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NCI COMMUNITY CANCER CENTERS PROGRAM

# *TRANSFORMING CANCER CARE & RESEARCH IN COMMUNITY HOSPITALS*:

# *NCI Community Cancer Centers Program Status Update*


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Applied Research Program

Division of Cancer Control and Population Sciences


*National Cancer Advisory Board, Bethesda, Maryland, February 18, 2010*

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# NCI Collaborative Effort

- **NCI OD**
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  - Dr. Sanya Springfield
- **DCCPS**
  - Dr. Steve Clauser
  - Dr. Julia Rowland
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- **DCTD**
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  - Dr. Leslie Derr
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  - Ms. Sabrina Islam-Rahman
- **SAIC-Frederick, Inc.**
  - Ms. Joy Beveridge
  - Mr. Shannon Jackson
  - Ms. Deb Hill
  - Mr. Frank Blanchard
- **Consultants**
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  - Dr. Mary Fennell
  - Ms. Donna O'Brien

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# NCCCP Status Report

- **Where We Have Been**
- **Where We Are**
- **Where We Are Going**

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# Defined the Need

- 85% of cancer patients receive their care in their local communities
- Practice patterns and quality, not optimal
- Disparities, a continued national challenge
- Limited research within community setting,

  3% of adults accrued to cancer trials
- Expanding science requires new approaches, infrastructure, connections

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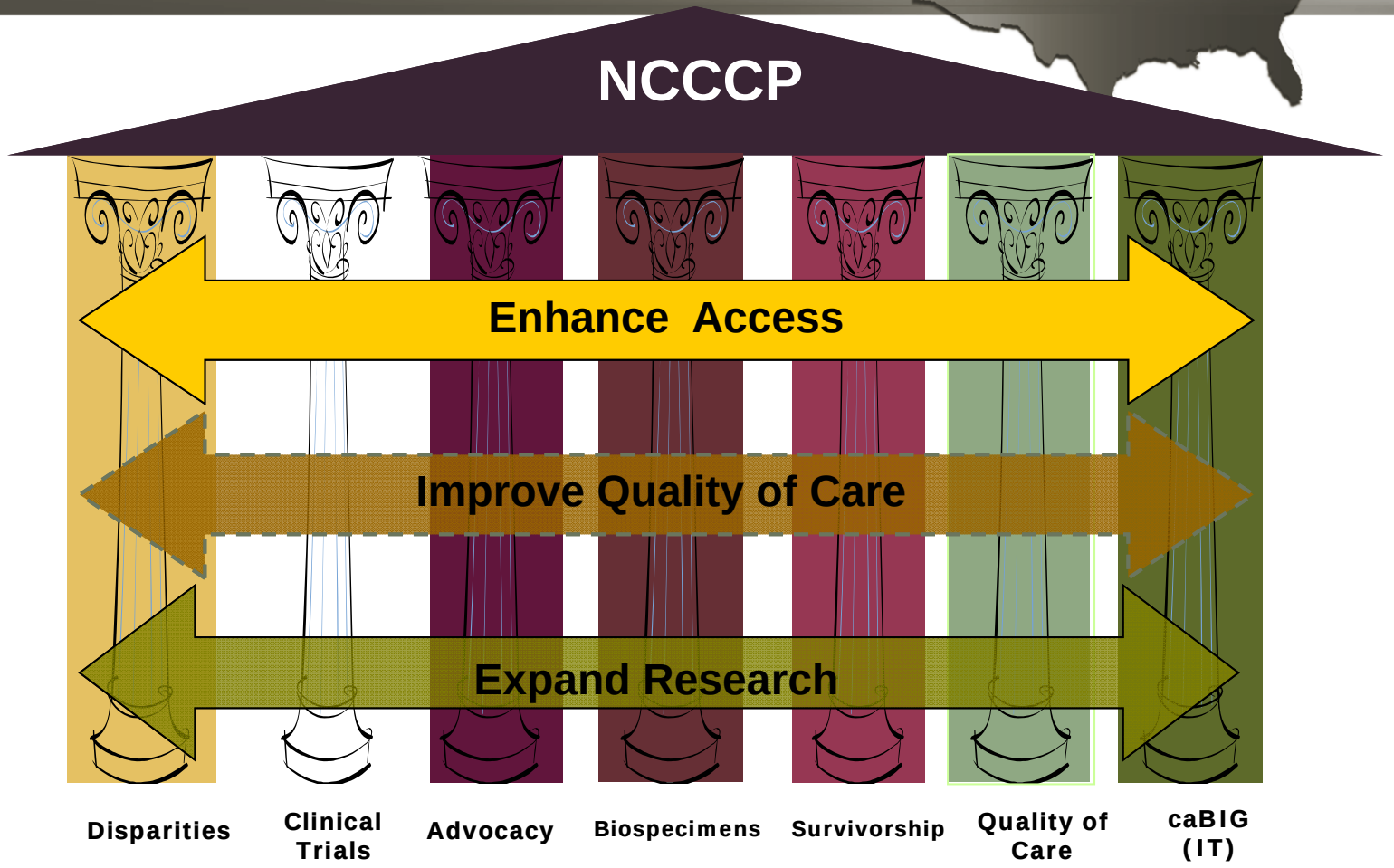
# Set NCCCP Goals and Mechanisms




**Cancer Continuum**

Prevention | Screening | Treatment | Palliative Care | Follow-up | Survivor Support | End-of-life Care

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# Awarded 10 Subcontracts with 16 sites in 2007

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# Emphasized Unique Program Attributes

- Public-Private Partnership
  - Local co-investment ($2.65 for every $1 NCI dollar)
- Physician-Management Partnership
  - Direct involvement of hospital leadership
- Networking Among Sites
  - Extensive subcommittee work and sharing of best practices
- Leveraging of NCI scientific resources
  - NCI-designated Cancer Centers
  - CCOPs, MB-CCOPS, CNPs, etc.
- Rigorous program evaluation methods
  - RTI International, independent evaluation contractor

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# Where we are – Progress and Challenges

- Healthcare Disparities
- Quality of Care
- Survivorship and Palliative Care
- Clinical Trials
- Biospecimens
- Information Technology

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# Healthcare Disparities

## Challenge

- Sites' knowledge and capacity to focus disparities efforts to drive measurable improvements

## Accomplishments

- Developed NCCCP Disparities Vision, Workplan and Dashboard with metrics to focus effort
- Improved sites understanding of how to identify and address healthcare disparities
- Sites have built capacity and invested in staff and programs
- Improved race/ethnicity tracking – OMB Guidelines

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# Quality of Care

## Challenge

- Data and care coordination issues related to working with private practice physicians

## Accomplishments

- Created and implemented site-assessment tools for multi-disciplinary care, & genetics counseling and testing
- Participating in National Quality Initiatives
  - Commission on Cancer's *Rapid Quality Reporting System*
  - ASCO Quality Oncology Practice Initiative® NCCCP data

# Commission on Cancer

## Rapid Quality Reporting System (RQRS)

A MULTIDISCIPLINARY PROGRAM OF THE AMERICAN COLLEGE OF SURGEONS

Home | Alerts | Case List | Comparisons

### RQRS Year-To-Date Estimated Performance Rates

Last Update: 03/03/2009

### Breast Cancer Measures

**BCS**

Details (BCS/RT)

Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer.

**MAC**

Details (MAC)

Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage II or III hormone receptor negative breast cancer.

**HT**

Details (HT)

Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0, or Stage II or III hormone receptor positive breast cancer.

### Colon Cancer Measures

**12RLN**

Details (12RLN)

At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.

**ACT**

Details (ACT)

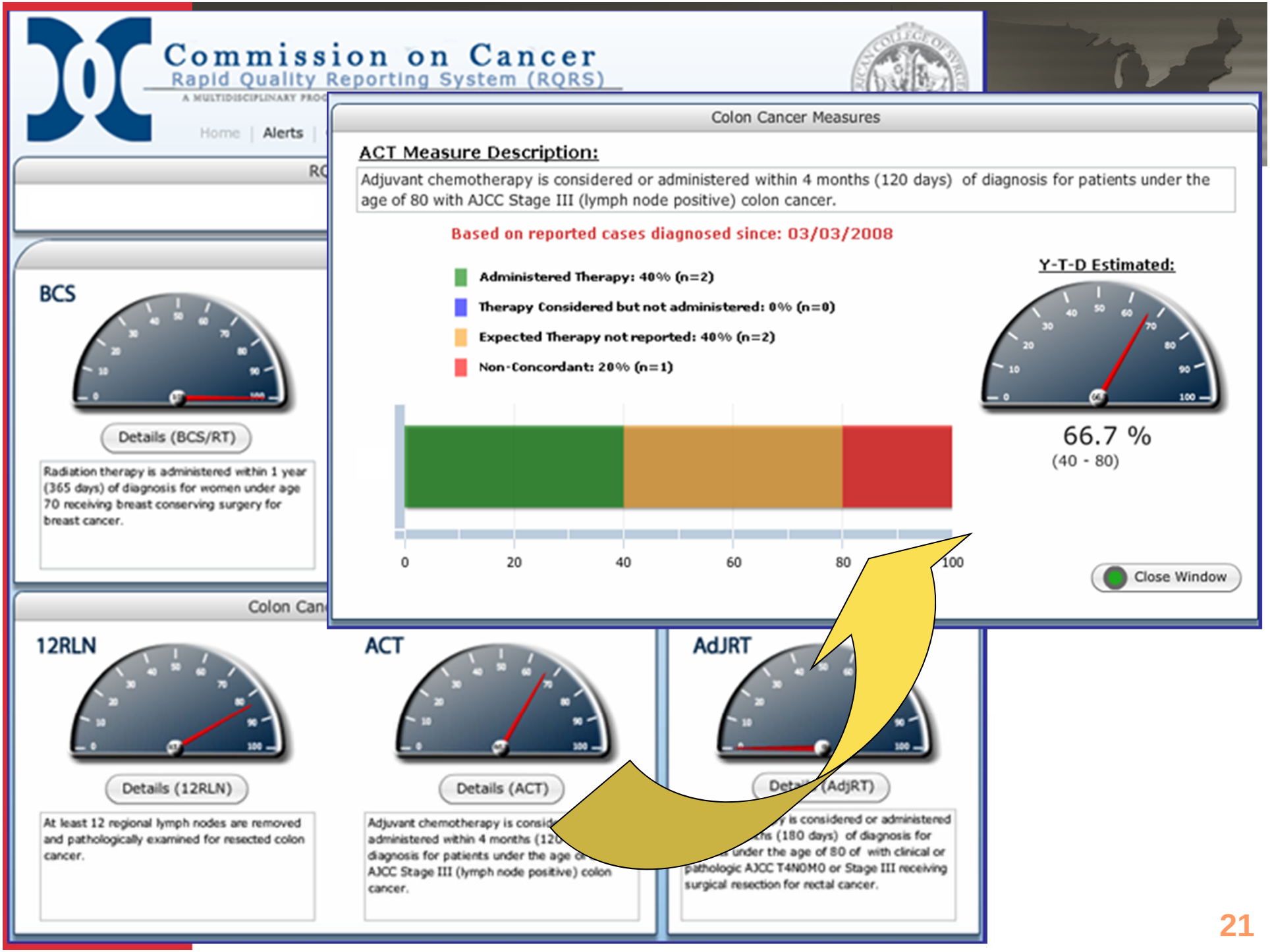
Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer.

### Rectal Measure

**AdJRT**

Details (AdjRT)

Radiation therapy is considered or administered within 6 months (180 days) of diagnosis for patients under the age of 80 of with clinical or pathologic AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer.


Commission on Cancer
Rapid Quality Reporting System (RQRS)
Home | Alerts
Colon Cancer Measures
ACT Measure Description:
Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer.
Based on reported cases diagnosed since: 03/03/2008
Administered Therapy: 40% (n=2)
Therapy Considered but not administered: 0% (n=0)
Expected Therapy not reported: 40% (n=2)
Non-Concordant: 20% (n=1)
0
20
40
60
80
100
Y-T-D Estimated:
66.7 %
(40 - 80)
Close Window
BCS
Details (BCS/RT)
Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer.
12RLN
Details (12RLN)
At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.
ACT
Details (ACT)
AdJRT
Details (AdjRT)
pathologic AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer.

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# NCCCP QOPI ® Program

- NCCCP-affiliated oncology practices volunteer to participate
- ASCO provides practice profiles at the NCCCP site level
- NCCCP QOPI ® physicians share improvement data, assess improvement opportunities, and QI targets

Siegel, RD., Clauser, SB., Lynn, JM. “A National Collaborative to Improve Oncology Practice: The NCI Community Cancer Centers Program QOPI Experience.” *Journal of Oncology Practice*, vol. 5(6) 2009.

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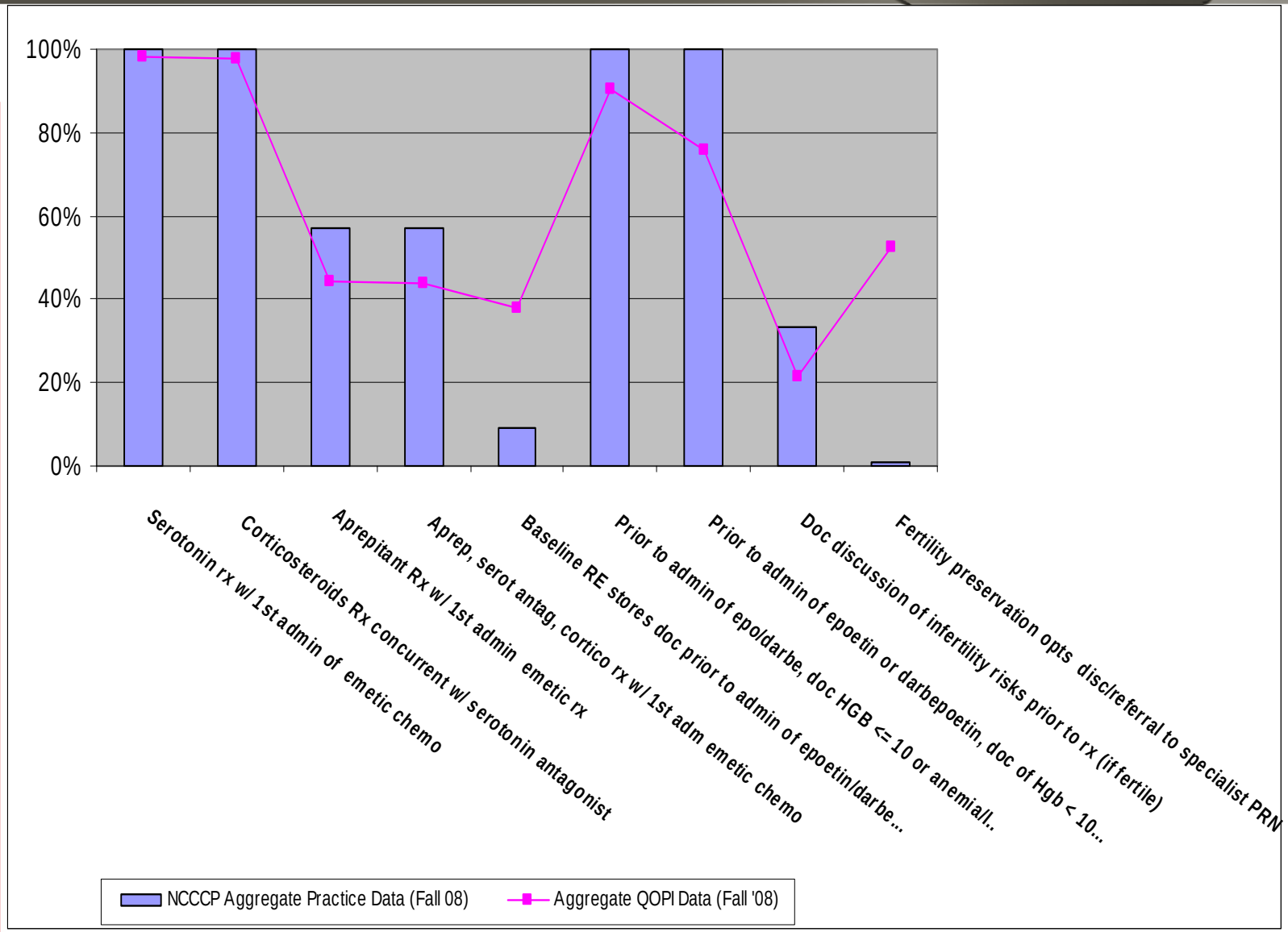
# NCCCP/QOPI® Summary Performance Symptom/Toxicity Module – Fall 2008



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# Survivorship and Palliative Care

## Challenges

- Lack of comprehensive approach and dedicated programs to address survivorship issues

## Accomplishments

- Shared best practices on implementation of treatment summary and care plan documents
  - NCCCP QOPI® network identified best practices and strongest performers that other sites could learn from
- Developed program matrix assessment tools for:
  - comprehensive palliative care delivery
  - comprehensive psychosocial care delivery
- Showcased model educational/intervention programs for survivors and their families

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# Clinical Trials

## Challenges

- Limited participation in clinical trials, including minority and other underrepresented populations

## Accomplishments

- High accrual to Wake Forest CLL Trial (Cancer Control):
  - Entered 63 patients (22% of trial total of 293) and provided 42% of the CTSU accrual
  - CCOP Research Base trial on CTSU menu with narrow accrual window
- Clinical trial log workgroup created a permanent IT application that allows for:
  - Dynamic data entry… reliable data
  - Site directed management / accountability
  - Real-time queries/outcomes
- Collaborative Effort with CCOP Leadership

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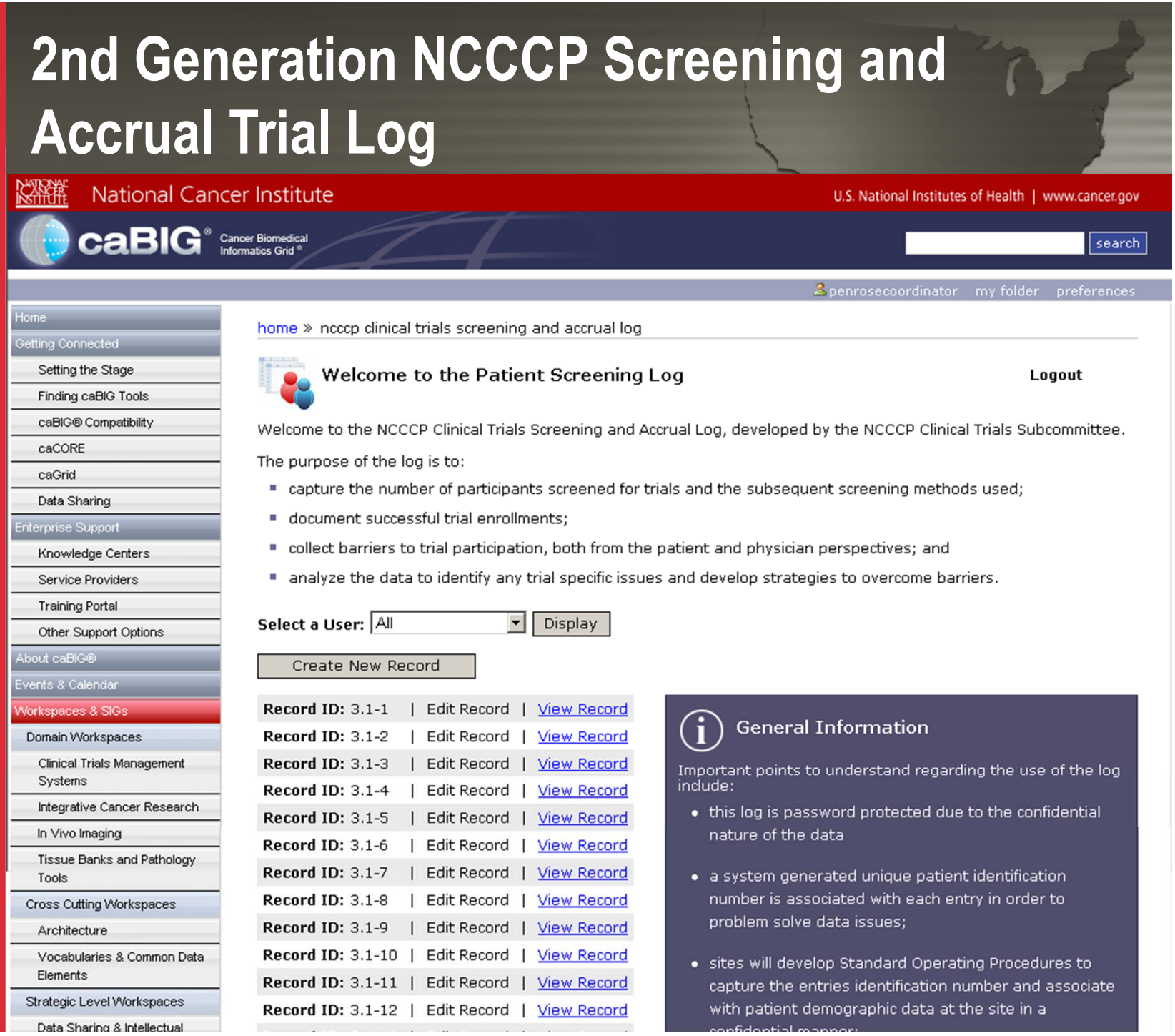
# 2nd Generation NCCCP Screening and Accrual Trial Log



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# Biospecimens

## Challenges

- Lack of high quality biospecimens for research purposes

## Accomplishments

- 100% of sites use best practice formalin-fixation protocol for breast cancer ER/PR/HER2 testing
- Developed a model protocol for non-routine biospecimen disposal with the Disparities Subcommittee
  - For example: special religious and cultural requests
- 3 sites participate in the NCI TCGA program
- 5 sites participate in the Moffitt Total Cancer Care (TCC) program
  - Hartford Hospital had highest tissue quality of ***all*** TCC tissue source sites

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# Information Technology – caBIG and EHRs

## Challenges

- caBIG® Technology Deployment – Lack of connectivity with national research cancer data network
- Limited use of EHRs and few linkages with private physicians

## Accomplishments

- 11 of 16 NCCCP sites are implementing caBIG® tools
  - 3 sites have caBIG® tools in use to date (caTissue and NBIA)
  - 8 sites to implement caBIG® tools by summer 2010
- 9 of 16 NCCCP sites have operational HER
  - 2 additional sites to deploy EHR by summer 2010
- ASCO/NCCCP Oncology EHR Whitepaper – Oct 2009

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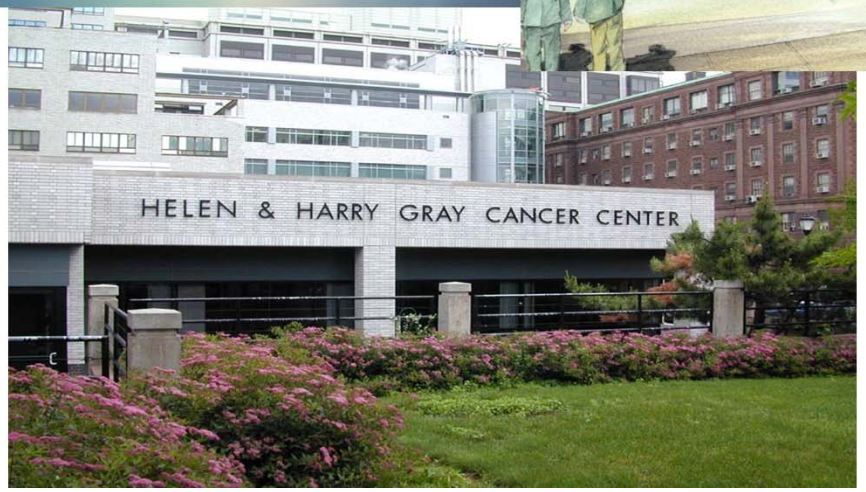
# Where We Are Going – New Initiatives



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# NCCCP Network is Expanding

- $80 million ARRA Investment

  (2 years of funding)

  - $40 million to current NCCCP organizations
    - 18 specific projects
    - Many NCI program collaborations (EDDP, CNP, PRO-CTCAE)
  - $40 million to new organizations
    - ~14 community cancer centers to join network
    - Raising the bar on program requirements
- Procurement process ongoing, awards anticipated by Spring 2010

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# QUESTIONS for the NCAB

- What is the role of NCI in developing community-based research infrastructure to enhance its mission?
- How can public-private partnership models (with local investment) be best leveraged by NCI?
- What do we need to learn during the next NCCCP funding period to inform the future of the program?

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# Extra Slides for Discussion

- End of Formal Presentation

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# New NCCCP Sites—Raising the Bar

- Implement caBIG®
- Collect biospecimens according to *NCI Best Practices for Biospecimen Resources*
- Electronic health records in place
- Increased baseline clinical trials accrual requirement and must be active in NCI-sponsored trials
- Race and ethnicity tracking by OMB guidelines across all areas

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# 18 ARRA Projects for Current Sites

- Projects span all NCCCP Components
  - Disparities, Clinical Trials, Quality of Care, Survivorship & Palliative Care, Biospecimens, Communications, and IT
- Includes New Partnership Opportunities
  - CTEP's Early Drug Development Program
  - CRCHD's Community Networks Program
  - DCCPS, CTEP and DCP's PRO-CTCAE
    - MSKCC partnership to pilot electronic patient-reported outcomes for adverse events (PRO-CTCAE) in a community setting

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# Program Expectations are Increasing (some examples)

| *Current Expectations (deliverables)* | *Current Success (exceeding deliverables)* | *Next Generation Program (new baseline)* |
|---|---|---|
| Assess caBIG® implementation | 9 sites implementing a component of caBIG® by June 2010 | Required implementation of caBIG® with data sharing capability |
| Assess NCI Best Practices for Biospecimens | 8 sites submitting tissue to TCGA or Moffitt TCC<br><br>16 sites → new formalin fixation guidelines | Progress in implementing NCI Best Practices required |
| No requirement to track OMB race and ethnicity | 9 sites tracking OMB race and ethnicity *(Note: CHI to all 70 hospitals)* | OMB race and ethnicity tracking required |
| Increase evidence based cancer care | 16 sites participating in CoC RQRS | NCCCP Quality initiative (e.g. RQRS) required |
| 25 Clinical Trial accruals/yr | NCCCP Electronic accrual log project | At least 8 NCI active trial accruals required + 25 |

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# Methods and Data Sources Timetable

| Evaluation Methods and Data Sources | Y1 | Y2 | Y3 |
|---|---|---|---|
| **Programmatic Data** | | | |
| Site surveys | Baseline | Interim | Final |
| Quarterly progress reports | Quarterly | Quarterly | Quarterly |
| Network meeting minutes & projects | Monthly | Monthly | Monthly |
| Subcontract deliverables | | | ● |
| **Evaluation Data** | | | |
| Site visits (i.e., interviews with program staff, key stakeholders) | ● | ● | ● |
| Patient focus groups | | ● | ● |
| Patient survey | | ● | ● |
| Micro-cost study | ● | ● | ● |
| Strategic case interviews | | ● | ● |
| Comparative data analysis (i.e., with NCDB via RQRS) | | ● | ● |
| Assessment of secondary data (e.g., American Hospital Association) | ● | ● | ● |

● = one data collection point

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# Upcoming Evaluation Reports

| *Evaluation Deliverables* | *Date Due* |
|---|---|
| ***Patient Survey Findings – Site Summaries*** | October 2009 |
| ***Micro-Cost Study Report (Year 1 Findings)*** | November 2009 |
| ***Cross-site Case Study Report (Year 1-2 Findings)*** | February 2010 |
| ***Overall Wave 1 Patient Survey Report*** | February 2010 |
| ***Year 3 Annual Evaluation Report*** | September 2010 |
| ***Final Evaluation Report*** | July 2011 |

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# NCCCP CT Screening & Accrual Log: Top reasons cited for barriers to accrual

- **Did not meet trial criteria**
  - Co-morbidities
  - Insufficient / Unavailable pathology samples
  - Time requirement from surgery or therapy
- **Patient declined participation**
  - Preference for standard treatment
  - No desire to participate in research
  - Perceived side effects too great
- **MD declined to offer participation**
  - Medical concerns re: age/frailty
  - Medical Concerns re: tolerating tx/performance status
  - Study on hold

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# NCCCP Publications


1. Wilkinson, K. “Cutting Edge Yet Close to Home: Cancer Research in the Community.” *ONS Connect*, December 2008.

2. Mealor, R., Canterbury, K., Paris, N., Irby, S., and Johnson, N. “Georgia on My Mind: One State’s Unified, Comprehensive Approach to Cancer Treatment.” *Oncology Issues*, May/June 2008.

3. Petrelli N. “I’m in a New York state of mind.” *Annals of Surgical Oncology*. vol.15 (8): 2069-2077, 2008.

4. Greene, FL. “Editorial: A Presidential Blueprint for Success and Change.” *Annals of Surgical Oncology*. vol. 15(9): 2355-2356, 2008.

5. Krasna, MJ. “Multidisciplinary Cancer Clinics: A vision for Optimal Cancer Care.” *Oncology Business Review.* January, 2009.

6. Krasna, M., Petrelli, N., Salner, A. “Part I Multidisciplinary Cancer Care: A New Model for Community Cancer Centers.” *The Journal of Multidisciplinary Cancer Care*. 2009, vol. 1(5).

7. Krasna, M., Petrelli, N., Salner, A. “Part II Roundtable on Multidisciplinary Care: The NCCCP.” *The Journal of Multidisciplinary Cancer Care.* 2009, vol. 2(5).

**8.** Johnson, MR., Clauser, SB., Beveridge, JM., O’Brien, DM. “Translating Scientific Advances in the Community Setting: The National Cancer Institute Community Cancer Centers Program Pilot.” *Oncology Issues*. May/June, 2009.

**9.** Siegel, RD., Clauser, SB., Lynn, JM. “A National Collaborative to Improve Oncology Practice: The NCI Community Cancer Centers Program QOPI Experience.” *Journal of Oncology Practice*, vol. 5(6) 2009.

10. Blaseg, K. “*Patient Navigation at Billings Clinic: An NCI Community Cancer Centers Program (NCCCP) Pilot Site,* Published in ACCC's *Cancer Care Patient Navigation: A Call to Action.* s15-s24, 2009.

**11.** Duggan, B. “*Clinical Oncology Requirements for the EHR (CORE)”* ASCO White Paper, October 6, 2009.

12. Koch, L., Swanson, J. “The Role of the Oncology Nurse Navigator in Distress Management of Oncology Inpatients, A Retrospective Study.” *Nursing Oncology Forum*, vol. 37(1) 2010.

**13.** Clauser, SB., Johnson, MR., O’Brien, DM. Beveridge, J., Fennell, ML. Kaluzny, AD. “A New Approach to Improving Clinical Research and Cancer Care Delivery in Community Settings: Evaluating the NCI Community Cancer Centers Program.” *Implementation Science*, vol. 4 (63) 2009.

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# NCCCP Posters and Presentations

1. Grubbs, S., Gonzalez, M., Krasna, M., Siegel, R., Bearden, JD., Tschetter, L., Hayenga, L., Shaw, E.G., Duggan, B., St. Germain, D., Denicoff A. “Monitoring Clinical trial Accrual Utilizing the NCCCP Web Based Tracking Tool.” Poster Presentation, American Society of Clinical Oncology Annual Meeting, 2009.

2. Siegel, R., Clauser S, and Lynn J. “The NCCCP Quality Oncology Practice Initiative National Collaborative”. American Society of Clinical Oncology Annual Meeting. 2009.

3. Servodidio, C., Bryant, D., Duggan, B., Ellison, C., Gonzalez, M., Neri, D., Sprouse, N. “Nursing Leadership of Successful Clinical trial Recruitment Strategies to an NCCCP Endorsed Study.” Plenary Presentation, Oncology Nursing Society, 2009.

**4.** O’Brien, D., Johnson, M., Fennell, M., Chu, K., Hood, D., Katurakes, N. “The Use of a Performance Based Dashboard to Address Cancer Healthcare Disparities.” Poster Presentation, Academy Health Annual Research Meeting, 2009.

5. Johnson, MR. “NCI Community Cancer Centers Program.” Keynote Address. Association of Cancer Executives Annual Meeting, 2009.

6. Johnson, MR., Honey, D., Hood, D., Clauser, S. “Embracing a Public / Private Partnership to Transform Cancer Care in Community Hospitals.” Panel presentations, American College of Healthcare Executives Annual Meeting, 2009.

7. Blaseg, K., Kile, M.,“Off the Beaten Path: Cancer Survivorship in Rural and Underserved Areas.” Poster Presentation, 2009 ONS Congress, May 2009.

8. Tesar, E., Spotted Bear, M., Blaseg, K., Scharff, J., Buehler, J. “Cancer Symptom Attribution in American Indian Populations: A Qualitative Research Pilot Study Utilizing Grounded Theory Methodology.” Poster Presentation, 2009 ONS Congress, May 2009.

9. Tesar, E. “Site-Specific Nurse Navigation for Newly Diagnosed Oncology/Hematology Patient.” Poster Presentation, 2009 ONS Congress, May 2009.