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POSTER ABSTRACTS

1. ORGANIZE & PRIORITIZE TRENDS TO INFORM KU CANCER CENTER MEMBERS (OPTIK)

The University of Kansas Cancer Center
Dinesh Pal Mudaranthakam

An increasingly diversified demographic landscape in rural America warrants the attention of The University of Kansas Cancer Center (KUCC) researchers, clinicians and administrators as the institution assesses ways to reach its expansive, bi-state catchment area. Although there are multiple sources available to assess the catchment area cancer burden, we lack a source that layers both public health and clinical data sources. A database that functions to Organize and Prioritize Trends to Inform KUCC (OPTIK) has been developed to streamline the process of consolidating data regarding demographics, cancer risk factors, and incidence rates. This data warehouse standardizes sources at the regional level to balance both the specificity of data required to perform predictive analyses while upholding a strict standard of patient privacy. Cancer burden data is categorized by region, part of a larger catchment area composed of the counties KUCC serves, and rural-urban county classification determined by Rural-Urban Continuum Codes (RUCC). Using this knowledge, researchers can model heat maps and create other visualizations that aid in prioritizing action items for their research to most effectively impact the communities within its reach.

2. DEVELOPMENT AND INITIAL VALIDITY OF A NEW MEASURE OF ARAB AMERICAN ETHNIC IDENTITY

ACCESS/University of Michigan Rogel Cancer Center
Asraa Alhawli, Ken Resnicow

Background: Southeast Michigan is home to the second largest Middle Eastern and North African (MENA) U.S. population. There is increasing interest in understanding correlates of health behaviors in this growing population. One potentially important health correlate is Ethnic Identity (EI). This paper reports the development, validity, and initial correlates of a new measure of MENA Identity named the MENA-IM.

Methods: The 20-item MENA-IM assesses: 1) connection to country of origin, 2) desire to preserve and transmit family heritage, 3) centrality of Arab American/Chaldean identity, 4) respect for other cultures, and 5) Arab American media use. We used convenience sampling at locations frequented by individuals of MENA descent. We also measured EI centrality, religiosity, cultural mistrust, substance use, and health status to assess convergent and divergent validity.

Results: We obtained data from 378 adults, 73% of whom identified as Arab and 27% as Chaldean. MENA-IM scores were higher amongst older, lower educated, non-US born respondents, and Arabic speaking respondents. Arab respondents reported significantly higher scores than Chaldeans. MENA-IM scores were positively associated with EI centrality, religiosity, importance of religion, and cultural mistrust. Higher MENA-IM scores were significantly associated with higher odds of past month marijuana and alcohol use. Higher MENA-IM scores were also significantly associated with lower odds of self-reported heart disease and better mental health status.

Discussion: The MENA-IM had high internal consistency and demonstrated convergent and discriminant validity. How the measure performs with MENA populations outside of Michigan, and how it may relate to other health outcomes merits investigation.

3. THE ASSOCIATION OF UNFAIRNESS WITH MENTAL AND PHYSICAL HEALTH IN A MULTI-ETHNIC SAMPLE OF MICHIGAN ADULTS.

ACCESS/University of Michigan Rogel Cancer Center

Ken Resnicow, Minal Patel, Molly Green, Alyssa Smith, Elizabeth Bacon, Stefanie Goodell, Dylan Kilby, Madiha Tariq, Asraa Alhawali, Nadia Syed, Jennifer Griggs, Matthew Stiffler

Introduction: Two psychosocial constructs that have shown consistent associations with health outcomes are discrimination and perceived unfairness. No studies have reported their joint effects. The current analyses report the effects of discrimination and unfairness on medical, psychologic, and behavioral outcomes from a recent cross-sectional survey conducted in a multi-ethnic sample of adults in Michigan.

Methods: Surveys were collected via; 1) Community Settings, 2) Telephone listed sample, and 3) Online panel. Unfairness was assessed with a single-item and everyday discrimination was assessed with the Williams 9-item scale. Outcomes included mental health symptoms, past month cigarette use, past month alcohol use, past month marijuana use, and lifetime pain medication use. Medical history included self-reported; 1) Cancer, 2) Diabetes or high blood sugar, 3) High blood pressure or hypertension, 4) Depression, or 5) Heart condition.

Results: A total of 2,238 usable surveys were collected. In bivariate analyses, higher unfairness values were significantly associated with lower educational attainment, lower age, lower household income, and being unmarried. Highest unfairness values were observed for Black and multiracial respondents followed by Middle Eastern or North African (MENA) participants. Unfairness was significantly related to worse mental health functioning, net adjustment for sociodemographic variables and everyday discrimination. Unfairness was also related to self-reported history of depression and high blood pressure although after including everyday discrimination in the model, only the association with depression remained significant. Unfairness was significantly related to 30-day marijuana use, 30-day cigarette use, and lifetime opiate use. Adding everyday discrimination scores to the model attenuated these effects.

Discussion: Our findings of a generally harmful effect of perceived unfairness on health are consistent with prior studies. Perceived unfairness may be one of the psychologic pathways through which discrimination negatively impacts health. Unfairness should be considered as a potential variable in studies of health and health disparities and may represent a potential intervention target.

4. COMPARING TRUST IN SOURCES OF CANCER HEALTH INFORMATION BETWEEN HISPANICS AND NON-HISPANIC WHITES IN THE SAN DIEGO COUNTY

UC San Diego Moores Cancer Center

Harvey Vu, Corinne McDaniels-Davidson, Priscila Chagolla, Yazmin San Miguel, Jesse Nodora, Sandip Patel, Maria Elena Martinez

Purpose: Receipt and processing of health information by individuals from different racial/ethnic groups is influenced by the degree of trust they have in the source. The purpose of this study was to assess levels of trust in receiving cancer health information and assess differences in these levels between Hispanics and Non-Hispanic Whites (NHW) in San Diego County, a large US-Mexico border county.

Methods: We mailed Spanish and English surveys to a random sample of 4,000 households and an additional 1,000 households in ZIP codes along the US-Mexico border in San Diego County. Surveys included a variety of questions aimed at assessing cancer-related knowledge, attitudes, and behaviors, along with sociodemographic constructs. Among the cancer-related questions were a series of items asking about the level of trust in receiving cancer information from different sources.

Results: Of the 720 surveys returned, 151 (21%) respondents identified as Hispanics and 446 (61.9%) identified as NHW. Differences in responses between Hispanics and NHWs were assessed using chi-square tests. Significantly more NHW reported trusting their doctors "a lot" (75.7%) compared to Hispanic (62%; $p=.001$). Hispanics were more likely than NHW to report "a lot" of trust in insurance companies (6.6% vs 1.6%; $p=0.002$) and in pharmaceutical companies (6.5% vs 2.8%; $p=.041$). Although not significant, a higher proportion of Hispanics responded that they trusted religious organizations and leaders "a lot" (4.4% in Hispanics vs 1.6% in NHW; $p=.058$). There were no significant differences between Hispanics and NHWs in reporting trust in charitable organizations, family or friends, government agencies, or health organizations.

Conclusion: Differences in trust were shown between Hispanics and NHWs. These feelings of trust by Hispanics and NHW should be taken into account when communicating health information to these populations. Fostering trust between these populations and their health information sources is critical to reducing health disparities in cancer screening, diagnosis, treatment, and survivorship.

5. CANCER-RELATED KNOWLEDGE, BELIEFS, AND SCREENING BEHAVIORS IN ADULT OREGON WOMEN

Knight Cancer Institute

Zhenzhen Zhang, Motomi Mori, Paige E. Farris, Devra O'Gara, Kenneth Xu, Jeong Youn Lim, Jackie Shannon

Background: Early detection and screening are proven to decrease cancer incidence and mortality among women. This study evaluates cancer knowledge, beliefs and screening behaviors among Oregon women. Results will guide our programs to increase awareness of cancer prevention and early detection.

Methods: We conducted a health assessment among Oregon adults 18 years old through both probabilistic and non-probabilistic approaches. Demographic and behavior information were collected from a questionnaire. Perceptions about the cause and prevention of cancer (cancer beliefs) were assessed from 5 questions and a composite score was calculated. We asked respondents' feelings and beliefs (4 questions) about their most recent search for health information and a composite score was calculated. Higher total scores were representative of more pro-active beliefs. Weighting methodology was applied in the analyses among probabilistic samples.

Results: There were significant differences in the majority of demographic characteristics (age, race, education, occupation, marital status, etc.) between the probability and non-probability samples, thus only results from the probability sample are reported. Analyses include data from 559 women. Younger age was associated with higher cancer beliefs score, while college graduate and healthy weight were associated with lower cancer belief score. People with health insurance had lower health information search belief score. For the three cancer screening behaviors among age-appropriate women examined: 1) college graduates and those with health insurance were significantly associated with mammogram-screening within 2 years; 2) college graduates and married women were more likely to have colonoscopy within 10 years; 3) women of younger age, college graduation, being employed, and having health insurance were more likely to have a pap test within 3 years. However, cancer beliefs and health information search beliefs were not associated with any of the screening behaviors.

Conclusions: College graduation was the consistent factor associated with Oregon women's screening behaviors.

6. GENDER DIFFERENCE IN CANCER-RELATED KNOWLEDGE, BELIEFS, AND SCREENING BEHAVIORS IN OREGON

Knight Cancer Institute

Zhenzhen Zhang, Motomi Mori, Paige E. Farris, Devra O'Gara, Kenneth Xu, Jeong Youn Lim, Jackie Shannon

Background: Gender differences in cancer susceptibility have been consistently reported in the literature. While hormone differences are often pointed to as the primary explanatory factor, gender differences in cancer prevention knowledge and behaviors may play a role as well. The present study examines, gender differences in cancer knowledge, perception and beliefs of cancer risks, and cancer-screening and health behaviors.

Methods: We used data collected from the Understanding Cancer in Oregon (UCanOR) project, a 47 item cross-sectional survey including measures of demographic and behavior information. The questionnaires were administered to participants randomly selected from the population through an area-based sampling strategy (N=777), and participants recruited from social media and community events (N=686). Using randomly selected participants' data, we conducted weighted multivariable linear regression and logistic regression to assess gender differences for multiple outcomes (screening knowledge/ behaviors, cancer perception/ beliefs) adjusting for confounding factors (age, race, education, marital status, BMI, cancer history, insurance status). Cancer beliefs was included in models for various behaviors.

Results: 72% of survey respondents were female (n=559). Women respondents were younger, more likely to be married, have a healthy weight and less likely to have a cancer history. In the adjusted weighted analysis, women were more likely to seek health information, have correct knowledge about mammogram-screening starting age, have colonoscopy within 10 years among 50 years old, have heard of HPV, not want to know their chance of getting cancer, and less likely to ever smoke 100 cigarettes. Men and women were equally likely to have correct knowledge on colonoscopy screening starting age, similar confidence level about health information search and cancer belief, and E-cigarette use.

Conclusions: Men and women show some differences in their cancer-screening knowledge and health-related behaviors, which may have implications when designing interventions aimed at promoting healthy cancer prevention behaviors and education among men.

7. CHARACTERIZING THE CANCER BURDEN OF ORANGE COUNTY, CA

Chao Family Comprehensive Cancer Center

Cevadne Lee, Jenny Chang, Argyrios Ziogas, Kiran Clair, Sora Park Tanjasiri

Orange County (OC) is the third-largest and second most densely populated county in California, and the primary catchment area for the University of California, Irvine's Chao Family Comprehensive Cancer Center (CFCCC). OC is home to 3.2 million people living in 44 cities and towns; 42% are non-Hispanic white, 34% Hispanic/Latino, 19.2% Asian American, 1.6% Black, and 3.3% mixed/other. Cancer is the second cause of death overall, but the leading cause for women, Hispanics/Latinos, and Asian Americans. Male incidence rates in OC are higher than the state average for cancers of the pancreas, skin (excluding basal squamous), melanoma, while female incidence rates are higher for skin, melanoma, and breast. Compared to the county average, White males experience higher incidence of cancers of the skin, melanoma, prostate, testis, and non-Hodgkin lymphoma; White females experience higher cancers of the lung/bronchus, skin, melanoma, and breast; Latino males experience higher incidence of liver cancer; and Latino females, Asian American and Pacific Islander males and females experience higher incidence of liver and stomach cancers (California Cancer Registry, 2019). We know that despite decades of focused research in cancer control, cancer health disparities remain for ethnic/racial populations and people with disabilities, who live in rural areas, and/or who have lower education and economic resources. In OC, the cities of Anaheim, Garden Grove, and Santa Ana represent over 25% of the total county population and have worse proportions of poverty, uninsured, educational attainment, poor health, smokers, obesity, physical inactivity and food insecurity compared to county averages (CHIS, 2014). Since launching CFCCC's Office of Community Outreach and Engagement in August 2018, our staff have undertaken an in-depth catchment area analysis and focused on strengthening the infrastructure of community partners to meet the prevalent and unique cancer needs of our communities.

8. DIFFERENCES IN RESPONDENTS REPORTING CANCER DIAGNOSIS IN VIRGINIA: PRELIMINARY RESULTS OF A MIXED PROBABILITY, MULTI-FRAME, MULTI-MODE SURVEY

University of Virginia Cancer Center

Rajesh Balkrishnan, Noelle Voges, Raj Desai, George Batten, Lindsay Hauser, Bryan Price, Wendy Cohn, Betsy Grossman, Kara S. Fitzgibbon, Hexuan Zhang, Thomas M. Guterbock, Roger T. Anderson

The UVA Cancer Center collected survey data on the health behaviors and beliefs of residents in its catchment area. UVA's catchment area spans parts of both Virginia and West Virginia, and it is among the most rural of all the NCI-designated centers. Multiple approaches including probability and non-probability sampling and adaptive design allowed surveys to be collected from residents throughout this economically, racially, and geographically diverse area. The multi-mode design incorporated paper, phone, web (including social media), and in-person interviews. A total of 1407 analyzable surveys (25% response rate) were collected with 52% web responses and 46% paper responses. Most of the sample demographics matched the catchment area with a higher percentage of white younger highly educated, married, employed patients responding. 90% of the sample was from Virginia, 95% had health care insurance of some type, most reporting to be in good or better health and having good or better quality of life. About a third of the sample smoked and about three quarters did some type of exercise. Approximately 15% of the surveyed subjects reported having ever received a cancer diagnosis. Compared to patients without cancer diagnosis, those reporting the diagnosis were significantly older, married, disabled and/or retired, and have health insurance (all $p < 0.05$). Additionally, respondents with cancer diagnosis were also more likely to have ever smoked and less likely to exercise ($p < 0.05$), although no significant differences in health status were detected. Our findings indicate that there is a significant burden of cancer in our catchment area with clear differences in respondents reporting cancer diagnosis that require further examination. Further analyses using population weights and pooling data from other survey centers will enhance our understanding of the burden of cancer in our region.

9. URBAN-RURAL DIFFERENCES IN CANCER KNOWLEDGE, BELIEFS AND PRACTICES ACROSS THE STATE OF ALABAMA

O'Neal Comprehensive Cancer Center

Salma Aly, Sejong Bae, Mona Fouad, Casey Daniel, Isabel Scarinci, Teri Hoenemeyer, Claudia Hardy, Monica Baskin, Cynthia Johnson, Cynthia Bowen, Aras Acemgil, Wendy Demark-Wahnefried

Background: Like many states in the Deep South, Alabama is largely rural. Previous studies suggest that cancer-related knowledge, beliefs, and preventive practices differ between urban versus rural populations. We undertook a cross-sectional survey among Alabamians to explore if such differences exist.

Methods: Using population-based methods, we approached 5,633 Alabamians to complete a 58-item survey (administered in-person, via telephone or the web). A 15.2% response rate was achieved, of which 178 respondents were considered urban and 660 were rural. Responses between urban-rural groups were compared using 2-tailed chi-square and t-tests (\$75K/year), employment (47% vs. 30%), and internet access (74.6% vs. 62.2%). Urban respondents were significantly less likely to endorse fatalistic belief statements (e.g., It seems like everything causes cancer) and the role of family history in portending cancer risk (42.3% vs. 53.5%), but perceived that they were more likely to develop cancer in their lifetime compared to rural counterparts (31.9% vs. 24.1%; $p=0.016$). No significant between-group differences were noted in body weight, sugar-sweetened beverage consumption, physical activity, tobacco use, or screening practices, though high need was noted in both populations, i.e., 77% overweight/obese, average 2/day sugar-sweetened beverages, 59% insufficiently active, 33% current smokers, and <20% of the eligible population up-to-date on cancer screening practices. Urban versus rural respondents also were significantly more likely to endorse raising the statewide tobacco tax (66.1% vs. 55.6%; $p=0.029$).

Conclusions: Despite more fatalistic cancer beliefs, rural respondents did not differ from urban respondents in preventive behaviors and screening practices, perhaps due to lower perceived susceptibility and education. However, the population of Alabama was generally non-adherent to guidelines for cancer prevention and early detection.

10. PRELIMINARY RESULTS FROM THE HERBERT IRVING COMPREHENSIVE CANCER CENTER COMMUNITY CANCER NEEDS ASSESSMENT

Herbert Irving Comprehensive Cancer Center

Grace Clarke Hillyer, Karen M. Schmitt, Meaghan Nazareth, Arahna Agarwal, Kimberly Burke, Mary Beth Terry

Monitoring cancer risk factors in the local communities is critical in planning cancer prevention and health education programs. To augment health data collected city- and state-wide, we conducted a cross-sectional community cancer needs assessment in 2019. We surveyed 1270 adults: 707 (55.7%) diagnosed and treated for cancer at the Herbert Irving Comprehensive Cancer Center; 315 (24.8%) receiving primary care at the New York Presbyterian Hospital Ambulatory Care Network; and 248 (19.5%) residents of the communities within our catchment area. Most participants were racial/ethnic minorities (other than non-Hispanic White); 96.0%, 87.3%, and 50.9% minority in the community, primary care, and cancer patient populations, respectively. Here we examined interest in learning personal genetic information, awareness of and participation in medical research/clinical trials and use of e-cigarettes/e-hookah/e-vaporizers and alternative tobacco products. Primary care patients followed by cancer patients more often than community participants stated that, if offered a blood test to learn their personal genetic information, they would have that test (78.7% and 70.9%, respectively vs. 63.3%, $p=0.006$). Compared to the community participants, cancer and primary care patients more often reported having heard of a clinical trial (78.9% and 69.5% vs. 39.1%, $p<0.001$) and ever participated in medical research/clinical trial (43.9% and 42.9% vs. 27.8%, $p=0.005$). Current study/trial participation did not vary between groups ($p=0.34$). Reported use of e-cigarettes was highest among primary care patients (21.9%), compared to 7.5% among cancer patients and 10.1% in the community ($p<0.001$) and particularly high in the 25-40 year age group (56.5%). Our findings indicate that most participants are very interested in learning their personal genetic information. Findings also suggest that greater educational efforts are needed to increase awareness of clinical trials and research to improve enrollment rates and that campaigns and interventions to reduce use of e-cigarettes and alternative tobacco products are essential.

11. PREDICTORS OF CANCER-RELATED HEALTH BEHAVIORS AND ATTITUDES AMONG THE POPULATIONS IN THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER (OSUCCC) CATCHMENT AREA

The Ohio State University Comprehensive Cancer Center

Electra D. Paskett, Gregory S. Young, Brittany M. Bernardo, Chasity M. Washington, Cecilia R. DeGraffinreid, James L. Fisher, Timothy R. Huerta

The OSUCCC catchment area (CA) has a variety of populations including whites, minorities (African American, Hispanic, Somali, and Asian), urban, rural and Appalachian. A CA-wide survey was conducted between 2017 to 2018 with 1005 respondents to identify differences in cancer-related behaviors and attitudes by residence and race. This information will complement information about cancer incidence and mortality within these population groups in the CA. Minorities were recruited through community organizations and snowball strategies while urban and rural whites and Appalachians were recruited through commercial lists. Comparisons were made using multiple logistic regression analysis among whites comparing Appalachian, urban and rural residents and among whites vs minorities for health behaviors (physical activity; dentist visit; Hepatitis B vaccination; overweight/obese; poor diet; ever smoked), and attitudes (cancer caused by lifestyle or behavior; cancer is fatal; age to start CRC screening; causes/risk/recommendations for preventing cancer; within guidelines for colon and breast screening). Results indicated that: 1) no differences were noted by residence for health behaviors or attitudes among the white participants; 2) among racial/ethnic groups, significant differences were observed for physical activity (Hispanics less likely), overweight/obese (African American more likely; Asian less likely), ever smoked (Hispanic, Somali, Asian less likely) compared to whites; 3) for attitudes, significant differences were noted across all variables except things to do to reduce risk of cancer, with mostly minorities less likely to have positive attitudes and correct knowledge related to cancer. Within the OSUCCC CA the many different populations have different cancer risk and also different cancer-related behaviors and attitudes. This information can help researchers better target both educational effort through Community Outreach and Engagement as well as research to improve the risk for developing and dying from cancer in all population groups, with attention to individual group-specific barriers to prevention.

12. THE NATIONAL OUTREACH NETWORK COMMUNITY HEALTH EDUCATOR (NON-CHE) PROGRAM AT USC NORRIS COMPREHENSIVE CANCER CENTER: ADDRESSING THE CANCER-RELEVANT NEEDS OF LATINOS AND INDIGENOUS GROUPS IN LOS ANGELES COUNTY

USC Norris Comprehensive Cancer Center

Lourdes Baezconde-Garbanati, Juan Carmen, Carolina Aristizabal, Rosa Barahona, Caryn Lerman

Introduction: Cervical cancer rates are disproportionately higher for Hispanic/Latinas and indigenous women from Latin America (Amerindians: Mayans, Mixtecs, Zapotecs, Nahua-Pipil) in Los Angeles County (LAC). However, the Human papilloma virus (HPV) vaccination and early screening can reduce the incidence of cervical and other types of HPV-related cancers. Latinas and indigenous women face greater disparities due to socioeconomic status, language, culture, education, and lack of access to care. They also have a lower prevalence of vaccination and higher morbidity and mortality rates of cervical cancer. Cervical cancer rates for Latinas is double than for Non-Hispanic Whites, 14.3% versus 7.5% respectively in LAC. The NON-CHE at USC NCCC focuses on a culturally and storytelling-based approach to increase HPV awareness and vaccination uptake, increasing cervical cancer screenings, and addressing barriers towards participation in clinical trials (CT) in underrepresented communities. Methods: To address these disparities, the NON-CHE conducts outreach, culturally responsive education and engagement in LAC, the catchment area of the NCCC. A series of interactive small community research meetings deliver information and monitor activities. Two signature programs of the NCCC are used for educational purposes, Es Tempo and Tamale Lesson, among other interventions based on the National Cancer Institute approved materials. Health education workshops on HPV and CT are delivered and their effectiveness assessed through pre-and post-test surveys at 3-months and 6-months following attendance. Educational materials are developed and culturally adapted to convey messages in Spanish and indigenous languages, as needed, using infographics and presentations. Results: 25 total monthly outreach activities were conducted with Latino and other populations sharing information on cancer related programs and CT at NCCC in CY2019. Conclusion: Increasing access to information on HPV, cervical cancer, and clinical trials may be more effective when culture, language, and systemic barriers affecting the underserved communities in the catchment area are considered.

13. DEFINING AND DESCRIBING THE LOS ANGELES COUNTY CATCHMENT AREA POPULATIONS OF THE USC NORRIS COMPREHENSIVE CANCER CENTER

USC Norris Comprehensive Cancer Center

Lourdes Baezconde-Garbanati, Mariana C. Stern, Dennise Deapen, Myles Cockburn, Carolina Aristizabal, Rosa Barahona, Caryn Lerman

Los Angeles County (LAC), the catchment area for the USC Norris Comprehensive Cancer Center (NCCC), has a population of 10.2 million people spread out over 4,751 square miles. If it were a state it would be the ninth largest state population-wise. This population is also extremely diverse, experiencing large cancer disparities. Hispanic/Latinos represent 47%, followed by Whites (30%), Asian/Pacific Islanders (17%), Blacks (7%), and a small percentage of Native Americans and of mixed ethnicity. LAC holds the largest population of Koreans outside the Korean peninsula, and the 7th largest African American population in the country. To define our catchment area, we identified all new analytic cases at the NCCC in 2018 and determined that 84% were LAC residents. To describe our catchment area, we engaged the leadership of NCCC as well as our Community Advisory Committee to examine demographic data from the U.S. Census, the LAC Cancer Surveillance Program, (a Surveillance Epidemiology and End Results program registry). We determined that breast, prostate, lung, and colorectal cancer are the top four incident cancers in our catchment area; and show disparities in incidence and/or mortality among minority populations: Blacks have higher incidence and mortality of lung, prostate cancer and colorectal cancer, and higher mortality of breast cancer. In addition, we identified three cancers that are of specific relevance for our catchment area given their burden on specific populations: liver cancer among Asians and Latinos; acute lymphoblastic leukemia among Latinos; and stomach cancer among Asians, specially Koreans, and Latinos. We worked with the Health Care system in a community needs assessment and an environmental scan, and identified variability in major cancer risk behaviors, setting as priorities tobacco use, obesity and cervical cancer screening. We have developed a strategic plan to be implemented by NCCC to address the needs identified in our catchment area.

14. LUCHA: A LATINO FOCUSED OUTREACH EFFORT TO INCLUDE A GREATER PERCENTAGE OF HISPANIC/LATINOS IN THE UC DAVIS COMPREHENSIVE CANCER CENTER'S 2019 CATCHMENT AREA POPULATION ASSESSMENT (CAPA)

UC Davis Comprehensive Cancer Center

Luis Carvajal-Carmona, Angelica Perez, Fabian Perez, Paul Lott, Elizabeth Quino, Michael Nguyen, April Vang, Alexa Morales Arana

Background: A Latino focused outreach effort was piloted at the UC Davis Comprehensive Cancer Center's 19-county catchment area to engage more Latino communities in the Catchment Area Population Assessment. Methods: Our primary collection method was a community based, in-person and web-based survey from Latino dense communities in Northern and Central California. Survey questions were selected from a standardized list developed by other NCI-designated cancer centers. Surveys were written in English and Spanish, and were administered in-person and read aloud to participants who could not read or write. Our surveys were primarily administered at community events with local partners, such as health fairs, cultural gatherings, support groups, and community clinics with the purpose of reaching people where they are. Results: We received responses from 14 out of the 19 counties in our target area. The response rate was approximately 25% (n=218), 63% of which were collected in Spanish. Of all respondents, 89% were of Mexican descent with a median age of 43. Compared to UC Davis Comprehensive Cancer Center CAPA, we found racial/ethnic and geographic differences in cancer risk factors. The results showed a high rate of compliance for mammogram and cervical cancer screenings compared to low rates among men in colorectal cancer screenings. Despite the fact that Latinos are less often diagnosed with cancer, cancer continues to be a main concern for all of our respondents. Conclusion: By using a culturally competent survey administered by bicultural research staff, community members were more willing to provide health information to the research team. The Latino CAPA findings are helping our research team prioritize and plan cancer preventative topics and geographical locations for future interventions.

15. FINANCIAL HARDSHIP OR SOCIOECONOMIC STATUS: WHICH IS MORE IMPORTANT FOR UPTAKE OF CANCER SCREENINGS?

Indiana University Melvin and Bren Simon Cancer Center

Monica L. Kasting, David A. Haggstrom, Joy Lee, Stephanie Dickinson, Susan M. Rawl

Background: Research suggests traditional measures of socioeconomic status (SES) do not fully explain patients' cancer screening behavior. This study examined associations between financial hardship and cancer screening in Indiana.

Methods: Surveys were mailed to 7,979 people ages 18-75 who were seen in the statewide health system and lived in counties with higher than average cancer mortality. Participants reported feelings about their finances and whether they had needed to see a doctor in the past year, but could not due to cost. This was compared to uptake of mammogram, colonoscopy/sigmoidoscopy, and Pap testing in separate best fit multivariable logistic regression analyses controlling for demographic and healthcare characteristics among eligible patients.

Results: 970 surveys were returned, with 52% female respondents, 75% non-Hispanic White, and 76% over age 50. One-fourth were finding life difficult on present income. 15% reported they had not been able to see a doctor due to cost, and this barrier was higher among Black than White participants (24% vs. 13%; $p=0.001$). In a best fit regression model for colonoscopy/sigmoidoscopy, those who reported they did not have to forego medical care due to cost had higher odds of screening compared to those who did (aOR=2.21; 95%CI= 1.19-4.10). The only other variables significant in the model were higher income (aOR=16.19; 95%CI=3.46-75.71), and occupational status (aOR=2.12; 95%CI=1.14-4.19). Financial hardship was not significantly associated with Pap testing, but not having health insurance was (aOR=0.15; 95%CI=0.04-0.53). For mammogram, not foregoing medical care due to cost remained in the model, but was not statistically significant (aOR=2.43; 95%CI=0.94-6.24).

Conclusions: Associations between financial hardship and cancer screening suggest the need to reduce barriers to cancer screening even among patients who already have accessed healthcare in the past year. Future research should explore barriers related to both healthcare (e.g., co-pays) and personal costs (e.g., time off work).

16. TARGETED OUTREACH TO INCLUDE RACIAL/ETHNIC POPULATIONS IN UC DAVIS COMPREHENSIVE CANCER CENTER'S 2019 CATCHMENT AREA POPULATION ASSESSMENT

UC Davis Comprehensive Cancer Center

Julie Dang, Luis Carvajal-Carmona, Angelica Perez, Fabian Perez, Ulissa K. Smith, Alexa Morales Arana, Elizabeth Quino, April Vang, George Tong Yang, Moon S. Chen Jr.

Background: In 2019 we conducted a Catchment Area Population Assessment (CAPA) to characterize the cancer burden of the University of California, Davis Comprehensive Cancer Center's (UCDCCC) 19-county catchment (inland northern California approximating the size of West Virginia).

Methods: Two methods were used: 1) address-based sampling by mail surveys based on a representative sample of US Postal addresses and 2) a supplementary community based, in-person and web-based survey from underrepresented populations (Hispanic and Asian American). Survey items were selected from a standardized list developed by other NCI-designated cancer centers. Surveys were translated into Spanish, and administered verbally for those (e.g., Chinese, Hmong, Spanish, Vietnamese) who could not read English or Spanish. For the supplementary community-based surveys, staff worked with community partners and harnessed social networks to recruit individuals who are not usually reached through mailed surveys.

Results: We received responses from all catchment counties. The sample of 1,207 respondents were White (46.7%), African American (4.4%), Hispanic (25.8%), Asian (21.1%), American Indian/Alaskan Native (1.9%). Seventy residents from rural counties (RUCC code greater than 4) responded. We found racial/ethnic and geographic differences in cancer risk factors as well as differences in attitudes, beliefs and health seeking behaviors. Most respondents from the mailed survey were White, thus the inclusion of the supplementary community-based surveys resulted in an overall majority of minority respondents, reflecting catchment area demographics. The majority of the in-person community-based surveys were completed verbally in-language.

Conclusion: By using both address-based and supplemental surveys, CAPA was able to be more inclusive of the catchment area's racial/ethnic diversity and included over-sampling of some groups. The use of the supplementary community-based surveys enhanced the generalizability of our assessment by ensuring that English limited individuals were included in our sample. Findings are informing UCDCCC's Community Outreach and Engagement priorities and directions.

17. ASSOCIATIONS BETWEEN MARITAL STATUS AND COLONOSCOPY SCREENING BEHAVIOR AMONG OREGON ADULTS OVER AGE 50

Knight Cancer Institute

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Background: Previous studies have suggested that social support related to marital status can significantly affect cancer detection, treatment and survival. Marriage may also impact these outcomes through differences in cancer-related knowledge, and screening behaviors. The present study examines the differences in colorectal cancer knowledge and screening behaviors by marital status in the state of Oregon.

Methods: Data was collected from the cross-sectional "Understanding Cancer in Oregon" project. The project collected demographic and behavior information from a constructed questionnaire. Participants were randomly selected from the Oregon population through an area-based sampling strategy as well as from social media and community events. Using area based sample data, weighted logistic regression was conducted to assess marital status differences for multiple outcomes adjusting for confounding factors.

Results: 57% of respondents were over the age of 50 (N = 443). The majority respondents were female (N = 304, 69%), non-Hispanic white (N = 425, 96%), and college graduates (N = 263, 59%). Among respondents over the age of 50, 61.9% were married/living as married (N = 274), 31.4% were divorced/widowed/separated (N = 139), and 6.7% were never married (N = 30). In adjusted weighted analysis, adults over age 50 who were married/living as married were more likely to have had a colonoscopy within 10 years compared to those who have never been married. However, there were no significant differences in colorectal screening knowledge between married/living as married, divorced/widowed/separated, and never married adults over 50.

Conclusions: Among Oregon adults over 50 years old, married/living as married individuals were more likely to have a colonoscopy screening in the previous 10 years compared to those never married; divorced/widowed/separated individuals had similar likelihood of colonoscopy screening behavior to never married individuals. This supports the idea that marriage may confer positive benefits for cancer-prevention, specifically with regards to screening behavior.

18. THREE LARGE SCALE SURVEYS HIGHLIGHT THE COMPLEXITY OF CERVICAL CANCER UNDER-SCREENING AMONG WOMEN 45-65 YEARS OF AGE IN THE UNITED STATES

University of Michigan Rogel Cancer Center

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Background: Large scale United States (US) surveys guide efforts to maximize the health of its population. Cervical cancer screening is an effective preventive measure with a consistent question format among surveys. The aim of this study is to describe the predictors of cervical cancer screening in older women as reported by three national surveys.

Methods: The Behavioral Risk Factor Surveillance System (BRFSS 2016), the Health Information National Trends Survey (HINTS 2017), and the Health Center Patient Survey (HCPS 2014) were analyzed with univariate and multivariate analyses. We defined the cohort as women, without hysterectomy, who were 45-65 years old. The primary outcome was cytology within the last 3 years.

Results: Overall, Pap screening rates were 71% (BRFSS), 79% (HINTS) and 66% (HCPS), among 41,657, 740 and 1571 women, respectively. BRFSS showed that women 60-64years old (aPR=0.88, 95% CI: 0.85, 0.91), and in rural locations (aPR=0.95, 95% CI: 0.92, 0.98) were significantly less likely to report cervical cancer screening than women 45-49-years old or in urban locations. Compared to less than high school, women with more education reported more screening (aPR=1.20, 95% CI: 1.13, 1.28), and those with insurance had higher screening rates than the uninsured (aPR=1.47, 95% CI: 1.33, 1.62). HINTS and HCPS also showed these trends.

Conclusions: All three surveys show that cervical cancer screening rates in women 45-65 years are insufficient to reduce cervical cancer incidence. Insurance is the major positive predictor of screening, followed by younger age and more education. Race/ethnicity are variable predictors depending on the survey.

19. AN EXAMINATION OF CAUSAL ATTRIBUTIONS OF CANCER FROM A POPULATION HEALTH ASSESSMENT

Massey Cancer Center

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Purpose: To determine factors associated with causal attributions of cancer among adults within the Virginia Commonwealth University Massey Cancer Center catchment area.

Methods: Data were obtained from a cross-sectional survey of 559 respondents of the Together for Health–Virginia Study, a population-based sample of adults. Individual-level factors including demographic (age, gender, race/ethnicity, rural identity) and socioeconomic (education, income) characteristics were assessed, as well as lifestyle (tobacco use, body mass index), medical history (family or personal history of cancer), delay discounting, and individuals' attitudes towards alternative therapies. Attitudes towards cancer were measured by eight items reported on a 4-point Likert scale (strongly agree to strongly disagree). The first four items reflected participants' agreement on the following as causes of cancer: behavior, tobacco, obesity, and HPV. The other four items included statements that reflected fatalism about cancer (e.g. everything causes cancer, there's not much you can do to lower your chances of getting cancer). Structural equation models were run separately for each type of belief modeled as a latent dependent variable.

Results: Respondents were 55.6 years (SD=15.8) on average, 72.6% White, 51.6% female, and 38.3% self-reported rural identity. Fatalistic beliefs about cancer was associated with rural identity ($\beta=0.1$, $p=0.02$) and believing in alternative therapies as a primary cancer treatment ($\beta=0.1$, $p=0.03$) while older age ($\beta=-0.3$, $p<0.01$), higher levels of education attainment ($\beta=-0.2$, $p<0.01$), and having a personal history of cancer ($\beta=-0.2$, $p<0.01$) were significantly associated with lower fatalism. Stronger beliefs in concrete causes of cancer were associated with higher educational attainment ($\beta=0.2$, $p<0.01$) and income levels ($\beta=0.2$, $p=0.01$). These beliefs were lower among Black respondents ($\beta=-0.2$, $p=0.02$).

Conclusions: This study provides evidence for the relationship between causal attributions of cancer and individual factors, emphasizing the role that culture may play. Future implementation research is needed to culturally adapt prevention efforts and cancer awareness messaging and campaigns using causal attributions of cancer.

20. CHALLENGES OF SAMPLING FOR CATCHMENT CANCER NEEDS ASSESSMENT

The Tisch Cancer Institute at Mount Sinai—Icahn School of Medicine at Mount Sinai

Rhaisili Rosario, Victoria Berges, Geetanjali Kamath, Lina Jandorf, Kezhen Fei, Nina A. Bickell

Purpose: To compare cancer screening rates via convenience community and random sampling from an academic medical center's data warehouse (DW), compared with random digit dialing.

Methods: We compared demographics & screening rates from NYC BRFSS for our Harlem catchment area, to data collected from random sampling from a medical center's DW and community convenience sampling recruited from community & faith-based organizations, public housing, people on the street and attending neighborhood events. We oversampled from Harlem to identify potential areas of need and focus for future research, outreach & intervention.

Results: We surveyed 1202 residents of our catchment area; 598 (50%) randomly chosen from the hospital's 2018 DW and 604 (50%) from the community. See table below for racial distribution & rates of breast, colorectal (CRC) & lung cancer screening. Randomly sampled DW reflected NYC racial distribution; community oversampling did not. Community convenience sampling reflected NYC rates of breast & colorectal cancer screening. Random sampling of hospital patients reflected NYC rates for breast cancer screening, but did not reflect NYC CRC rates. Lung cancer screening rates were significantly higher in the DW and Community than NYC. Data Warehouse Community NYC p Race 30 pk yr smokers 55-79yr) 36% 29% 4% 0.0003*** %p: comparison between DW & Community; *p: comparison between Community & NYC; **p: comparison between DW & NYC.

Conclusions: For cancer screening, community sampling may be more representative of the challenges Community Outreach & Engagement programs face and can inform future directions for community based research, education, outreach and intervention.

21. OPIATES FOR CANCER PAIN IN HARLEM

The Tisch Cancer Institute at Mount Sinai—Icahn School of Medicine at Mount Sinai
Rhaisili Rosario, Victoria Berges, Geetanjali Kamath, Kezhen Fei, Lina Jandorf, Nina A. Bickell

Purpose: To determine whether national trends to restrict opiate prescribing impact cancer patients' access to opiates.

Methods: We surveyed residents from Central Harlem (CH) (n=480) and East Harlem (EH) (n=498), predominantly minority and poor neighborhoods and the Upper East Side (UES) (n=224), a predominantly white and wealthy neighborhood. Half our cohort (n=598) were randomly sampled from an academic medical center's data warehouse; 18% had a cancer diagnosis. Half (n=604) were recruited from the community; 10% had a cancer diagnosis. We recruited via street fairs (23%), friends or family (23%), flyers posted in the neighborhood (18%), public housing (12%), community-based organizations (9%), the street (8%), faith-based organizations (8%) & senior centers (6%). We compared residents' reports of ease of availability of prescribed opiate medication for cancer patients' pain.

Results: Among 1202 respondents, 10% (114/1173) reported personally needing or knowing someone with cancer who needed opiates for cancer pain relief, 19% of whom had a personal history of cancer. Rate of prior history of cancer differed by neighborhood (CH: 10%, EH, 13%, UES: 23%, $p<.0001$), and by race (B: 10%, H: 11%, W: 22%, $p<.0001$). Among people who ever had cancer (N=37), 26% experienced pain caused by cancer and of these, 36% (5/14) who had cancer pain reported difficulty getting opiates for cancer pain. Of those knowing someone with cancer pain, 39% of residents in CH ($p=0.05$) and 29% of East Harlem ($p=0.2$) as compared to 14% of UES reported that it was hard to obtain opiate medication. There was no racial difference in difficulty obtaining the medication (B=33%; H= 33%; W=14%; $p=0.24$).

Conclusion: In the nearly 2 decades since disparities in availability of opiates in NYC pharmacies were described, we find little has changed. Access to opiates for cancer patients in poorer predominantly minority neighborhoods appears to remain significantly lower than in a wealthier, predominantly white neighborhood.

22. THE WINDS OF CHANGE – WHAT'S HAPPENING WITH PROSTATE CANCER SCREENING IN HIGH PROSTATE CANCER RISK COMMUNITIES?

The Tisch Cancer Institute at Mount Sinai—Icahn School of Medicine at Mount Sinai
Rhaisili Rosario, Victoria Berges, Geetanjali Kamath, Kezhen Fei, Lina Jandorf, Nina A. Bickell

Purpose: With US Preventive Task Force prostate cancer (PCa) guideline changes & uncertainty as to what to do, we describe current experience with PCa screening practices in 3 neighborhoods with 1 high & 2 low rates of PCa.

Methods: We surveyed residents from Central Harlem (CH) (n=480) and East Harlem (EH) (n=498), predominantly minority & poor neighborhoods & the Upper East Side (UES) (n=224), a predominantly white and wealthy neighborhood. Half our cohort (n=598) were randomly sampled from an academic medical center's data warehouse. We asked men >40 years old, to capture those with a family history who might need to screen at a younger age, if a provider ever talked with them about the pros and cons of PSA screening. We compared rates of discussion of PSA testing by race, neighborhood, family history (FH) and access barriers (having a usual site of care for routine care; insurance) and modeled significant bivariate risk factors.

Results: 189 men ages 40-69 responded of whom 22% were white (W,) 44% black (B) & 34% Hispanic (H). 18% had a + FH with no racial difference (22%W,13%B, 22%H; $p=0.326$). Overall, 58% (62/106) of men ages 55-69 had a PSA discussion with their provider, no different than the 56% of those with a positive family history. 72% of men who have a usual place for routine care report a discussion compared with 20% of those without ($p<0.0002$). Similarly, 66% of men with insurance report PSA discussion compared with 27% of uninsured men ($p=0.02$). Multivariate model ($c=.69$; $p=0.004$) found that lack of a regular care site (OR=0.12; 95%CI: 0.03-0.47) and lack of insurance (OR=0.22; 95%CI: 0.05-0.99) reduced likelihood of a PCa screening discussion; having a positive family history did not increase the chance of discussion (OR=1.14; 95%CI: 0.37-3.54). Neighborhood and race were not significant and dropped from the model.

Conclusions: Since the 2012 USPTF change in PCa screening guidelines, there is no difference in rates of discussion about PSA screening in neighborhoods with vastly different rates of prostate cancer incidence. We must increase efforts to address PCA screening among high risk men.

23. CANCER RISK BEHAVIORS, CANCER BELIEFS AND HEALTH INFORMATION SEEKING IN A MULTIETHNIC UNDERREPRESENTED POPULATION: DIFFERENCES BY SEXUAL ORIENTATION AND GENDER IDENTITY

UCSF Helen Diller Family Comprehensive Cancer Center

Eduardo J. Santiago-Rodriguez, Natalie A. Rivadeneira, Urmimala Sarkar, Robert A. Hiatt

Introduction: Compared to the general population, sexual and gender minorities (SGM) are at increased risk of some types of cancer, in part due to engagement in high risk behaviors and lack of adequate preventive care. Understanding how SGM perceive cancer risk and their practices and preferences for accessing health information is key for improving the preventive and healthcare services they receive.

Methods: In this cross-sectional study we analyzed data of the San Francisco Health Information National Trends Survey (SF-HINTS). SGM were identified by self-report. Differences in cancer risk factors and cancer beliefs as well as health information seeking behaviors and preferences were evaluated by sexual orientation and gender identity (SOGI) using multivariable logistic regression models.

Results: Out of 1027 participants, 130 (13%) reported being SGM. In multivariable models adjusting for age, sex at birth, education and race/ethnicity current smoking was more common in SGM than non-SGM respondents (OR=1.62, 95% CI=1.03, 2.54). Overall, the preferred source of health information was internet and the preferred method for exchanging health information was email. No differences in health information seeking behaviors, preferences and cancer beliefs were observed by SGM status. However, SGM reported significantly higher odds of feeling frustrated during the most recent health information search (OR=1.71, 95% CI=1.14, 2.56).

Conclusions: In this diverse urban population, consistent with previous studies, SGM were more likely to be current smokers. No differences in preferences for accessing and exchanging health information were reported by SGM status. The drivers of increased feelings of frustration while seeking health information and its implications for SGM health and care merit further evaluation. Also, tobacco cessation interventions should be promoted in this community.

24. PROJECT PLACE: A COMMUNITY AND ACADEMIC PARTNERSHIP TO ADVANCE HEALTH EQUITY

Duke Cancer Institute

Nadine J. Barrett, Laura Fish, Kearston Ingraham, Steven Patierno

Achieving cancer health equity is a national imperative. Cancer is the 2nd leading cause of death in the United States and in North Carolina (NC), where the disease disproportionately impacts traditionally underrepresented race and ethnic groups, those who live in rural communities, the impoverished, and medically disenfranchised and/or health-disparate populations at high-risk for cancer. These populations have worse cancer outcomes and are less likely to be participants in clinical research and trials. It is critical for cancer centers and other academic health centers to understand the factors that contribute to poor cancer outcomes, the extent to which they impact the cancer burden, and develop effective interventions to address them. Key to this process is engaging diverse stakeholders in the development and execution of community and population health assessments, and the subsequent programs and interventions designed to address the need across the catchment area. Project PLACE (Population Level Approaches to Cancer Elimination), is an Duke Cancer Institute academic and community partnered population health assessment funded by the National Cancer Institute (NCI)-funded reaching 2315 respondents in 7 months, resulting in a community partnered research agenda to advance cancer equity within the DCI catchment area. In this presentation we illustrate the implementation of a community partnered population health assessment and Project PLACE outcomes, including examples of newly developed strategic projects, scholarly productivity, successes, lessons learned, and strategic next steps. Project PLACE illustrates and underscores the importance and impact of authentic community engagement and well-established partnerships as key to conducting community and population health assessments and improving population health through collaborative programs and research.

25. CONSIDERATIONS FOR DEFINING UNIVERSITY OF ALABAMA AT BIRMINGHAM, O'NEAL COMPREHENSIVE CANCER CENTER'S CATCHMENT AREA

O'Neal Comprehensive Cancer Center

Meghan Tipre, Claudia Hardy, Molly Richardson, Tara Bowman, Monica L. Baskin

Introduction: As one of the original National Cancer Institute (NCI)-designated cancer centers, the Comprehensive Cancer Center (CCC) at the University of Alabama at Birmingham (UAB) has been offering high quality cancer care while advancing cancer research since 1971. Since 1995, the UAB CCC has been actively conducting outreach and education activities focusing on cancer health disparities in medically-underserved communities through community-based participatory education, training, and research. As the first CCC in the Deep South, UAB has historically served populations across state lines; however, with new cancer centers in the region, our catchment area (CA) has evolved over time. In preparation for the next NCI cancer center support grant renewal, leaders from the recently renamed O'Neal Comprehensive Cancer Center (OCCC) expressed the need to reassess the CA and population health.

Goal: To define OCCC's catchment area (CA) and areas of focus for outreach and engagement.

Methods: An executive committee (EC) comprised of OCCC scientists and external advisory committee members, considered several factors to define the CA: (i) cancer case definition; (ii) UAB patient data sources (hospital electronic medical records vs. tumor registry); and (iii) duration of patient data (5 years vs. 10 years). Geographic information systems was used to create heat maps to identify hotspots for UAB cancer cases reported to the Alabama Cancer Tumor Registry between 2010 and 2019.

Results: UAB received cases from all 67 counties in Alabama, the majority from North-Central Alabama. About 10% of cases came from neighboring states. Considering the practical implications and challenges in addressing the needs of wide-ranging demographics, the EC unanimously defined the OCCC's CA as state of Alabama. We believe our state-wide definition is the best approach to ensure improved saturation of outreach and engagement activities and will allow us to better assess the unique needs of this population.

26. INNOVATIVE APPROACHES TO PRIORITIZE CANCER RESEARCH, CONTROL AND OUTREACH ACTIVITIES WITHIN A SELF-DEFINED CATCHMENT AREA

Research Center for Health Equity, Cedars-Sinai Cancer

Loraine A. Escobedo, Zul Surani, Laurel Finster, Laura Thompson, Myles Cockburn, Robert Haile

The Research Center for Health Equity (RCHE), developed as part of the part of Cedars-Sinai Cancer (CSC) within the Cedars-Sinai Health System, conducts research and outreach to achieve health equity for underserved populations in Los Angeles County and throughout California. Tasked with defining CSC's catchment area using the criteria developed by the National Cancer Institute, the RCHE focuses on priority populations disproportionately burdened by late-stage screenable cancers and affected by socioeconomic and institutional barriers. These neighborhoods within CSC's catchment area are within four of the eight Service Planning Areas (SPA) in Los Angeles County: Antelope Valley, San Fernando Valley, West and Metro (where CSC is located). RCHE is collaborating with the population-based Los Angeles Cancer Surveillance Program to describe the cancer burden in these neighborhoods and identify local areas where early screening for breast cancer, colorectal cancer, lung cancer, cervical cancer, prostate cancer and melanoma among specific race/ethnic/sexual and gender minority groups may be most impactful. RCHE is also integrating various data relevant to the cancer burden to produce an interactive data visualization to inform research questions and tailor cancer control activities at CSC. RCHE's Community Outreach and Engagement program is already partnering with diverse communities in Los Angeles County to increase compliance to cancer screening in a culturally appropriate manner. Previous analyses using kernel density estimation found spatial variations in the distribution of invasive cancer at the sub-county level which has been useful in guiding outreach strategies such as the Health and Faith Partnerships. These approaches that prioritize and tailor cancer control and prevention activities for the unique needs of priority populations within the CSC's catchment area are part of CSC's overall strategic plan to reduce cancer incidence and mortality, and address cancer health disparities.

27. THE ASSOCIATION OF CANCER SCREENING AND PREVENTION TO QUALITY OF LIFE CONCERNS AND THE SOCIAL DETERMINANTS OF HEALTH IN AN INNER-CITY CATCHMENT AREA

Albert Einstein Cancer Center
Bruce Rapkin, Brieyona Reaves

Background: Increasing adherence to cancer screening and prevention is a major challenge in the. This study examines how social determinants and quality of life affect preventative health behavior in the communities we serve. Although social determinants can impede health behavior, the effects of specific stressors likely depends upon individuals' priorities and concerns.

Methods: A subset of 649 patients from the 2018 Bronx Community Health Survey completed a site-specific module including the PROMIS10 health-related quality of life survey, the Urban Stress Index, and the Brief Appraisal Inventory, a measure of matters to individuals' quality of life. Logistic regression analyses examined how these aspects of well-being and personal concern were associated with adherence to screening and smoking cessation.

Results: Quality of life, stressors, and personal concerns each contributed significantly to the likelihood of adherence. For example, among 385 women over age 40, having had a mammogram in the past two years was associated with greater emotional well-being (OR = 1.31, CI = 1, 1.73), less fatigue (OR = 0.66, CI = 0.47, 0.93) and less bodily pain (OR = 1.25, CI = 1.13, 1.4). Adherence was reduced among women with greater work/family stress (OR = 0.38, CI = 0.28, 0.52). Mammography was positively associated with the desire to remain independent (OR = 1.51, CI = 1.14, 1.99) and active (OR = 1.27, CI = 0.97, 1.64) but negatively associated with the desire to achieve calm when negative events occur (OR = 0.62, CI = 0.47, 0.82). Ever having a colonoscopy, smoking and other health behaviors were similarly influenced by quality of life concerns and stress.

Conclusion: Findings demonstrate that personal concerns overall well-being influence adherence to cancer screening. Examining the interplay of these factors may inform engagement strategies that are more sensitive to the individual and their social, economic and cultural context.