OP-ED

In breast cancer screening, Black women overlooked

By Christine Edmonds and Oluwadamilola Fayanju

October, even during an ongoing pandemic, is Breast Cancer Awareness Month. As breast cancer physicians, we welcome this time of year as an opportunity to look beyond the daily demands of patient care and reassess our profession's goals and progress. How are we doing as physicians, and as health-care communities, in meeting women's breast cancer screening and treatment needs? How can we reach more patients and deliver better care?

Approximately one in eight women will be diagnosed with breast cancer in her lifetime. Since 1990, mortality from breast cancer has steadily declined, due to earlier cancer detection via mammography and continued improvements in therapy. Unfortunately, progress has not been achieved equally across racial and ethnic groups.

Black women, in particular, experience marked inequities in breast cancer treatment and survival. Recent statistics from the American Cancer Society demonstrate widening breast cancer mortality rates between Black and white women, with a 41% higher death rate for Black women. This striking disparity reflects a combination of factors, including more advanced disease at diagnosis among Black women and differential treatment receipt. Black women experience greater socioeconomic barriers and bias from oncologists.

Black women are also more likely to develop a particularly aggressive breast cancer subtype known as triple-negative breast cancer. Twenty-one percent of breast cancers in Black women are triple-negative, compared with just 10% among white women. Triple-negative cancers carry a significantly worse prognosis, largely due to a paucity of effective drug therapies.

Despite continual improvements in screening and treatment, we are still failing Black women. Where do we start, and what do we need Black patients and their physicians to understand?

Despite having higher rates of triple-negative breast cancer, the subtype with the least effective treatment options, Black women remain drastically underrepresented in clinical trials. This underrepresentation hinders development and optimization of treatment regimens that may benefit this specific patient population.

Similarly, most of the breast cancer risk assessment models — computer-based algorithms that estimate a woman's lifetime risk of breast cancer based on her personal and family history — were developed and validated primarily in white women. These models help determine which patients carry an "elevated risk" of breast cancer, and may therefore need supplemental screening, such as breast MRI, or preventative medications, such as tamoxifen. However, because the models failed to include diverse women during development, they often underestimate Black women's risk, preventing them from obtaining supplemental screening and treatment. Thus, the exclusion of Black women from clinical trials and risk models has widened breast cancer-related disparities.

Finally, current mammographic screening recommendations do not protect the specific screening needs of Black women. Currently, breast cancer diagnosis rates among Black and white women are nearly equivalent. However, among women under age 45, rates are higher among Black women, whose median age of diagnosis is four years younger. Thus more years of life are lost per breast cancer death among Black women.

In the U.S., annual screening mammography beginning at age 40 has been standard of care for women with an average lifetime risk of developing breast cancer. However, despite evidence showing population-level mortality reductions from initiating screening at 40, current guidelines from the United States Preventive Services Task Force (USPSTF) discourage screening women ages 40-49 and emphasize that screening this age group leads to unnecessary biopsies and patient anxiety. Although USPSTF recommendations do not directly dictate patient care, they guide the clinical practice of primary care physicians and impact screening in federal programs such as the Veterans Affairs health system, a racially and ethnically diverse patient base. While delaying screening until age 50, as recommended by the USPSTF, jeopardizes the health of all women, it disproportionately harms Black women, who are diagnosed with breast cancer at younger ages.

This October, we again ask ourselves where we're falling short. The answer is painfully obvious. Despite continual improvements in screening and treatment, we are still failing Black women. Where do we start, and what do we need Black patients and their physicians to understand?

We want clinicians and patients alike to recognize the high-risk status of Black women, including those under age 50. Per the recommendations of the Society of Breast Imaging, we encourage Black women to undergo a breast cancer risk assessment with their primary clinician at age 30 to assess their lifetime risk of breast cancer and determine whether screening prior to age 40 is needed. In addition, while we advocate for all of our average-risk patients to initiate screening at 40, it is of particular importance for Black women to begin yearly screening mammography no later than 40. For now, insurance coverage of annual screening mammography for all women ages 40 and above remains protected under the 2021 Consolidated Appropriations Act. Until the USPSTF appropriately recognizes the high-risk status of Black women and appropriately guides screening for this group, we encourage physicians to advocate for Black women, and for these patients to advocate for themselves.

Christine Edmonds is a breast radiologist at the Hospital of the University of Pennsylvania and Oluwadamilola "Lola" Fayanju is the chief of breast surgery for Penn Medicine.

PRO CON

Should there be a COVID vaccine mandate for nursing home staff?

One of the communities hit hardest by COVID-19 is our elderly citizens, particularly those living in nursing homes. In Pennsylvania, more than 10,000 residents have died so far. Although this group was among the first to be offered the COVID-19 vaccine, only two-thirds of nursing home staff in the state have accepted it, leaving a substantial number unvaccinated.

Pennsylvania has fallen short of its goal of vaccinating 80% of nursing home staff by this month, leaving facilities to face a looming federal mandate. In Philadelphia, staff at long-term care facilities could lose their job if they don't get their first shot by Oct. 15, unless they receive a medical or religious exemption.

The Inquirer tapped two local leaders who fight for the rights of nursing home residents and staff to debate: **Is it fair to ask unvaccinated staff at nursing homes to choose between the shot and their jobs?**

Yes Too many unvaccinated put residents at risk.

By David R. Hoffman

Pennsylvanians residing in nursing homes want to live, which explains why 87% have been vaccinated. But without a mandate, too many staff are unnecessarily exposing them to danger from COVID-19, a now preventable disease.

Approximately 66% of nursing home staff in the state are vaccinated, leaving the remaining 34% to pose a significant health risk to our most frail and vulnerable population. That vaccination rate is an average; I have recently been in nursing homes where the rate among staff is much lower.

That vaccination rate is a national average; I have recently been in nursing homes where the rate among staff is much lower.

We have learned a very costly lesson from the pandemic — approximately 155,000 lost lives among nursing home residents and frontline health-care staff. And even though nursing home residents and staff were among the first to be offered the COVID-19 vaccine, they remain at substantial risk: Following the rise of the delta variant, nursing homes in the U.S. reported almost 1,800 deaths among residents and staff in August, the most since February.

So we need mandates. But we must also provide support that addresses the many reasons why nursing home staff are saying no to the vaccine. First, nursing home providers must provide one-to-one education regarding the safety of the vaccine, listen to staff concerns, and address them in a meaningful way. Respected members of the community or leaders within the facility who have been vaccinated should participate in those discussions.

Next, nursing home owners must ensure the vaccine is available to staff during all shifts, so those only there overnight do not miss their opportunity for the shot. Most importantly, facilities must offer staff paid time off if they have any reaction to the vaccine and require time to recover.

Providers have claimed that vaccine mandates will force them to lose staff. However, if there is an industry-wide mandate, there is no alternative workplace available.

Importantly, I view the recent mandate through both an ethical and legal lens. Vaccine mandates have been upheld by the Supreme Court dating back to the early 1900s. Federal law also mandates that nursing home residents have a right to live free from "neglect," defined as "failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." I know of several breakthrough COVID-19 cases experienced by fully vaccinated nursing home residents. I suspect that those cases were caused by exposure to unvaccinated staff and, as such, the facility violated its legal and ethical duty to ensure that residents are free from neglect.

The more compelling argument is the ethical obligation to protect nursing home residents. This must be the compass that points us out of this pandemic. Health-care workers have taken oaths to do no harm, to treat patients' interests and protection as paramount. The vast majority of nursing home personnel have shown a strong commitment to protecting our most vulnerable population segment against harm by, for example, getting flu shots in the fall.

And yet, after months of having access to a lifesaving vaccine that will protect them and the residents they care so deeply for, too many nursing home staff remain willing to place residents in harm's way. Even if an unvaccinated staff member doesn't infect anyone, if they test positive, the facility may go into lockdown — again — which affects residents' quality of life and causes psychological damage.

Some nursing home providers have already successfully implemented a vaccine mandate, and it is time for all to do so.

David R. Hoffman is the president of David Hoffman and Associates, a national health-care consulting firm that focuses on patient and resident safety and compliance.

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PRO CON

No Facilities can't afford to lose more staff.

By Zach Shamberg

Remember the phrase "health-care heroes"?

Throughout the COVID-19 pandemic, our frontline caregivers more than earned that title.

But today, it seems we have forgotten their heroic efforts because we are now being told to fire them.

In mid-August, instead of appreciation, many of our frontline workers were given notice of a pending pink slip. President Joe Biden directed the Centers for Medicare and Medicaid Services (CMS) to develop regulations requiring all nursing home workers to receive the COVID-19 vaccine — without exception. Any nursing home provider that employs unvaccinated workers will have to forfeit the government funding that tens of thousands of Pennsylvania nursing home residents rely on for their care.

The reality is, there is no choice. Without Medicaid and Medicare funding — which pays for most of all care delivered in Pennsylvania nursing homes — facilities will be forced to close their doors, evict their residents, and erase the future of care in a state with one of the oldest populations in the country.

So much for standing with our heroes — and the residents they care for.

Why are nursing homes subject to this unfair practice of "mandates without exception"? Gov. Tom Wolf has not forced state-run nursing homes to get rid of unvaccinated employees, who can keep their jobs if they submit to weekly testing. President Biden's mandate for large businesses in the private sector also gives workers the option of regular testing instead of the shot.

Oddly, a testing option doesn't exist for nursing homes, which have spent the last year setting the standard on testing. In areas with high levels of COVID-19, unvaccinated workers are tested twice a week. Yet our governing bodies moved the goalpost for a sector in the midst of navigating a dire workforce crisis.

The Pennsylvania Health Care Association (PHCA), where I am president and CEO, recently surveyed member facilities, revealing their struggle to simply meet minimum staffing requirements. That is why 85% of nursing home respondents are currently limiting new admissions, and 50% of facilities say they have a waiting list, all due to a lack of staff. Firing workers and cutting funding will only exacerbate the problem.

It's clear vaccine hesitancy exists. The vaccination rate for Pennsylvania nursing home workers mirrors the state population rate at 66%. But the need for care also exists, and vaccination rates will be irrelevant if a facility cannot remain open.

This isn't just a problem here. In New York, state leaders are preparing to send in the National Guard to fill shifts of terminated unvaccinated health-care workers.

With a workforce crisis, the loss of even one worker is significant. And Pennsylvania nursing homes could lose many workers: The 34% of unvaccinated workers equates, by our calculations, to about 32,000 people who are admirably working at the epicenter of the COVID-19 pandemic.

The COVID-19 vaccine provides a level of protection for everyone. And providers continue to educate their workers about its benefits.

But a mandate that disregards the concerns of providers — experts on the front line of care — will cause more harm than good. Instead, it's beyond time for our government leaders to assist and collaborate with long-term care, rather than hurl threats and punishments. And it's time to once again rally around our health-care heroes with support and trust, to create success and sustainability for residents in long-term care.

Zach Shamberg is the president and CEO of the Pennsylvania Health Care Association (PHCA), a statewide advocacy organization for Pennsylvania's most vulnerable residents in long-term care and their providers of care.

Pharmacist Nadine M. Mackey (left) administers the COVID-19 vaccine to a nursing home nurse. JOSE F. MORENO / Staff Photo