Improving Patient Access to Cancer Care

Cancer Care in Low-Resource Areas
National Cancer Policy Forum

Augusto Ochoa MD
Gulf South – Minority Underserved - NCORP
LSU Cancer Center
New Orleans

LSU Health NEW ORLEANS
School of Medicine
Stanley S. Scott Cancer Center

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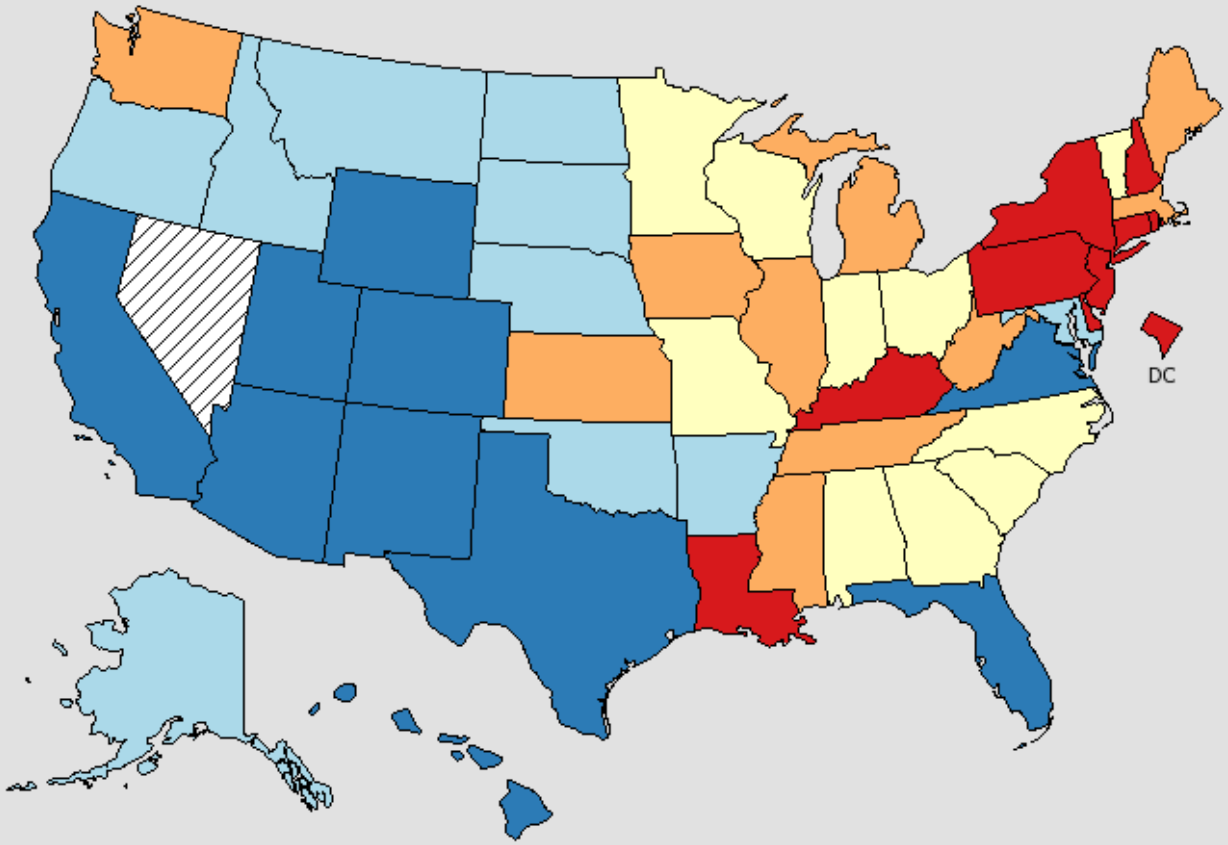
Incidence Rates† for United States

All Cancer Sites, 2008 - 2012

All Races (includes Hispanic), Both Sexes, All Ages



Age-Adjusted

Annual Incidence Rate

(Cases per 100,000)

Quantile Interval

- 386.6 to 434.9
- 434.9 to 451.5
- 451.5 to 465.9
- 465.9 to 483.1
- 483.1 to 510.9
- Data Not Available ◇

US (SEER + NPCR)
Rate (95% C.I.)
453.8 (453.5 - 454.1)

Notes:

Created by statecancerprofiles.cancer.gov on 04/05/2016 3:19 pm.

Data for the United States does not include data from Nevada.

State Cancer Registries may provide more current or more local data.

Data presented on the State Cancer Profiles Web Site may differ from statistics reported by the State Cancer Registries (for more information).

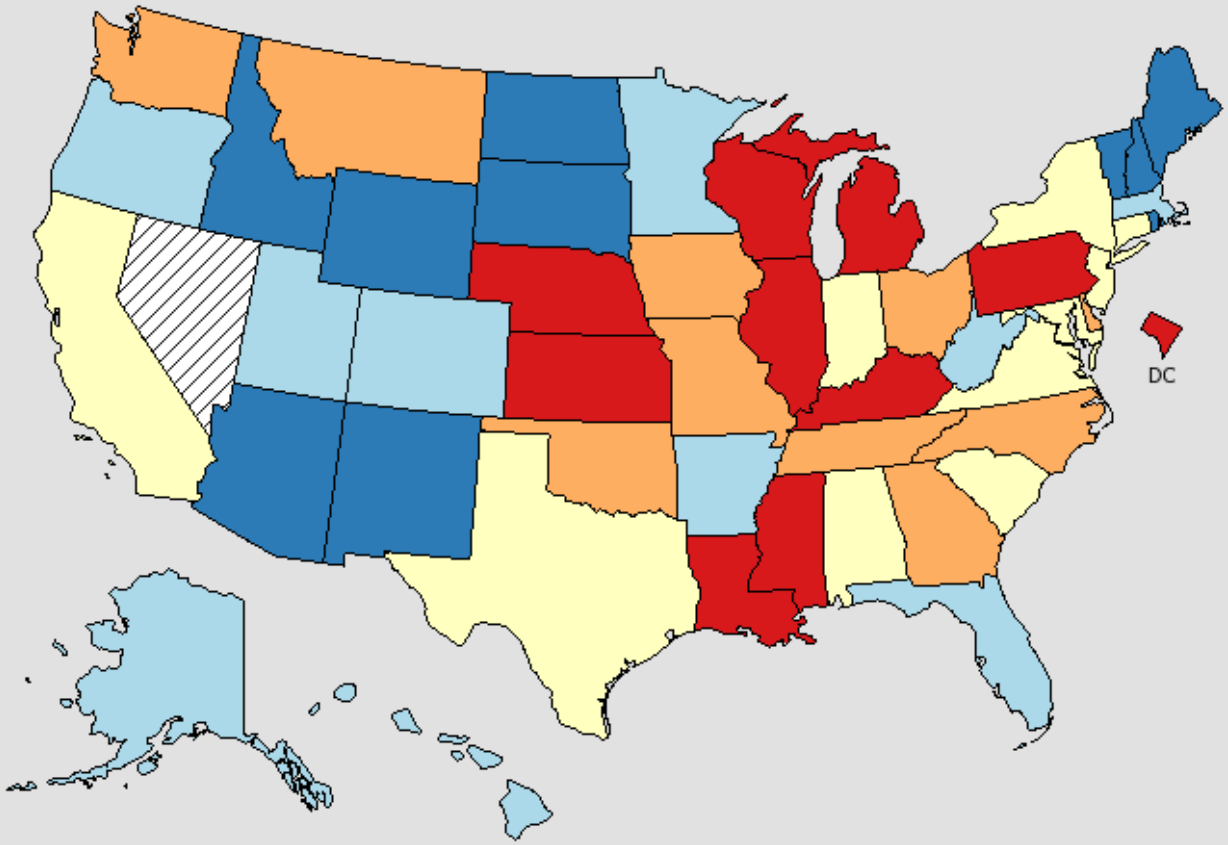
† Incidence rates (cases per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ... , 80-84, 85+). Rates are for invasive cancer only (except for bladder which is invasive and in situ) or unless otherwise specified. Rates calculated using SEER*Stat. Population counts for denominators are based on Census populations as modified by NCI. The 1969-2013 US Population Data File is used for SEER and NPCR incidence rates.

◇ Data not available for this combination of geography, statistic, age and race/ethnicity.

Incidence Rates† for United States

All Cancer Sites, 2008 - 2012

Black (includes Hispanic), Both Sexes, All Ages



Age-Adjusted

Annual Incidence Rate

(Cases per 100,000)

Quantile Interval

- 215.1 to 394.5
- 394.5 to 450.4
- 450.4 to 463.0
- 463.0 to 493.2
- 493.2 to 537.7
- Data Not Available ◇

US (SEER + NPCR)
Rate (95% C.I.)
465.8 (464.7 - 466.8)

Notes:

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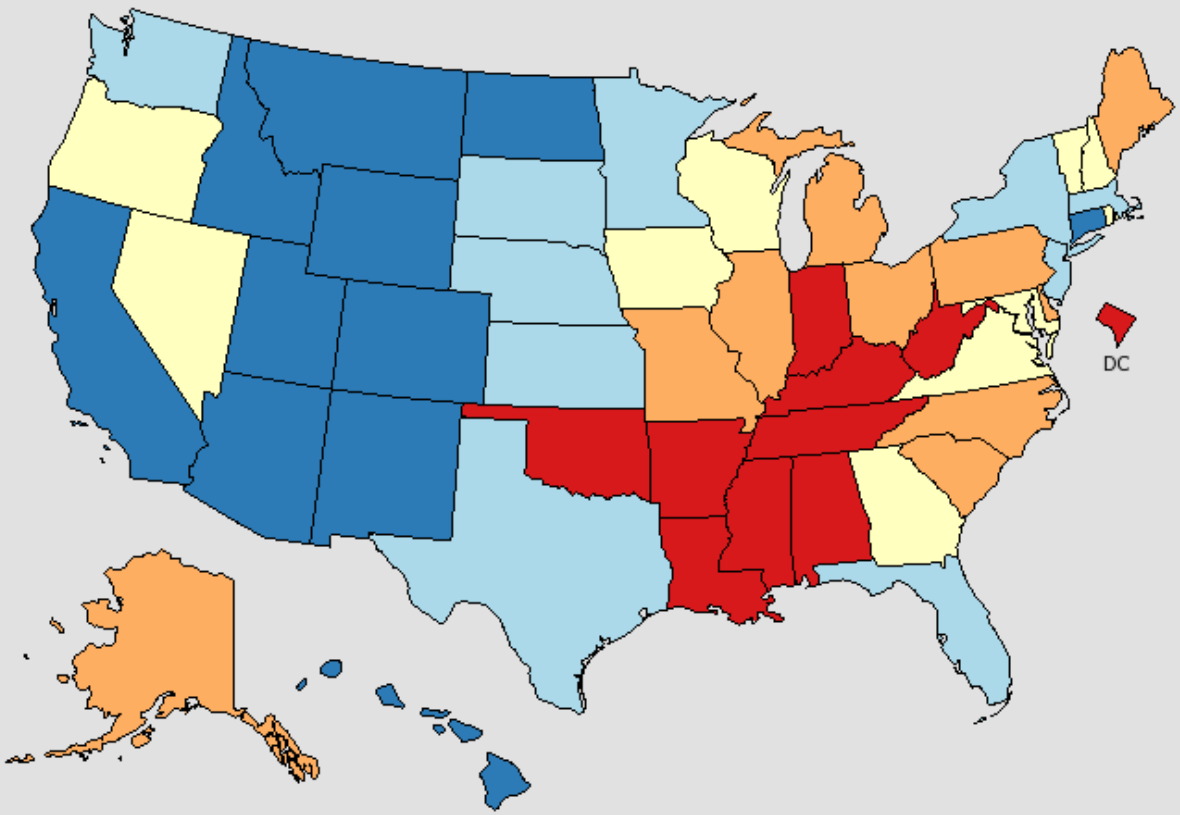
◇ Data not available for this combination of geography, statistic, age and race/ethnicity.

Death Rates for United States
All Cancer Sites, 2008 - 2012
All Races (includes Hispanic), Both Sexes, All Ages



Age-Adjusted

Annual Death Rate

(Deaths per 100,000)

Quantile Interval

- 127.6 to 160.4
- 160.4 to 170.5
- 170.5 to 173.7
- 173.7 to 186.9
- 186.9 to 204.4

United States
Rate (95% C.I.)
171.2 (171.0 - 171.4)

Healthy People 2020
Goal C-1
160.6

Notes:
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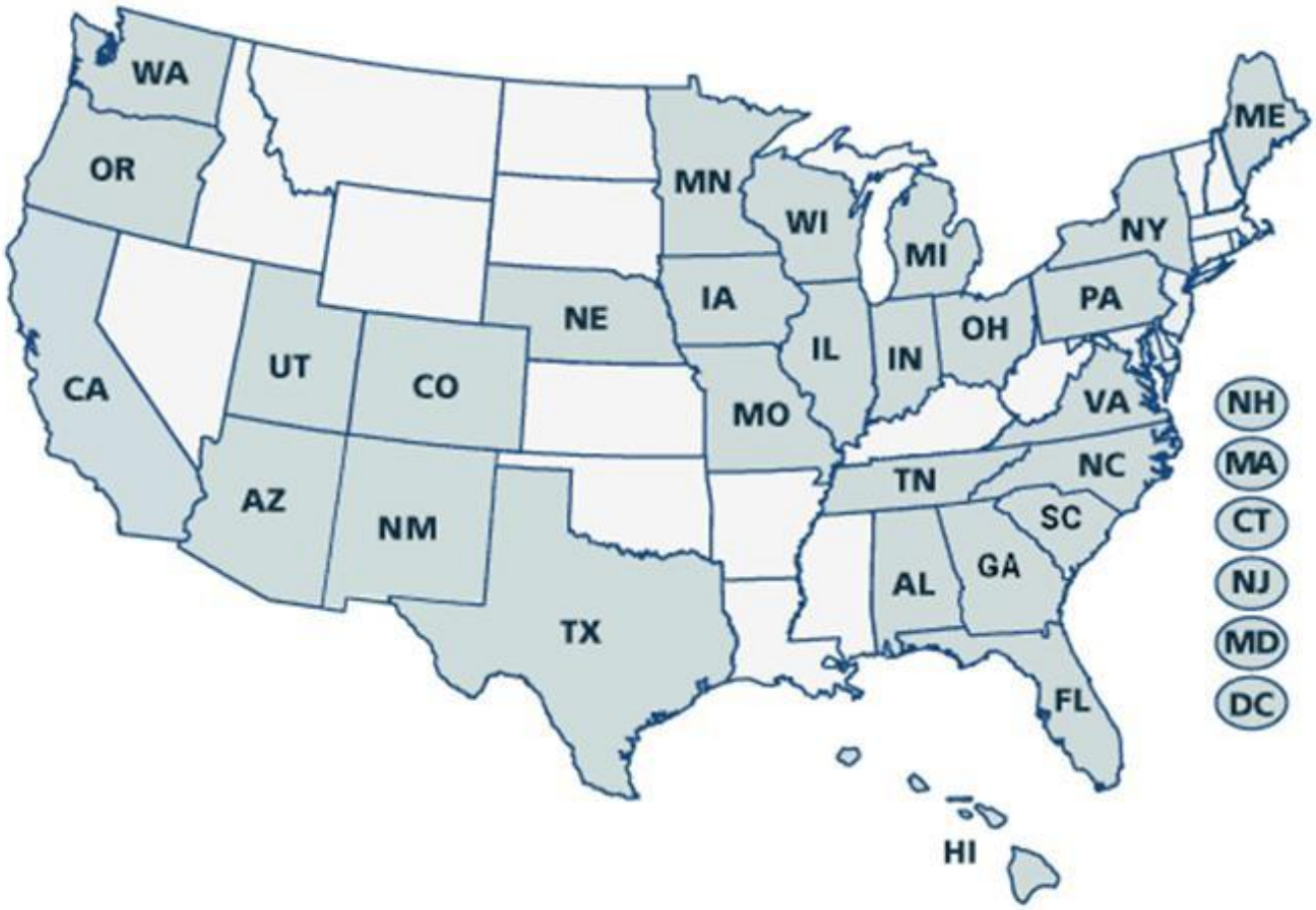
State Cancer Registries may provide more current or more local data.
Data presented on the State Cancer Profiles Web Site may differ from statistics reported by the State Cancer Registries (for more information).
Source: Death data provided by the National Vital Statistics System public use data file. Death rates calculated by the National Cancer Institute using SEER*Stat . Death rates (deaths per 100,000 population per year) are age-adjusted to the 2000 US standard population (19 age groups: <1, 1-4, 5-9, ... , 80-84, 85+). The Healthy People 2020 goals are based on rates adjusted using different methods but the differences should be minimal.
Population counts for denominators are based on the Census 1969-2013 US Population Data File as modified by NCI.
Healthy People 2020 Goal C-1 : Reduce the overall cancer death rate to 160.6.
Healthy People 2020 Objectives provided by the Centers for Disease Control and Prevention .

Sites of the NCI Designated Cancer Centers



Realities for the Oncology Patient in the Community

- >90% Adult Cancer patients do not participate in a clinical trial.
- Most community oncologists are not located within 100 miles of comprehensive cancer centers
- Many patients, even insured by Medicare/Medicaid cannot afford to travel for extended periods of time
- Minority-underserved have even fewer options for prevention, early detection and follow-up.

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Choices for the Community Oncologist

- Use standard of care
- Enroll patient on a pharmaceutical trial provided by the local drug representative
- Refer patient to the closest academic center and “loose” the patient.

- If given the right opportunity the community oncologist will participate in structured clinical trials.

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Hurricane Katrina 8/29/2005

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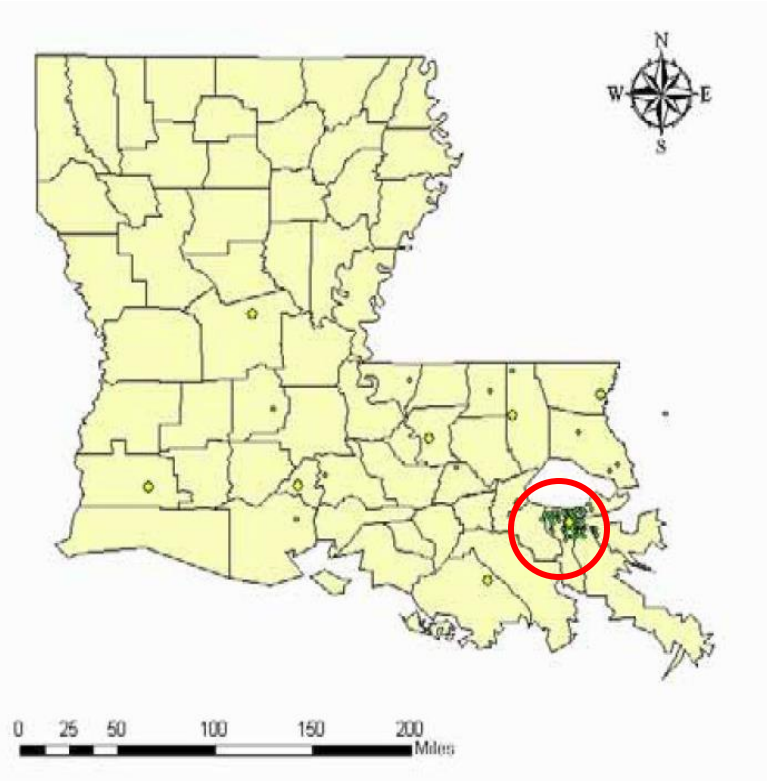
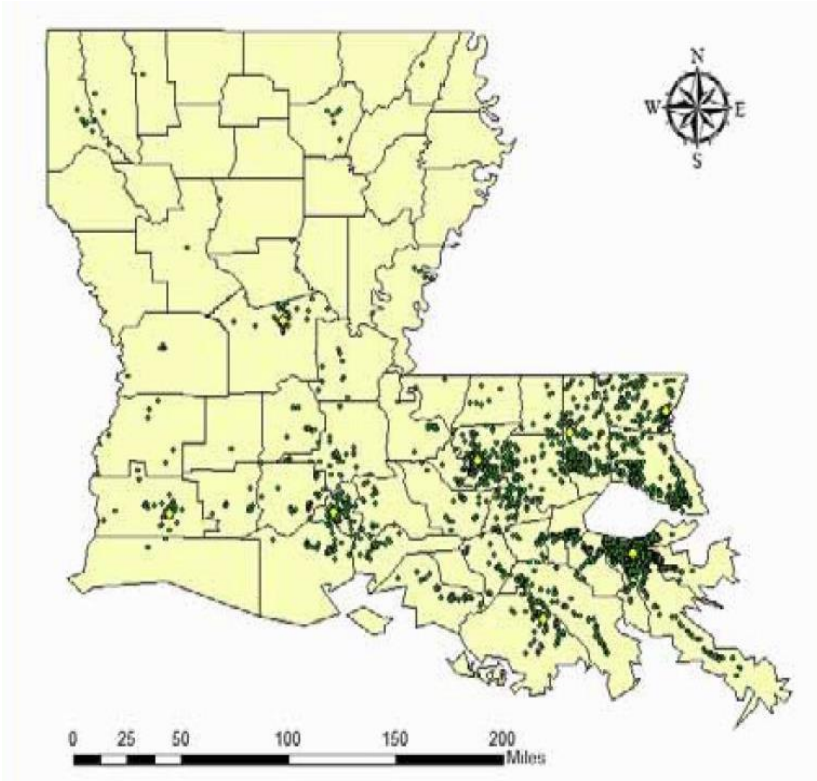
Challenge for the Clinical Trials Program

MCLNO/Charity Patients

Pre-Katrina (Aug 2005)



Post-Katrina (Sept 2007)



80% MB - CCOP patients tracked by mid 2007

Xiao & Harris, LSU SPH
Butler & Kaiser, LSU HCSD

Meetings with Community Oncologists

Assess

- What was their level of interest in Clinical Trials
- What were the barriers for their participation.
- What would be the incentives to participate

C. Oncologist Opinions

- Very interested to participate in CT as a group not individually.
- Barriers:
  - Too many cooperative groups: complex regulatory, audits, data monitoring etc.
  - Could not detract from their financial bottom line.

Partnerships
Academic Center – Community Oncologist

Academic Center

- Compete for and manage the grant (NCORP)
- Provide regulatory and data management support
- Provide EMR for clinical trials
- Support participation of C. Oncologists to cooperative group meetings

Community Oncologist

- Accept the academic or C-IRB as the IRB of record (facilitated by C-IRB)
- Provide research nursing support and maintain records for audits
- Use EMR provided by academic center
- Agree to minimum number of enrollments
- Participate in monthly clinical trials meeting

NCTN/NCORP

- Stimulus to consolidate smaller CCOP's, NCCCP into more effective NCORP's
- C-IRB- Streamlined regulatory
- Cancer Care Delivery Research – Health Disparities Research
  - Cancer care is more than just clinical trials
  - Understand cancer in your region: Tumor Registries
  - Know your patients in their environment: CCDR-HD
  - Develop participation of the communities: CBPR
  - Develop partnerships – Tumor registry – HIE programs

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- Two (2) MB-CCOP's + NCCCP
- Louisiana and southern Mississippi: 26 sites
- Increasing interest from community oncologists
  - Access to biology/genomics trials
  - Referral of patients without "loosing" the patient
  - Joint management of complex cases
  - Addition of 4 new sites in New Orleans – E Jeff Hosp; W Jeff Hosp; Touro Clinic; St. Charles Clinic
- Integrate State Tumor Registry and LA HIE in trial selection

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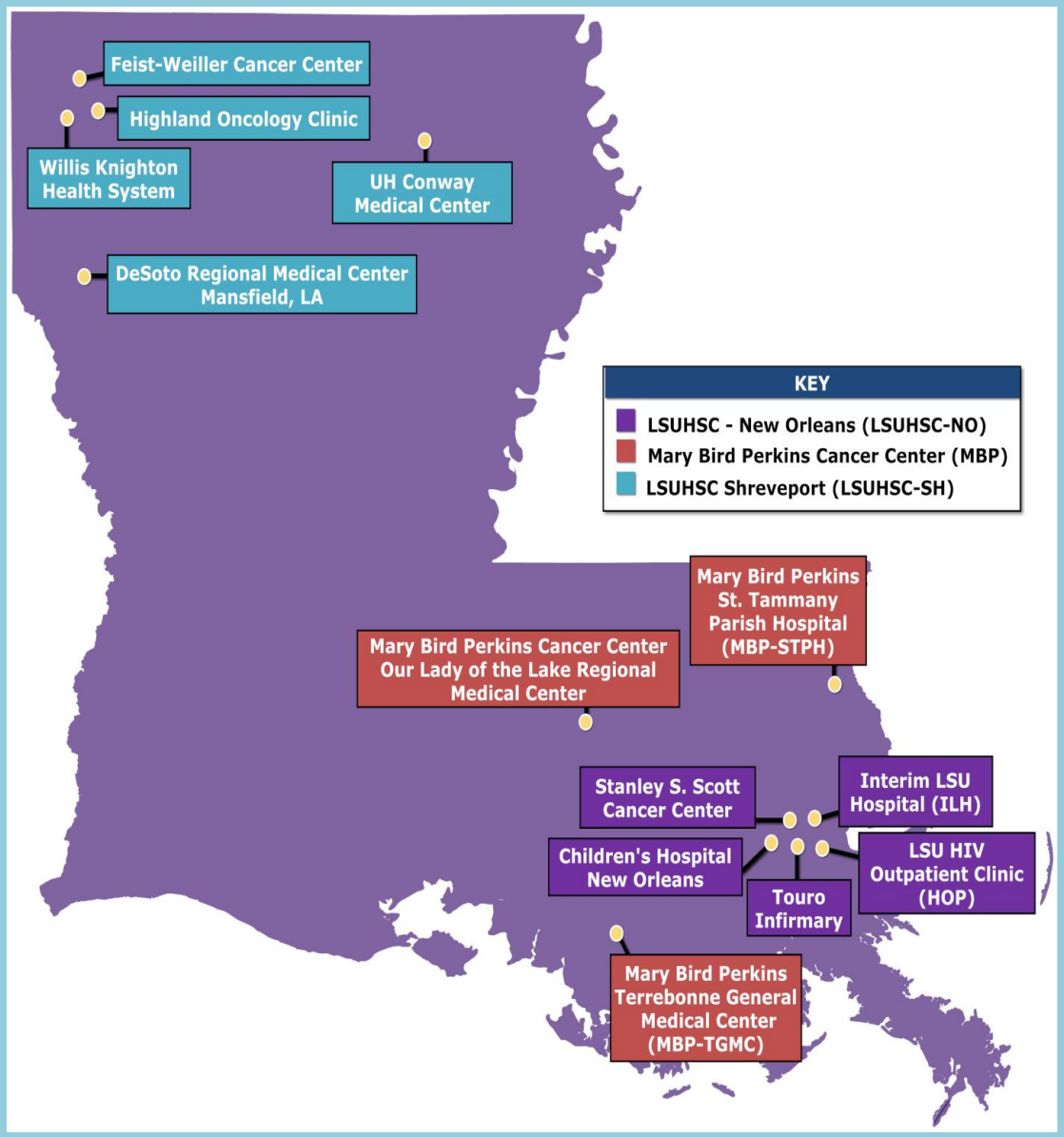

What does the GS-NCORP Offer

- >50 active trials for different types of cancer
- 26 different community sites throughout Louisiana and Mississippi offering cancer clinical trials = patients can get treated closer to home
- Increased enrollment by 4X - 2015-2016

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Outcomes

- Shortened time for protocol approval
- Increased referrals from community oncologists
- Increased self- referrals for 2nd opinions
- New requests from community practices to participate in NCORP
  - 4 new sites in New Orleans
  - 1 new site in Shreveport
- Increased patient enrollment
- Increased participation in non-treatment trials

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New Initiatives

- Research initiatives
  - Collaborations with PCORI projects – smoking cessation and pre-enrollment
  - State-wide Health Disparities research programs

- Training
  - Minority research nurses (CRA's) and navigators: P20 with Dillard University
  - State-wide training course on new billing practices for clinical trials

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Challenges for the NCORP Sites

- Funding the infrastructure
- Staying engaged – Early stage clinical trials, biology/genomics trials, academic credit for clinical trials.
- Incentivizing the community oncologist – access to cutting edge clinical trials, adjunct faculty position.
- Incentivizing the community to participate – CBPR, stay closer to home
- Keep the community (clinicians and patients) informed

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Lessons Learned

- Partnerships have to be a win:win situation
- Choose your champions (doctors and nurses):
  - Commitment to patients
  - Commitment to clinical trials
  - Willing to resolve the problems
- Give them “ownership” of the decision process
- Let them shine - incentives
- Bring in the legislature

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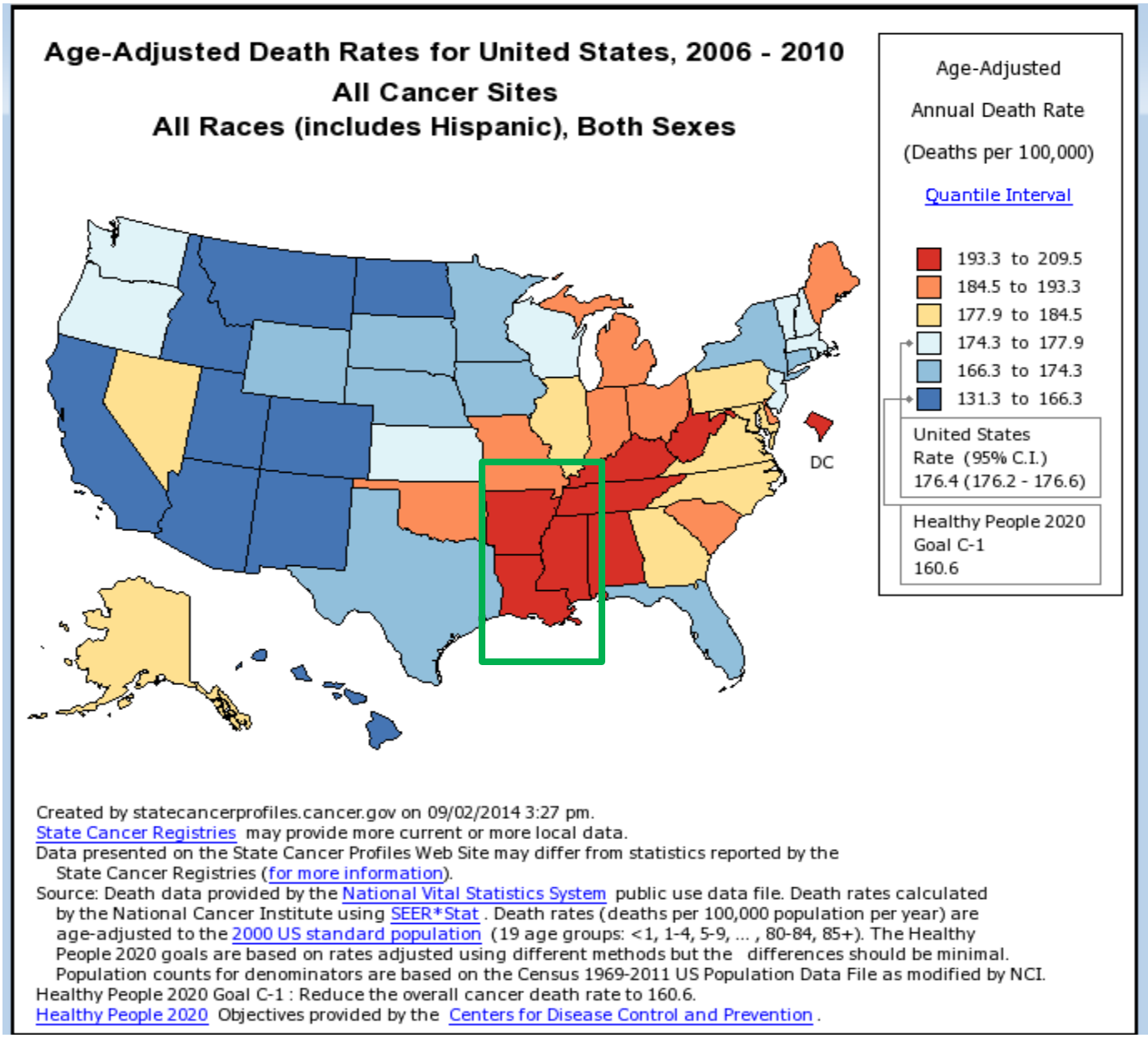
Managing Cancer in the Community Setting



Statecancerprofiles.cancer.gov

Thank You – Questions?