



# Advancing Cancer Care for Low Income Asian Americans in Orange County, CA

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## INTRODUCTION

Asian Americans (AAs) represent 5.6% of the US population and are the fastest growing racial group surpassing Hispanics in the last decade. California is home to 5.7 million AAs, which represents the largest population in the US, and approximately 10% of the state's AA population resides in Orange County, California. OC's three largest AA sub-ethnic groups are Vietnamese (171,170), Korean (88,266), and Chinese (76,951), which are 70%, 71%, and 66% foreign-born (respectively) (PolicyLink, 2019). populations.

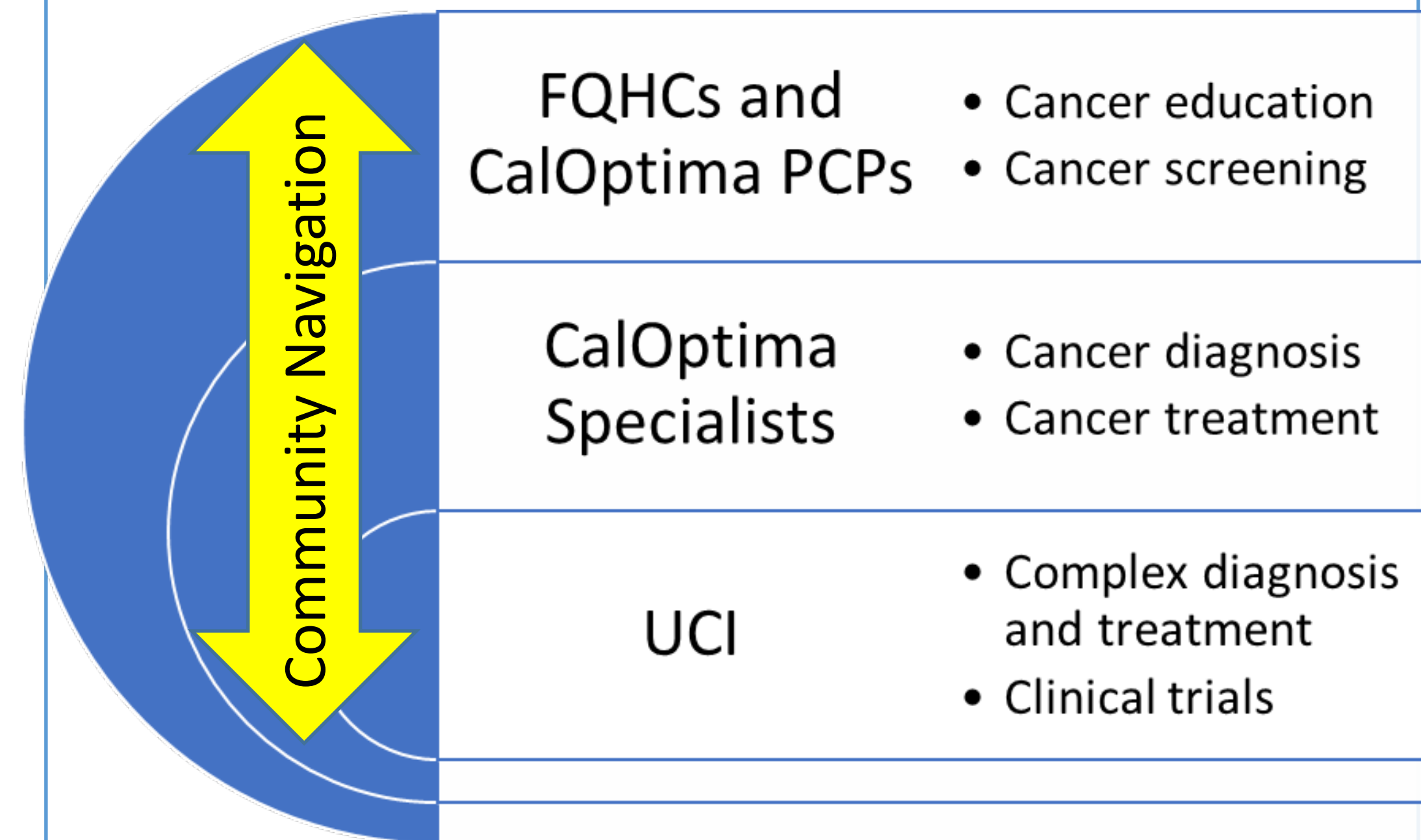
Cancer remains the leading cause of death among AAs. Although AAs as an aggregated group have a lower cancer-related mortality burden compared to non-Hispanic Whites, patterns of cancer-related mortality for specific cancers – including cervical, stomach and liver cancers are particularly high among Chinese, Koreans, and Vietnamese populations (McCracken et al., 2007). The paramount access to care concern in OC is the lack of a single county-wide safety-net hospital for cancer-related secondary and tertiary care. Currently, cancer care across the continuum including education, screening, diagnosis, treatment and survivorship is provided by a diverse and often-disparate set of entities including community-based organizations (loosely organized in the Orange County Cancer Coalition), the county Medi-Cal managed care entity (CalOptima), and the academic medical center (University of California, Irvine's NCI-designated Chao Family Comprehensive Cancer Center).

## OBJECTIVES

The **long-term goal** of the Achieving Cancer Care Together (ACCT) Project is to increase access to timely quality cancer care for Chinese, Korean and Vietnamese Medi-Cal beneficiaries in OC. The **objectives** include:

- 1) increase individual AA adult knowledge, attitudes and guideline-adherent behaviors across the cancer care continuum (from prevention through treatment and survivorship, where applicable);
- 2) increase community navigator-facilitated access by individuals to providers across the cancer care continuum;
- 3) increase hub/spoke provider coordination of cancer-related cases from screening through survivorship; and
- 4) sustain model of care through dissemination and increased collaboration, improved patient outcomes, establishing cost effectiveness, and identifying additional funding mechanisms.

## HUB/SPOKE MODEL



The hub/spoke model has been successfully adopted in many other industries including education, retail, and healthcare (Elrod & Fortenberry, 2017). With its origins in the transportation industry, the potential benefits of this model include increasing efficiencies to allow community primary care and oncology providers to identify patients with the most complex needs to have an expedited evaluation and initiation of treatment at a tertiary level cancer center.

Our model includes the following partners:

Partner	Population	ACCT Services
OC Coalition of Community Health Centers	340 patients/year	FQHCs: KCS Health Center Southland Integrated Services
CalOptima	800 low-income members; 7,200 primary and specialty providers	CalOptima Community Network (CCN)
UCI	Scientists and clinicians from 32 departments	Specialists in cervical, breast, colorectal, gastric and liver
OC Herald Center, OC Asian Pacific Islander Community Alliance, and Vietnamese American Cancer Foundation	Chinese, Korean and Vietnamese clients	Outreach education, cancer navigation, interpretation, referrals, and support groups

## METHODS

Progress to date:

- Monthly meetings with the hub/spoke partners
- Identification of existing in-language community-based and CalOptima patient education materials to be adopted for this project
- Creation of a one-page summary of prevention and screening guidelines
- Creation of NCCN-guideline adherent clinical pathways for each cancer site
- Kick-off meeting with Community Advisory Board
- Invitations to 16 CalOptima PCPs (serving 1008 AA patients in 2018) and 7 specialists (serving 55 AA patients in 2018)
- Planning CME materials and kick-off training
- IRB approval for baseline chart-reviews

Planned Process and Outcome Variables:

- Education: Numbers and locations of educational activities conducted by community, numbers and types of materials provided, and numbers and types of patients subsequently seen by clinical pathway
- Diagnosis/treatment: Numbers and types of patients treated by clinical pathway by provider/site, numbers and types of participating PCPs, oncologists and FQHCs/clinics recruited, numbers of MOUs established, numbers and characteristics of providers trained, numbers and characteristics of navigators trained, numbers and characteristics of patients receiving primary/secondary/tertiary care, and numbers and characteristics of navigators
- Model: Numbers and characteristics of AA patients (cancer type, complexity, risk stratification, telemedicine needs) entering the hub/spoke model of care; provider knowledge and confidence, and provider implementation of clinical pathways



Picture: Community Advisory Board meeting on Feb 26, 2019

## FUTURE ACTIVITIES

Our next steps in model solidification include:

- Material translation and review
- Chart reviews for baseline screening, diagnosis, and treatment rates and timeframes
- Navigation core variable and navigator trainings
- Provider CME training on NCCN guideline-adherent care
- Outreach education

## REFERENCES

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