

Issues in Oncology: ASCO20 Virtual Scientific Program Highlights for the Advanced Practitioner



Josh Epworth, ARNP, of Seattle Cancer Care Alliance/University of Washington Medical Center, distills three influential abstracts from the ASCO virtual meeting and reflects on how advanced practitioners can use the findings to improve the care of their patients with cancer.

Abstract LBA110

Patients With Cancer Infected With COVID-19 Have More Severe Illness and Higher Mortality Rates Than the General Population

By The ASCO Post Staff

Visit <https://meetinglibrary.asco.org/record/191968/abstract> to read the full abstract and view author disclosures.

A large cohort study by the COVID-19 and Cancer Consortium evaluating the impact of COVID-19 on patients with cancer has found that all-cause 30-day mortality and severe illness were significantly higher in this population than previously reported in the general population. Mortality and severe illness were associated with general risk factors, as well as those unique to patients with cancer, although can-

cer type and treatment were not independently associated with increased 30-day mortality.

Longer follow-up is needed to better understand the impact of COVID-19 on outcomes in this patient population, including the ability to continue specific cancer treatments. The study was presented by Jeremy L. Warner, MD, and colleagues at the ASCO20 Virtual Scientific Program and featured in a press briefing prior to the meeting.

Study Methodology

The researchers analyzed data from 928 patients with cancer infected with COVID-19 accrued during March and April 2020. The participants included patients with active or prior hematologic or invasive solid malignancies reported across academic and community sites.

Median age of the patients was 66 years. Breast cancer (20%) and prostate cancer (16%) were the most prevalent cancers in the cohort. Nearly half (43%) of the patients had active cancer and 39% were on active cancer treatment.

Study Results

According to the researchers' data analysis, 121 patients (13%) have died and 26% met the composite outcome of death, severe illness requiring hospitalization, and/or mechanical ventilation.

After partial adjustment for several baseline factors, patients with progressing cancer were found to be 5.2 times more likely to die within 30 days compared with patients in remission or with no evidence of disease.

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In multivariable logistic regression analysis, independent factors associated with increased 30-day mortality were age, male sex, obesity, former smoking, Eastern Cooperative Oncology Group (ECOG) performance status (2 vs 0/1: adjusted odds ratio [AOR] = 2.88, 95% confidence interval [CI] = 1.21–6.61; 3/4 vs 0/1, AOR = 6.23, 95% CI = 2.44–15.94), progressive malignancy (AOR = 3.29, 95% CI = 1.24–8.52), and receipt of azithromycin and hydroxychloroquine.

Hispanic ethnicity was associated with a significantly lower mortality (AOR = 0.29, 95% CI = 0.08–0.95). Tumor type, number of comorbidities,

recent surgery, and type of active cancer therapy were not significant factors for mortality.

“All-cause 30-day mortality and severe illness in this cohort were significantly higher than previously reported for the general population and were associated with general risk factors as well as those unique to patients with cancer. Cancer type and treatment were not independently associated with increased 30-day mortality. Longer follow-up is needed to better understand the impact of COVID-19 on outcomes in patients with cancer, including the ability to continue specific cancer treatments,” concluded the study authors. ●

The Advanced Practitioner Perspective

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At the time of this writing, COVID-19 has caused nearly 150,000 deaths in the United States. Infection rates continue to rise, and scenarios developed by the Institute of Health Metrics and Evaluation project nearly 220,000 deaths by November 1. This infection has a 2.3 to 3.7 times higher mortality rate among Black Americans than White or Asian Americans depending on age. According to the CDC, 79.6% of disease deaths between February and May were over the age of 65; however, this did not take into account underlying medical conditions.

In this abstract by Warner and colleagues, the outcomes of patients with COVID-19 infections in the setting of underlying cancers was reviewed. As expected, there was a higher level of all-cause 30-day morbidity and mortality among the cancer population with COVID-19 than in the general population with the same infection.

Effects of Malignancy

Providers who treat cancers have a baseline concern regarding immunosuppression secondary to chemotherapy and/or disease. The risk of infection and poor outcomes is a significantly higher risk for oncology patients than for the general population. Given the spread of COVID-19, this concern is magnified. A great number of oncology patients are concerned and seeking guidance regarding the best approach to preventing and responding to infection.

Reducing the Risk of Infection

Given the poor outcomes in the cancer population with COVID-19 infections, preventing exposure is the best policy. As advanced practitioners, we can enhance our understanding of this disease with information from reputable sources, and then educate and counsel our patients regarding their behaviors and the behaviors of family members and caregivers. Early identification and treatment of COVID-19 may improve outcomes as with any infection in this population.

Disclosure: Mr. Epworth has no conflicts of interest to disclose.

Abstract 2003**Study Finds Cancer-Related Deaths Declined in States With Expanded Access to Medicaid**

By Jo Cavallo

Visit <https://meetinglibrary.asco.org/record/185990/abstract> to read the full abstract and view author disclosures.

States that adopted Medicaid expansion after passage of the Affordable Care Act (ACA) in 2010 saw a decline in cancer mortality rates by 29% compared with 25% in states that did not expand access to Medicaid, according to a study by Anna Lee, MD, MPH, of Memorial Sloan Kettering Cancer Center, New York, presented during a press briefing prior to the ASCO20 Virtual Scientific Program.¹ Of the minority groups assessed, Hispanic patients had the highest differential cancer mortality benefit in states with Medicaid expansion. Cancer mortality overall was worse for black patients in states without Medicaid expansion than in states with expanded coverage. In expanded states, the estimated drop in cancer deaths among all patients in 2017 was 785.

A central goal of the ACA, enacted into law in 2010, is to significantly reduce the number of uninsured Americans by providing affordable insurance coverage options through Medicaid and the Health Insurance Marketplace. The law expands Medicaid coverage for most low-income adults to 138% of the federal poverty level. As of April 2020, 37 states, including the District of Columbia, have expanded Medicaid coverage.

Study Methodology

The researchers analyzed age-adjusted mortality rates per 100,000 from the National Center for Health Statistics database from 1999 to 2017 to establish trends. They included only deaths due to cancer in patients younger than age 65. Absolute change in cancer mortality was calculated from 2011 to 2013 and from 2015 to 2017 (with 2014 as a washout year). Changes within subpopulations (gender, race, and ethnicity) were also assessed. Mortality changes between expanded and nonex-

panded groups were analyzed using a statistical technique called difference in differences.

Study Results

The researchers found that from 1999 to 2017, overall age-adjusted cancer mortality in the United States fell from 66.9 to 48.8 per 100,000. States that expanded Medicaid coverage had higher populations (157 vs 118 million) with fewer black/African Americans (19.2 vs 21.8 million) and more Hispanics (33.0 vs 21.7 million) than nonexpanded states (all examples from 2017).

The overall age-adjusted cancer mortality was consistently worse in the nonexpanded states. Cancer mortality fell from 64.7 to 46.0 per 100,000 in expanded states and from 69.0 to 51.9 per 100,000 in nonexpanded states from 1999 to 2017 (both trends $P < .001$, comparison $P < .001$). When the researchers compared the mortality changes in the peri-ACA years (2011–2013 vs 2015–2017) between the two cohorts, they found the difference in differences between expanded and nonexpanded states was -1.1 and -0.6 per 100,000, respectively ($P = .006$ expanded, $P = .14$ nonexpanded).

The estimated overall cancer mortality benefit gained in expanded states after Medicaid expansion is -0.5 per 100,000 ($P =$ nonsignificant). In expanded states, this translates to an estimated 785 fewer cancer deaths in 2017.

Age-adjusted cancer mortality per 100,000 was worse in nonexpanded states for black patients (58.5 expanded vs 63.4 nonexpanded in 2017); however, there was no differential mortality benefit after ACA expansion when comparing between the peri-ACA years. Of the subpopulations assessed, the researchers found that Hispanics in expanded states had the highest differential cancer mortality benefit at -2.1 per 100,000 ($P = .07$).

“This is the first study to show a directly measured cancer survival benefit from the ACA on a national scale using a comprehensive database. Hispanic populations appear to have the highest differential cancer mortality benefit after Medicaid expansion. Further study is needed to elucidate why other populations like Black patients did not appear to reap the same mortality decrease,” concluded the study authors.

Clinical Relevance

“This study provides needed data to understand the effects of Medicaid expansion on cancer care. Better access to quality cancer care, in this case through state expansion of Medicaid, led to fewer cancer deaths,” said Richard L. Schilsky, MD, FACP, FSCT, FASCO, Chief Medical

Officer and Executive Vice President of ASCO, in a statement. ●

Reference

1. Lee A, Shah K, Chino J, et al: Changes in cancer mortality rates after adoption of the Affordable Care Act. ASCO20 Virtual Scientific Program. Abstract 2003. Presented in pre-meeting press briefing May 12, 2020.

The Advanced Practitioner Perspective

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The Affordable Care Act (ACA) was designed to provide access to insurance for parts of the US population that traditionally had lower levels of coverage. This abstract reviews the impact of the ACA on cancer deaths by comparing mortality rates in patients below the age of 65 in states that expanded Medicaid coverage with those that did not. The study found improvements in favor of the expansion cohort, most notably in the Hispanic population. The lowest level of improvement was in Black patient populations.

What This Means

Increasing access to insurance translated to improvements in survival for patients with cancer. Whether through improved screening, expanded access to high-quality care, or oth-

er factors, the ACA coincided with decreased cancer mortality.

What This Means for APs

This abstract examined the impact of increased levels of insurance coverage on cancer mortality and, as stated earlier, it showed improvement for those covered compared with those who were not. However, having insurance and having access to a cancer care provider are not synonymous. Even with coverage, some patients may have difficulty finding an oncology provider in their locale. Advanced practitioners, with their presence in traditionally underserved areas, play a vital role in expanding the availability of cancer care. The ACA's effectiveness in improving survival among the Hispanic population, as well as improvements that still need to be made for the Black population, speaks to the necessity of continued access to insurance.

Disclosure: Dr. Epworth has no conflicts of interest to disclose.

Abstract 11000

Diversity in Oncology: A Discussion of Evidence-Based Transformation

By The ASCO Post Staff

Visit <https://meetinglibrary.asco.org/record/185955/abstract> to read the full abstract and view author disclosures.

Reshma Jagsi, MD, DPhil, of the University of Michigan, speaks with Narjust Duma, MD, of the University of Wisconsin Carbone Cancer Center, on the state of diversity in the hematology-oncology workforce, mechanisms that lead to inequities, promising interventions, and where the field should go next (Abstract 11000). Below is a transcript of their discussion that has been edited for length.

Reshma Jagsi, MD, DPhil: Dr. Duma, thank you so much for joining me today to discuss the important issues of equity, diversity, and inclusion in oncology, which mean so much to the both of us and to the field as a whole. May I ask you to begin by describing a bit about what has motivated you to study these issues?

Narjust Duma, MD: Thank you, Dr. Jagsi. I think the first thing is my own experiences. I moved from Venezuela to the United States for training. I was used to a more homogeneous environment, and I noticed that right after intern year, my opinion may not be taken at the same level than my peers. I was often labeled as too colorful, too Latina, and that actually produced consequences for my own self-esteem. And later when I became a mentor, I noticed that that was also affecting my mentees.

Despite speaking up, I didn't see many changes. But then I found out that when you get data,

when you present data, you can make a difference. And I found that I get more ears to hear if the data is there.

Reshma Jagsi, MD, DPhil: You certainly have been masterful at developing compelling data for our field. I would like to ask you now to summarize the findings of your most recent study. You have of course done brilliant work in this field more generally. But could you tell us a bit about your most recent study that was presented at ASCO?

Narjust Duma, MD: I think a lot of the credit comes to Dr. Velasquez Manana. She's a wonderful physician and researcher. She's currently a fellow at the University of California, San Francisco.

We looked at the past 10 years to see if we were improving the diversity in our workforce. Many things have happened, and we wanted to know, "Are we doing better?" Unfortunately, we continue to struggle in this area. We lack representation of Blacks, Hispanics, and Native Americans in our workforce. Despite increasing the number of medical students from underrepresented groups in medicine, we still struggle with this. It was a good point to stop and reset and realize that we need to do something different.

Reshma Jagsi, MD, DPhil: What do we know from your work and the work of others about the mechanisms that allow this inequity and lack of diversity in our field or foster that?

Narjust Duma, MD: I think there are many mechanisms, such as unconscious bias and structural problems. But I think one of the main issues that I have encountered personally, and for many other people, is mentorship. There's a belief that faculty should mentor underrepresented groups and medicine students, but there are not enough of us to mentor all minority students who are entering the medical schools every day. I think that we need to change the perception that one group needs to mentor another group. I think we need allies with all different backgrounds and genders to help with that.

Another aspect is how we see diversity. Instead of just seeing it as a tokenism that makes an institution look better, I think we have to value diversity for what it is. It presents more opinions, more opportunities to learn, and more ways to help our patients. Representation in leadership is important as well.

Reshma Jagsi, MD, DPhil: Can you comment a bit about promising interventions at either the institutional level or individual actions that we can undertake to improve diversity in our workforce?

Narjust Duma, MD: I think I'm going to divide that into two things. The first thing is that ASCO developed the Diversity Inclusion Taskforce. And I'm very thankful to be part of it. Dr. Karen Wingfield has been a great person to follow. When I was an intern, she told me I belong in medicine. She was the first person who told me that.

I think pairing the underrepresented groups in medicine in the Pairing Mentorship Program at ASCO is also very promising. I think following how we're doing with those mentorship relationships would be good and making sure these relationships continue.

As for institutions, I think what's key is making sure that every day that opinion, that person that has been there, has treated patients like this, is taken into account.

As for individual work, I think it is very important to mentor and mentor and mentor. Mentorship is still a struggle for many of us. And you don't have to be a specialist in diversity inclusion, you can just offer help. Answer their emails. I think answering emails is one of the things that doesn't take that much time but means a lot for trainees.

Reshma Jagsi, MD, DPhil: And finally, in closing, can you comment on where you think the field should go next?

Narjust Duma, MD: This paper has shown that 10 years of doing what we did didn't work to increase diversity. Sometimes we have to start again. Because when we don't account for the mistakes or the things that didn't work, we're going to repeat them. What can we do differently? How we can be more welcoming and how we can reach others?

There are amazing, brilliant minds being developed in many medical schools. And we cannot forget the effect that mentors have on many of us. I'm here because of a mentor. My parents are surgeons. So I think that's what we can do. And I think we can do it together, all as a big family. Because we're here for the same thing, Dr. Jagsi. And that's to improve the care of our patients with cancer.

Reshma Jagsi, MD, DPhil: Thank you for those inspiring words. You know, I started in this area more than a decade ago, studying these same issues.

And have to admit feeling somewhat disheartened when I saw your data showing how little things have changed. Although as you commented, ASCO has done some amazing things and our profession as a whole has made some strides. But I have to say that after hearing you speak and seeing the tremendous

work that you're doing, I'm filled with hope for the future. And so pleased to have had the opportunity to interview you. So thank you for sharing your wisdom, your time, your insights, and your energy in this interview and with the field in general. Thank you.

Narjust Duma, MD: Thank you, Dr. Jagsi. ●

The Advanced Practitioner Perspective

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In a recent conversation, Dr. Duma reviews what a decade of work at improving diversity in the hematology/oncology workplace has yielded. While the number of medical students from underrepresented groups has increased, Dr. Duma notes that this has not translated into greater diversity, in terms of both race and gender, in oncologic subspecialties. Dr. Duma points out a number of factors that stymie this, including unconscious bias, the absence of underrepresented groups in leadership positions in both medical schools and hospital/clinic administration, and the absence of mentors for these students.

How This Affects APs

The lack of diversity in oncology subspecialties that Dr. Duma points out in her study is similarly reflected in the ranks of oncology advanced practitioners. The majority of nurse practitioners and physician assistants are White. Given the growing role of advanced practitioners as caregivers for underserved populations in both urban and rural settings, as well as the benefits that can be reaped from having providers of similar backgrounds as their patients, it is critical to expand diversity among advanced practitioners working in oncology.

Pathways to Change

The issues that hamper increased diversity in the oncology workplace extend from personal to institutional barriers. Opportunities for improvement can come through a host of approaches.

1. Assess our own implicit bias: We may not consider ourselves biased, racist, or influenced by race, but resources such as the Project Implicit from Harvard University (<https://implicit.harvard.edu/implicit/>) may help illuminate some unconsidered blind spots.

2. Initiate discussions: The Association of American Medical Colleges suggests engaging in a frank, introspective discussion among colleagues about race, power, privilege, and social justice.

3. Provide mentoring: As suggested in the interview, Dr. Duma has cited the value of providing a mentor/mentee relationship. The consistent and supportive presence of a mentor throughout the course of a career is invaluable to producing satisfied providers who feel welcome at their workplace.

4. Act: Engage the administrative team to develop meaningful, implementable and measurable changes to recruit and consistently support underrepresented hires whether as providers, professors, or administrators.

Disclosure: Mr. Epworth has no conflicts of interest to disclose.