Advanced Practitioner
Society for Hematology
and Oncology

APSHO AP Academy

Addressing Health Disparities in Substance Use Disorder in the Oncology Setting

Wendy Vogel, MSN, FNP, AOCNP, FAPO
BroadcastMed

Cyndi Davis, RN, MSN, FNP
Cayuga Cancer Center

Disclosures

- Cyndi Davis has no relevant financial relationships to disclose
- Wendy Vogel has no relevant financial relationships to disclose

Learning Objectives

- Define substance use disorder (SUD) and describe health disparities related to this
- List factors contributing to health disparities in SUD
- Discuss the role of the advanced practitioner in addressing health disparities in the patient with SUD

Outline

- Definitions of SUD and health disparity
- Factors contributing to health disparities in SUD within the oncology setting
- Substance use and SUDs and treatment utilization in minority populations
- SUD treatment barriers
- Role of the AP in mitigating health disparities
- Summary

CDC Definition: Health Disparity

- Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

CDC website. Health Disparities.

SAMHSA Definition: SUD

- Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

SAMHSA website. Mental Health and Substance Use Disorders.

Substance Use and Cancer Risk

- **Alcohol use** may increase risk of certain cancers such as pancreatic and gastric/esophageal
  - Alcohol use accounts for 6% of all cancer and 4% of cancer deaths in the United States
- **Tobacco use** causes about 20% of all cancer and about 30% of cancer deaths in the United States
- **Illicit drugs**
  - May be mixed with cancer-causing additives, called cutting agents (eg, phenacetin)
    - Case reports link to various renal pelvic and urothelial tumors
  - Anabolic steroids increase the risk of prostate cancer, cervical, and endometrial cancer

American Cancer Society website. Cancer Facts & Figures 2020; “Phenacetin.” Pharmaceuticals. IARC Monographs on the Evaluation of Carcinogenic Risks to Humans, No. 100A.

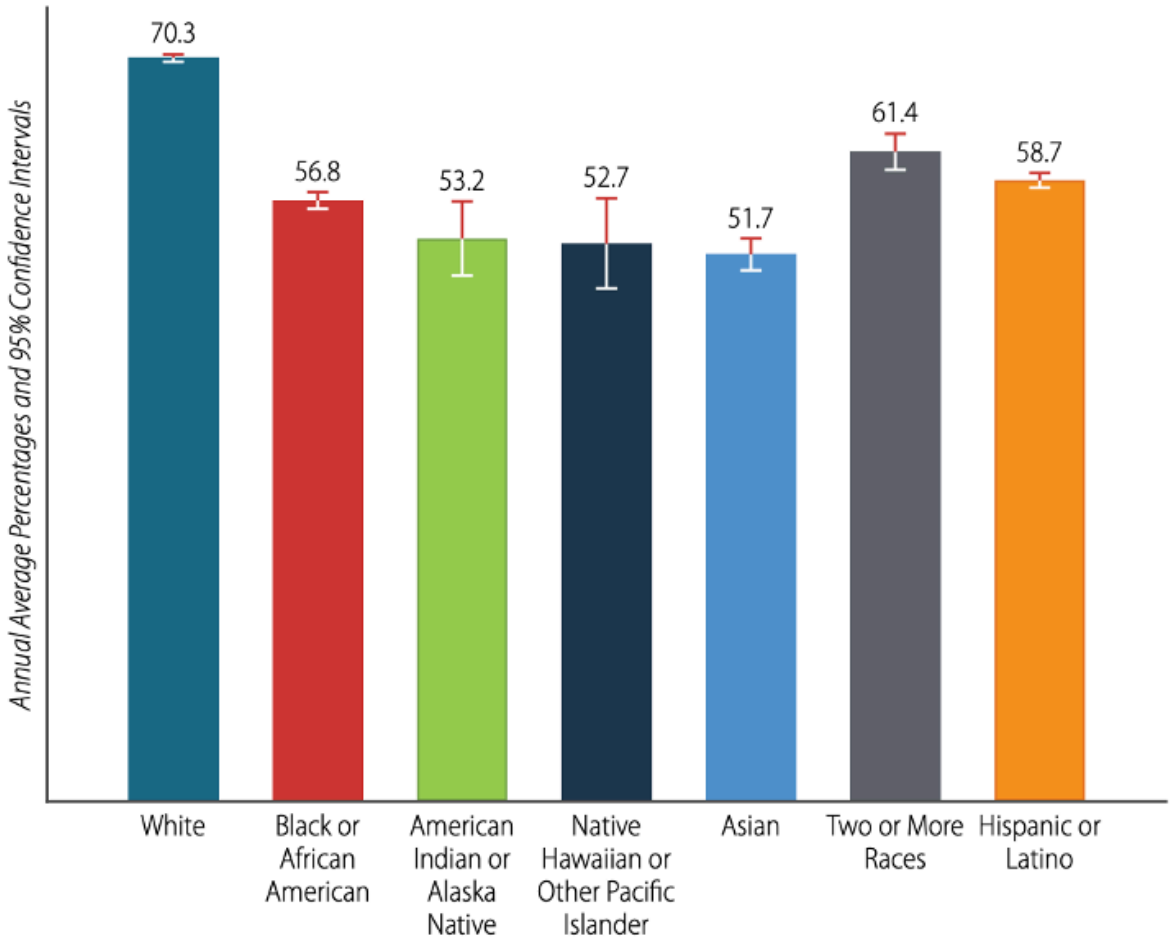
Alcohol Use and Cancer Risk

- Higher use associated with higher cancer risk (esophageal, oral cavity, laryngeal, pharyngeal, liver, colorectal, female breast, pancreatic and lung cancers)
- Higher use associated with cancer mortality
- Highest among those with moderate to heavy levels of drinking
- Reduce risk by lowering alcohol use/completing cessation
- Lowest risks between 1 to <5 drinks per week
- May also be associated with use of other substances, such as smoking

Bagnardi V, et al. *Br J Cancer.* 2015;112:580-593; Freedman ND, et al. *JAMA Netw Open.* 2022;5:e2228552; Kunzmann AT, et al. *PLoS Med.* 2018;15:e1002585.

Alcohol Use by Race/Ethnicity

FIGURE 3.4 **Alcohol Use in the Past Year among People Aged 12 or Older, by Race/Ethnicity: 2015–2019, Annual Averages**



SAMHSA website. Racial/Ethnic Differences in Substance Use, Substance Use Disorders, and Substance Use Treatment Utilization Among People Aged 12 or Older (2015-2019).

Alcohol Use Disorder by Race/Ethnicity

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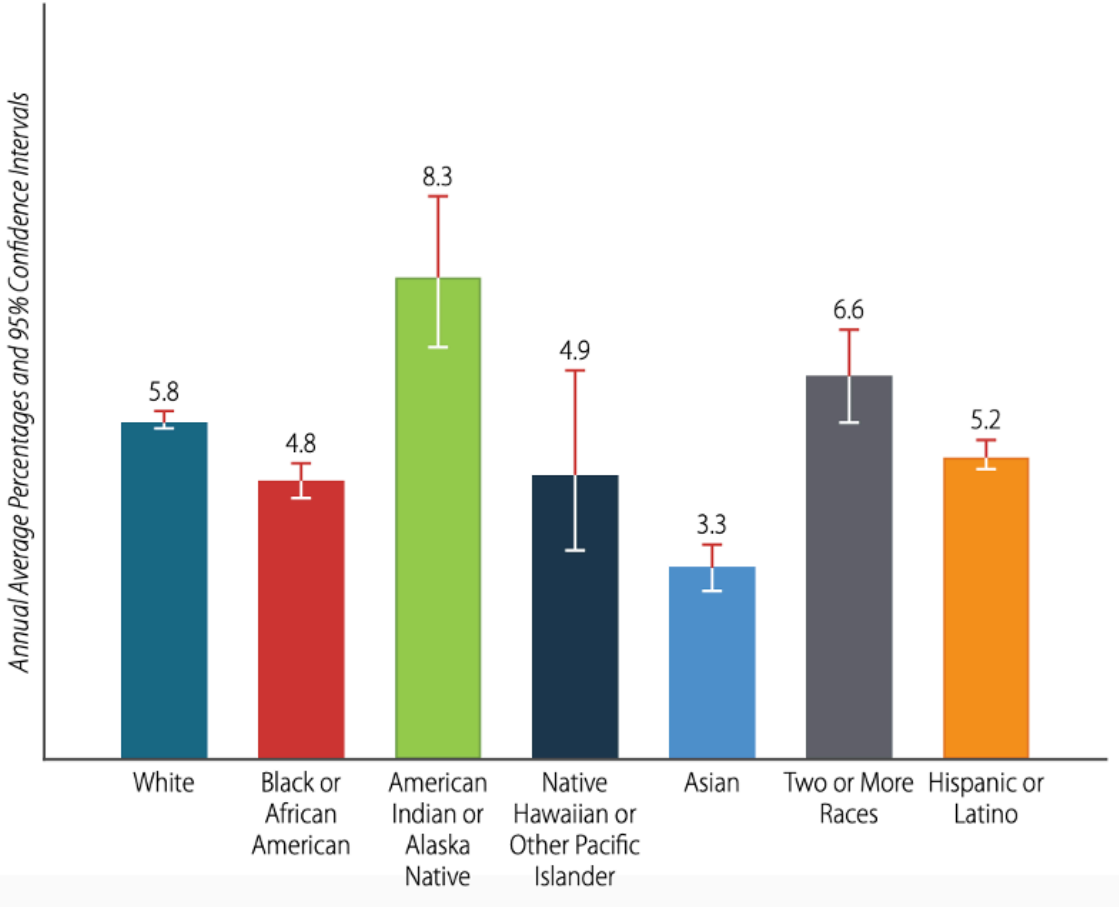

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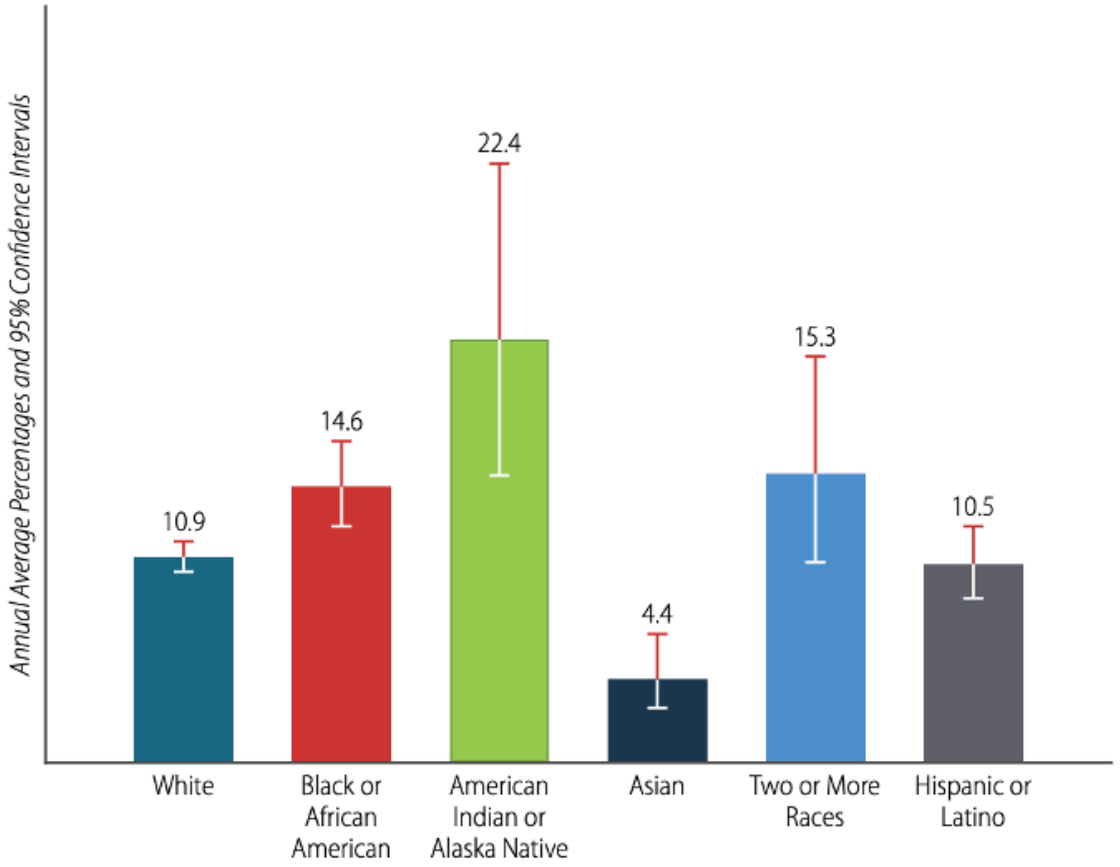
Alcohol Use Treatment Utilization

FIGURE 6.1 **Received Alcohol Use Treatment at Any Location in the Past Year among People Aged 12 or Older Who Needed Alcohol Use Treatment in the Past Year, by Race/Ethnicity: 2015–2019, Annual Averages**



Note: Estimate of Native Hawaiian or Other Pacific Islander not reported due to low precision.

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Illicit Drug Use by Race/Ethnicity

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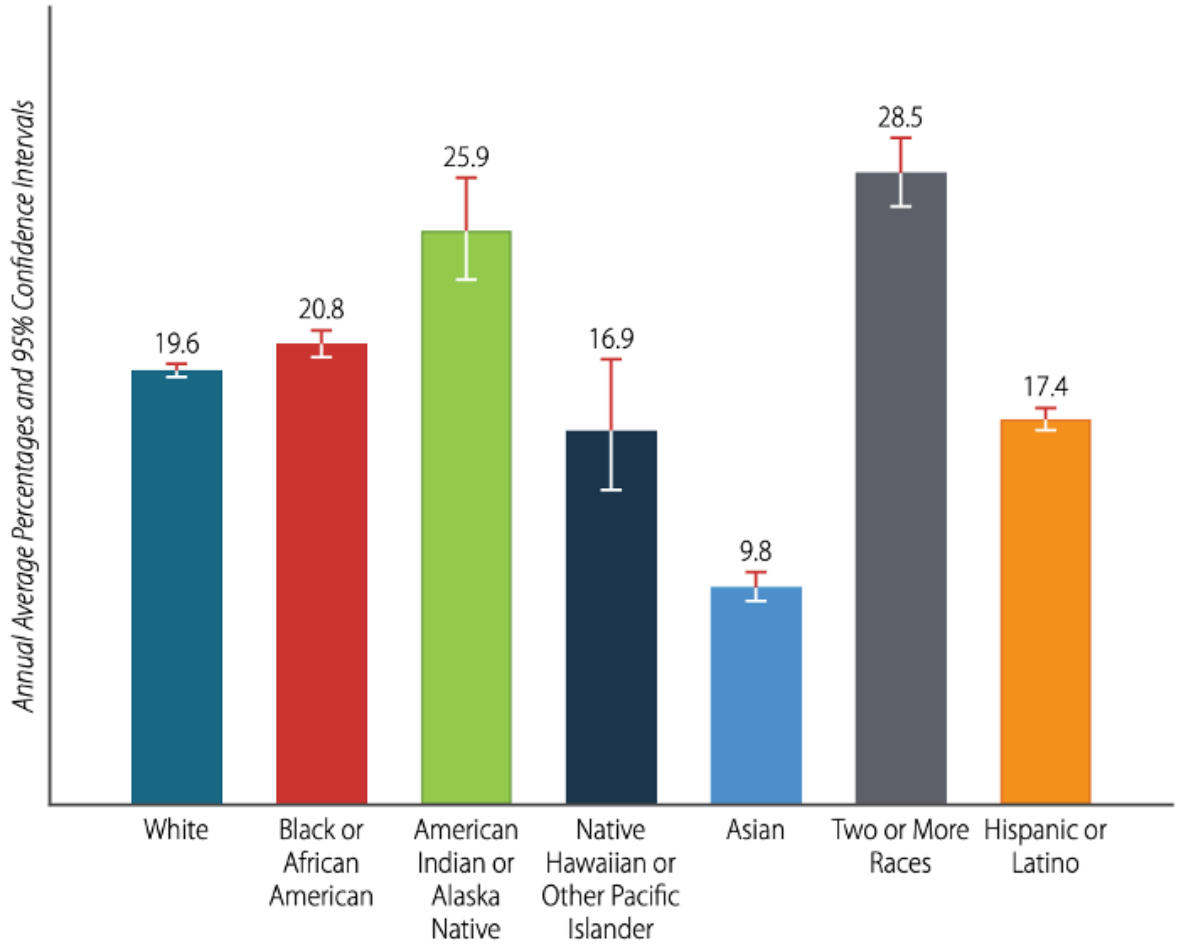

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Illicit Drug Use Disorder by Race/Ethnicity

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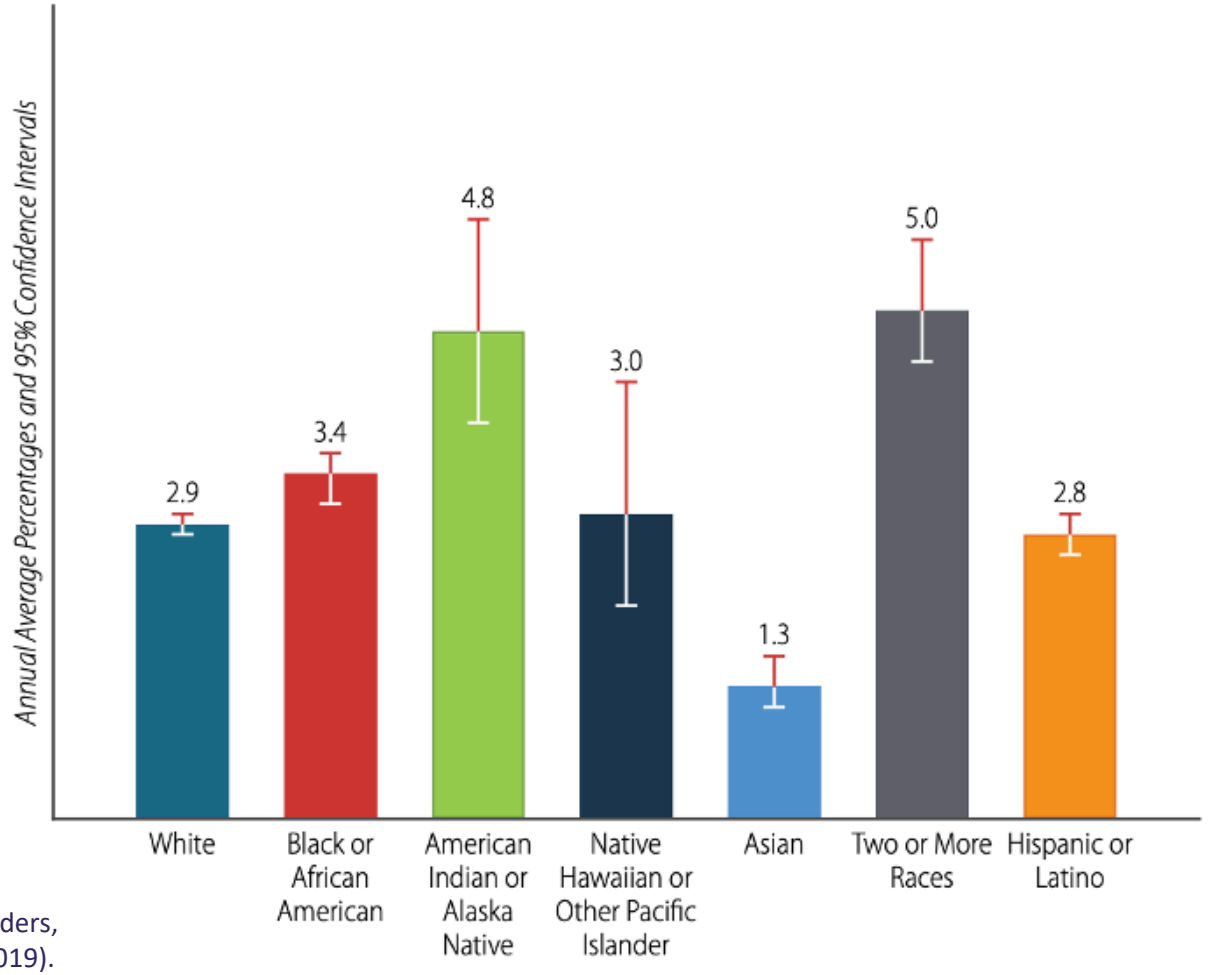

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Illicit Drug Use Treatment by Race/Ethnicity

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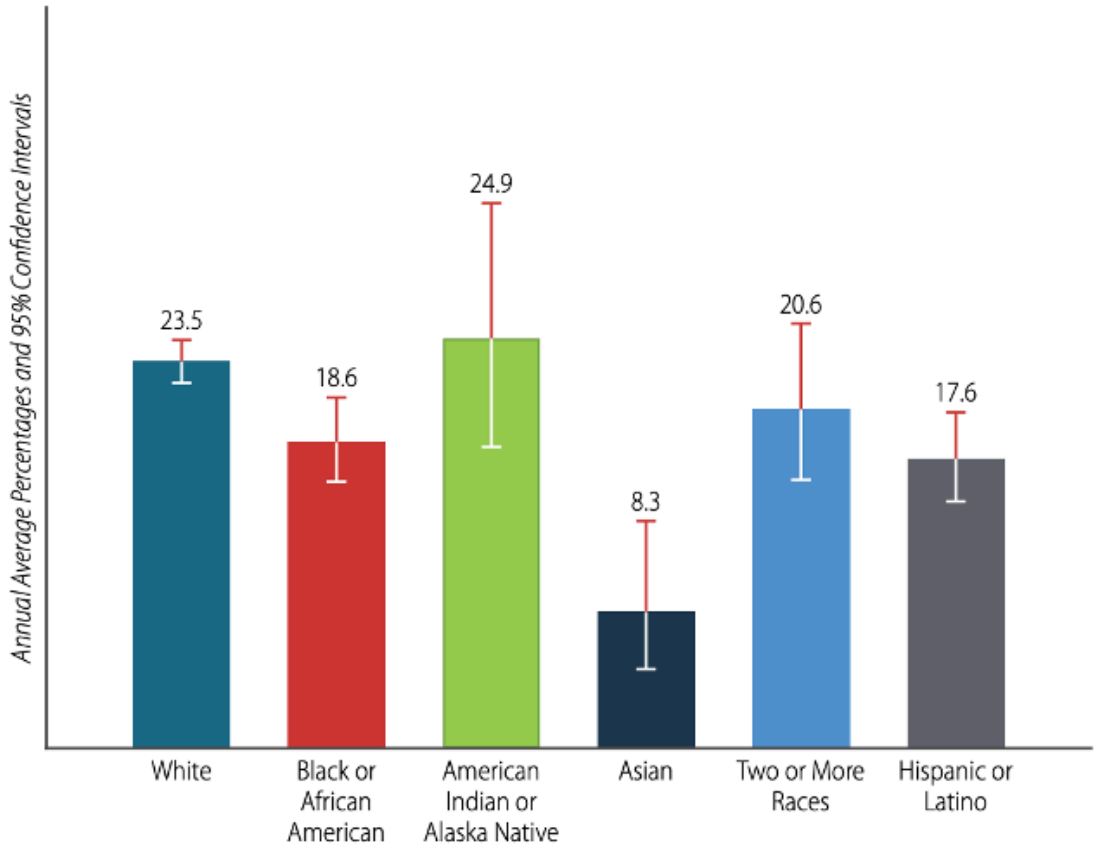

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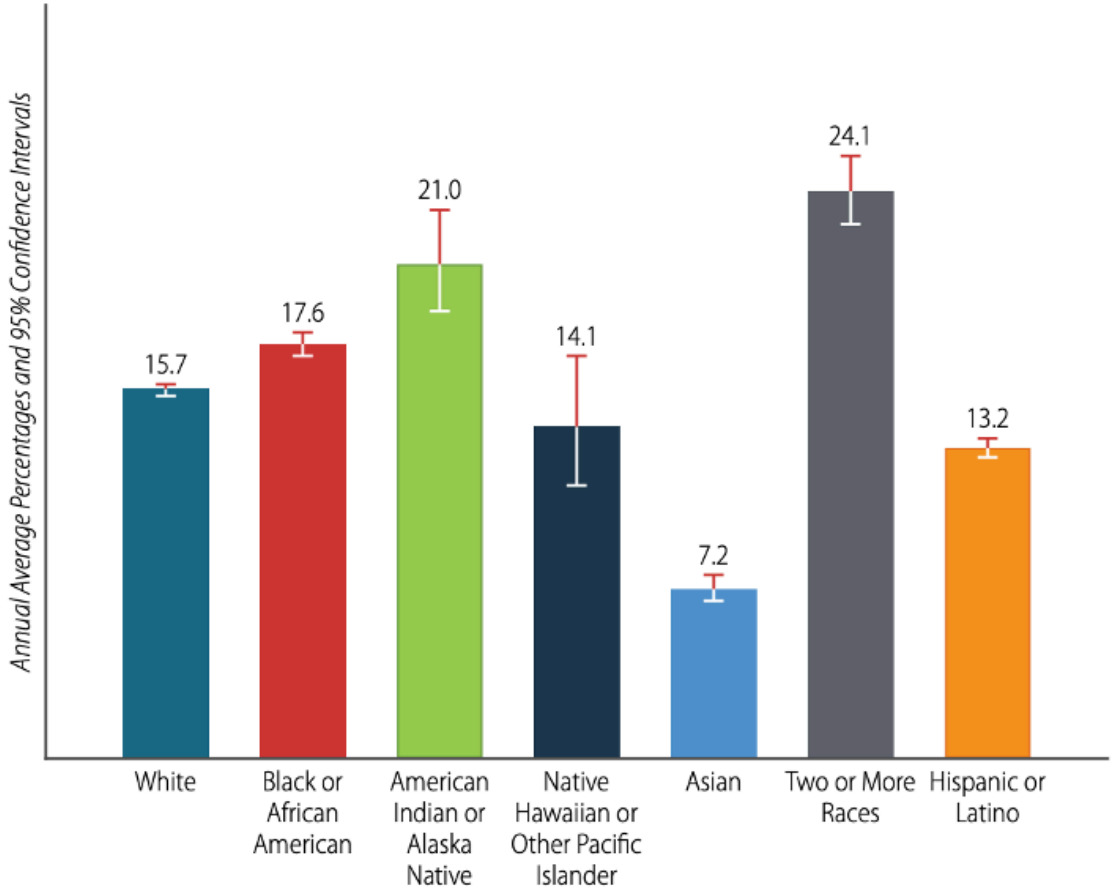
SAMHSA website. Racial/Ethnic Differences in Substance Use, Substance Use Disorders, and Substance Use Treatment Utilization Among People Aged 12 or Older (2015-2019).

Marijuana Use by Race/Ethnicity

FIGURE 3.7 **Marijuana Use in the Past Year among People Aged 12 or Older, by Race/Ethnicity: 2015–2019, Annual Averages**



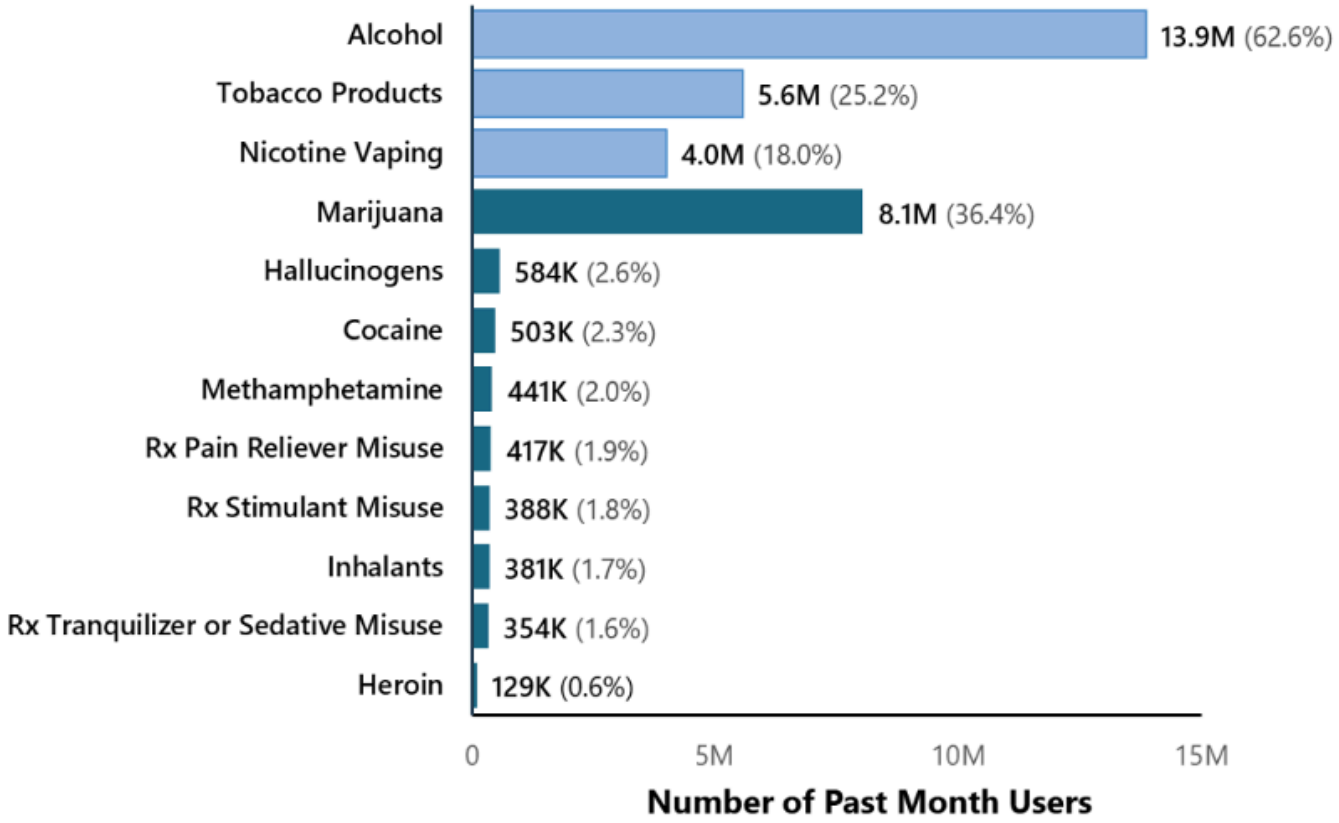
SAMHSA website. Racial/Ethnic Differences in Substance Use, Substance Use Disorders, and Substance Use Treatment Utilization Among People Aged 12 or Older (2015-2019).

Substance Use and Misuse in LGBTQ+ Community

- Only recently reported in federally funded surveys
- Overall, it appears that sexual minorities have higher rates of substance misuse and SUD than heterosexual people
- 41.3% reported use of marijuana, compared to 18.7% of overall population
- 6.7% misused opioids (prescription or heroin), compared to 3.6% of overall population
- 21.8% had alcohol use disorder, compared to 11% of overall population
- Higher rates of using vape or e-cigarettes
- Higher rates of tobacco use (in addition to vape/e-cigs)

SAMHSA website. 2022 National Survey on Drug Use and Health: Among the Lesbian, Gay or Bisexual (LGB) Population Aged 18 or Older.

Substance Use in LGB Adults



Note: The estimated numbers of current users of different substances are not mutually exclusive because people could have used more than one type of substance in the past month.

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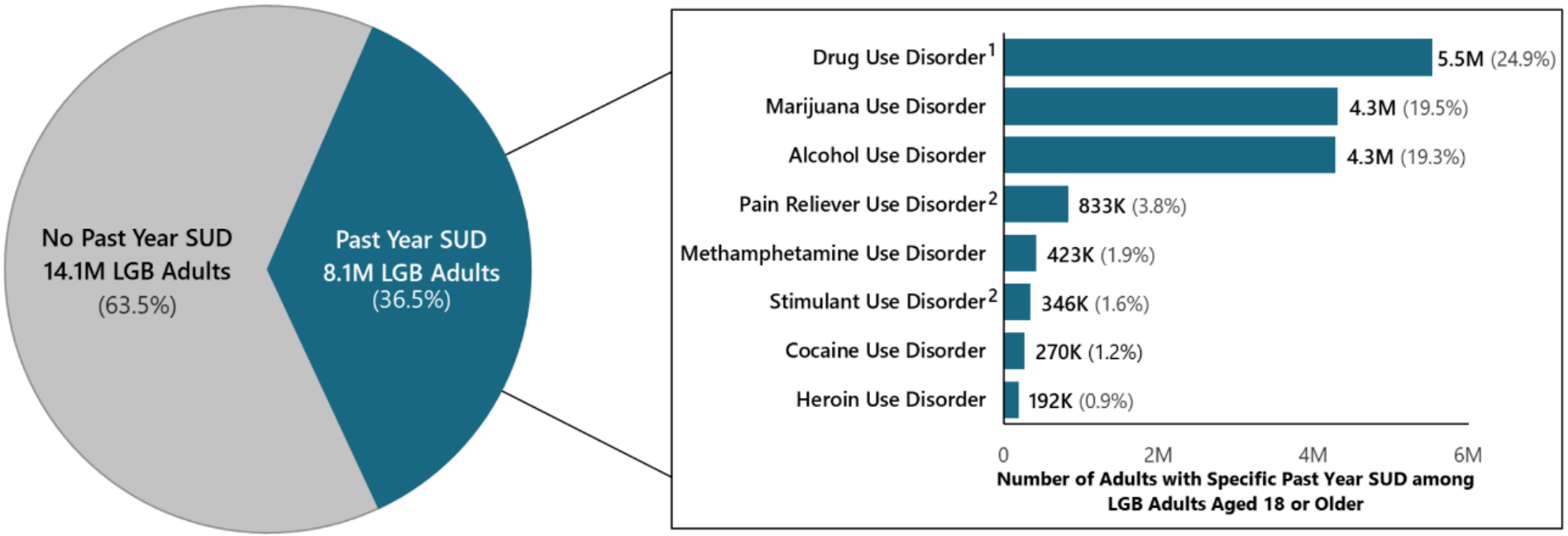
SUD in LGB Adults

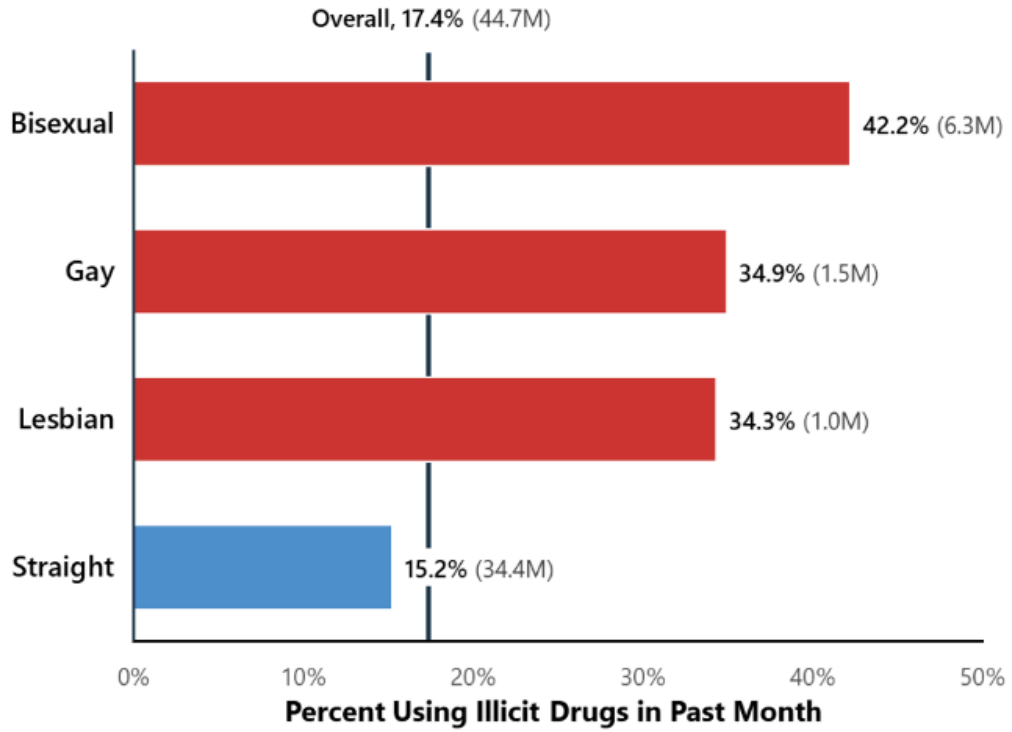


Note: The estimated numbers of current users of different substances are not mutually exclusive because people could have used more than one type of substance in the past month.

1. Includes data from all past year users of marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription psychotherapeutic drugs (ie, pain relievers, tranquilizers, stimulants, or sedatives); 2. Includes data from all past year users of the specific prescription drug.

SAMHSA website. 2022 National Survey on Drug Use and Health: Among the Lesbian, Gay or Bisexual (LGB) Population Aged 18 or Older.

Illicit Drug Use by Sexual Identity



- LGB adults were more likely to use illicit drugs than Straight adults

SAMHSA website. 2022 National Survey on Drug Use and Health: Among the Lesbian, Gay or Bisexual (LGB) Population Aged 18 or Older.

Tobacco Use and Cancer

- Remains highest modifiable risk factor for cancer
- Tobacco cessation essential after diagnosis as well
  - Tobacco use can:
    - Lower survival
    - Increase risk for recurrence
    - Decrease efficacy of treatments
    - Increase treatment-related complications
    - Increase cancer-related symptoms and reduce quality of life
- Study by Talluri et al noted that at time of cancer diagnosis, smoking rates may be as high as 24%
- 14%-58% of patients continue to smoke after treatment

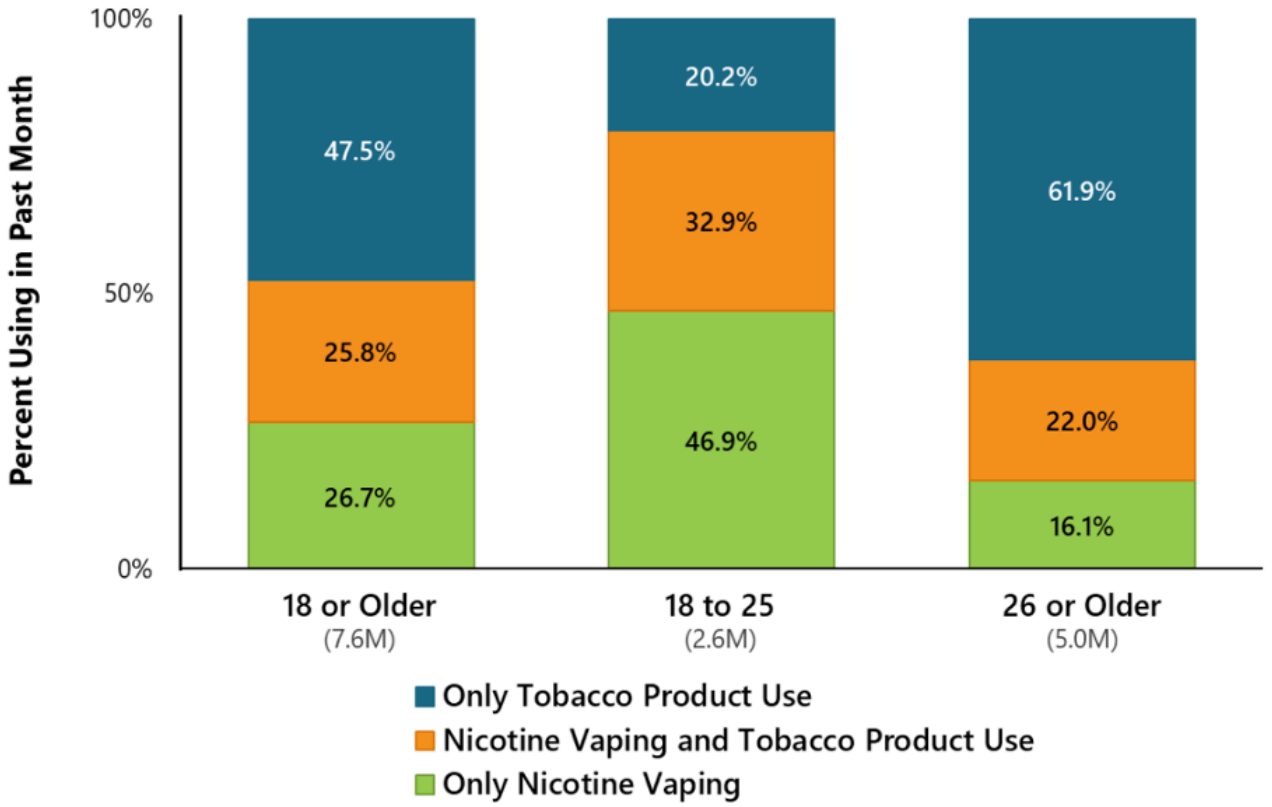
Talluri R, et al. *JAMA Netw Open.* 2020;3:e2012164.

Smoking Rates Among Various Race/Ethnic Groups

- Non-Hispanic American Indian/Alaska Native – 27.1%
- Non-Hispanic Adults from other racial backgrounds – 19.5%
- Non-Hispanic White – 13.3%
- Non-Hispanic Black – 14.4%
- Hispanic – 8%
- Non-Hispanic Asian – 8%

Cornelius ME, et al. *MMWR Morb Mortal Wkly Rep.* 2022;71:397-405.

Tobacco Product Use: LGB Adults



- Among current nicotine product users, the use of specific nicotine products varied by age group
- An estimated 46.9% of LGB young adults aged 18 to 25 who used nicotine products in the past month only vaped nicotine products compared with 16.1% of LGB adults aged 26 or older

Substance Abuse and Mental Health Services Administration. 2022

Tobacco Use in People Experiencing Homelessness

- In 2022, there was an estimated 582,462 people experiencing homelessness in the United States
- Tobacco use estimated to be between 57% and 82% (compared to 11% of the general population)
- Barriers to quitting:
  - Higher relapse rates than those not facing homelessness
  - Co-occurring psychiatric disorders and other SUD
  - Social norms of smoking in homeless service centers
  - Inability to access treatment services/medications

Baggett TP, et al. *N Engl J Med.* 2013;369:201-204; Cornelius ME, et al. *MMWR Morb Mortal Wkly Rep.* 2023;72:475-483; Pearson JL, et al. *Nicotine Tob Res*. 2021;23:885-887; UCSF Smoking Cessation Leadership Center website. People Experiencing Homelessness.

Tobacco Use in Those Who Have Experienced Incarceration

- 50%-80% of individuals who have been incarcerated are smokers
  - Highest in Black/African American men and women compared to other groups
- Higher chronic disease rates including cancer
- Prolonged exposure to chronic stressful environment increases likelihood of relapse
- Barriers to quitting:
  - Tobacco used as “currency" while incarcerated
  - Tobacco used as coping mechanism while incarcerated
  - Re-entry into society – vulnerable time

UCSF Smoking Cessation Leadership Center website. Justice Involved.

Racism Not Race?

- "Explicitly or implicitly framing race/ethnicity as a causal determinant of tobacco-related health disparities is problematic and may impede progress toward health equity."
- May lead to erroneous assumptions:
  - Biological cause and therefore no modifiable
  - Cultural cause and therefore the "fault" of the group themselves

Pearson JL, et al. *Nicotine Tob Res*. 2021;23:885-887.

SUD Treatment

SUD Treatment Utilization by Race/Ethnicity

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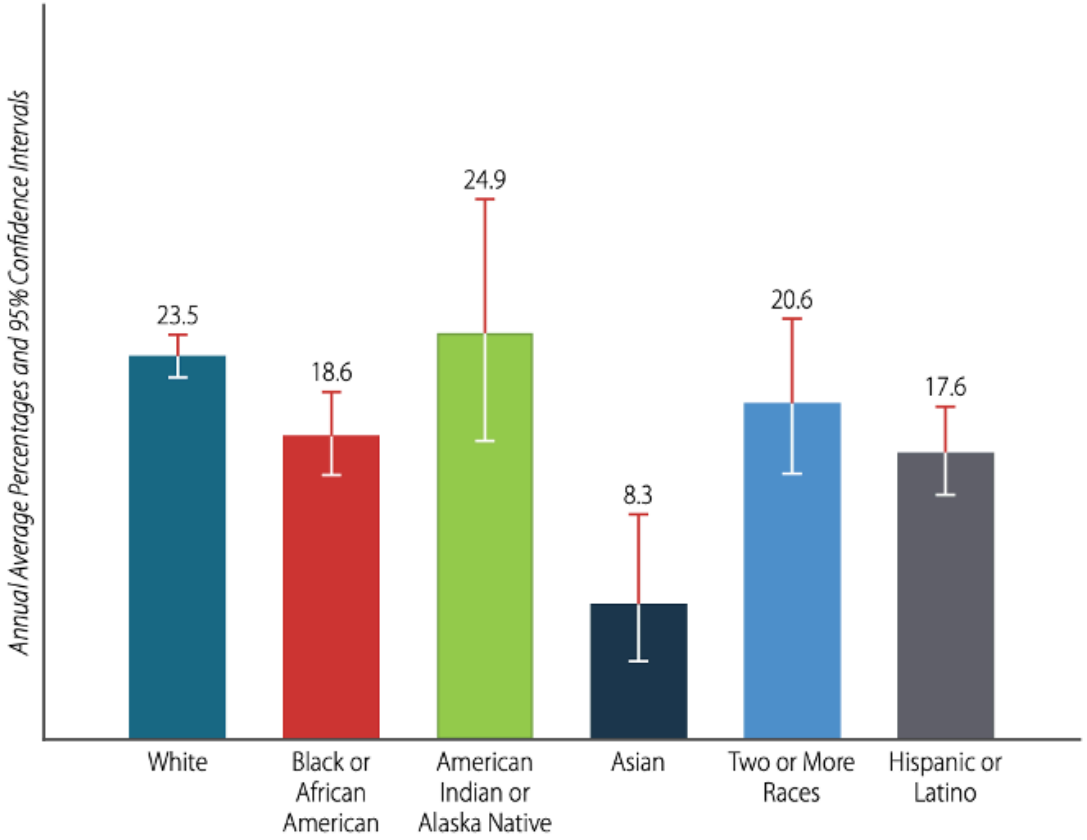

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SUD Treatment Barriers

- Provider barriers
- Access barriers
- Stigma related to SUD and/or health disparities
- Cultural barriers
- Environment barriers

Treatment Barriers Related to Providers

- Lack of diverse representation among providers working treatment facilities (ie, same race/ethnicity, gender, etc, as patient)
- Healthcare providers may:
  - Assume SUD is based on lack of willpower
  - Be dismissive, not view SUD as a medical problem or disease
- Limitations in infrastructure of treatment (eg, provider turnover, fatigue/burnout, lack of resources)
- Conflicts of treatment practices with cultural practices (eg, American Indian tribal and healing practices)
- Lack of knowledge regarding SUD treatment
- Differences in inpatient consultation orders and receipt of treatment
- Use of stigmatizing language
- Underrepresentation of minority populations in clinical trials for SUD

Abbott P, et al. Culture and Substance Abuse: Impact of Culture Affects Approach to Treatment. *Psychiatric Times*; Lindsay AR, et al. *J Gen Intern Med.* Epub ahead of print. 2023; Paschen-Wolff MM, et al. *Subst Abuse Treat Prev Policy.* 2024;19:2; Patrick SW, et al. *Subst Abus.* 2019;40:356-362; Perez GK, et al. *J Racial Ethn Health Disparities*. Epub ahead of print. 2023 Jul 19.

Treatment Barriers Related to Access

- Cost: People with Medicaid/CHIP, higher levels of income, or commercial insurance are more likely to receive SUD treatment
  - High deductibles/copayments
  - Providers not accepting all types of insurance
- Waiting times
- Travel time to treatment facility

van Wijk EC, et al. *Prev Med.* 2019;123:143-151; Lu W, et al. *Drug Alcohol Depend Rep.* 2023;8:100181.

Treatment Barriers Related to Stigma

- Stigma leads to social isolation, which exacerbates SUD
- Stigma impedes access to treatment, but may also perpetuate SUD
- Discrimination
- Stigmatizing language
- Pregnant women often don't seek treatment due to fear of legal repercussions and/or provider discrimination

Paschen-Wolff MM, et al. *Subst Abuse Treat Prev Policy.* 2024;19:2.

Treatment Barriers Related to Culture

- Cultural identity associated with SUD
  - “Cultural recovery”
- Media glorification of substance use
- Social media influences
- Fatalism
  - "I already have cancer so what does it matter?"

Abbott P, et al. Culture and Substance Abuse: Impact of Culture Affects Approach to Treatment. *Psychiatric Times*; Paschen-Wolff MM, et al. *Subst Abuse Treat Prev Policy.* 2024;19:2.

Treatment Barriers Related to Environment

- Social isolation of recovery
- Adverse childhood experience/trauma
- Chronic stress and poor coping mechanisms
- Lack of social support

Dyar C, et al. *J Rural Health.* Epub ahead of print. 2023 Dec 19.

Barriers to Long-Term Sobriety

- Access to medications like buprenorphine
  - Individuals less likely to receive:
    - Younger age
    - Older age (> 50 years)
    - Females
    - Black/African American
    - Hispanic/Latino
- Unemployment
- Diagnosis of hepatitis C

Hadland SE, et al. *JAMA Pediatr.* 2017;171:747-755; Lagisetty PA, et al. *JAMA Psychiatry.* 2019;76:979-981; Weinstein ZM, et al. *J Subst Abuse Treat*. 2017;74:65-70.

Role of the AP: Use of Non-Stigmatizing Language

- Use person-first language

Instead of	Use
Addict	Person with SUD
Substance/drug user	Patient
Drunk	Person who misuses alcohol
Alcoholic	Person with alcohol use disorder
Former addict	Person in recovery
Clean (if patient has a negative toxicology screen)	Testing negative
Dirty (if patient has a negative toxicology screen)	Testing positive
Addicted baby	Baby born to a mother who used drugs while pregnant

National Institute on Drug Abuse website. Words Matter: Terms to Use and Avoid When Talking About Addiction.

AP Role in Addressing Disparities

- Policies
  - Develop and enforce nondiscrimination policies
  - Raise awareness of disparities – continuously work in health equity
  - Develop and enforce policies for routinely sharing names and pronouns as part of the provider/staff – patient introductions
  - Include racial/ethnic diversity and gender-diverse individuals in policy making
- Racial/ethnic and gender-specific services
  - If possible, create targeted programs (eg, LGBTQ+ only SUD treatment programs)
  - If not possible, then create specific groups within larger SUD treatment programs
  - Provide visual cues of an affirming environment

Herron JL, et al. *J Racial Ethn Health Disparities*. 2023;10:603-632; Paschen-Wolff MM, et al. *Subst Abuse Treat Prev Policy.* 2024;19:2.

AP Role in Addressing Disparities

- Facility/staff
  - Ensure minority representation on the treatment team
  - Run cultural competency trainings
  - Use sensitive intake forms
  - Ensure staff awareness of the potential coexistence of SUD and trauma and/or PTSD
  - Encourage participation in SUD clinical trials
  - Avoid stigmatizing language/documentation
  - View each patient holistically – accounting for unique experiences
  - Train staff on how to intervene when discrimination, stigma, or aggression is noted within the facility
  - Create single-stall gender-neutral bathrooms

Herron JL, et al. *J Racial Ethn Health Disparities*. 2023;10:603-632; Paschen-Wolff MM, et al. *Subst Abuse Treat Prev Policy.* 2024;19:2.

AP Role in Addressing Disparities

- Community
  - Be aware of community resources
  - Work to expand available resources (ie, rural communities)
  - Increase health literacy by offering community education sessions
  - Collect and access local data on health disparities and SUD
  - Assist in raising awareness of health-related consequences of SUDs
- Nationally
  - Engage with policymakers to review health disparity data and recommend expanding health coverage/access
  - Partner with organizations to address root causes of health disparities

Herron JL, et al. *J Racial Ethn Health Disparities*. 2023;10:603-632; Paschen-Wolff MM, et al. *Subst Abuse Treat Prev Policy.* 2024;19:2.

Summary of Key Points

- There are significant racial/ethnic/gender-diverse health disparities in SUDs and SUD treatment in the United States
- Minority populations are underrepresented in SUD clinical trials
- Multiple treatment barriers affect access, the provider, the environment, culture, and stigma related to either the SUD or minority status
- The AP in hematology/oncology has multiple opportunities to address these barriers

Thank you!

You may now proceed to the post-test questions

Pre-Post Question #1

Which of the following are examples of a health disparity?

A. Gap in mortality rates between Caucasian and Black adults
B. Life expectancy between two races
C. Burden of disease such as lung cancer between southern states in the United States vs northwestern states
D. Rate of uninsured persons between racial and ethnic groups
E. All of the above

Pre/Post Test Question #2

What ethnic group has the highest rate of tobacco use?

A. African American
B. Asian American
C. White
D. American Indian/Alaska Native

Pre/Post Test Question #3

How can the AP get involved in addressing health disparities?

A. Completing/engaging in cultural competency trainings
B. Avoiding stigmatizing language and documentation
C. Referring patients in minority populations to clinical trials
D. All of the above