ASCO Dec 4, 2020

We are pleased to respond to your inquiries on this issue and to share our views on the impact of the use of race within clinical algorithms. To do this, we reached out to some of our members who are experts in cancer and health equity. This document is a compilation of their feedback. We hope that this background is helpful and look forward to working with you on policies that can reduce disparities in cancer.

1. **What strategies has ASCO undertaken to reevaluate the scientific basis for the use of race in the Rectal Cancer Survival Calculator (RCSC), the National Cancer Institute Breast Cancer Risk Assessment Tool (NCIBC), and the Breast Cancer Surveillance Consortium Risk Calculator (BCSC)?**
    a. **How will ASCO work to support, encourage, and coordinate with other specialty organizations that are also conducting a reevaluation of the misuse of race in clinical algorithms?**

<u>Use of Race/Ethnicity to Calibrate Tools Which Historically Ignored Underserved Populations</u>

Although ASCO's Clinical Practice Guidelines and Quality Measures do not use race as a factor to determine treatment pathways or practice standards, there are tools in the cancer care community that do take the patient's race into consideration. ASCO has not weighed in on these tools, but the following background may be helpful when thinking about them.

The National Cancer Institute's (NCI) Surveillance, Epidemiology and End Results Program (SEER) estimates that 1 in 8 women (12%) in the United States will develop breast cancer over their lifetime. Historically, risk assessment tools have been developed to help identify women who are at higher-than-average risk for developing breast cancer. Those who are identified as having higher risks, may benefit from targeted risk reduction strategies, including interventions such as endocrine prevention therapy or supplemental breast screening.

The National Cancer Institute Breast Cancer Risk Assessment Tool (NCIBC) and the Breast Cancer Surveillance Consortium Risk Calculator (BCSC) were tools initially developed and validated in a predominately Caucasian population. The exclusion of racial and ethnic minorities in the development and validation of these tools resulted in incomplete data, negatively impacting their usefulness for patients in diverse populations. Further refinements have been made to the NCIBC to allow for application to additional populations including African American, Asian American, and Hispanic American women. There is large body of literature acknowledging the strengths and limitations of these clinical tools for predicting a woman's risk of developing breast cancer.

<u>Research Efforts to Optimize Risk Assessment Tools and the Importance of Minority Inclusion</u>

ASCO is encouraged that research efforts to improve the calibration and accuracy of cancer risk assessment tools are ongoing. Experts continue to expand the number of risk factors that are incorporated into risk tools and recognize the importance of ongoing validation in various racial and ethnic populations to improve generalizability. As these efforts continue, it is imperative that racial and ethnic minorities are included in this work, to ensure that the tools are accurate in assessing risk for all populations.

ASCO is committed to ensuring all individuals have access to high quality cancer care, including timely and appropriate screening, based on the patient's needs. To help ensure the use of race in these reflects current science and best achieves societal goals of health equity, ASCO has begun planning to convene a roundtable of experts on this issue. It is our hope that through these roundtable discussions, ASCO can aid in the process of reevaluating the impacts and effectiveness of the use of race in clinical algorithms and risk assessment tools.

2. **What has ASCO done and what does it plan to do to inform clinicians of the connection between the use of race in the RCSC, NCIBC, and the BCSC and racial health inequities in cancer outcomes?**
    b. **While ending the misuse of race in these tools could take some time to implement, what guidance can ASCO issue quickly to redirect clinical practices and communicate the problem of misuse of race in these tools to patients?**

ASCO Guidelines for Assessment of Eligibility for Endocrine Prevention Therapy and Genetic Risk Assessment

The United States Preventive Services Task Force (USPSTF) recommends that clinicians use combinations of risk factors (including risk factors not included in risk assessment tools) to identify women at increased risk for developing breast cancer who may benefit from endocrine prevention therapy to lower their risk. The USPSTF acknowledges the limited discriminatory accuracy of the NCIBC and BCSC tools and cautions that there is no single cutoff for defining increased risk for all women. The ASCO 2019 Clinical Practice Guideline outlines several criteria in addition to risk assessment tools that clinicians should use for identifying women at increased risk, who may benefit from endocrine prevention therapy. Some of these criteria include prior diagnosis of atypical hyperplasia or lobular cancer in situ, relative risk of at least 2 times the average for their age group if age is 45 to 69 years and at least 4 times the average for their age group if age is 40 to 44 years. Similarly, several criteria are used to identify women at increased risk who would benefit from supplemental breast cancer screening with breast magnetic resonance imaging (MRI). The 2007 American Cancer Society recommendation for the use of MRI screening includes selected groups of women with known hereditary genetic syndromes in addition to those with a 20% to 25% or greater lifetime risk of breast cancer based on specialized breast cancer risk-estimation models that predict both breast cancer risk and genetic carrier status.

ASCO's Educational Efforts to Increase Clinician Awareness of Cancer Risk Assessments

Approximately 5% to 10% of cancers are attributable to a hereditary cancer predisposition syndrome. ASCO offers educational opportunities, guidance on assessment tool use, and resources that can assist physicians in effectively integrating hereditary cancer risk into practice.

For more information on these resources please visit https://www.asco.org/practice-policy/cancer-care-initiatives/genetics-toolkit

3. **What interventions could ASCO develop to ensure improved cancer screening and care for patients who have not received it because of misuse of race in these tools?**

c. **What role could the federal government play in support of this kind of initiative, if any?**
d. **What specific racial health equity metrics and outcomes will ASCO track and work to improve? Please provide details, including the timeframe.**

Risk assessment tools flag when a patient is more at-risk for developing cancer than the average person. The inclusion of race and ethnicity in these algorithms may result in a recommendation to screen a patient earlier or more often but does not reduce the standard recommendation for screening. For example, breast cancer screening for the vast majority of patients is recommended on an age-basis. If a risk assessment tool determines race makes a patient more at risk for breast cancer, then a provider may recommend breast cancer screening earlier than the age-based standard. Alternatively, if a tool determines race reduces a patient's risk for breast cancer, the provider will adhere to the standard age-based recommendation for screening.

ASCO efforts to promote cancer screening and equitable cancer care e.g. Roadmap to Recovery and Policy Statement on Cancer Disparities and Health Equity

Health equity and cancer disparities have long been a focus in ASCO's programs and policy work. The recently published Cancer Disparities and Health Equity Policy Statement summarized past efforts and made numerous recommendations to the broader cancer care community. These recommendations include the promotion of policies and systems to address persistent barriers to equitable care, such as equitable payment reforms, alternative payment models, and financial assistance programs. The policy statement also highlighted persistent shortcomings in the clinical cancer research enterprise, as well as structural barriers to equitable care, and proposed solutions to address these obstacles to cancer health equity.

In response to the COVID-19 pandemic, ASCO will soon publish a report outlining lessons learned from the public health emergency that can be used to drive improvements in clinical research and cancer care. The report makes specific mention of our commitment to centering equity in future efforts, including efforts to enhance clinical trial participation, including among minority and low-income patients with cancer who have been disproportionately affected by COVID-19.

4. **Black, Indigenous, and Latinx scholars have a leading and vital perspective on these issues and the proposed solutions, despite being underrepresented in medicine. How is ASCO ensuring racial diversity in the discussion and strategy development relating to health equity?**

Developing a physician workforce that reflects the diversity of patients with cancer will bring increased intercultural responsiveness, foster, and comfort in patients, and improve attitudes, awareness, and biases toward minorities in healthcare. A diverse workforce will also help expand healthcare access, enhance research and discovery in minority populations, and can lead to better health outcomes for patients. A diverse oncology workforce is especially important in the discussion and strategy development relating to health equity.

In the U.S., less than nine percent of active physicians identify as Black, Hispanic, American Indian, or Alaska Native. Of the physician workforce practicing oncology, only 2.3 percent of those physicians identify as Black and 3 percent identify as Hispanic or Latino. To address this disparity ASCO launched its

Diversity Mentoring Program in 2013, to connect medical students and trainees from historically underrepresented minority groups with oncologists who can provide career and educational guidance. In its most recent year, this program provided one-on-one mentoring opportunities, professional guidance, and resources for more than 22 trainees.

In 2017, the Society continued its commitment to health equity by publishing its Strategic Plan for Increasing Racial and Ethnic Diversity in the Oncology Workforce, a plan approved by our board of directors to enhance "existing programs and create new opportunities that will move us closer to the vision of achieving an oncology workforce that reflects the demographics of the U.S. population it serves." To support diversity in clinical research, the Society's Diversity in Oncology Initiative has provided more than $1 million in grant and funding support for clinical research led by historically underrepresented minority trainees to attend and present their research at ASCO's Annual Meeting. ASCO continues to stand by its commitment to diversify the oncology workforce to ensure it is representative of the patients it serves.

While the Association and the Society have worked to improve health equity in cancer care, we acknowledge that health inequities still impact minority patients with cancer. Both the Society and the Association stand ready to assist in your efforts to advance solutions to this pressing concern. We are optimistic that our roundtable discussions on this topic will be beneficial in determining next steps regarding the use of race in clinical algorithms. For questions about health equity in the cancer space, please contact Tyler Hanson at Tyler.Hanson@asco.org.