BRINGING ONCOLOGY SPECIALTY CARE TO THE COMMUNITY USING NURSING NAVIGATION

Christopher S. Lathan, M.D., M.S., M.P.H.
Assistant Professor of Medicine

Faculty Director of Cancer Care Equity,
**Dana-Farber Cancer Institute**

OVERVIEW

- Disparities in cancer care
  - Issues in Precision Medicine
  - SES/Race

- Intervention

- Future considerations and thoughts

RACIAL DISPARITIES IN HEALTH CARE

- Racial Disparities in health are well documented

- Racial and ethnic minorities receive a lower quality of health care even when income and access are accounted for

- Disparities exist through all sectors of the health care system

DISPARITIES FRAMEWORK

Kawaga-Singer CA, 2010
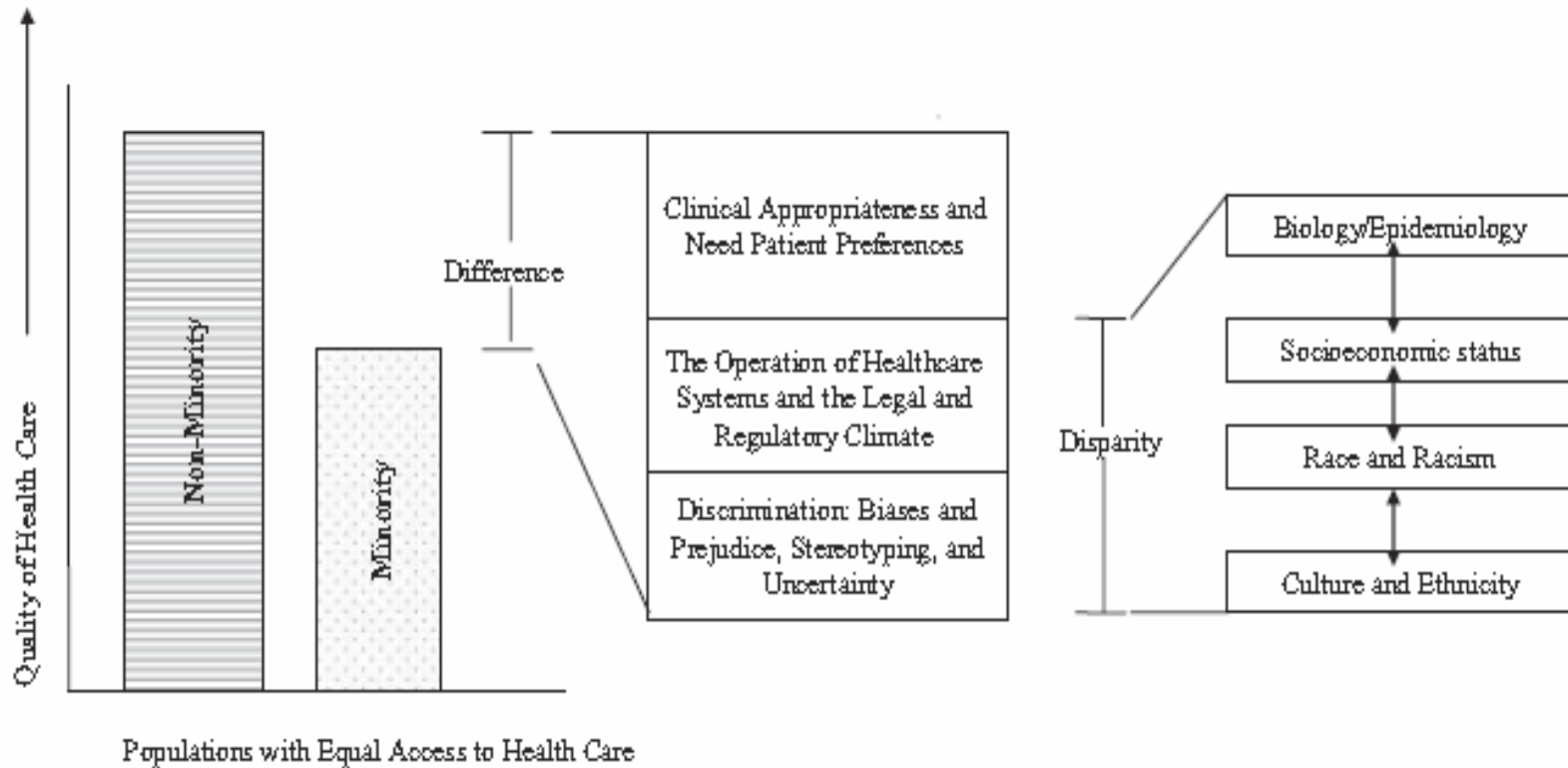
Trends in 5-year Relative Survival Rates* (%) by Race, US, 1975-2010

	All Races			White			Black		
	1975-77	1987-89	2004-10	1975-77	1987-89	2004-10	1975-77	1987-89	2004-10
All sites	49	55	68†	50	57	69†	39	43	62†
Brain & other nervous system	22	29	35†	22	28	33†	25	32	42†
Breast (female)	75	84	91†	76	85	92†	62	71	80†
Colon	51	60	65†	51	61	67†	45	52	56†
Esophagus	5	9	20†	6	11	21†	4	7	13†
Hodgkin lymphoma	72	79	88†	72	80	88†	70	72	85†
Kidney & renal pelvis	50	57	74†	50	57	74†	49	55	72†
Larynx	66	66	63†	67	67	64	58	56	52
Leukemia	34	43	60†	35	44	61†	33	35	54†
Liver & intrahepatic bile duct	3	5	18†	3	6	17†	2	3	13†
Lung & bronchus	12	13	18†	12	13	18†	11	11	15†
Melanoma of the skin	82	88	93†	82	88	93†	57‡	79‡	75
Myeloma	25	27	47†	24	27	47†	30	30	47†
Non-Hodgkin lymphoma	47	51	71†	47	51	73†	48	46	63†
Oral cavity & pharynx	53	54	66†	54	56	67†	36	34	45†
Ovary	36	38	45†	35	38	44†	42	34	36
Pancreas	3	4	7†	3	3	7†	2	6	7†
Prostate	68	83	>99†	69	84	>99†	61	71	98†
Rectum	48	58	68†	48	59	68†	44	52	63†
Stomach	15	20	29†	14	18	28†	16	19	28†
Testis	83	95	97†	83	96	97†	73‡#	88‡	90
Thyroid	92	94	98†	92	94	98†	90	92	96†
Urinary bladder	72	79	79†	73	80	80†	50	63	64†
Uterine cervix	69	70	70	70	73	71	65	57	62
Uterine corpus	87	82	83†	88	84	85†	60	57	65†

*Rates are adjusted for normal life expectancy and are based on cases diagnosed in the SEER 9 areas from 1975 to 1977, 1987 to 1989, and 2004 to 2010, all followed through 2011. †The difference in rates between 1975-1977 and 2004-2010 is statistically significant (p<0.05). ‡The standard error is between 5 and 10 percentage points. #Survival rate is for cases diagnosed from 1978 to 1980.

Source: Howlader N, Noone AM, Krapcho M, et al. (eds). SEER Cancer Statistics Review, 1975-2011, National Cancer Institute, Bethesda, MD, http://seer.cancer.gov/csr/1975_2011/, based on November 2013 SEER data submission.

American Cancer Society, Inc., Surveillance Research, 2015

Race and Economic Opportunity in the United States: An Intergenerational Perspective*

Raj Chetty, Stanford University and NBER
Nathaniel Hendren, Harvard University and NBER
Maggie R. Jones, U.S. Census Bureau
Sonya R. Porter, U.S. Census Bureau

March 2018

Abstract

We study the sources of racial and ethnic disparities in income using de-identified longitudinal data covering nearly the entire U.S. population from 1989-2015. We document three sets of results. First, the intergenerational persistence of disparities varies substantially across racial groups. For example, Hispanic Americans are moving up significantly in the income distribution across generations because they have relatively high rates of intergenerational income mobility. In contrast, black Americans have substantially lower rates of upward mobility and higher rates of downward mobility than whites, leading to large income disparities that persist across generations. Conditional on parent income, the black-white income gap is driven entirely by large differences in wages and employment rates between black and white men; there are no such differences between black and white women. Second, differences in family characteristics such as parental marital status, education, and wealth explain very little of the black-white income gap conditional on parent income. Differences in ability also do not explain the patterns of intergenerational mobility we document. Third, the black-white gap persists even among boys who grow up in the same neighborhood. Controlling for parental income, black boys have lower incomes in adulthood than white boys in 99% of Census tracts. Both black and white boys have better outcomes in low-poverty areas, but black-white gaps are *larger* on average for boys who grow up in such neighborhoods. The few areas in which black-white gaps are relatively small tend to be low-poverty neighborhoods with low levels of racial bias among whites and high rates of father presence among blacks. Black males who move to such neighborhoods earlier in childhood earn more and are less likely to be incarcerated. However, fewer than 5% of black children grow up in such environments. These findings suggest that reducing the black-white income gap will require efforts whose impacts cross neighborhood and class lines and increase upward mobility specifically for black men.

Race: Why is it hard to discuss?

Secure | https://www.nytimes.com/interactive/2018/03/27/upshot/reader-questions-about-race-gender-and-mobility.html

READER CENTER | 'When I See Racial Disparities, I See Racism.' Discussing Race, Gender and Mobility

MORE | 23

The Lone Journalist on the Scene When King Was Shot and the Newsroom He Rallied

We Want to Hear From You

TECH WE'RE USING
Twitter, Facebook, Slack: Using Every Tool to Hear What Readers Think

We Want to Hear From Public School Teachers

'Glee, Satisfaction and Weeping': How America Reacted When Martin Luther King Died

BULLETIN BOARD
What Topics Should the 'Tech We're Using' Column Tackle Next?

BULLE
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Expl

course of their lives.

— **Emily Badger**, Reporter, The Upshot

Jump to topic:

Causes of Inequality

Comparing Women and Men

Addressing Inequality and Racism

How the Research Was Done

How the Article Was Made

- COLLAPSE ALL

Why is racism the only explanation for this phenomenon? Perhaps something happens to black boys while they are growing up that makes them less capable of succeeding in the U.S. economy. For instance, maybe cultural forces cause black boys — but not black girls — to focus on activities that leave them with poorer time management skills than those that boys of other races are developing. So, why do the authors take the easy way out and blame amorphous racism instead of exploring more subtle explanations that do not make the situation seem hopeless?

Michael Sundel, Falls Church, Va.

Actually, the easy way out is to say there must be something wrong with these black boys. It is the easy way out that Americans have historically taken in trying to explain racial disparities in our society since the founding of the United States. Either there is something wrong with our policies, or there is something wrong with black boys (or black people). Either the United States is riddled with racist policies or inferior black boys. We have all sorts of evidence of racist policies. Where is the evidence that black boys *as a group* have "poorer time management skills" than white boys *as a group*? Personal observations of individual behavior is not evidence of group behavior. Racist ideas of black inferiority is the easy way out.

— **Ibram X. Kendi**, History and international relations professor, American University, and director, The Antiracist Research and Policy Center

It's hard to conclude from this study that the problem here is "culture" for two reasons: Girls don't appear to face the same racial disparities in income as boys, and boys face these disparities whether they're raised poor or rich, by two parents or one. If culture were the primary driver here, you'd have to argue that boys and girls *raised in the same family* are exposed to fundamentally different cultures. You'd have to argue that rich black boys

Extensive Data Sh....html

Show all

Socioeconomic Status and Cancer

CANCER OUTCOMES AND SES
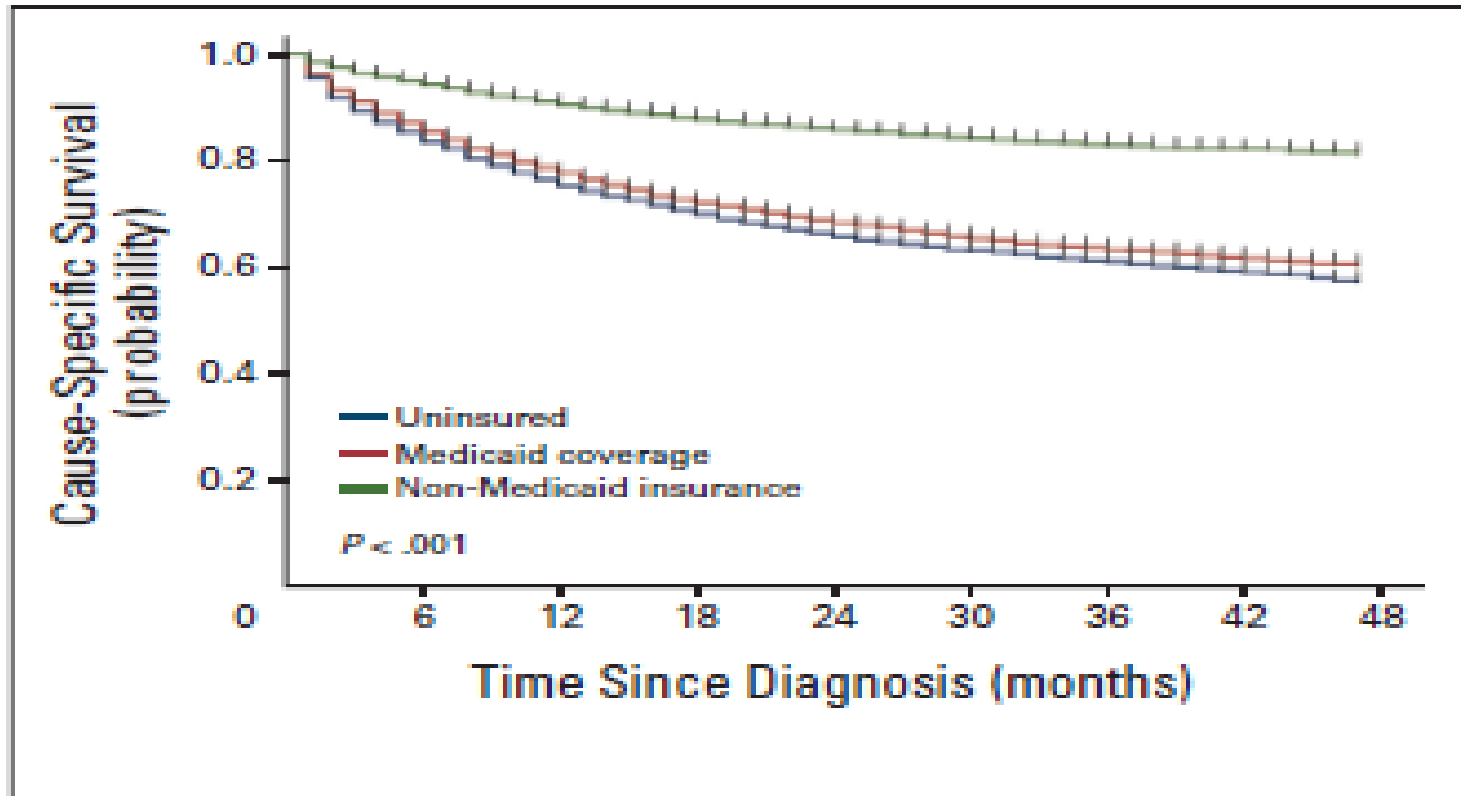
Fig 3. Unadjusted Kaplan-Meier curve illustrating cause-specific survival by insurance status for patients with one of 10 most deadly cancers. $P < .001$.

Walker et al, JCO 2014

CANCER OUTCOMES AND SES
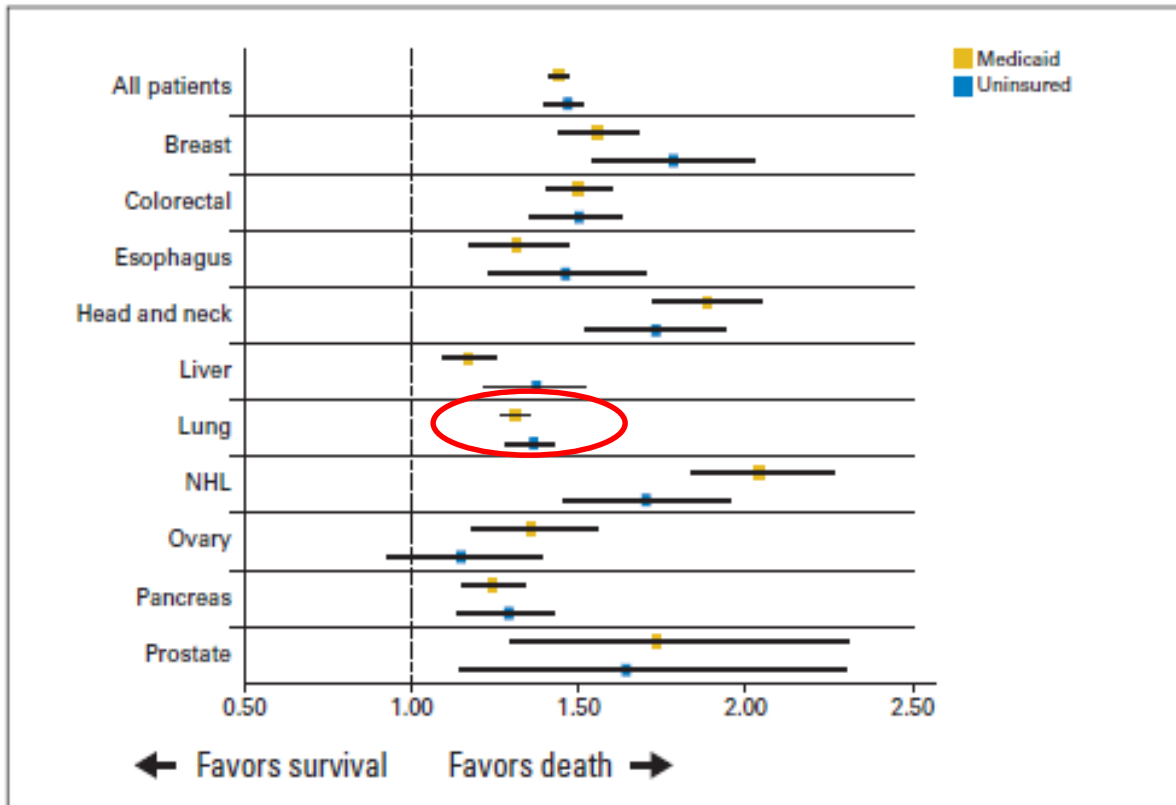
Fig 4. Forest plot depicting hazard ratios and 95% CIs for cancer-specific death for patients with Medicaid coverage and those with no insurance as compared with patients with non-Medicaid insurance. All sites controlled for age, race, sex, marital status, stage (local, regional, or distant), residence (urban v rural), percent of county below federal poverty level, and undergoing cancer-directed surgery and/or receiving radiation therapy. Breast and prostate sites also controlled for estrogen receptor and prostate-specific antigen and Gleason score, respectively. NHL, non-Hodgkin lymphoma.

Walker et al, JCO 2014

Bringing specialist care to the patients: Oncologists seeing patients at a community health center
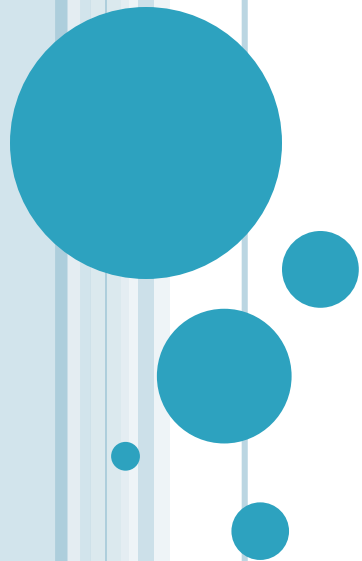
QUESTIONS FOR CANCER CENTERS

1. Where do patients of color, low SES, and immigrants get their cancer care?
   - Not getting treated?
   - Community cancer centers
   - Lack of data

2. How do we give high quality care to vulnerable populations while respecting fiscal realities?
   - Other medical specialties do it (renal dialysis)
   - Varied mix of payers (private insurers, Medicare, state safety net programs)

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

Rationale:

Inequities in care are present at every level, and data corresponded with local needs assessment.

Goal:

To improve local outcomes for the underserved across the spectrum of cancer-related disease by facilitating clinical access to the spectrum of preventive medicine, treatment, and clinical trials.

COMMUNITY HEALTH CENTER PARTNER

- Federally Qualified Heath Center: Grant under PHS, goal to improve access to care for underserved patient populations. 25,000 individual visits. Majority under the poverty line.

- Long-standing, existing relationships with DFCI and Brigham and Women's Hospital

- New building created opportunity for an outreach program, clinical facilities, onsite mammography and resource room

CANCER IN BOSTON

Population by Race/Ethnicity

Pie chart: White 48%, Asian 9%, Black 22%, Latino (of any race) 17%, Two or more races 2%, Other race 2%
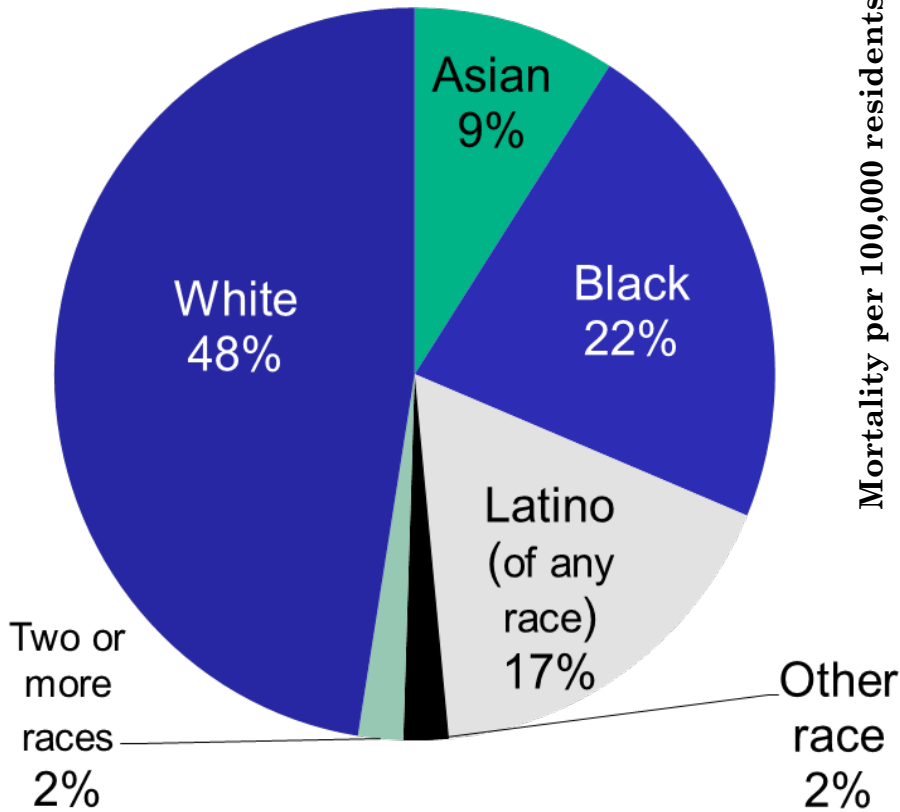
Boston Cancer Mortality Rates

Bar chart — Mortality per 100,000 residents vs. Race/Ethnicity (Asian, Black, Latino, White)

Patient

Has PCP

Does not
have PCP

**Primary Care
Physician (PCP)**

**Emergency
Department (ED)**

Patient sees
PCP

Patient sees ED physician

Scenario 1:
Asymptomatic
patient
undergoes
routine
screening

Scenario 2:
Patient presents
with non-urgent
cancer-related
symptoms

Scenario 3:
Patient presents
with urgent
cancer-related
symptoms
(referred to ED)

Scenario 1:
Symptoms
warrant *in-
patient care*
(referred to
specialists)

Scenario 2:
Symptoms
warrant *out-
patient care*
(referred to
specialists)

Evaluation follow-up

Normal
findings; no
referral
needed / back
to usual care

Abnormal
findings /
further
evaluation;
referral to
specialist

Oncology and
non-cancer
specialists

Outpatient treatment / follow-
up

- - - - - - - - - - - - - -

Potential loss to follow-up / referral

Waldman et al, Healthcare 2013

IMPLEMENTATION

Conceptualizing a clinical program:

- Oncology had limited physical presence in underserved communities

- Little interaction between oncology and primary care at the diagnostic stage of cancer

- Waiting for a "tissue diagnosis" before medical oncology involvement is problematic

- Over 1yr process of gauging interest, resulted in a partnership

- Enter the Fast Track process…

WHAT IS FAST TRACK?

A problem-solving methodology that enables teams to:
- Solve problems quickly
- Implement solutions within 90 days
- Improve sustainable outcomes

Requirements for a successful Fast Track:
- Clearly defined problem statement and goals
- The right stakeholders: those closest to the problem
- Enough information to develop solutions
- Skilled facilitation throughout process
- Immediate decision making by senior sponsors
- Solutions <u>and</u> implementation by stakeholders

<u>Key to Success</u>: Implementation of strategies and action plans by those who are closest to the issues.

SETTING THE FAST TRACK GOALS

Fast Track Goal Criteria: Best Goals Are:
-Measurable and tangible   -Results-Oriented
-Short-term, 90-100 day target   -Quantitative
-A significant improvement   -Simple and clear
-Achievable with defined   -Memorable
resources and authority   -Inspiring

Fast Track goals for the clinical outreach program

Structure	administrative processes and clinical care	for 10 pilot patients to obtain a resolution of their cancer symptoms within 21 days	within 100 days
Action Verb	What Will Be Changed	Measurement of Success	Time Frame

Waldman et al, Healthcare 2013

Patient Referral Process Flow

Internal Medicine, Community Health Center (CHC)

1. Internal Medicine refers patient to Cancer Center oncology program at CHC for integrated evaluation services

10. Patient follows up with PCP at CHC (no cancer)

Cancer Center Medical Oncologist

8. Patient sees medical oncologist at CHC

Work-up required?

From Box 11

18. Medical oncologist reviews work-up results

Does patient have cancer?

Start Box 11 or 15

Provide ongoing treatment?

19. Patient sees medical oncologist at CHC (cancer-related)

Cancer Center Oncology Program Nurse

2. Program Nurse performs clinical assessment; also notifies Cancer Center Access Management to obtain insurance clearance

7. Program Nurse schedules appt. w/ medical oncologist at CHC

5. Program Nurse schedules appointment with medical oncologist at CHC and informs medical oncologist that patient has high-risk insurance

Does patient have high-risk insurance?

15. Program Nurse notifies Access Management and TCAMC Referral Coordinator about patient work-up/treatment required

9. Program Nurse refers patient back to Internal Medicine

11. Program Nurse completes "Mini-Registration"; schedules work-up, treatment, and/or follow-up appoint *(provides facesheet)*;

17. Program Nurse works w/ Internal Medicine / Referral Coordinator to schedule work-up / treatment at other facility

End CHC process; start Cancer Center "New Patient Process – No Insurance Follow-Up"

Cancer Center Access Management

6. Access Mgmt notifies Program Nurse of insurance clearance

3. Access Mgmt verifies patient's insurance coverage and benefits (within 24 hours)

Insurance concerns? *(Other Facility, Self-Pay, etc.)*

Can/does patient want to switch insurance?

4b. Access Mgmt assists with/ confirms insurance switch/coverage

4a. Access Mgmt notifies Program Nurse that patient has high-risk insurance

16. Access Mgmt requests authorization for Imaging only

Authorization obtained?

Tertiary Care Academic Medical Center (TCAMC)

12. TCAMC registers patient; schedules work-up / treatment

Referral Coord. requests auth for work-up/treatment; excludes Imaging

13. TCAMC specialist provides work-up/treatment

14. TCAMC bills insurance/payer

Waldman et al, Healthcare 2013

Patient

Primary Health Care Center

Follow-up ←→ 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

Clinical Data Collection

Clinic open for 6 yrs.

- Computerized New Patient intake form & Patient navigation database in Redcap

- Evaluation of data from the cohort

- Pre program data from the health center

Evaluation of the Intervention

Baseline Data:
Total Number of Cancer Diagnoses, 2005-11

Type of cancer	# DX	# Dx 2009-11	# Dx pre-2009	% Treated at BMC
Breast	35	11	24	57.14
GI (liver, colon, rectal)	21	13	8	66.67
GU (bladder, kidney, prostate)	42	14	28	42.86
Lung	6	5	1	66.67
Gyn (cervix, ovarian)	19	4	15	13.79
Heme (lymphoma, leukemia)	4	1	3	25.00
Other (skin, brain, thyroid)	9	1	8	33.33
Total	136	49	87	43.84

CLINIC VISIT DATA

Percentage

41%

59%
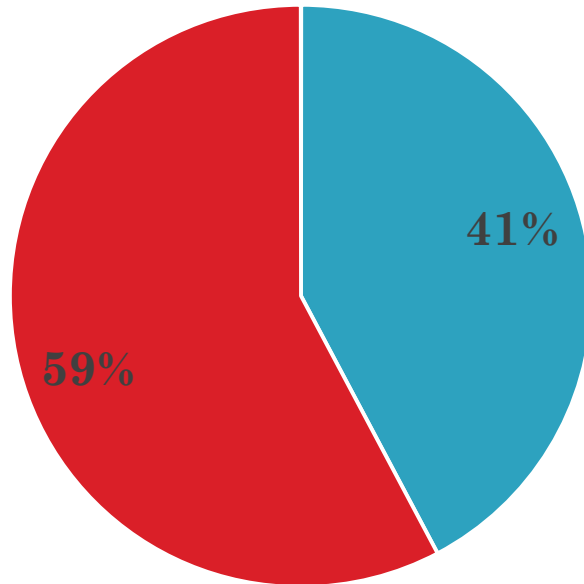
■ **Heme/Onc Dx** ■ **Non Heme/Onc Dx**

869 total patient visits

- 479 new patients

- 390 follow-ups

PATIENT DEMOGRAPHICS: OUTREACH

Age Category	N	Percentage
18 - 29	52	10.9
30 - 39	66	13.8
40 - 49	72	15.0
50 - 59	134	28.0
60 - 69	113	23.6
70 - 79	29	6.1
80+	13	2.7
Total	**479**	**100.0**

Gender	N	Percentage
Female	285	59.5
Male	194	40.5
Total	**479**	**100.0**

PATIENT DEMOGRAPHICS: OUTREACH

Primary Race	N	Percentage
American Indian or Alaskan Native	4	< 1
Asian	2	< 1
Black or African American	311	67.0
Native Hawaiian or other Pacific Islander	1	< 1
White	110	23.7
Other	19	4.1
Two or more	17	3.7
Missing	15	2.8
Total	**479**	**100.0**

Hispanic Ethnicity	N	Percentage
Yes	219	45.7
No	257	53.6
Missing	3	0.7
Total	**479**	**100.0**

PATIENT DEMOGRAPHICS: OUTREACH

Insurance	N	Percentage
Commercial Insurance	53	11.0
Commonwealth Health Care	18	3.8
HSN or Free Care	37	7.7
Medicaid	254	53.0
Medicare	112	23.3
Other	3	0.7
Missing	2	0.4
Total	**479**	**100.0**

PATIENT DEMOGRAPHICS: OUTREACH

Education Status	N	Percentage
Some primary or elementary school	35	7.5
Some secondary or high school	79	16.8
Secondary or high school graduate or GED equivalent	125	26.7
Vocational/technical school graduate	27	5.8
Some University, but did not graduate	98	20.9
Bachelors Degree	63	13.4
Graduate/Professional Degree (e.g., MA, PhD)	32	6.8
Other	10	2.1
Missing	10	2.1
Total	**479**	**100.0**

Employment Status	N	Percentage
Employed 32 hrs/wk or more	161	34.0
Employed less than 32 hrs/wk	60	12.5
Full-time student	6	1.3
Unemployed, seeking work	77	16.0
Employed less than 32 hrs/wk & part-time student	3	0.6
Homemaker	28	5.8
Unable to work due to disability	74	15.4
Retired	65	13.7
Missing	5	1.0
Total	**479**	**100.0**

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	479

CANCER DIAGNOSIS
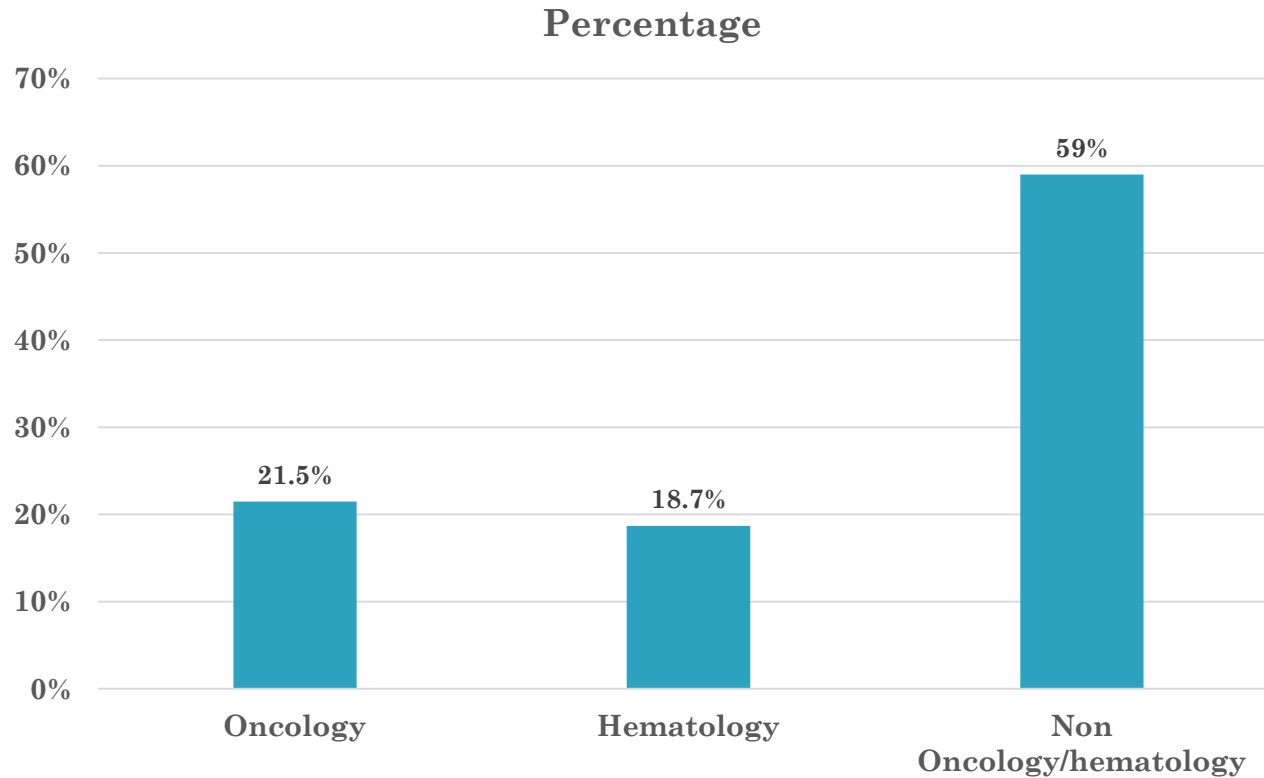
Percentage

103 oncology visits
90 heme visits
283 Non Onc/heme visits

PATIENT REFERRALS

% of Total Patient Referrals
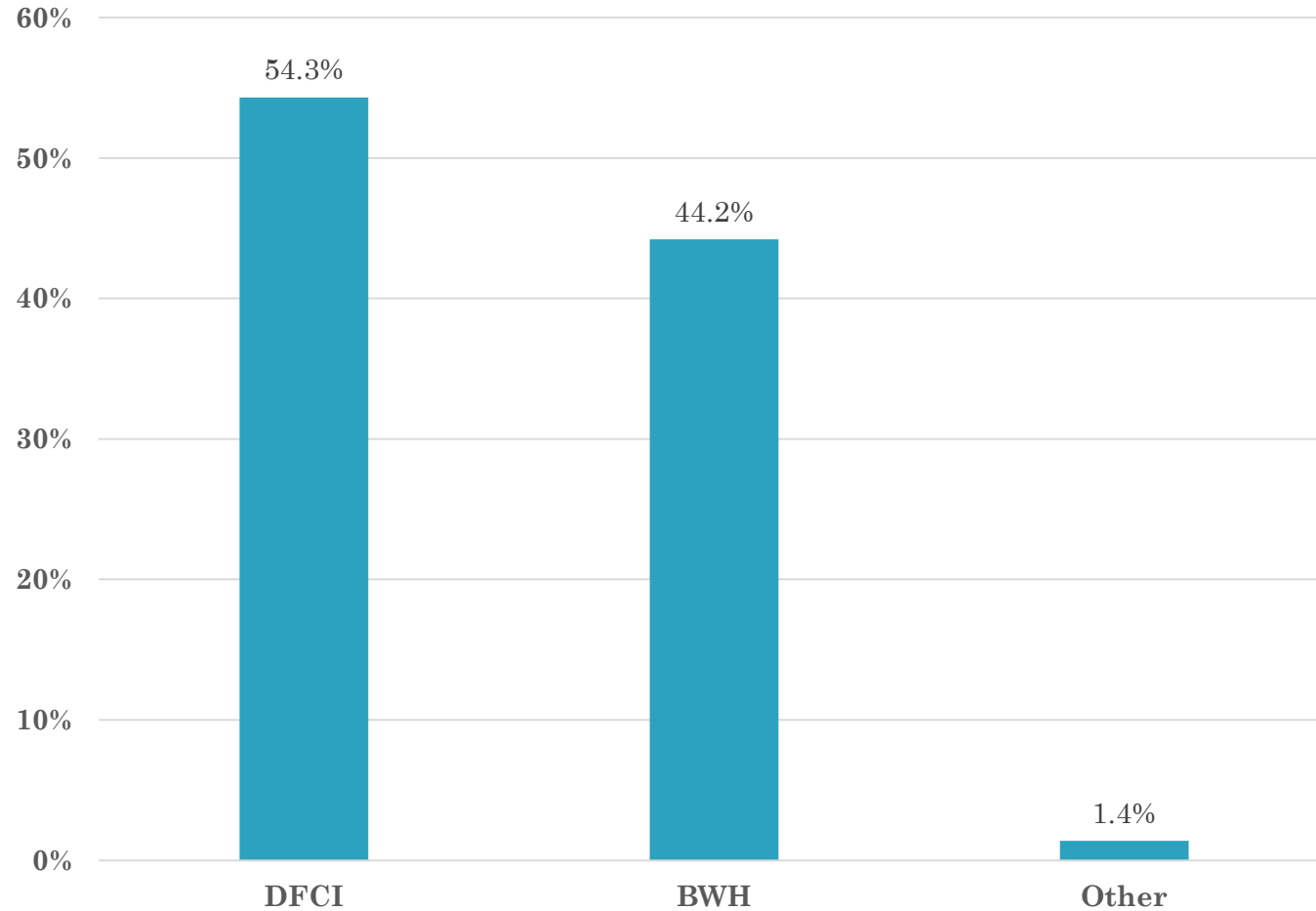
FIRST DISEASE CENTER REFERRED TO

Percentage

TYPE OF RESOLUTION

% of total patients n= **479**

% of those with Dx n= **193**
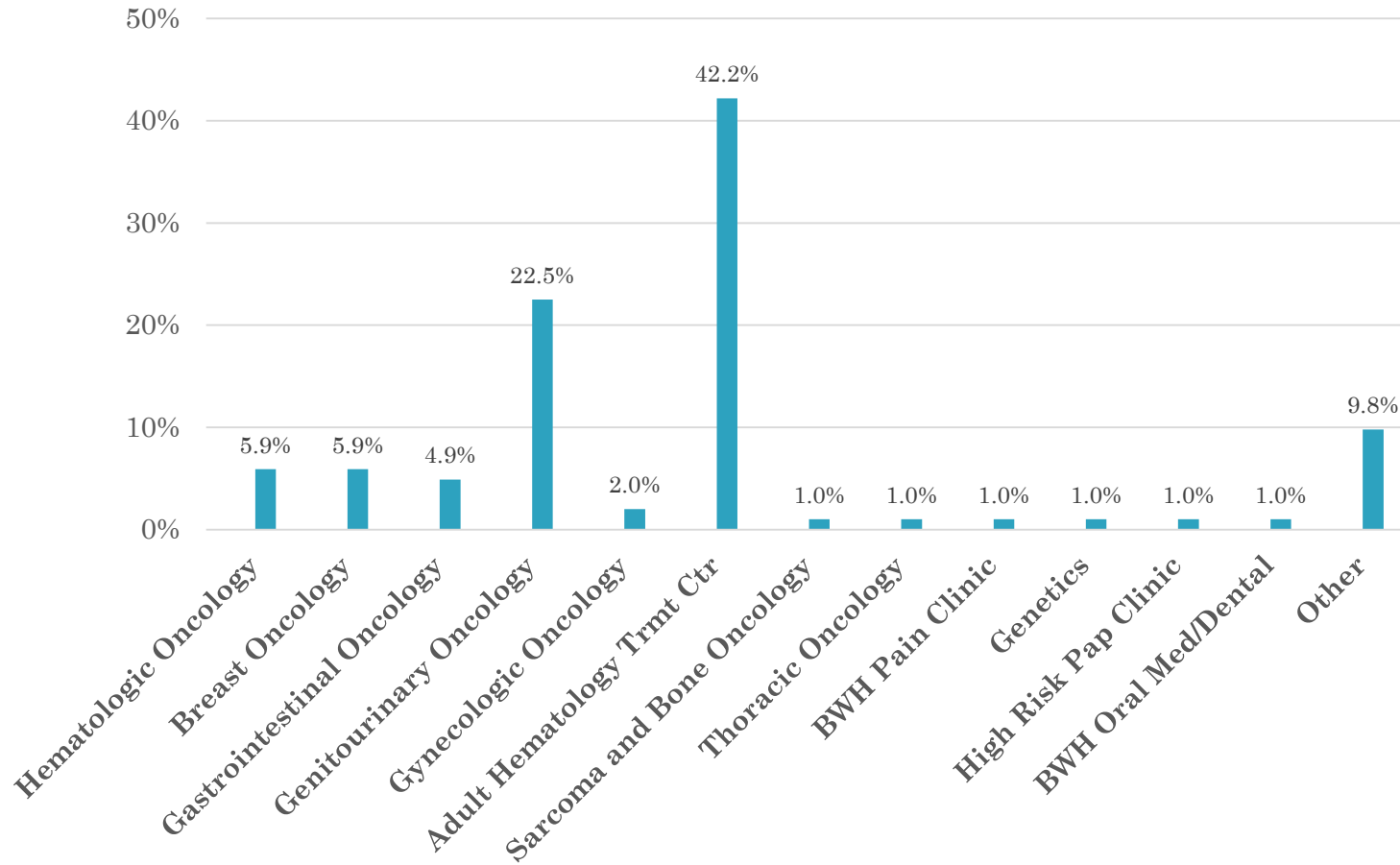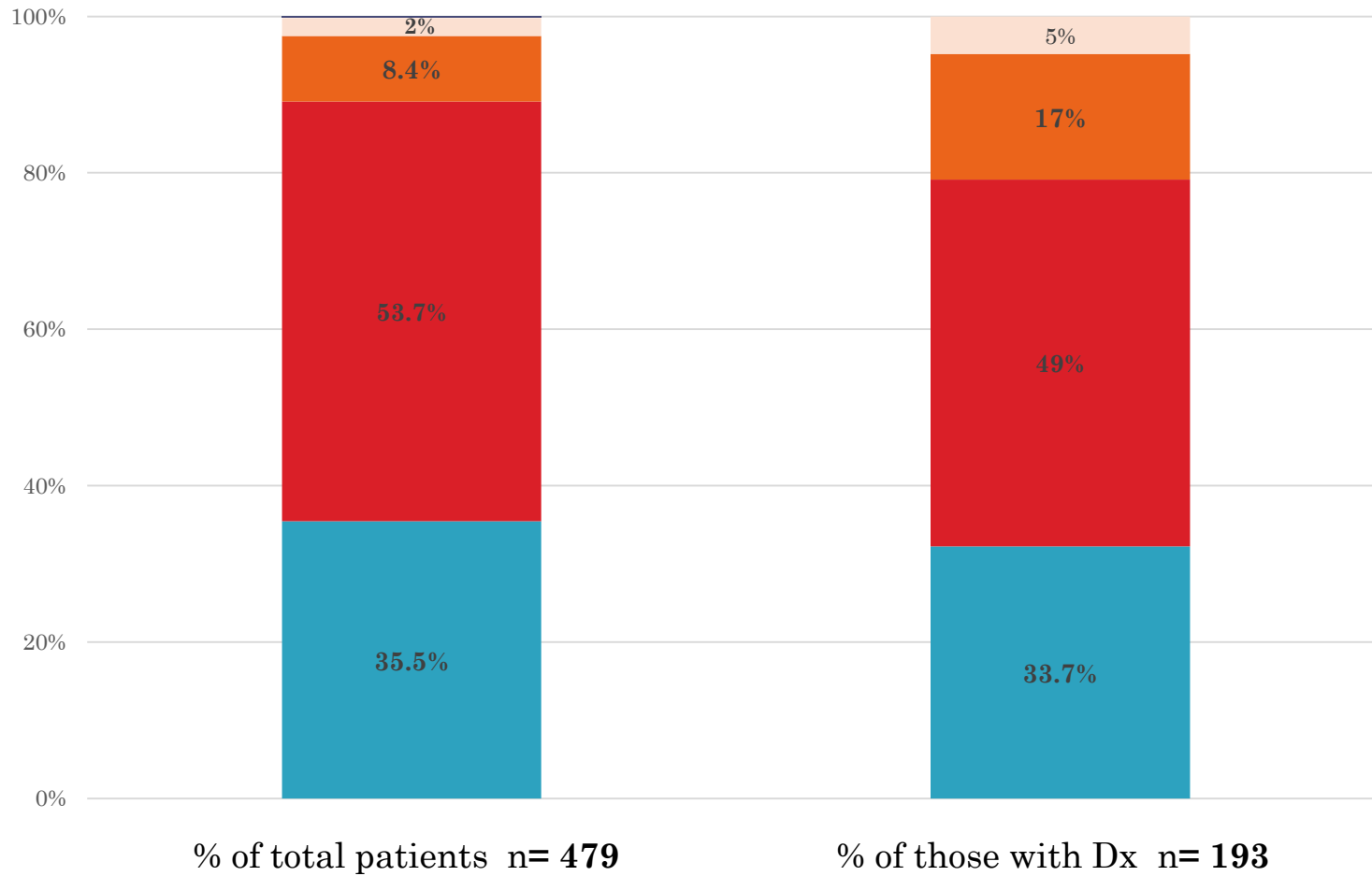
Referred to PCP ■ Surveillance Plan ■ Treatment Plan ■ Unresolved ■ Other

EVALUATION OF ONCOLOGY PATIENT NAVIGATION

Metrics for Evaluating Patient Navigation During Cancer Diagnosis and Treatment

Crafting a Policy-Relevant Research Agenda for Patient Navigation in Cancer Care*

B. Ashleigh Guadagnolo, MD, MPH[1]; Daniel Dohan, PhD[2]; and Peter Raich, MD[3]

BACKGROUND: Racial and ethnic minorities as well as other vulnerable populations experience disparate cancer-related health outcomes. Patient navigation is an emerging health care delivery innovation that offers promise in improving quality of cancer care delivery to these patients who experience unique health-access barriers. Metrics are needed to evaluate whether patient navigation can improve quality of care delivery, health outcomes, and overall value in health care during diagnosis and treatment of cancer. **METHODS:** Information regarding the current state of the science examining patient navigation interventions was gathered via search of the published scientific literature. A focus group of providers, patient navigators, and health-policy experts was convened as part of the Patient Navigation Leadership Summit sponsored by the American Cancer Society. Key metrics were identified for assessing the efficacy of patient navigation in cancer diagnosis and treatment. **RESULTS:** Patient navigation data exist for all stages of cancer care; however, the literature is more robust for its implementation during prevention, screening, and early diagnostic workup of cancer. Relatively fewer data are reported for outcomes and efficacy of patient navigation during cancer treatment. Metrics are proposed for a policy-relevant research agenda to evaluate the efficacy of patient navigation in cancer diagnosis and treatment. **CONCLUSIONS:** Patient navigation is understudied with respect to its use in cancer diagnosis and treatment. Core metrics are defined to evaluate its efficacy in improving outcomes and mitigating health-access barriers. *Cancer* 2011;117(15 suppl):3565-74. © 2011 American Cancer Society.

KEYWORDS: patient navigation, treatment adherence, quality of cancer care.

Core metrics during cancer screening and diagnosis
- Diagnostic resolution
- Timeliness of care
- Patient education
- Continuity of care

Core metrics during cancer treatment
- Goals of treatment
- Timeliness of care
- Treatment adherence
- Guideline adherence
- Clinical trial participation

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 (475): Mean: 32, Median:16
   SD: ± *53.2* days
  Oncology/heme patients (193): Mean: 29,
   Median:**13.0**, SD: ± *48.5* days (from WSHC median **32** days)
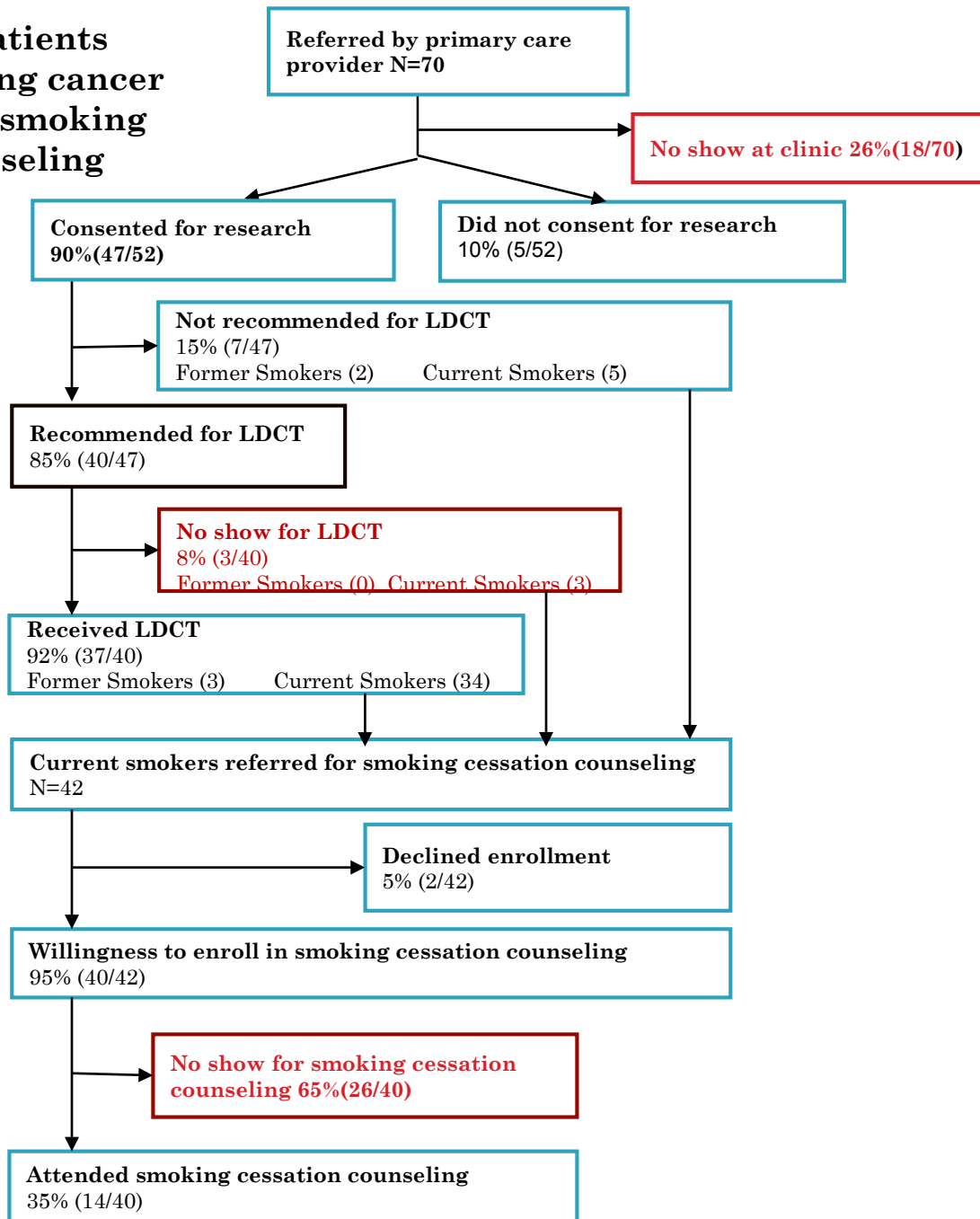
EARLY CONCLUSIONS AND ACCOMPLISHMENTS

- Significant number of cancer patients in the primary care setting

- Patients and physicians recognize utility of the program. *Clinical trial enrollment-***7.4%** of all patient with cancer Dx (14/193).

- **17%** of pts on active treatment

- Formation of a clinical patient cohort with IRB approval of 364 patients with **89%** (364/407) response

- Patient navigation database for tracking patient data

RESEARCH PROJECTS

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%).

**Summary of patients referred for lung cancer screening and smoking cessation counseling**

Referred by primary care provider N=70

No show at clinic 26%(18/70)

Consented for research 90%(47/52)

Did not consent for research 10% (5/52)

Not recommended for LDCT 15% (7/47)
Former Smokers (2)   Current Smokers (5)

Recommended for LDCT 85% (40/47)

No show for LDCT 8% (3/40)
Former Smokers (0) Current Smokers (3)

Received LDCT 92% (37/40)
Former Smokers (3)   Current Smokers (34)

Current smokers referred for smoking cessation counseling N=42

Declined enrollment 5% (2/42)

Willingness to enroll in smoking cessation counseling 95% (40/42)

No show for smoking cessation counseling 65%(26/40)

Attended smoking cessation counseling 35% (14/40)

RESEARCH PROJECTS

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

o 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 a 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.

o Race, gender, presence of cancer diagnosis and comorbidities were not associated with financial distress.

o 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).

Fig. Quality of Life by Patient Characteristics
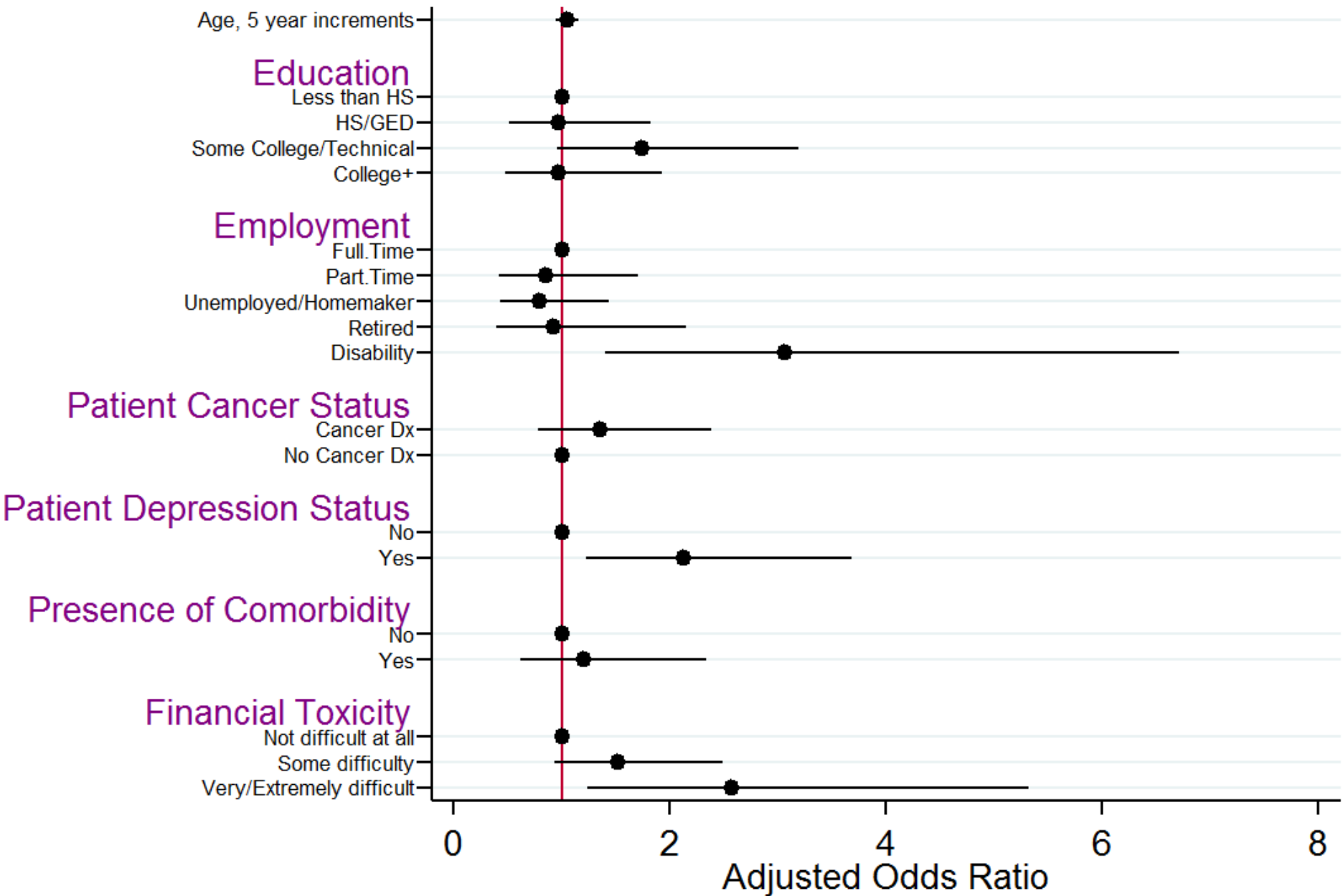
RESEARCH PROJECTS

3. Cancer Genetic Counseling, Testing, and Outcomes in Two Distinct Patient Settings. (Rana et al. Journal of Community Genetics)

- 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.

SUMMARY

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

CHALLENGES

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

CONCEPTS

- This model can be used in both licensed and unlicensed health clinics
- Increases the flow of patient to the cancer center
- Strengthens bonds in the community
- Allows for integration of prevention/educational programs:
  - Genetics
  - Lung cancer Screening
  - Dental Referrals for head and neck cancer
  - Tobacco education initiative in residential addiction recovery programs

SUMMARY

- Descriptive research in disparities is useful, but the only way to try to address outcomes is via community based interventions.

- Community based interventions take time, and effort to establish relationships, and sustain efforts

- Our outreach initiative needs thorough prospective evaluation of the metrics, although some suggestion of improvement in clinical trial involvement, and time to resolution has been seen.

- Limited by small n. Cost effectiveness can follow after clinical effectiveness is evaluated.

CCEP

Christopher Lathan, MD, MS, MPH
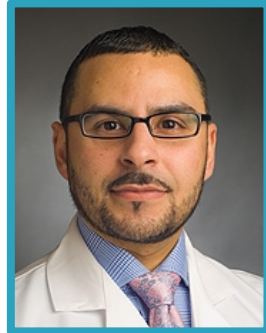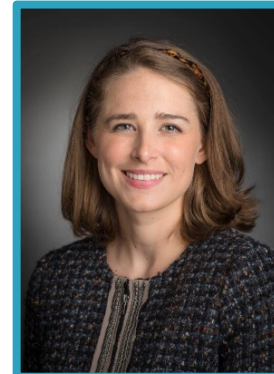
Aymen Elfiky, MD, MPH

Huma Rana, MD

Ludmila Svoboda, RN, BSN, MA, OCN

Sarah Cochrane, MS, LGC

Leah Stockman, Project Manager

Rebecca Jackson, Community Health Educator

Audrey D'Atri, Administrative Assistant

ACKNOWLEDGEMENTS

Ludmila Svoboda
Ruth Akindele
Audrey D'Atri
Rebecca Jackson
Daniel Gunderson
Aymen Elfiky
Anne Levine
Lori Buswell

Deb Schrag
Joe Jacobson
Karen Marr
Kitty Hooper
Rachel Allende
Nancy Pena
Rina Bernadez