TAKING AIM AT CANCER
IN LOUISIANA

Statewide Cancer Strategy Kick-Off
May 11, 2018

manatt

Statewide Cancer Strategy
Taking Aim at Cancer in Louisiana:
Cancer in Louisiana Landscape Analysis and Collaboration Opportunity

May 11, 2018

TAKING AIM AT CANCER
IN LOUISIANA

Louisiana's Cancer Incidence and Mortality

Louisiana cancer incidence and mortality rates exceed U.S. rates by 7% and 13% respectively, with a handful of cancers causing a disproportionate share of the suffering.

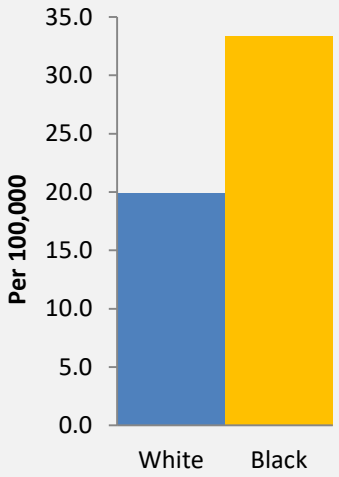
Average Annual # Deaths & Mortality per 100,000 (Age-Adjusted)			
Cancer Type	**Louisiana (2011-2015)[1]**		**U.S. (2011-2015)[2]**
	Average Annual # Deaths	*Mortality Rate*	*Mortality Rate*
Lung	2,701	53.6	43.4
Breast (female)	651	23.7	20.9
Prostate	412	21.6	19.5
Colorectal	874	17.5	14.5
Pancreas	653	13.1	10.9
All Cancer	**9,362**	**187.8**	**163.5**

By reducing Louisiana's cancer mortality rates to the national average, 1,500 fewer Louisianans would die each year from cancer.

Cancer Disparities in Louisiana

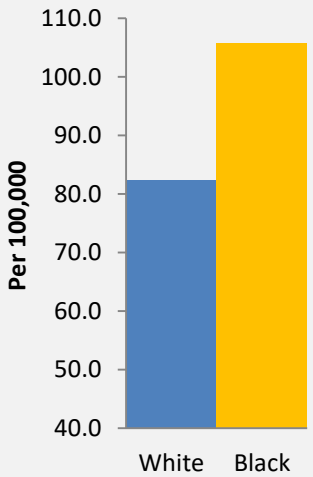
Persistent and large racial disparities exist among the five most common cancers.

Breast: Mortality (Women)



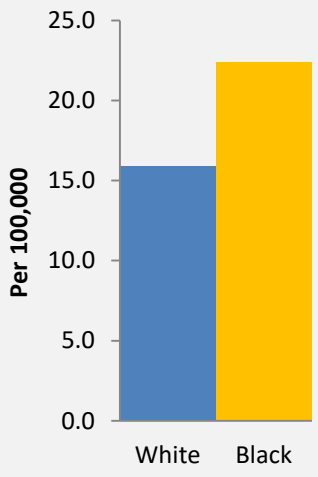
68% higher for black women than for white women

Lung: Incidence (Men)



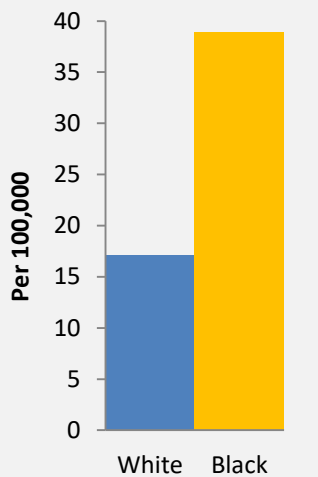
58% higher for black men than for white men

Colorectal: Mortality (Men & Women)



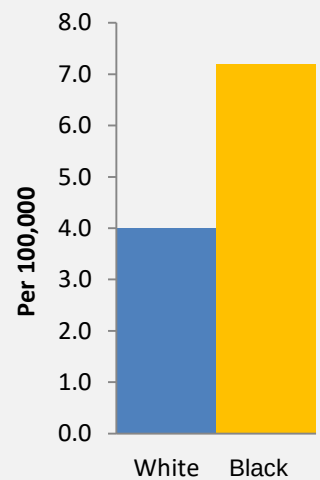
40% higher for black people than for white people

Prostate: Mortality (Men)



128% higher for black men than for white men

Cervical: Late Stage Diagnosis



80% higher for black women than white women

Sources: Louisiana Tumor Registry

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Opportunity to Work Together

The concentration of cancer care delivery and payment signal that by working together, we can make significant in-roads in reducing the devastating impact of cancer in Louisiana.

Eight health systems provide +80% of inpatient cancer care

Baton Rouge General
Franciscan Missionaries of Our Lady Health System
HCA
Lafayette General Health
LCMC
Ochsner
St. Tammany
Willis Knighton Health

Ten payers cover vast majority of cancer patients

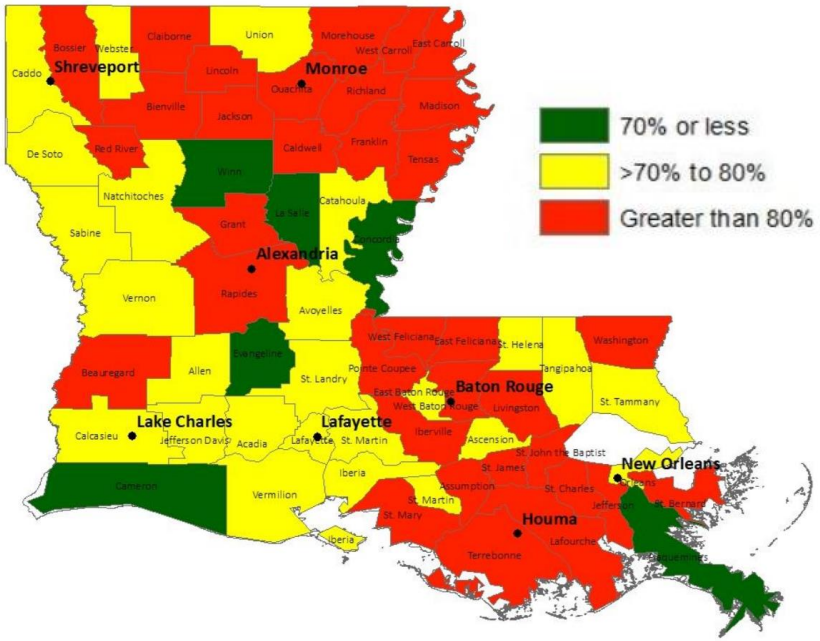
Aetna
AmeriGroup
Blue Cross Blue Shield
Cigna
Humana
Louisiana Healthcare Connections
Medicaid (Fee for Service)
Medicare (Fee for service)
Peoples
United

Louisiana Cancer Care Collaborative – Objective & Focus

Objective	To improve cancer outcomes in Louisiana by expanding residents' access to cancer prevention, screening and standard of care treatment
Guiding Principles	▪ Fact-based & transparent dialogue ▪ Broad-based decision-making ▪ Coordination & alignment
Initial Interventions	▪ Colorectal cancer screening ▪ Breast cancer treatment

A CRC intervention focused on improved access to screening can reverse state trends of high mortality and high treatment cost due to late stage diagnoses.

Colorectal Cancer Screening



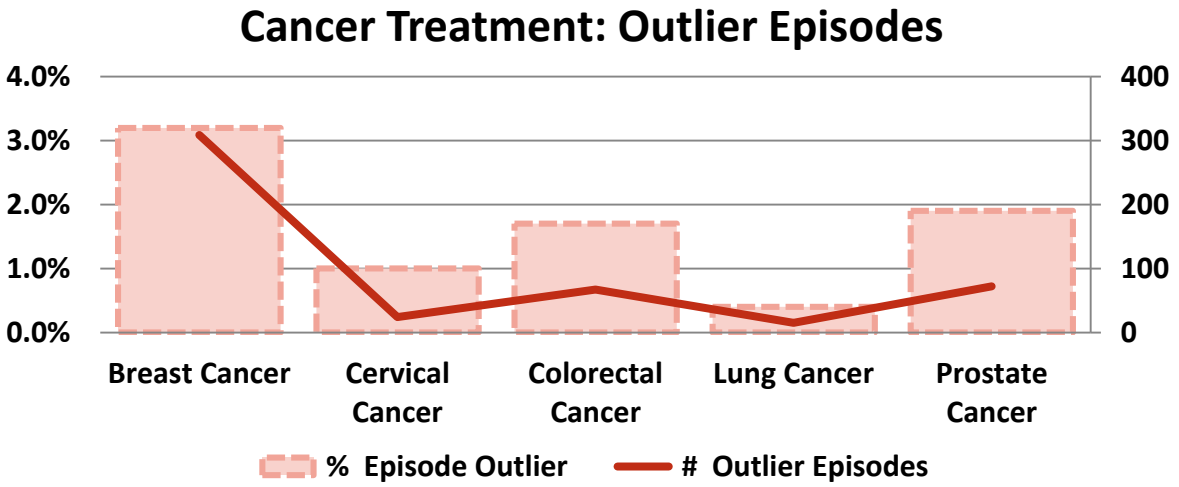
Proposed Intervention Highlights

- ✓ Mobile medical clinics
- ✓ Navigator program
- ✓ Screening and treatment guidelines
- ✓ Incentives for providers and patients
- ✓ Public education and outreach
- ✓ Screening rate targets

Note: Respondents fifty years of age and older who have not had a blood stool test within the past two years
Source: Louisiana Comprehensive Cancer Control Plan 2017-2021.

Louisiana's Current State & Proposed Intervention

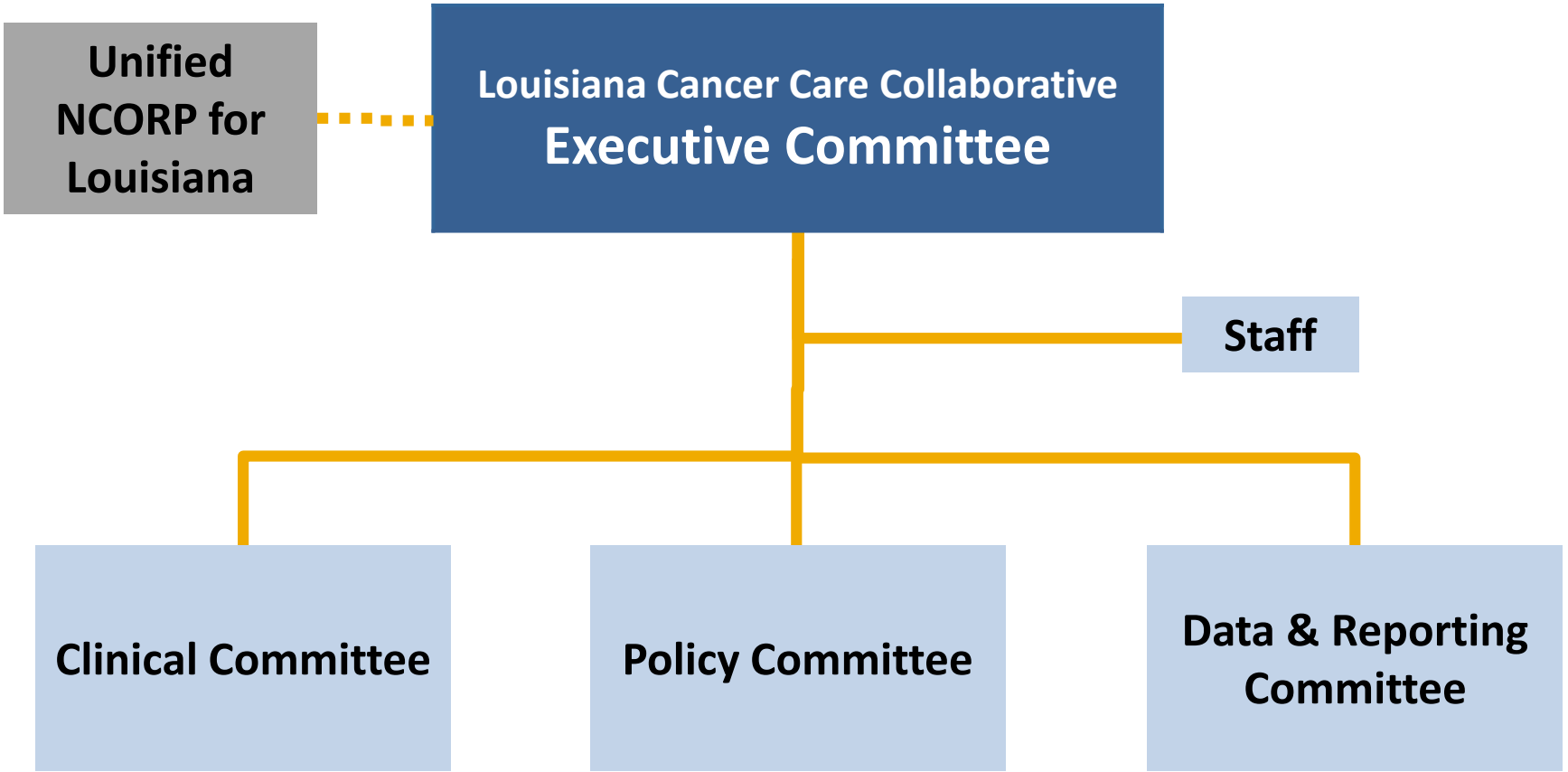
Existing outliers in breast cancer treatment and costs in Louisiana may be reduced via an intervention focused on improving outcomes and reducing treatment variation.



Proposed Intervention Highlights

- ✓ Community standard of care
- ✓ Provider & payer engagement in guideline development
- ✓ Community-based clinical trial
- ✓ Care bundles & incentives
- ✓ Process & outcome measures

Louisiana Cancer Care Collaborative – Proposed Structure



Proposed Roadmap

The committees will launch initial interventions in the first year, refine/enhance approaches in the second, and demonstrate value and results to support longer term planning in the third.

	Year 0	Year 1	Year 2	Year 3
Executive Committee	• Define operating model • Constitute committees and charters • Identify and retain Director • Define initial targets & set annual goals	• Select year two interventions • Fundraising	• Select year three interventions • Fundraising	• Direct development of next three-year strategic plan • Select new fundraising target
Clinical Committee	Assess and define initial priorities including target conditions and associated interventions	• Define and implement guidelines and interventions • Define and implement program elements • Recruit sites/physician champions as needed	• Refine interventions and guidelines • Recommend year 2+ priority areas and interventions	• Contribute to evaluation of clinical intervention impact • Recommend guidelines and interventions to support strategy
Policy Committee	• Conduct economic impact analysis • Assess cost of care variation	• Convene stakeholders to define and prioritize intervention recommendations • Define short-term policy and programmatic changes that are needed to promote better access, reduced cost, and higher quality	Implement short-term policy and programmatic changes	Contribute to evaluation of impact of short-term policy and programmatic changes
Data & Reporting Committee	• Assess mortality rate and incidence • Identify variation in care, treatment patterns, cost and utilization outliers • Define service provision • Define disparity parameters	• Assess variations, high cost clinical areas • Define measures (clinical, financial, access, experience) • Establish baseline measure and reporting • Begin any new data collection for baseline	• Continue to refine registry, claims, and other data collection elements • Measure & publish results (i.e. baseline Y1 outcomes)	Lead evaluation of interventions and generate reports
Staff	• Director recruited and on-boarded	• Facilitate committees, selection and implementation of interventions • Facilitate fundraising	• Facilitate committees, selection and implementation of interventions • Facilitate fundraising	• Facilitate committees, development of three-year strategic plan • Facilitate fundraising

Eliminating Colorectal Cancer Disparities in Louisiana: A Public Health Conundrum

Charles R. Rogers, PhD, MPH, MS, CHES®

Assistant Professor

Dept. of Family Medicine & Community Health

University of Minnesota Medical School

Louisiana Statewide Cancer Strategy Kickoff

Division of Administration Claiborne Building

Baton Rouge, LA

Friday, May 11, 2018

: @crrogersPhD

University of Minnesota

Fall 2009

Thank You: 4/13/16

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THE PROBLEM

- Colorectal Cancer (CRC)
  - 2nd leading cancer killer among African Americans (and Cajuns)
    - 3rd leading cause of death
- Compared to Whites, African Americans (AAs) have:
  - **Poorer** survival once diagnosed
  - **Lower** 5-year relative survival
- Compared to White men, AA men (AAM) live sicker & die younger
  - **27%** ↑ CRC incidence
  - **52%** ↑ CRC mortality

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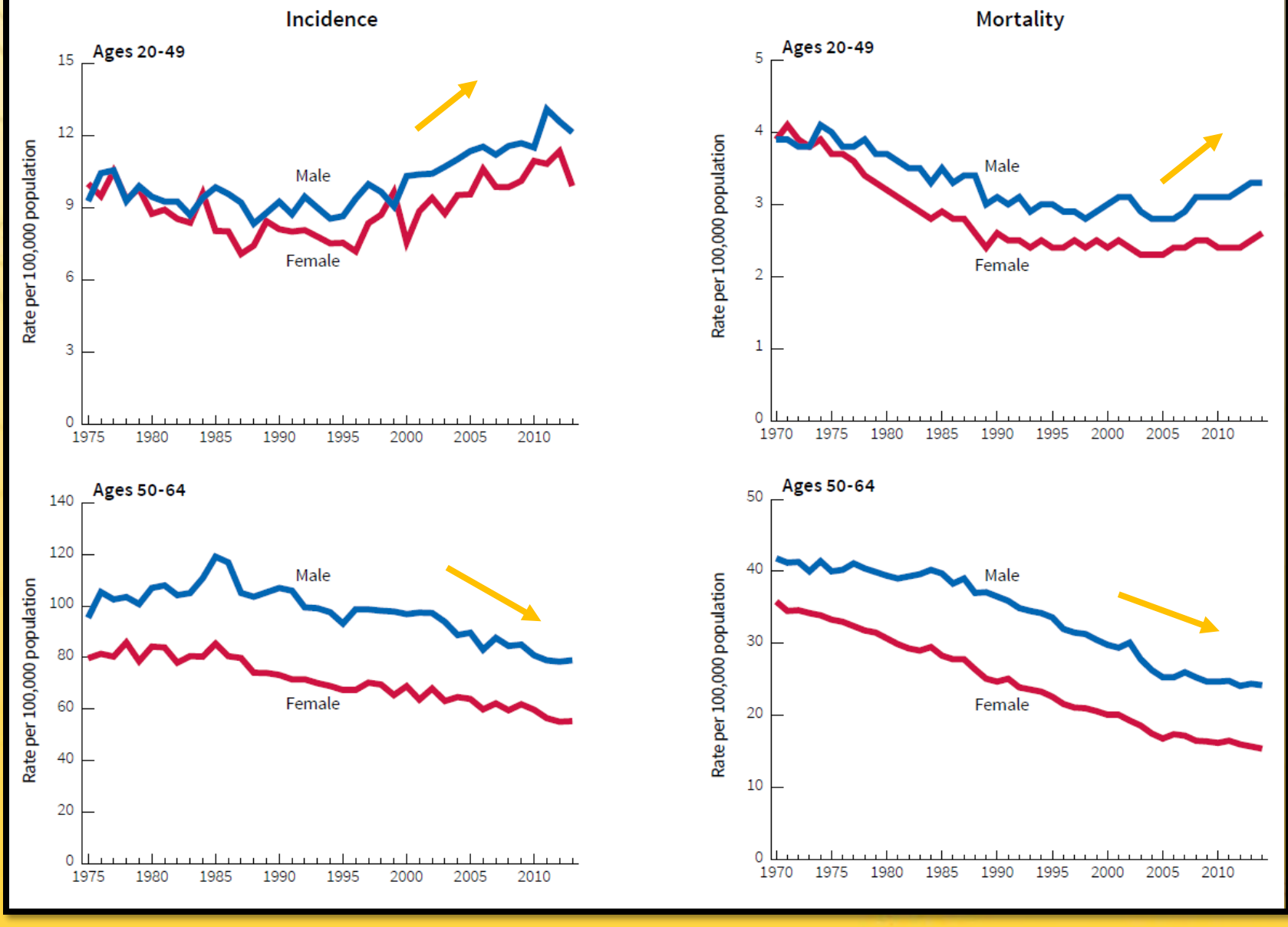
American Cancer Society (ACS), 2014, 2016

THE PROBLEM

ACS, 2017

Figure 5. Trends in Colorectal Cancer Incidence (1975-2013) and Mortality (1970-2014) Rates by Age and Sex, US

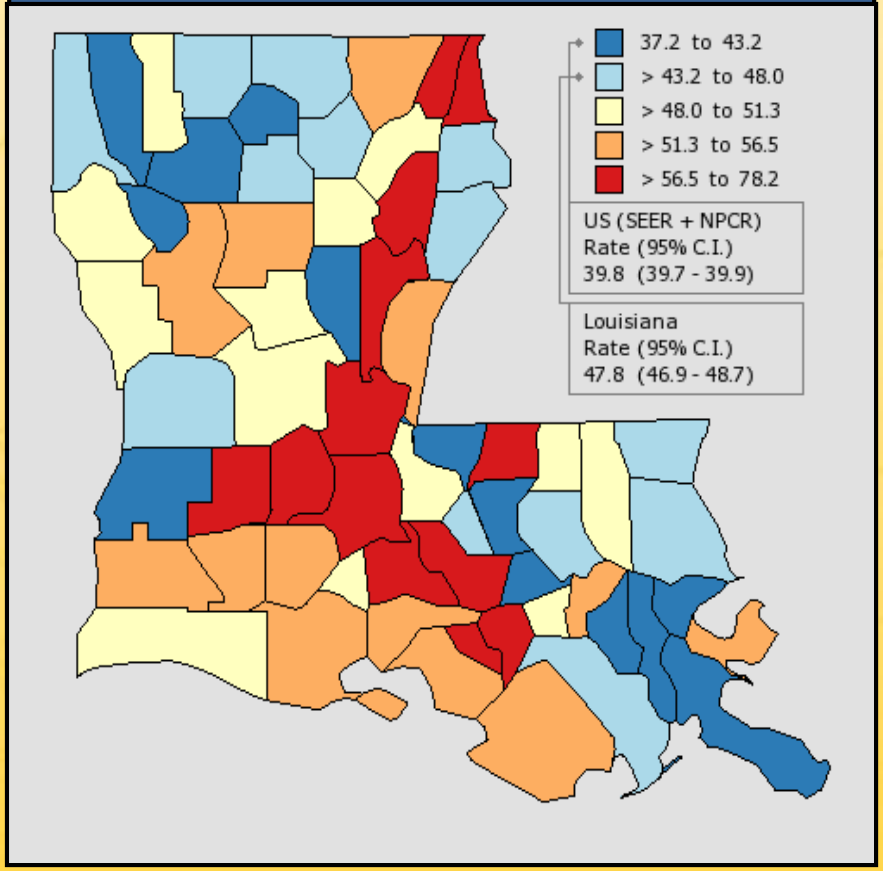


THE PROBLEM

Louisiana has the 4th highest CRC mortality rate in the U.S.!

- High mortality is partially driven by LA's CRC incidence rate, which is the **third highest** in the country
- The high incidence rate is related to Lynch syndrome amongst the Cajun population, who have a CRC incidence rate that is 23% higher than the average U.S. population
- Lower than average screening rates also contribute to higher mortality; 1/3 of Louisianans over the age of 50 have never had an endoscopy

Colorectal Cancer Incidence Rates: 2010-2014



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Sources: Louisiana Tumor Registry, Clinical and Translational Gastroenterology (2014) 5, e60; doi:10.1038/ctg.2014.10

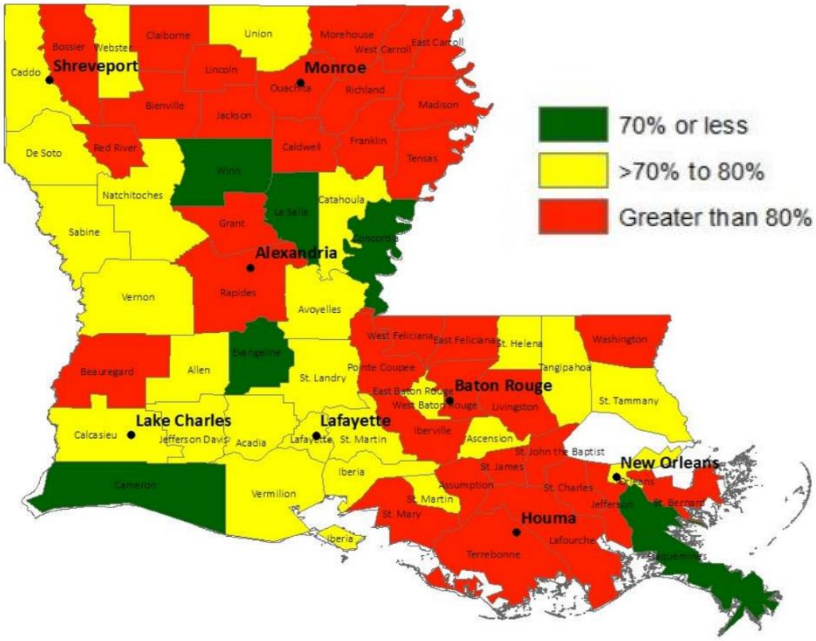
CRC is **preventable** & **curable**, yet **disparities** exist

Screening: effective test to detect precancerous polyps so they can be removed before turning into cancer.

Low CRC screening rates result in more late stage diagnoses, higher mortality, & higher cost.

Colorectal Cancer Screening[2]

Respondents 50 years of age & older who have not had a blood stool test within the past 2 years

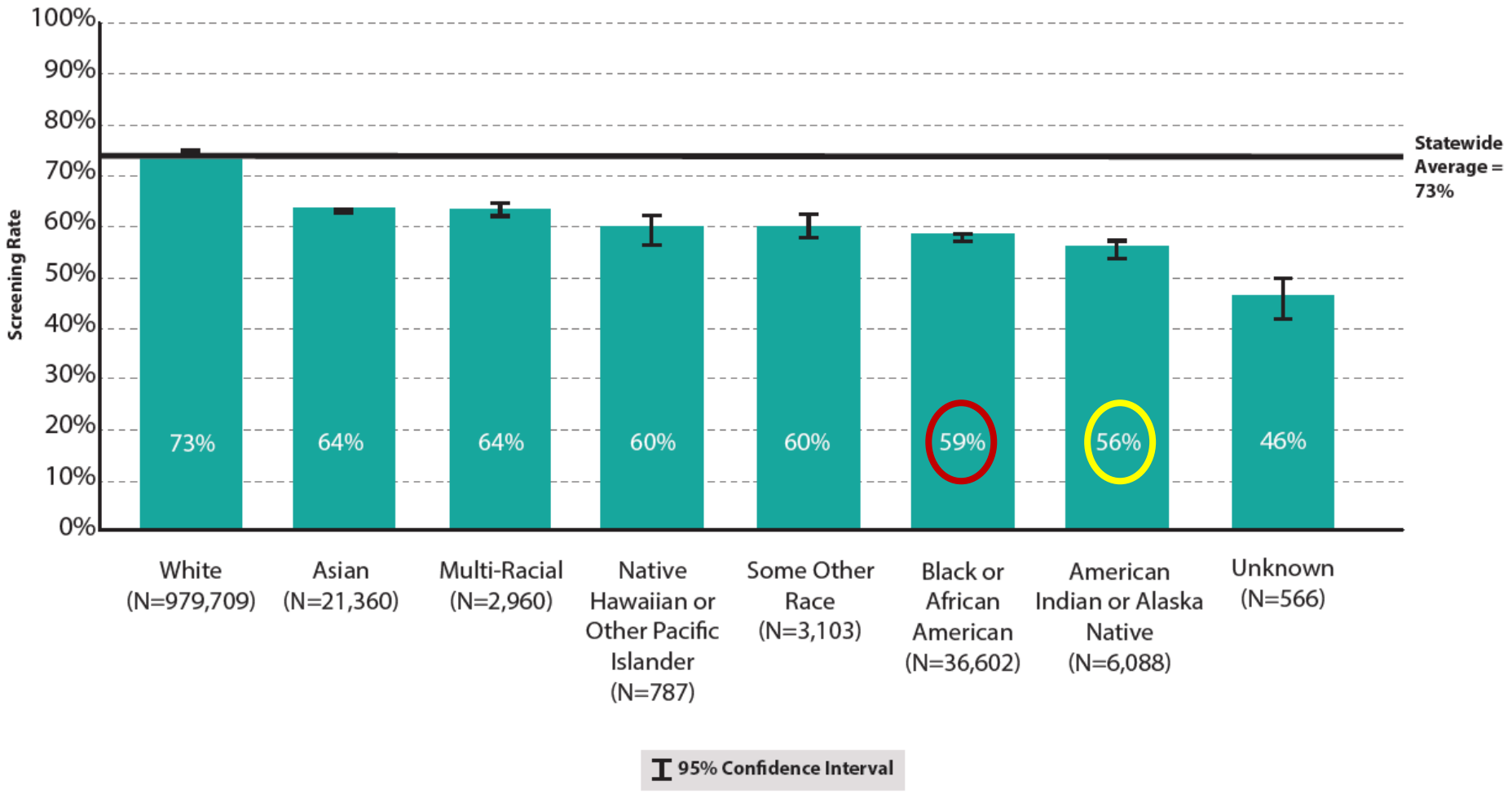


	Advanced Stage Cancer Diagnoses in Louisiana (2011-2016)[1]		Advanced Stage Cancer Diagnoses in U.S. (SEER 2009-2013)	
	Whites	Blacks	Whites	Blacks
Males	55.1%	55.7%	52.9%	53.5%
Females	55.3%	55.7%	52.8%	52.5%

	Spending & Survival Rates			
	Stage I	Stage II	Stage III	Stage IV
First Year Spending Per Patient[4]	$49,189	$66,613	$83,980	$108,599
5-Year Survival Rate[3]	92%	IIA: 87% IIB: 63%	IIIA: 89% IIIB: 69% IIIC: 53%	11%

- Louisiana Tumor Registry, Louisiana Cancer Prevention & Control Program;
- Louisiana Comprehensive Cancer Control Plan 2017-2021,
- 2004-2010, American Cancer Society: https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/survival-rates.html
- Medicare spending, in: Styperek, A.; Kimball, A.B. Malignant Melanoma: The Implications of Cost for Stakeholder Innovation. Am. J. Pharm. Benef. 2012, 4, 66–76.

FIGURE 59: STATEWIDE RATES FOR COLORECTAL CANCER SCREENING BY RACE



MN Community Measurement
Measure Up To Better Health

University of Minnesota

DR. ROGERS' PAST RESEARCH

"A Progress Report of African American Men's Intentions to Screen for CRC in Minnesota"

***7* days**

COLON CANCER
iPrevent. iTreat. iBeat.

N = 297

n > 24,600

Purpose: Test a conceptual model of factors influencing intentions to screen for CRC among African American men (ages 18-65) in Minnesota employing on-line survey research methods.

Central hypothesis: [1] male role norms (masculinity) indirectly influence these men's intentions to screen via perceived barriers; [2] these men **lack** the appropriate knowledge and espouse **negative** attitudes toward CRC screening.

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Rogers, Goodson, Dietz, & Okuyemi (2016)

Did you know that African American men have a 50% higher chance of dying from colon cancer than White men?

COLON CANCER

iPrevent. iTreat. iBeat.

Let's prevent, treat, and beat colon cancer.

The *playing field* is **not even** as it relates to deaths from colorectal cancer for African American men. In order to begin addressing this complex issue & assure a win in **your** favor, your pertinent participation in a research study is requested **today!**

MEET US AT THE MINNESOTA STATE FAIR

AUG. 22-24, 29-SEPT. 1, 2014
9AM-9PM
DRIVEN TO DISCOVER BUILDING

Am I Qualified?

- Are you a male?
- Do you live in Minnesota?
- Are you between 18 and 65 years old?
- Do you consider yourself African American?

If you answered yes to these questions, then you're qualified to participate by completing a 15 min. survey on an iPad in the **Driven to Discover building** at the **MN State Fair and** eligible to enter a random drawing for 1 of 6 prizes. *Prizes shown on reverse side.*

Items included in 6 Prize Drawings

Amazon Kindle FireHD

Samsung 51" Plasma HDTV

Apple AppleTV1080P

Apple iPad Mini

Beats by Dre Solo HD Headphones

Google Nexus 7 Tablet

Supported by:

Masonic Cancer Center, University of Minnesota

Program in Health Disparities Research, www.healthdisparities.umn.edu, University of Minnesota Medical School

minnesota cancer alliance — working together to eliminate the burden of cancer

Q Health Connections — A division of Southside Community Health Services, Inc.

mngi — Minnesota Gastroenterology, P.A. — *Premier Gastroenterology Care*

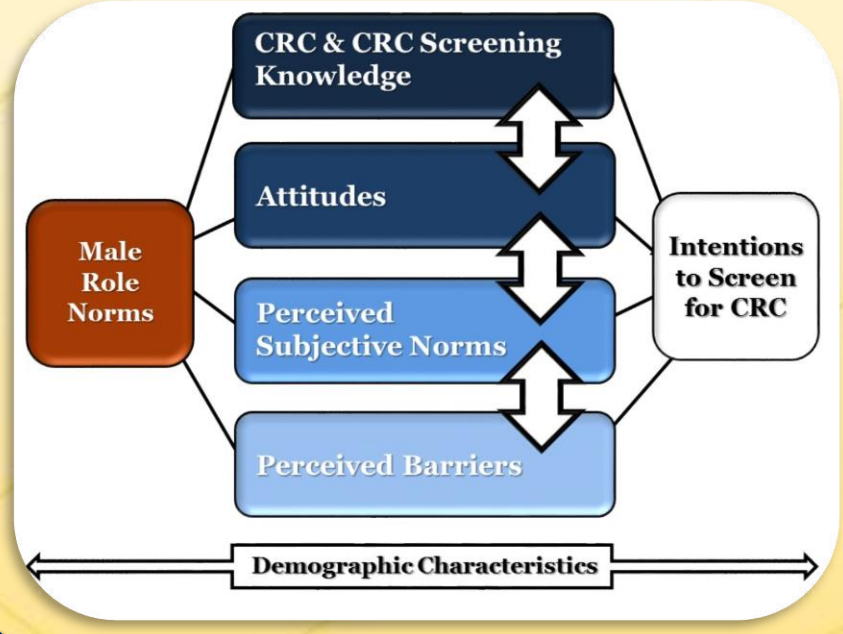
www.dbranddesigns.com

For more information/questions, contact the Primary Investigator, Dr. Charles R. Rogers, at: crrogers@umn.edu or 612-626-3894

EXIT

University of Minnesota

Rogers, Goodson, Dietz, & Okuyemi (2016)



Modified Source:
Rogers & Goodson (2014)

KEY FINDINGS

- Of 286 study participants, 223 (78%) indicated they planned to obtain CRC screening in the future.
- **Age** (β = 1.507, $\chi 2$ = 28.119, $p < 0.0001$) was significantly (& positively) associated with CRC screening intention when demographic variables alone are considered.
- **Age** (β = 1.861, $\chi 2$ = 25.696, $p < 0.0001$) & **perceived subjective norms** (β = 1.269, $\chi 2$ = 23.124, $p < 0.0001$) were significant predictors of CRC screening intent.
- Alike, **Age** (β = 1.916, $\chi 2$ = 21.732, $p < 0.0001$) & **perceived barriers** (negatively) (β = -0.853, $\chi 2$ = 8.404, p = 0.0037).

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Rogers, Goodson, Dietz, & Okuyemi (2016)

Shifting Political Paradigms in Louisiana

MINN POST

Rogers (2014)

"Minnesota should lower the recommended CRC screening age for African Americans"

- The fact that CRC treatment costs are rising at a ***higher*** rate than the average ***increase*** in health costs is unacceptable since costs associated with this preventable disease are ***cheaper*** if caught earlier *(Fight Colorectal Cancer, 2012).*
  - Nationally, patients diagnosed with CRC in early stages have the ***lowest*** treatment costs ($27,551)
  - Followed by patients with distant stage ($29,933), &
  - Patients with advanced CRC having the ***highest*** cost ($30,748) *(Luao et al., 2009).*

Colon Cancer: the disease no one has to die from.

-Rogers, C.R. (January, 2015)

MSR NEWS ONLINE

Prince's home state: the land of 10,000 disparities.

-Rogers, C.R. (July, 2016)

University of Minnesota

Opportunities for CRC Screening Intervention Success

CRC screening initiatives across the country have been shown to reduce incidence & mortality, and may be feasible to implement at a statewide level in Louisiana.

➢ **Delaware Cancer Consortium (DCC):** statewide CRC screening program

- **Who?**
  - With state legislature $$$, DE Govenor Minner developed the program in 2003
  - DE law tasked DCC with coordinating cancer prevention & control activities
  - DCC members included: reps from the DE House of Representatives & State Senate, the Governor's Office, the Sec. of the Department of Health & Social Services, & cancer center physicians
- **How?**
  - Insurance coverage for screening
  - Use of nurse navigators to conduct screening outreach & recruitment
  - Treatment for those with a CRC diagnosis
- **Successful?**
  - 41% CRC mortality rate decrease in AAs (compared to 13% decrease in Whites)
  - 34% CRC incidence rate decrease in AAs (compared to 26% decrease in Whites)
  - While the DCC screening costs approximately $1 million annually, the program saved $8.5 million annually from reduced CRC incidence & earlier stage diagnoses.
  - From 2003-2011, the program provided 5,000^{+} CRC screenings.
    - *"The results we achieved in DE can be replicated across the country…"* -Congressman John Carney

Opportunities for CRC Screening Intervention Success

- **Kentucky CRC Program** (2001) focuses on increasing CRC screening. The program resulted in 24% reduction in CRC incidence & 30% reduction in CRC mortality (2002-2012).
- **New Hampshire CRC Screening Program** offered *patient navigation services* for CRC screening. The program resulted in 96% of navigated patients received CRC screening, compared to 69% of non-navigated patients.
- **South Carolina CRC Prevention Network** provided open access colonoscopy to uninsured residents of SC through *statewide partnerships and patient navigation:* improved screening, drastically reduced no-show rates, & resulted in ~90% good to excellent bowel preparation.
- **HealthPartners** (MN health care provider & health insurance company) launched *Fecal Immunochemical Test (FIT) kit*-focused pilot projects to improve screening rates. With FIT instructions & follow-up call reminders (both in 7 different languages), their disparity gap was narrowed by 11% for patients of color aged 50-75 not current with CRC screening (2009-2017)

SAGE
MINNESOTA'S COLORECTAL CANCER SCREENING PROGRAM Scopes

UNIVER

ACKNOWLEDGMENTS

- Participants who made these studies possible
- Community Partners
- Co-Authors, Research Teams
- Funders
- Louisiana Department of Health
- Carrie Vogelsang, MPH
- YOU!

Email: crrogers@umn.edu

: @crrogersPhD

TEAM
TOGETHER EVERYONE ACHIEVES MORE

Masonic Cancer Center
University of Minnesota
Program in Health Disparities Research
www.healthdisparities.umn.edu
minnesota cancer alliance
working together to eliminate the burden of cancer
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MINNESOTA GASTROENTEROLOGY, P.A.
Premier Gastroenterology Care
www.dbranddesigns.com

NIH National Institute on Aging

NIH National Cancer Institute

EDUCATION & HUMAN DEVELOPMENT
TEXAS A&M UNIVERSITY

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A Statewide Quality Improvement Collaborative:

Michigan Oncology Quality Consortium (MOQC)

May 11, 2018

Louisiana Cancer Strategy Kick Off Event

Douglas W. Blayney, MD

Stanford Cancer Institute

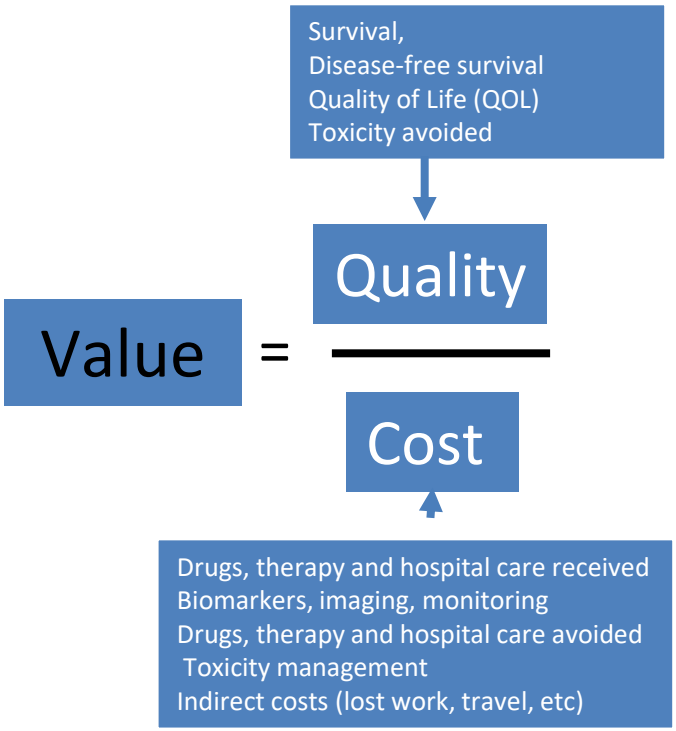
Clinical Excellence Research Center, Stanford

Quality

- Outcome
- Process
- Structure

- Because testing the effect of an intervention on survival takes years…
- Focus on processes
  - Develop evidence-based guidelines
  - Measure adherence to guidelines
  - Targeted interventions to improve adherence

Value

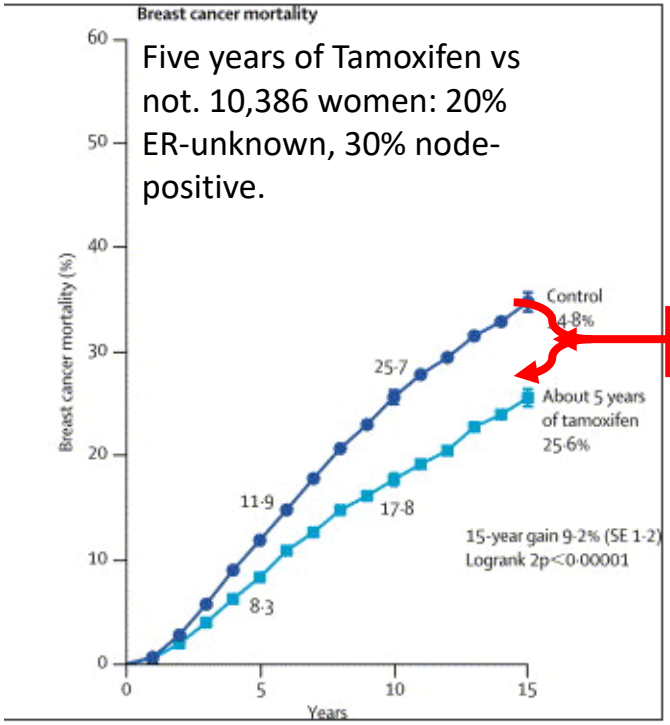


Health

Defining Quality Cancer Care

Example: Tamoxifen Increases Survival in Early Stage Breast Cancer

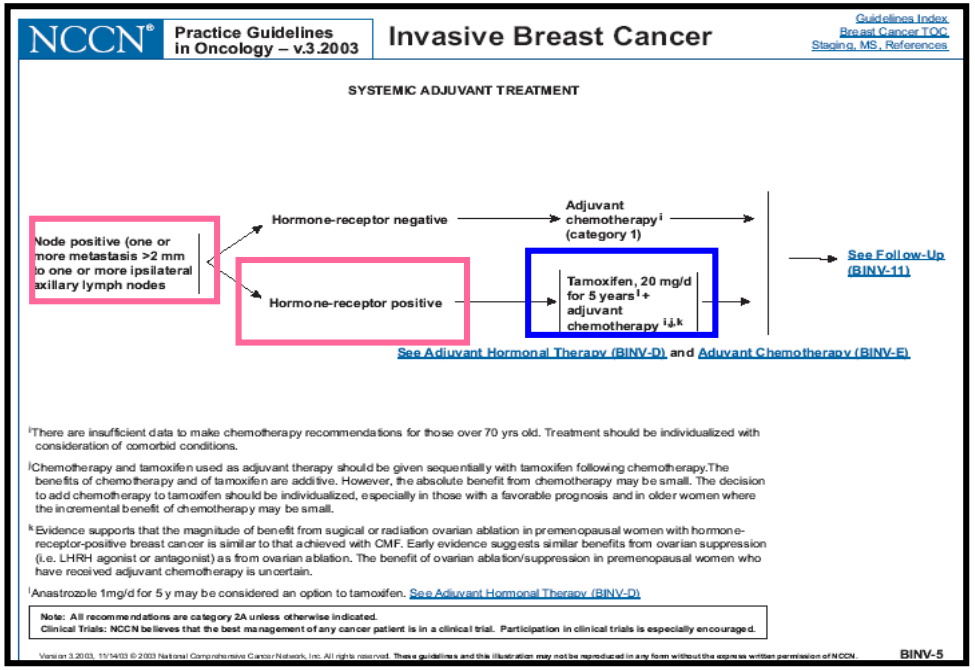
Clinical Trial Results



9.2%

EBCTCG. The Lancet 2005; **365**:1687-1717

Guidelines



Quality Oncology Practice Initiative (QOPI®)

- Outpatient practice-based voluntary program
- Foster a culture of self-examination and improvement in
- Facilitate performance improvement
- Measures oncology care processes
- Measures are
  - Evidence-based
  - Guideline-based
  - Consensus-based
- Continually reviewed and u

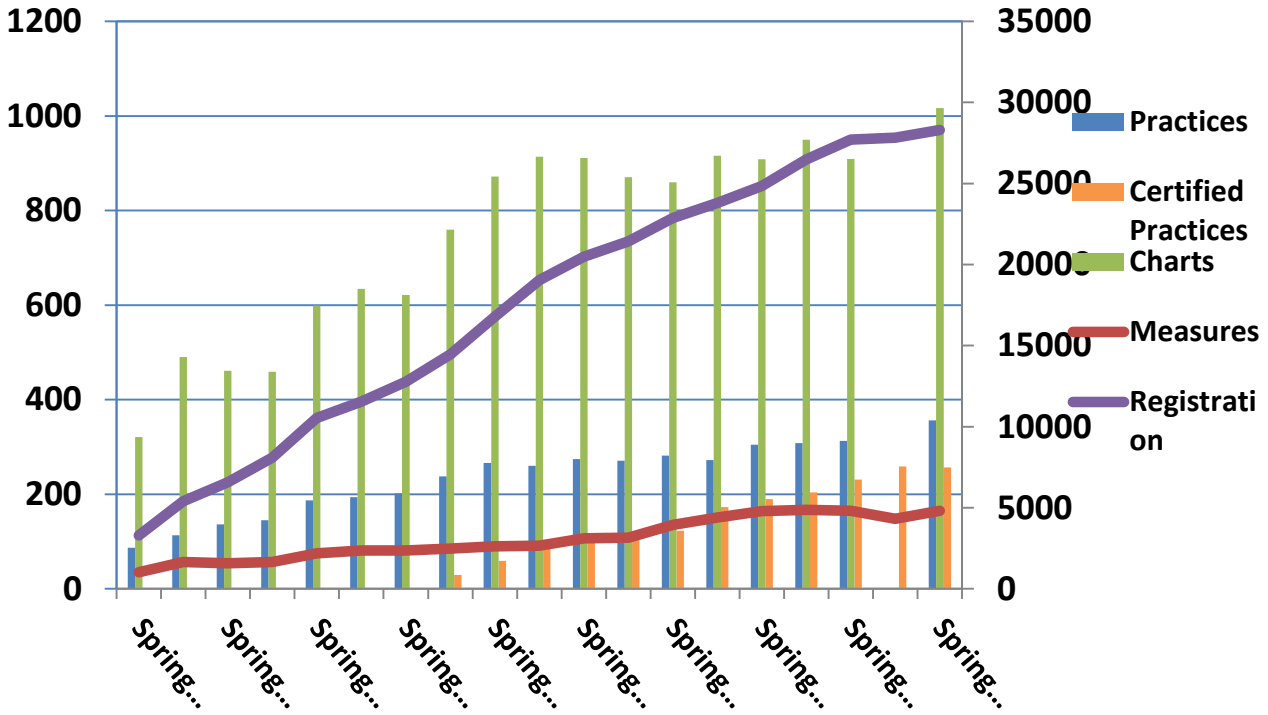
QOPI® The Quality Oncology Practice Initiative

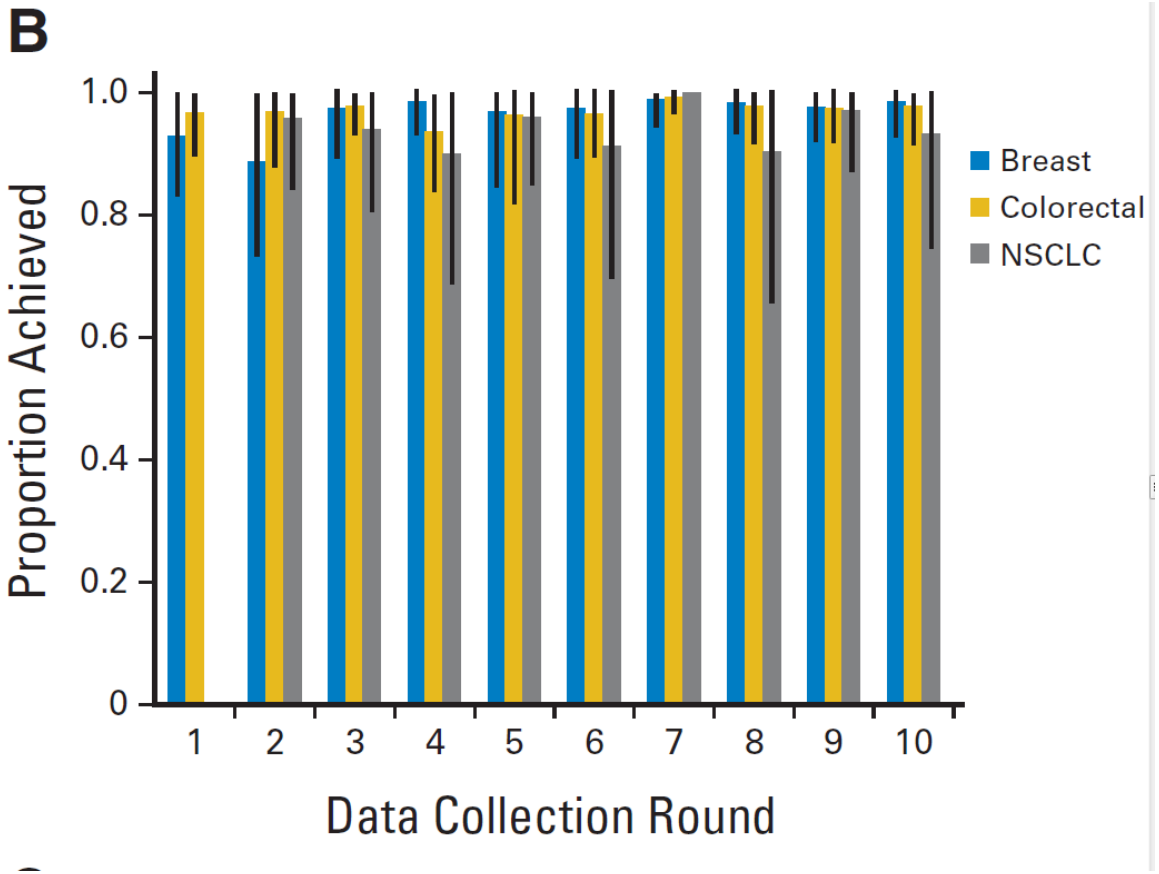
QOPI measures adherence to processes of care

QOPI® The Quality Oncology Practice Initiative

Quality Cancer Care: Pursuing Excellence

Growth





From 2006 to 2010, 308 unique practice groups with approximately 2,100 physicians participated in at least one of the 10 possible rounds of data collection.

Published Ahead of Print on March 11, 2013 as 10.1200/JCO.2012.43.3300
The latest version is at http://jco.ascopubs.org/cgi/doi/10.1200/JCO.2012.43.3300

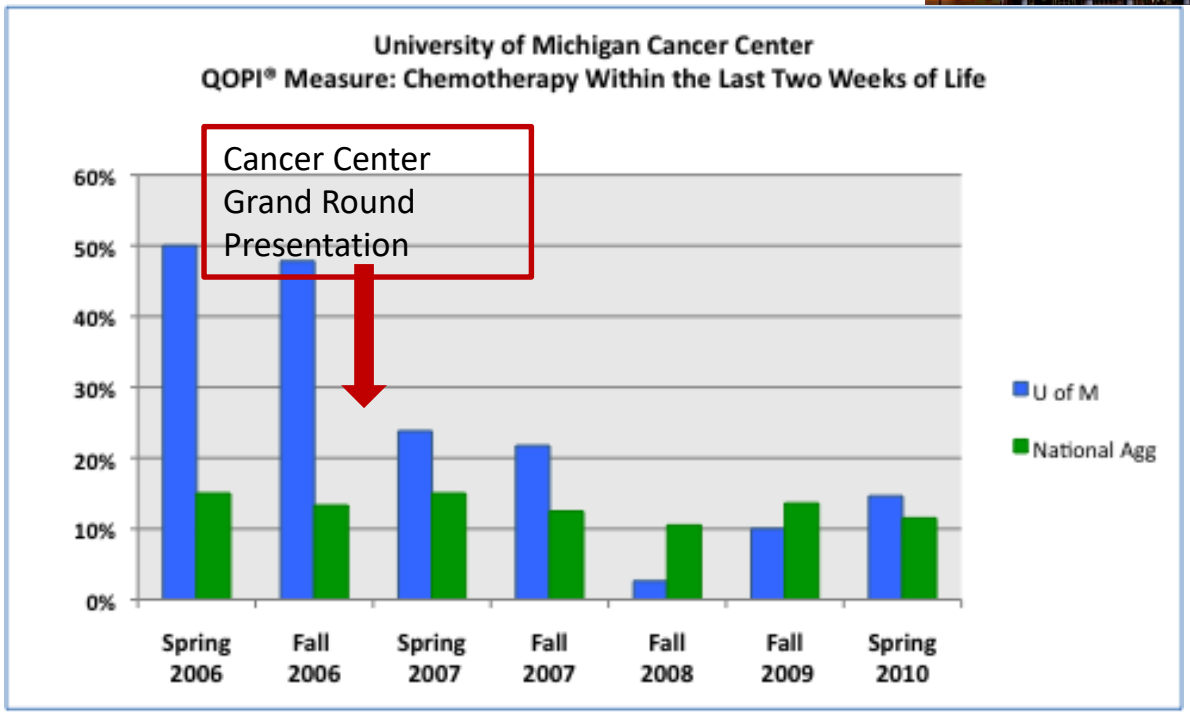
JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

Measuring the Improving Quality of Outpatient Care in Medical Oncology Practices in the United States

Michael N. Neuss, Jennifer L. Malin, Stephanie Chan, Pamela J. Kadlubek, John L. Adams, Joseph O. Jacobson, Douglas W. Blayney, and Joseph V. Simone

ASCO's QOPI Program shows most practices have maxed out on treatment process measures

QOPI Process Improvement
Large Academic Medical Center

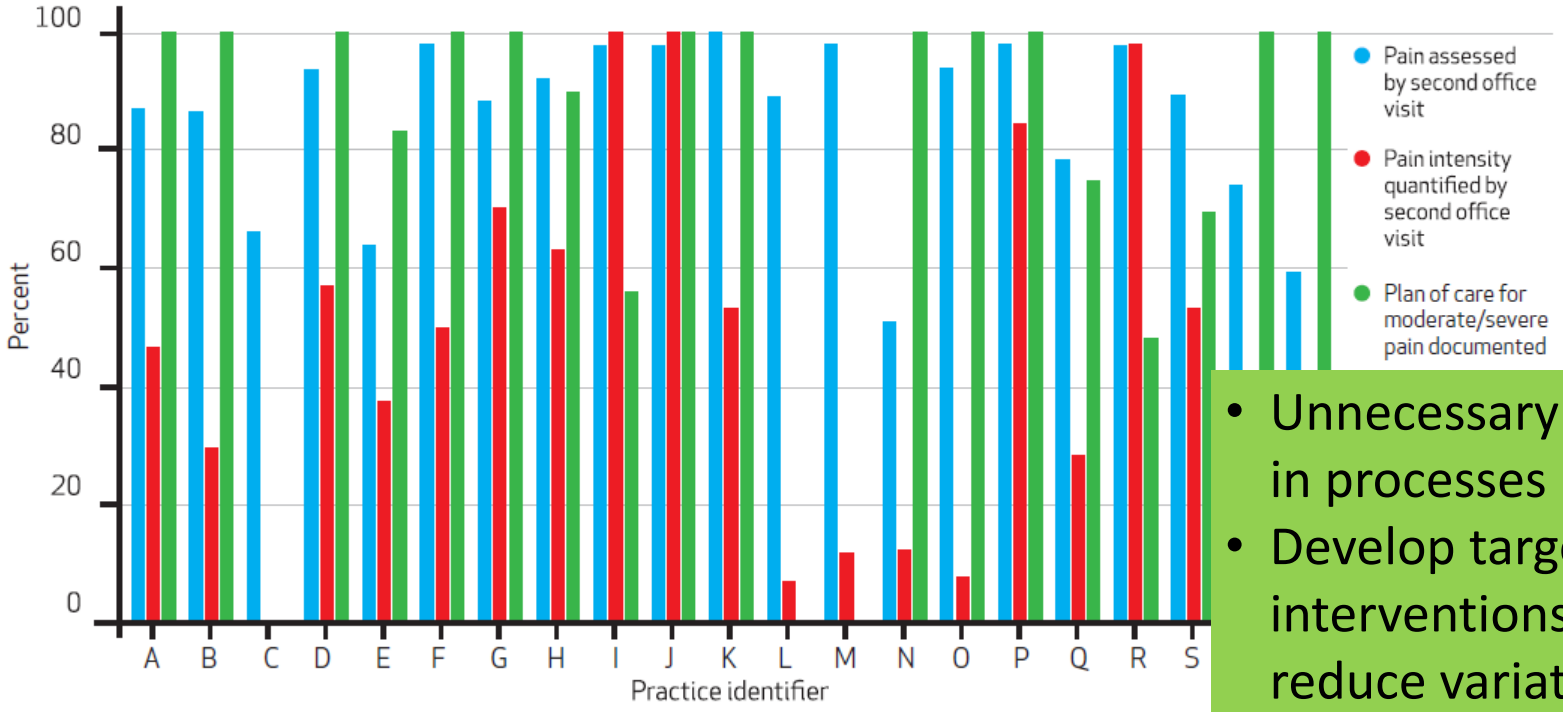


Blayney, et al, JCO 27:3802, 2009

http://moqc.org

- Physician groups:
  - Develop consensus guidelines
  - Review data
  - Develop interventions
- Coordinating Center
  - Coordinate meetings
  - Support interventions
  - Hold confidential data and data use agreements
  - Chart abstraction
- ASCO
  - QOPI is a member benefit
  - Practice-level reports
- Payers
  - Provide support
  - Claims data

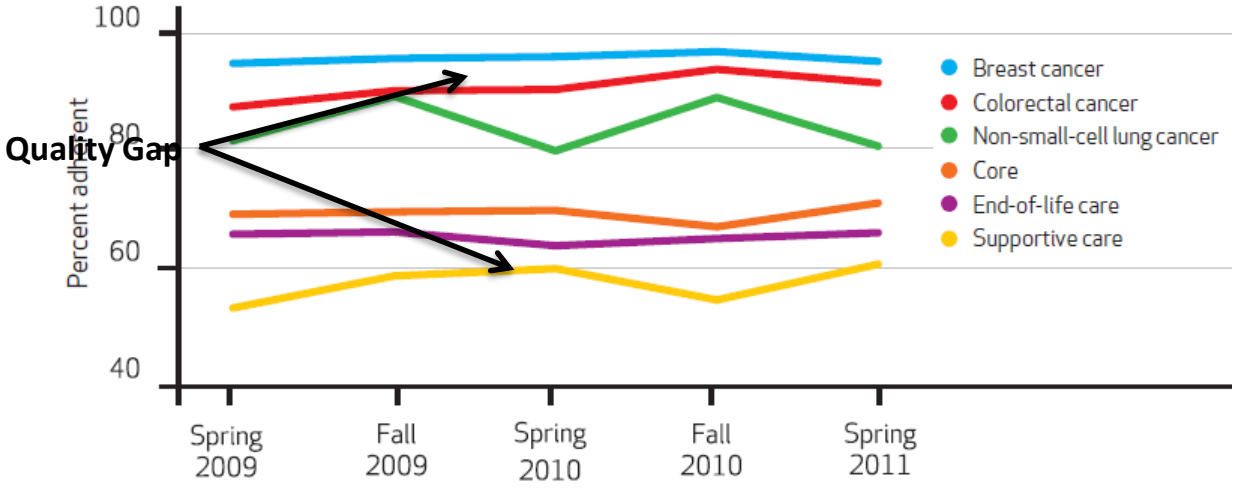
Performance Of Medical Practice Groups In The Michigan Oncology Quality Consortium (MOCQ) On Process Measures For Pain Management For New Patients, Fall 2010



- Unnecessary variation in processes of care.
- Develop targeted interventions to reduce variation and improve care

Blayney, *et al*. Health Affairs 2012 Apr;31(4):729.

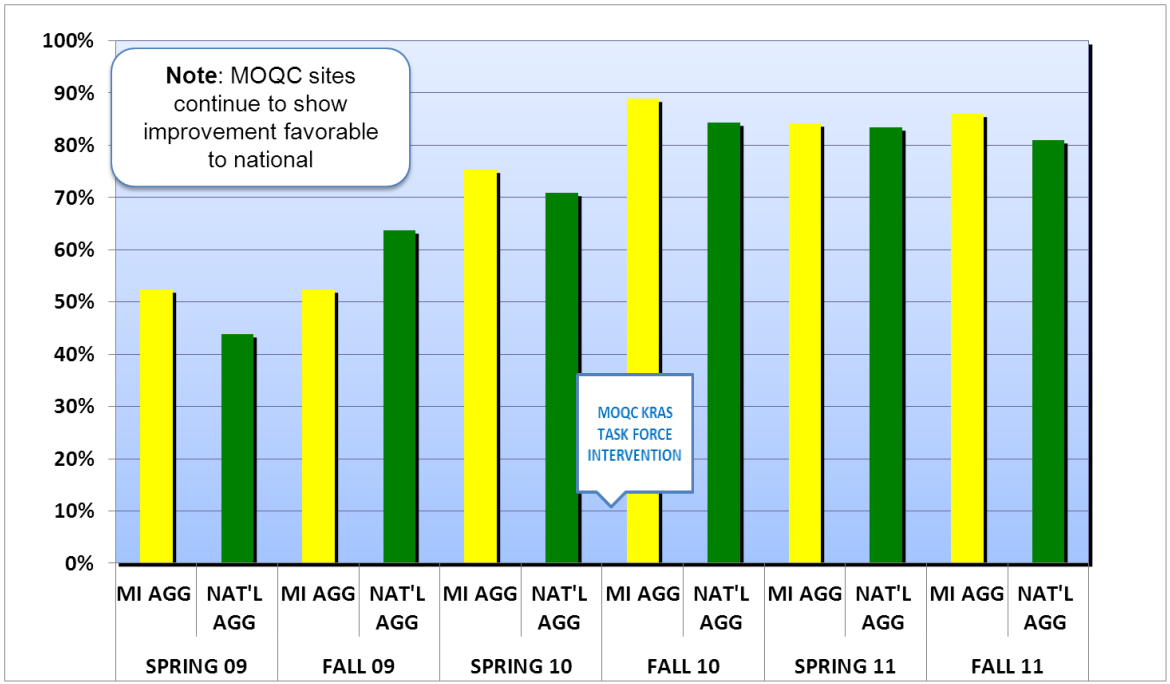
Performance Of Medical Practice Groups In The Michigan Oncology Quality Consortium (MOCQ) On Process Measures, Spring 2009–Spring 2011



Measured adherence with treatment measures is generally high. Measured adherence with processes of supportive care (management of toxicities and symptoms) and end of life care was lower and only slightly improved over time

Blayney, *et al*. Health Affairs 2012 Apr;31(4):729.

QI Activity #1: KRAS Results

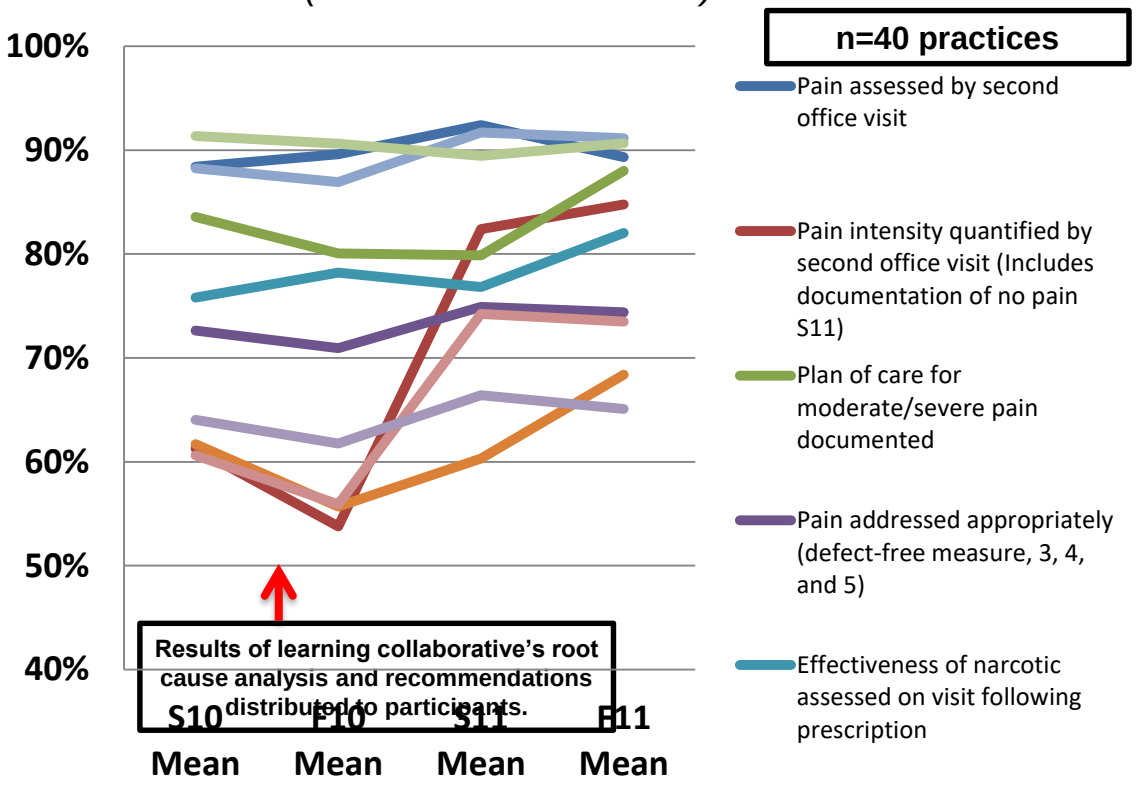


MI vs. National QOPI Scores:
KRAS testing for patients with metastatic colorectal cancer who received anti-EGFR MoAb therapy
(Higher Score- Better)

Michigan Oncology Quality Consortium

QI Activity #2: Pain Management Results

(Summer 2010-Fall 2011)



Michigan Oncology Quality Consortium

Critical Success Factors

- Guidelines
  - Evidenced based
  - Local modifications
  - No payer input
- Coordinating center
  - Build consensus
  - Committee of local experts
  - Neutral, unbiased third party
  - Confidential data
  - Move slowly (no initial “naming and shaming”)
- Payer and Business Community
  - Commitment to right care, right patient, right time

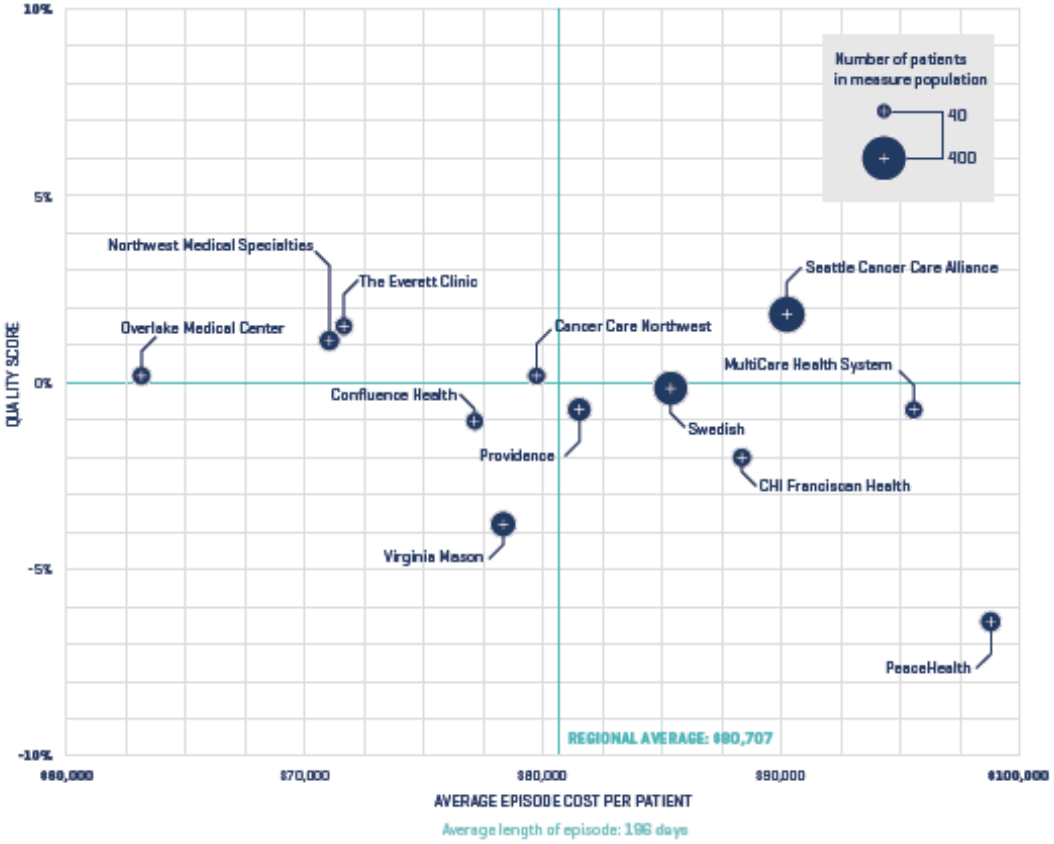
Challenges and Barriers

- Overcoming provider reluctance
- Data abstraction
- Data use agreements (!start early!)
- IT support
- No claims data from payers
- Implementation science (?what’s that?)

FRED HUTCH
HICOR | HUTCHINSON INSTITUTE FOR CANCER OUTCOMES RESEARCH

1B: RECOMMENDED TREATMENT FOR BREAST CANCER

Figure 1B.4: Recommended treatment for breast cancer
Summary quality score and cost



Quality

Value

Health

- Outcome
- Process
- Structure

- Because testing the effect of an intervention on survival takes years…
- Focus on processes
  - Develop evidence-based guidelines
  - Measure adherence to guidelines
  - Targeted interventions to improve adherence

=

Survival

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INTERVIEW

A Founder of Quality Assessment Encounters A Troubled System Firsthand

Shortly before his death, Avedis Donabedian talked with Fitzhugh Mullan about health care and the management of his own cancer care.

by Fitzhugh Mullan

secret of quality is love.

Drugs, therapy and hospital care avoided
Toxicity management
Indirect costs (lost work, travel, etc)

TAKING AIM AT CANCER

IN LOUISIANA