

Lori Pierce: Every patient deserves high quality, equitable care. And it's more than just words. Every patient deserves an equal chance to be treated and cured of their cancers. And we shouldn't let social determinants of health, where people live, as people say, their zip code. We must find ways to be able to continue to provide equitable care.

Scott Redding: Welcome to The 3Ps of Cancer podcast where we'll discuss prevention, preparedness, and progress in cancer treatments and research. Brought to you by the University of Michigan Rogel Cancer Center. I'm Scott Redding. We're here with Professor of Radiation Oncology, Dr. Lori Pierce, to talk about disparities in healthcare. She is the current president of the American Society of Clinical Oncology. While her cancer focus is in breast cancer, she speaks often of addressing the need and importance of diverse populations in clinical trials and screenings to best treat underserved populations. Welcome, Lori.

Lori Pierce: Hi Scott.

Scott Redding: In your role as the ASCO President, you recently came out with some new recommendations around reducing cancer disparities. Can you tell us about that?

Lori Pierce: Sure. First of all, ASCO has been focused on equity of care since its inception. Everything about ASCO focuses on improving the quality of care for everyone. And so they've had many initiatives through the years. And actually at one point we had a health disparities group and that has now emerged and is now the Health Equities Committee. And that committee has really put forward a lot of initiatives through the society. And most recently the policy statements that you're referring to that was just published a couple of months ago in the Journal of Clinical Oncology. And it contains recommendations that frame necessary steps for health equity. And it's going to lead to a more formal strategic plan for the society. So it's not my plan, even though I'm happy to have been a part of it. It is something that the Health Equity Committee has been working on for quite some time. And it is a very, very impressive framework.

And it outlines four main areas that are important to achieve equity and care. The first one they talk about is ensuring equitable access to high quality care. And that basically includes things such as address barriers to care, promote payment reforms that can support health equity, advocate for policy changes that the current policies result in poor outcomes, and improvement in policies can improve outcomes.

And an example of this is something that we're dealing with right now, which is the Most Favored Nation Model for Medicare Part B, drug reimbursement, that if it goes forward as of January one, it's going to cut reimbursement for a lot of cancer drugs. And that's going to limit access care for Medicare beneficiaries. And so it is something that certainly ASCO was focusing very strongly on this, as are many cancer organizations, to appeal to the administration, not to move



ROGEL CANCER CENTER
MICHIGAN MEDICINE

this forward. So that would clearly be something that would negatively affect access to high quality care.

So then getting back to the policy statement, another point they emphasize is ensure equitable access to research. And this includes ideas such as promoting partnerships between academic institutions and community institutions, so that you have a larger, more robust system. Because of course, the majority of cancer patients are seen in community centers. And it's important to have that strong connection between community centers and academic centers.

Address structural barriers, that is a key part of the report. That's certainly very important and we need to have more a diverse workforce at every level so that our workforce mirrors the population that we serve. We need to promote culturally sensitive care and implicit bias, acknowledge that. And I can talk about that later. But we need to basically look at our institutional policies and look at them very critically and make sure that we are maximizing our outreach to the community.

And then the last point of the four points was an increased awareness and action. We all need to advocate for equity of care. And we need to work with our lawmakers, either at the local level, at the state level, at the national level, and make sure they're aware of some of the negative impacts of current policies and make changes so that they too can promote equity of care. So it's a very broad, very comprehensive statement that gives us a lot to act on going forward.

Scott Redding: You referred to this, came back and referred to this as health equities. And so is that something we need to be looking at? Because I look at other things and I hear the mixture between racial disparities and health equity. Are they one in the same? Or are they separate? Where's that line between those?

Lori Pierce: Well, I think initially many of us focused on disparities. And disparities are very important. Health equity is what we strive toward. You have to acknowledge the disparities and then you develop the plans for health equity. So it's certainly along the same continuum and it's really taking a more positive view of what we can do to eliminate the disparities and promote global health equity.

Scott Redding: You mentioned structural barriers, can you explain more about that? Is that like the actual access to care, like clinics, being able to get to clinics, closeness. I know that there can be in certain cases, if someone's not close enough to a clinic or maybe a clinic doesn't treat that. And so then they have to go far away. Can you explain a little bit more about what structural barriers are?

Lori Pierce: Everything you said is structural barriers. They're all structural barriers and more. There's so many different types of structural barriers, so many layers. You can consider implicit bias as a significant structural barrier. That there may be caregivers that are assuming certain things that may not necessarily be the case.

I'll give you an example. We know that there is an under-representation of people of color in clinical trials. And so a provider could think, "Well, I've got a very busy clinic. I've got to trial. But why should I even try to bother putting this person and talking to this person about a trial? Because I don't have a lot of time and we know they're not going to go on trial anyway." That's absolutely not right.

And so I think we all need to acknowledge our biases and I am a very strong believer in implicit bias training. Do I believe it's going to answer all the questions? No. All the issues? No. It's not going to address everything. But it does give you a greater awareness of your own internal biases. And so you can check those at the door. You can realize that that is something that you didn't realize you were thinking, but you probably were. So that's a structural barrier.

And then you alluded to this in your question, you get into all of the social determinants of health. And so many of these are structural barriers. For instance, economic stability. Do you have a job? What's your income? Are you in debt? Do you have transportation? We have so many wonderful therapies, but if patients can't come in because they can't get off from work or they have no transportation or whatever, that's a huge barrier.

There's a long list. The education, literacy, access to healthy foods. All these are barriers to our health. And obviously, healthcare providers, we can't write all the wrongs of the world. We can't make them all go away, but some we can address. And then we can also ask the questions to our patients, what barriers are they facing when they are trying to get cancer care? And if you elicit that history, we say, take a social determinants of health history and understand some of the barriers that patients are facing, there are things that we can do. And we can also advocate on their behalf.

So that's a long answer to your question, but the structural, it's a huge topic. And at every juncture, there are barriers that we're not even thinking about. And so everything you could possibly think of and more could be lumped into what we consider structural barriers to be.

Scott Redding: Along those lines, though, if that is an area of focus, as you work through that, and at every section, like you just said, that there could always be additional barriers on top of that. How do you start to make a way in to start to break down some of those barriers?

Lori Pierce: Yeah. So, I think you look through cancer care through the lens of the patient because many of us, on we're on the other side. And we forget just what patients are going through. And we simply asked the question, when we're seeing patients in consult, go through some of the issues such as transportation, such as exercise. Go through some of these issues to really understand what the patient's facing.

I think once we do that, we are in a better position to see what is changeable within our domain and what we need to advocate for, for the domain of others. We as healthcare providers, we can be very passionate advocates for issues on behalf of our patients. We have to understand those issues. We have to realize that these are issues that patients are facing. And then we're in a better position to begin to strategize and answer the question that you asked. But it's also a case where we clearly have to partner with other aspects of society. Healthcare can't do it all. There's a lot we can do, but we can't do it all. And so we really have to set up these very strong partnerships.

Scott Redding:

You mentioned implicit bias and that part of the recommendations doesn't include that in implicit bias training. Are there other trainings that also might help with getting to that point of being able to start to maybe listen to that more with the patients? Because as established physicians that, a lot of times, especially in the community, they're just sometimes just going through the moments, and they're not taking that time necessarily to listen. Are there plans or goals to start to get some of that training? And for new physicians, as they're going through medical school and into their realm. What's being done to be able to achieve some of these goals through some of those trainings?

Lori Pierce:

Another great question. So, there's implicit bias. There's also more cultural sensitivity, which is distinct from implicit bias, even though they're connected, they are separate. And so having trainings and programs that you are more culturally sensitive, that you are just more collegial to your colleagues. If you're collegial, if you learn how to take a moment and take a deep breath, and be more collegial to your colleagues. We have trainings like that at the University of Michigan. That will certainly translate into your interactions with patients.

In terms of education, you hit upon a really important point, and that is education of our students as they are maturing in their careers, in oncology or other areas as well. We at ASCO, one of the initiatives that I've started this year is an education into social determinants of health and modifiable risk factors. And we're setting this up as a series of podcasts and videos and written pieces to focus on different aspects of social determinants of health. And again, the modifiable risk factors for cancer.

Our primary audience for this is going to be fellows, as well as early career oncologists, because they are our future for oncology. And this will be an enduring set of podcasts and videos that will be used hopefully for years and years to come. And it's certainly open to all members of ASCO. But we're focusing primarily on our fellows and early career oncologists. And I have a task group that also is made up of the fellows and early career people so that we can make sure we're hitting on topics that would be applicable to them. And this will be something that we hope many of the training programs will bring into their training programs as well.



ROGEL CANCER CENTER
MICHIGAN MEDICINE

And so the way we set it up, and I won't go into all the details, but we're doing one podcast or video every month. And we, as the steering group, the task force, we meet every two months to plan the next set of videos. So we've done two already. The first one, I was in it and the chair of the Health Equity Committee and the chair of the Prevention Committee, and one of the fellows actually from Johns Hopkins. It was basically a social determinants of health 101. What are the social determinants of health? What are the things you need to be thinking of? Framing the issues.

The second one was done by Cliff Hudis, the CEO at ASCO, and one of the staff members at ASCO to focus on some of the initiatives that ASCO specifically had. We've done the planning for the one that will come out in January and February. We do it two months at a time. And the one in January, I'm really looking forward to it. It's going to be how to take a social determinants of health history, what I talked about earlier. Hitting on somebody that the things that we need to be more sensitive to and ask our patients and elicit that feedback. And then the next one that we've planned is on some of the financial toxicities of cancer care. So I think resources like this will be very helpful in educating people on the issues that our patients are facing. I'm pretty excited about it, actually.

Scott Redding: I talked about social determinants of health a few times. And I'm not quite sure exactly what that means. So could you maybe explain a little bit more about that?

Lori Pierce: Social determinants of health, if you look at the definition, there are many different definitions, but the one that we use, the standard from the World Health Organization, it's conditions in which people are born, grow, live, work, and age. So, basically it's all of the conditions in our life. And so much of it is controlled by money and power. And so you can see a breakdown of various areas, if it's going to include things such as economic stability, the neighborhood, the physical environment in which we live and we work, education, literacy, higher education, language issues, food. Are there food insecurities? How difficult is it for people to access healthy options? The social context of the support systems, the stress that everyone's under, but they're various degrees. And certainly, the healthcare systems that we work with, how accessible is it for a patient to access the healthcare system? How available are our primary care providers? What's the quality of care?

So all of these factors affect the health outcomes of patients. And depending upon where you are largely in the power and money area, it will certainly factor into the social determinants that affect your immediate life.

Scott Redding: And if those are going to be questions that are asked to patients, are those can be asked across the board? Or is it more of in this case, of a cancer patient? Maybe they've got an issue going on. They find a lump in their breast, and they're seeing their family medicine doctor, their primary care doctor, and they get consent for a mammogram. And then they found that they have cancer. Is



ROGEL CANCER CENTER
MICHIGAN MEDICINE

that a conversation that would happen before a referral, or would that happen after a referral? How is the process of actually asking the questions?

Lori Pierce:

Yeah, no, I think anytime there is a history being taken, a health history that we do all the time, it would be an appropriate time to factor in these types of questions. There's no limit to the number of times that one should ask. And in our system now, as you know, we take histories at many points in the patient's progress, in caring for their disease. And all of those time points would be a good time to really understand and ask the questions for potential barriers. So, if you're looking at a breast patient, I'm sure they take a history before they do the biopsy. Of course, the surgery, they take a history. For medical oncology, take a history, for radiation oncology. So it's important.

And I think by doing this, yes, there will be some duplication as there currently is in our system. And that's a good thing because sometimes one person will find out things because the patient didn't really think about it at the previous interaction as they did. So, that's a good thing. But then there also will be perhaps things that more specific to that particular discipline that may come out in that history taking and social determinants of health. So I think like all of the above is the right answer.

Scott Redding:

Well, we've talked about the barriers for equitable care. And you get out more of the history through the social determinants of health. Are there other issues or other reasons why people of color might have a higher cancer risk?

Lori Pierce:

I guess the first part of my answer would apply to all patients. And that gets back to the modifiable risk factors for cancer. It's astounding to me that up to 40, 45% of cancers are preventable. And you look at the deaths from cancer, and comparable about 40% of deaths from cancer can be prevented. So it says that we do have some control. There's some things we don't have control over, but there are some things that we do. And we need to obviously do what we can to minimize the risk of getting cancer. And so that statement would apply for all patients. But then there are certain areas that perhaps are more applicable to people of color.

Tobacco, smoking. You can't find literally a factor that impacts cancer risk more than smoking. And that is strictly completely in our domain. And it's not just lung cancer. There are other cancers that clearly are promoted by smoking. And we know for many years, the tobacco industry put billboards disproportionately in neighborhoods of people of color, so that this is a modifiable risk factor and probably a factor that did effect more people of color because they were the target of the tobacco industry. But that people can now push back.

Drinking in moderation. Alcohol. We know alcohol clearly causes cancer. And this is for all populations. And we need to ideally not drink alcohol, but far more realistically, just be very judicious and do it in moderation.

Obesity, exercise, diet. These are very much modifiable risk factors for cancer. And we know there's a disproportionate rate of obesity in the African-American population. And we need to be able to promote healthy lifestyles in terms of the choices that we make to eat. Now, that may be a little bit more difficult in certain populations where, and people who don't have a lot of resources are poorer patients. They may live in neighborhoods where there are not a lot of options for healthy foods in their grocery stores. They live in food deserts essentially. And so we as providers, we need to be able to help to educate them for things that they can access, how they can still make healthy choices.

And we also need to remember that we need to promote exercise. Absolutely. Exercise is so important, it minimizes, keeps down obesity. It helps to keep us healthy overall. But we have to be aware that there are some members of our communities that live in communities that are not safe and that have a lot of violence. And so they can't go out and go jogging, like perhaps I can go in Ann Arbor and go jogging. And so we have to be able to, again, be mindful of the barriers that our patients are facing and come up with suggestions of exercise programs they can do within their home in a safe environment.

Vaccines. Vaccines against viruses. We know that there are some viruses that cause cancer. And we have to make sure that we advocate for all populations to get the appropriate vaccines so that they don't get hepatitis B, they don't get head and neck cancers, HPV, things that are preventable with vaccines. And there's a lot of talk now about vaccines. And so people are very much focused on vaccines. And this is one of the very positive signs of vaccines.

Sun exposure. There are so many things that we can educate people that would use their risk. And certainly, we need to talk about early detection screening and making sure that patients are seeing their primary care doctors and that there's a checklist and that they're getting the appropriate screening. There's a lot in our domain that we can control, be a person black, white, purple, or whatever. But there are some touch points that are more germane and among people of color.

Scott Redding: As part of the recommendations, is there a large education aspect too?

Lori Pierce: Absolutely. I think we as providers, we must broadly educate in terms of other health providers, all members of our healthcare team, and certainly patients. And education is a very, very strong part of what ASCO has been doing overall, and it's been being further emphasized in our current policy statement.

Scott Redding: You briefly mentioned vaccines. And with obviously, there's a lot of talk about vaccines right now too just because of the COVID vaccine. How does that, especially since we know that COVID has affected people of color a lot harder, how is that with everything's going on equity, health equity and disparities with that, how's the rollout look, do you think?

Lori Pierce:

Yeah. So this is a very straightforward question, but it can be a bit complicated. And I'd like to make it less complicated. You mentioned, and you're absolutely right, there's a disproportionate effect of COVID among people of color. People of color were frontline workers. So they had a greater chance of being exposed to the virus. And many of these frontline workers had co-morbidities, which made them more at risk for getting the virus.

And actually to the credit of our state government, Michigan was one of the first states to actually dis-aggregate in the initial, some of their COVID data by race to actually look at race. And they were one of the first to identify that there was a disproportionately higher incidence of COVID in the African-American population. So one of the many things that I think our state government has done well.

So it should be very straightforward, that now that a vaccine, the first of many vaccines, I assume it will be approved, has been approved and will be approved by the FDA, that there are concerns now that there will be disproportionate number of people of color not taking the vaccine. And I think that in part reflects a history of distrust, of people of color, of the medical field.

And some of that distrust is appropriate, thinking of some of the things that have happened that I don't want to spend a lot of time on, but I do want to acknowledge that we all have to acknowledge that these things happened. Tuskegee happened, HeLa cell line. All those things happened. And we should never forget they happened. And even though there are affirm guard rails in place that these will never happen again, we should never forget they happened. So we always can educate our future caregivers that these things happened and we can never let history repeat itself.

And so there's still that element of distrust. But it is my firm belief that as more and more people get the vaccine and they are fine, people don't feel like they have to be a guinea pig because this hasn't been tried out. The trials, perhaps, were not as big as what they wanted them to be. That as we go through the rollout with the availability of the vaccine, that people will feel more and more comfortable with the safety of the vaccines, and that this will work its way through. But it is a concern. It is very much a concern that there may be particular concerns in the African-American community that will keep people back from getting the vaccine.

Scott Redding:

You kind of mentioned it earlier. And you just mentioned now, too, but as we look at this vaccine, and in clinical trials in general, and some of the concerns with potentially not getting the vaccine, do you know if in the trials, if there was enough representation across all people for the vaccine?

Lori Pierce:

Now, when you ask about, was there enough representation? I think we look at that as being ... if you look at the percent of ethnic groups in the general population, was that mirrored for the trial? And no, there were many attempts



ROGEL CANCER CENTER
MICHIGAN MEDICINE

to do that, but I believe there were on one trial that was, I think 10% African-American. We're 13% in the community. So there were many attempts to enrich that population, but it wasn't quite what we would like it to be. But there were still quite a few people of different ethnicities in these trials. And we saw that patients did very, very well and the toxicity profiles were low throughout.

Scott Redding:

And I know that this is also an issue because you mentioned earlier, for cancer clinical trials as well. Are there ways to start to break through some of those barriers? And I know that you alluded to the history. But are there other ways to break through that? And why it's important for people of color to participate in these trials?

Lori Pierce:

Yeah. So I'll go with the second question first, because this is a very important issue. And so, as we talked about before with the COVID trials, when you think about a clinical trial, you want to have representation and the same percentage of the trial as you have in the general population. So if you look at African-Americans, about 13% of a general population are African Americans, about 18% for Hispanics. And if you look at the cancer clinical trials for both of those groups, even in the best of trials, they're generally less than 5% representation of African-Americans and less than 5% for Hispanics. So there's a lot we need to do to have better representation.

And it's important, to the second part of your question, it's very important because you want to be able to show that the effectiveness of new therapies and the safety of these therapies are the same no matter what race, ethnicity you are. And you also, I guess, secondarily certainly want to have a greater acceptance of these therapies in those populations. And so it would help to have better representation in those trials.

So then the first part is, is truly hard to answer. There's no one factor why you see an under-representation of certain racial and ethnic groups in clinical trials. And this has been something that's been studied for quite a while. And if you actually look at the literature, you will see that there are publications of some experiences that have been very successful in doing this, but they haven't been broadly disseminated through our cancer research community.

And this is another initiative that I'm happy to be working on this year in conjunction. So ASCO's working on this in conjunction with ACCC. That's the Association of Community Cancer Centers. The president of ACCC is Dr. Randy Boyer. One of the focuses of his presidency was to increase enrollment of minorities in clinical trials. Having more uptake of minorities and clinical trials, something I was very interested in too. So basically we are collaborating. The two societies are collaborating. And it is a very time intensive collaboration. And it's a very important collaboration. And we have a steering group of a lot of researchers whose careers have been focused on improving enrollment in clinical trials. And we have the infrastructure of ASCO and ACCC. We are in the



ROGEL CANCER CENTER
MICHIGAN MEDICINE

process now of paring down our ideas that we are then going to pilot in certain practices in ASCO and ACCC.

So I've spent a lot of time thinking about this. And I think one very important point to highlight to the people who are listening to this is that people want to go on clinical trials. And yes, there's a lot of bias and a lot of history in the African-American community. But there was a very important paper that was just accepted into JNCI, which looked at all of the publications that have studied enrollment of minorities onto clinical trials. And it shows that if you have a clinical trial that a patient is eligible for, it made no difference what race they were, but the same percent accepted enrollment in trial. So it was about 54, 55% for African-Americans, about 53% for whites.

So the point is you have to offer them the trial. You have to have a trial, first of all, that they're eligible for. And then you have to offer the trial. And it is not a case where when you do that, there'll be a disproportionate decision not to go on trial if you're black. No, it's the same, whether you're black or white. So that tells me that our strategies to improve enrollment in clinical trials basically has to be to get the trials to the patients. We have to work with pharma and others who write the trials to make sure the eligibility criteria are not so strict that many of our patients can't get on the trials, that their various co-morbidities keep them out. And there's work being done by ASCO and the Friends of Cancer Research and the FDA to do that very thing. And they've already gotten many of the pharma companies to relax some of the eligibility criteria. That will significantly help.

The other piece is when you're in a busy clinic, you got to have the infrastructure to be able to have the time, and it may not be the physician. It may be the nurse. It may be some of the APPs, but we had to be able to get the trials to the patients. So that will tell you, in a nutshell, without saying too much at this point, where our focus will be in this collaboration with ASCO and ACCC.

Scott Redding:

A lot of the underserved populations, they live in communities that don't have necessarily direct care to say the Rogel Cancer Center because they live inner city Detroit. As it relates to clinical trials, are there opportunities as well to work closely with some of those clinics in those communities to share that importance?

Lori Pierce:

Yeah, no, I think that goes back to something we talked about earlier in terms of networks. It's a win-win because the community practices are often closer to the patients. And certainly in the rural practices, for sure. And here we are in Ann Arbor, and we have all of these studies. But we don't have access to those patients. So you know certainly much of what Michigan Medicine is doing is setting up networks. So it's actually easier for us because the infrastructure is already being created to bring in many of these practices.



ROGEL CANCER CENTER
MICHIGAN MEDICINE

But yes, I think that is a key part. And so the providers in these clinics are able to participate from afar if you will, in clinical trials. And their patients benefit from that, the physicians benefit that in terms of maintaining those ties with the academic institution. And the academics certainly a benefit as well in terms of having more robust enrollment of patients on trials. So I think it's important to have these networks set up. You don't want to trial that's going to take years to be able to accrue because at that time, perhaps the question being asked is not the relevant question anymore. So we really need to be able to do this for our patients. And it just helps clinical research in general.

Scott Redding: I really appreciate the time today. If there's one key point that the listeners take away from this, what would that be?

Lori Pierce: Every patient deserves high quality, equitable care. And it's more than just words. Every patient deserves an equal chance to be treated and cured of their cancers. And we shouldn't let social determinants of health, where people live, as people say their zip code. We must find ways to be able to continue to provide equitable care. And some of this we can do. Some of this is within our own domain, but we also need to advocate to our lawmakers, advocate for our patients because there's a big part that they can do and should do so we can achieve equitable care.

Scott Redding: Thank you again.

Lori Pierce: My pleasure.

Scott Redding: Thanks for listening. And tell us what you think of this podcast by rating and reviewing us. If you have suggestions for additional topics, you can send them to cancercenter@med.umich.edu, or message us on Twitter at UM Rogel Cancer. You can continue to explore the 3Ps of Cancer by visiting rogelcancercenter.org.



ROGEL CANCER CENTER
MICHIGAN MEDICINE