

Action Steps to Address Inequities in Cancer Care Access, Treatment, and Outcomes in Your Community



CMEO Podcast

Scott Cook:

Hello, everybody. My name is Scott Cook. On behalf of CME Outfitters, I would like to welcome you to today's educational activity entitled "Action Steps to Address Inequities in Cancer Care Access, Treatments, and Outcomes in Your Community." Today's program is supported by an educational grant from Bristol Myers Squibb and Merck Sharp & Dohme corporation.

I would like to introduce our faculty for tonight. Again, my name is Scott Cook, and I co-direct a national program of the Robert Wood Johnson Foundation based at the University of Chicago, called Advancing Health Equity, Leading Care Payment and Systems Transformation. I also spend part of my time as a quality improvement and care transformation strategist with the University of Chicago Health System. We're an academic medical center and health system in South Chicago and Northern Indiana. I'd like to, also then, introduce Dr. Naing, one of our other faculty members. Dr. Naing.

Aung Naing:

Hello. My name is Aung Naing, and I am from University of Texas, MD Anderson Cancer Center. I am an oncologist, and I do the clinical trials, particularly focusing on immunotherapy trials. Nice to be here. Thank you.

Scott Cook:

And then also, Dr. Velazquez.

Ana Velazquez Manana:

Hi, everyone. Very nice to be here today. My name is Ana Velazquez. I am an assistant professor and a medical oncologist at UCSF in San Francisco. I'm the Assistant Director of Diversity, Equity, Inclusion, and Accessibility of the Helen Diller Cancer Center. I am a lung cancer doctor, and also a health disparities researcher.

Scott Cook:

Awesome. Thank you so much. Tonight's learning objective is to develop strategies to reduce health disparities in patients experiencing immune-related adverse events, or IRAEs. Dr. Naing, you have a great deal of experience with immunotherapies, in general, and addressing adverse events. I'm wondering if you can give us a little bit of background on IRAEs.

Aung Naing:

Of course, Dr. Cook. Immune-related toxicity, we call it IRAE, it is quite unique. The way that we see the immune-related toxicities, whenever there is a disruption of homeostatic mechanism, if that induces a unique spectrum of

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side effects, this is called IRAE. Particularly when we are treating our patients with the immunotherapy, we always have to be mindful about the immune-related adverse events.

When you look at the prevalence of the IRAE, it depends on what type of the treatment you are using, and what grade of the IRAE that you are discussing. If you talk about that, you can see all grades of the IRAE up to 88%, grade three and above from 5 to 25%. If we are using a combination, for example, combining with the anti-CTLA-4, anti-PD-1s, you have more IRAE, so more grade three IRAEs. But when you look at what the most common IRAE is, the skin reaction dermatitis is the most common immune-related toxicity, followed by the enterocolitis, transaminitis, and endocrinopathies.

The issue is that if we do not recognize immune-related toxicity, if these IRAEs are left untreated, they can actually, starting from the grade one, they can rapidly, rapidly progress to the life-threatening condition, and eventually we might lose a patient. It is quite, very important to recognize immune-related toxicity at the early stage, intervene, and if we could, we reverse so that these patients do not suffer from the immune-related toxicity, and we can continue with the treatment.

There are, in fact, several guidelines how we would take care of our patients with the immune-related toxicities. You have got ASCO and ESMO, SITC, and NCCN. There are several guidelines out there. The guidelines, in general, are quite similar. The key point is if there is a grade one immune-related toxicity, most of the time... I would not call it all the time. Most of the time, you can continue with immunotherapy, but you have to be, of course, closely monitoring the patient. Then I will go to the grade four, if it is a grade four toxicity, typically you discontinue the immune-related toxicity, but there are also some exceptions.

When you look at the grade one, when you are continuing with the immunotherapy, there are few immune-related toxicity that you should not continue, even if it is a grade one, such as neurologic or cardiac toxicity. When it comes to the grade four, most of the time we stop them. But however, if this is the endocrinopathy such as thyroiditis or hypophysitis, once the patient has got a good hormone replacement, you can continue, even though this is a grade four. So, grade one and grade four, more or less similar approach, but there are some exceptions.

But when you look at the grade two, typically we hold the immune-related toxicity, and then we resume that when those immune-related toxicity recover to the grade one or less. Here, we use the not-very-high dose of the corticosteroids. When it comes to the grade three, we hold the immunotherapy, and then we start the high-dose corticosteroids. One of the things that we want to make sure is that we need to take not very rapidly, at least four to six weeks over that. Then if the patients do not respond to the first-line steroids, in that case, you can go to the next line of the treatment to take care of the immune-related toxicity. That is about the immune-related toxicity, Dr. Cook.

Scott Cook:

Thank you very much. I appreciate that. That's a great solid introduction to the topic. We're now going to shift to discussing barriers and obstacles that patients can experience when accessing immunotherapies, and then definitely when trying to deal with, or managing immune-related adverse events. We have a polling question to get us started.

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We have some results in. It looks like our most popular answer is “any barrier that challenges access to general care.” We also have some answers coming in for ancestry and inherited genetic factors, and then another chunk of folks who aren't sure. Dr. Velazquez and Dr. Naing, I'm wondering what you might have to say, in terms of explaining what we believe to be the correct answer of “any barrier that challenges access to general health care,” and how that might be different than ancestry and inherited genetic factors.

Ana Velazquez Manana:

I can start. I think that there's probably more than one right or wrong answer when we approach questions like this one. I would agree with the majority of our audience saying that, really, any barrier that challenges access to general health care can result in inequities in management of IRAEs. Those are things that we think, generally, when we speak about social determinants and other factors that may limit how patients access care, connect with their medical team, with their oncology team, or are able to receive care in X or Y type of facilities.

When we think more about ancestry and inherited genetic factors, those may tend to drive more, or affect and influence how patients may metabolize, for example, a medication like the immunotherapies, how they may be predisposed at higher rates to certain adverse events, because they may have underlying higher prevalence of some specific immune diseases to begin with. A lot of those are questions that are still, I think, unanswered, but that we are still really interested in exploring, though they may not be directly as related when we think of things that can result to inequities in the management, which are more directed towards ability and processes of receiving health care.

I'm very, I think, surprised to a certain degree that there's 0% that thought of care team staffing shortages as an answer. I think that I would've probably flipped the coin between both of answer B here and D. Particularly now, as we think in the current pandemic and with COVID, and all the care team staffing shortages that we've seen across the nation, from nursing, from physicians, et cetera, it really has affected how we deliver care daily. Definitely, it's something that we should take into account, and that is part of those barriers that challenge how patients access care.

Scott Cook:

Yeah, thank you. Sorry, Dr. Naing, were you going to jump in there?

Aung Naing:

I agree with Dr. Velazquez in talking about some of those inherited genetic factors. Sometimes we see that two patients, same age, same sex, same race, given the same treatment, but one may get just a grade one toxicity, and the other one may get grade three toxicity. One is going to get a colitis, and the other one may be having a dermatitis. This is a really an active area of the investigation. Why, if you have everything almost all the same, why people are reacting differently to the immunotherapy, and why they are having the different side effects?

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Scott Cook:

The issue of inequities in care and addressing immune-related adverse events is a complicated or complex one. There's lots of ways to think about it, as you've described. One of the ways that I think about it, too, is you can look at things on a broad level, like nationally, how do those inequities come about? It could be that care team staffing shortages may be differentially impacting certain communities, or certain populations, or types of care settings. Then if you look at it within a particular care setting, one might expect that care team staffing shortages may not be having a differential effect between patient subpopulations, because they might be impacting everybody coming to that place, similarly.

It's a good start to the next part of our conversation, where we want to look at, what are the things that we might be able to actually control? What's happening in our patient populations, the patients that we're working with in our settings? I'm going to turn it over to you, Dr. Velazquez, to start talking us through some of those ideas.

Ana Velazquez Manana:

Thank you, Dr. Cook. As we really start thinking and diving into, how do we analyze what are some of those barriers for patients to be able to access immunotherapies, and to access treatments for IRAEs and the identification of those IRAEs, we have to think of what are the different levels in which our environment, and for patients, environment can affect their ability to access care.

Here on the right, we're showing you this figure which is called a socio-ecological model. I love really this, because it's similar to an onion. You're peeling pieces of this onion and trying to identify, when we look at the person and the patient in particular, what are things and drivers that may cause their ability or inability to access care, when we think about how they relate to their environment, and interpersonal relationships to organizations, primarily in health care, and when we think about oncology care, or cancer centers, or oncology clinics, their community.

When we think about in a society level, we're talking about public policies at a national, at a local level, and within communities. It allows us to really try to dig deep, and you'll see these little circles or layers of the audience are getting bigger and bigger as they move out, of what are really the drivers that cause barriers to accessing or adhering to care, managing care. These really mirror what we think of accessing health care, in general, for all patients.

One thing that I think we want to highlight is that, of course, immunotherapies are relatively new. They've been, over the last decade, expanded in terms of how much we use them and see them across the clinic. There's very little data still about what are some of the barriers or differences in managing IRAEs. Here, we're going to really start to extrapolate from when we think of overall health care challenges, how do these also affect patients in the perspective of IRAEs, in particular?

Some of the factors that can influence access to immunotherapies, particularly at the patient level, we have to think of what are things that are directly to the patient that can affect, specifically, how they can access or receive treatments. Historically, people would think there are things like race, for example, or age, or ethnicity, or your gender that can affect and drive inequities. But is it really somebody's race or their age, something that leads to their ability or not to get an immunotherapy? Or is it the fact that at the provider level, there may be biases, or at

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the systemic level, there may be barriers to access if you come from a lower income or higher income community?

We need to shift a little bit, our mindset, and start thinking and recognizing, what are really the patient factors that can influence their access to health care? Are there things like comorbid conditions? Are you too ill? Do you have underlying interstitial lung disease, that may put you at higher risk or not of developing pneumonitis. It may compromise the ability to give you, then, immunotherapies. Is your overall health status too poor? Somebody that comes in with a very poor performance status, Dr. Naing, would you offer them immunotherapies or not in one of your clinical trials?

Similar thinking about patient knowledge and what their beliefs are, because somebody may believe in our type of medicine and participating in trials, but some of them may not. That may be rooted in culture, religious beliefs, in other particular things. Dr. Naing, I would love to hear if you have any specific examples or thoughts of how this affects or guides your conversations in clinic.

Aung Naing:

Yes, thank you, Dr. Velazquez. Particularly, when we are treating the patients, the points that you mentioned are really important. Because when you are putting the patients on a treatment that can potentially cause some level of side effects, you want to make sure that you got the really better understanding, and you are able to communicate, and when the patient has got actually side effects, that you will be able to find out immediately and take care of those patients. That is quite critical, otherwise, we are not going to be doing anything good to our patients. I think the points that you mentioned are very critical, particularly before we put the patients on the clinical trial, whether we will be able to take care of our patients adequately and safely.

Ana Velazquez Manana:

Definitely. Trying to really recognize that the patients are not the problem, but rather broader culture of the health care system, and trying to identify truly what are some of those factors that can influence their ability early on, and do it for everyone, I think is key.

Now, I want to briefly talk also about what are some of those provider level specific factors that can influence access to health care, to immunotherapies, and treatments of IRAEs. I alluded to this a little bit on the prior slide, in which there may be beliefs that are conscious or unconscious within ourselves. Every person has different biases that may lead us to identify more readily on certain group of patients, in particular immune adverse events, or not in a different one. For example, if we have a patient who has darker skin, it may be harder to identify a rash that we may be able to see on a patient who has fair skin. We have to be conscious and really aware of what some of the different biases that we have as providers are, to be able to identify readily and be able to treat our patients.

The other part is to think of, are there barriers and factors that make us really not being able to provide guideline-concordant care for patients? Limiting access to trials, to biomarker testing, not being able to keep up with the literature, and being aware of every single new indication that exists for an immunotherapy, or receive training, being on practice for many, many years, and being able to have a huge panel of patients.

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These are placed here, I think, on purpose, because when we think about them, we have to also think, similar to with the patient, are some of these things really a fault of the provider as an individual, or a fault of the health care system? Is the fact that our providers do not have the knowledge or training to be able to identify or manage IRAEs, an issue that is related to lack of knowledge and training of the actual provider, or what is the root of it? Is it that they have huge patient panels and are seeing patients five days a week from 8:00 AM until 5:00 PM, and you have 30, 40 patients per day that you're seeing every 15 minutes? Then you're not really able to address them equally. Then when we think of that, those tend to be more in the line of systemic-specific levels of barriers. I wonder if from your institutions, Dr. Cook or Dr. Naing, there's specific ways in which you're able to identify some of those barriers that are provider, but maybe related to the system, too?

Scott Cook:

Yeah. One of the things I think that we encourage the organizations that we work with as they try to identify and reduce inequities and care and outcomes is to go through a process of what we call a *root cause analysis*, which is kind of a fancy way of asking the question why, repeatedly. For example, why does our organization have a higher rate of immune-related adverse events for a particular set of patients, compared to other patients? Looking at from multiple perspectives, the patient's perspective, other providers, the care team, and you will very quickly be able to find probably many reasons. Some of those are going to be systems level. Some of those things are going to be how the organization operates in terms of providing care for patients.

Ana Velazquez Manana:

Definitely. Dr. Naing, you wanted to say something.

Aung Naing:

I think this is an area that we also look into, how we could do actually better in those area. Particularly, looking at the data is an area that we could improve. The thing, also, what's really important is really to plan ahead, before actually you treat this patient, anticipating that there could be potential side effects, and when that happens, how are we going to solve those issues?

Ana Velazquez Manana:

Thank you.

Aung Naing:

One of our attendees has asked a question. Sorry, just to pull in some attendee questions. Asked about financial toxicity, and notes it's often a significant barrier to care for patients that limits options for testing and treatment. Do either of you have strategies for how you would work around this barrier, or try to have your organizations work around that barrier, and help patients access needed treatment?

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Ana Velazquez Manana:

Definitely. We know that financial toxicity is a huge problem in oncology care, more with increasing cost of medications, and similarly with testing. I think as different health care systems and clinical sites getting a standardized approach, in which we screen every patient for their risk of financial toxicity, what their medical insurance is, their ability to pay or not, or afford medications, and connect them early on with financial counselors, social workers is key.

We're going to talk a little bit more about that in the next couple of slides. But, for example, there are different resources at our institution to try to identify, whether it is foundational money, charity, similar to help with copays, or through the different pharmaceutical companies. They may have patient assistant programs, similarly, that patients are able to apply for. But all of that, of course, requires identifying that it is a problem earlier on, which is what we have to work on.

Scott Cook:

Absolutely, yes.

Ana Velazquez Manana:

When we think, those are part of what the systemic, really, and societal level factors and barriers that influence access to care are. We have to think of things like geography, the ability to really access centers that may be academic, or have clinical trials infrastructure. Think about those processes, similar to reimbursement referrals, our ability for patients to be able to connect with social workers. Do we have the staffing to be able to do that? Do we have patient navigators, and are those, for example, able to provide cultural competence care? Are they diverse and look like the patients?

All of those are issues--you'll see this list is a lot longer than the prior two--that affect and really influence how patients are able to connect with care, and where we have to start really thinking and pushing within our different health care systems of how do we make this better? How do we identify what our actual barriers here are? Where are we deficient? And ask for really investment and accountability, in making sure that these are measures that are followed, that data is available, and that we are able to make lead way and move forward. Particularly, because we know that all of these things that are listed here are things that actually influence access, and if improved, can increase patients' ability to receive higher quality of care, to be engaged in care, and receive better care overall.

As the society, similar, we have those social drivers of health, or social determinants that a lot of people know and have heard about, and are those that are in our environment. We're born within them. We cannot really change, but it's how this environment in which we are, drives our ability or not to get care. Socioeconomic and health care policies at the state and national level are very important. We know, for example, things like expansion or not of Medicaid services affects patients who are of lower income and their ability to receive access to health care, in general. Similarly, recently, with the new passing of policies hoping to cap those copays, we are making some progress and lead way into really managing the financial toxicity that is associated with cancer therapeutics and care.

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These things are really drivers of inequities within our patients that affect care. When we think of patients may not have adequate medical coverage, or may not have a job, and may not be able to pay those copays, or may not have access to a higher education that leads to a job that gives them a higher income, or they don't live in a city that doesn't have adequate public transportation or a rural area. It's not easy to come to an infusion every three or six weeks, or come for a follow-up appointment. All of those problems, we may identify easily and think of as individual patients specific, but not really. They are driven by our society, our policies, and affect the individual, per se.

Scott Cook:

Great, thank you very much. I'm going to, for the purpose of time, move us on to our next topic, which is obviously still related to inequities, but is addressing specifically disparities in biomarker testing in lung cancer. We know that clinical trials offer the best opportunity for patients to access emerging therapies today, and that those emerging therapies will become the standards of care in the future. However, Black and Hispanic patients are severely underrepresented in clinical trials. Before we even talk about clinical trial participation and inequities in participation, let's talk about very quickly disparities in biomarker testing. Dr Naing, again, very briefly high-level discussion of those types of disparities in biomarker testing.

Aung Naing:

Thank you, Dr. Cook. Even if we do testing, there is actually several issues with the biomarker testing, because this area is, in fact, evolving. For example, let's pick PDL-1 testing. There are several, actually, testing assays out there. Then also, we are just looking at, are we testing the primary tumor, or are we testing the metastatic tumor? Then, what are the cut-off points that we are using? Sometimes we use the 1%, and sometimes we use the 5%. I think this area is evolving. I think it's important for us to have a really unifying type of way, that this is how we are testing, this is the assay, this is the area, how all the specimens should be. Those are the things that I think we need to work on in that.

I think bringing back, actually, to the access to the clinical trials. This is, actually, a beautiful study. As we all discussed earlier, the primary barriers to the trial participation is our developers. You mentioned about the structural barriers. But if those patients are, in fact, offered, if you look at the results of the participation, it is in fact quite encouraging. Here, we see that nearly more than 57% of the Black, and we have 61% of the Asian actually are willing to participate in the trial.

I think that goes back to: What are the primary barriers to the trial participation? One of the things that what we need to, in fact, hear, particularly when we are working with the immunotherapy, there is something called the "missing patient voice." When we are even assessing the side effects from the patients, of course it's important how we evaluate the patient, what the patient is going through when we see the patient. At the same time, we need to be listening how they are feeling at home, and what is happening to them. I think when we evaluate our patients, we should incorporate some platform to hear their missing voice. Yes, Dr. Cook.

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Scott Cook:

Great, thank you. As we think about these different levels of barriers in the health system, and what can the health system do, whether it's at the provider level, the system level, or even the broader policy levels to support the patient? We also, again, as you mentioned, Dr. Velazquez, need to think about not so much framing the patients as the problem, that they're the reasons these inequities exist, but instead, how can the health system change in order to better serve the patients? As we think about these, we start to think about social determinants of health, as we discussed before, and ways to try to assess those, and ways to try to think of those. Dr. Velazquez, what are your thoughts about that topic?

Ana Velazquez Manana:

Thank you. There's a question from the audience that I think is very related to this, in particular, of how, when, and who should talk to patients or ask about social determinants of health? That's a great question. This is one of the tools that has been validated and is broadly used on different community settings, and community clinics, emergency rooms, pediatrics and adults. There's different types, but this is the most common one. It's from the Affordable Health Communities from CMS. It's a way in which to standardize asking patients, at their individual level, how do social determinants of health affect them.

Whether or not this should be done by providers? I would argue that probably there's other members of our systems that are able to address and really find solutions to these problems, like housing issues, being able to afford or not gas, electricity, and food, and connect patients with care. But using tools like this one that ask standardized questions in every single patient that is seen in your practice, at least during initial visits or periodically, really would help connect them with the services they need, whether that is patient navigators, community health care workers, social workers. Each of those areas of support that our health care system has are able to connect patients with different resources.

Answering similarly, another question that the audience asked, patient navigation services do really improve patient outcomes. We know that they increase patient quality of life, their ability to engage with care, their ability to receive screening, and many other factors, and are things that besides tons of data and randomized trials, focusing and showing improvement in health care access, we still are not able to fully support. Many health care systems don't have them yet, or don't have enough to support the patients. Being able to-

Scott Cook:

Actually, sorry. Just to throw in there, Dr. Velazquez, while you're on that very specific topic and answering that question, in terms of the health disparities intervention literature, not only does patient navigation and peer-based models, such as community health workers, improve access to care and outcomes in general. They can be very effective in reducing the inequities between patient populations, specifically, or especially if they're tailored to the particular populations that are experiencing the inequities. Just wanted to throw that in there in terms of that part, as well.

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Ana Velazquez Manana:

Definitely. I think that takes us to, also, what the next, I think, area slide that we wanted to discuss, which is thinking of how do we really provide culturally competent care, and center on the patients, in particular. We know that the United States is extremely diverse, and is getting more diverse as we move along. We have to start thinking, as health care systems and health care providers, how are we able to really provide competent care for our patients?

We need to put aside fears of being labeled X or Y, racist, sexist, homophobic, and trying to identify what stereotypes we may have that are positive or negative about specific members of the patient population that we're treating, and really try to become aware of what are some of our barriers, and take out the fear. We are not all perfect. We're not going to get it right to begin with, but we need to be open to receiving training on cross-cultural communication, to identifying what our specific unconscious biases are, and to then be able to provide better care for our patients.

Some best practices... And this one you'll have access to the slides and can read... to be able to provide that cultural competency and care are one, to of course, have a diverse workforce. But to center on everything we're doing as a health care system, what the value of diversity, equity, and inclusion is. That really means every single project, every single new process that we adopt in clinic, any material that you produce, the signing that you have in your clinic, should be something that is tailored to what your specific patient population is.

If we are, for example, in San Francisco and we have a very large Asian immigrant population that speaks Cantonese, then have materials that are in Chinese. We should have patient navigators that are from that culture and able to speak that language. To be able to identify those issues, we need to know who our patients are. We need to measure, how are we doing? We need to be accountable, in terms of making sure that we are meeting the community that we are actually serving.

Scott Cook:

Dr. Velazquez, I would like to take that point, or several of those points that you just made, to address one of the questions that's come in about, how do we address biases by our coworkers in the clinic, and without creating an antagonistic environment? That can be a tough challenge.

I know one of the things that we're doing at U Chicago Health System is we're trying to create or change the overall culture. We literally provide training to staff members and team members around how to ask that very question of coworkers, to be able to point out that we feel that there may be bias in a situation, or in something that they're saying or doing, and giving people the skills to do that in a way that can facilitate conversation and try to reduce negative and harmful interactions. It's too much to go into, a training like that here. But the point I guess I wanted to make, is that as part of a systems' intervention can be training staff and providing the opportunities to learn those skills. How do we intervene in what can be uncomfortable or difficult conversations?

I'm going to move us forward in terms of time, just because we're getting up near the end, and we may have a couple of more questions. I'll briefly, these next three slides are about a program called Advancing Health Equity. That's one I mentioned at the very beginning as part of my job. I won't go into a lot of detail, except you can visit

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our website. It's at solvingdisparities.org and learn about the program. But we basically have worked with health care organizations around the country to conduct research on disparities reduction interventions. We've also done systematic reviews of the literature on what's worked. What have others done to reduce inequities in care and in patient outcomes?

Some of the principal findings from all of that work, you can see here on the slide. We've already mentioned some of them, patient navigation being one. But multidisciplinary teams, multifactorial interventions, in general. But one of the things that we stress with the program is that inequities come about for very specific reasons, and in very specific communities, and in health care organizations. We all know our health care organizations are very different. Any particular intervention that worked to reduce inequities in another organization, may or may not work in our own. We need to do the homework of figuring out by talking to patients who are experiencing the inequities, by talking with our staff who are delivering the care. They all will have very valid views and perspectives about why the inequities are occurring and why they're happening, and then taking that information to design interventions. I already mentioned broader attempts to change the culture of the organization that will support all of these efforts, whether it's a broad effort or a particular intervention, such as in this case to reduce inequities in immune-related adverse events.

To summarize, we have talked about barriers to accessing care in patients experiencing immune-related adverse events. We've talked about some of the ways to think about that, some of the tools that might be available. We've talked about the importance of systemic changes or systematic changes to improve immune-related adverse events.

We would like to encourage everybody to set some goals, in terms of taking some steps to identify and be aware of your own biases, to incorporate an equity lens into all of your work, like Dr. Velazquez was talking about. That slide we had earlier, when you go back and look at these slides, you can see those facilitators of culturally competent care. Then partnering with patients and communities. They're going to have answers and ways of thinking about this, that we don't, and it's important to involve them. The research shows, in terms of the inequities intervention research, that you are much more likely to succeed in reducing inequities if you're working directly with the patients and communities living with them.

I thought I would ask, because Dr. Velazquez, Dr. Naing, one of the questions is how do pharmacists contribute to reducing cancer disparities? I'm wondering if you have thoughts about that.

Ana Velazquez Manana:

I think that they're key to our health care teams. I would say an example in our institution, two ways in which pharmacists are able to help, is one, they are able to connect patients with resources, for example, a patient assistance program, and identify tools for that financial toxicity aspect to medications that have really high copays. On the other institution in which I work, which is a safety net system, really our pharmacists have been key in helping us lead QI projects that increase, how do we deliver, for example, chemo teaching and education about the different TKIs and drugs that we use. How do we improve access to even COVID vaccinations, and identifying who are the patients who had missing doses of vaccines? Definitely, there's multiple ways. It's making sure that they're incorporated as part of the team.

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Aung Naing:

But also, when we are managing those immune-related toxicity, we work so closely with our pharmacists because they actually help us with it, giving us a reminder. "Hey, how long you've been using the steroids? Too short, too long?" Then they are the really great resource, and we manage our patients together. They have been very valuable for us.

If I may answer also, one of the question is are the immune checkpoint inhibitor labels too narrowly defined for patient population? I think, positively, this area is moving very well. In fact, when we started many years ago, you have got one or two indications and now you have got multiple indications. You are now taking more patients, and then your inclusion criteria are actually broader. I like to see this. This is going in a very positive direction.

Scott Cook:

Great. Thank you very much. We are just about at time. I would like to thank you, Dr. Naing, thank you, Dr. Velazquez, for joining me this evening. It's been a great conversation. We could talk about this for days, and there still would be more to go. I see this as a very great intro for our attendees, and there's a lot more to dig into.

I also want to remind the audience that this is one activity in a series of four, and I hope that you watch the entire series. If you visit the CME Outfitters Oncology Hub, you'll have access to additional activities relevant to oncology topics. Then also, there's Diversity and Inclusion Hub for discussions of inequities in health care, as well as resources and patient education materials. Thank you, again, everybody. Thanks for attending. And I hope you have a good evening.