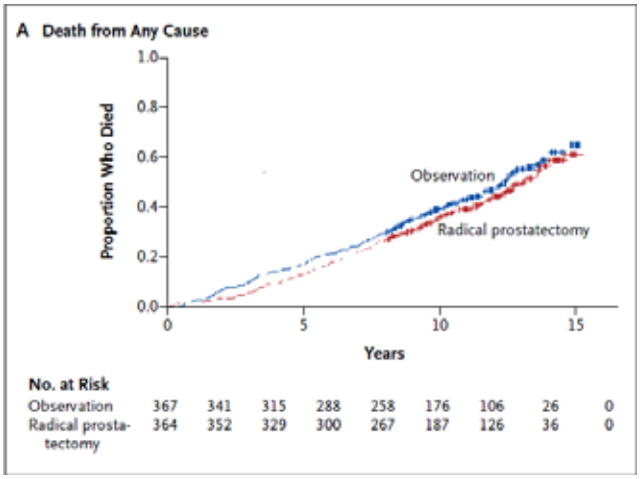
No. at Risk

Radical prostatectomy	157	154	145	136	115	67
Watchful waiting	166	157	144	118	91	54

Prostate cancer Intervention Versus Observation Trial (PIVOT)

- Randomized men ≤75yrs old to radical prostatectomy vs. expectant management with all-cause mortality as primary end-point
- 731 men studied
- Median f/up 10 years
- Different than Scandinavian trial
  - looked at same thing, but now in PSA screening era

Prostate cancer Intervention Versus Observation Trial (PIVOT)



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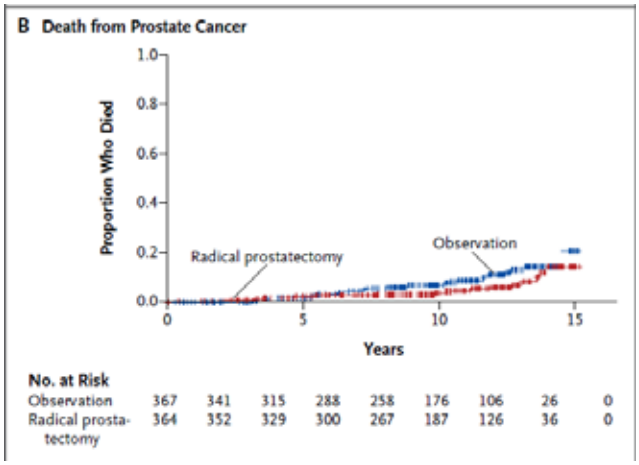
Prostate cancer Intervention Versus Observation Trial (PIVOT)



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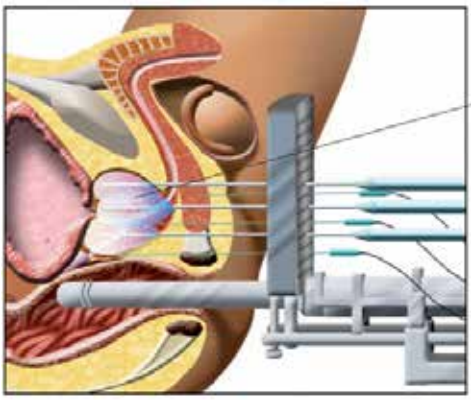
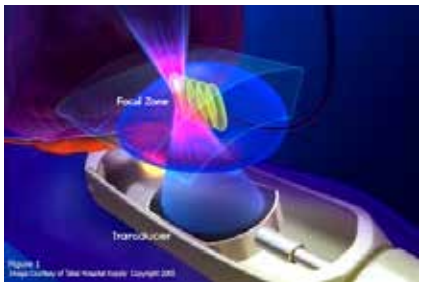
Focal therapy

- Focal Brachytherapy
- Cryotherapy
- HIFU

Cryotherapy



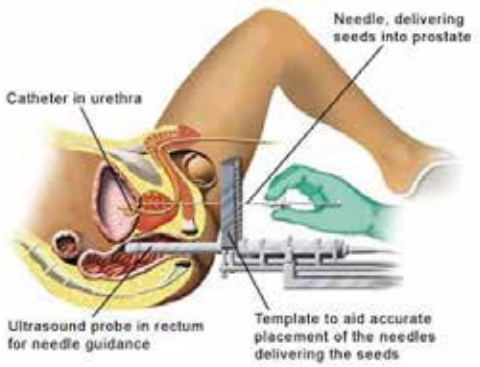
HIFU

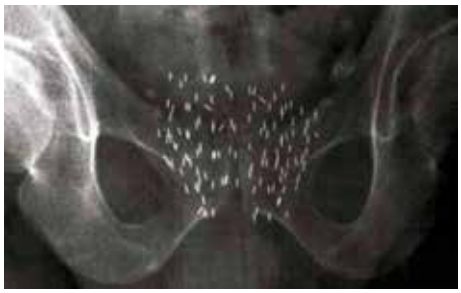


Focal therapy FDA

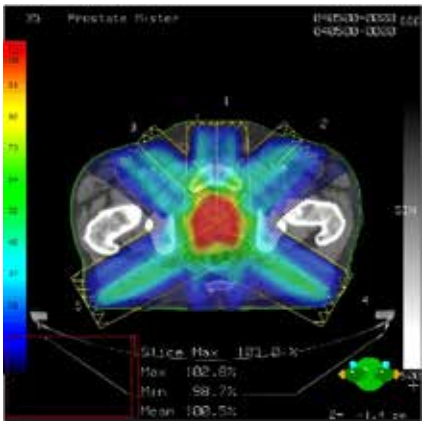
- FDA approved devices were approved for ablating tissue not for clinical effectiveness
- General consensus: current technologies are capable of selective ablation with reasonable accuracy but criteria for selecting patients, long term outcome remains to be established
- Concerns of excessive unnecessary use for patients with very low and low risk prostate cancer and inadequate treatment due to underestimation of the disease risk

Brachytherapy





IMRT (EBRT)



DATA FOR HYPOFRACTIONATION IN PROSTATE CANCER

STUDY	STD ARM	HFX ARM	Risk	PT #	EFFICACY	LATE TOXICITY
RTOG 0415	73.8 Gy/41 fx	70 Gy/28 fx	Low risk	1092	85% vs 86% DFS 5.4 yr	Mod >Gr 2 GI and GU toxicity
CHHiP	74 Gy/37 fx	60 Gy/20 fx 57 Gy/19 fx	Most intermediate	1000 each arm	BCF: HR for 60 Gy 0.83 88.3 vs 90.5 vs 85.8%	>acute GI Late Gr 2+ similar
PROFIT	78 Gy/39 fx	60 Gy/20 fx	intermediate	1204	BCF 79% at 5 yr in both	Late Gr 3: trend better for short arm
HYPRO	78 Gy/39 fx	64.6 Gy/19 fx			Similar	>GU

Androgen Deprivation Therapy (ADT)

- Indications:
  - Adjunct therapy to surgery or radiotherapy in localized prostate cancer
  - Metastatic prostate cancer
- With the increased survival of prostate cancer, larger and larger numbers of patients are on ADT

Androgen Deprivation Therapy (ADT) Adverse Effects

- Decrease in bone mineral density
- Metabolic changes such as weight gain, decreased muscle mass, and increased insulin resistance
- Increased risk of diabetes and cardiovascular events
- Decreased libido and sexual dysfunction
- Hot flashes
- Fatigue
- Gynecomastia
- Reduced testicle size
- Anemia

Androgen Deprivation Therapy (ADT) Adverse Effects

- Treatments for some adverse effects:
  - Bone loss: Calcium, Vitamin D, bisphosphonates, denosumab, selective estrogen receptor modulators,
  - Metabolic syndrome: Exercise, diet, metformin
  - Gynecomastia: Tamoxifen, prophylactic radiation
  - Muscle loss: Resistance and aerobic exercise
  - Hot flashes: Venlafaxine, medroxyprogesterone, cyproterone acetate, gabapentin, SSRI's.

Summary

- Prostate cancer remains a very important cancer with high prevalence, incidence, morbidity, mortality and impact
- Nowadays, there are numerous effective treatments for both localized and metastatic prostate cancer
- Active surveillance is one of the options for selected cases of localized prostate cancer in addition to prostatectomy and radiotherapy
- Increasing numbers of patients continue to live with controlled metastatic prostate cancer

Summary (continued)

- The PCP has a very important role not only in referring patients with prostate cancer to urologists, but also in supporting them along the long path of localized and metastatic disease
- Understanding active surveillance helps patients improve compliance
- Treatment of adverse effects of ADT may improve QoL in patients with metastatic prostate cancer

Weill Cornell Medicine

Screening on Wheels

Bradley B. Pua, M.D. FSIR
Associate Professor of Radiology in Cardiothoracic Surgery
Chief, Interventional Radiology
Director, Lung Cancer Screening

2022

Lung Cancer Data

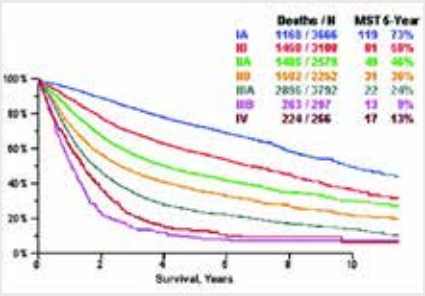
- 1900 – 140 known cases published in medical literature.
- 2020 – World Health Organization
  - 2.21 million cases worldwide
  - 1.8 million deaths
  - High fatality
- 2022 – ACS - US
  - 236,740 new cases
  - 130,180 deaths

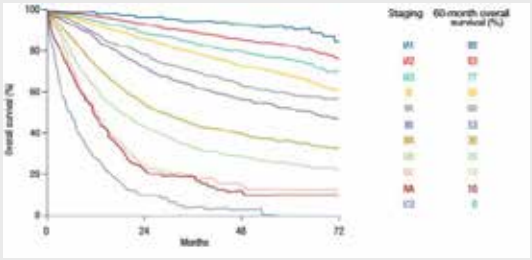
2015 – Cancer death costs 94.4 billion in lost earnings and 9.7 million years of life lost

Lung cancer largest economic impact – 21.3 billion

Lung Cancer Diagnosis

- Majority diagnosed at late stages, secondary to lack of symptoms.
- Stage of diagnosis & subsequent availability of treatment options is related to long term survival.





Early Detection

- 2011 - NLST (National Lung Screening Trial) – LDCT can reduce lung cancer specific mortality by at least 20% as compared to chest x-rays.
- 2013 – USPSTF – Grade B recommendation; 55-74 current or former smoker with 30 pack year history
- 2020 - American Lung Association –only 22.9% of lung cancers found early
- 2021 - USPSTF – endorses expansion of screening to 50-80 years current or former smoker with 20 pack year history. – increases eligibility
  - Affordable Care Act – any screening exam with Grade B and above recommendation is covered without co-payments.

Despite above:

- screening rates remain low (up to 18%) among eligible individuals
  - substantial sociodemographic disparities

NLST research team. N Engl J Med 2011;365:395-409.

Disparities in lung cancer incidence, diagnosis, treatment and mortality

- Racial inequities in rates of lung cancer screening, diagnosis, staging, treatment and outcomes:
  - In the US, Black Americans have the highest rates of developing cancer and lowest survival of any ethnic group.
    - Black men have the highest incidence (71.2/100,000 v 35.1-65.3/100,000)
    - More likely to be diagnosed at later stages, younger age and report a lower quality of life.
  - In NYC
    - Rate of lung cancer cases among Asian New Yorkers 43.1 v 34.6
    - Black and Latino patients less likely to be diagnosed early, undergo PET/CT and received immunotherapy regardless of insurance

- Barriers
  - Cost
  - Healthcare system mistrust
  - Health literacy
  - Smoking and lung cancer stigma
  - Referring provider education
- Challenge
  - Deliver equitable access:
    - Screening/Prevention
    - Navigation
    - Downstream care

Possible solution?

- Barriers
  - Cost
  - Healthcare system mistrust
  - Health literacy
  - Smoking and lung cancer stigma
  - Referring provider education
- Challenge
  - Deliver equitable access:
    - Screening/Prevention
    - Navigation
    - Downstream care

- Solution?
  - Education on coverage
    - $ for uninsured
  - Education of populace
  - Education of providers
  - Bring care to the patient
    - Mobile?
    - Relationships with FQHCs and trusted providers/leaders
  - Strong navigation

Pilot Mobile Project

- **Objective**
  - **Demonstrate feasibility of mobile CT screening in an urban setting**
    - **High quality screening**
    - **Patient navigation**
    - **Assess community engagement strategies**
      - Council members
      - Community leaders
      - News/Media
      - Social Media

– December 2019 – January 2020

Project Structure

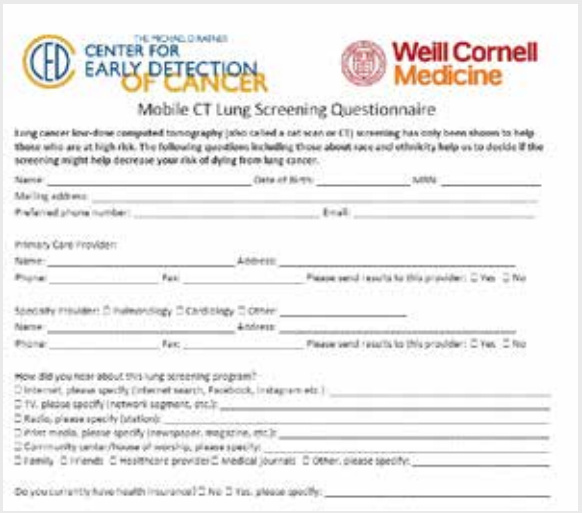
- **Location - Brooklyn – Metrotech Commons**
- **Online scheduling system & 1-800 number**
- **Screening**
  - **Free of charge**
  - **Screen**
    - **USPSTF Draft guidelines**
      - Age 50-80 years
      - Current or former smoker with 20 pack year history
        - if former, quit within past 15 years

Project Structure

- **Staff**
  - **Nurse Navigator/Coordinator**
  - **Nurse Practitioner – Shared decision**
  - **CT technologist**
  - **Patient liaison**
  - **Remote Radiologist interpretation**

Workflow

- Scheduling – determine eligibility
- Day of test
  - meet NP for shared decision
  - paperwork
- Results - patient and referring MD (if applicable) within 24-48 hours
- Follow-up - RN navigator facilitates appointment for downstream care



https://www.unitedstateszipcodes.org

Results

	Patients (n= 216)
Gender	
Female	48.1% (104)
Male	51.9% (112)
Age	
<55	22.2% (48)
55-77	76.4% (165)
78-80	1.4% (3)
Ethnicity	
Hispanic or Latino	12.5 % (27)
Black or African American	28.2% (61)
Asian	2.8% (6)
Caucasian/White	37.5% (81)
American Indian/ Indigenous/ Alaska Native	0.46% (1)
Other	5.6% (12)
Not Reported	13.0% (28)
Smoking Status	
Current smoker	58.3% (126)
Former smoker	41.7% (90)
Pack Years	
<30	28.7% (62)
30+	71.3% (154)
Source of Information	
Community Center	1
Family	4
Friends	7
Internet	42
Media (TV, Radio, Magazines)	104
Print Media	37
Other	20
Not Reported	1

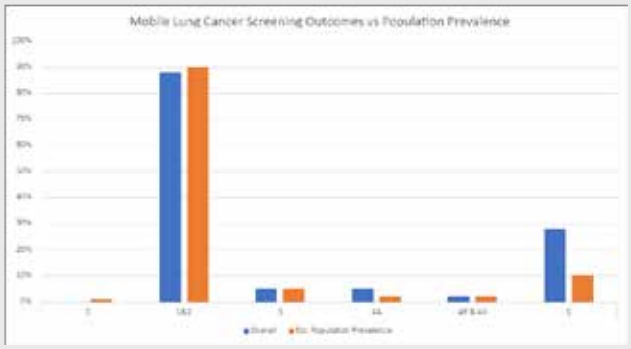
216 people screened

	Patients (n= 216)
Medical Insurance Status	
Insured	81.0% (175)
Uninsured	12.1% (26)
Not Reported	6.9% (15)
Education Level	
Less than 8 years	4
8 through 11 years	9
High School or Equivalent	45
Vocational/ Technical School	12
Some College	52
College Graduate	58
Postgraduate	32
Not reported	4
Occupational Status	
Employed	94
Unemployed	19
Student	2
Retired	51
Disabled	16
Other	4
Not Reported	30
Income Level	
Less than $ 20,000	48
$20,000 to $34,999	25
$35,000 to $49,999	28
$50,000 to $74,999	35
$75,000 to $99,000	14
$100,000 or more	18
Not reported	48

Results

- 88.4% negative (LungRADS 1 & 2)
- 11.6% positive (LungRADS 3 & 4)

- S – 28.2%



Lung- RADS Score		
Lung- RADS 1	95	44.0%
Lung- RADS 2	96	44.4%
Lung- RADS 3	11	5.1%
Lung- RADS 4A	10	4.6%
Lung- RADS 4B	4	1.9%
Total patients	216	100.0%
S modifier	61	28.2%

Results

- **Positive**
  - **25 patients**
  - **2 cancers – both stage IIB**
    - **Both underwent surgery**
    - **One receiving adjuvant chemo**
- **S Findings (not suspicious for cancer, but follow-up recommended)**
  - **52.5% (32) – moderate to severe coronary calcification**
  - **14.8% (9) – moderate to severe emphysema**
  - **22.9% (14) – lung or mediastinal findings**
  - **22.9% (14) – abdominal findings**
  - **further follow-up is pending**

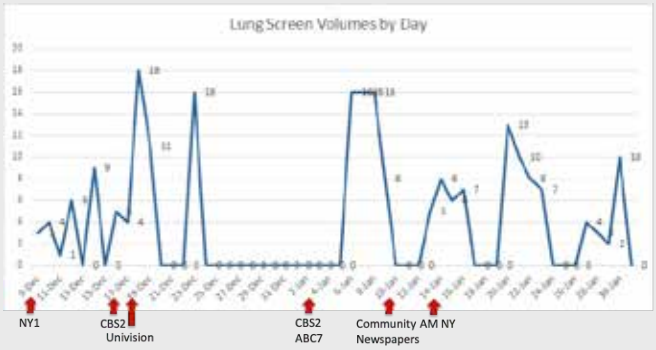
Lessons Learned

- **Demonstrate feasibility of mobile CT screening in an urban setting** ☑
  - **High quality screening**
  - **Patient navigation**
  - **Assess community engagement strategies**
    - Council members
    - Community leaders
    - News/Media
    - Social Media

Community engagement strategies

Community engagement strategies

- Outreach through purchased ads
  - 68/216 learned through TV, radio or magazines
- Internet advertising (facebook)
  - 48/216 through internet
- Traditional media (earned media)



Engagement Strategies

- **Main weakness – failure to mobile local community leaders and organizations**
  - **11/216 learned through family or friends**

Zip codes of those screened

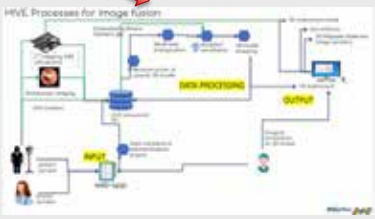
Future Steps

- **Challenges**
  - **Access**
  - **Identifying key partners**
  - **Identify target cancers**
    - **Lung**
    - **Colorectal**
    - **Prostate**
  - **Delivering equitable care and navigation**
  - **Streamline downstream & cohesive care**
  - **Multiparametric database**

Mobile Lung Unit

- Federally Qualified Health Centers (FQHC)
  - Community health
  - Migrant health
  - Healthcare for homeless
  - Health centers for residents of public housing
- Community leaders
- City council members

- Lung Screening workflow
  - Assigned to NP
  - RN navigation
  - Rapid downstream care coordination at WCM/BMH/LMH/NYHQ



- Lung
  - Tobacco cessation
  - Rapid multidisciplinary review for suspicious cases
- Prostate
  - Same day prostate imaging, biopsy and urology consult

Weill Cornell Medicine

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Weill Cornell Medicine

Memorial Sloan Kettering Cancer Center

*FOOD: Food Insecurity Interventions to Improve Cancer Outcomes

***Food to Overcome Outcomes Disparities**

June 17, 2022
Francesca Gany, MD, MS
Chief, Immigrant Health and Cancer Disparities
Memorial Sloan Kettering Cancer Center
www.MSKCC.org

Immigrant Health and Cancer Disparities (IHCD) Center

Mission

To promote health equity for immigrant, minority, low socioeconomic status, and other underserved communities

locally, nationally, globally

Research, Outreach, Community Engagement, Service Delivery, Training, Program and Policy Development

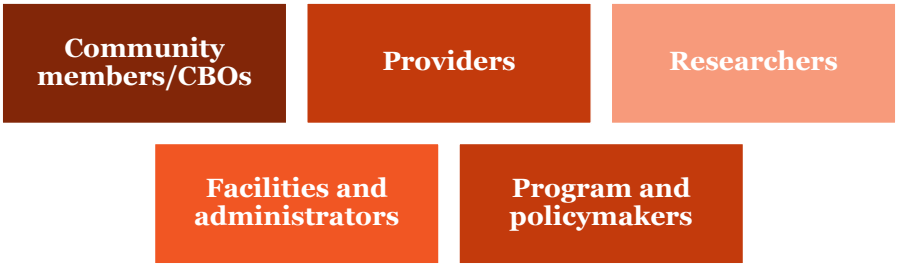
Interrelated

We use a social determinants lens in all of our work

Memorial Sloan Kettering Cancer Center

ICCAN : Integrated Cancer Care Action Network
Cancer Outcomes Equity Platform Partnership → FOOD

- **364 Organizations/Resources**
- **Address SDoH**



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ICCAN: Integrated Cancer Care Access Network: Access Facilitation Program

- Case management services at 14 safety net and other cancer clinics in NY
- Access Facilitator
  - Performs essential needs assessment
  - Develops with each patient a plan of action
  - Follows up in person or by phone with individuals to ensure each action point is addressed

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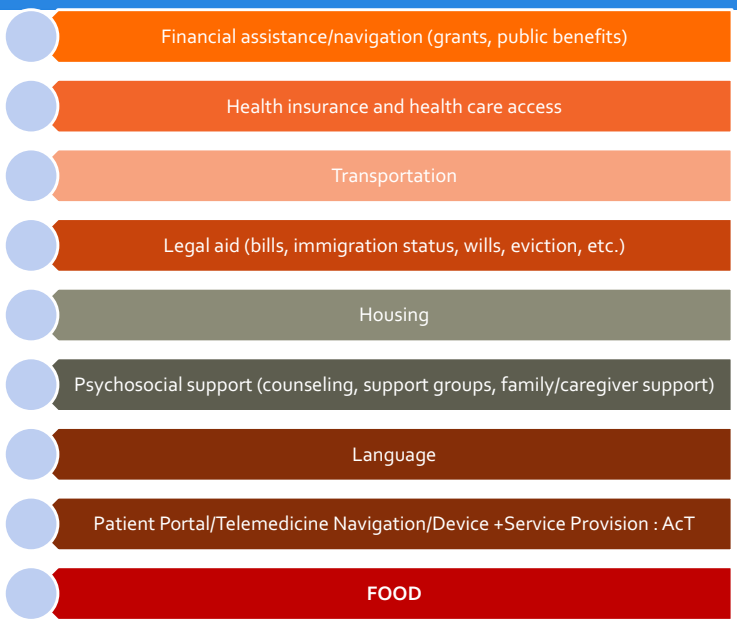
ICCAN: Areas of Greatest Need



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ICCAN: Access Facilitation RCT (NCI U54)

- 2-arm: ICCAN vs U&C
- 12 months
- 2 safety net cancer clinics
- Preliminary Results (N=152)
  - ICCAN treatment completion significantly higher

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Food Insecurity (FI) and Cancer Care

- Cancer patients often have increased nutritional needs[1-6]
- Treatment-related costs (e.g. co-pays, Rx, travel) and income loss contribute[6-8]
  - FI goes hand in hand with financial toxicity of cancer treatment but precedes it for many
- FI → Poorer functional, emotional, and social well-being, higher depression risk[9-13]
- FI → Care delays, cost-related med non-adherence[1, 10, 14-18]→ Poorer outcomes
  - McDougall, Anderson, Adler Jaffe et al. (2020) – New and persistent food insecurity strongly associated with forgoing, delaying, or altering cancer care

Vitally important to screen for and address food insecurity in cancer patients to potentially improve treatment adherence and decrease outcomes disparities[19]

And for surveillance/ to track outcomes of clinical and policy interventions

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FOOD: Foundational Data

- Cancer patients in NYC safety net cancer clinics (N=404)
  - 56% food insecure:
    - Associated with treatment nonadherence
  - SNAP recipients as likely to be FI as those not receiving SNAP[37]
- Comprehensive Cancer Center (N=238)
  - 18%-30% food insecure
- Emergency food system does not address cancer patient needs(hours, location, foods)
- FI is a window into other essential needs
  - Housing status, type associated with food security status

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FOOD: Pantry Intervention

- Medically tailored cancer clinic-based food pantries + food navigation
- Culturally, Linguistically Adapted Cancer and Nutrition Education
- Public and not-for-profit partners

Health Bucks

- Policy Changes
  - Screening for FI, other essential needs
  - A pantry in every clinic

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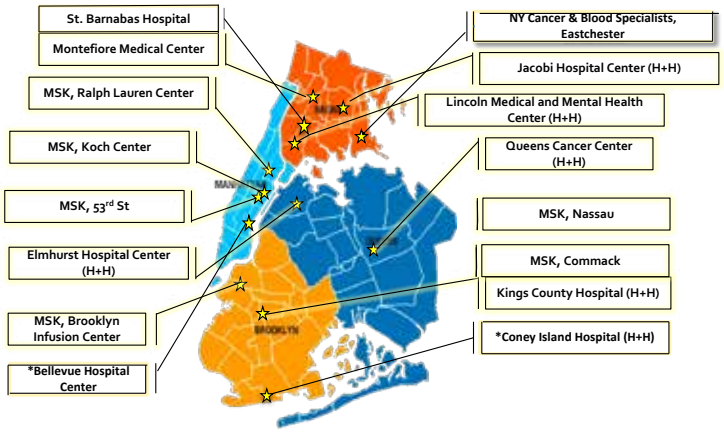
FOOD Pantry Intervention Sites



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*Pending sites

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Additional Interventions-RCT Study Arms

Arm 1	**Cancer Clinic-Based Pantry Only** • Choice pantry once weekly, nutritionally tailored • Food for five lunches and five dinners • Approximately $35 per bag per week • Culturally + Linguistically Tailored Nutrition Education
Arm 2	**Voucher (debit cards) + Pantry** • Monthly $230 debit card (food and non-alcohol beverages) • Given in-person at clinic • Bring receipts every month • Access to clinic-based pantry weekly • Culturally + Linguistically Tailored Nutrition Education
Arm 3	**Delivery + Pantry** • Weekly commercial grocery delivery: healthful products • Delivery worth approximately $57 to $60 per week • Chose food from master grocery list, recorded/tracked • Access to clinic-based pantry weekly • Culturally + Linguistically Tailored Nutrition Education

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FOOD (Food to Overcome Outcomes Disparities) RCT

- 6 months of participation
- Participants (N=117)
  - food insecure (USDA 18-item screener)
  - adult cancer patients at 4 NYC safety net cancer clinics
  - starting chemo, RT or both
  - any cancer diagnosis/stage
  - English, Spanish, Mandarin speakers

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Outcomes

Treatment Completion (Primary Outcome)	• Receipt of prescribed cycles of chemotherapy and/or RT by study completion • Determined by EHR abstraction
Appointment Attendance	• Chemo/RT appointments tracked through EHR
Food Security Score/Status Change	• 18-item USDA Household Food Security Module[20] • Raw score ≥3 = food insecure[20]
QoL and Depressive Symptoms	• 9-item Patient Health Questionnaire (PHQ-9)[21] • Functional Assessment of Cancer Therapy-General (FACT-G)[21]

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Voucher Arm Food Choices

- Patients spent the most on animal protein (22% of voucher money), fruits (15%), and vegetables (13%)

- 77% of funds spent on “healthy” food
  - Patients with limited English proficiency spent more on healthy foods than English-speaking patients (P=0.01)
  - Patients born outside the U.S. spent more on healthy foods than U.S.-born peers (P=0.001)

Paolantonio L, Kim SY, Ramirez J, Roberts-Eversley N, Li Y, Melnic I, Wu M, Jutagir DR, Smith J, Oladele M, Gany F. Food Purchasing Behavior of Food Insecure Cancer Patients Receiving Supplemental Food Vouchers. Support Care Cancer. 2020 Aug;28(8):3739-3746. doi: 10.1007/s00520-019-05183-4. Epub 2019 Dec 11. PMID: 31828492; PMCID: PMC8054702.

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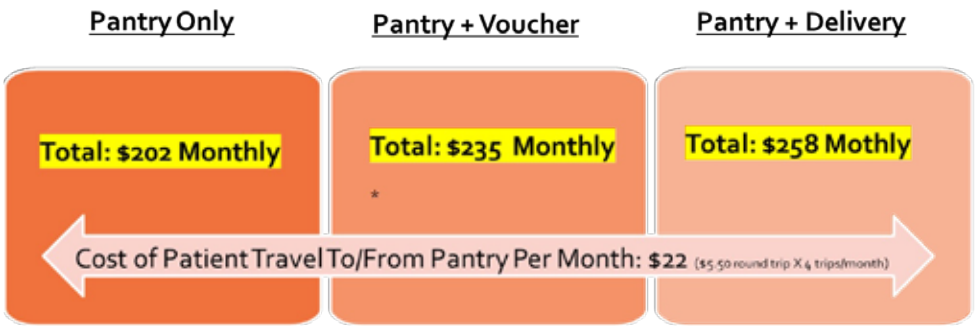
Cost Comparisons



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COVID-19 Pivot: Home Delivery for All

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FOOD Lessons Learned

- What worked
  - Universal FI Screening: Do you need help getting food?
  - FI Interventions→ Treatment Completion
  - Vouchers Best Outcome, but Medically Tailored Pantries Co-located in Cancer Clinics, and Home Deliveries also Impactful
    - Vouchers may be easier policy solution + patient choice
- Challenges that arose
  - Delivery reliability, fresh produce, delivery zip codes, debit card acceptance at bodegas

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FOOD Next Steps

- Next Steps
  - Further Screening and Intervention Dissemination
  - Unify FI Clinical Screening and Surveillance Questions
  - Track Longer Term Outcomes
  - Larger multisite RCT underway: smaller monthly food allowance
  - Pending study with addition of an MTM arm
  - Pending D&I study across varied sites/locales

FOOD

Memorial Sloan Kettering Cancer Center

The FOOD RCT Team

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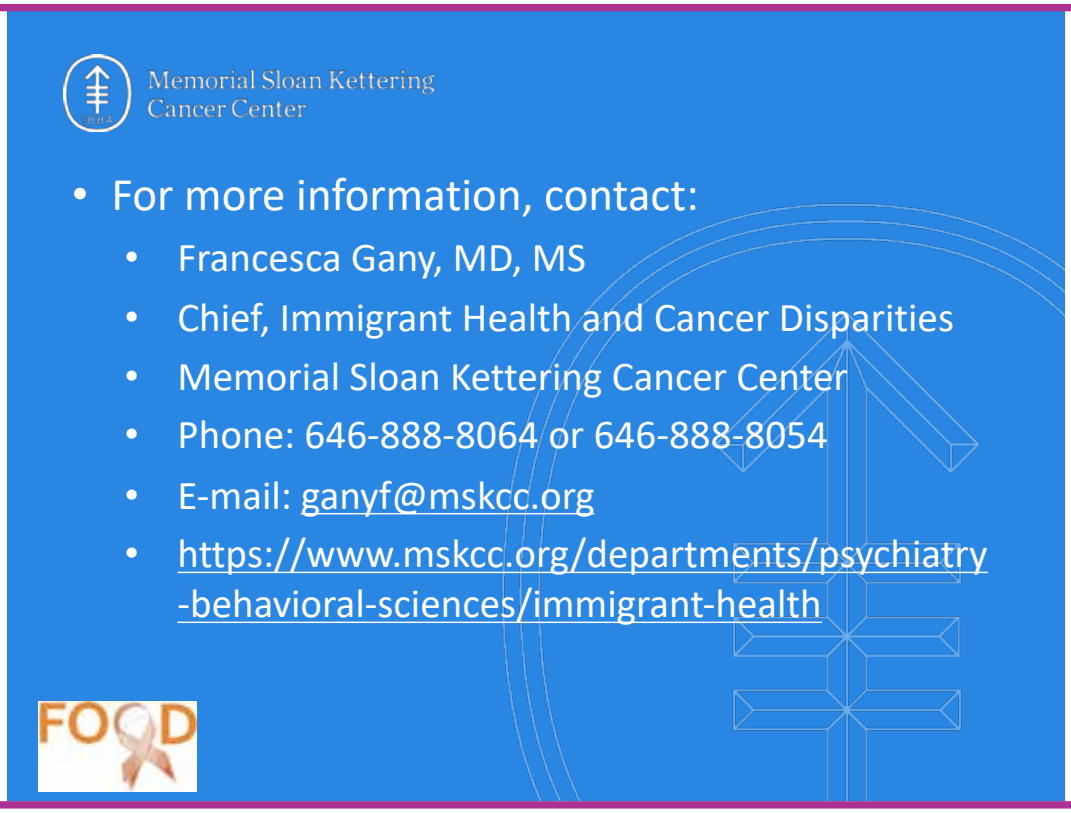
Memorial Sloan Kettering
Cancer Center
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• https://www.mskcc.org/departments/psychiatry-behavioral-sciences/immigrant-health
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COMMUNITY-BASED APPROACHES TO ADDRESS CANCER HEALTH INEQUITIES

Joseph Ravenell, MD, MS

Associate Professor of Population Health and Medicine

Associate Dean for Diversity Affairs

New York Grossman University School of Medicine

NO CONFLICTS OF INTEREST TO DISCLOSE

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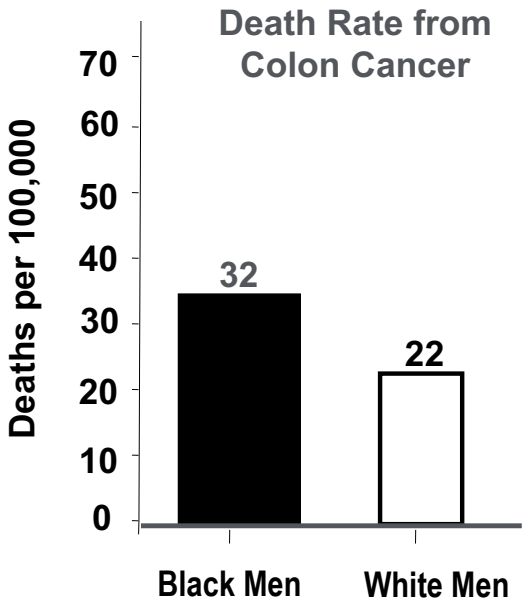
Colorectal Cancer Mortality Disparity



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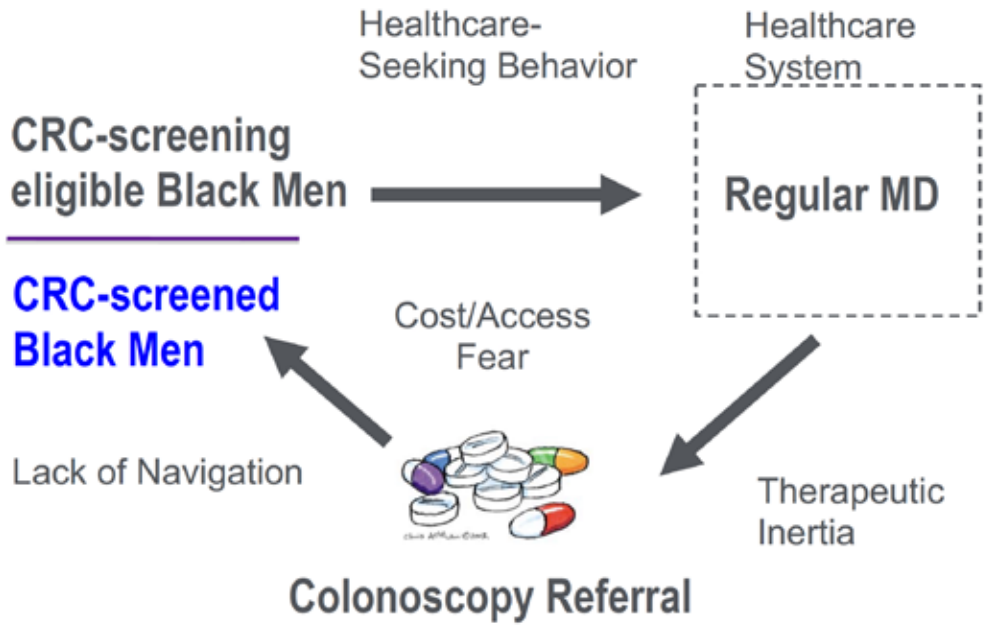
Barriers to Colorectal Cancer Prevention



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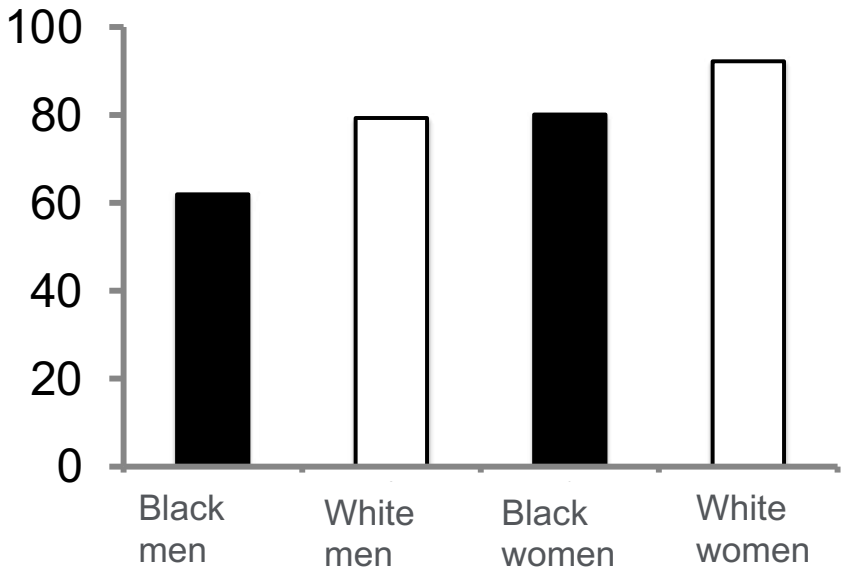
Black men are less likely to have a primary care provider



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How can we reach Black Men? The Church and the Barbershop: Cultural Institutions

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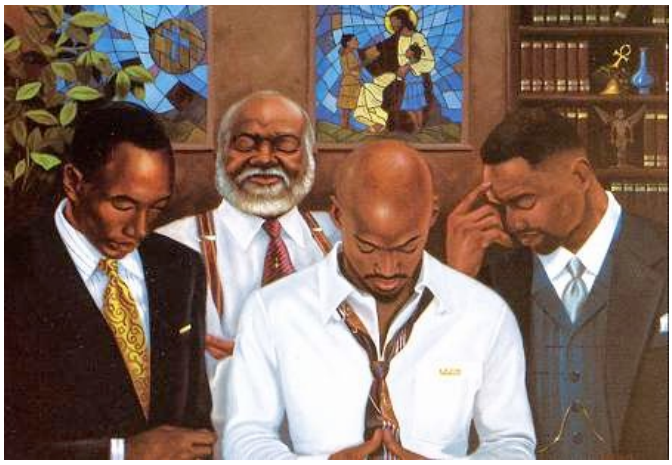
Why black churches for reaching black men?



- A church in every neighborhood
- Churches are a trusted, non-medical setting
- In urban black communities, 65-80% attend church regularly
- 51% of older black men attend church at least once a month
- Black men comprise 35% of congregants in large predominantly black churches

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The Barbershop: A Cultural Institution

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Why Barbershops?

- "The Black man's Country Club"
- Relaxed non-medical atmosphere
- Frequent follow up (q 1-4 weeks)
- Tradition of "Barber Surgeons"
- Barbers as key opinion leaders ("important others"; set social norms)

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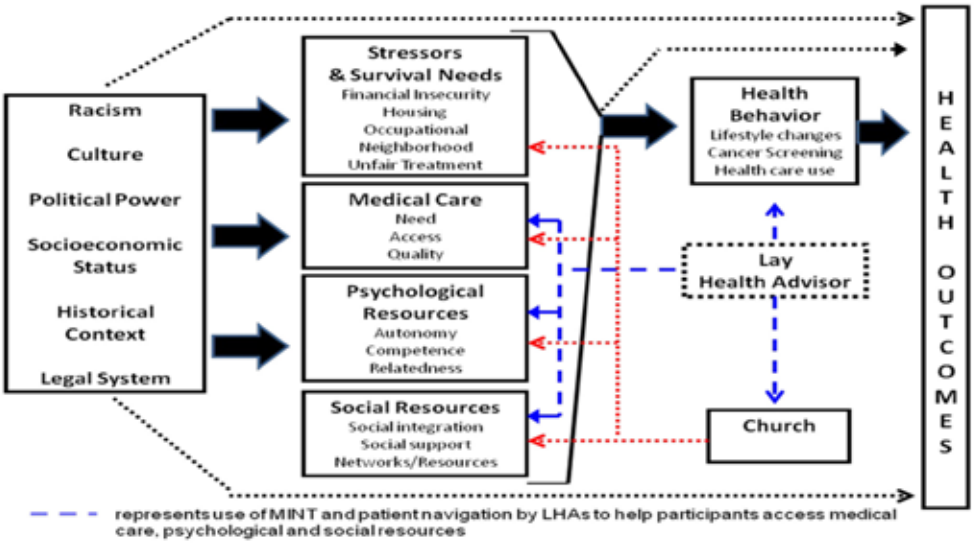
Social Determinants of Health Framework



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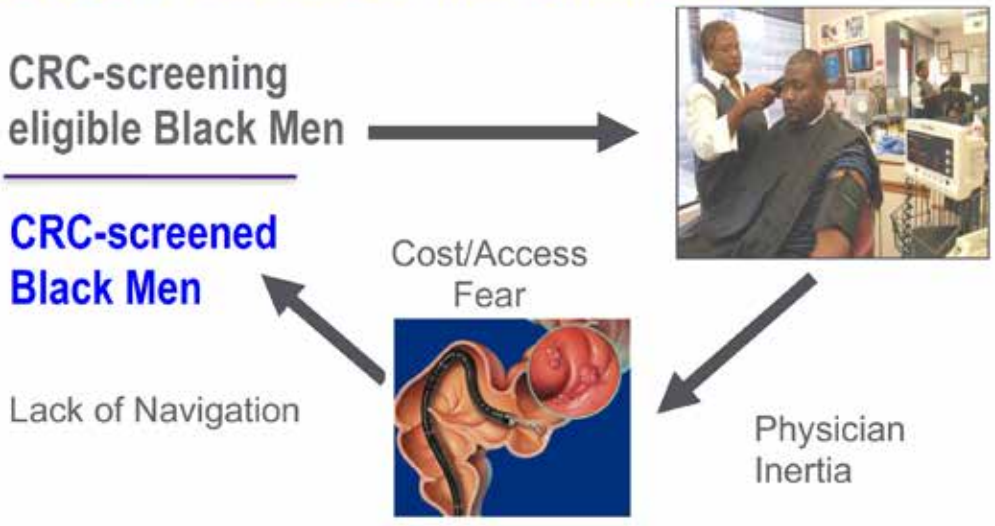
The NYU Men's Health Initiative

YU Langone Health

Can we identify unscreened men and 'navigate' them from the community?



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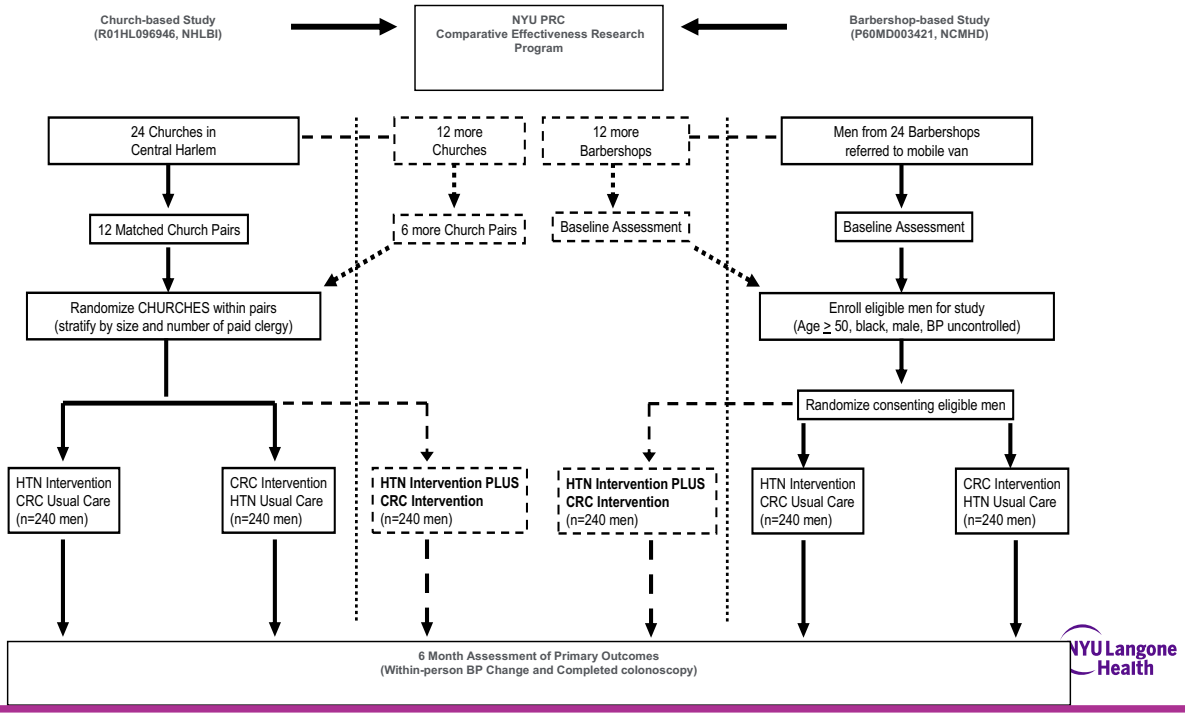
NYU Men's Health Initiative Research Program



Patient Navigation Intervention

Session 1
Within 2 weeks of baseline interview

Follow-up Sessions
As needed for duration of study period (~3)

- **Session 1 (in-person):**
  - Education on CRC and need for screening
  - Elicit barriers
  - Assess readiness
- **Follow-up sessions (telephone):**
  - Revisit barriers
  - Assist with scheduling
  - Navigate to appropriate screening facility
  - Check in prior to screening
  - Check-in after screening to debrief

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NYU Men's Health Initiative

Milestones	MISTER B	FAITH CRC	Total
Black Men Over 50 screened	4312	3310	7622
Eligible	1049	650	1699
Randomized	740)	451	1191

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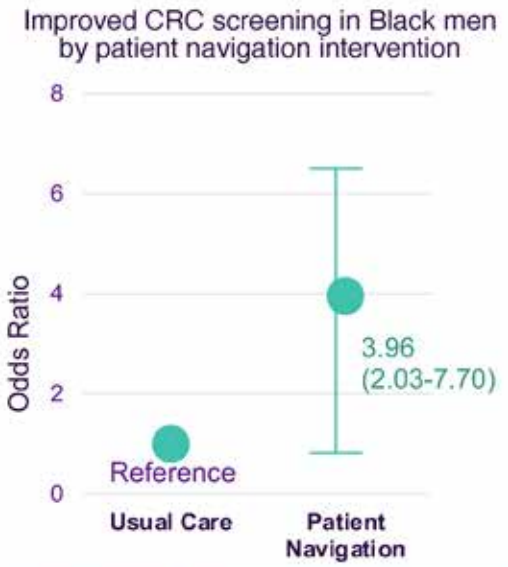
Barbershop Model for CRC Prevention



Funded: NIH/NIMHD 5P60MD003421-05; CDC U48DP002671-03

AJPH

Community-Based, Preclinical Patient Navigation for Colorectal Cancer Screening Among Older Black Men Recruited From Barbershops: The MISTER B Trial, ***AJPH, September 2017***

Helen Cole DrPH, Hayley S. Thompson PhD, Marilyn White MD, Ruth Browne PhD, Chau Trinh-Shevrin DrPH, Scott Braithwaite MD, MS, Kevin Fiscella MD, MPH, Carla Boutin-Foster MD, MS, and Joseph Ravenell MD, MS

- Barbershop
- Church Site
- Social Services Org
- Mosque
- Food Pantry/Soup Kitchen
- Community Health Fair/Festival

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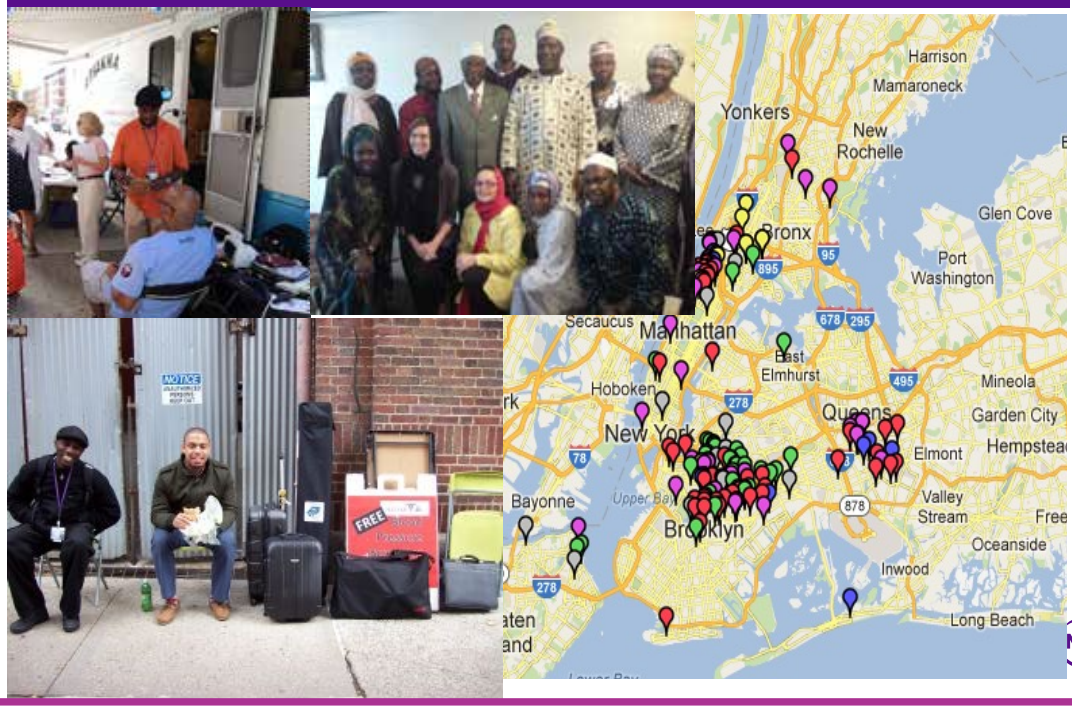
Non-Clinical ‘Places’



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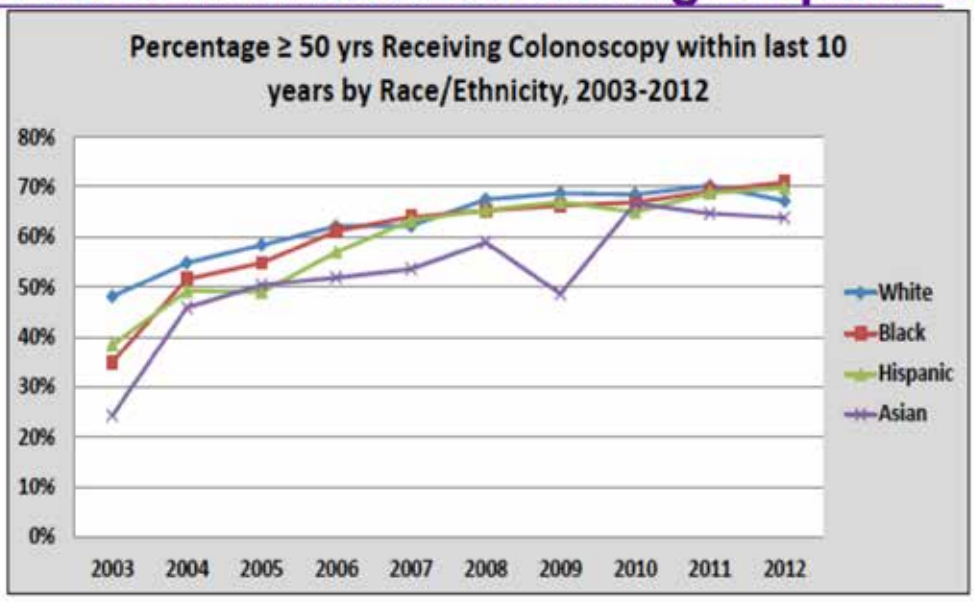
NYC has Eliminated Screening Disparities



Source: http://cdn.c5nyc.org/

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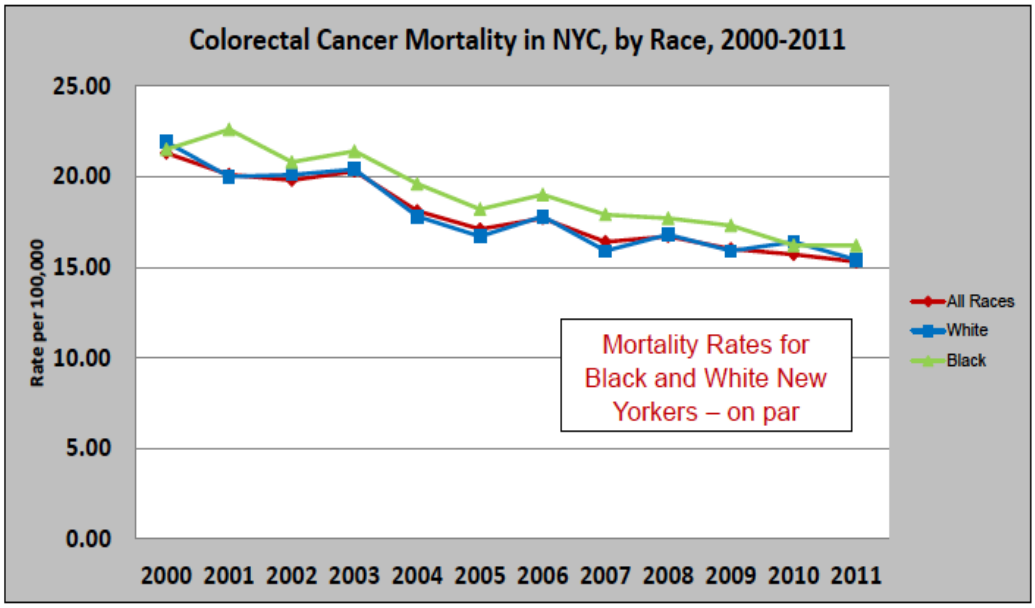
…and Mortality Disparities



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The Beatrice W. Welters Breast Health Outreach and Navigation Program

- The **Beatrice W. Welters Breast Health Outreach and Navigation Program** at the Perlmutter Cancer Center **educates** women about **breast cancer** and the critical **importance of screening**. The program also assists women in navigating the healthcare system through **one-on-one guidance** and **direct interaction**.
- Through the **Welters Program**, patient navigators identify women who could benefit from breast cancer screening through outreach and educational programs in community venues that women routinely visit. Our patient navigators also help women secure breast health services, such as free or low cost mammograms, and provide them with active support, from diagnosis and treatment to survivorship.

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Stamp Out Cancer Brooklyn (SOCB)

Stamp Out Cancer Brooklyn (SOCB) is a community-engaged initiative of the **PCC Community Outreach and Engagement (COE)** Core to reduce the burden of cancer and alleviate disparities.





"SOCB offers an opportunity to build trust with the community and leadership buy-in for essential cancer wrap-around services like financial counseling/navigation to connect uninsured people to high quality care with cultural competency free from shame."

Dr. Marilyn Fraser, CEO of Arthur Ashe Institute for Urban Health
SOCB Kick-Off Retreat, 2/27/2020

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Why Brooklyn?

- NYC's **most populous borough** (~2.6 million) and home to the largest number of PCC patients
- **3rd largest city** in the nation if it was a standalone metropolis
- Residents speak **>200 different languages**
- ~38% **foreign-born**
- Disproportionately **high cancer burden** and unique disparities
- 2 out of 3 residents are **45 years or younger**
- **Microcosm** of the larger PCC catchment area and future United States

Opportunity to bend the cancer disparity curve






Street art in the Sunset Park, East Flatbush and Bay Ridge Neighborhoods of Brooklyn

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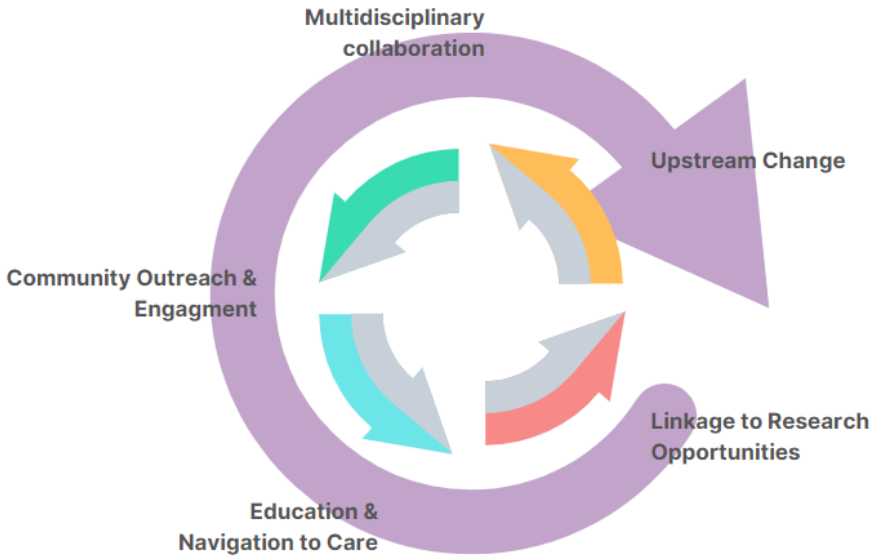
Framework



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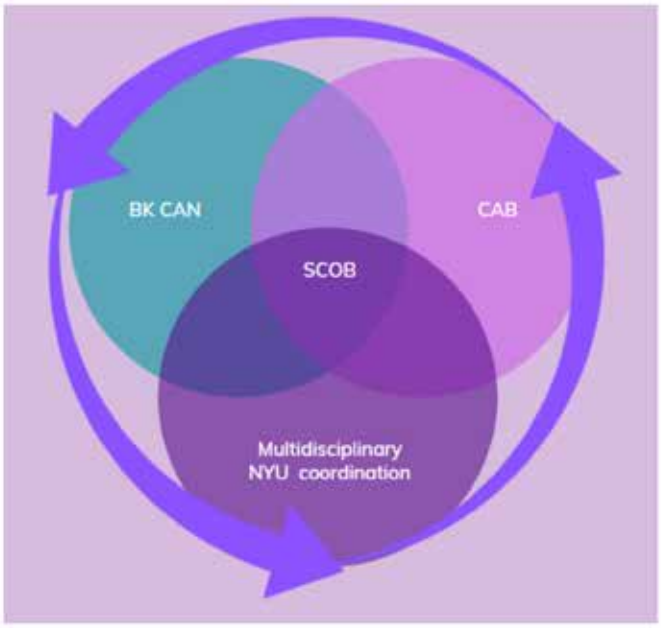
Stakeholder Engagement



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Brooklyn Community Action Network (BK CAN)

Acknowledgements

- Men's Health Initiative team
- 200+ community partner organizations
- 7000+ participants in the Initiative
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- Centers for Disease Control and Prevention (1U48DP002671)
- Beatrice Welters Beast Health and Navigation Program
- NYU Langone Health Perlmutter Cancer Center

THANKS!

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THANK YOU

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About Healthfirst

Healthfirst is New York's largest not-for-profit health insurer, earning the trust of 1.7 million members by offering access to affordable healthcare. Sponsored by New York City's leading hospitals, Healthfirst's unique advantage is rooted in its mission to put members first by working closely with its broad network of providers on shared goals. Healthfirst takes pride in being pioneers of the value-based care model, recognized as a national best practice. For nearly 30 years, Healthfirst has built its reputation in the community for top-quality products and services New Yorkers can depend on. It has grown significantly to serve the needs of members, offering market-leading products to fit every life stage, including Medicaid plans, Medicare Advantage plans, long-term care plans, qualified health plans, and individual and small group plans. Healthfirst serves members in New York City and on Long Island, as well as in Westchester, Sullivan, and Orange counties.

For more information on Healthfirst, visit **healthfirst.org**.

Thank You for Attending Best Practices and Innovations:
Caring for New Yorkers with Cancer