The Impact of Segregation in Cancer Care

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4.19.24 | EXPOSING MODERN DAY JIM CROW

Disclosures: I am the surviving niece of Jeannette Barnes

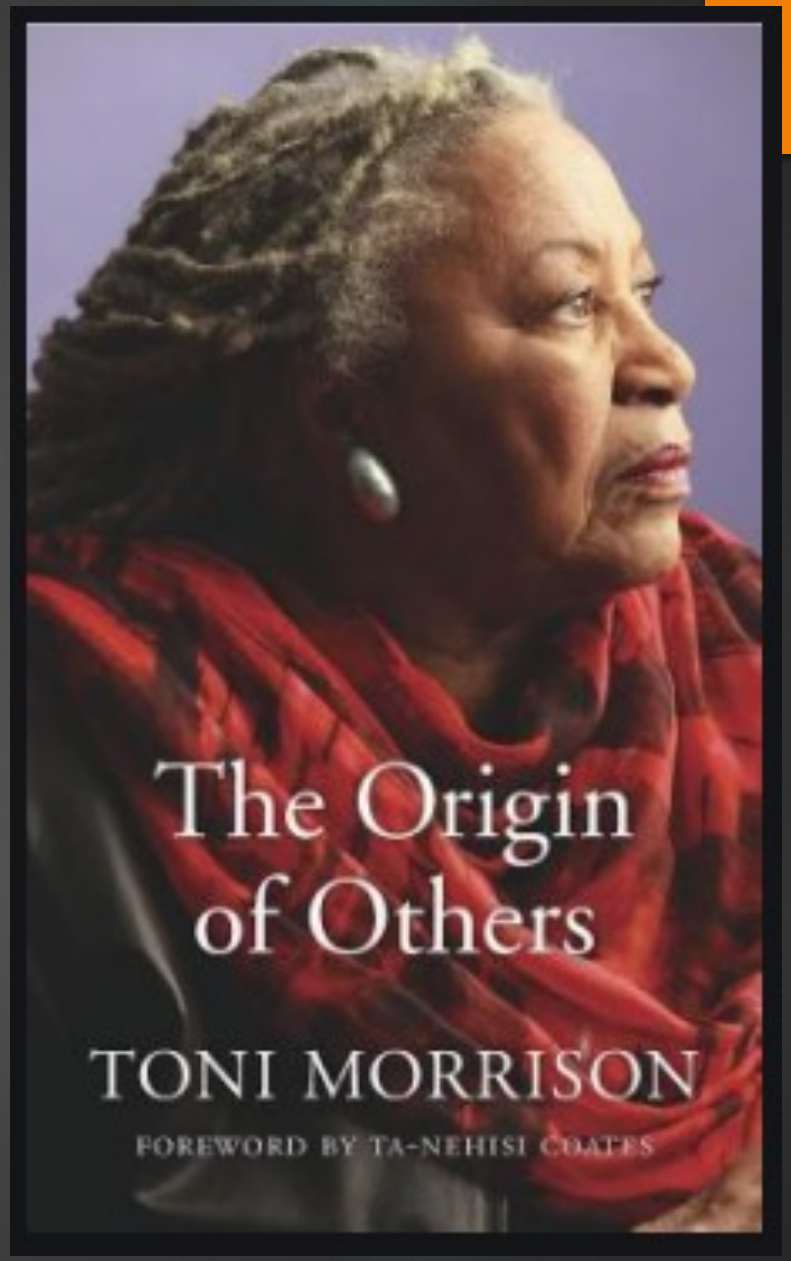
Norfolk, Virginia 1985

Jeannette Barnes (1935-1993)

- 58 years old
- Presents with a locally advanced, fungating breast mass
- Admitted for IV antibiotics & chemotherapy; no radiation therapy available or offered)
- Died in the hospital

The Origin of Others

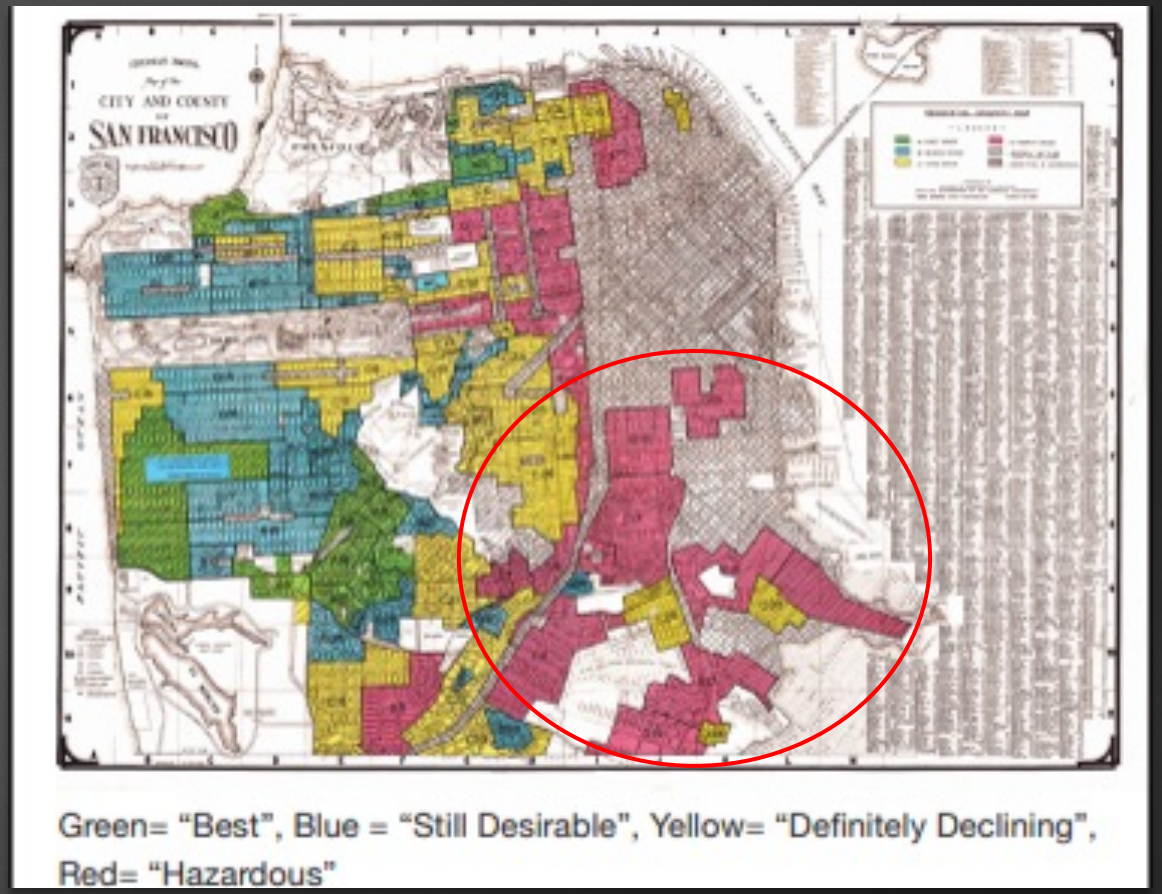
- African American people are not immigrants
- Slavery required "otherization" to justify itself
- Status of "other" was medicalized & preserved over time
  - Special diagnoses for Black people
  - Incapable of survival outside of slavery
- Following Abolition
  - Separate but (not) equal
  - Jim Crow segregation



“Otherization” justified segregation across sectors

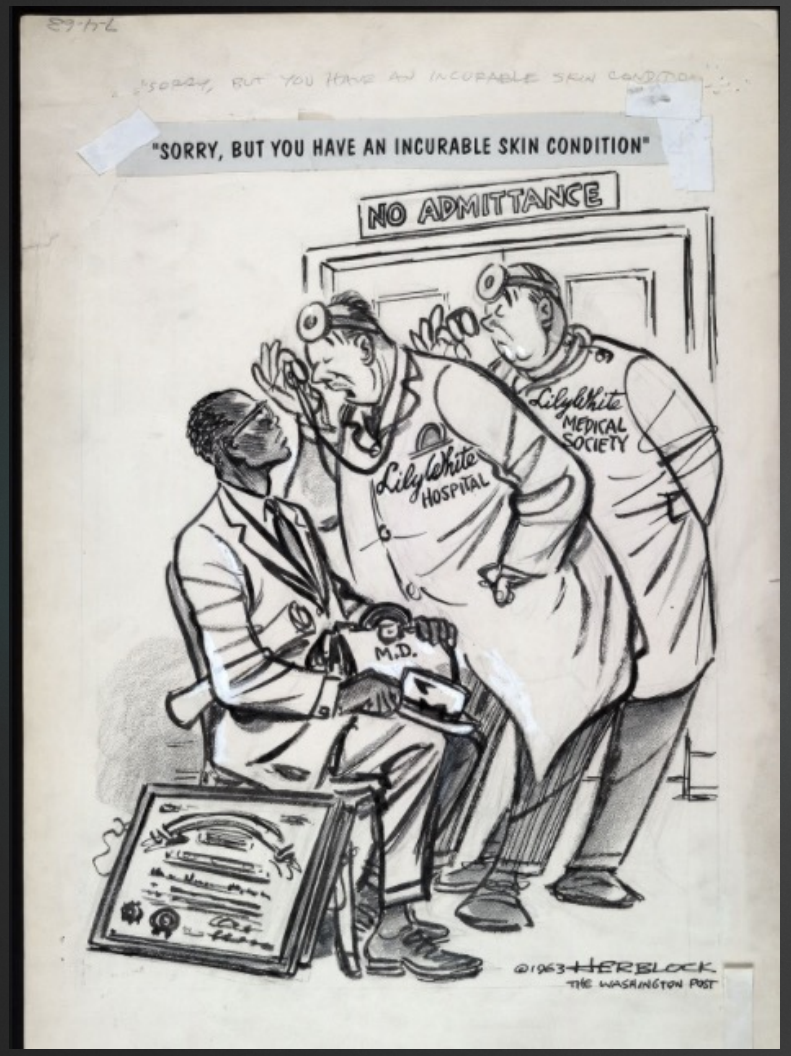
HOUSING

Redlining practices in San Francisco in the 1950’s meant African American/Black people were clustered into neighborhoods with “hazardous” living conditions



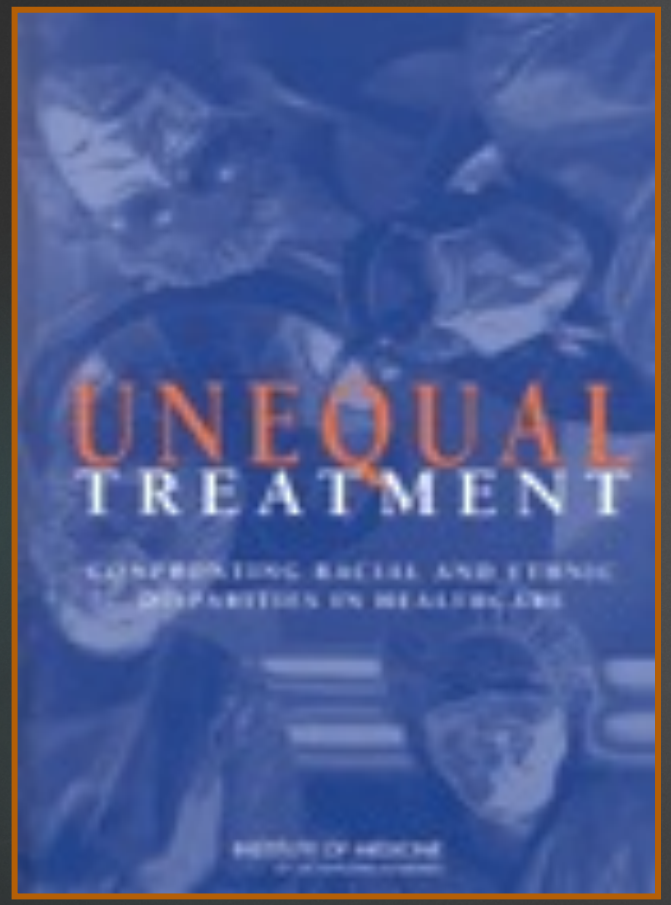
Green= “Best”, Blue = “Still Desirable”, Yellow= “Definitely Declining”, Red= “Hazardous”

Segregation across sectors drive segregation in healthcare



- In Education
  - Including medical school; residency training
- In Healthcare
  - Segregated professional societies; hospital staffing; patient admissions
  - AMA excludes Black physicians; NMA emerges to represent doctors serving Black patients in segregated settings
  - NMA advocates for Medicaid

High Medicaid hospitals have limited resources constraints



"Because of Medicaid's low reimbursement rates for doctors and hospitals, **poor, disproportionately minority beneficiaries** are subject to largely separate, often segregated systems of hospitals and neighborhood clinics. These systems often adopt their own norms of medical practice, shaped by tight resource constraints."

Unequal Treatment, Confronting Racial and Ethnic Disparities in HealthCare , IOM 2002

Racial/ethnic minorities in California cluster in High Medicaid hospitals for cancer care

Patient Characteristics (n=18,000)	High Medicaid Hospital (%)	Non-High Medicaid Hospital (%)
Race/Ethnicity		
White (non-Hispanic)	38.6	76.5
Black (non-Hispanic)	12.5	6.2
Hispanic	24.9	9.9
Asian Pacific Islander	24.0	7.4
Insurance Status		
Private Insurance	25.5	49.2
Medicaid	16.6	2.5
No Insurance	10.7	1.4
Medicare	37.9	45.1
Unknown	9.3	1.8

Rhoads KF, Dudley RA. J Am Coll Surg 2008

Healthcare Segregation & Minority Serving Hospitals

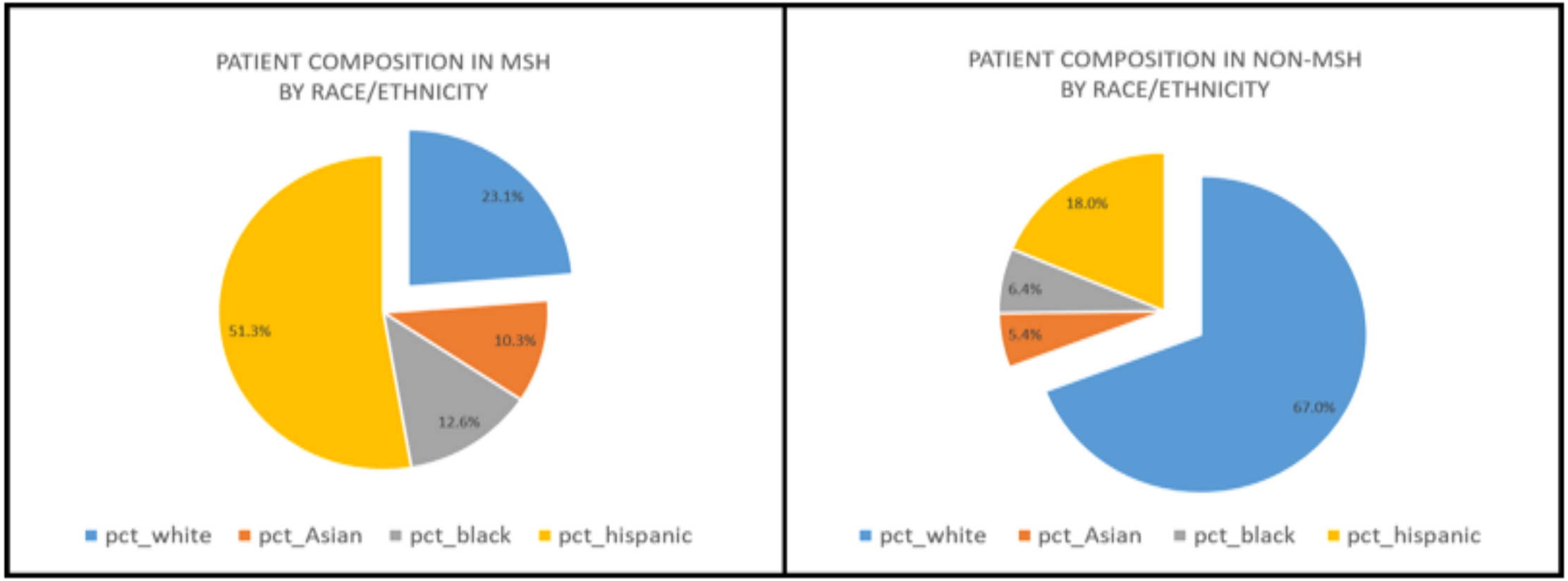
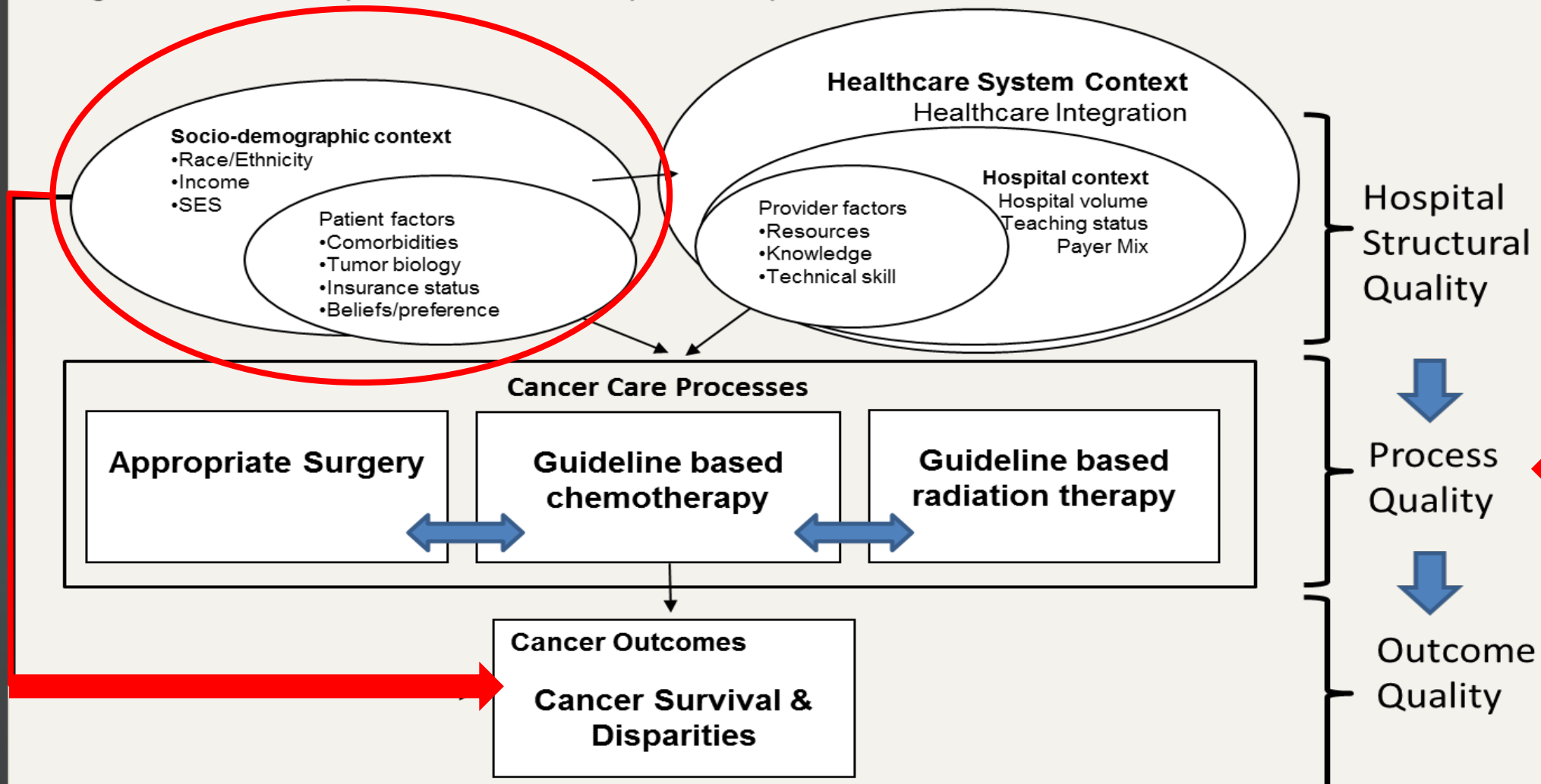


Figure 1. Distribution of patients in MSH and non-MSH settings

Figure 1. A conceptual model to explain disparities in cancer treatment and outcome



Adapted from Morris & Rhoads, et al. *J Am Coll Surgeons 2010*

Access to Specialists & cutting-edge therapies

Access to Clinical Trials

PLACE MATTERS

Where you go for cancer treatment determines what type of care you receive, including the availability of clinical trials, and can influence cancer outcomes (including disparities)

UCSF Helen Diller Family Comprehensive Cancer Center

Better outcomes *can* be achieved at NCI Centers

Pediatric Blood & Cancer

ONCOLOGY: RESEARCH ARTICLE | Full Access

Impact of location of inpatient cancer care on patients with Ewing sarcoma and osteosarcoma—A population-based study

Our results suggest that treatment for EWS and OS at a SCC is associated with significantly improved survival even after adjustment for known prognostic factors. The superior survival among those
clinical trials and services at SC

https://onlinelibrary-wiley-com.ucsf.idm.oclc.org/doi/

Cancer

Miscellaneous | Free Access

Do cancer centers designated by the National Cancer Institute have better surgical outcomes?

gery at NCI-designated cancer
treated at comparably high-volume
2005. © 2004 American Cancer

785

Influence of NCI cancer center attendance on mortality in lung, breast, colorectal, and prostate cancer patients

https://pubmed-ncbi-nlm-nihgov.ucsf.idm.oclc.org/19454624/

cancer-specific mortality using multilevel logistic regression models. NCI cancer center attendance was associated with a significant reduction in the odds of 1- and 3-year all-cause and cancer-specific mortality. The mortality risk reduction associated with NCI cancer center attendance was most apparent in late-stage cancers and was evident across all levels of comorbidities. Attendance at NCI cancer centers is associated with a significant survival benefit for the four major cancers among Medicare beneficiaries.

Canc

Original Article | Free Access

**Decreased early mort
acute myeloid leukem
designated cancer cer**

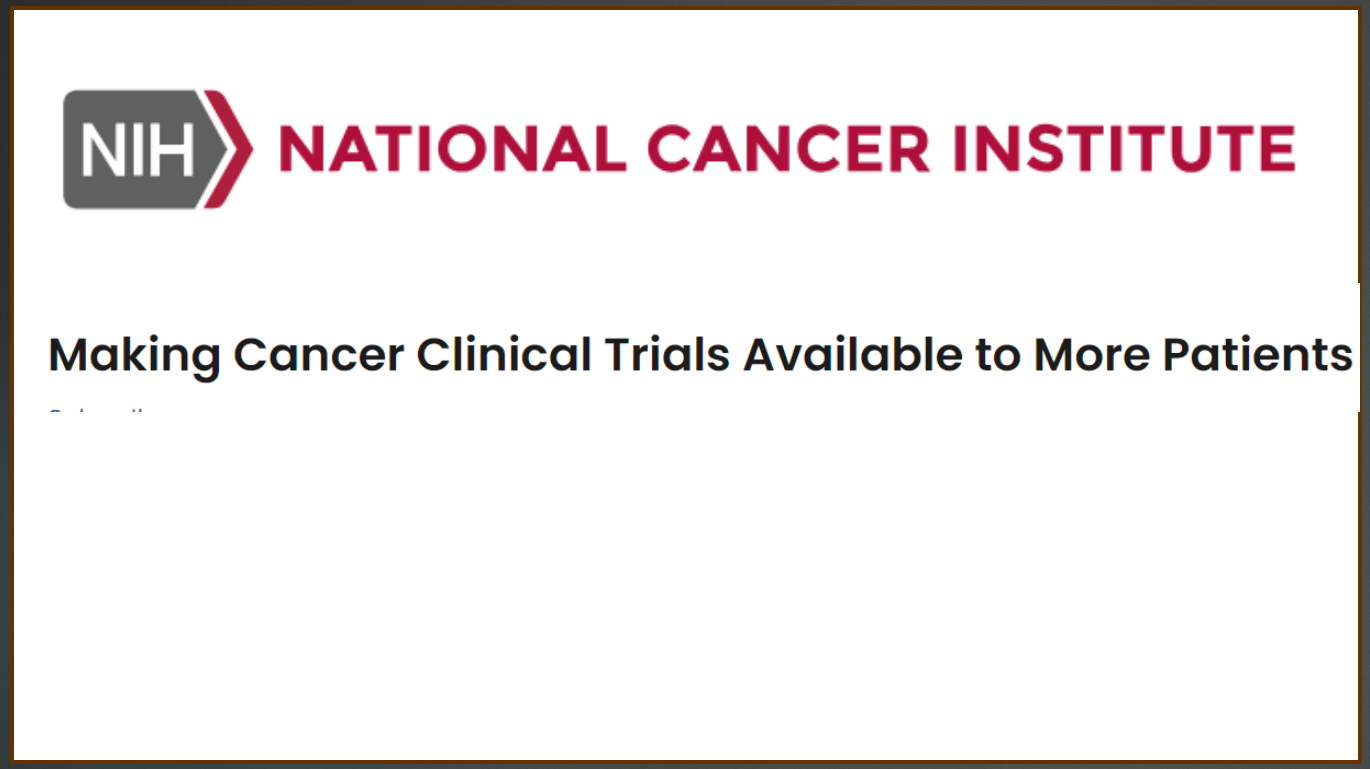
The initial treatment of adult patients with AML at NCI-CCs is associated with a 53% reduction in the odds of early mortality compared with treatment at non-NCI-CCs. Lower early mortality may result from differences in hospital or provider experience and supportive care. ***Cancer* 2018;124:1938-45**. © *2018 American Cancer Society*.

https://acsjournals-onlinelibrary-wiley-com.ucsf.idm.oclc.org/doi/full/10.1002/cncr.31296

illary thyroid cancer: Are
er centers?

Conclusions: Patients with PTC who have their initial thyroidectomy at non-CCC have higher recurrence rates, higher rates of positive tumor margins on pathology, and increased need for additional operations. These data suggest that patients who have their initial procedure at a CCC for PTC have better long-term outcomes.

https://www.americanjournalofsurgery.com/article/S0002-9610(21)00109-4/fulltext



NCI Centers are a focal point for Clinical Trial access

Clinical trial participation has been associated with closing survival disparities gaps

original report

Overall Survival of Black and Whit Metastatic Castration-Resistant Pr Treated With Docetaxel

Susan Halabi, PhD[1]; Sandipan Dutta, PhD[1]; Catherine M. Tangen, PhD[2]; Mark Rosenthal, MD[3]; Thompson Jr, MD[5]; Kim N. Chi, MD[6]; John C. Araujo, MD, PhD[7]; Christopher Logothetis, MD[7]; Davi MD, PhD[9]; Michael J. Morris, MD[10]; Mario A. Eisenberger, MD[11]; Daniel J. George, MD[1]; Johanr Higano, MD[2]; Ian F. Tannock, MD, PhD[13]; Eric J. Small, MD[14]; and William Kevin Kelly, DO[15]

abstract

PURPOSE Several studies have reported that among patients with localized pros shorter overall survival (OS) time than white men, but few data exist for men with primary goal of this analysis was to compare the OS in black and white men with prostate cancer (mCRPC) who were treated in phase III clinical trials with docet DP-containing regimen.

Halabi; JCO 2019 Feb 10;37(5)

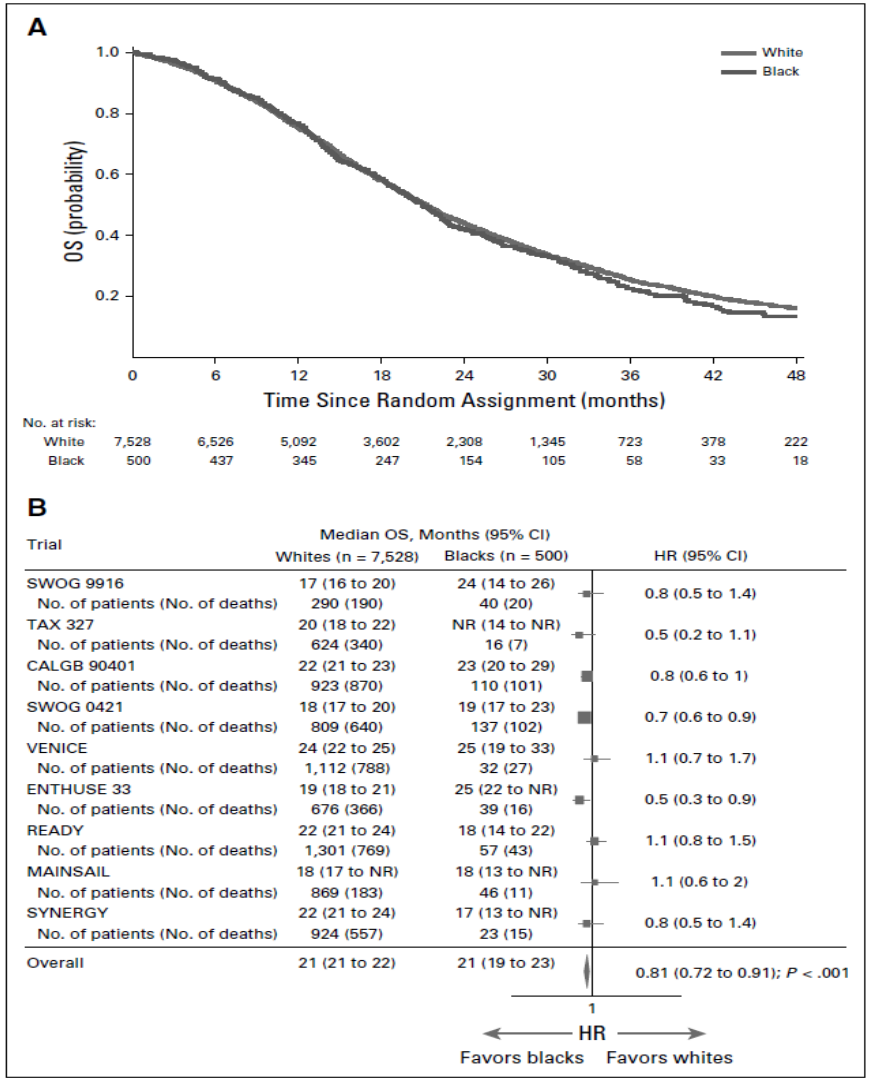


FIG 2. (A) Kaplan-Meier curves of overall survival (OS) by race and (B) forest plot with hazard ratios (HRs) comparing black men with white men (reference group, white men; Q = 10.738; *df* = 8; *P* = .217; I^2 = 0.255). CALGB, Cancer and Leukemia Group B; ENTHUSE 33 (ClinicalTrials.gov identifier: NCT00617669); MAINSAIL (ClinicalTrials.gov identifier: NCT00988208); NR, not reported; READY (ClinicalTrials.gov identifier: NCT00744497); SYNERGY (ClinicalTrials.gov identifier: NCT NCT01188187); SWOG, Southwest Oncology Group; SWOG 0421 (ClinicalTrials.gov identifier: NCT00134056); SWOG 9916 (ClinicalTrials.gov identifier: NCT00004001); SWOG 90401 (ClinicalTrials.gov identifier: NCT00110214); TAX 327 (Docetaxel Plus Prednisone or Mitoxantrone Plus Prednisone for Advanced Prostate Cancer; VENICE (ClinicalTrials.gov identifier: NCT00519285).

Participation in clinical trials is associated with improved prostate cancer survival for Black men

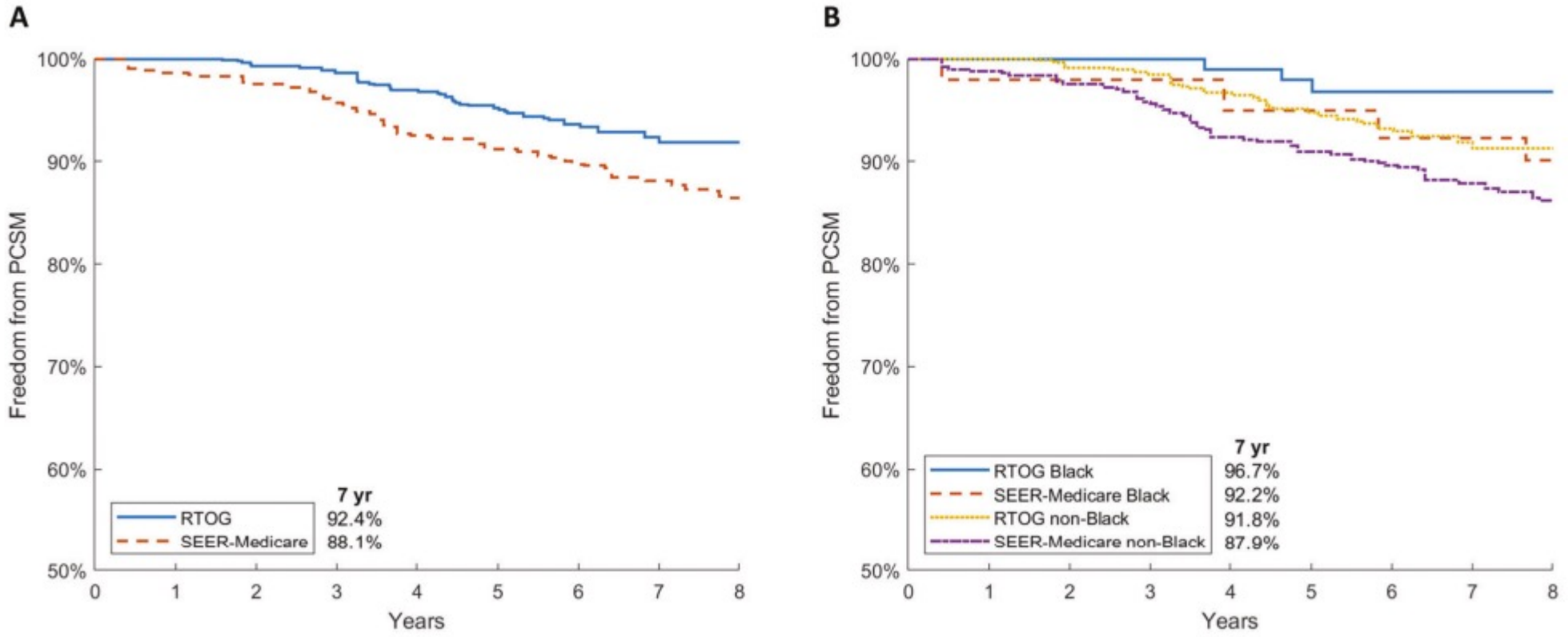


Fig. 1 Freedom from prostate cancer-specific mortality (PCSM) in clinical trial (RTOG 0521) versus real-world (SEER-Medicare) settings. (**A**), stratified by trial/real-world setting; (**B**), stratified by trial/real-world setting and race.

Ma TM, Feng FY; Prostate Cancer Prostatic Dis. 2023 Sep;26(3) PMID: 36966268

Minority Serving Hospitals: Segregation in Quality

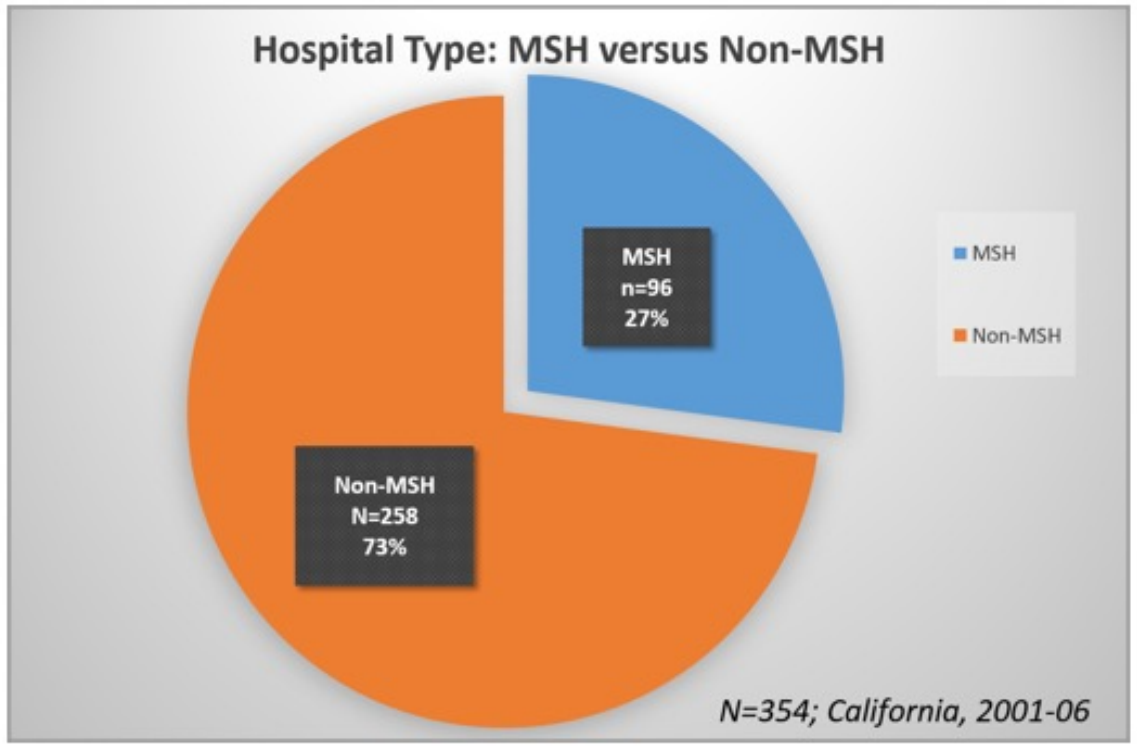
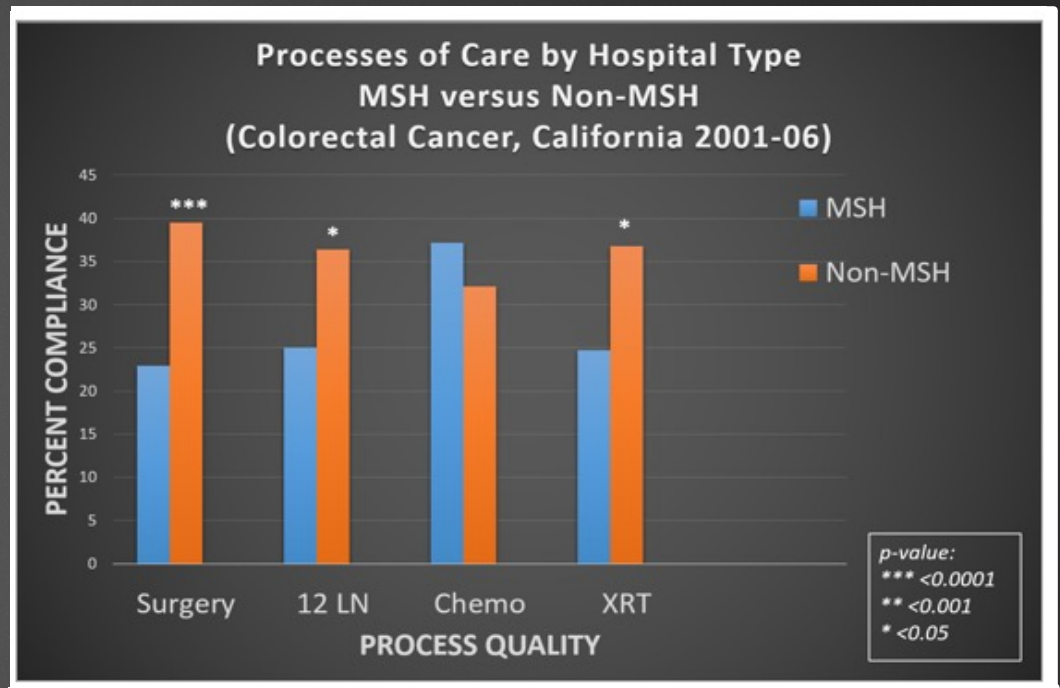


Figure 2. Distribution of MSH and non-MSH settings



MSH deliver lower rates of guideline concordant care for colorectal cancer

California Hospitals Are *Still* Segregated

Table of High White by High Asian				
		High Asian		
		0	1	Total
High White	0	179 49.86	90 25.07	269 74.93
	1	90 25.07	0 0.00	90 25.07
	Total	269 74.93	90 25.07	359 100.00

High White x High AA/Black				
		High AA/Black		
		0	1	Total
High White	0	181 50.42	88 24.51	269 74.93
	1	88 24.51	2 0.56	90 25.07
	Total	269 74.93	90 25.07	359 100.00

High White x High Latino				
		High Latino		
		0	1	Total
High White	0	199 55.43	70 19.50	269 74.93
	1	70 19.50	20 5.57	90 25.07
	Total	269 74.93	90 25.07	359 100.00

Overlap between White serving & those serving other groups is limited

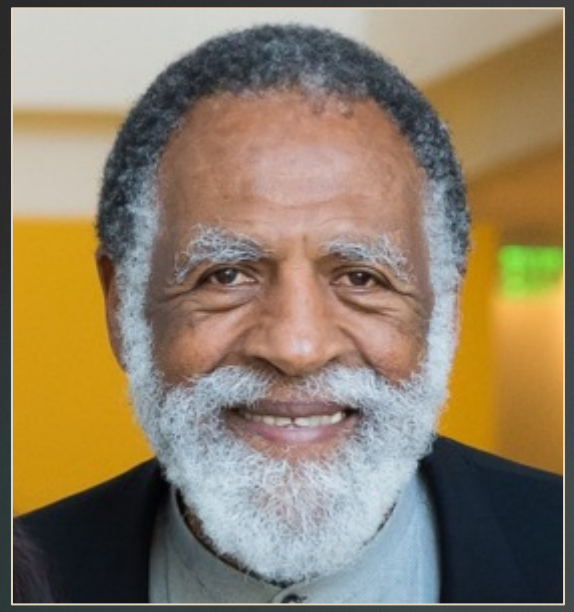
There is a lot more overlap between Black, Asian and Latino serving hospitals

Table of High AA/Black by High Latino				
		High Latino		
		0	1	Total
High AA/Black	0	204 56.82	65 18.11	269 74.93
	1	65 18.11	25 6.96	90 25.07
	Total	269 74.93	90 25.07	359 100.00

Table of High AA/Black by High Asian				
		High Asian		
		0	1	Total
High AA/Black	0	204 56.82	65 18.11	269 74.93
	1	65 18.11	25 6.96	90 25.07
	Total	269 74.93	90 25.07	359 100.00

Table of High Latino by High Asian				
		High Asian		
		0	1	Total
High Latino	0	191 53.20	78 21.73	269 74.93
	1	78 21.73	12 3.34	90 25.07
	Total	269 74.93	90 25.07	359 100.00

UCSF Helen Diller Family Comprehensive Cancer Center



"After all is said and done, a lot more is said than done"

--ARNOLD PERKINS, FOUNDING MEMBER, AND RECENT PAST CHAIR, HDFCCC COMMUNITY ADVISORY BOARD

We have a lot of work to do to counter the effects of healthcare segregation on cancer outcomes.

What action will you take?

The Impact of Segregation in Cancer Care

THANK YOU!

KIM F. RHOADS, MD, MS, MPH, FACS

CONTACT: HDFCCCOCE@UCSF.EDU

FOLLOW: @KFRHOADS @UCSFCANCER_OCE @UMOJAHEALTH