Bringing Oncology Specialty Care to the Community using Nursing Navigation

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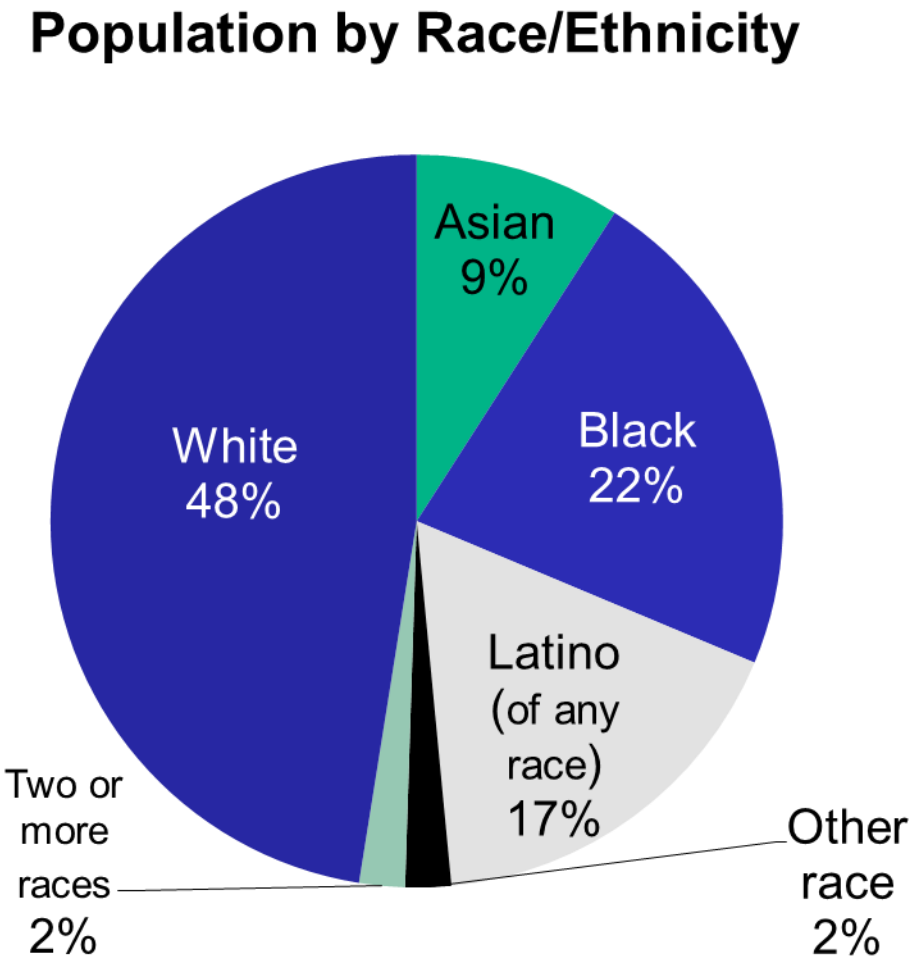
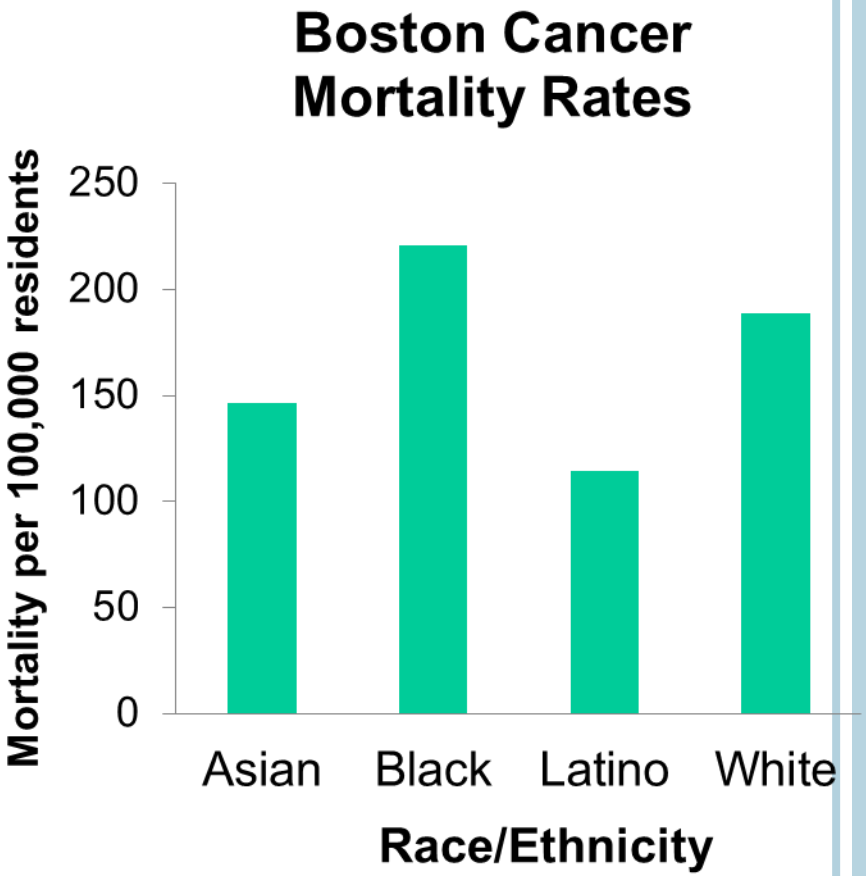
Overview

- Brief Background
- Summary Data
- Current projects
- Future considerations

Cancer in Boston 2010

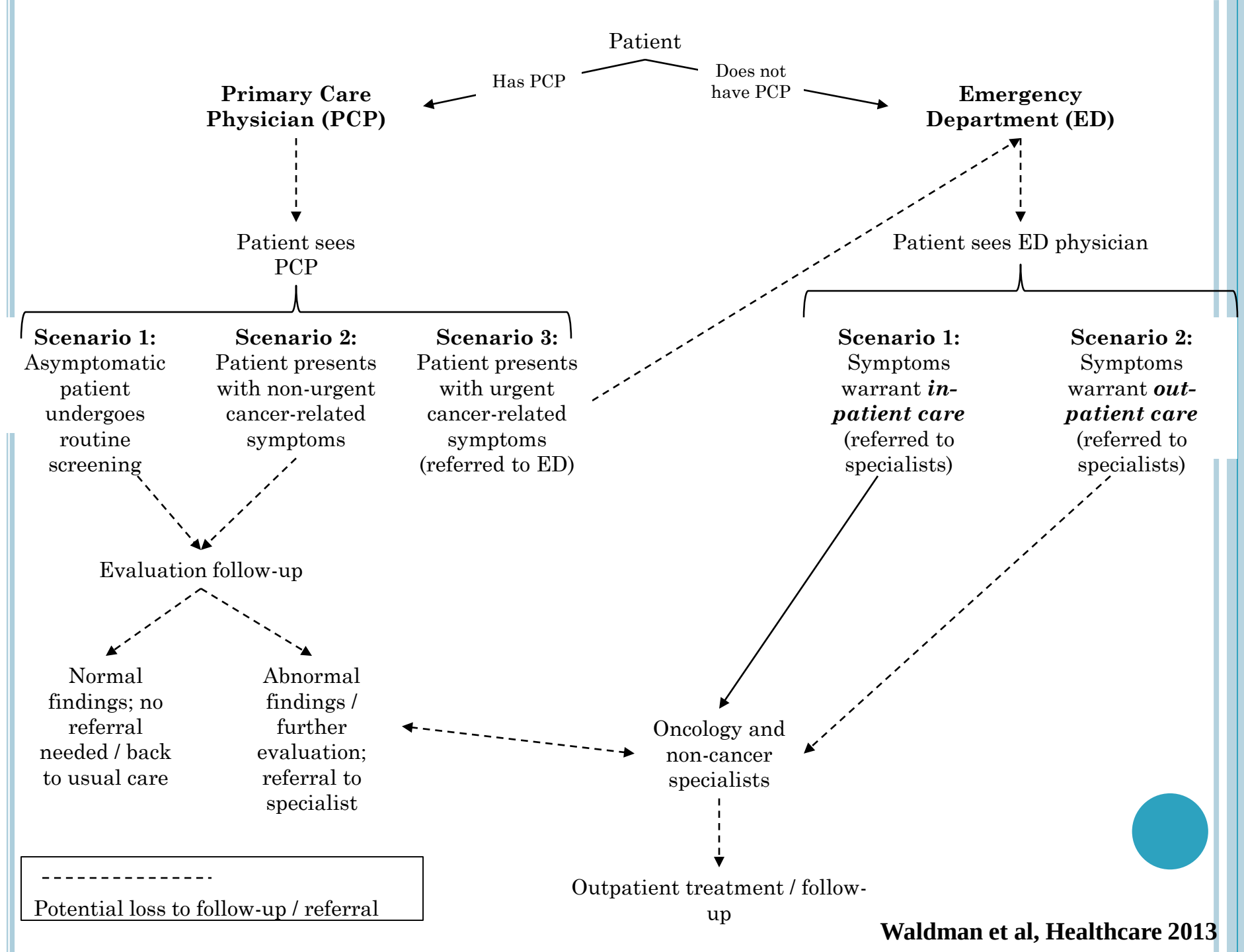




Source: Health of Boston, 2012-13

Cancer Care Equity Program

- Cancer Centers are integral to NCI's plan for the Elimination of Disparities
- Disparities by race and class exist, and with the changes coming in treatment (personalized medicine) this will continue
- Disparities program = Equity in outcomes, treatment and access
- Vulnerable populations: underrepresented minorities, immigrants, LGBTQ, lower SES and rural poor.



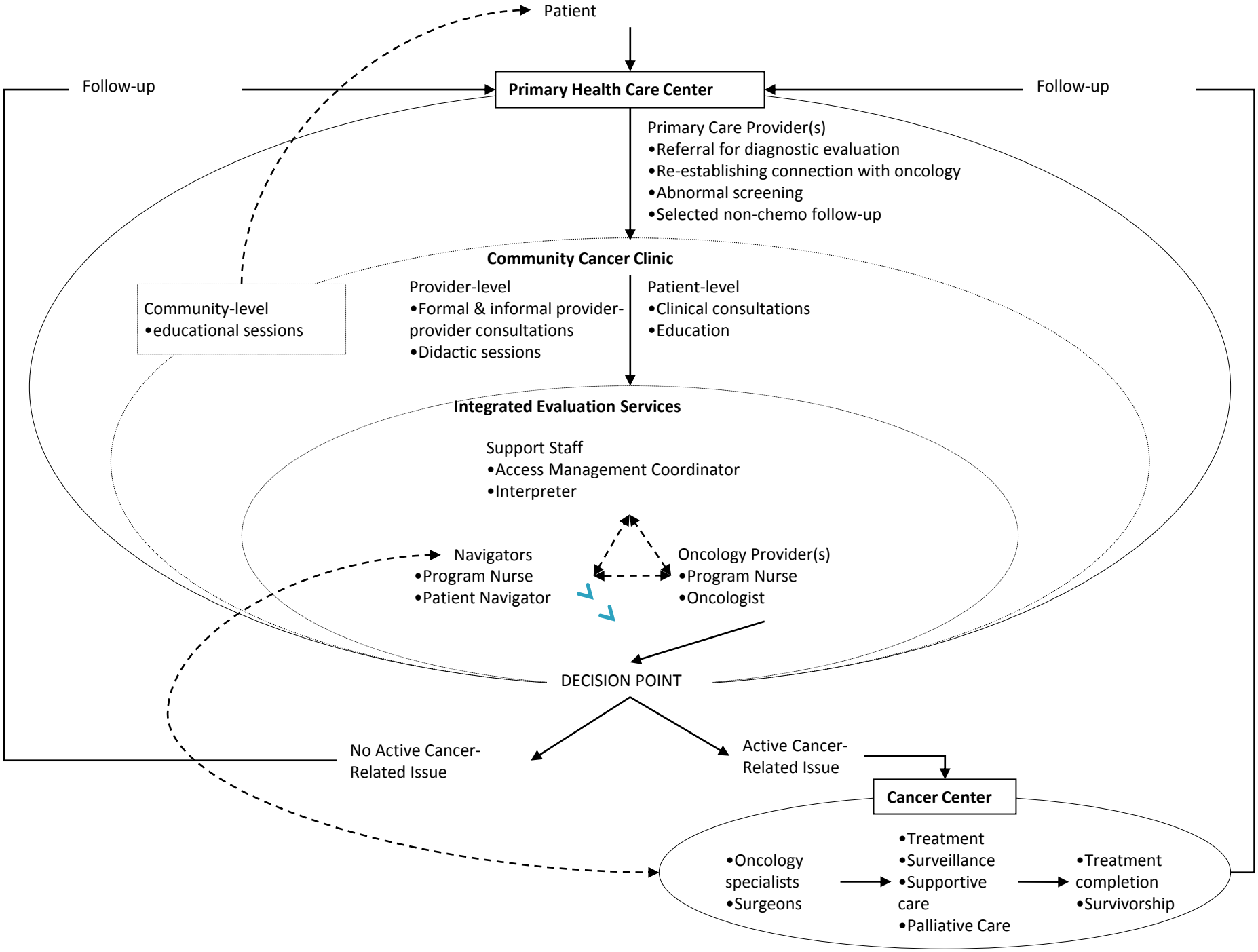
Waldman et al, Healthcare 2013

Cancer Care Equity Program

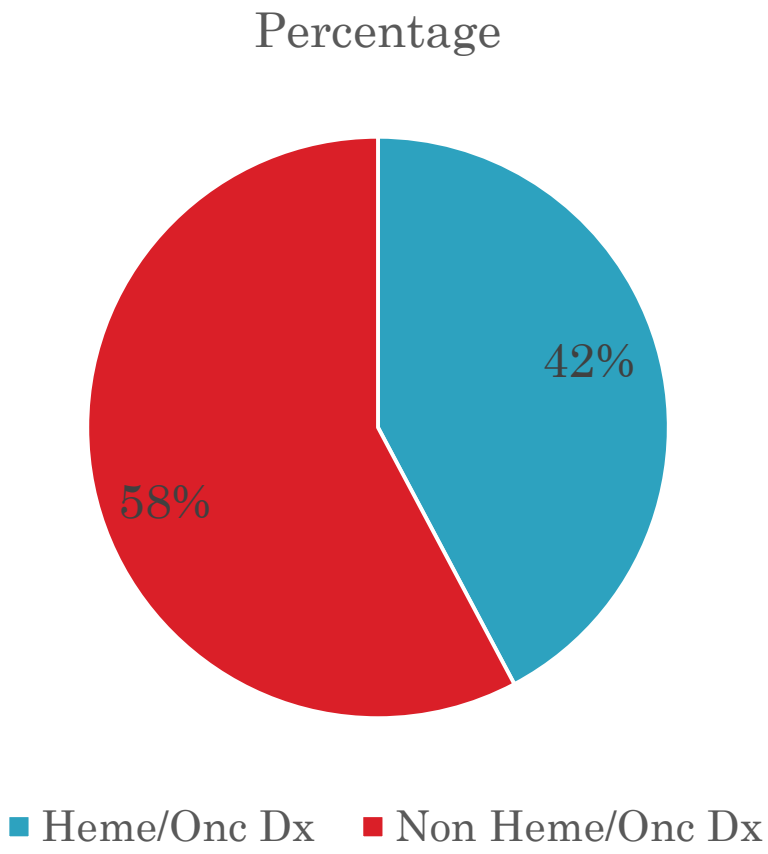
- Focused effort to maximize research/and clinical efforts to combat racial disparities in cancer care
- Supported at all levels of DFCI leadership in collaboration with External Affairs
- Funded by philanthropic gift from the Kraft Family Foundation (CVS x 2, individual donors)

Cancer Care Equity Program: Integral Components

- Transdisciplinary research program
- Outreach to community/ Community Based Research program
- Pilot program for streamlined access to cancer center for newly diagnosed underserved
- Clinical Trial Accrual
- Effort to examine equity/quality metrics
- Assist DFCI in uniting disparities efforts and increasing awareness


Patient
Follow-up
Primary Health Care Center
Follow-up
Primary Care Provider(s)
•Referral for diagnostic evaluation
•Re-establishing connection with oncology
•Abnormal screening
•Selected non-chemo follow-up
Community Cancer Clinic
Community-level
•educational sessions
Provider-level
•Formal & informal provider-provider consultations
•Didactic sessions
Patient-level
•Clinical consultations
•Education
Integrated Evaluation Services
Support Staff
•Access Management Coordinator
•Interpreter
Navigators
•Program Nurse
•Patient Navigator
Oncology Provider(s)
•Program Nurse
•Oncologist
DECISION POINT
No Active Cancer-Related Issue
Active Cancer-Related Issue
Cancer Center
•Oncology specialists
•Surgeons
•Treatment
•Surveillance
•Supportive care
•Palliative Care
•Treatment completion
•Survivorship

Clinic visit data



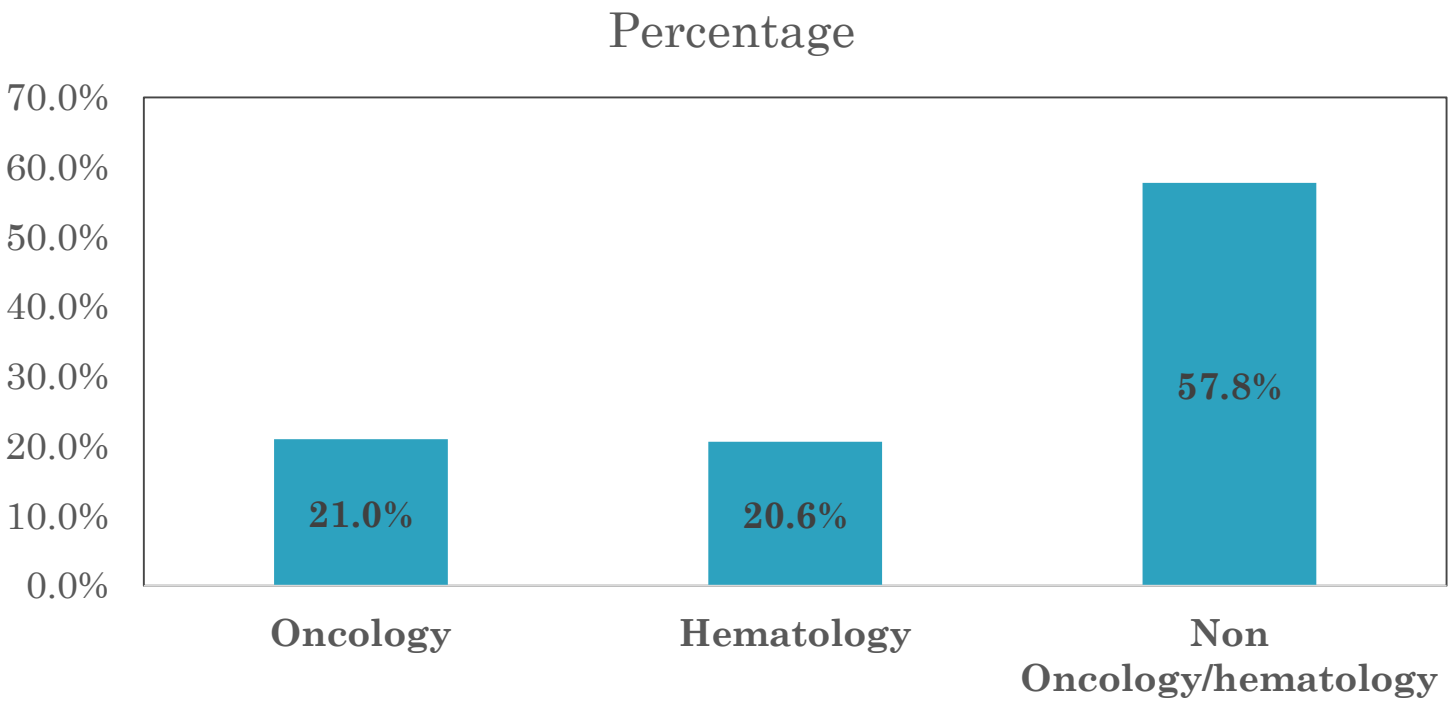
736 total patient visits

431 new patients,
305 follow-ups

REASONS FOR REFERRAL

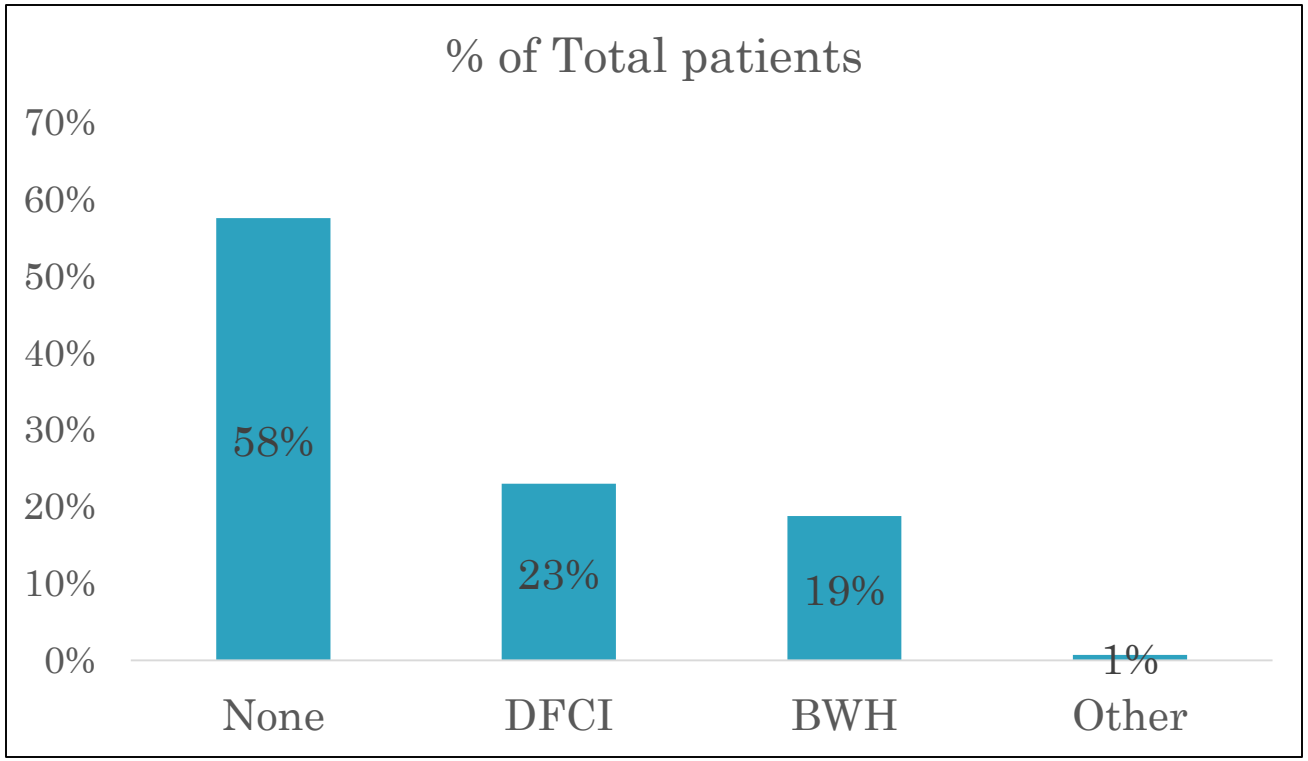
Reasons for Referral	N(%)
Hematological consult	89 (20.6)
Evaluate for cancer	128 (29.7)
Genetic counseling and testing	88 (20.4)
Lung cancer screening /smoking cessation counseling	70 (16.2)
Follow up care for cancer	47 (10.9)
Cancer treatment	9 (2.1)
Total	431

Cancer Diagnosis

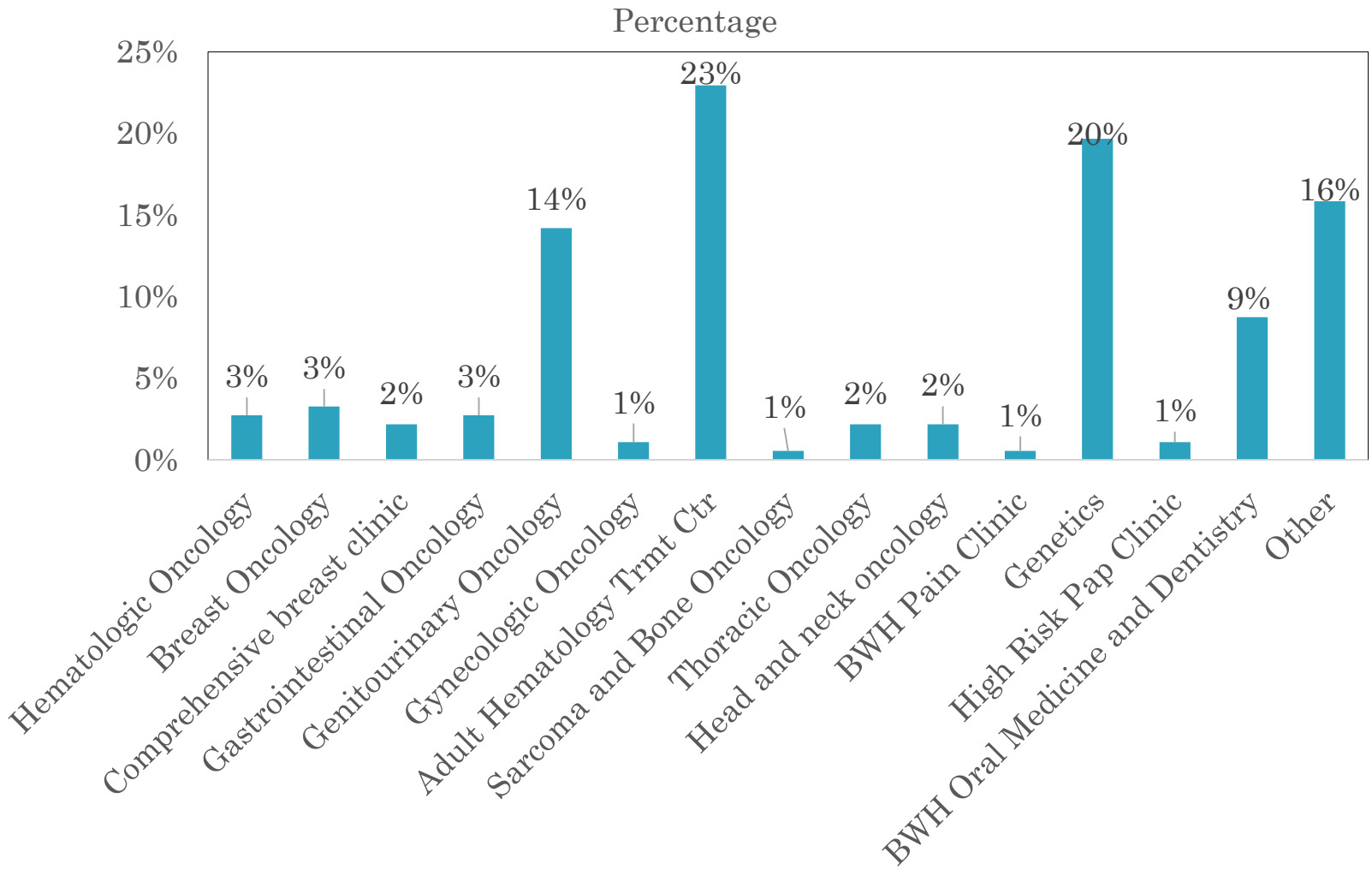


93 oncology visits
89 heme visits
249 Non Onc/heme visits

Patient Referrals



First Disease Center Referred to



TYPE OF RESOLUTION

Type of Resolution	All Patients (431) N(%)	Oncology/Heme Dx (182) N(%)
Referred to PCP	151(35)	63(35)
Surveillance Plan established	233(54)	88(48)
Treatment Plan established	37(9)	30(16)
Unresolved	10(2)	1(1)

Early Conclusions and Accomplishments

- Significant number of cancer patients in the primary care setting
- Patients and physicians recognize utility of the program. *Clinical trial enrollment* **15%** of all patient with cancer dx. 14/93. (**24.7%** of pts on active treatment)
- Formation of a clinical patient cohort with IRB approval of 326 patients with 89% (325/366) response
- Patient navigation database for tracking patient data

Outcomes of Interest

- Most important outcome is time to resolution in days.
- Given the low N only the univariate non parametric test median test can be performed at this time due to small sample size.
- ***Days to resolution is defined as clinic date - date of resolution.***

  All patients (420): Mean 33.8, Median 19

  SD: ± 55.3 days

  Oncology/heme patients (180): Mean: 30,

  Median:**12.5**, SD: ± *50* days (from WSHC median **32** days)

1. **Clinic Utilization and Smoking Cessation Practices among Ethnic Minority Patients Referred for Paired Lung Cancer Screening and Tobacco Treatment Services at a Community Cancer Program. (**AACR Conference on the Science of Cancer Health Disparities 2016)

- 70 patients: 26% clinic no show rate. Despite expressing a willingness to participate, the no show rate of study participants for smoking cessation counseling (65%) was significantly higher than the no show rate for the LDCT screenings (8%).

2. **Self-Reported Financial Stress Among Patients Evaluated at A Community Cancer Program.** (ASCO Annual Meeting 2017)

- 288 participants: In an adjusted analysis, patients who reported financial stress were more likely to be younger in age (OR = 4.03, $p < 0.001$) unemployed (OR = 3.24, $p = 0.002$), have less than bachelor's degree (OR = 0.035, $p=0.018$), insured by Medicaid (OR=3.22, $p < 0.011$), and were more likely to rate their QOL (OR = 3.76, $p = 0.031$) as poor, compared to those without financial stress. Race, gender, presence of cancer diagnosis and comorbidities were not associated with financial distress. Independent predictors of poor QOL were disability (OR = 3.12, $p = 0.005$), depression (OR=2.12, $p=0.007$) and extreme financial difficulty (OR = 2.57, $p = 0.011$). There was a nearly perfect positive correlation between overall QOL and QOH ($r = 0.984$, $p < 0.001$).

Summary

- An integrated model service model
  - Diagnosis—treatment—survivorship-end of life care
- Streamlined diagnostic services
  - Diagnostic clinic
  - Co-location in community health center
  - Tailored to the community health centers needs
- Internal Medicine and Oncology
  - Prevention
  - Screening
  - Survivorship

Concepts

- This model can be used in many settings clinics
- Increases the flow of patient to the cancer center
- Strengthens bonds in the community
- Allows for integration of prevention programs:
  - Genetics
  - Lung cancer Screening
  - Dental Referrals for head and neck cancer

Challenges

- Changing health care climate
- Competition often dilutes the mission
- Academic centers→ Community
- The work tends to be personality driven not institution driven
- Community goals versus academic center goals
- Sustainability

Summary and Next Steps

- Small sample size, but pilot data indicates that there could be some effect on median days to resolution.
- Sustainability
- Evaluation, qualitative, and qualitative: (diagnosis times, satisfaction evaluation, clinical operation efficiency review)
- Increase patient volume via expansion of the model to other sites
- Operationalize using an NP model

New Lung cancer screening Site: Dimock Health Center

- DHC, in Dorchester, Massachusetts, is one of the oldest community health centers in the Boston metro area, and serves an urban underserved patient population.

- Both WSHC and DHC are FQHCs with PCMH certification from the National Committee for Quality Assurance serving communities in Boston and the greater Boston area.

CCEP

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Supplemental Slides

Current Projects

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Current Projects

4. Cancer Genetic Counseling, Testing, and Outcomes in Two Distinct Patient Settings. Rana et al. (manuscript completed)

- Compared outcomes of cancer genetics consultations at DFCI and WSHC (58 tertiary and 23 FQHC patients) from 2013-2015.
- The two groups differed in race, ethnicity, use of translator services and type of insurance coverage. There were also significant differences in completeness of family history information, with more missing information about relatives in the FQHC group.
- In spite of these differences, genetic testing rates among those offered testing were comparable across the two groups with 74% of tertiary patients and 60% of FQHC patients completing testing
- Discussion focused on consideration for genetic testing in this populations even with less complete family history.