AGL 2022

51st GLOBAL CONGRESS ON MIGS

December 1–4, 2022 | Gaylord Rockies Resort and Convention Center | Aurora, Colorado

SYLLABUS

Panel 4: Recognizing and Addressing Racial, Ethnic and Socioeconomic Disparities in Gynecologic Care Needs Screening to Their Own Practice

Table of Contents

Disclosure of Relevant Financial Relationships

As an ACCME accredited provider, AAGL must ensure balance, independence, and objectivity in all CME activities to promote improvements in health care and not proprietary interests of an ineligible company. AAGL controls all decisions related to identification of CME needs, determination of educational objectives, selection and presentation of content, selection of all persons in a position to control content, selection of educational methods, and evaluation of the activity. Course chairs, planning committee members, faculty, authors, moderators, and others in a position to control the content of this activity are required to disclose all financial relationships with ineligible companies. All relevant financial relationships are appropriately mitigated, and peer review is completed by reviewers who have nothing to disclose. Learners can assess the potential for commercial bias when disclosure, mitigation of conflicts of interest, and acknowledgment of commercial support are provided prior to the activity. Informed learners are the final safeguards in assuring that a CME activity is independent from commercial bias. We believe this mechanism contributes to the transparency and accountability of CME.

Asterisk (*) denotes no financial relationships to disclose.

PLANNER DISCLOSURE

The following members of AAGL have been involved in the educational planning and/or review of this course (listed in alphabetical order by last name).

Linda J. Bell, Admin Support, AAGL*
Linda D. Bradley, MD, Medical Director, AAGL*
Erin T. Carey, MD, MSCR
Honorarium: Med IQ
Research Funding: Eximis
Mark W. Dassel, MD*
Linda Michels, Executive Director, AAGL*
Vadim Morozov, MD
Speaker: AbbVie
Consultant: Medtronic, Lumenis
Erinn M. Myers, MD
Speakers Bureau: Intuitive Surgical
Amy J. Park, MD
Speaker: Allergan
Nancy Williams, COO, CME Consultants*
Harold Y. Wu, MD*
Anna L. Beavis, MD – Consultant: Ethicon Endo-Surgery; Contracted Research: Pfizer

SCIENTIFIC PROGRAM COMMITTEE

Andrew I. Sokol, MD - Medical Legal Defense: Johnson & Johnson
Angela Chaudhari, MD - Consultant: Johnson & Johnson
Cara R. King, DO*
Mario Malzoni, MD – Consultant: KARL STORZ
Jessica Opoku-Anane, MD, MS – Consultant: Boston Scientific; Myovant Sciences; AbbVie
Shailesh P. Puntambekar, MD, PHD*
Frank F. Tu, MD, MPH*
Jonathon M. Solnik, MD – Consultant: Olympus; Medtronic; Stockholder: Field Trip Health, Inc.; Felix Health
Linda D. Bradley, MD, Medical Director*
Linda Michels, Executive Director, AAGL*

FACULTY DISCLOSURE

The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the "best available evidence" from medical literature (in alphabetical order by last name).

Anna L. Beavis, MD – Consultant: Ethicon Endo-Surgery; Contracted Research: Pfizer
Abdulrahman Sinno, MD*
Maria Victoria Vargas, MD*

Panel 4: Recognizing and Addressing Racial, Ethnic and Socioeconomic Disparities in Gynecologic Care

Chair: *Anna L. Beavis, MD, MPH*

Faculty: *M. Victoria Vargas, MD, Abdulrahman Sinno, MD*

Course Description

Racial, ethnic, and socioeconomic disparities continue to plague gynecologic patient outcomes. This session will not just describe disparities but will propose proactive strategies to address them at the provider, institution, community, and policy level. We will review the origin of racial and ethnic disparities in gynecologic care, and explore how individualized, internalized, and institutional racism continues to affect access to care and outcomes. We will discuss how we, as providers and community members, can begin to address racial and ethnic disparities in benign and malignant gynecologic outcomes. Lastly, we will highlight the impact of the social determinants of health and provide a practical example of how to integrate screening for social needs into routine outpatient care to help address these drivers of disparities.

Learning Objectives

At the conclusion of this course, the participants will be able to: 1) Identify the impact that individual, internalized, and systemic racism have on racial and ethnic disparities in gynecologic care, 2) Develop tools to address the drivers of inequity in their own gynecologic practice, 3) Differentiate between social needs and social determinants of health, and prepare to implement social needs screening to their own practice.

Course Outline

3:15 pm	Welcome, Introduction and Course Overview	A.L. Beavis
3:20 pm	Racial and Ethnic Disparities in Minimally Invasive Gynecologic Surgery: Origins and Proposed Solutions	M.V. Vargas
3:35 pm	Racial and Ethnic Disparities in Gynecologic Cancers: Current Trends and Next Steps	A.L. Beavis
3:50 pm	Integrating Social Needs Assessments Into the Gynecology Visit: A Powerful Tool to Address Inequities Driven By the Social Determinants of Health	A. Sinno
4:05 pm	Questions & Answers	All Faculty
4:20 pm	Adjourn	

Recognizing and addressing racial, ethnic, and socioeconomic disparities in gynecologic care

Panel chair: **Anna Beavis**, MD, Johns Hopkins Medicine, Department of Gyn/OB, Division of Gynecologic Oncology

AAGL 2022
51st GLOBAL CONGRESS ON MIGS
December 1–4, 2022 | Aurora, CO | congress.aagl.org

Disclosure

- Dr. Beavis: I have the following financial relationships:
  - Member of advisory board: Ethicon
  - Research grant recipient: Pfizer
- Dr. Vargas: I have no financial relationships to declare
- Dr. Sinno: I have no financial relationships to declare

Introductions: course faculty

Anna Beavis, MD, MPH

- Gyn Onc, Johns Hopkins

Maria Victoria Vargas, MD

- MIGS, Sibley Memorial Hospital

Abdulrahman Sinno, MD

- Gyn Onc, University of Miami

Course overview

Part 1: Racial and ethnic disparities in minimally invasive gynecologic surgery: origins and proposed solutions – *Dr. Vargas*

Part 2: Racial and ethnic disparities in gynecologic cancers: current trends and next steps – *Dr. Beavis*

Part 3: Integrating social needs assessments into the gynecology visit: a powerful tool to address inequities – *Dr. Sinno*

Objectives

- Identify the impact that individual, internalized, and systemic racism have on racial and ethnic disparities in gynecologic care

- Develop tools to address the impact of racism in your own gynecologic practice

- Differentiate between social needs and social determinants of health, and apply social needs screening to your own practice

Definitions

Disparity

An uneven rate of a given health outcome or risk *between* populations.

Difference

An element that separates or distinguishes contrasting people, things, or situations.

Inequity

An avoidable, systematic difference in the distribution of resources between groups.

Part 1

Racial and ethnic disparities in minimally invasive gynecologic surgery: origins and proposed solutions

Maria Victoria Vargas, MD, MS
Assistant Professor in OB/GYN
John’s Hopkins SOM
Director of MIGS, National Capitol Region

Historical Context

"Any honest examination of racism as a widespread affliction of American medical practice must acknowledge that the medical profession was entangled in the institution of slavery from its beginnings."

Owens DC, Fett SM. Black Maternal and Infant Health: Historical Legacies of Slavery. Am J Public Health. 2019 Oct;109(10):1342-1345. doi: 10.2105/AJPH.2019.305243.

Historical Context

- 1807-1808 End of transatlantic slave trade
  - Enslaved women's fertility and reproduction becomes a focus for American physicians.
  - *partus sequitur ventrem*
- 1846-1849 J. Marion Sims, developed vesicovaginal fistula repair on enslaved women
  - Betsy, Lucy, and Anarcha
- 1831 François Marie Prevost experiments technique for cesarean section on enslaved women

Painting of Anarcha by Robert Thom

Owens DC, Fett SM. Black Maternal and Infant Health: Historical Legacies of Slavery. Am J Public Health. 2019 Oct;109(10):1342-1345. doi: 10.2105/AJPH.2019.305243.

Historical Context

- 1907 Eugenics movement
  - Forced sterilization becomes legal, coerced sterilization practiced previously
  - By WW2 60,000 women sterilized
- 1950 Meigs early theories of endometriosis
  - “The scourge of the private patient”
- 1951 Henrietta Lacks cervical cancer cells researched without her knowledge or consent

Henrietta Lacks 1920-1951

Owens DC, Fett SM. Black Maternal and Infant Health: Historical Legacies of Slavery. Am J Public Health. 2019 Oct;109(10):1342-1345. doi: 10.2105/AJPH.2019.305243.

Current state of healthcare

- 2007 Black patients receive less pain medication for broken bones and cancer.
- 2015 Black children receive less pain medication for appendicitis.
- 2016 Half of White medical students and residents held unfounded beliefs about intrinsic biologic differences between Black and White people.
  - Black patients' pain assessed as less severe
  - Less appropriate treatment decisions for Black patients.

Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Proc Natl Acad Sci U S A. 2016 Apr 19;113(16):4296-301
Ghoshal M. Special Report: Race, Pain Management, and the System. Pract Pain Manag. 2020;20(5).

State of MIGS

- BIPOC women have lower rates of MIS hysterectomy and myomectomy
- BIPOC women have worsened outcomes of MIS hysterectomy and myomectomy
- BIPOC women less likely to be offered surgery during hospital admission for pelvic pain
- BIPOC women more likely to have laparotomy, worse outcomes, and inappropriate surgery for endometriosis

Barnes WA, Carter-Brooks CM, Wu CZ, Acosta DA, Vargas MV. Racial and ethnic disparities in access to minimally invasive gynecologic surgery for benign pathology. Curr Opin Obstet Gynecol. 2021 Aug 1;33(4):279-287.
Orlando MS, Luna Russo MA, Richards EG, King CR, Park AJ, Bradley LD, Chapman GC. Racial and ethnic disparities in surgical care for endometriosis across the United States. Am J Obstet Gynecol. 2022 Jun;226(6):824.e1-824.e11.

Disparities in Hysterectomy

- Disparities persist despite accounting for:
  - Comorbidities
  - Disease severity
  - Income
  - Insurance
  - Hospital characteristics (volume, patient population)

Barnes WA, Carter-Brooks CM, Wu CZ, Acosta DA, Vargas MV. Racial and ethnic disparities in access to minimally invasive gynecologic surgery for benign pathology. Curr Opin Obstet Gynecol. 2021 Aug 1;33(4):279-287.

Disparities in Hysterectomy - Outcomes

- Retrospective cohort study of 183,679 women undergoing hysterectomy for benign conditions
  - AA patients had higher rates of:
    - rehospitalization – OR 1.31
    - digestive complications – OR 1.98
    - urologic complications – OR 1.16
    - surgical-site infections – OR 1.34
  - Asian/PI patients had higher rates of:
    - intraoperative injury to abdominal/pelvic organs – OR 1.16
    - urologic complications – OR 1.48
    - hemorrhage/hematoma – OR 1.33
  - Hispanic patients had higher rates of:
    - Rehospitalization – OR 1.11

Barnes WA, Carter-Brooks CM, Wu CZ, Acosta DA, Vargas MV. Racial and ethnic disparities in access to minimally invasive gynecologic surgery for benign pathology. Curr Opin Obstet Gynecol. 2021 Aug 1;33(4):279-287.

What can be done?

- Studies have shown that racial concordance between patients and providers is associated with
  - Better communication
  - Patient satisfaction
  - Greater sense that a physician a has knowledge about challenges faced

Shen MJ, Peterson EB, Costas-Muñiz R, Hernandez MH, Jewell ST, Matsoukas K, Bylund CL. The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature. J Racial Ethn Health Disparities. 2018 Feb;5(1):117-140.
Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient-physician racial concordance and the perceived quality and use of health care. Arch Intern Med. 1999 May 10;159(9):997-1004

What can be done?

- Studies have shown that racial concordance between patients and providers is associated with
  - Greater acceptance of preventative care recommendations
  - Increased healthcare utilization
  - Lower mortality for newborns
  - Trend for lower mortality for mothers

Alsan Owen, Marcella; Garrick, Owen; Graziani, Grant C. Does diversity matter for health? Experimental evidence from Oakland. National Bureau of Economic Research. June 2018. Working paper 24787. DOI 10.3386/w24787
Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician-patient racial concordance and disparities in birthing mortality for newborns. Proc Natl Acad Sci U S A. 2020 Sep 1;117(35):21194-21200.

AAGL/FMIGS

- ACGME accreditation requires that all residency training programs implement and report on policies and procedures to recruit and retain URM physicians and medical leadership.

- Efforts to improve faculty diversity at academic medical institutions nationwide have not made meaningful impacts.

Avakame EF, October TW, Dixon GL. Antiracism in Academic Medicine: Fixing the Leak in the Pipeline of Black Physicians. ATS Sch. 2021 May 4;2(2):193-201

The current state of trainees

- Minority residents report racial discrimination
  - frequent misidentification as nonmedical staff
  - explicitly racist comments from patients or senior physicians
- Additional burdens placed on them to promote diversity at their institutions
- Black residents either leave or are terminated from training programs at far higher rates than white residents.

Avakame EF, October TW, Dixon GL. Antiracism in Academic Medicine: Fixing the Leak in the Pipeline of Black Physicians. ATS Sch. 2021 May 4;2(2):193-201

Table 1. Suggested approaches to antiracism in academic medicine
Antiracism in the formal curriculum
Establish antiracism training as an ACGME common program requirement
Include scholarship on race and medicine in journal club discussions
Develop specific formal didactics on issues of racism in medicine
Incorporate issues of racism in medicine into typical didactic exercises
Antiracism in the hidden curriculum
Normalize discussing potential impacts of racism on specific clinical cases
Call out interpersonal racism in team conversations
Reexamine performance evaluation processes for vulnerabilities of racial bias
Establish mechanisms for remedying harms and providing corrective feedback
Antiracism in faculty advancement
Encourage sponsorship and mentorship of Black junior faculty
Relieve the “minority tax” of administrative burden
Allocate protected time and resources to diversity and inclusion-related committees
Review promotion and tenure criteria to reward equity-focused work
Identify sources of funding for equity-based research
Add minority faculty to selection committees
Require a diverse pool of applicants for all new hires

AAGL/FMIGS

- Offer away resident MIGS rotations for candidates without MIGS at their home institution
- Prioritize recruitment of BIPOC trainees
- Integrate meaningful curricular focus on antiracism

Institutions

- Collect data
  - Epidemiology
  - Basic science
  - Interventions
  - Surgical outcomes
  - Patient perspectives
  - Methods to decrease disparate outcomes

Institutions

- Prioritize diversity recruitment and retention
- Include faculty development

Institutions
Standardize care and create objective measures

- Standardize pathways for determining route of hysterectomy
- Prioritize hiring practices that ensure the presence of high-volume gynecologic surgeons with experience in complex pathology
- Publish hospital data on MIS volume and make it accessible to patients
- Incentivize quality improvement at institutions with lower rates of MIS

Barnes WA, Carter-Brooks CM, Wu CZ, Acosta DA, Vargas MV. Racial and ethnic disparities in access to minimally invasive gynecologic surgery for benign pathology. Curr Opin Obstet Gynecol. 2021 Aug 1;33(4):279-287.

Individuals

- Identify and acknowledge our own biases
- Become educated
- Listen

Concluding thoughts

- The structure of the healthcare system perpetuates disparities and inequities and this is deeply rooted at all levels.

- Ameliorating disparities will take efforts at all levels:
  - Training leadership (FMIGS and other programs)
  - Organizational bodies (AAGL, ACOG, SGS, SGO, etc…)
  - Institutions (Hospital systems)
  - Individual actions (Us)

Concluding thoughts

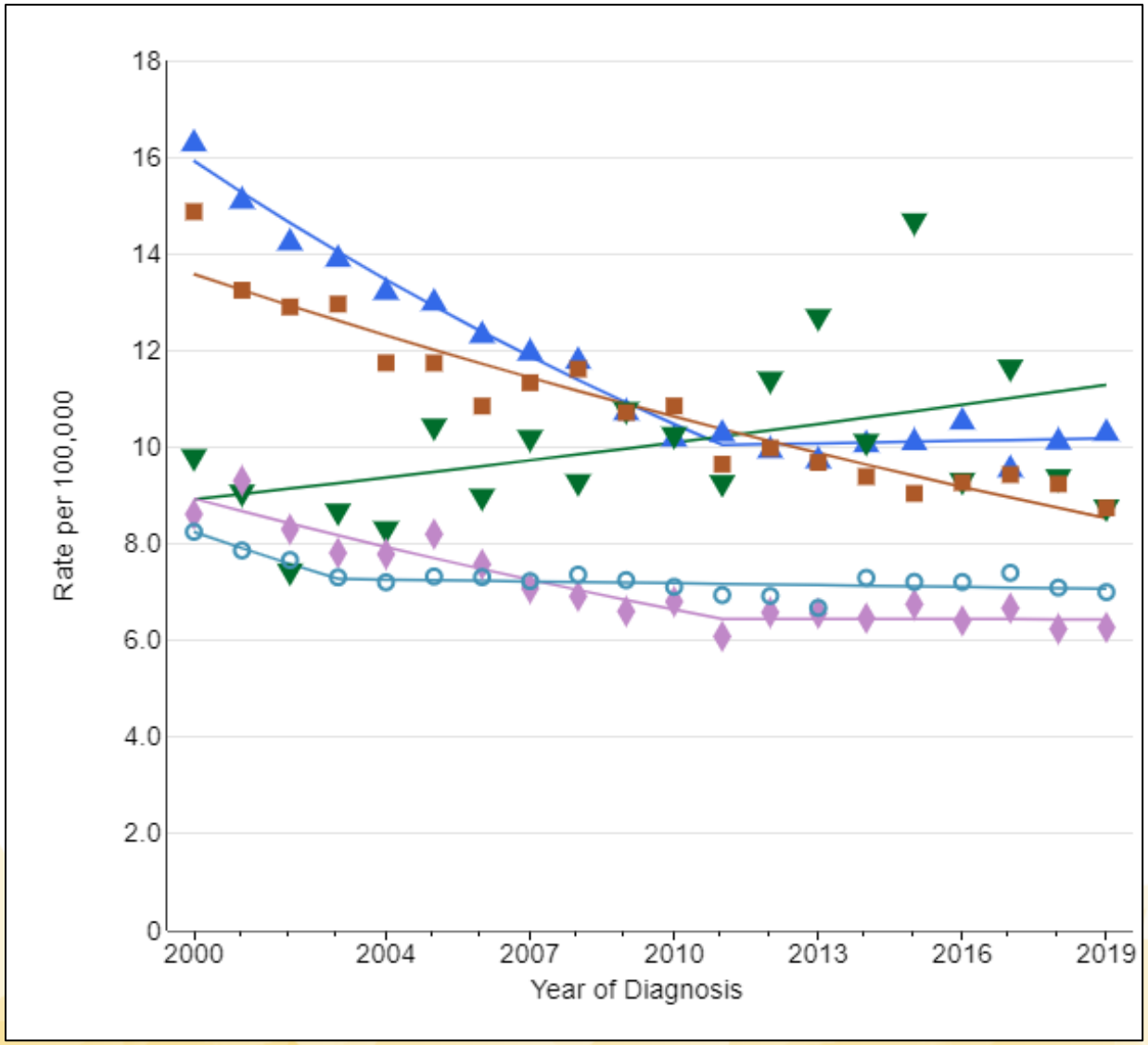
- There are actionable interventions
  - Create a meaningful focus on diversity at the trainee level
  - Engage with leadership to work on a systematic review of policies, procedures, and hiring practices
  - Research

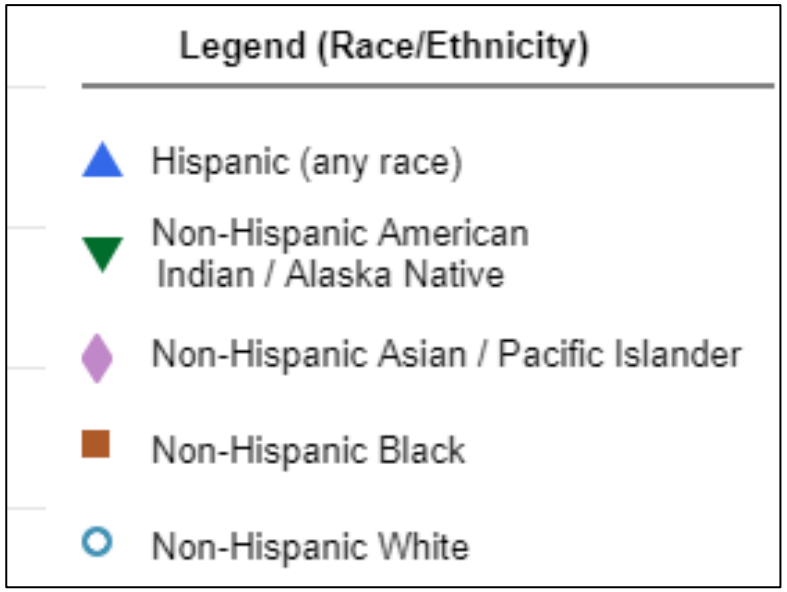
Part 2

Racial and ethnic disparities in gynecologic cancers: current trends and next steps

Anna Beavis, MD, MPH
Assistant Professor
Johns Hopkins SOM
Department of GYN/OB
Division of Gynecologic Oncology

Cervical cancer incidence trends

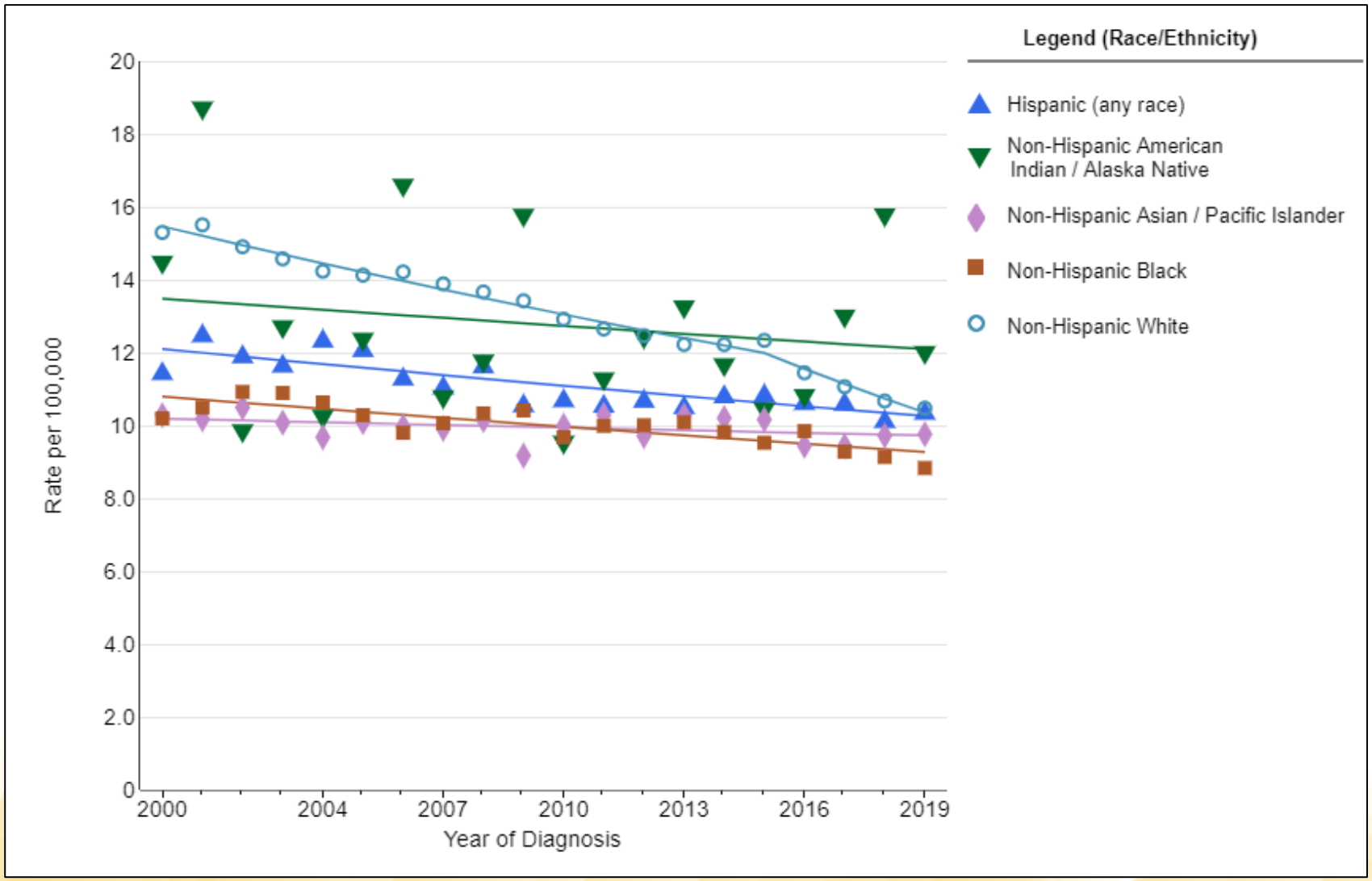




- **↓ rates in all groups except AI/AN**
- **The Hispanic, Black, AI/AN to White disparity persists**

Figure created on: https://seer.cancer.gov/statistics-network/explorer/

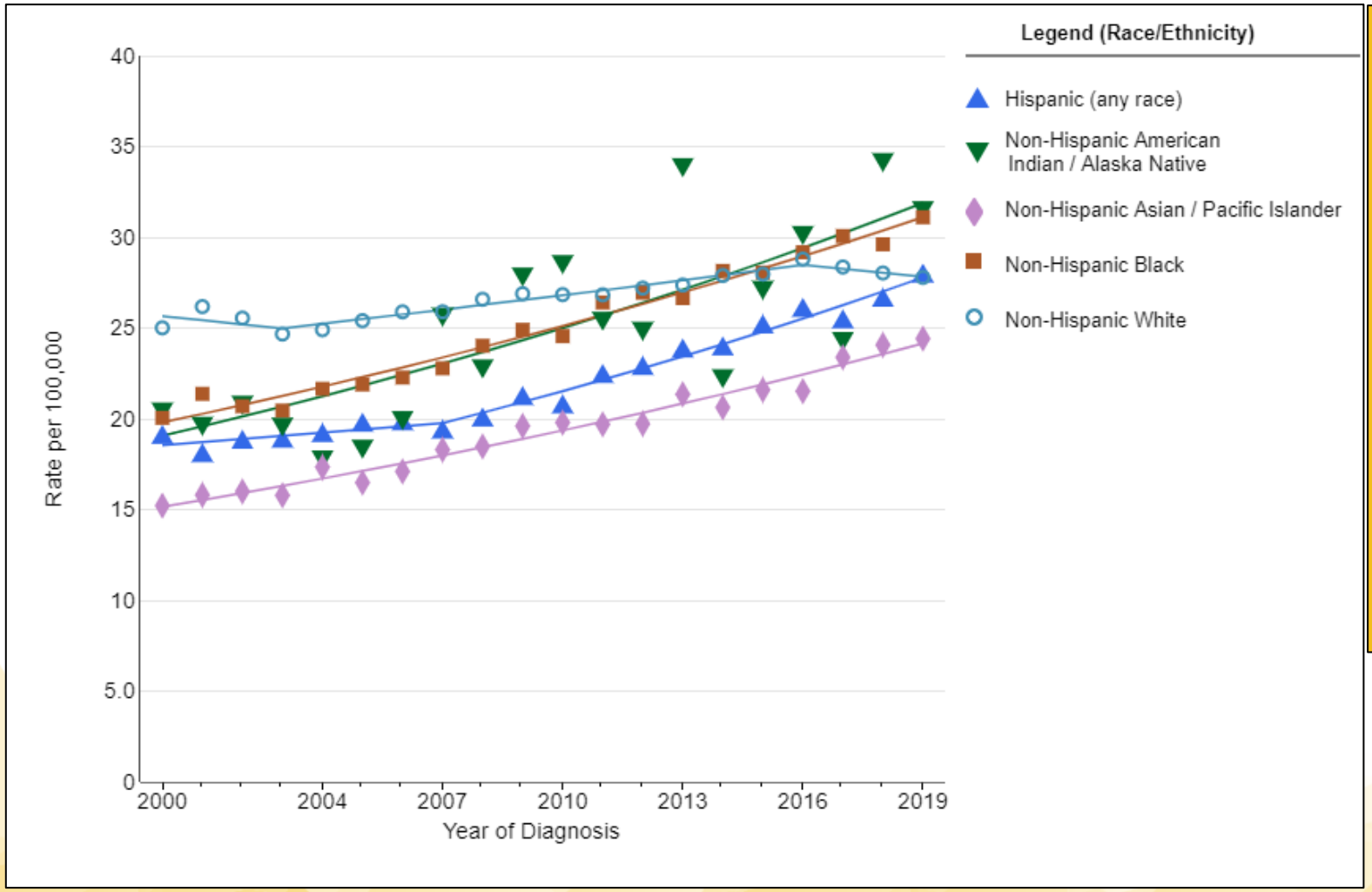
Ovarian cancer incidence trends



- **↓ rates in Black, White, and Hispanic populations**
- **Overall still more common in White populations**

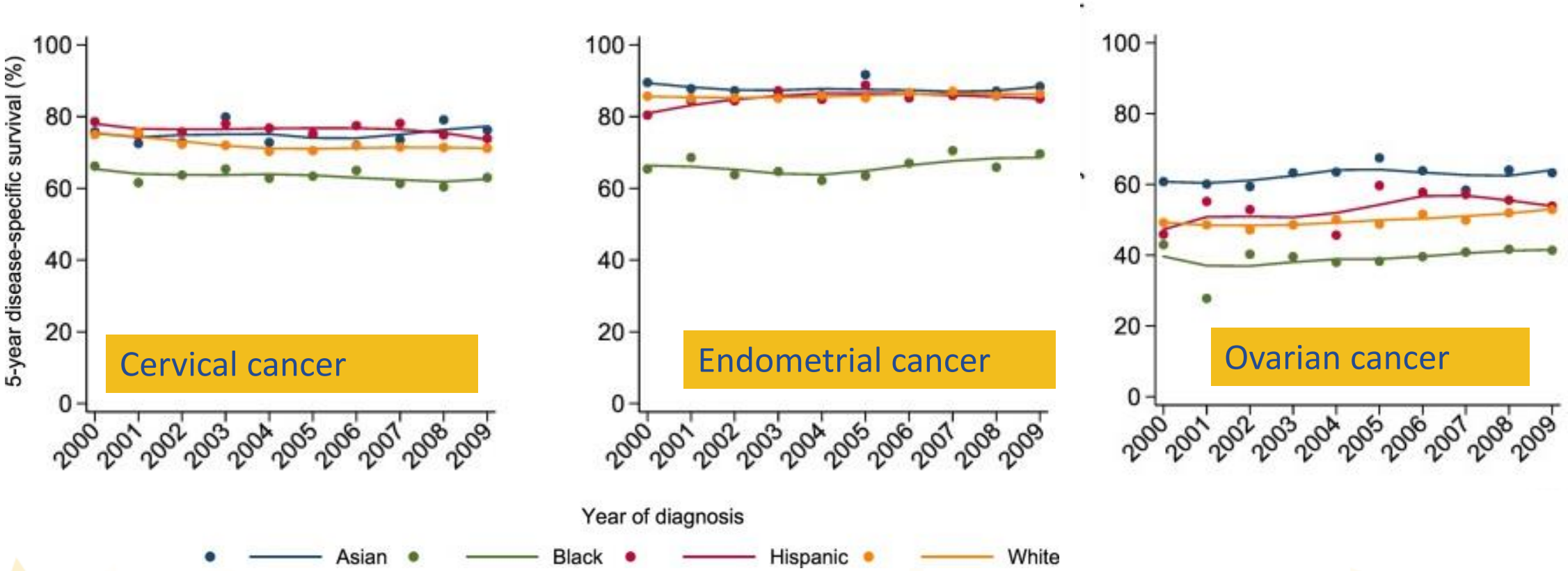
Figure created on: https://seer.cancer.gov/statistics-network/explorer/

Uterine cancer incidence trends



- **Incidence rising in all populations**
- **Incidence rates in Black populations now exceed those of White populations**

Trends in disease-specific survival from gynecologic cancers

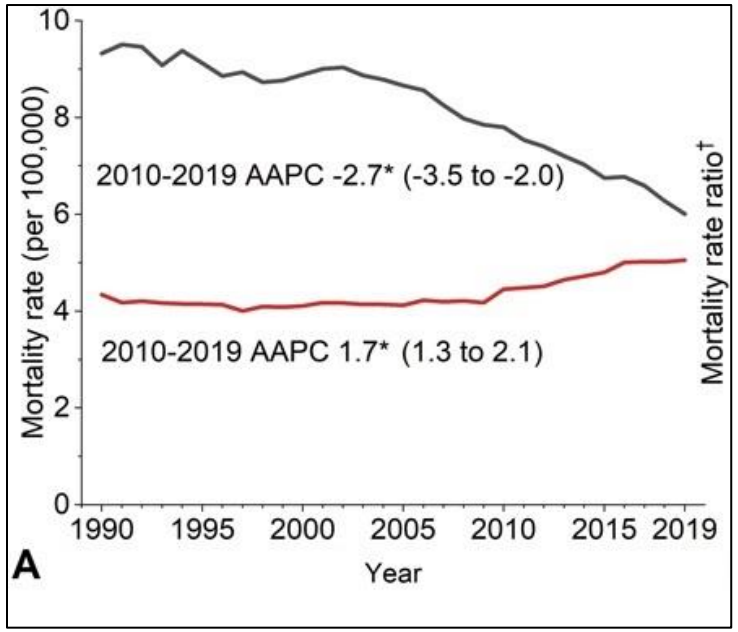


- Black women have the worst survival in all gynecologic cancers

Figure from: Rauh-Hain JA, Melamed A, Schaps D, Bregar AJ, Spencer R, Schorge JO, Rice LW, Del Carmen MG. Racial and ethnic disparities over time in the treatment and mortality of women with gynecological malignancies. Gynecol Oncol. 2018 Apr;149(1):4-11

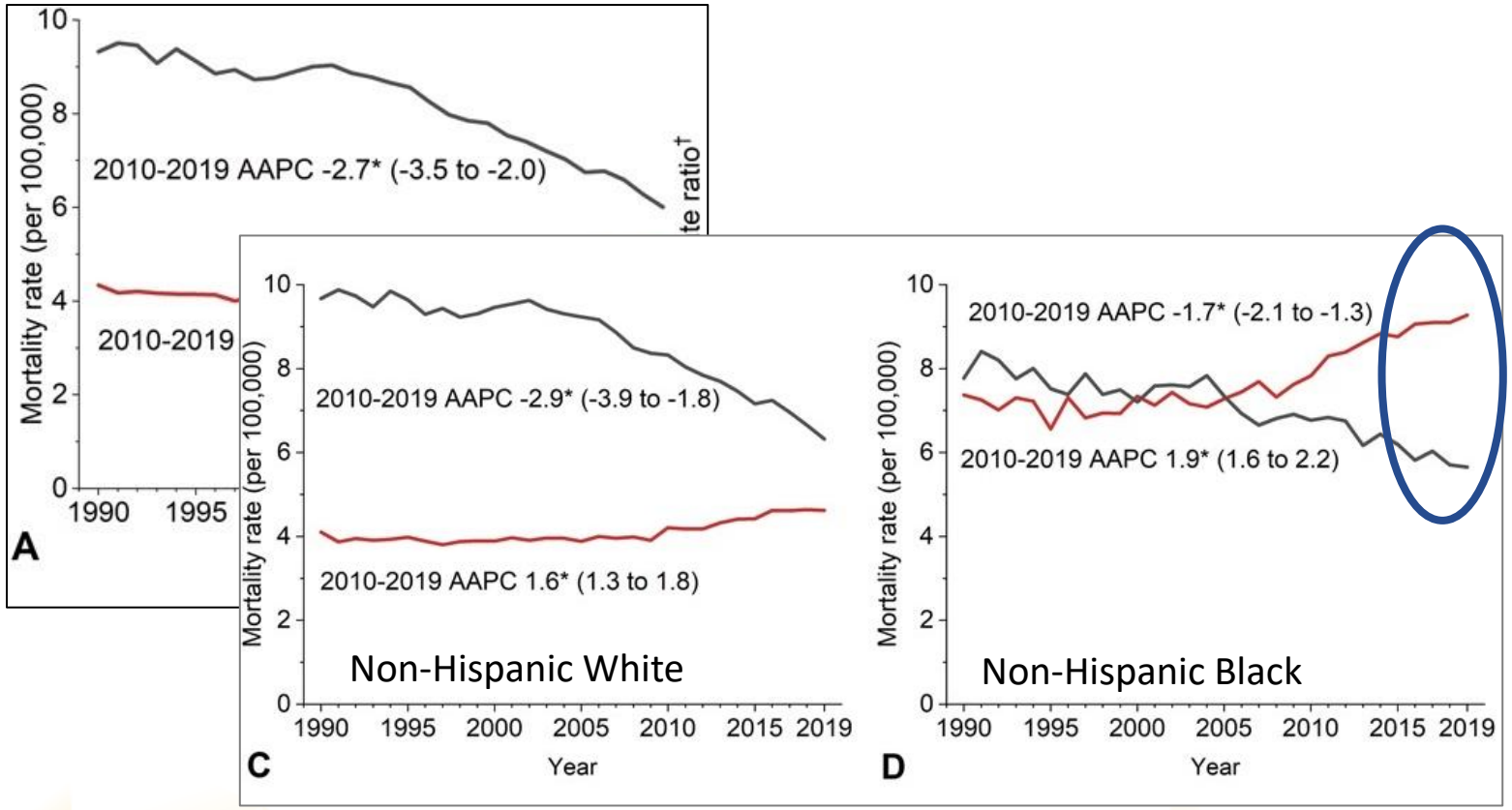
2022 headline:

Endometrial cancer <u>mortality rates</u> approaches those of ovarian cancer, disproportionately affect Black women

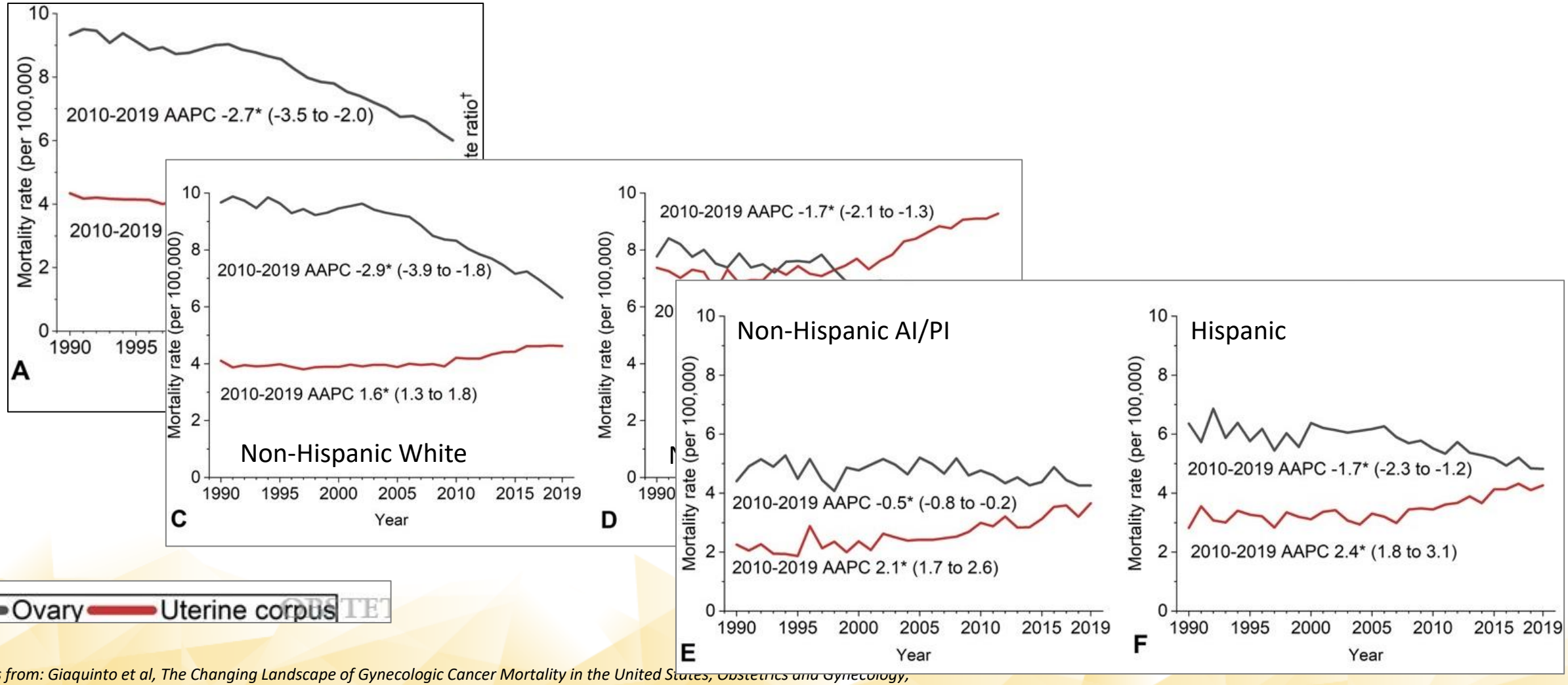


Figures from: Giaquinto et al, The Changing Landscape of Gynecologic Cancer Mortality in the United States, Obstetrics and Gynecology, 2022.

2022 headline:
Endometrial cancer <u>mortality rates</u> approaches those of ovarian cancer, disproportionately affect Black women



2022 headline:
Endometrial cancer <u>mortality rates</u> approaches those of ovarian cancer, disproportionately affect Black women



Gyn Cancer Rates: Importance of Accounting for Hysterectomy

- **Hysterectomy is more prevalent** in Black women
- Women s/p total hysterectomy are **no longer at risk of cervical/endometrial cancer**
- True disparities in **incidence/mortality need to be corrected** for hysterectomy prevalence

Beavis AL, Gravitt PE, Rositch AF. Hysterectomy-corrected cervical cancer mortality rates reveal a larger racial disparity in the United States. Cancer. 2017 May 15;123(6):1044-1050.

Example of hysterectomy correction: endometrial cancer incidence rates

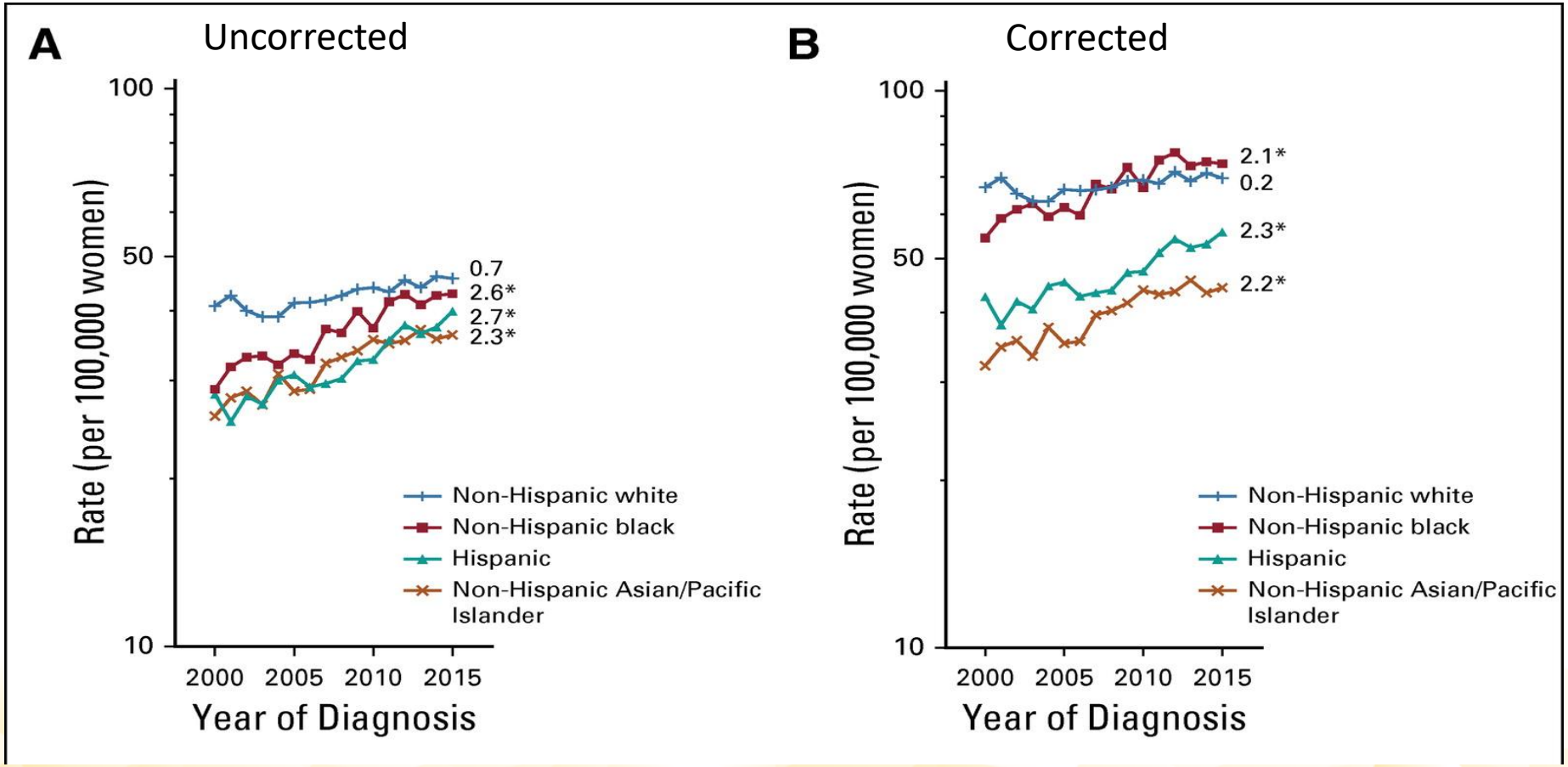


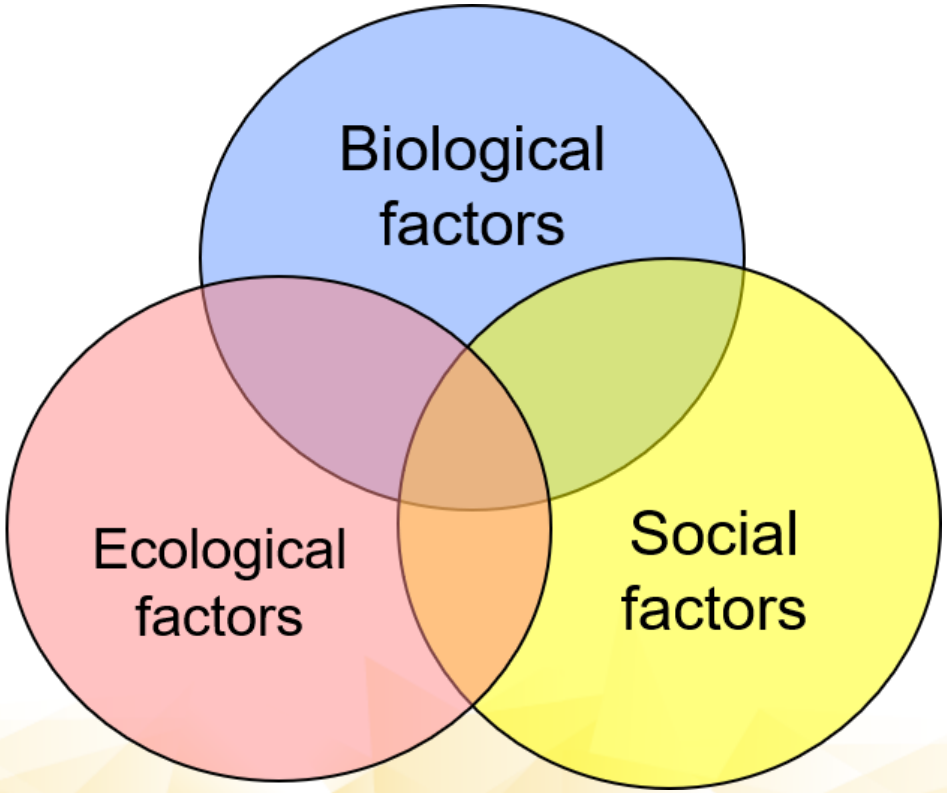
Figure published in: Megan A. Clarke et al; *Journal of Clinical Oncology* 2019 371895-1908.

Gyn Cancer Summary

- **Cervical cancer:**
  - Decreasing incidence and mortality
  - Black, Hispanic, AI/AN populations continue to suffer disproportionately
- **Ovarian cancer:**
  - Incidence, mortality decreasing
  - Incidence lower in Black women but mortality higher
- **Endometrial cancer:**
  - Rising incidence and mortality
  - Racial disparities worsening

Ecosocial Theory of Disease Distribution

- Each individual biologically ‘embodies’ their unique social and ecological exposures in their expression of disease



Krieger N. Theories for social epidemiology in the 21st century: an ecosocial perspective. Int J Epidemiol. 2001 Aug;30(4):668-77.

Concept: “Amenability Index”

How amenable a disease is to intervention

- **Cervical cancer:** highly amenable
- **Ovarian cancer:** poorly amenable
- **Endometrial cancer:** highly amenable

The more amenable a disease is to intervention, the larger the impact of social/ecological factors and the larger the disparity

Tehranifar, P., Neugut, A. I., Phelan, J. C., Link, B. G., Liao, Y., Desai, M., & Terry, M. B. (2009). Medical advances and racial/ethnic disparities in cancer survival. *Cancer Epidemiology Biomarkers and Prevention*, *18*(10), 2701–2708. https://doi.org/10.1158/1055-9965.EPI-09-0305

Concept: “Amenability Index”

How amen

- **Cervica**
- **Ovarian**
- **Endome**

Endometrial cancer has:
- Rising incidence
- Rising mortality
- Worsening racial disparities

&

- Detectable early symptoms

The more amenable a disease is to intervention, the larger the impact of social/ecological factors and the larger the disparity

Tehranifar, P., Neugut, A. I., Phelan, J. C., Link, B. G., Liao, Y., Desai, M., & Terry, M. B. (2009). Medical advances and racial/ethnic disparities in cancer survival. *Cancer Epidemiology Biomarkers and Prevention*, *18*(10), 2701–2708. https://doi.org/10.1158/1055-9965.EPI-09-0305

Black-white disparities along the EC continuum of care

Pre-diagnosis

- Less likely to undergo appropriate workup
- Patient/provider lack of recognition of symptoms
- Medical mistrust

Diagnosis

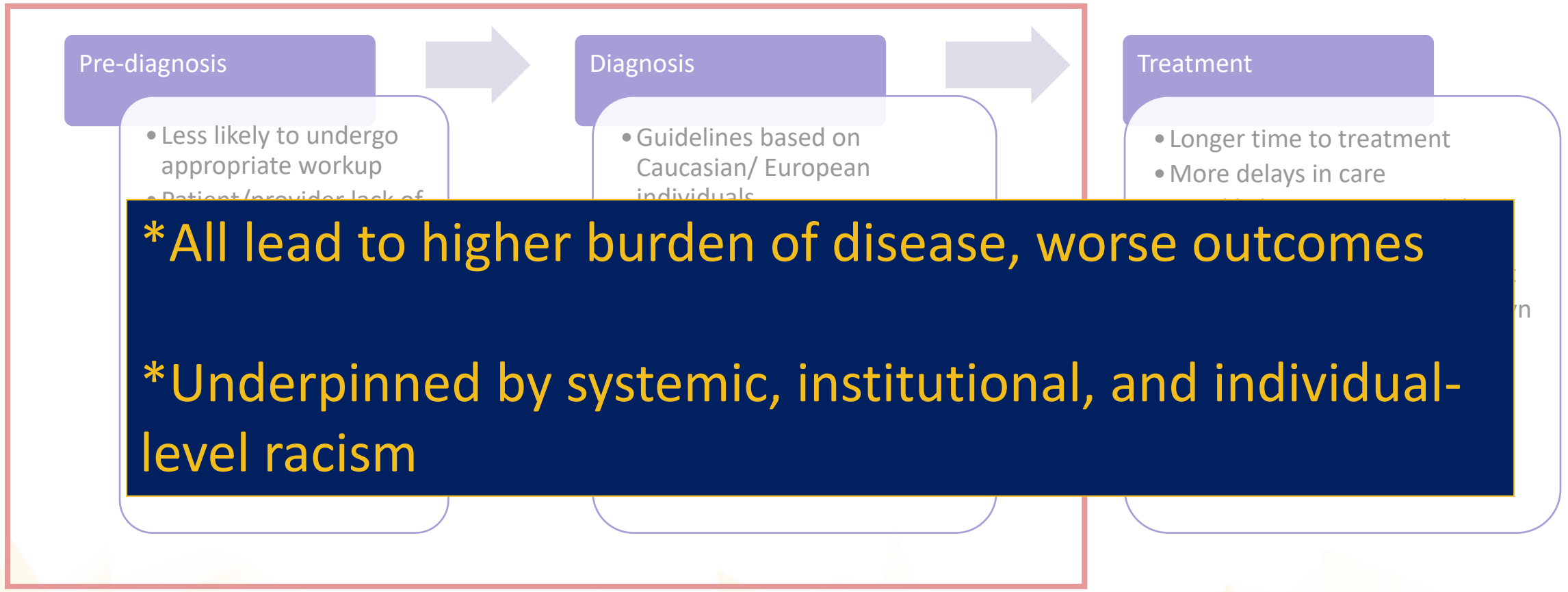
- Guidelines based on Caucasian/ European individuals
- Longer time to diagnostic imaging or biopsy
- More likely to be diagnosed at later stage

Treatment

- Longer time to treatment
- More delays in care
- Less likely to receive guideline concordant care
- More likely to refuse treatment
- Less likely to be treated by a Gyn Onc
- Less likely to enroll in clinical trials

Grubbs A, Barber EL, Roque DR. Healthcare Disparities in Gynecologic Oncology. Adv Oncol. 2022 May;2(1):119-128.

Black-white disparities along the EC continuum of care



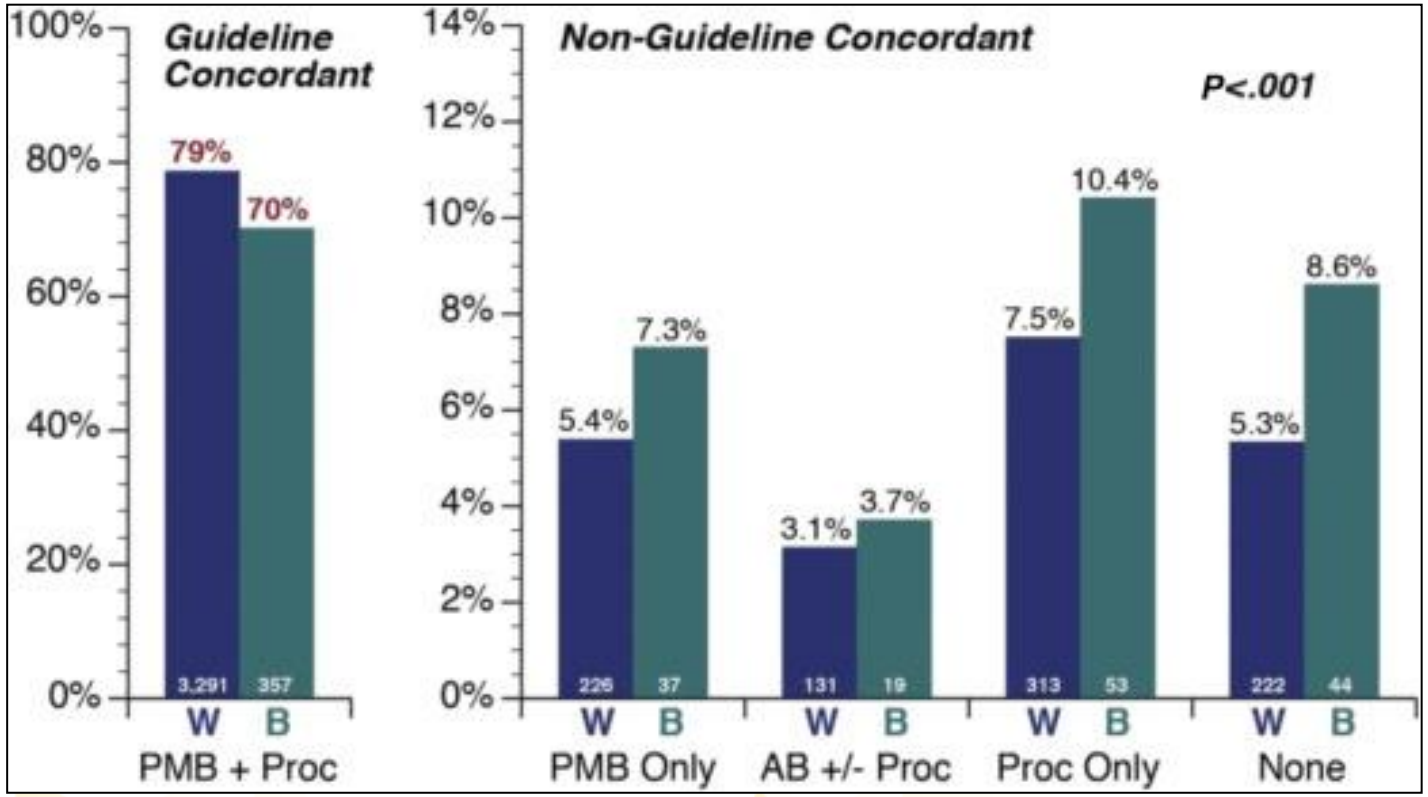
Grubbs A, Barber EL, Roque DR. Healthcare Disparities in Gynecologic Oncology. Adv Oncol. 2022 May;2(1):119-128.

Endometrial Cancer

Pre-diagnosis → Diagnosis → Treatment

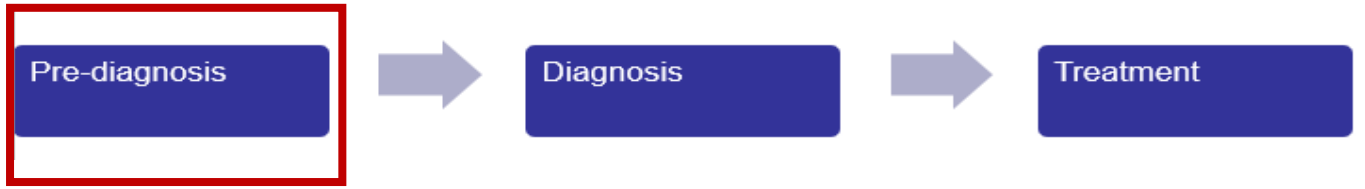
- Black are women less likely to undergo guideline-concordant evaluation for postmenopausal bleeding

- Providers may not recognize symptoms as abnormal



Doll KM, Khor S, Odem-Davis K, He H, Wolff EM, Flum DR, Ramsey SD, Goff BA. Role of bleeding recognition and evaluation in Black-White disparities in endometrial cancer. Am J Obstet Gynecol. 2018 Dec;219(6):593.e1-593.e14.

Endometrial Cancer



- Patients may not recognize symptoms as abnormal
  - Misinterpretation as resumption of menses
  - Interpreted as normal part of menopause
  - Unknown cancer concern

Doll KM, Hempstead B, Alson J, Sage L, Lavallee D. Assessment of Prediagnostic Experiences of Black Women With Endometrial Cancer in the United States. *JAMA Netw Open.* 2020;3(5):e204954.

Endometrial Cancer

- Guidelines on endometrial biopsy may not be appropriate

ACOG COMMITTEE OPINION

Number 734 • May 2018 *(Replaces Committee Opinion Number 440, August 2009)*

The Role of Transvaginal Ultrasonography in Evaluating the Endometrium of Women With Postmenopausal Bleeding

"Transvaginal **ultrasound is <u>usually sufficient</u>** as an initial evaluation…**if the ultrasound images reveal a thin** endometrial echo (**less than or equal to 4mm**)…"

Endometrial Cancer

- Simulated cohort of 367,073 Black and White women with postmenopausal bleeding

EEC cut-off	Sensitivity	
	Black women	White women
≥ 3mm	51%	90%
≥ 4mm	48%	88%
≥ 5mm	44%	86%

There is no EEC cut-off that is racially equitable

Romano SS, Doll KM. The Impact of Fibroids and Histologic Subtype on the Performance of US Clinical Guidelines for the Diagnosis of Endometrial Cancer among Black Women. Ethn Dis. 2020 Sep 24;30(4):543-552.

Endometrial Cancer

- Simulat… …with postme…

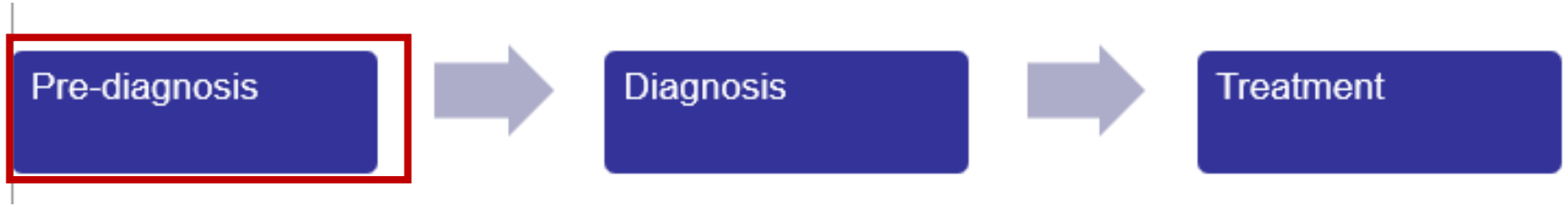
EEC		
		…en
≥ 3r…		
≥ 4r…		
≥ 5mm	44%	86%

*"Current clinical guidelines …**may disproportionately underperform** in Black women … and represent an example of **structural racial inequity** in care"*

There is no EEC cut-off that is racially equitable

Romano SS, Doll KM. The Impact of Fibroids and Histologic Subtype on the Performance of US Clinical Guidelines for the Diagnosis of Endometrial Cancer among Black Women. Ethn Dis. 2020 Sep 24;30(4):543-552.

Addressing contributors to disparities



Contributor	Potential solutions
Patient lack of recognition of abnormal bleeding symptoms	- Patient education - Community-engaged participatory research
Provider lack of recognition of abnormal bleeding symptoms	- Provider education & outreach
Medical mis-trust	- Change hiring practices to increase BIPOC gynecologists - Anti-racism training - Increased community engagement

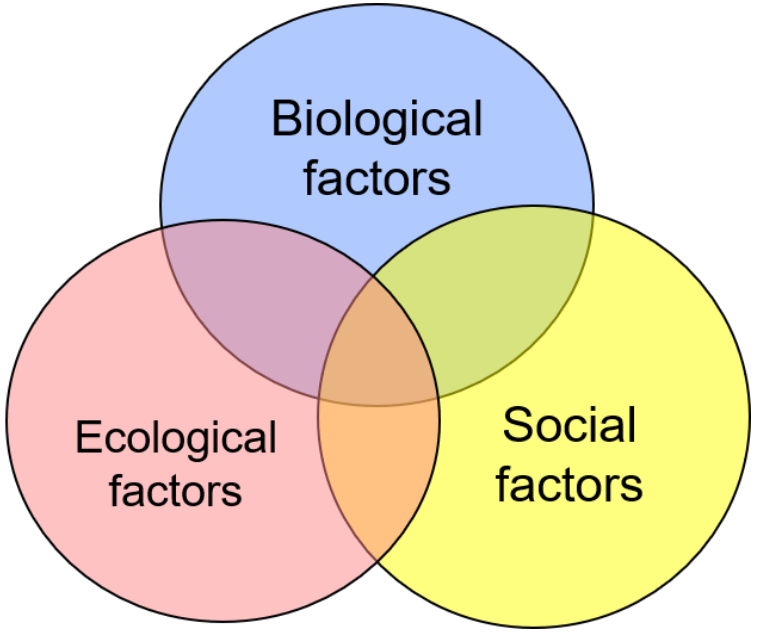
Addressing contributors to disparities

Contributor	Potential solutions
Guidelines not based on BIPOC individuals	- Support ongoing research examining appropriateness of guidelines in non-White populations
Longer time to diagnostic imaging or biopsy	- Standardized protocols for who is triaged to biopsy that account for differences in risk - Reduce barriers to care

Addressing contributors to disparities

- Social and ecological factors persist along the continuum of care

- **Screening for and addressing social needs**
  - May be one way to improve disparities by disproportionately helping the populations with the most needs



Re-iterating Dr. Vargas' thoughts

- Ameliorating disparities **will take efforts at all levels:**
  - Training leadership (FMIGS and other programs)
  - Organizational bodies (AAGL, ACOG, SGS, SGO, etc…)
  - Institutions (Hospital systems)
  - **Individual actions (Us)**

Part 3

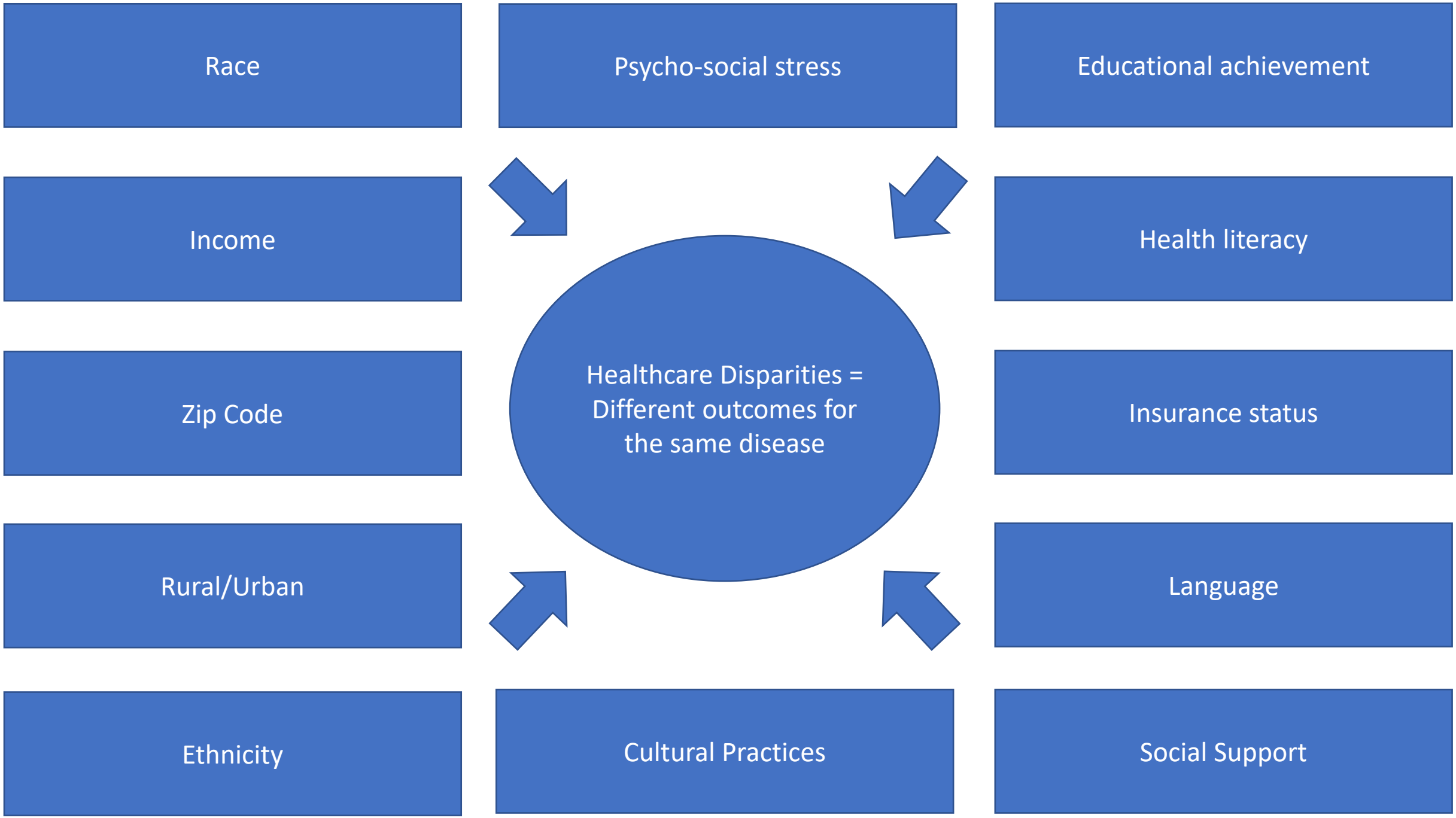
Integrating social needs assessments into the gynecology visit: a powerful tool to address inequities

Abdulrahman K. Sinno, MD, FACOG
Associate Proffesor
Director of Surgical Research and Education
Division of Gynecologic Oncology, Sylvester Comprehensive Cancer Center
University of Miami Miller School of Medicine

Defining the SDOH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

1. Economic Stability
2. Education access and quality
3. Healthcare access and quality
4. Neighborhood and built environment
5. Social community and context


Race
Psycho-social stress
Educational achievement
Income
Health literacy
Zip Code
Healthcare Disparities = Different outcomes for the same disease
Insurance status
Rural/Urban
Language
Ethnicity
Cultural Practices
Social Support

Contents lists available at ScienceDirect

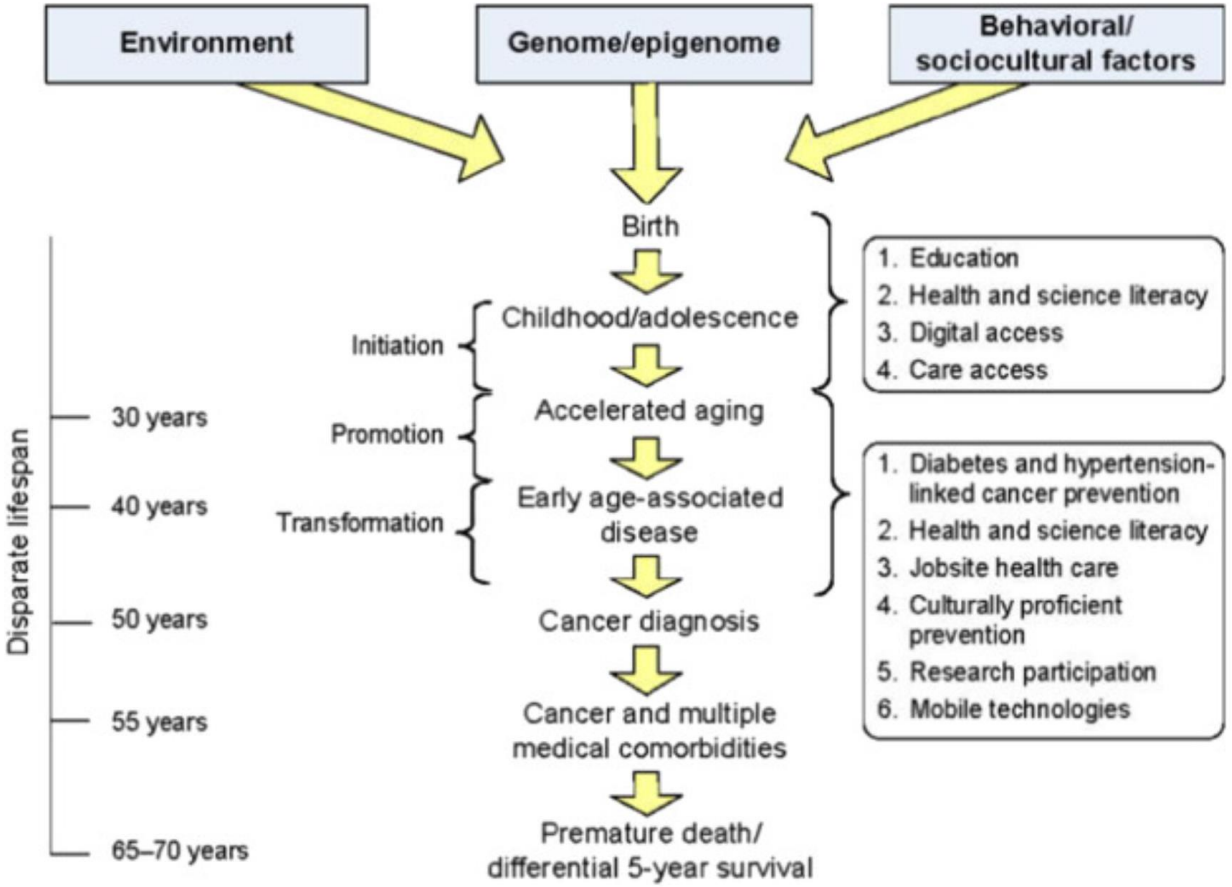
Gynecologic Oncology

journal homepage: www.elsevier.com/locate/ygyno

Review Article

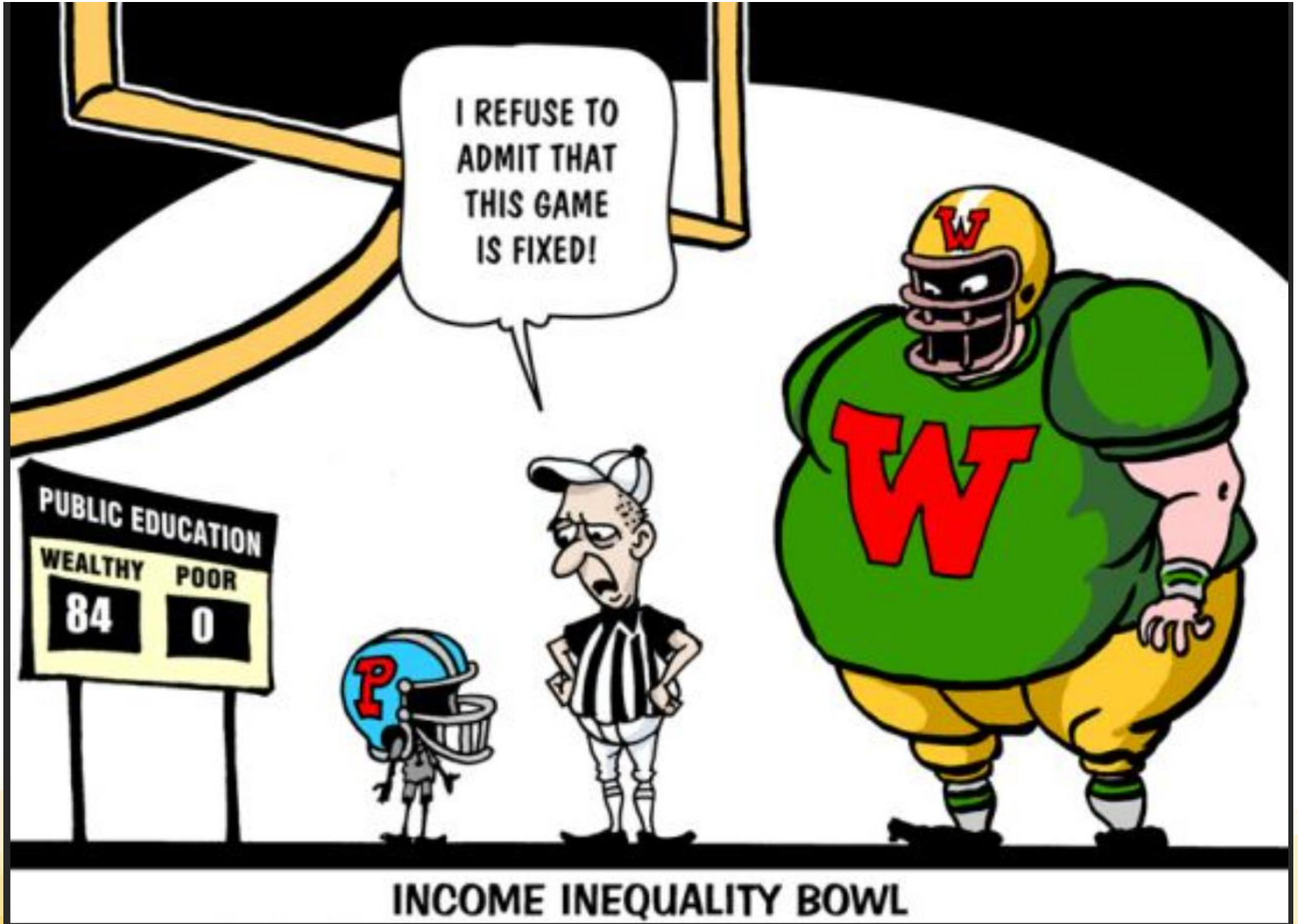
A contemporary framework of health equity applied to gynecologic cancer care: A Society of Gynecologic Oncology evidenced-based review

Sarah M. Temkin [a], B.J. Rimel [b], Amanda S. Bruegl [c], Camille C. Gunderson [d], Anna L. Beavis [e], Kemi M. Doll [f,*]

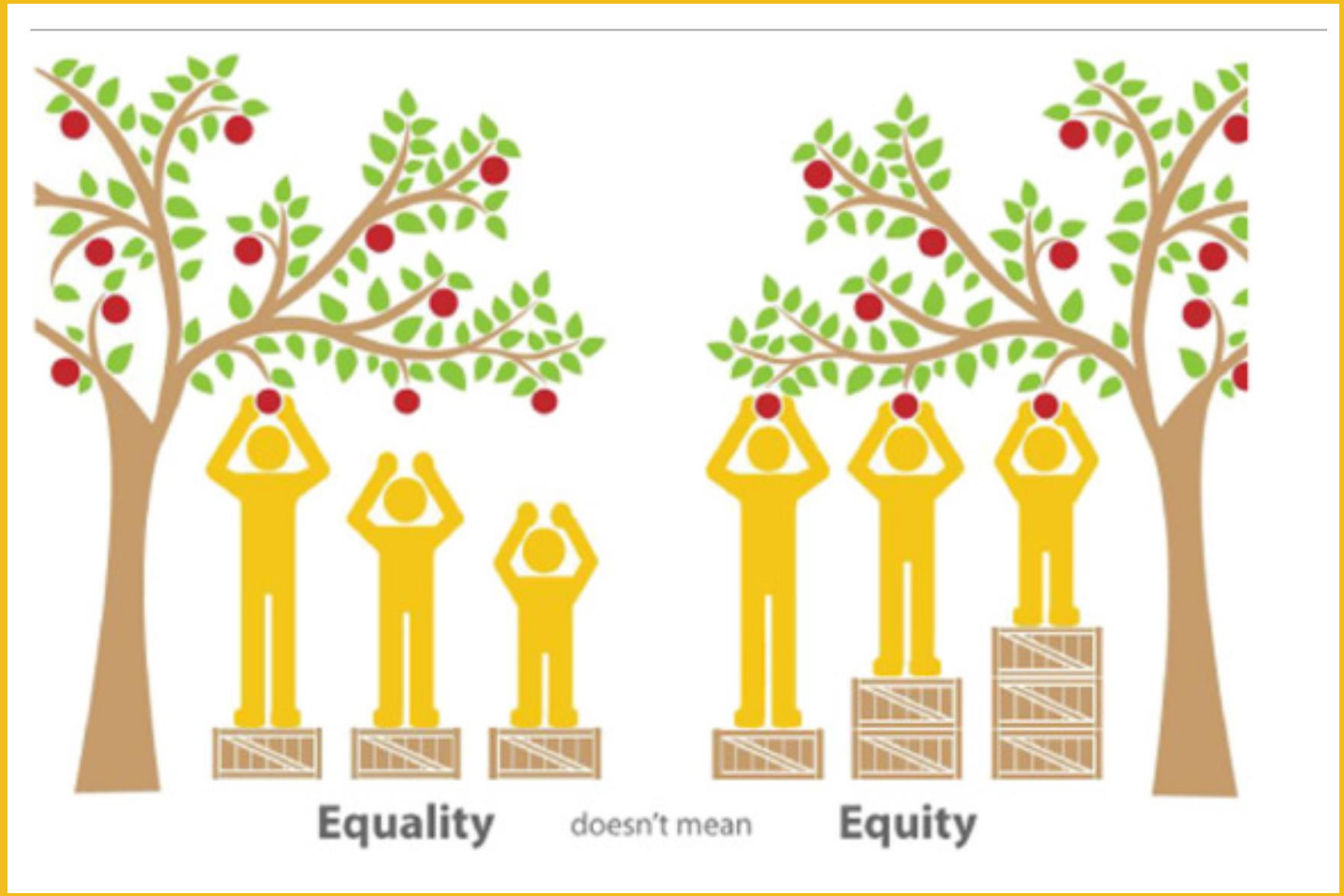


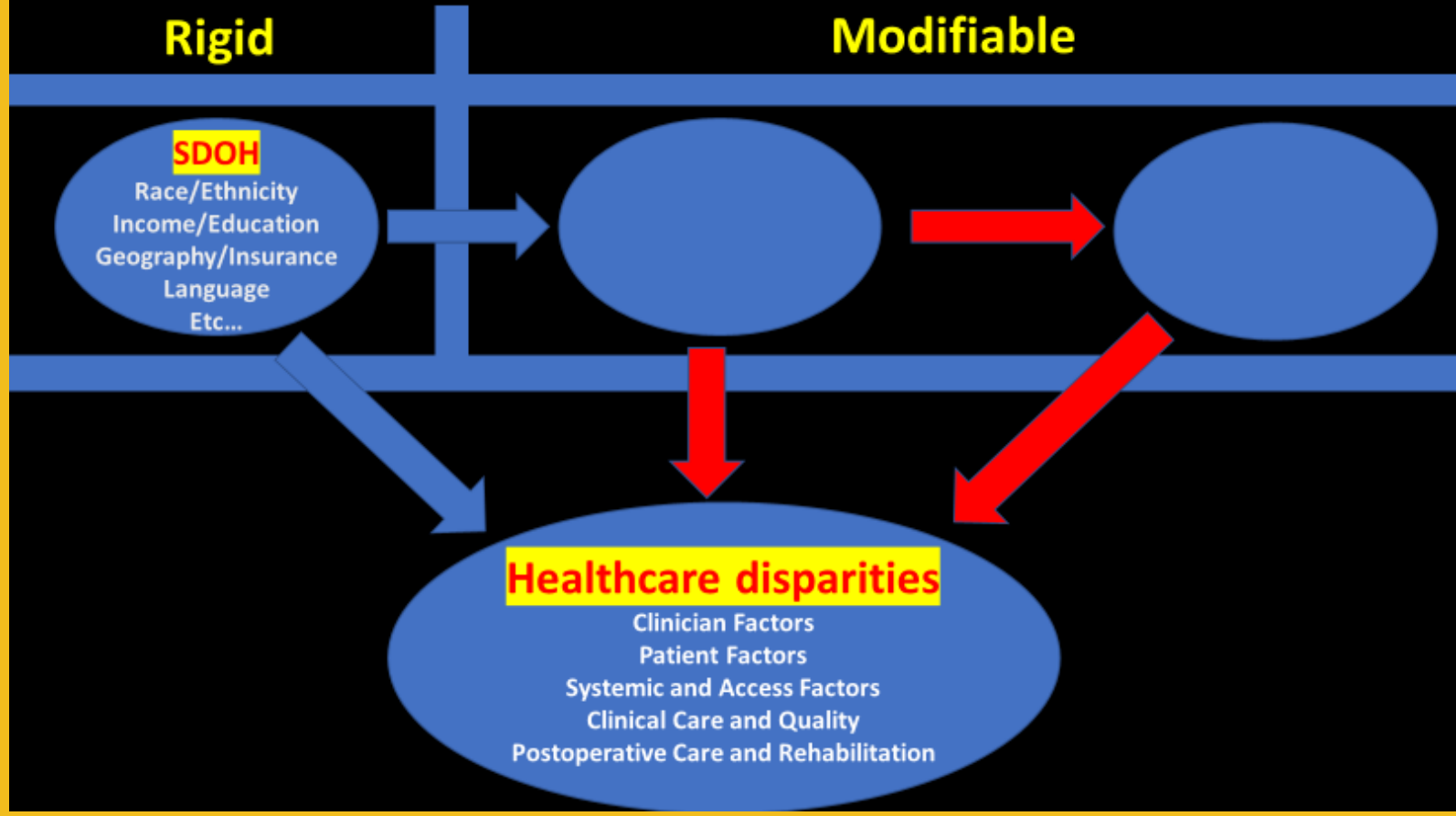
National Institute on Minority Health and Health Disparities Research Framework

		Levels of Influence*			
		Individual	**Interpersonal**	**Community**	**Societal**
Domains of Influence *(Over the Lifecourse)*	**Biological**	Biological Vulnerability and Mechanisms	Caregiver–Child Interaction Family Microbiome	Community Illness Exposure Herd Immunity	Sanitation Immunization Pathogen Exposure
	Behavioral	Health Behaviors Coping Strategies	Family Functioning School/Work Functioning	Community Functioning	Policies and Laws
	Physical/Built Environment	Personal Environment	Household Environment School/Work Environment	Community Environment Community Resources	Societal Structure
	Sociocultural Environment	Sociodemographics Limited English Cultural Identity Response to Discrimination	Social Networks Family/Peer Norms Interpersonal Discrimination	Community Norms Local Structural Discrimination	Social Norms Societal Structural Discrimination
	Health Care System	Insurance Coverage Health Literacy Treatment Preferences	Patient–Clinician Relationship Medical Decision-Making	Availability of Services Safety Net Services	Quality of Care Health Care Policies
Health Outcomes		**Individual Health**	**Family/ Organizational Health**	**Community Health**	**Population Health**


I REFUSE TO ADMIT THAT THIS GAME IS FIXED!
PUBLIC EDUCATION
WEALTHY
POOR
84
0
INCOME INEQUALITY BOWL

Do these frameworks help clinicians achieve equity in the clinical setting? Do they help inform implementation research?





Proposing a novel framework for implementation of health disparity research

Gynecologic Oncology
Volume 158, Issue 3, September 2020, Pages 521-525

Clinical Practice Statement

Social needs in gynecologic oncology: A Society of Gynecologic Oncology (SGO) clinical practice statement

K. Esselen [a], A.K. Sinno [b], J. Varughese [c], S.L. Wethington [d], E. Prendergast [e], C.S. Chu [f]

- Social needs are specific social conditions that are associated with poor health such as lack of transportation, housing instability, or social isolation
- Social needs are practical downstream mediators of SDOH
- They can be patient reported
- Can not be abstracted from standard healthcare databases

Social Needs VS Social Determinants of Health

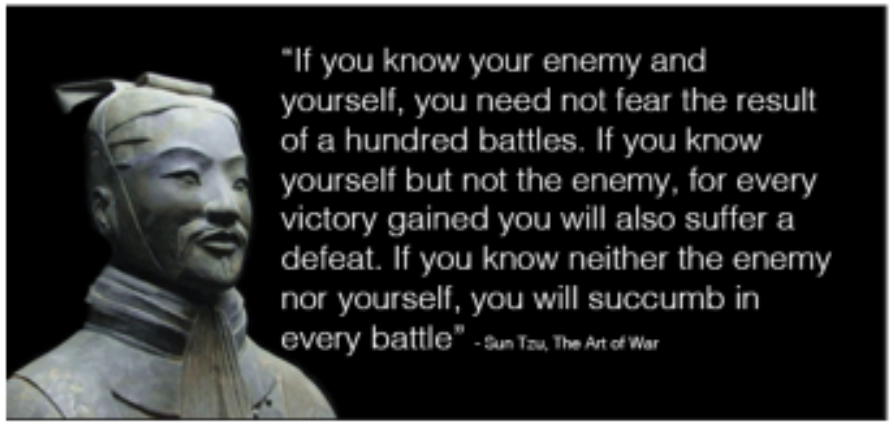
Social Determinant of Health

- Rural location
- Low educational achievement
- Poverty
- Social fragmentation/poor social environment
- Lack of insurance

Social Need

- Transportation
- Needing help reading hospital material
- Food insecurity, housing instability
- Safety at home, Social isolation
- Lack of access to primary care, lack of access mental health

Identifying the Social Needs of a Population



Screening Toolkits

- The Health Leads Social Needs Screening Toolkit
- The Accountable Health Communities Health-Related Social Needs Screening Tool (AHC-HRSN)
- The PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) assessment tool

Health Leads Screening Questionnaire

Name: _____ Phone number: _____

Preferred Language: _____ Best time to call: _____

		Yes / No
	In the last 12 months*, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has the **electric, gas, oil, or water company threatened to shut off your services** in your home?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work or study?** *(leave blank if you do not have children)*	Y N
	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Do you often feel that **you lack companionship?**	Y N
	**Are any of your needs urgent?** For example: I don't have food tonight, I don't have a place to sleep tonight	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N

**time frames can be altered as needed*

FOR STAFF USE ONLY:

- Place a patient sticker to the right
- Give this form to the patient with patient packet
- PRINT your name and role below.

Staff Name: _____

Place patient sticker here

Recommended Demographics to Collect

The following socio-demographic data elements will be useful for identifying patients' social needs, as well as patients' eligibility for specific benefits or resources.

DEMOGRAPHIC FIELD	WHERE TO COLLECT	REASON FOR COLLECTING
Age (Date of Birth)	Already in EHR	May influence eligibility for resources or benefits, may help determine case complexity
Gender	Already in EHR	May influence eligibility for resources or benefits, may help determine case complexity
Race and Ethnicity	Already in EHR	May influence eligibility for resources or benefits, may help determine case complexity
Marital Status	Already in EHR	May influence eligibility for resources or benefits, may help determine case complexity
Education Level	Already in EHR	May help determine case complexity
Language(s) Spoken	Screening Form	Confirm at screening to ensure services are being provided in a language the patient understands
Health Insurance Status	Screening Form	Confirm at screening if the EHR may not be up fully updated; finding viable health insurance may be a need for the patient
Current Benefits Received	Screening or Intake	May help determine which resources or benefits to discuss with the patient
Sexual Orientation	Intake Conversation	May influence eligibility for resources or benefits, may help determine case complexity
Employment Status	Intake Conversation	Unemployment or under-employment may be a social need to discuss with the patient
Household Income	Intake Conversation	Influences eligibility for resources or benefits
Caring for Elder	Intake Conversation	May influence eligibility for resources or benefits, may help determine case complexity

Health Leads

SOCIAL NEEDS SCREENING TOOLKIT

FOOD INSECURITY

SCREENING QUESTIONS LIBRARY

Essential to include on your screening form

Examples: Limited or uncertain access to adequate food

Recommended Screening Question

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

Yes, No

Why we recommend this question: This question is from the USDA Household Food Survey and has been widely adopted as a standard question to ask when screening for food insecurity. It is written at a 7th grade reading level, which may be somewhat challenging for low-literacy populations to understand.

Alternative Options

	VALIDATED	PRECISION	GRADE LEVEL
The food that we bought just didn't last, and we didn't have money to get more. Was that often, sometimes, or never true for your household in the last 12 months? (USDA, The Hunger Vital Sign)	✓		5th
Within the past 12 months we worried whether our food would run out before we got money to buy more. (USDA, The Hunger Vital Sign)	✓		8th
We couldn't afford to eat balanced meals. Was that often, sometimes, or never true for you in the last 12 months? (USDA)	✓		4th
In the past year, have you ever used a Food Pantry/Soup Kitchen or received a food donation? Yes, No (Children's HealthWatch)	✓		7th

HOUSING INSTABILITY

SCREENING QUESTIONS LIBRARY

Essential to include on your screening form

Examples: Homelessness, unsafe or unhealthy housing conditions, inability to pay mortgage/rent, frequent housing disruptions, eviction

Recommended Screening Question

Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?

Yes, No

Why we recommend this question: This question was written by the Veterans Administration and is a good proxy for immediate housing challenges. It comes from a validated instrument and is written at a 10th grade level, which may be somewhat challenging for low-literacy populations to understand.

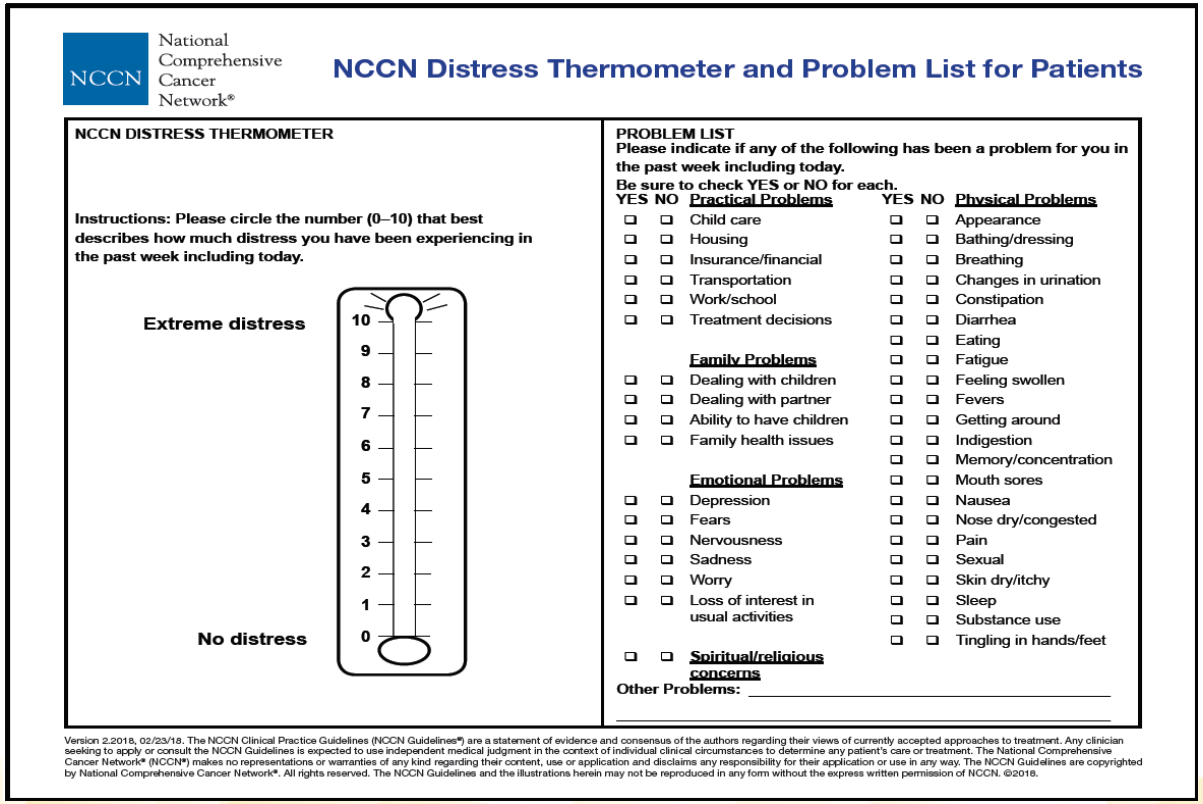
Alternative Options

	VALIDATED	PRECISION	GRADE LEVEL
Do you think you are at risk of becoming homeless? Yes, No (WeCare)	✓		5th
Think about the place you live. Do you have problems with any of the following? Check all that apply: Bug infestation, mold, lead paint or pipes, inadequate heat, oven or stove not working, no or not working smoke detectors, water leaks, none of the above (PRAPARE, adapted for AHC screen)	✗		5th

Sources & Additional Options

- Accountable Health Communities (AHC)
- PRAPARE
- Veterans Affairs Homelessness Screening Tool 2009

NCCN Distress and Emotional Thermometers



National Comprehensive Cancer Network®

NCCN Distress Thermometer and Problem List for Patients

NCCN DISTRESS THERMOMETER

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress 10 9 8 7 6 5 4 3 2 1 0 **No distress**

PROBLEM LIST

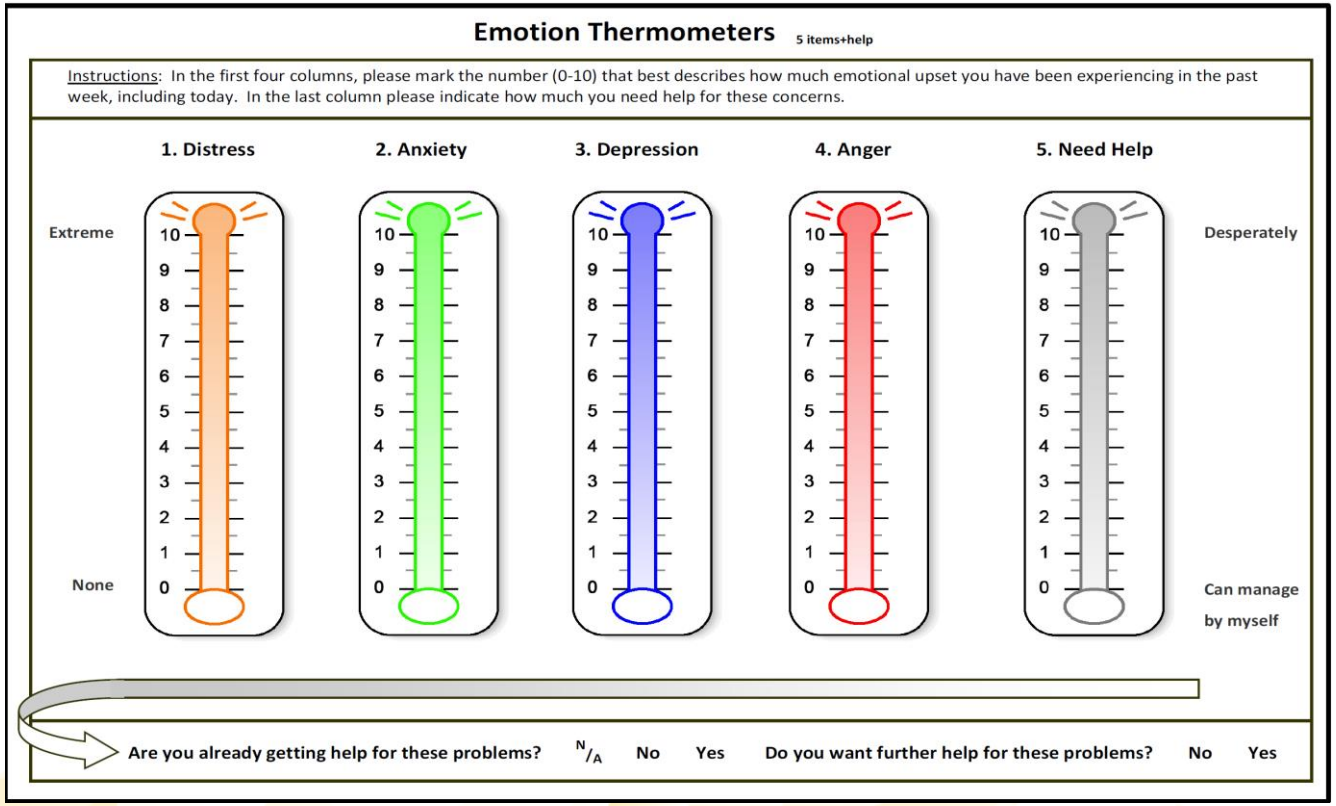
Please indicate if any of the following has been a problem for you in the past week including today.

Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions
		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues
		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	**Spiritual/religious concerns**

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance use
❑	❑	Tingling in hands/feet

Other Problems: _____



Emotion Thermometers 5 items+help

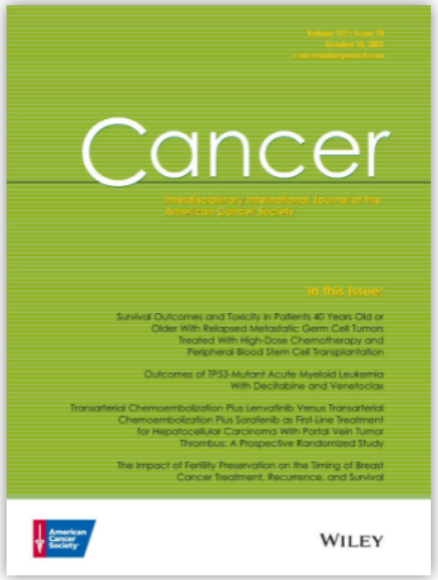
Instructions: In the first four columns, please mark the number (0-10) that best describes how much emotional upset you have been experiencing in the past week, including today. In the last column please indicate how much you need help for these concerns.

1. Distress	2. Anxiety	3. Depression	4. Anger	5. Need Help
Extreme 10 9 8 7 6 5 4 3 2 1 0 None	10 9 8 7 6 5 4 3 2 1 0	10 9 8 7 6 5 4 3 2 1 0	10 9 8 7 6 5 4 3 2 1 0	10 9 8 7 6 5 4 3 2 1 0 Desperately … Can manage by myself

Are you already getting help for these problems? N/A No Yes Do you want further help for these problems? No Yes

Universal social needs assessment in gynecologic oncology: An important step toward more informed and targeted care in the public safety net

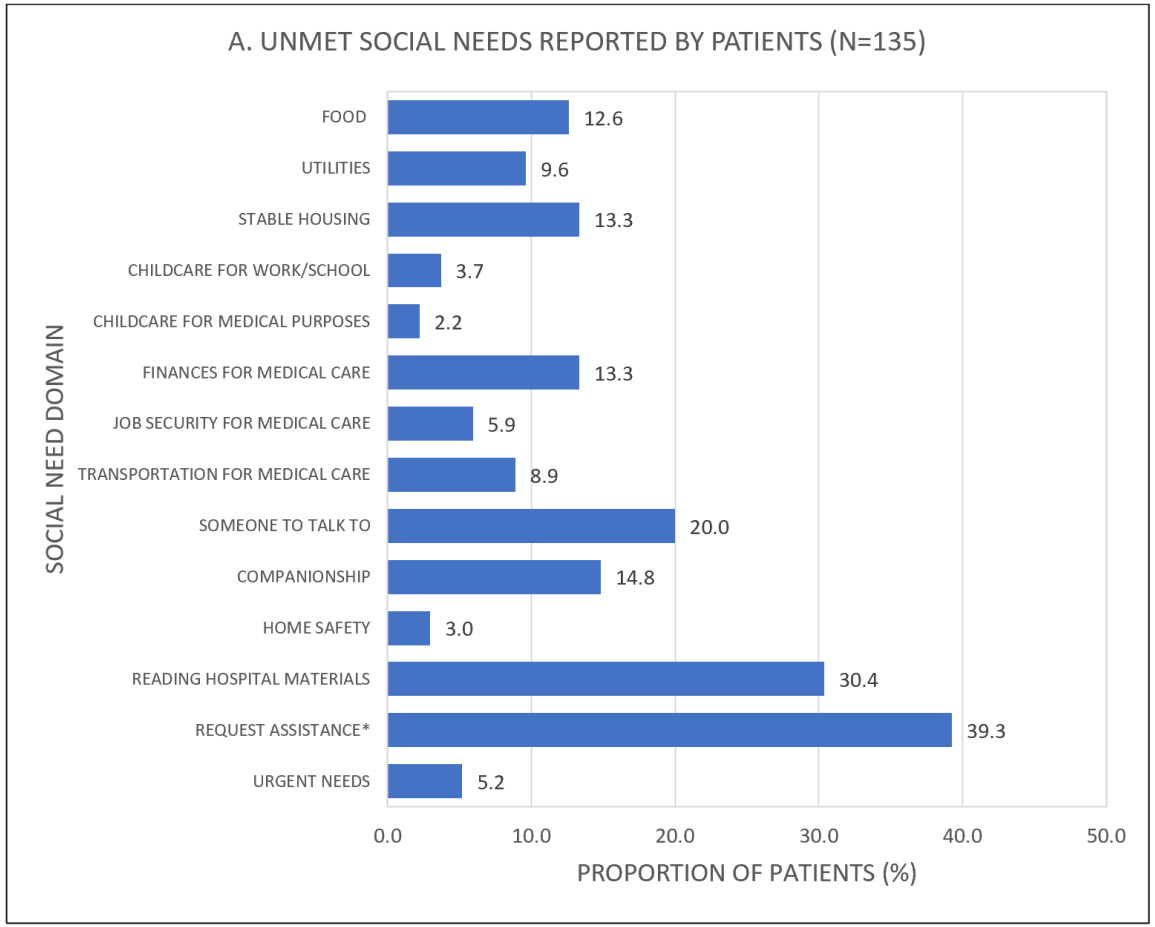
Natsai C. Nyakudarika MD, Christine H. Holschneider MD, Abdulrahman K. Sinno MD ✉,

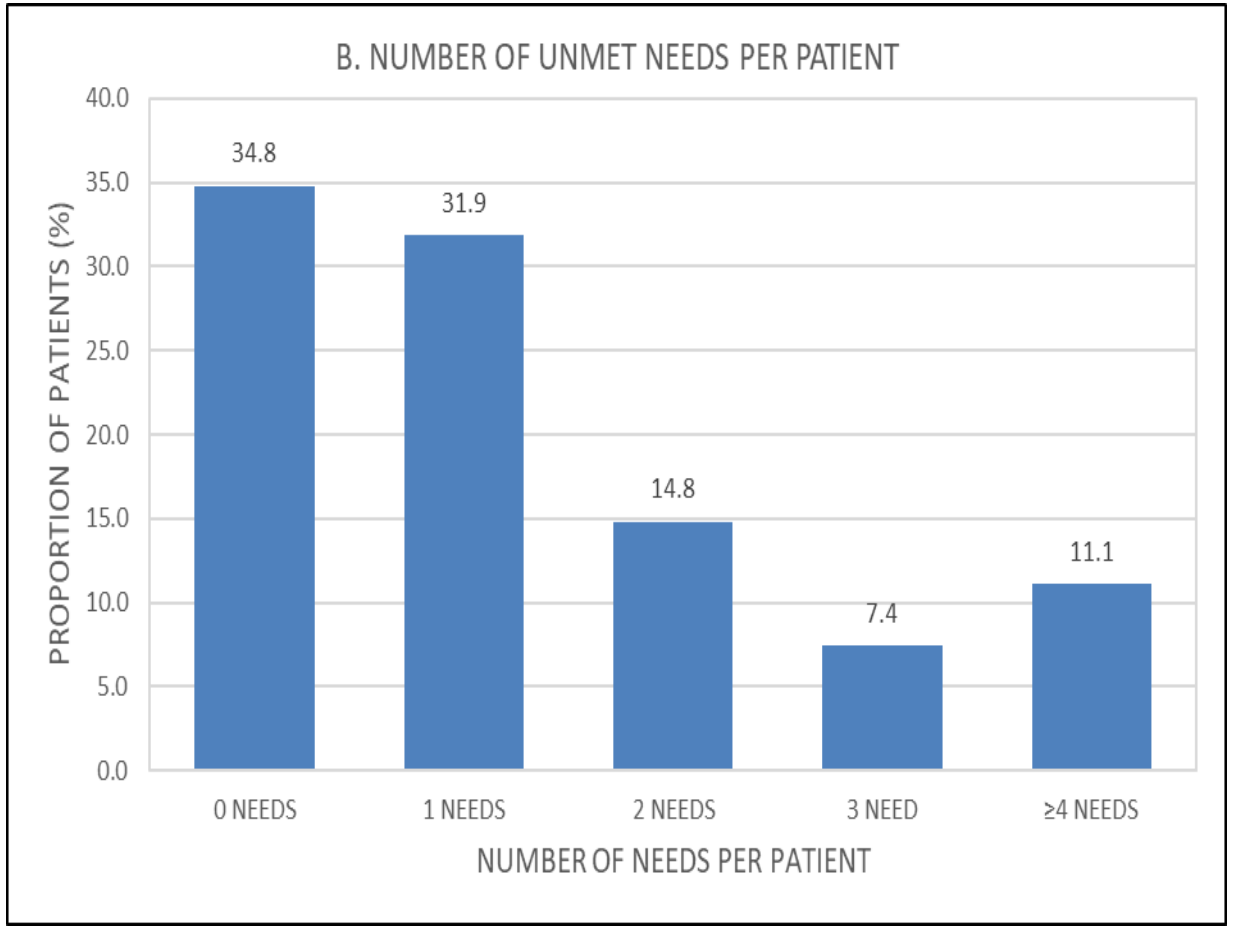


Volume 127, Issue 20
October 15, 2021
Pages 3809-3816

- Prospective cohort PIP
- 135 women
- Social needs assessment and distress screening
- Health Leads Social Needs Screening Toolkit, the National Comprehensive Cancer Network Distress Thermometer, and the Emotion Thermometers Tool.

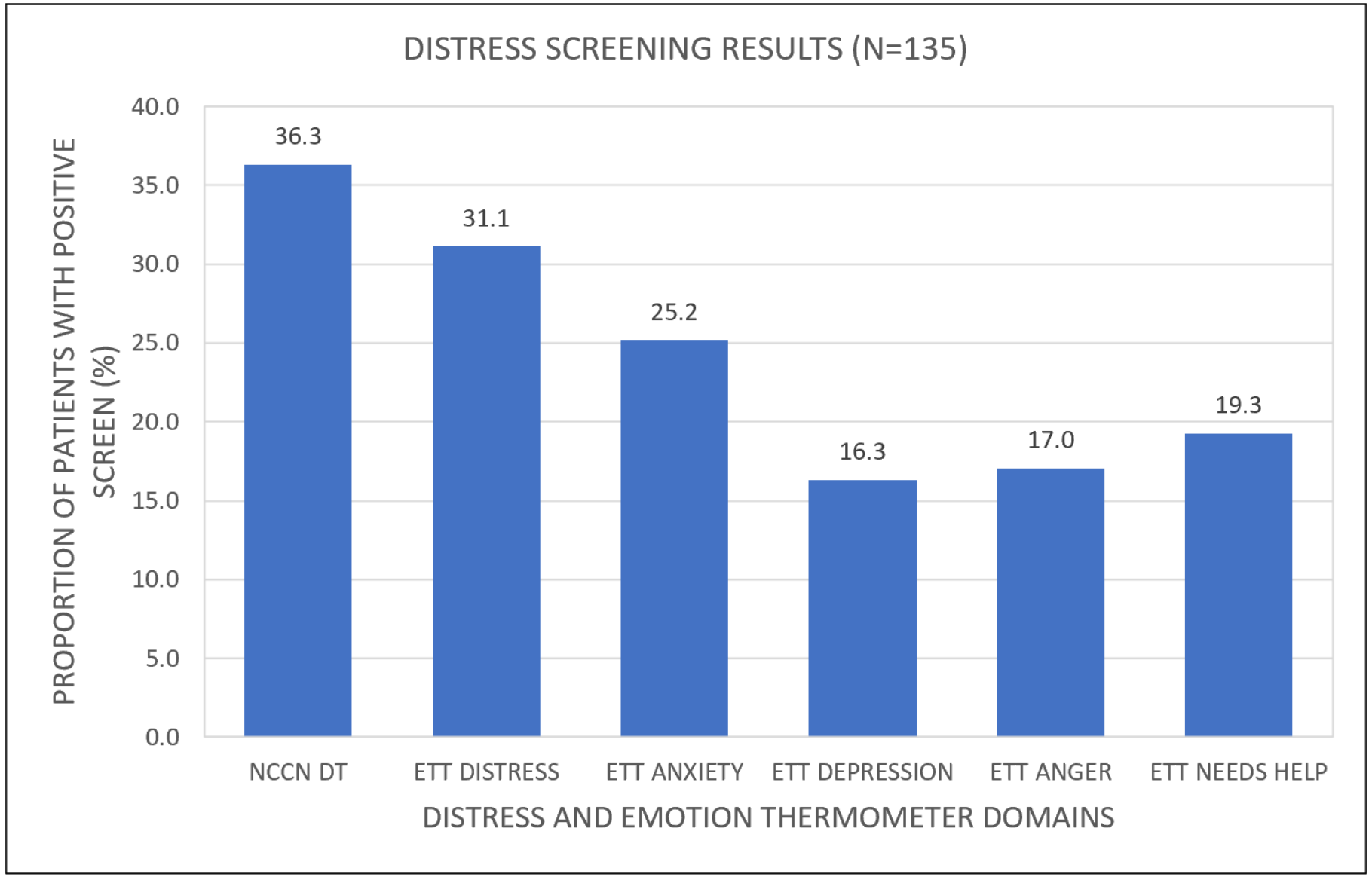
FIGURE 1: RESULTS OF HEALTH LEADS SOCIAL NEEDS SCREENING





***** This queries whether patients would like to receive assistance with any of the above needs.

FIGURE 2: RESULTS OF DISTRESS SCREENING



Food Insecurity

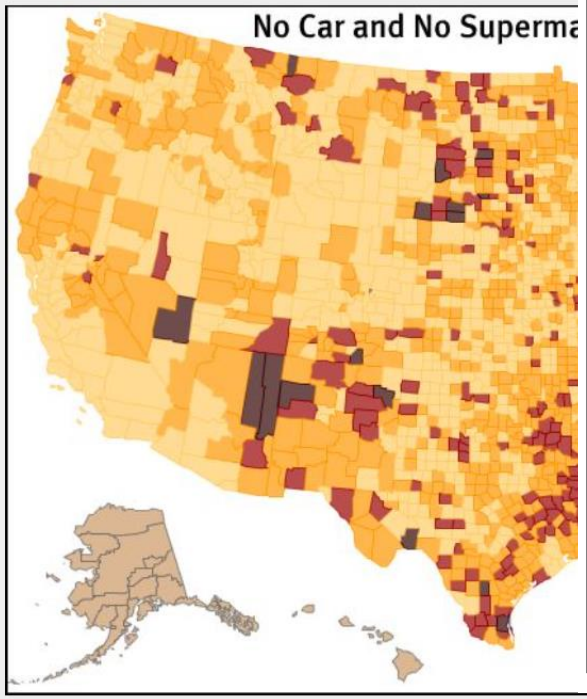
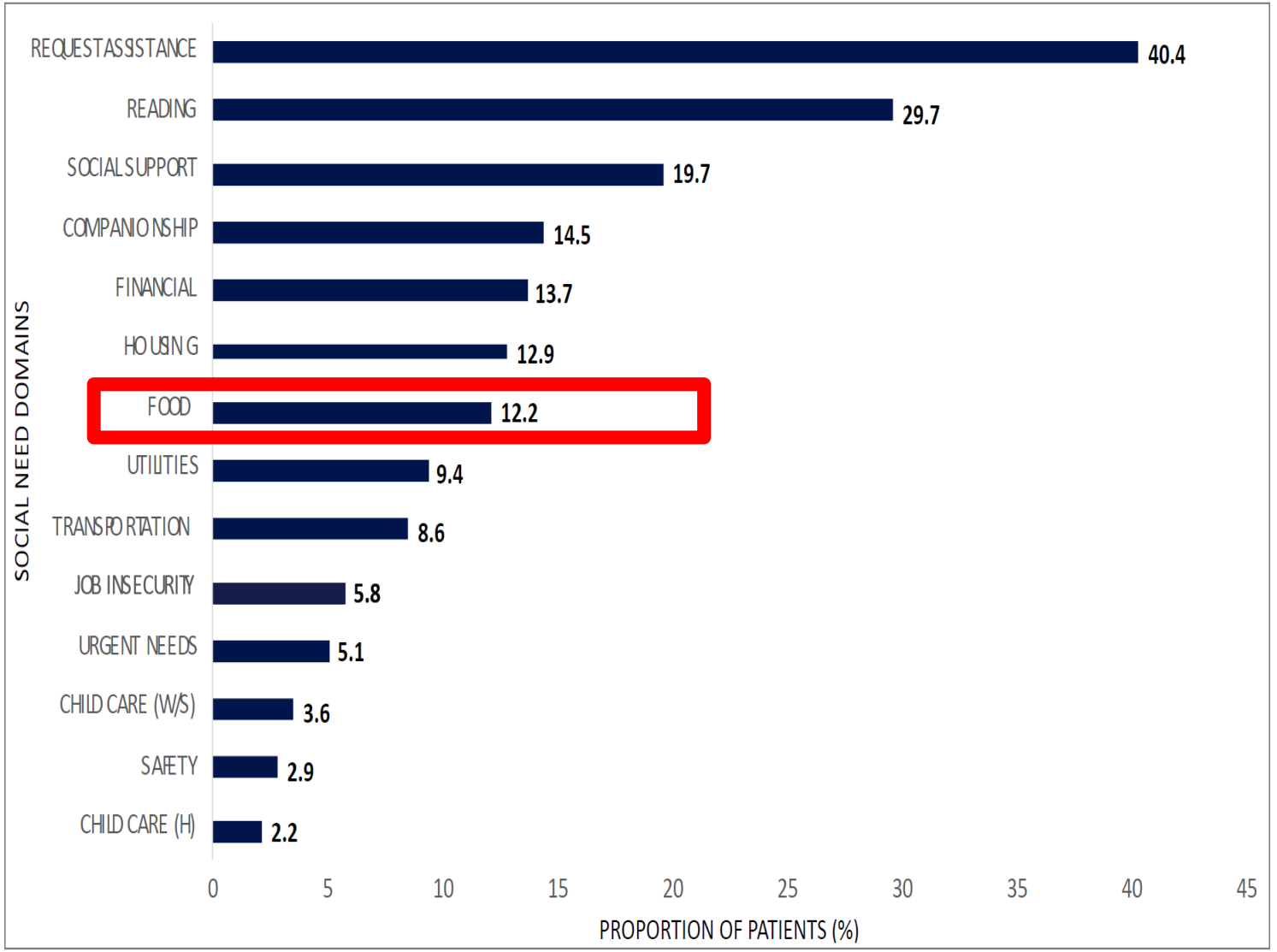


FIGURE 1: RESULTS OF HEALTH LEADS SOCIAL NEEDS SCREENING



ess to
propriate

eals

efore having

ial reasons

JAMA Netw Open. 2018 Oct; 1(6): e183146.
Published online 2018 Oct 5. doi: 10.1001/jamanetworkopen.2018.3146
PMCID: PMC6324449
PMID: 30646225

Factors Associated With Cancer Disparities Among Low-, Medium-, and High-Income US Counties

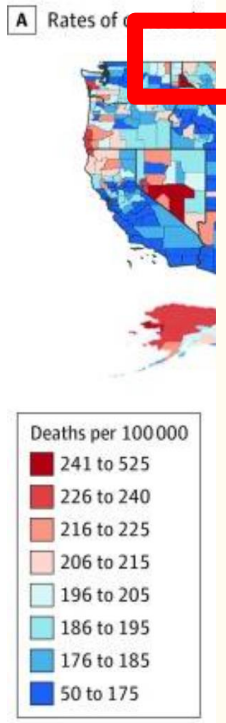
Jeremy M. O'Connor, MD, MHS,[1,2] Tannaz Sedghi, MPH,[1,3] Meera Dhodapkar,[4] Michael J. Kane, PhD,[5] and Cary P. Gross, MD[1,2,3]

- Cross-sectional study
- Assess cancer disparities between counties on the basis of socioeconomic status
- Identify clusters of counties with high cancer death rates.
- Identify factors associated with the disparities
- To assess geographic variation calculated a standardized risk score that we called the **disparity risk index.**

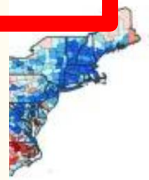
Disparity Index

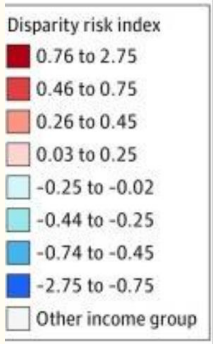
A composite measure of the factors that may mediate the association between county levels of income and cancer death rates

- 229.7 deaths per 100 000 person-years in low-income counties
- 204.9 deaths per 100 000 person-years in medium income counties
- 185.9 per 100 000 person-years in high-income counties



Health behaviors		
Obesity	−0.07 (−0.09 to −0.05)	10.8
Smoking	−0.08 (−0.10 to −0.06)	12.7
Physical inactivity	−0.08 (−0.10 to −0.06)	12.2
Clinical care		
Unaffordable care	−0.03 (−0.05 to −0.02)	5.2
Low-quality Care	−0.11 (−0.14 to −0.09)	17.9
Health policies		
Smoke-free laws	−0.01 (−0.01 to −0.003)	1.1
Medicaid-Medicare fee index	−0.01 (−0.02 to −0.01)	1.7
Health environment		
Food insecurity	−0.12 (−0.17 to −0.08)	19.1
Total indirect (mediated)	−0.52 (−0.58 to −0.46)	81.3[d]





Oconnor et alJAMA 2018

PROJECT ANGEL FOOD

Food Banks

Food Banks throughout California provide United States Department of Agriculture (USDA) commodities for distribution to eligible individuals and households within their respective service areas. In order to be eligible for USDA commodities, an individual or household must reside in the geographical area being served and meet established income guidelines. To connect with the food programs that can provide assistance, please see the list below:

Housing Insecure and Selected Adverse Health Behaviors and Outcomes

Health Risk Behaviors	Housing Insecure[a]		Prevalence Ratio (95% CI)		
	Yes	No	Unadjusted	Adjusted for SES[b]	Adjusted for SES and Demographics[c]
Current smoker	26.9	9.8	2.8 (2.3–3.3)	1.8 (1.5–2.2)	1.4 (1.1–1.7)
Past 30-day binge drinker	16.8	15.0	1.1 (0.9–1.4)	1.1 (0.9–1.4)	0.9 (0.8–1.1)
Delayed doctor visit because of costs	33.3	5.9	5.7 (4.7–6.8)	4.0 (3.2–4.9)	2.6 (2.1–3.3)
Health outcomes					
Poor/fair health status	26.3	11.3	2.3 (2.0–2.7)	1.5 (1.3–1.8)	1.9 (1.5–2.4)
≥14 days in the past 30 days					
Poor health limiting daily activity	14.3	5.0	2.9 (2.3–3.6)	2.0 (1.6–2.5)	2.0 (1.5–2.6)
Poor physical health	17.4	8.4	2.1 (1.8–2.5)	1.4 (1.2–1.7)	1.5 (1.2–1.9)
Poor mental health	22.9	5.8	4.0 (3.3–4.8)	2.9 (2.3–3.6)	2.3 (1.8–3.0)

Abbreviation: CI, confidence interval; SES, socioeconomic status.

[a] Housing insecure participants responded always, usually, or sometimes to the question "How often in the past 12 months would you say you were worried or stressed about having enough money to pay your rent/mortgage?"

[b] Socioeconomic measures include education, income, and home ownership.

[c] Demographics include sex, health insurance status (aged 18–65 years), Hispanic ethnicity, age, marital status, veteran status, presence of children in the home, and adverse childhood experiences.

Stahre M etal. 2011. Prev Chronic Dis 2015

Slide courtesy of Sarah m Temkin MD

Housing for Health

Housing for Health
About Us
Programs
Highlights
Resources
Training
Contact Us

SOCIAL NEED DOMAINS

Treating Depression in Predominantly Low-Income Young Minority Women

A Randomized Controlled Trial

Jeanne Miranda, PhD; Joyce Y. Chung, MD; Bonnie L. Green, PhD; et al

Patients enrolled from WIC and Title X

8 weeks CBT

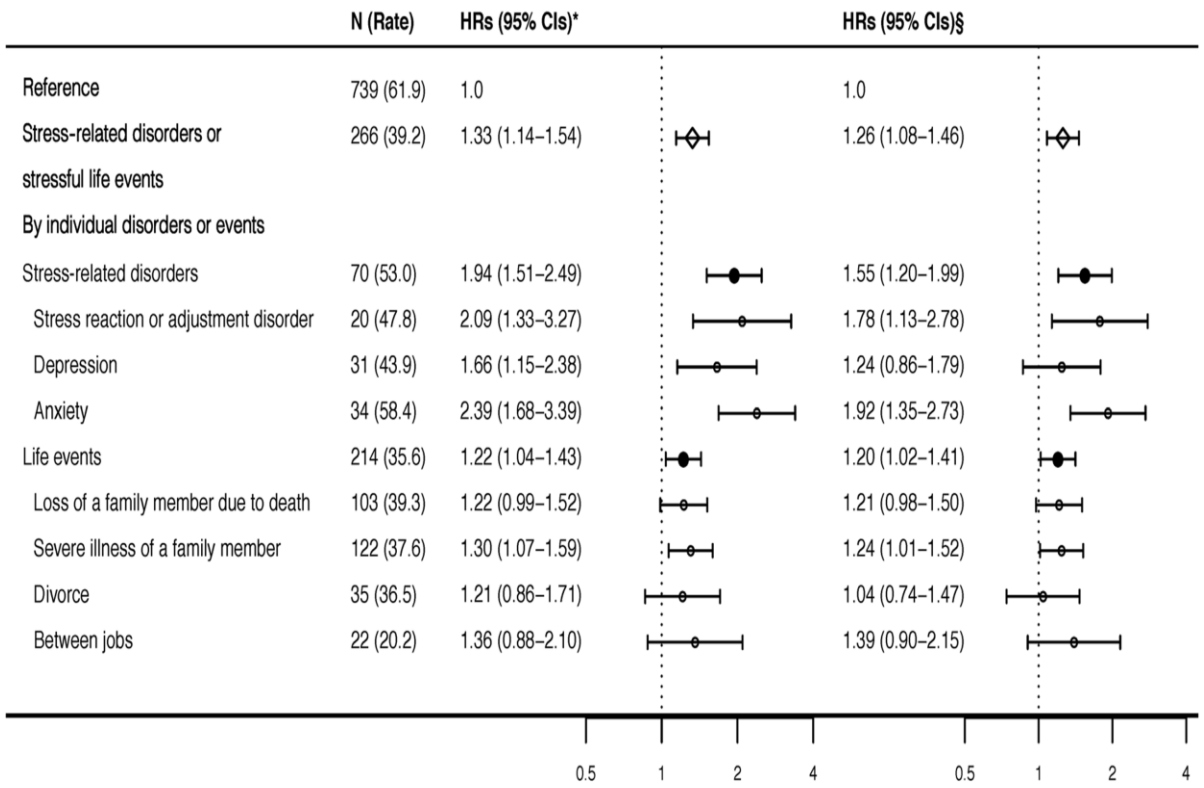
Pharmacologic intervention

Referral to community clinic

No. of children, mean (SD)	2.3 (1.4)
Education	
Less than high school	99 (37.1)
High school or GED	87 (32.6)
Some trade or college	63 (23.6)
College graduate	18 (6.7)
Ethnicity	
Black	117 (43.8)
White	16 (6.0)
Latina	134 (50.2)
Insurance	
Uninsured	173 (64.8)
Medical assistance	40 (15.0)
Private	54 (20.2)
Employment	
Working or looking for work	219 (82.0)
Not working or disabled	48 (18.0)
Poverty†	
Below federal poverty	149 (60.0)
Near poor (100%-200% poverty guidelines)	88 (34.2)
Not impoverished	20 (7.8)

- The majority of impoverished patients referred to community health clinics did not keep their appointments due to barriers including transportation and childcare.
- When assistance to overcome these barriers was provided in the other two arms of the study, patients had significantly higher compliance.
- Furthermore, there were no ethnic differences in response to treatment, dispelling any myths about needing radically different treatment approaches in underserved minority patients.

Depression and Mortality in Cancer Patients

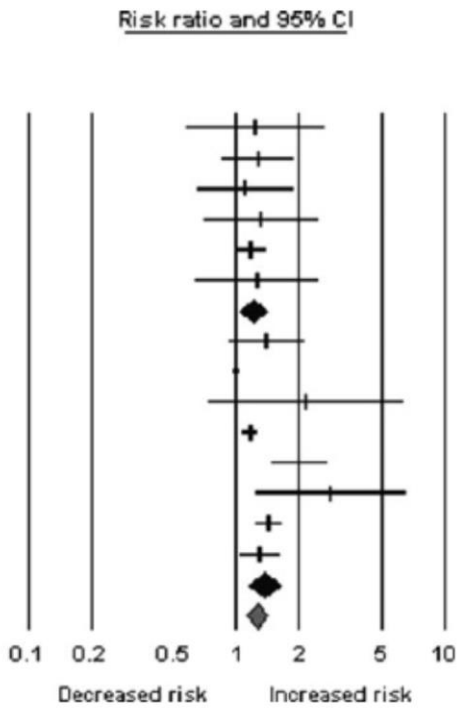


- Mortality rates 25% higher in patients experiencing depressive symptoms (RR unadjusted = 1.25; 95% CI, 1.12-1.40; $P < .001$
- Mortality rates 39% higher in patients diagnosed with major or minor depression (RR unadjusted = 1.39; 95% CI, 1.10-1.89; $P = .03$).

Satin et al Cancer 2009

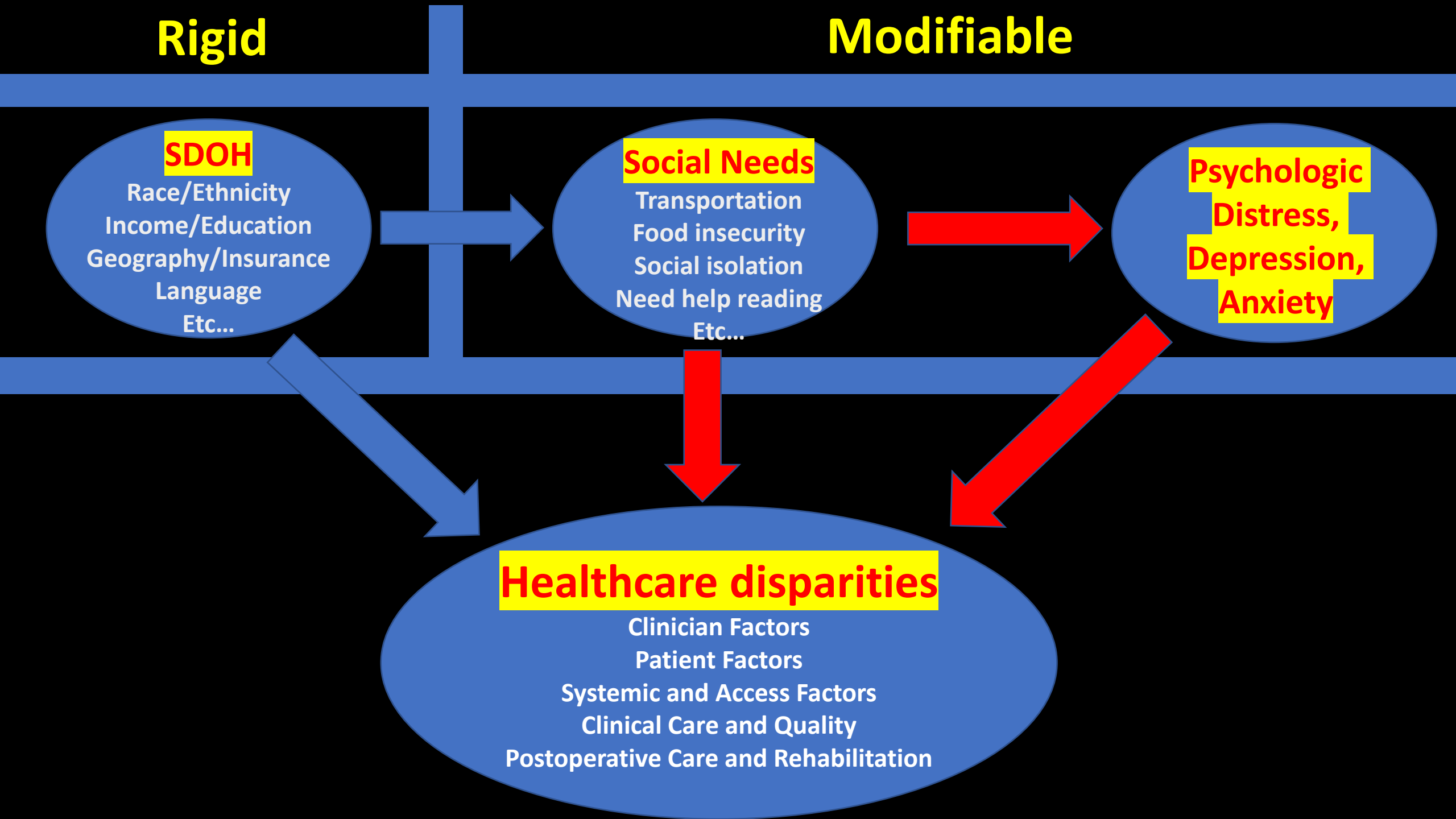
Distress as a Predictor of Cervical Cancer Specific Mortality

Group by Length of follow-up	Study name	Risk ratio	Lower limit	Upper limit	p-Value
5 years +	Beresford 2006	1.23	0.57	2.64	0.605
5 years +	Mainio 2006	1.27	0.85	1.89	0.243
5 years +	Nakaya 2006	1.09	0.63	1.88	0.747
5 years +	Watson 2005	1.30	0.69	2.44	0.413
5 years +	Onitilo 2006	1.17	0.97	1.40	0.104
5 years +	Phillips 2008	1.25	0.63	2.48	0.520
5 years +		1.19	1.02	1.38	0.024
Less than 5 years	Buccheri 1998	1.38	0.90	2.13	0.141
Less than 5 years	Broers 1998	0.99	0.96	1.02	0.516
Less than 5 years	Richardson 1990	2.15	0.73	6.35	0.166
Less than 5 years	Ringdal 1996	1.16	1.06	1.27	0.001
Less than 5 years	Gripp 2007	2.00	1.47	2.72	0.000
Less than 5 years	Pirl 2008	2.83	1.23	6.50	0.014
Less than 5 years	Nakaya 2008	1.42	1.23	1.63	0.000
Less than 5 years	Steel 2007	1.29	1.03	1.61	0.029
Less than 5 years		1.35	1.13	1.61	0.001
Overall		1.25	1.12	1.40	0.000



- Patients exposed to psychologic distress had an increased risk of cancer-specific mortality (HR 1.33; 95% CI, 1.14–1.54).
- The association was primarily driven by distress experienced within one year before or after diagnosis (HR 1.30; 95% CI, 1.11–1.52), but not thereafter (HR 1.12; 95% CI, 0.84–1.49).

Lu et al Cancer Res, 2019.


Rigid
Modifiable
SDOH
Race/Ethnicity
Income/Education
Geography/Insurance
Language
Etc…
Social Needs
Transportation
Food insecurity
Social isolation
Need help reading
Etc…
Psychologic Distress, Depression, Anxiety
Healthcare disparities
Clinician Factors
Patient Factors
Systemic and Access Factors
Clinical Care and Quality
Postoperative Care and Rehabilitation

Acknowledgments

- Khara Simpson, MD
- Christina Lipscombe, MD

Questions?

Anna L. Beavis
abeavis2@jhmi.edu

Maria Victoria Vargas
mvarga10@jhmi.edu

Abdulrahman K. Sinno
ak.sinno@med.miami.edu

References

Owens DC, Fett SM. Black Maternal and Infant Health: Historical Legacies of Slavery. Am J Public Health. 2019 Oct;109(10):1342-1345. doi: 10.2105/AJPH.2019.305243.

Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Proc Natl Acad Sci U S A. 2016 Apr 19;113(16):4296-301

Ghoshal M. Special Report: Race, Pain Management, and the System. Pract Pain Manag. 2020;20(5).

Barnes WA, Carter-Brooks CM, Wu CZ, Acosta DA, Vargas MV. Racial and ethnic disparities in access to minimally invasive gynecologic surgery for benign pathology. Curr Opin Obstet Gynecol. 2021 Aug 1;33(4):279-287.

Orlando MS, Luna Russo MA, Richards EG, King CR, Park AJ, Bradley LD, Chapman GC. Racial and ethnic disparities in surgical care for endometriosis across the United States. Am J Obstet Gynecol. 2022 Jun;226(6):824.e1-824.e11.

Shen MJ, Peterson EB, Costas-Muñiz R, Hernandez MH, Jewell ST, Matsoukas K, Bylund CL. The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature. J Racial Ethn Health Disparities. 2018 Feb;5(1):117-140.

Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient-physician racial concordance and the perceived quality and use of health care. Arch Intern Med. 1999 May 10;159(9):997-1004

Alsan Owen, Marcella; Garrick, Owen; Graziani, Grant C. Does diversity matter for health? Experimental evidence from Oakland. National Bureau of Economic Research. June 2018. Working paper 24787. DOI 10.3386/w24787

Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician-patient racial concordance and disparities in birthing mortality for newborns. Proc Natl Acad Sci U S A. 2020 Sep 1;117(35):21194-21200.

https://seer.cancer.gov/statistics-network/explorer/

Rauh-Hain JA, Melamed A, Schaps D, Bregar AJ, Spencer R, Schorge JO, Rice LW, Del Carmen MG. Racial and ethnic disparities over time in the treatment and mortality of women with gynecological malignancies. Gynecol Oncol. 2018 Apr;149(1):4-11

Beavis AL, Gravitt PE, Rositch AF. Hysterectomy-corrected cervical cancer mortality rates reveal a larger racial disparity in the United States. Cancer. 2017 May 15;123(6):1044-1050.

Clarke MA, Devesa SS, Harvey SV, Wentzensen N. Hysterectomy-Corrected Uterine Corpus Cancer Incidence Trends and Differences in Relative Survival Reveal Racial Disparities and Rising Rates of Nonendometrioid Cancers. J Clin Oncol. 2019 Aug 1;37(22):1895-1908.

Krieger N. Theories for social epidemiology in the 21st century: an ecosocial perspective. Int J Epidemiol. 2001 Aug;30(4):668-77.

Tehranifar, P., Neugut, A. I., Phelan, J. C., Link, B. G., Liao, Y., Desai, M., & Terry, M. B. (2009). Medical advances and racial/ethnic disparities in cancer survival. *Cancer Epidemiology Biomarkers and Prevention*, *18*(10), 2701–2708. https://doi.org/10.1158/1055-9965.EPI-09-0305

Grubbs A, Barber EL, Roque DR. Healthcare Disparities in Gynecologic Oncology. Adv Oncol. 2022 May;2(1):119-128.

Doll KM, Khor S, Odem-Davis K, He H, Wolff EM, Flum DR, Ramsey SD, Goff BA. Role of bleeding recognition and evaluation in Black-White disparities in endometrial cancer. Am J Obstet Gynecol. 2018 Dec;219(6):593.e1-593.e14.

Doll KM, Hempstead B, Alson J, Sage L, Lavallee D. Assessment of Prediagnostic Experiences of Black Women With Endometrial Cancer in the United States. *JAMA Netw Open.* 2020;3(5):e204954.

ACOG Committee Opinion No. 734: The Role of Transvaginal Ultrasonography in Evaluating the Endometrium of Women With Postmenopausal Bleeding. Obstet Gynecol. 2018 May;131(5):e124-e129.

Romano SS, Doll KM. The Impact of Fibroids and Histologic Subtype on the Performance of US Clinical Guidelines for the Diagnosis of Endometrial Cancer among Black Women. Ethn Dis. 2020 Sep 24;30(4):543-552.

GRAPHIC ELEMENTS – PLEASE USE AS NEEDED

CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

The California Medical Association (CMA) announced new standards for Cultural Linguistic Competency and Implicit Bias in CME. The goal of the standards is to support the role of accredited CME in advancing diversity, health equity, and inclusion in healthcare. These standards are relevant to ACCME-accredited, CMA-accredited, and jointly accredited providers located in California. AAGL is ACCME-accredited and headquartered in California.

CMA developed the standards in response to California legislation (Business and Professions (B&P) Code Section 2190.1), which directs CMA to draft a set of standards for the inclusion of cultural and linguistic competency (CLC) and implicit bias (IB) in accredited CME.

The standards are intended to support CME providers in meeting the expectations of the legislation. CME provider organizations physically located in California and accredited by CMA CME or ACCME, as well as jointly accredited providers whose target audience includes physicians, are expected to meet these expectations beginning January 1, 2022. AAGL has been proactively adopting processes that meet and often exceed the required expectations of the legislation.

CMA CME offers a variety of resources and tools to help providers meet the standards and successfully incorporate CLC & IB into their CME activities, including FAQ, definitions, a planning worksheet, and best practices. These resources are available on the CLC and IB standards page on the CMA website.

Important Definitions:

Cultural and Linguistic Competency (CLC) – The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health.

Implicit Bias (IB) – The attitudes, stereotypes and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics.

Diversity – Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.

Direct links to AB1195 (CLC), AB241 (IB), and the B&P Code 2190.1:

Bill Text – AB-1195 Continuing education: cultural and linguistic competency.
Bill Text – AB-241 Implicit bias: continuing education: requirements.
Business and Professions (B&P) Code Section 2190.1

CLC & IB Online Resources:

Diversity-Wheel-as-used-at-Johns-Hopkins-University-12.png (850×839) (researchgate.net)
Cultural Competence In Health and Human Services | NPIN (cdc.gov)
Cultural Competency – The Office of Minority Health (hhs.gov)
Implicit Bias, Microaggressions, and Stereotypes Resources | NEA
Unconscious Bias Resources | diversity.ucsf.edu
Act, Communicating, Implicit Bias (racialequitytools.org)
https://kirwaninstitute.osu.edu/implicit-bias-training
https://www.uptodate.com/contents/racial-and-ethnic-disparities-in-obstetric-and-gynecologic-care-and-role-of-implicitbiases
https://www.contemporaryobgyn.net/view/overcoming-racism-and-unconscious-bias-in-ob-gyn
https://pubmed.ncbi.nlm.nih.gov/34016820/