

WELCOME

Eastern New England Council of Advisors Meeting
October 6, 2020

Achieving Equity in Breast Cancer Right
Here In Boston: *Can We Work Together?*



Agenda

- Welcome
 - ACS Priority- Health Equity
 - Purpose and Goals of the Council
 - Meeting Goals
 - The Boston Breast Cancer Equity Coalition
 - Overview
 - Discussion
 - Translating Research Into Practice Regional Collaborative
 - Overview
 - Challenges to Success
 - Discussions
 - Health Systems
 - Data Sharing
 - Identifying and Responding to Social Needs
 - Wrap Up and Closing Comments
- Mark Goldberg
- Rachel Freedman and Sharon Bak
- Tracy Battaglia
- Tracy and TRIP consortium
- Mark

National Mission Strategic Plan

Save Lives Celebrate Lives Lead the Fight for a World Without Cancer

Reduce 2015-2035 Mortality by 40%

Leadership Roles



Lead efforts in the prevention and early detection of cancer

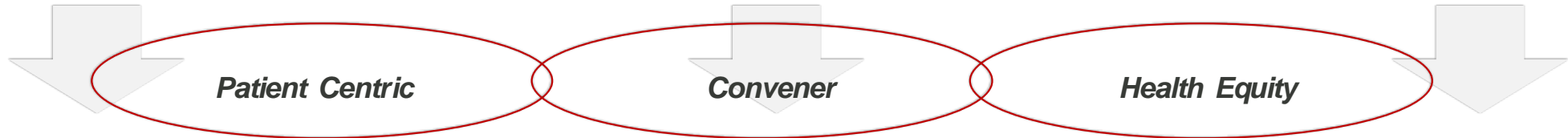


Improve equitable access to quality care



Accelerate innovations to improve patient outcomes

Filters



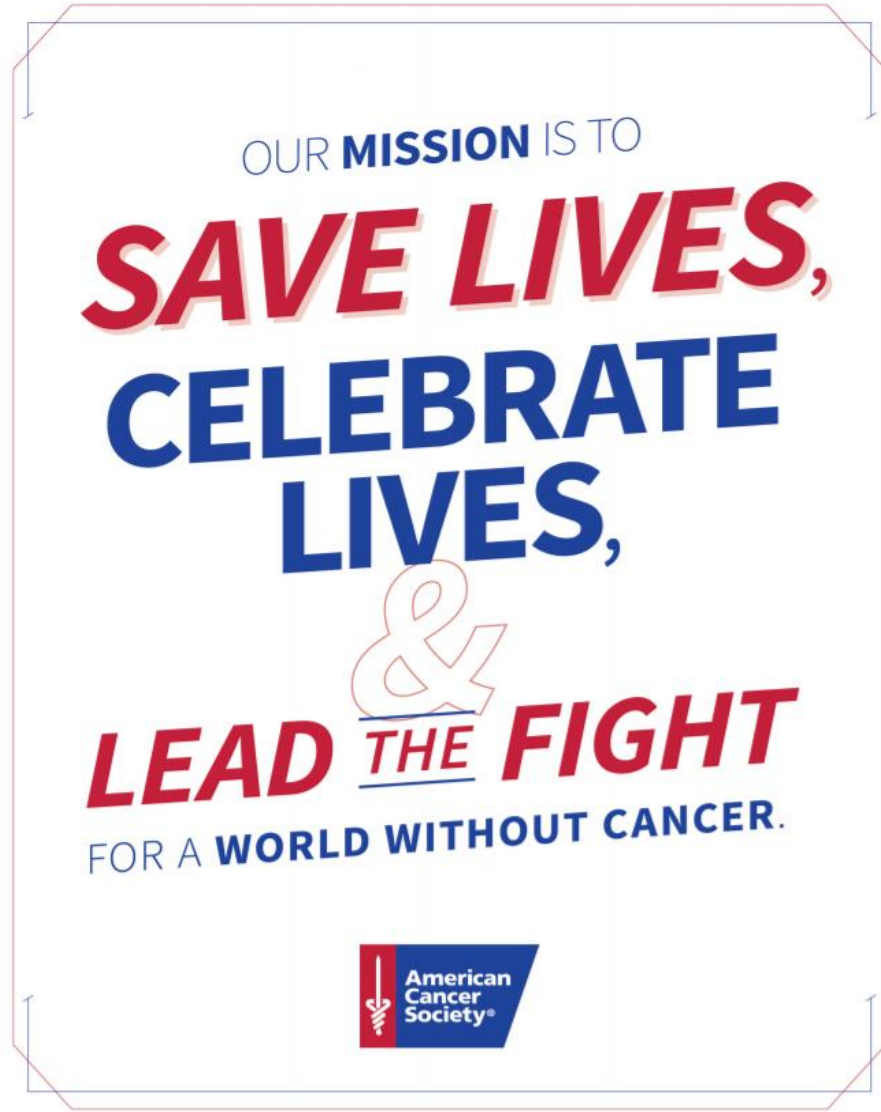
Goals

1. Reduce cancer burden related to tobacco use
2. Increase quality screening rates and address the screening continuum
3. Increase cancer prevention vaccination rates
4. Improve healthy eating and active living

1. Reduce uninsured and underinsured rates
2. Reduce structural and financial barriers
3. Provide access to relevant, accurate information based on patient's need
4. Improve patient and caregiver experience

1. Maximize investment in federal funding of cancer research
2. Increase participation rates in clinical trials, particularly for diverse populations
3. Advance cancer control through data science
4. Leverage innovative technologies and data to advance scientific knowledge and implement effective interventions

Definition of Health Equity Through A Cancer Lens



Everyone has a fair and just opportunity to prevent, find, treat, and survive cancer.

No one should be disadvantaged in their fight against cancer because of how much money they make; the color of their skin; their sexual orientation; their gender identity; their disability status; or where they live.

Eastern New England Council of Advisors

Purpose:

- The Council of Advisors brings together **senior healthcare leaders** in **academia, industry, and government** to provide advice and guidance to the American Cancer Society (ACS) to help advance the mission.

Goals:

- Engage senior healthcare leaders unable to commit to the Area Board
- Strategically focus on public health issues and mission priorities
- Position ACS as a leader by convening a cross-functional group of senior healthcare leaders
- Increase awareness and understanding of the goals and priorities of ACS
- Leverage the expertise of council members to advise ACS and champion efforts within their industry and spheres of influence
- Enhance collaboration and be a catalyst for new connections and synergies

Eastern New England Council of Advisors

Timeline:

- Council recruited and formed in 2018
- Inaugural meeting held in October 2018- Topic: **Increasing HPV Vaccination in Massachusetts**
- Meeting # 2 held in October 2019- Topic: **Increasing Colorectal Cancer Screening in Massachusetts: 80% In Every Community**
- Meeting # 3 October 2020- Topic: **Achieving Equity in Breast Cancer Right Here In Boston**

Our Goals For Today

- Convene a cross-functional group of healthcare leaders to focus on addressing health equity and the social determinants of health, with a focus on breast cancer
- Increase awareness and understanding of current partnerships, research, and work happening to impact equity in breast cancer outcomes
- Leverage the expertise and influence of council members to address challenges and champion improvement efforts within their spheres of influence
- Enhance collaboration and be a catalyst for new connections and synergies

Achieving Equity in Breast Cancer Right Here in Boston: *Can We Work Together?*

The TRIP Consortium
ACS Council of Advisors Meeting
October 6, 2020



The TRIP Consortium

Principal Investigators



Tracy Battaglia, MD MPH
Boston Medical Center



Jennifer Haas, MD MSPH
Mass General Hospital

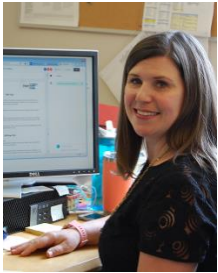


Karen M. Freund, MD MPH
Tufts Medical Center



Stephenie Lemon, PhD
UMass Medical Center

Co-Investigators



Amy LeClair, PhD MPhil
Tufts Medical Center



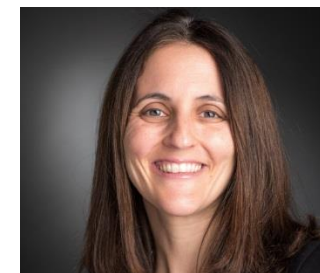
Cheryl Clark, MD ScD
Brigham and Women's
Hospital



Christine Gunn, PhD
Boston Medical Center



Sharon Bak, MPH
Boston Medical Center



Rachel Freedman, MD MPH
Dana-Farber
Cancer Institute



Karen Burns White, MS
Dana-Farber
Cancer Institute

Boston Breast Cancer Equity Coalition

Agenda

1. The Boston Breast Cancer Equity Coalition
2. *Translating Research Into Practice* Regional Collaborative
3. Challenges to Success: Discussions
 - Health systems
 - Data sharing
 - Identifying and responding to social needs



Evolution of The *Boston Breast Cancer Equity Coalition*



Black:White disparities in breast cancer mortality

- Across the 50 largest cities in the U.S
- Race-specific breast cancer mortality rates
- Rate ratios between 1990-1994 (T1) and 2005-2009 (T2)
- 35 cities **increase** in Black:White rate ratio
- Increase largely because White rates improved substantially
- Boston had the **fifth-highest** rate ratio: **1.49**; 95% CI: (1.18, 1.88)

1710 excess Black deaths annually, about 5 each day

The Boston Breast Cancer Equity Coalition

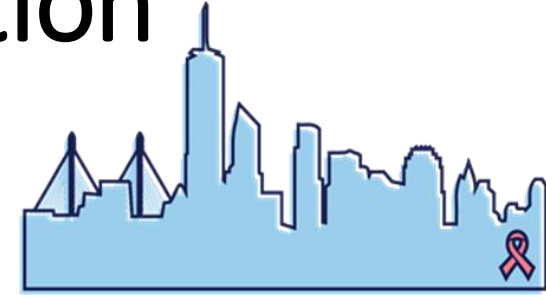
- Est. in 2014 in response to Hunt article
- Multidisciplinary stakeholders: Nonprofits, government agencies, institutions and providers, patients, survivors, advocates, policy makers, researchers
- Mission = to develop city-wide solutions with the specific aim of eliminating inequities in breast cancer outcomes



www.bostonbcec.org

The Boston Breast Cancer Equity Coalition

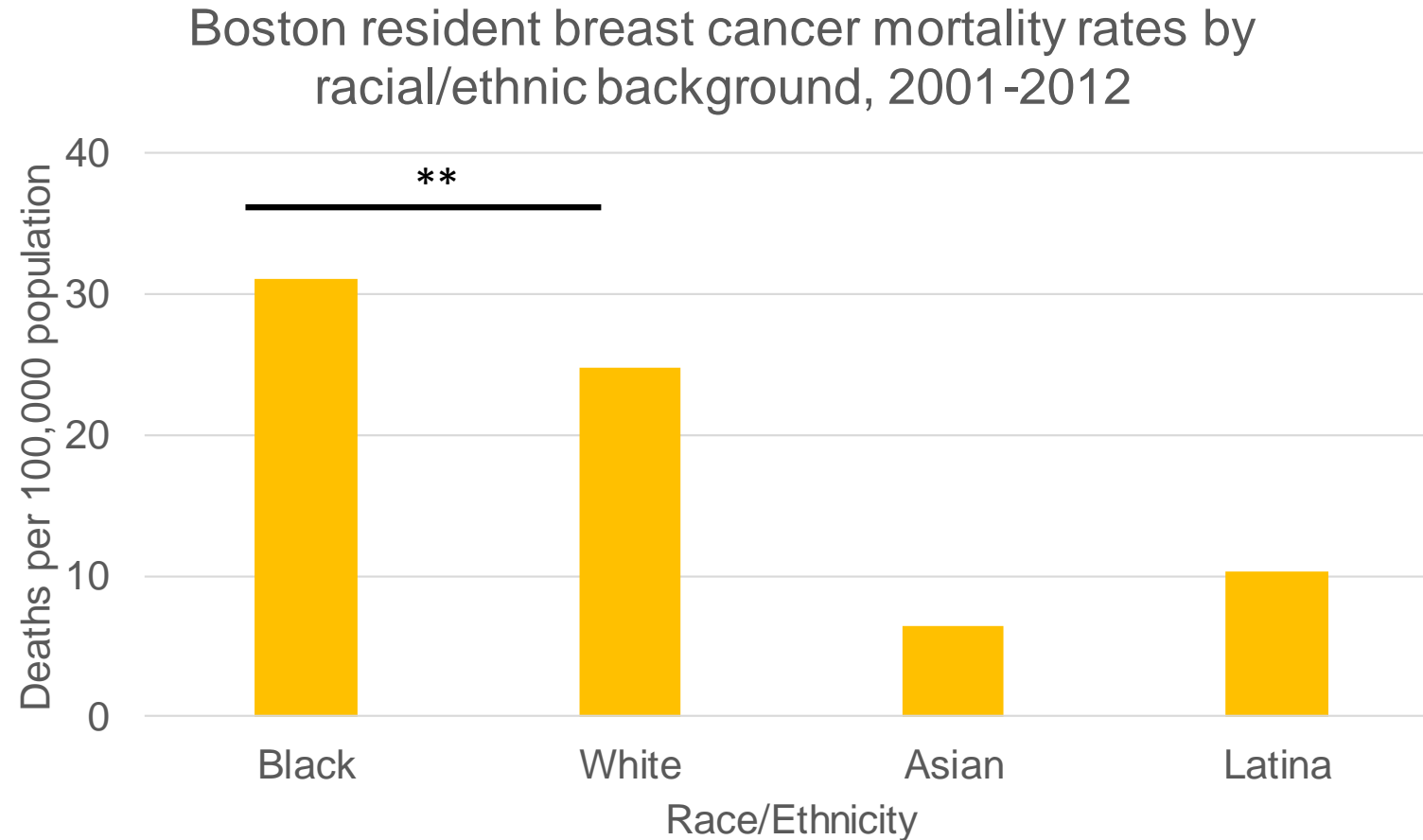
- Data driven collaborative
- Promote evidence-based best practices and policy



Member Organizations

- American Cancer Society
- Asian Women for Health
- Beth Israel Deaconess Medical Center
- Boston Medical Center
- Boston Public Health Commission
- Brigham and Women's Hospital
- Dana-Farber Cancer Institute
- Dana-Farber/Harvard Cancer Center
- Faulkner Hospital
- MA Department of Public Health
- Massachusetts General Hospital
- Medical-Legal Partnership, Boston
- Pink and Black Education and Support Network
- Susan G. Komen New England
- Tufts Medical Center
- Region 1 Office of Women's Health
- YWCA Boston

MA Cancer Registry confirmed the disparity in Boston



**p<0.01

Death rates are average annual (i.e., annualized 12-year) age-adjusted rates.

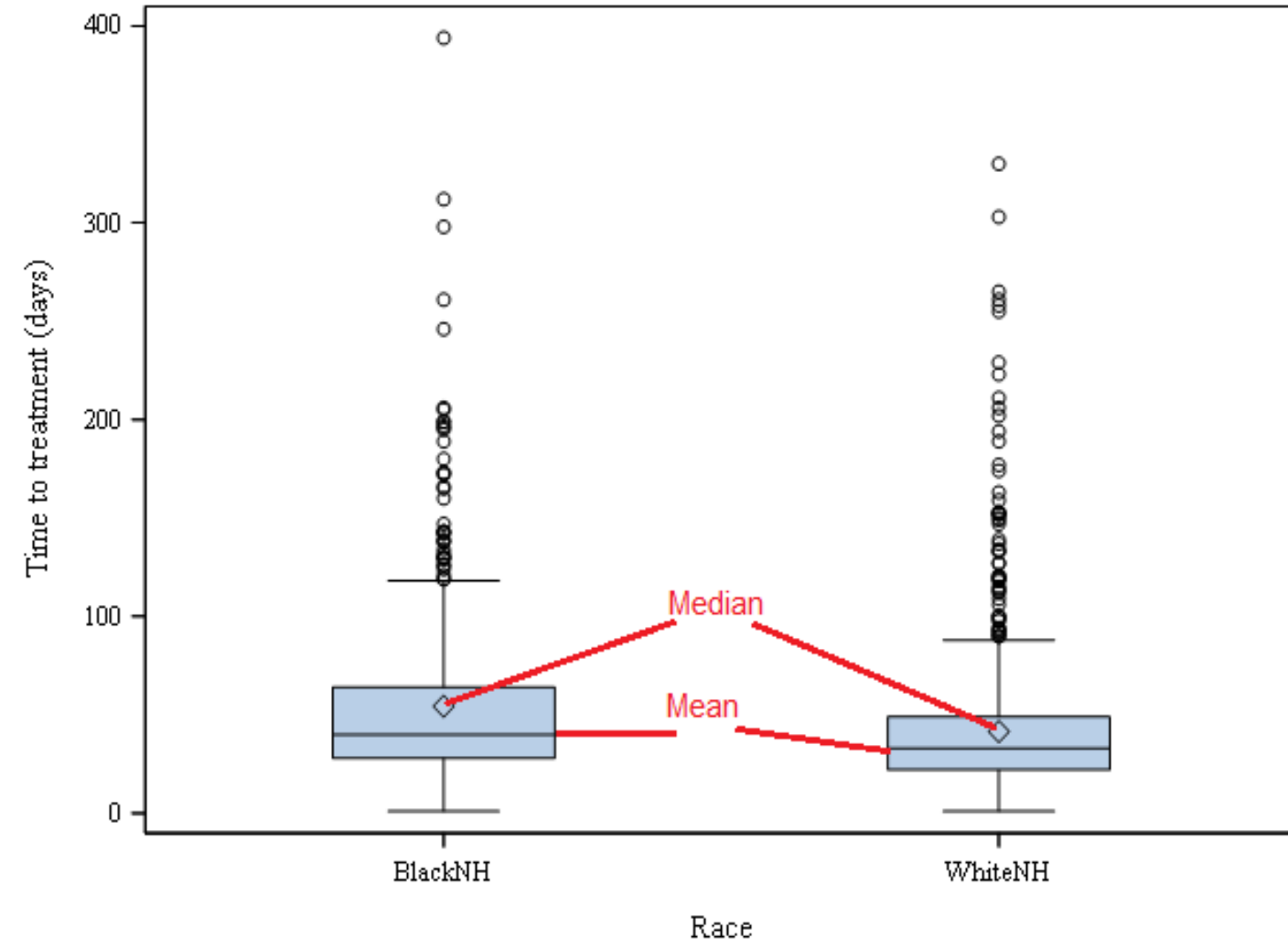
Death data for 2012 is preliminary.

DATA SOURCE: Boston Resident Deaths, Massachusetts Department of Public Health

DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office

Treatment Delays Lead to Disparities

Distribution of time_tx by race



Black non-Hispanic patients and patients using Medicaid are 2-3 times more likely to have delays > 60 days between diagnosis and initiating treatment

	Adjusted Odds Ratio (95% CI)
Black non-Hispanic vs. White non-Hispanic	2.2 (1.6, 3.1)
Medicaid vs. Private Insurance	2.8 (1.8, 4.3)

Community Health Needs Assessment

Challenges to *treatment* exist for those in need of cancer care.

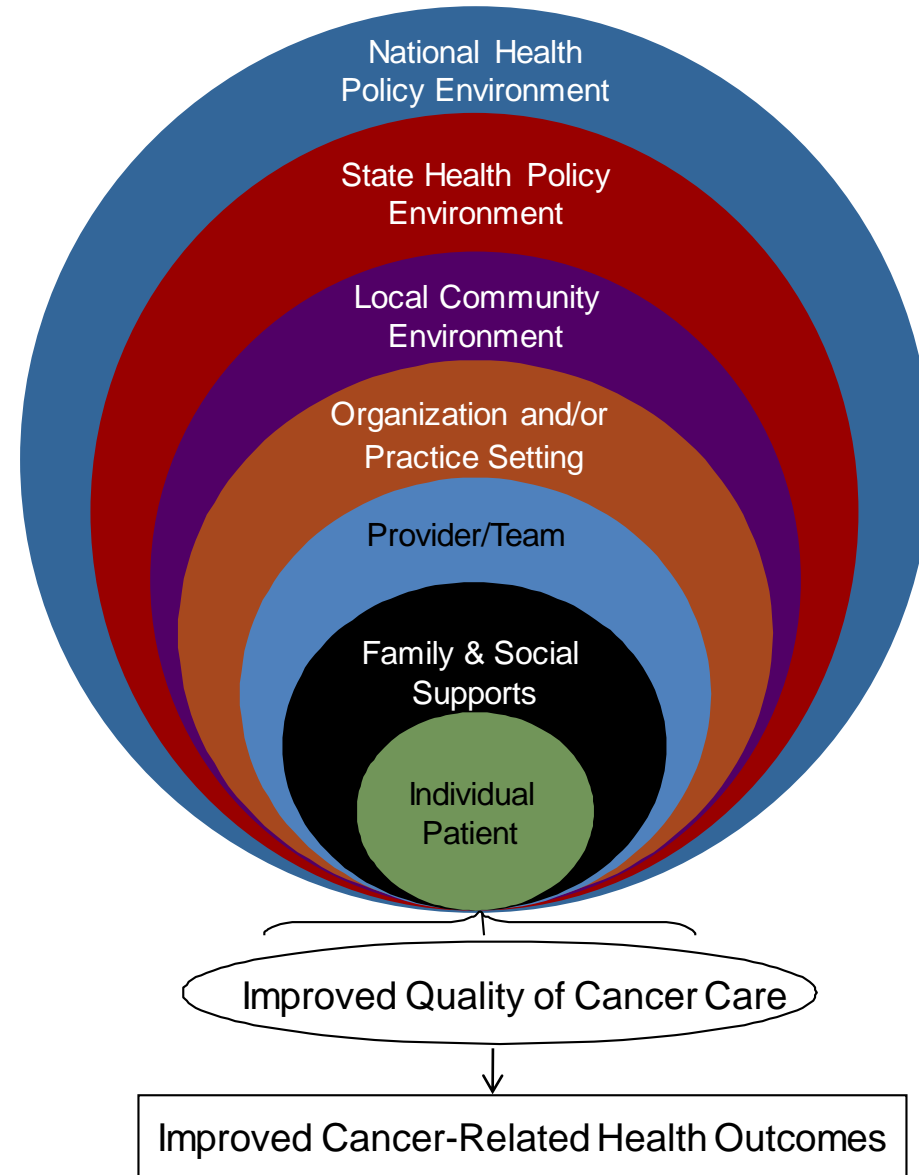
- Lack of care coordination
- Cost of treatment
- Maintaining employment
- Transportation
- Childcare
- Language barriers
- Lack of cultural competency among providers
- Institutional racism
- Lack of clinical trial opportunities

Enhance support to help patients navigate cancer services and related care

Boston environment promotes unequal challenges to accessing care

- Large number of healthcare systems
- Challenges accessing care are unequally borne
- In 2015: Household median net worth
 - White households: \$247,500
 - African American households: \$8
 - Black Caribbean households: \$12,000
 - Puerto Rican households: \$3,020
 - Dominican households: \$0
- 3rd most gentrified city in the US over 2013-2017
- Transfers between systems can contribute to treatment delays if healthcare systems don't coordinate patient care

The Layered Context of Care





Approach to Addressing Disparities

- Address multiple levels of the layered context of care
- Coordinate care across levels of care
 - Between departments
 - Across health systems
 - Between health systems and community partners
 - Between health systems and payers
 - Between health systems and policy makers
- Regional approach, not institutional approach
- In collaboration with community

DISCUSSION



- Based on your respective roles in oncology care, what are your thoughts or suggestions about the BBCEC approach?
- Do you see a role for you or your organization on the BBCEC?
- Do the goals of the BBCEC align with your organization's priorities?
- What are some opportunities to collaborate?

Translating Research Into Practice

- National Center to Advance Translational Science
- Collaborative Innovation Award between ≥ 3 universities/CTSA programs
- Disparities initiative
- Community-driven research methods
- \$8.9 million NIH funded study (2017-2022)

TRIP: Addressing disparities together

Tracy Battaglia, MD MPH

Karen Freund, MD MPH

Jennifer Haas, MD MPH

Stephenie Lemon, PhD



Boston
Patient Navigator
Network



Clinical
Advisory
Panel



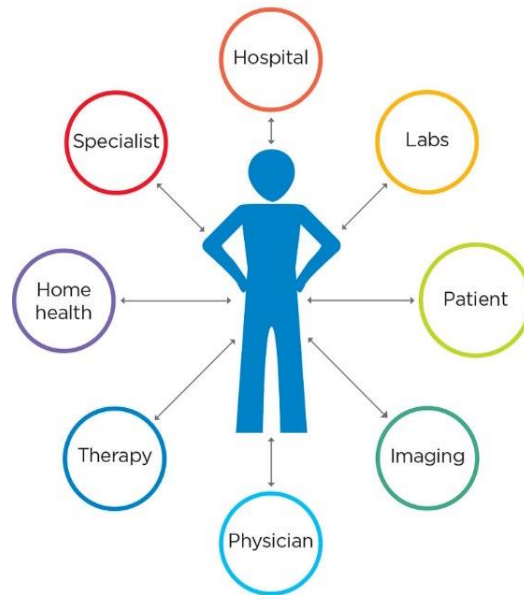
Funded by:



Research Gap: Evidence-based strategies for coordinating breast cancer care delivery are not systematically implemented within or across hospitals



Real-time Patient Registry
population management
Health System level



Patient Navigation Services
coordinate care delivery
Patient level
Provider/Team level
Health system level



Screening (and referral)
interpersonal barriers to care
Patient Level
Health system level

TRIP: The Research Question

“Can we systematically implement evidence-based coordination of care across the city of Boston to reduce delays in treatment and reduce disparities?”

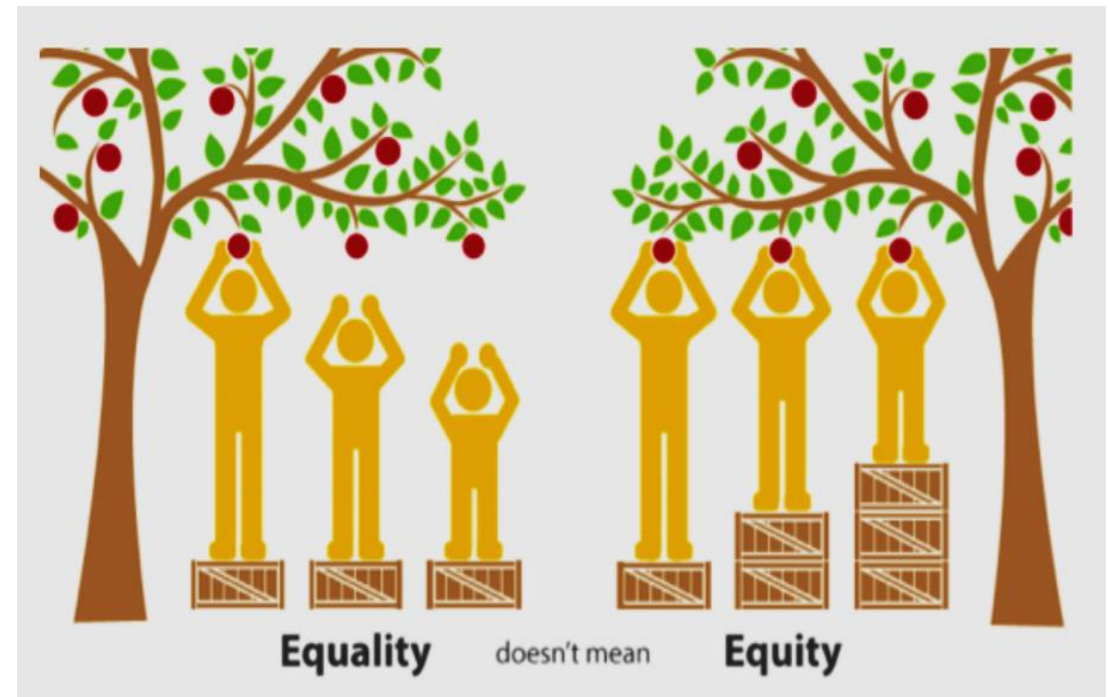


Research Methods

- **Community-engaged implementation science**: Integrating evidence-based interventions in partnership with key stakeholders
- **Randomized cluster stepped wedge study design**: Pragmatic clinical trial allows for rolling out iteratively in real life practice settings
- **Type 1 hybrid clinical effectiveness-implementation trial**:
 - *Clinical outcomes*: time to initiation of treatment; quality of care
 - *Implementation outcomes*: acceptability, adoption, fidelity to protocol, sustainability, and cost

Who is our target population?

- Adult female breast cancer
- Greater Boston area (25 miles)
- Have one or more risk factors for experiencing delays in care:
 - Black
 - Hispanic/Latina
 - Non-English preferred language
 - Uninsured or public insurance



Demographics of TRIP Population

		Total n=194
Race	White	40 (21%)
	Black	100 (52%)
	Asian	27 (14%)
	Other Race	31 (16%)
Ethnicity	Hispanic	50 (26%)
Preferred Language	Non-English Speaking	95 (49%)
Insurance Status	Private Insurance	58 (30%)
	Uninsured	1 (1%)
	Medicare	39 (20%)
	Medicaid	105 (54%)

Data from 9/1/2018 to 9/1/2020; patients can select more than one racial identity and have more than one insurance

Health-Related Social Needs

Characteristic	Response	Percentage of eligible TRIP patients with a baseline assessment (Total n=194)
Number of Social Needs	No needs reported	72 (37%)
	1 need identified	20 (10%)
	2+ needs identified	56 (29%)
	Incomplete assessment	8 (4%)
	Missing assessment	38 (20%)

Top Domains of Need



Food (22%)



Employment (21%)



Utilities (18%)

TRIP Progress to date

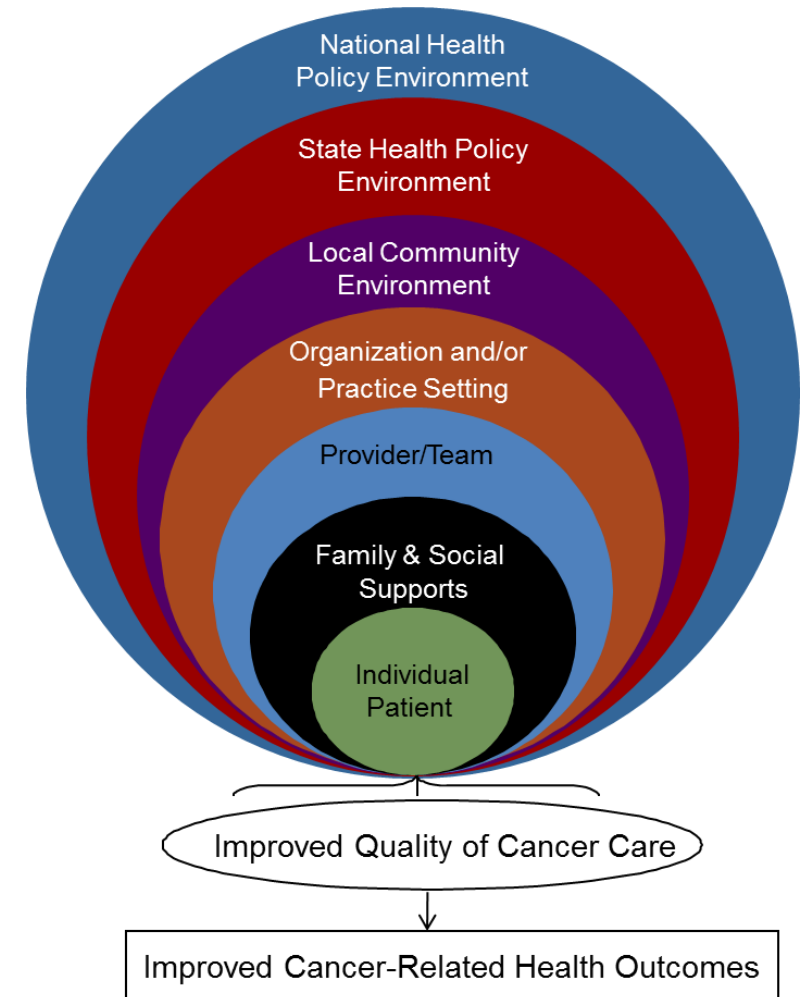
- Formative assessments informed design of integrated intervention
 - Standardized patient navigation protocol*
 - Shared REDCap patient registry system
 - Aunt Bertha platform for systematic social needs assessment and referral
- “Stepped” intervention rollout across 6 Boston hospitals
 - Implementation Strategies: Clinical Advisory Panel, regular monitoring and feedback, technical assistance, navigator learning collaborative
- Implementation data collection completed 3/6 hospitals
 - Interviews, observations, surveys

DISCUSSION



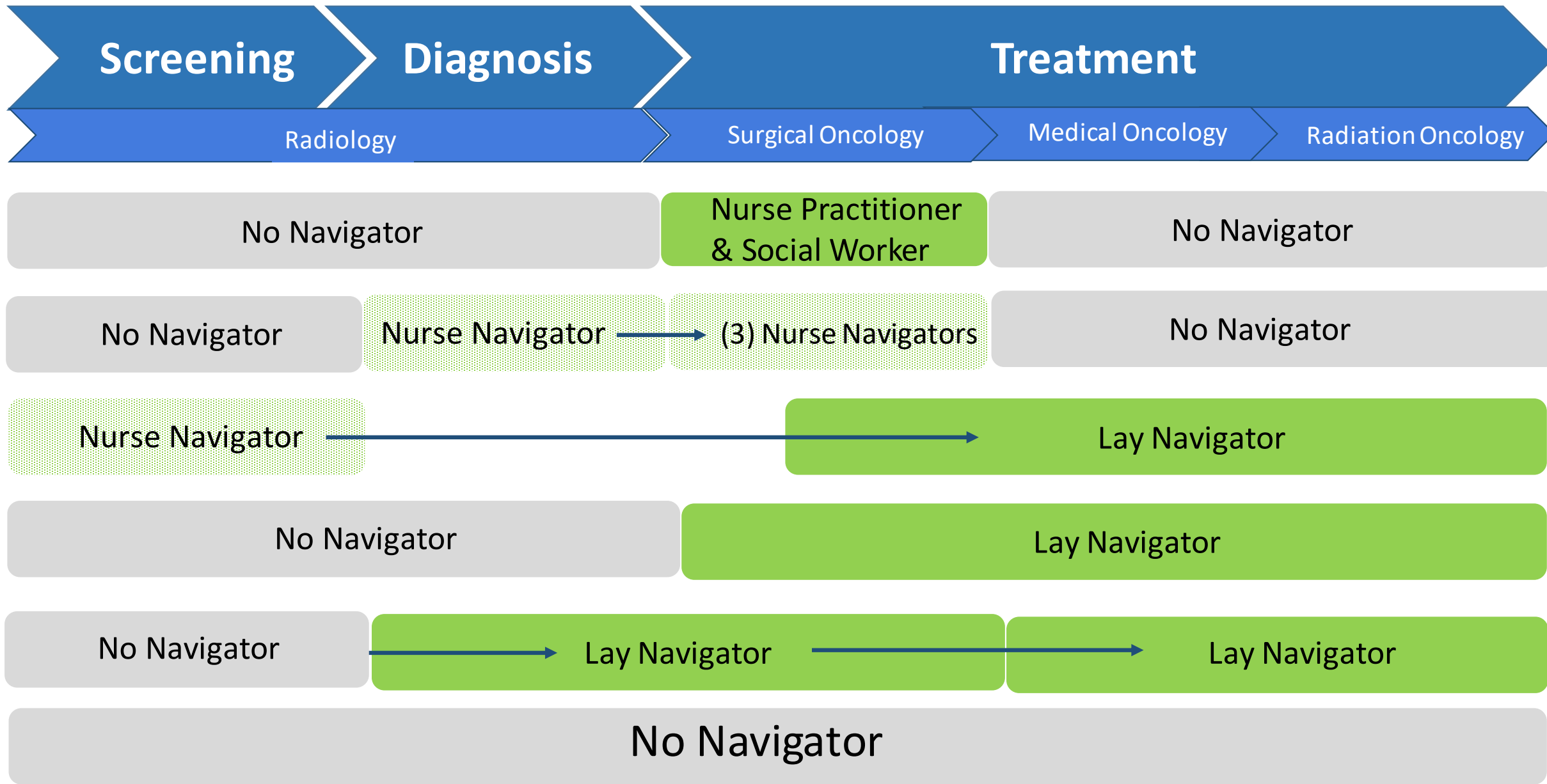
Challenges to Achieving Equity: Lessons from TRIP

1. Health System Practice Barriers
 - Organization/practice level, provider/team level
2. Data sharing/Technical Challenges
 - Organization level, Policy level
3. Identifying and addressing Social Needs
 - Individual level, Community level



Health System Challenges

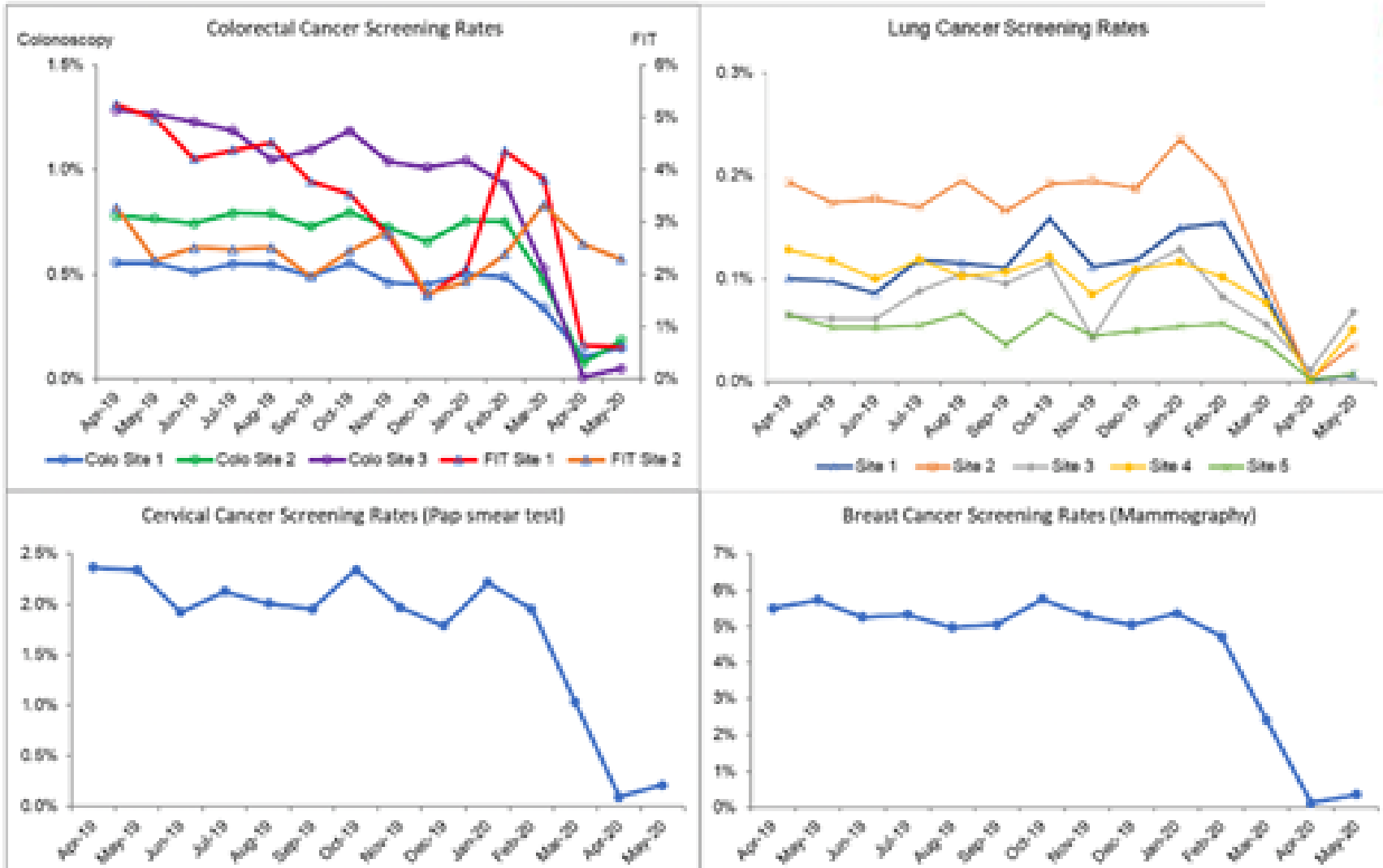
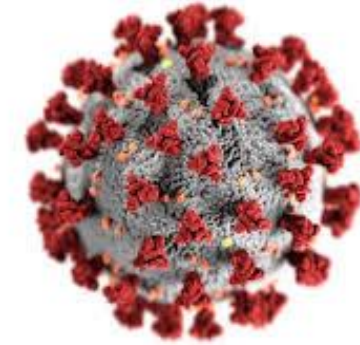
- Fragmented oncology care delivery programs
- Resistance to change in existing workflows
- Lack of central home for patient navigation
- Lack of sustainable funding for navigators
- Numerous information systems that don't talk to one another
- COVID 19 disruptions



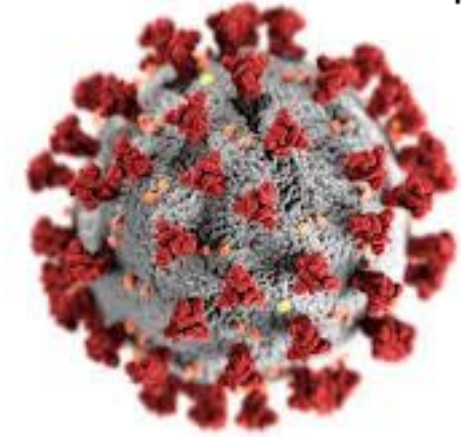
Currently, navigation is a series of gaps

Data as of January 2018

COVID-19 impact on cancer care



COVID-19 impact on navigation



- Several navigators furloughed, offsite, or redeployed to COVID-19 duties
- Learning and coordinating telehealth was challenging, as was teaching patients to use the technology
- Patients fearful of coming into appointments, unsure safe practices around COVID-19 – navigators educated patients on COVID-19
- Patients experiencing loneliness and psycho-social needs

DISCUSSION: HEALTH SYSTEMS CHALLENGES

- What challenges that we've encountered resonate with you?
 - E.g. fragmentation within/across hospitals, sustainable models to support non-reimbursable services
- How can we leverage COVID-inspired collaboration across health systems to continue our work?
- What are 1-2 actions you can commit to?
 - E.g. one change at your institution, one connection between different stakeholders

Challenges to Data Sharing – How do we facilitate handoffs between hospitals?



Regional approach to health disparities



Population-level tracking in real time



Siloed providers within health care systems

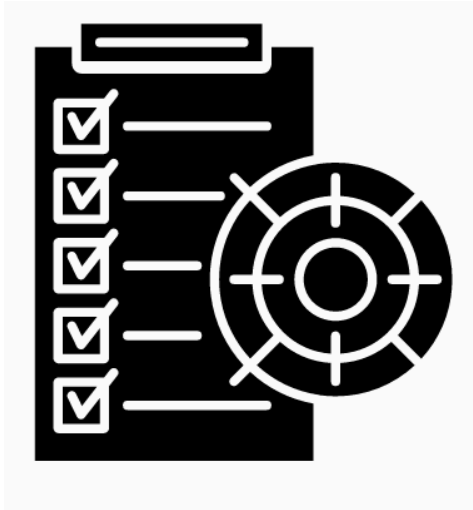


Technology not always helpful



Balance privacy/care continuity

Developing Technology Solutions to Facilitate Handoffs across Hospital

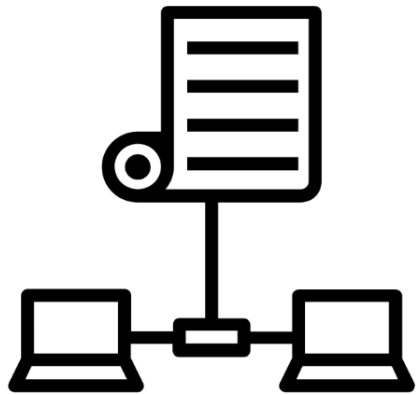


- Developed solution in the context of this study using REDCap
- How do we translate this into a sustainable solution?

Case Study: Problem



- Patient Navigator 1 (PN1 – at Hospital 1) met a patient to coordinate the patient’s biopsy appointments with imaging and the breast health doctor.
- After the patient’s DCIS diagnosis, PN1 noticed that the patient did not show for her pre-surgical visit at Hospital 1.
- PN1 learned through EPIC that the patient had other visits completed at Hospital 2, and she wondered if the patient was being seen there.
- When PN1 reached out to the patient, she learned that the patient was seeking a second opinion.

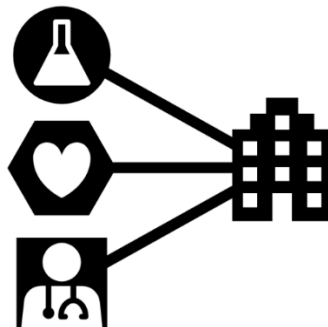


Case Study: Solution

- PN1 utilized the REDCap messenger system to connect to Patient Navigator 2 (PN2) at Hospital 2 to check in with the patient.
- REDCap provided direct line of communication between navigators and hospitals.
- PN1 ensured the patient received hand off on transfer to Hospital 2.

DISCUSSION: Data Sharing to Prevent Gaps in Care

- What challenges that we have encountered resonate with you?
- What changes can our institutions implement?
- How can you help facilitate data sharing to improve care coordination?



Identifying and Addressing Social Needs

- What are your experiences with systems for addressing health-related social needs?
 - Performing screening?
 - Addressing identified needs?

Health-Related Social Needs

Characteristic	Response	Percentage of eligible TRIP patients with a baseline assessment (Total n=194)
Number of Social Needs	No needs reported	72 (37%)
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	Missing assessment	38 (20%)

Top Domains of Need



Food (22%)



Employment (21%)



Utilities (18%)

Barriers to Identifying and Addressing Social Needs

- Integrating timely, systematic needs assessment challenging
 - “Sometimes patients don't realize what they need until they're going through more treatment and they realize, ‘Oh no, I've missed three days of work this month and my job's on the line’ or ‘I don't have the \$150 I need now to pay for food for my family’ or whatever it is.”
- Navigators default to ‘usual’ resources
 - “When at first [Aunt Bertha] was introduced, it was kind of difficult to kind of think of just transitioning over to it...the resources I had were generally more helpful or things that I already was used to.”
- Hard to “close the loop” and know if patient could access resource
 - “I never know on the other end whether they're really receiving things, number one or whether they understand it, number two.”
- Resources are vulnerable – in Mar/Apr 2020 many resources closed

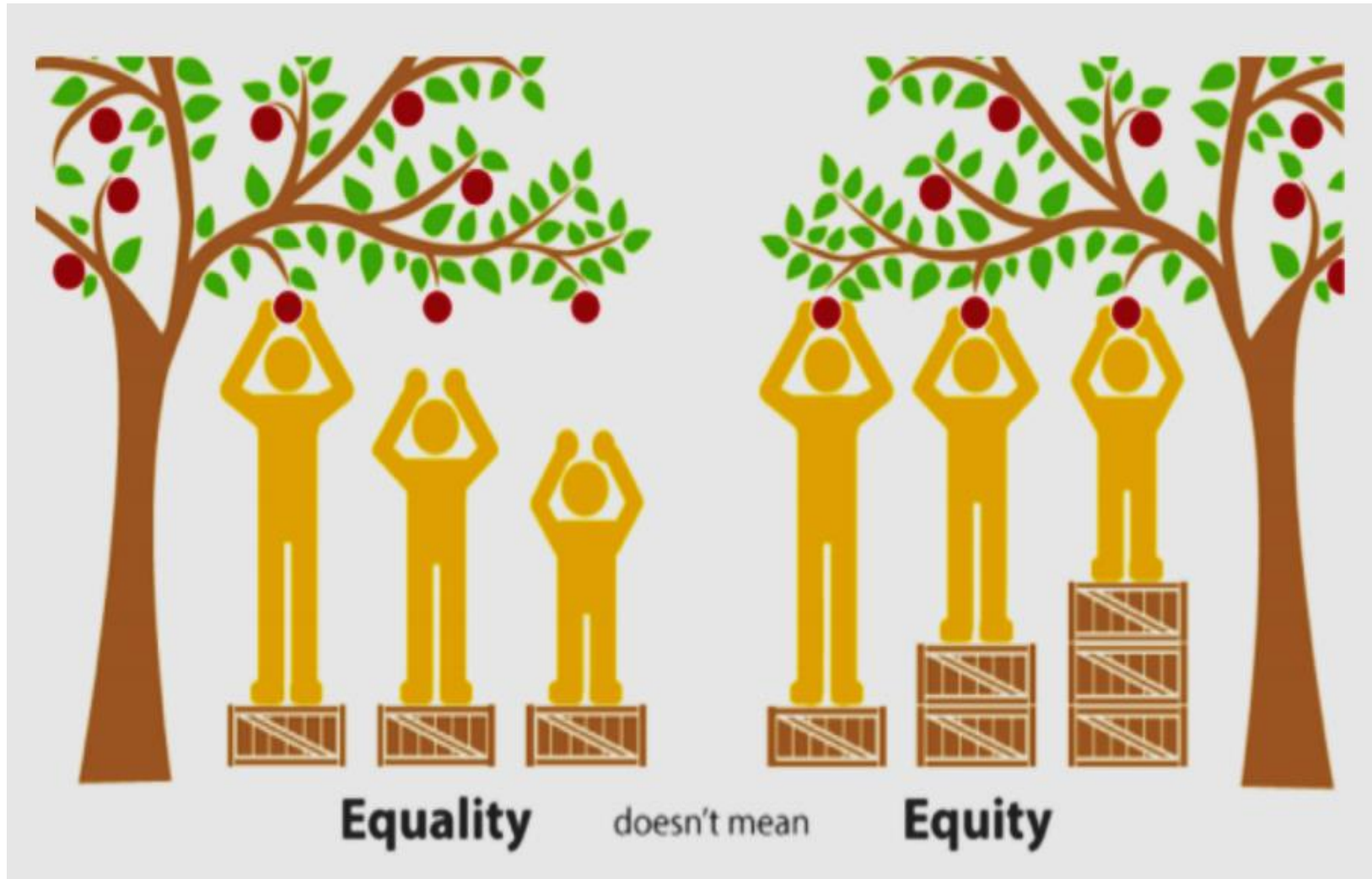
Implementation of Social Needs Screening

- Routine interaction:
 - Weekly site reports
 - Monthly stakeholder newsletter
 - Review with clinical leadership at sites
 - Site visits
- Additional training for skill building:
 - Skill share session with a tobacco cessation treatment specialist
 - Session on empathetic inquiry training

DISCUSSION: Identifying and Addressing Social Needs

- Do the challenges we've encountered resonate with you?
- Can we leverage other similar initiatives to advance this practice?
- What are 1-2 actions to facilitate identifying and addressing social needs that you can commit to?

Achieving equity requires collaboration!



THANK YOU



EXTRA SLIDES

2019 Report: Mortality disparity persists

Cancer Mortality for Boston Females by Race/Ethnicity					
	All	Asian	Latina	Black	White
All Breast Cancer	19.9	9.9	8.2	26.2	21.3
Breast Cancer <65 Years	8.1	11.1	4.4	10.9	7.1

DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Deaths, 2015-2017 combined

Stepped Wedge Study Design

	Pre-TRIP	Year 1	Year 2	Year 3	Year 4	Year 5
1			BW-Faulkner Hospital			
2			Beth Israel Deaconess Medical Center			
3			Tufts Medical Center			
4			Boston Medical Center			
5			Mass. General Hospital			
6			Dana-Farber Cancer Institute			

536 historical controls and 564 intervention = 1100 women.

TRIP Protocol

CANCER
December 15, 2019

TABLE 1. Recommended Standardized Patient Navigation Activities With Timeframes and Evaluation Metrics for Patients Diagnosed With Breast Cancer

Patient Navigation Activity	Recommended Activity	Timeline for Activity	Monitoring the Navigation Program
A. Identify patients in need of navigation			
1. Identify eligible patients	Use a standardized system to identify patients with newly diagnosed cancer. Each system may have unique processes and use existing electronic health records, including pathology reports or upcoming initial appointments. Each system requires a process for identifying the patient group for the focus of navigation, which is based on local data on who would benefit the most from navigation	Identify each patient within 1 wk of the breast cancer diagnosis	Evidence of weekly monitoring of systems to identify newly diagnosed patients
2. Establish initial contact by the patient navigator with the patient	Meet with the patient in person or by telephone to complete the intake assessment. The meeting may include the family or designee of the patient	After the patient has been informed by his or her provider of his or her diagnosis, ideally within 1 wk of the pathologic diagnosis	Time from diagnosis until first contact with the patient by the patient navigator Proportion of patients who receive the initial contact in person Number of required fields in the intake process completed
3. Establish the frequency of routine ongoing contact	Meet with the patient in person or by telephone at least every 3 mo or at the time of each transition to another care modality (eg, surgery, chemotherapy, or radiation therapy)	Every 3 mo or ideally within 1 wk of each transition of care modality	Documentation of the timing of navigator visits with the patient with respect to transitions of clinical care Proportion of patients who receive in-person contact
B. Identify logistic barriers or social needs (social determinants of health)			
1. Complete the social needs assessment	Complete a systematic assessment. Provide targeted referrals based on assessment findings (See the supporting information for screening questions)	1) Within 1 wk of the diagnosis 2) Every 3 mo and/or within 1 wk of each transition of care modality	Documentation of the completion of the assessment Documentation of referrals to relevant resources
C. Support patients in addressing social barriers and logistic needs to receive care			
1. Ensure follow-up regarding social needs referrals	The navigator should ask the patient at each follow-up encounter if his or her identified social needs have been met and document results. If needs have not been met, additional referrals should be made	At each routine follow-up encounter or an encounter for a missed appointment or at the request of the patient	Documentation of whether new referral needs have been identified Documentation of referrals to resources
2. Communicate with the health care team	Communicate with the health care team (eg, oncologists and nurses) through electronic health record modalities, by email, by phone, or in person throughout the patient's treatment and coordinate navigation services with the clinical course	Within 48 h of each initial oncology consultation and within 2 wk of each transition in treatment (eg, surgery, chemotherapy, or radiation therapy)	Documentation of navigator and clinical team communication in the navigator notes in the electronic health record
3. Complete the recommended number of attempts when attempting to reach the patient	For each activity that involves contacting the patient, attempt to reach the patient by the preferred contact method, usually by phone at least 3 times, including once during evening hours, followed by 1 follow-up letter from the clinical site	With each contact initiated by the navigator (see #4). Contacts should be attempted over 3 d when one is unable to reach the patient	Documentation within the electronic health record of navigator outreach attempts
4. Follow-up process after missed appointment follow-up ^a	Any missed patient appointments should result in a navigator phone call and completion of the social needs assessment. If the patient has had prior missed appointments, the navigator should make a reminder call the day before every scheduled appointment	Within 48 h of the missed appointment	Documentation within the electronic medical record
5. Manage patients lost to follow-up ^b	After unsuccessful attempts to contact the patient, evidence of outreach to the named patient contacts, and contact with the health care team members and affiliated electronic records (including connections to other health care systems) to identify the location of the patient	After 3 contact attempts and when one is unable to reach the patient and he or she is not showing for scheduled appointments	Documentation within the electronic medical record

4535

REDCap Shared Patient Registry

Number of results returned: **215**

Total number of records queried: 614

('records' = total available data across all designated events)

[Stats & Charts](#)
[Print Page](#)
[Edit Report](#)

Live filters: [Current PN]

Patient Tracking Report

Search

[Re-enable floating table headers](#) ?

Patient Registry ID pid	Event Name redcap_event_name	Repeat Instrument redcap_repeat_instrument	Repeat Instance redcap_repeat_instance	Active active	Intake Completed intake_required	Initial Social Needs Assessment (SNA) completion status sdoh_initial_new	Date of initial SNA initial_sdoh_date	Target date for 2nd SNA initial_sdoh_date90	Date of 2nd SNA first_rsns_date	PN Transfer transfer_pn	Current PN pn_current	Days since diagnosis days_since_dx	System last updated: date_today
	Intake			Active (1)	Yes (1)	Completed (1)				No (0)			08-31-2020
	Intake				Yes (1)	Missing (3)				No (0)			08-31-2020
	Intake			Active (1)	Yes (1)	Missing (3)				No (0)			08-31-2020
	Intake			Active (1)	Yes (1)	Missing (3)				No (0)			08-31-2020

Aunt Bertha: Platform for Identifying Social Needs and referring to local resources

The screenshot shows the TRIP Aunt Bertha platform interface. At the top left is the TRIP logo. At the top right are links for Support, Sign Up, and Log In. The main content area features a heading: "Complete the TRIP needs assessment to identify free or reduced cost services like medical care, food, job training, and more." Below this is a search form with the label "Zip", a text input field containing "90210", and a blue "Search" button with a magnifying glass icon. To the right of the search form is a large TRIP logo. At the bottom of the main content area, a line of text states: "Aunt Bertha is providing valuable support for Navigators and their Patients at all participating TRIP project hospitals". At the very bottom, a small link reads: "By continuing, you agree to the Terms & Privacy".

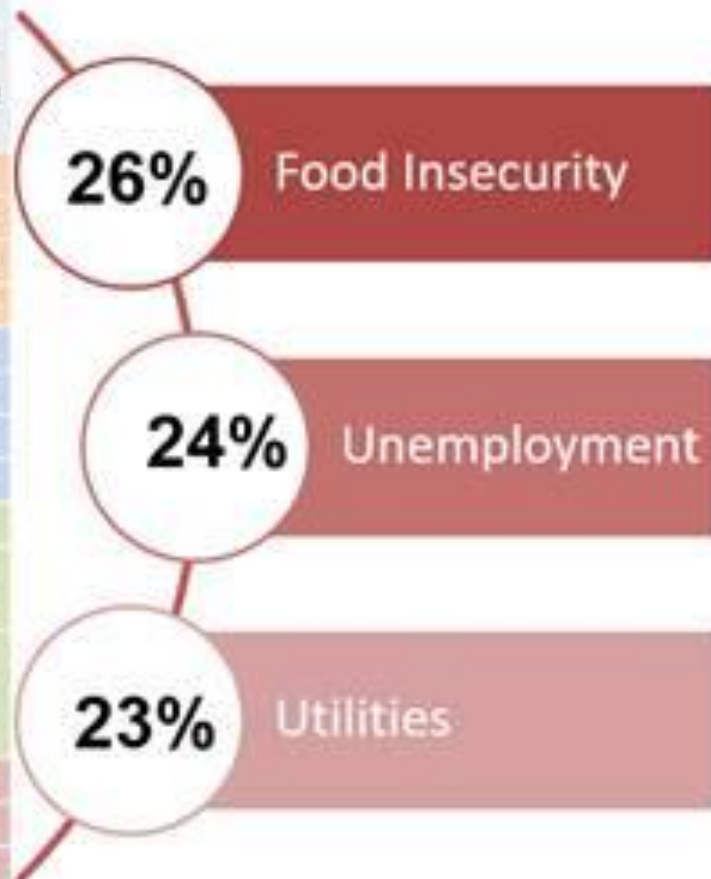
Baseline variability of navigation across practices

	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6
# full-time navigators	0	2	1	2	1	1
Lay or nurse navigator	N/A	Nurse	Lay	Lay	Lay	Lay
Sources of funding for navigators	<ul style="list-style-type: none"> Grants Philanthropy Hospital operating funds 	<ul style="list-style-type: none"> Hospital operating funds 	<ul style="list-style-type: none"> Grants 	<ul style="list-style-type: none"> Hospital Operating Funds 	<ul style="list-style-type: none"> Grants 	<ul style="list-style-type: none"> Grants Philanthropy Hospital operating funds
Department covered	<ul style="list-style-type: none"> Surgery 	<ul style="list-style-type: none"> Surgery 	<ul style="list-style-type: none"> Research/Medical Oncology 	<ul style="list-style-type: none"> Medical Oncology 	<ul style="list-style-type: none"> Medical Oncology 	<ul style="list-style-type: none"> Patient Services
Patient eligibility criteria for navigation services	<ul style="list-style-type: none"> All patients eligible 	<ul style="list-style-type: none"> All patients eligible 	<ul style="list-style-type: none"> Primary language; low SES 	<ul style="list-style-type: none"> All patients eligible 	<ul style="list-style-type: none"> Patients with PCP at affiliated community health center 	<ul style="list-style-type: none"> All patients eligible
System for assigning navigation services	<ul style="list-style-type: none"> Referred by care team Patient request 	<ul style="list-style-type: none"> Navigator review of schedule for newly diagnosed patients 	<ul style="list-style-type: none"> Navigator review of schedule for newly diagnosed patients 	<ul style="list-style-type: none"> Referred by care team 	<ul style="list-style-type: none"> Based on eligibility for clinical trial 	<ul style="list-style-type: none"> Referred by care team Patients with high # missed appointments flagged in EMR

Social Determinants of Health

Social needs among breast cancer patients in the Translating Research into Practice (TRIP) Study

Characteristic	Response	Total eligible TRIP patients (N=161)
Age	<40	15 (9.3%)
	40-54	46 (28.6%)
	55-64	49 (30.4%)
	65 and older	51 (31.7%)
Race/Ethnicity	Hispanic	41 (25.5%)
	Non-Hispanic White	17 (10.6%)
	Non-Hispanic Black	86 (53.3%)
	Non-Hispanic Asian	17 (10.6%)
Insurance	Private/Commercial	40 (24.8%)
	Medicare (including private/Medicare advantage)	29 (18.0%)
	Medicaid (including dual Medicare/Medicaid) or Uninsured	91 (56.5%)
	No needs reported	52 (32.3%)
Number of Social Needs	1	16 (9.9%)
	2	19 (11.8%)
	3+	35 (21.7%)
	Missing**	39 (24.3%)



Source: J. Haas, S. Lemon, K. Freund, T. Battaglia
 Unpublished Data. Do not cite or reproduce.