Livestream: Addressing Barriers in Advancing Equitable Biomarker Testing in Community Oncology

SYLLABUS & COURSE GUIDE

A Free, 90-Minute Live Activity
Premiere Date: Wednesday, October 16, 2024
3:00 PM - 4:30 PM ET

Login:
www.cmeoutfitters.com/biomarkerstream

Faculty:
Diana Brixner, BPharm, PhD, FAMCP (Moderator)
Zach Rivers, PharmD, PhD
Dusty Donaldson (Survivor and Patient Advocate)

Take advantage of our LIVE Q&A segment during this webcast!

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Information for Participants

Statement of Need

Biomarker or molecular testing to help oncologists match patients with the best cancer treatment can be challenging in the community oncology setting and for patients in underserved communities. At present, patients with cancer in racially or ethnically underserved communities are not getting biomarker testing at the same rate as White patients in communities with greater access to care. Barriers to testing include insurance restrictions, conflicting guidelines, and the reliance of community oncologists on single-gene testing instead of multi-gene panels used more often by academic oncologists. In the multidisciplinary setting of community oncology, healthcare professionals (HCPs) would benefit from education on best practice models that provide cost-effective molecular testing services for the undertested underserved population, especially given that more recently U.S. Food and Drug Administration (FDA)-approved treatments require biomarker testing.

In this CME Outfitters livestream symposium expert faculty will evaluate the latest biomarker testing strategies in prostate, bladder, and lung cancer, discussing how to integrate all members of the interdisciplinary care team in community oncology settings, identifying root causes of health inequity in cancer care and how to incorporate strategies to address unconscious bias and provide the latest biomarker testing services in cancer care management.

Learning Objectives

At the conclusion of this activity, learners will be able to better:

- Evaluate the latest biomarker testing strategies in prostate, bladder, and lung cancer, including their impact on treatment decision-making
- Integrate all members of the care team in strategies to provide equitable biomarker testing in community oncology settings
- Identify the root causes of health inequity in cancer care
- Incorporate action-oriented strategies to address unconscious bias and patient social determinants of health (SDoH) in cancer care management

Financial Support

Supported by an educational grant from Janssen Biotech, Inc., administered by Janssen Scientific Affairs, LLC.

Target Audience

Managed care physicians and pharmacists, community oncologists, oncology physician associates (PAs) and nurse practitioners (NPs), oncology nurses, and oncology pharmacists

Faculty

DIANA BRIXNER, BPHARM, PHD, FAMCP (MODERATOR)
Professor Emeritus
Department of Pharmacotherapy
University of Utah
Huntsman Cancer Institute Cancer Control and Population Sciences
Center for Genomic Medicine
Salt Lake City, Utah

Diana Brixner, BPharm, PhD, FAMCP is Emeritus Professor in the Department of Pharmacotherapy and is a Founder of the Pharmacotherapy Outcomes Research Center (PORC) at the University of Utah in Salt Lake City, Utah. She has been a member of both the Huntsman Cancer Institute Cancer Control and Population Sciences and the Center for Genomic Medicine. She also serves as a principal of the Millcreek Outcomes Group, LLC where she consults on translating evidence to value to support payer decision making. Prior to her academic appointment in 2002 Dr. Brixner worked both in the biotech (NeoRx) and pharmaceutical (SmithKline Beecham, Novartis) industry focused on value assessment of their technologies in the early years of the field. Dr. Brixner was a Past President of both the Academy of Managed Care Pharmacy (AMCP) and International Society of Pharmacoeconomics and Outcomes Research (ISPOR). She has served as a one-year Scholar-in-Residence for AMCP, recently served on the scientific advisory board of Lumanity and is a member of the Executive Board of the International Market Access Society.

Dr. Brixner received her BS degree in 1982 from the University of Rhode Island, Pharmacy. In 1987 she received her PhD in Medicinal Chemistry from the University of Utah. She received a Modeling Approaches for Health Technology Assessment Certificate in 2010, a Clinical Epidemiology Certificate in 2013 and a Certificate in the Introduction to Health Technology Assessment in 2015 from the University of Health Sciences, Medical Informatics and Technology, Hall in Tirol, Austria where she did a sabbatical in 2011.

Dr. Brixner's research focus is on the design, conduct, and communication of pharmacoeconomic and outcomes research studies to demonstrate the value of pharmaceutical and related therapies from the perspective of the private and public payer. Much of her work is focused on oncology and personalized medicine. She has published over 150 articles in peer-reviewed journals, authored three book chapters, has one issued patent, and has been an invited speaker at a variety of national and international professional meetings.

> **Dr. Brixner** reports the following relationships:
>
> Advisory Board: Bayer and Jazz Pharmaceuticals, Inc.
>
> Consultant: LEO Pharma; Millcreek Outcomes Group, LLC; Sanofi; and Tandem Therapeutics
>
> Grants: Dexcom, Inc.

ZACH RIVERS, PHARMD, PHD
Senior Scientist II
Tempus AI, Inc
Chicago, IL
Clinical Oncology Pharmacist
UVM Medical Center
Burlington, VT

Zach Rivers, PharmD, PhD is a passionate clinician-scientist with over 15 years of experience in outpatient infusion and oral chemotherapy. Dr. Rivers' research is centered on integrating personalized and precision medicine into cancer care utilizing large datasets to identify opportunities for precision medicine and develop health economic simulation models to assess the impact of novel biomarkers on health policy and implementation. He is especially interested in how different biomarker testing approaches can increase health equity in traditionally underserved populations.

Dr. Rivers reports the following financial relationships:

Stock Shareholder (ownership interest): Tempus AI, Inc.

Employment: Tempus AI, Inc.

DUSTY DONALDSON
Survivor and Patient Advocate
LiveLung
President, LungCAN
High Point, NC

Dusty Donaldson is Founder and Executive Director of LiveLung, a 501c3 nonprofit serving the lung cancer community. She is also President of the Lung Cancer Action Network (LungCAN), a collaborative association of lung cancer nonprofit organizations and patient advocacy groups. In 2016, she co-authored the book "*The ABCs of Lung Cancer for Patients and Advocates*," and is working on the 2nd Edition soon to be released. Dusty has been a reviewer for lung cancer research proposals for the American Society of Clinical Oncology's (ASCO's) Conquer Cancer Foundation and the Congressionally Directed Medial Research Program's Lung Cancer Research Program. She is a contributing writer for www.lungcancer.net and serves on the National Lung Cancer Roundtable's Survivorship, Stigma & Nihilism Task Group. In 2022, Dusty received the International Association for the Study of Lung Cancer (IASLC) Patient Advocate Educational Award. Prior to being diagnosed with early-stage lung cancer in 2005, Dusty was a journalist and public relations professional. She earned undergraduate and graduate degrees in journalism.

Ms. Donaldson reports no financial relationships to disclose.

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	Scott J. Hershman, MD, FACEHP, CHCP – no disclosures to report
	Sharon Tordoff – no disclosures to report

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This activity was planned by and for the healthcare team, and learners will receive 1.5 Interprofessional Continuing Education Credit for learning and change.

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Addressing Barriers in Advancing Equitable Biomarker Testing in Community Oncology

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LO #1

Evaluate the latest biomarker testing strategies in prostate, bladder, and lung cancer, including their impact on treatment decision-making

LO #2

Integrate all members of the care team in strategies to provide equitable biomarker testing in community oncology settings

LO #3

Identify the root causes of health inequity in cancer care

LO #4

Incorporate action-oriented strategies to address unconscious bias and patient social determinants of health (SDoH) in cancer care management

To Ask a Question

To submit a question, please go to the *Ask Question* tab at the bottom of the screen.

Cancer Biomarkers

- Types of biomarkers
  - Predictive biomarkers are indicative of therapeutic efficacy because there is an interaction between the biomarker and therapy relative to patient outcome
  - Prognostic biomarkers inform the odds of patient survival independent of the treatment received
  - Genes, proteins, lipids, metabolites, bits of DNA or microRNA
    - DNA biomarkers are most commonly use for treatment decision making
- Biomarker testing to detect actionable targets as part of a diagnostic work up can help personalize care
  - Biomarkers point to more effective, less toxic therapies, while avoiding ineffective therapies and unnecessary toxicities
  - Use of biomarkers reduces the overall costs of cancer care

Cancer Biomarkers

- National Comprehensive Cancer Network (NCCN) guidelines recommend biomarker testing in most patients with cancer
- Biomarker testing ≠ genetic testing
  - Anyone can have genetic testing to identify inherited mutations that predispose them to cancer
  - Somatic biomarker testing is specific to cancer since cancer has undergone mutations that make it different than the patient
  - However, there can be some overlap (e.g., BRCA mutations, Lynch syndrome)
- Biomarker testing may or may not be necessary prior to using specific targeted therapies — it's complicated and constantly evolving

In almost all cancer types, biomarker analyses are recommended prior to initiating therapy

National Cancer Institute. NCI website. 2021. https://www.cancer.gov/aboutcancer/treatment/types/biomarkertesting-cancer-treatment.

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Actionable Cancer Biomarkers

Bladder	NSCLC	Prostate
FGFR3	EGFR KRAS ALK ROS1 MET	HRR genes (e.g., BRCA1, BRCA2, ATM, PALB2, FANCA, RAD51D, CHEK2, CDK12, others) PSMA
Tumor-agnostic:	NTRK, PD-L1, MSI-H/dMMR, TMB, BRAF V600E, RET, HER2	

HRR, homologous recombination repair; MSH, microsatellite instability high; TMB, tumor mutational burden
NCCN Guideline. Prostate Cancer. v4.2024. https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf.
NCCN Guideline. Non-Small Cell Lung Cancer. v10.2024. https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf.
NCCN Guideline. Bladder Cancer. v4.2024. https://www.nccn.org/professionals/physician_gls/pdf/bladder.pdf.
Subbiah V, et al. *CA Cancer J Clin* 2024;74(5):433-452.

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Rising Use of Multi-gene Biomarker Analyses

- Single gene testing is rapidly being abandoned in favor of more comprehensive approaches (e.g., NGS, WGS, WES)
  - Expanding repertoire of biomarker-based therapy options, including tumor-agnostic indications

	SNV/ Indels	Fusions	CNV	TMB	MSI	HRD	Gene Expression	Tissue Need	Cost	TAT	Germline Correlation Needed
Sanger sequencing	✓							+	$	<1 week	No
NGS- targeted panel (20–100 genes)	✓							+	$	1–2 weeks	No
FISH		✓	✓					++	$	<1 week	No
NGS-large panel (hundreds)	✓	✓	✓	✓	✓	✓		++	$$	2+ weeks	Desired
WES	✓		✓	✓	✓	✓		++	$$$	Weeks–months	Yes
WGS	✓	✓	✓	✓	✓	✓		+++	$$$	Weeks–months	Yes
WTS	✓	✓					✓	++	$$$	Weeks–months	N/A

CNV, copy number variant; FISH, florescence in situ hybridization; HRD, homozygous repair deficiency; MSI, microsatellite instability; SNV, single nucleotide variant; TAT, turn-around time; TMB, tumor mutational burden; WES, whole exome sequencing; WGS, whole genome sequencing; WTS, whole transcriptome. sequencing.

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Sholl LM, Halmos B. *Brit J Cancer.* 2022;127(7):1177-1179.

Benefits and Limitations of Biomarker Assessment Techniques

	DNA and RNA				Protein
	NGS	RT-PCR	PCR	FISH	IHC
Benefits	• Large throughput • High accuracy • Rich content information • Multiple types of genetic alterations	• Highly sensitive • Detects fusion transcripts at the RNA level	• Allows for rapid testing	• Knowledge of fusion partner not required • Rearrangements can be discriminated from polysomy/ amplifications	• Sensitive • Familiar • Time saving and easily automatable • Cost-friendly • Many validated antibodies available
Limitations	• Turnaround time • Tissue sample needs • Reports can be hard to interpret • Wide variety of NGS assay platforms	• Poor quality of FFPE RNA samples • Limited number of variants tested at once	• Only test 1 gene at a time • Requires high tumor enrichment	• Not all rearrangements produce an expressed fusion transcript • May miss unknown variants	• May require confirmatory test • Accuracy can vary by fixative and background • Insufficient tumor content of tissue • Skilled pathologist required

IHC, immunohistochemistry; PCR, polymerase chain reaction; RTPCR, reverse transcriptase PCR
Bruno R, Fontanini G. *Diagnostics (Basel).*2020;10(8). Frankel D, et al. *Int J Mol Sci* 2022;23(18).
Pennell NA, et al. *Am Soc Clin Oncol Educ Book*2019(39):533-542. Sholl LM, Halmos B. *Brit J Cancer.* 2022;127(7):1177-1179.

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Landscape of Biomarker Testing Coverage

- 15 states have laws mandating biomarker coverage (May 2024)
- >50% of U.S. population may not be covered by legislative mandates governing insurance coverage
- State mandates may not significantly impact those most affected by healthcare disparities (e.g., uninsured or some Medicaid populations)

>2.0 Million
people are estimated to be diagnosed with cancer in 2024 in the United States

>$1,200
upfront costs for broad panel biomarker testing

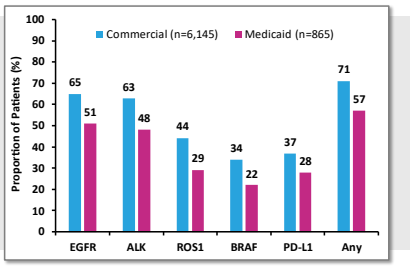
66%
oncology providers reporting lack of biomarker testing coverage as a barrier to care

Siegel RL, et al. *CA Cancer J Clin.*2024;74(1):12-49. Lin GA, et al. *JAMA.* 2024;331(22):1885-1886.
Dieguez G, Carioto J. Milliman website. 2022. https://www.milliman.com/en/insight/the-landscape-of-biomarker-testing-coverage-in-the-US.
Association of Cancer Care Centers. ACCC website. 2023. https://www.acccancer.org/acccbuzz/blogpost-template/accc-buzz/2023/12/12/the-cost-of-biomarker-testing-moving-from-support-based-to-sustainable-solutions.

CME OUTFITTERS

Biomarker Testing Patterns by Insurance Type

- Coverage issues remain a leading concern of providers
- Disconnect between covering tests vs drugs
- Retrospective analysis of nationwide U.S. healthcare database of patients receiving a diagnosis of advanced NSCLC from 2011–2019
- Receipt of biomarker testing (ALK, EGFR, ROS1, BRAF, and PD-L1) was assessed



Gross CP, et al. *J Natl Compr Canc Netw* 2022;20(5):479-487.

Which of the following did community oncology clinicians identify as the factor that would make them LEAST likely to order biomarker testing for their patients with NSCLC?

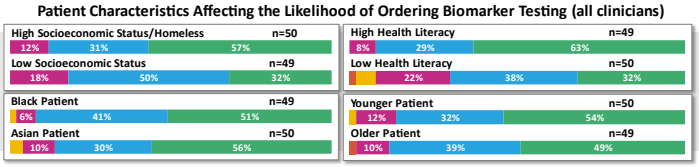
A. Low economic status
B. Low health literacy
C. Black ethnicity
D. Older patient
E. I don't know

Which of the following did community oncology clinicians identify as the factor that would make them LEAST likely to order biomarker testing for their patients with NSCLC?

A. Low economic status
B. Low health literacy
C. Black ethnicity
D. Older patient
E. I don't know

Gaps in Biomarker Testing between Community and Academic Oncology Settings

Patient Characteristics Affecting the Likelihood of Ordering Biomarker Testing (all clinicians)



- 99 clinicians (67% community setting) who treat patients with NSCLC responded to an online survey from ACCC (2020)

While most clinicians surveyed discuss biomarker testing with their patients with lung cancer, the likelihood of ordering guideline concordant testing decreased for patients with lower socioeconomic status and health literacy.

Boehmer L, et al. *J Clin Oncol* 2021;39(suppl 28): 123.

Gaps in Biomarker Testing between Community and Academic Oncology Settings

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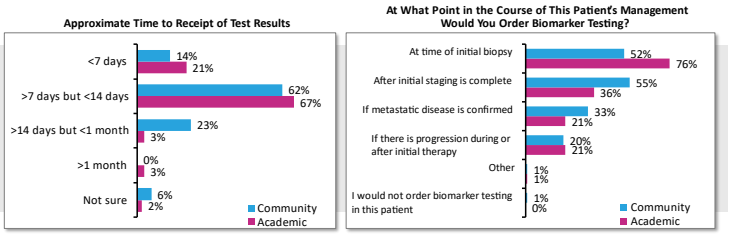


ACCC, Association of Cancer Care Centers; NSCLC, non-small cell lung cancer.

Boehmer L, et al. *J Clin Oncol* 2021;39(suppl 28):123.

Real-world NSCLC Biomarker Testing Rates

Retrospective observational chart review of metastatic NSCLC (mNSCLC) patients initiating first -line therapy between (April 2018 –March 2020)

- 90% of patients received ≥1 biomarker test
- 46% received all 5 biomarker tests
- Next-generation sequencing (NGS) testing increased from 33% to 44% (P<0.0001)
- Time from mNSCLC diagnosis to biomarker results: 14 –21 days
- Turn around time (TAT) from biomarker testing orders to results: 10–15 days
- Time from mNSCLC diagnosis to first-line therapy: 35 (22, 55) days

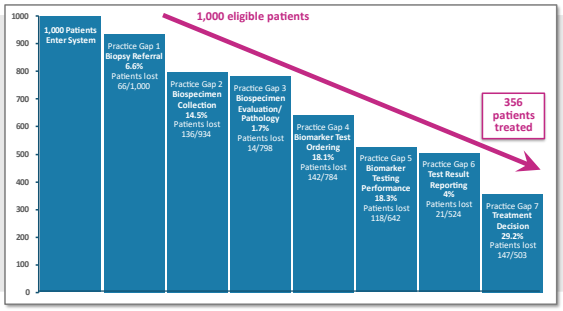
	Total Patients	Cohort 1 Biomarker Test Result Received Prior to First Line	Cohort 2 Biomarker Test Result Received During/After First Line	Cohort 3 No Biomarker Test
Overall n (%)[a]	3,474	2,752 (79)	371 (11)	351 (10)
Any biomarker test[a]	3,123	2,752 (88)	371 (12)	NA
5 biomarker tests[b]	1,602	1,230 (77)	372 (23)	NA
Biomarker testing, n (%)[a]				
ALK	2,446	1,986 (57)	460 (13)	1,028 (30)
BRAF	1,912	1,489 (43)	423 (12)	1,562 (45)
EGFR	2,443	1,979 (57)	464 (13)	1,031 (30)
PD-L1	2,882	2,526 (73)	356 (10)	592 (17)
ROS1	2,348	1,897 (55)	451 (13)	1,126 (32)

[a]Row percentage denominator: 3,474
[b]Row percentage denominator: total patients with test
Note: Additional biomarkers have been deployed since this study was undertaken

Robert NJ, et al. *J Clin Oncol* 2021;39(15_suppl):9004.

Clinical Process Gaps Result in Lung Cancer Patients Missing the Opportunity to Benefit from Personalized Medicine

"The data was normalized to a patient population of **1,000** to easily demonstrate the number of eligible patients that may be lost to receiving targeted therapies due to each clinical practice gap."

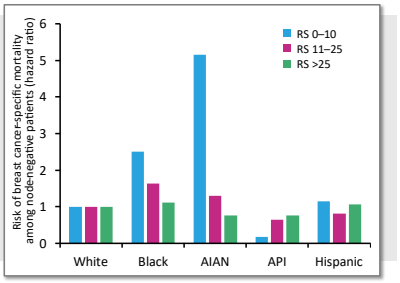


Sadik H, et al. *JCO Precis Oncol* 2022;6:e2200246.

Underrepresentation of Ethnic Groups in Biomarker Development

- 21-gene Oncotype DX Breast Recurrence Score (RS) test is used for risk-adapted treatment decisions among patients with early breast cancer
- The landmark trial validating the RS included only 5% Black women
- This study examined the prognostic accuracy of the RS in ethnic minority groups

Multivariant analysis adjusted for age, year of diagnosis, tumor size, progesterone receptor status, type of surgery, and administration of radiotherapy and chemotherapy

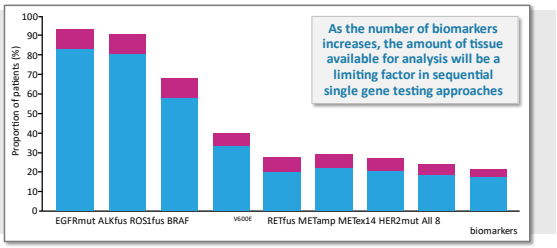


AIAN, American Indians and Alaska Natives; API, Asian and Pacific Islanders.
Paik S, et al. *N Engl J Med* 2004;351(27):2817-2826.

Barriers to NSCLC Biomarker Testing
Tissue Limitations

Prospectively enrolled patients with previously untreated mNSCLC undergoing physician discretion SoC tissue genotyping submitted a pretreatment blood sample for comprehensive cell-free DNA analysis

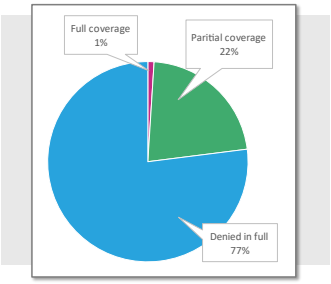
- 68.1% of patients were under genotyped*
  - Only ~18% of patients were tested for all eight recommended biomarkers by tissue biopsy



SoC, standard of care.
*Did not have a guideline recommended biomarker identified and were not assessed for all guideline recommended biomarkers
Leighl NB, et al. *Clin Cancer Res* 2019;25(15):4691-4700.

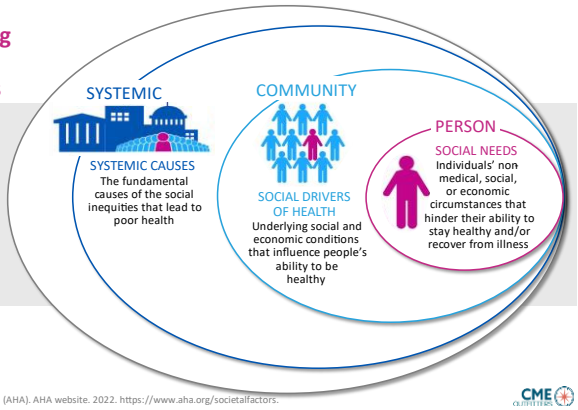
Barriers to NSCLC Biomarker Testing
Payer Coverage

- In 2020, a study among 246 cases (January 2017–March 2018) in New York showed majority of tests denied payer coverage and only 10.75% of the total NGS service charge was reimbursed
- Coverage through private payers may be variable



Leighl NB, et al. *Clin Cancer Res* 2019;25(15):4691-4700.

Factors Contributing to Health Disparities



American Hospital Association (AHA). AHA website. 2022. https://www.aha.org/societalfactors.

U.S. Cancer Disparities

Complex and interrelated factors contribute to cancer health disparities in the United States. Adverse differences in many, if not all, of these factors are directly influenced by structural and systemic racism. The factors may include, but are not limited to, differences or inequalities in:

Environmental Factors
- Air and water quality
- Radon
- Transportation
- Housing
- Community safety
- Access to healthy food sources and spaces for physical activity

Behavioral Factors
- Tobacco use
- Diet
- Excess body weight
- Physical inactivity
- Adherence to cancer screening and vaccination recommendations

Social Factors
- Education
- Income
- Employment
- Health literacy

Clinical Factors
- Access to health care
- Quality of health care

Cultural Factors
- Cultural beliefs
- Cultural health benefits

Psychological Factors
- Stress
- Mental health

Biological and Genetic Factors

Mitchell E, et al. *J Natl Med Assoc* 2022;114(3):236-250.
National Cancer Institute. NCI website. Updated 2024. https://www.cancer.gov/about-cancer/understanding/disparities.

Biomarker Testing in Underserved Patient Populations

- Insurer coverage important for provider uptake and patient access to biomarker testing
  - Coverage differs greatly across the multiple public and private U.S. payers
  - Clinical utility often required —"experimental" biomarkers often used in clinical trials may not be covered

All Patients with NSCLC				
	NSCLC Overall N=14,768	White n=9,793	Black/AA n=1,288	*P*-value White vs Black/AA
Ever tested	11,297 (76.5%)	7,477 (76.4%)	948 (73.6%)	0.03
Tested prior to first-line therapy		6,064 (61.9%)	784 (60.9%)	0.47
Ever NGS tested	7,185 (48.7%)	4,904 (50.1%)	513 (39.8%)	<0.0001
NGS tested prior to first-line therapy		3,081 (31.5%)	332 (25.8%)	<0.0001
Patients with Non-squamous NSCLC				
	Non-squamous N=10,333	White n=6,705	Black/AA n=922	*P*-value White vs Black/AA
Ever tested	8,786 (85%)	5,699 (85%)	764 (82.9%)	0.09
Tested prior to first-line therapy		4,881 (72.8%)	662 (71.8%)	0.52
Ever NGS tested	5,494 (53.2%)	3,668 (54.7%)	404 (43.8%)	<0.0001
NGS tested prior to first-line therapy		2,452 (36.6%)	274 (29.7%)	<0.0001

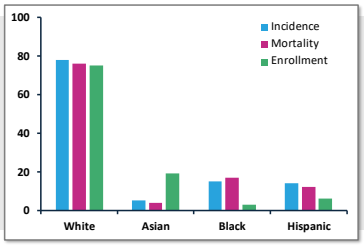
AA, African American.

American Cancer Society (ACS). ACS Action Network website. 2022. https://www.fightcancer.org/policyresources/improving-access-biomarker-testing.
Bruno DS, et al. *JCO Oncol Pract*. 2021;2015_suppl:e906.

Black Patient Representation in Clinical Trials

- Trial participation is lowest among Black patients
- Patient-cited barriers to clinical trial enrollment
  - Mistrust of clinical research
  - Perceived harms
  - Costs
  - Transportation
  - Unclear about goals of trials
  - Time
  - Fear
  - Family

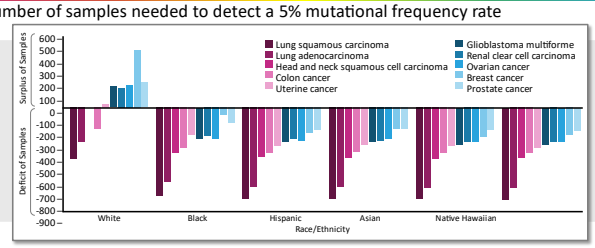
Relative proportion among U.S. patients with cancer compared with trial participants in FDA-approval trials between July 2008 and June 2018.



Ford JG, et al. *Cancer*. 2008;112(2):228-242. Unger JM, et al. *JNCI Cancer Spectr*. 2020;4(4):pkaa034.

Importance of Diversity in Precision Medicine

- Number of samples needed to detect a 5% mutational frequency rate



- Despite the advances gained from genomic sequencing, dedicated efforts beyond TCGA are needed to avoid widening the cancer health disparities gap
- Ethnic diversity in genomic sequencing efforts is important to the generalizability and availability of genomic -based treatments

Spratt DE, et al. *JAMA Oncol* 2016;2(8):1070-1074.

Factors That Influence Access to Cancer Care

- Patient level
- Provider level
- Systemic level
- Societal level

- Comorbid conditions, overall health status
- Patient health literacy
- Health care beliefs and participation in decision-making
- Personal support system
- Affluency

Recognize the patient is not the "problem," but that the broader society and health care organizations and providers are additional sources of barriers

Osarogiagbon RU, et al. *Am Soc Clin Oncol Educ Book* 2021(41):66-78.

Factors That Influence Access to Cancer Care

- Patient level
- Provider level
- Systemic level
- Societal level

- Failure to provide guideline-recommended care
  - Biomarker testing
  - Cancer treatments
  - Clinical trials
- Provider knowledge, training, skillsets, years of practice, specialty
- Beliefs and attitudes (e.g., conscious and unconscious biases)

Osarogiagbon RU, et al. *Am Soc Clin Oncol Educ Book* 2021(41):66-78.

CME

Factors That Influence Access to Cancer Care

- Patient level
- Provider level
- Systemic level
- Societal level

- Geographic location
- Availability of culturally competent services
  - Inadequate medical interpretation services
- Health care worker diversity
- Affiliation with research or academic health care systems
- Inequities of physical infrastructure and technology
- Processes (e.g., reimbursement contracts, scheduling and referrals, hours of operation, and availability of language options)
- Inadequate staffing (burnout and workload)

Osarogiagbon RU, et al. *Am Soc Clin Oncol Educ Book* 2021(41):66-78.

CME

Factors That Influence Access to Cancer Care

- Patient level
- Provider level
- Systemic level
- Societal level

- Social "drivers" of health
- Socioeconomic and health care policies
- A high proportion of uninsured or underinsured individuals in a population adversely affects access to care and overall quality of care in the whole population
  - Inadequate medical insurance
  - Unequal/disparate job opportunities
  - Unequal/disparate educational opportunities
  - Inadequate public transportation infrastructure

Osarogiagbon RU, et al. *Am Soc Clin Oncol Educ Book* 2021(41):66-78.

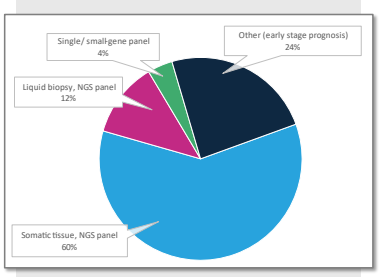
CME

Texas Oncology PMQI Program

Goal: To improve testing rates and provide patients access to targeted therapies/clinical trials

Methods

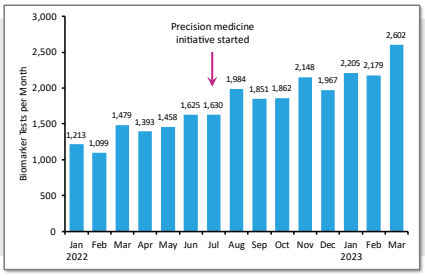
- Patients with eligible solid tumors
- PMQI recommended testing utilizing a broad panel NGS test
- Somatic tissue or liquid biopsy
- Testing ordered through clinical support tool
- Testing order tracked through EHR and tracking tools
- Retrospective analysis January 2022 –March 2023



PMQI, Precision Medicine Quality Initiative.
Brisbin L, et al. *JCO Oncol Pract* 2023;19(11_suppl):385.

CME

Texas Oncology PMQI Program

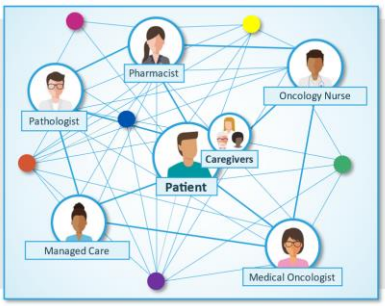


- Biomarker testing increased across all tumor types
- Broad-panel NGS tests were ordered increasingly over single gene or small-panel tests
- Liquid biopsies more than doubled
- Testing increased in rural/underserved regions

Brisbin L, et al. *JCO Oncol Pract* 2023;19(11_suppl):385. Mirsalehi A, et al *JCO Oncol Pract* 2023;19(11_suppl):513.

CME

Team-based Approach for the Management of Patients with Cancer



In general, treatment recommendations should be made by a multidisciplinary team (MDT).

MDTs increase treatment personalization, improve outcomes, preserve quality of life, and increase overall patient satisfaction.

Each person on the care team should:

- Verify timely use of biomarker analyses
- Encourage use of multi-gene assays over single-gene assays

Cornelius LA, et al. *Oncologist* 2021;26(9):e1644-e1651. Daly ME, et al. *J Clin Oncol* 2022:40(12).
NCCN Guideline. Non-small Cell Lung Cancer. v10.2024. https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf.

CME

Questions & Answers

Summary

- Biomarker testing is a critical step in assuring compliance with evidence-based treatment guidelines
- Structural racism, SDoH, and unconscious bias contribute to cancer care disparities, including screening and treatment
- Eliminating cancer care disparities will require a multiprong approach that engages the patient, provider, healthcare system, and society
- Addressing barriers to care requires culturally-appropriate, linguistically-aligned shared decision making and coordinating coverage through community oncology and managed care providers

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Put information into action!

Takeaways from this program can be implemented into your practice to improve patient care.

- Ensure that each patient with cancer receives comprehensive biomarker screening through documentation in the EHR system, and if documentation is not present, follow up with request for comprehensive testing and documentation in the EHR of outcome from the request
- Alert supervisors if you see intentional or unintentional biases by your coworkers that affects cancer care
- Engage in thoughtful self reflection on your own biases and preconceived ideas about patients
- Encourage use of a navigator to assist with all the issues of coverage and affordability, working with specialty pharmacy to address these issues, patient support from manufacturers, etc.
- Work with supervisors and team members to revise processes that impede patients from receiving guideline-concordant biomarker screening

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Addressing Barriers in Advancing Equitable Biomarker Testing in Community Oncology

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