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Project CoMMunity: A local learning network deployed to address multiple myeloma care gaps in two communities

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Introduction

- Treatment advances in multiple myeloma (MM) have resulted in 5-year survival improvements[1]
- Gaps remain in access to and adoption of standard-of-care (SOC) therapies, resulting in variation in MM care[2–7]
- Project CoMMunity is a multicenter, local learning network in the United States that aims to:
  - Detect unmet needs in MM care
  - Understand barriers impacting access to or adoption of SOC and innovative MM treatments
  - Address care gaps through innovative oncology partnerships and targeted community interventions

Methods

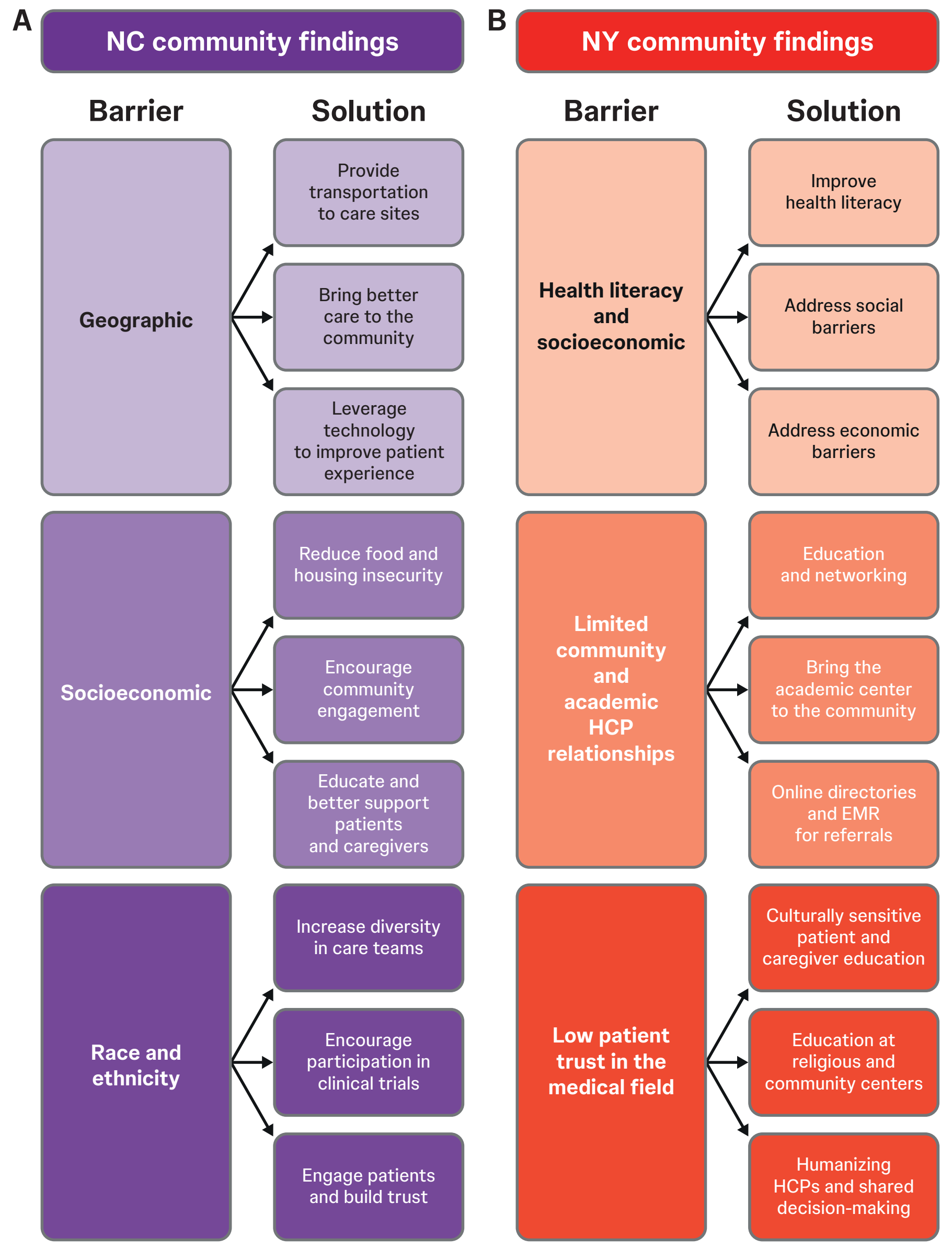
- A multi-method approach was utilized, including:
  - Community roundtable sessions with clinicians, social workers, and patient advocates
  - Retrospective quantitative analysis of electronic medical record (EMR) data (July 2021 to December 2023) of patients with MM and:
    - ≥18 years of age
    - Diagnosed between January 1, 2022, and December 31, 2023
    - Treated with SOC MM drugs after diagnosis
    - ≥2 progress notes in the 3 months after diagnosis
  - Qualitative 1-to-1 prospective interviews with healthcare professionals
    - 30–60-minute interviews from December 2024 to February 2025

Results

Community roundtables were used to understand barriers, co-create solutions, and guide the variables selected to detect population and care differences between the communities

- In total, 12 clinicians and 4 social workers/patient advocates across two communities (NC and NY) participated in the roundtables
- Universal barriers impacting access to or adoption of SOC and innovative MM therapies identified in both communities included socioeconomic factors, health literacy, cultural and racial issues, and geographic access
- NC participants reported prioritized regional barriers of geographic factors, socioeconomic factors, and race and ethnicity (**Figure 1A**)
  - Co-created solutions focused on improving transportation, technology, and community engagement; increasing diversity; and building trust
- NY participants reported prioritized regional barriers of health literacy and socioeconomic factors, limited relationships, and low patient trust (**Figure 1B**)
  - Co-created solutions included addressing issues with social and economic barriers, education, and cultural sensitivity; and humanizing shared decision-making

FIGURE 1: Proposed solutions and actions to address prioritized barriers to MM care for the NC (A) and NY (B) communities identified during the roundtables



EMR, electronic medical record; **HCP**, healthcare professional; **MM**, multiple myeloma; **NC**, Atrium Health Wake Forest Baptist Comprehensive Cancer Center, Winston-Salem, North Carolina; **NY**, Mount Sinai Health System, New York City, New York.

Quantitative EMR analysis based on roundtable insights was used to detect differences in population characteristics and care

- Of 332 patients (NC, n=95; NY, n=237; **Table 1**), quantitative EMR analysis highlighted clinical variation (**Table 2**) in:
  - Time from diagnosis to MM specialist visit (NC 62 days vs NY 34 days)
  - First line of therapy (1 LOT) count (quadruplet therapy: NC 11.6% vs NY 62.0%; triplet therapy: NC 78.9% vs NY 34.2%)
  - Stem cell transplant incidence (NC 50.5% vs NY 30.8%)
  - Receipt of innovative therapies (e.g., chimeric antigen receptor T-cell therapy, bispecific antibodies; NC 6.3% vs NY 4.6%)
- Time from diagnosis to 1 LOT and proportion of patients referred to MM specialists were consistent between communities

TABLE 1: Study population demographics and clinical characteristics

Characteristic	Overall (N=332)	NC community (n=95)	NY community (n=237)
Age, years			
Mean (SD)	–	64 (12.7)	64.2 (10.4)
18–44	12 (3.6)	4 (4.2)	8 (3.4)
45–65	136 (41.0)	35 (36.8)	101 (42.6)
>65	184 (55.4)	56 (58.9)	128 (54.0)
Female sex	165 (49.7)	40 (42.1)	125 (52.7)
Race			
White	181 (54.5)	64 (67.4)	117 (49.4)
Black/African American	83 (25.0)	30 (31.6)	53 (22.4)
Asian	11 (3.3)	1 (1.1)	10 (4.2)
Other/unknown	57 (17.2)	0	57 (24.1)
Ethnicity			
Non-Hispanic/Latino	251 (75.6)	93 (97.9)	158 (66.7)
Hispanic/Latino	45 (13.6)	2 (2.1)	43 (18.1)
Unknown or not reported	36 (10.8)	0	36 (15.2)
CRAB symptoms at initiation of 1 LOT	188 (56.6)	91 (95.8)	97 (40.9)
Hypercalcemia	48 (14.5)	17 (17.9)	31 (13.1)
Renal impairment	83 (25.0)	38 (40.0)	45 (19.0)
Anemia	101 (30.4)	63 (66.3)	38 (16.0)
Bone lesions	119 (35.8)	60 (63.2)	59 (24.9)
ECOG performance status			
0	87 (26.2)	15 (15.8)	72 (30.4)
1	207 (62.3)	58 (61.1)	149 (62.9)
2–4	36 (10.8)	20 (21.1)	16 (6.8)
Unknown or not reported	2 (0.6)	2 (2.1)	0

Data are n (%) unless otherwise stated. The period of assessment for all characteristics was at index date (initiation of 1 LOT), except for CRAB symptoms assessed during the baseline period. –, not available; **1 LOT**, first line of therapy; **CRAB**, calcium elevation, renal insufficiency, anemia, and bone abnormalities; **ECOG**, Eastern Cooperative Oncology Group; **NC**, Atrium Health Wake Forest Baptist Comprehensive Cancer Center, Winston-Salem, North Carolina; **NY**, Mount Sinai Health System, New York City, New York; **SD**, standard deviation.

TABLE 2: Clinical variation in treatment characteristics and therapy initiation in MM

Characteristic	Overall (N=332)	NC community (n=95)	NY community (n=237)
First-line MM therapy			
Monotherapy	1 (0.3)	0	1 (0.4)
Doublet therapy	16 (4.8)	8 (8.4)	8 (3.4)
Triplet therapy	156 (47.0)	75 (78.9)	81 (34.2)
Quadruplet therapy	158 (47.6)	11 (11.6)	147 (62.0)
Unknown or not reported	1 (0.3)	1 (1.1)	0
Time from diagnosis to MM specialist visit, days			
Mean (SD)	–	62 (104)	34 (55)
Median (IQR, Q1/Q3)	–	0 (126, 0/126)	12 (30, 4/34)
Time from diagnosis to initiation of 1 LOT, days			
Mean (SD)	–	31 (47)	33 (41)
Median (IQR, Q1/Q3)	–	19 (25, 9/34)	21 (27, 12/39)
Received stem cell transplantation	121 (36.4)	48 (50.5)	73 (30.8)
Received innovative therapies (e.g., CAR-T therapy, bispecific antibodies)	17 (5.1)	6 (6.3)	11 (4.6)

Data are n (%) unless otherwise stated. –, not available; **1 LOT**, first line of therapy; **CAR-T**, chimeric antigen receptor T-cell; **IQR**, interquartile range; **MM**, multiple myeloma; **NC**, Atrium Health Wake Forest Baptist Comprehensive Cancer Center, Winston-Salem, North Carolina; **NY**, Mount Sinai Health System, New York City, New York; **Q**, quartile; **SD**, standard deviation.

Qualitative clinician interviews were used to validate and further understand the quantitative EMR data and the root causes of care gaps and barriers

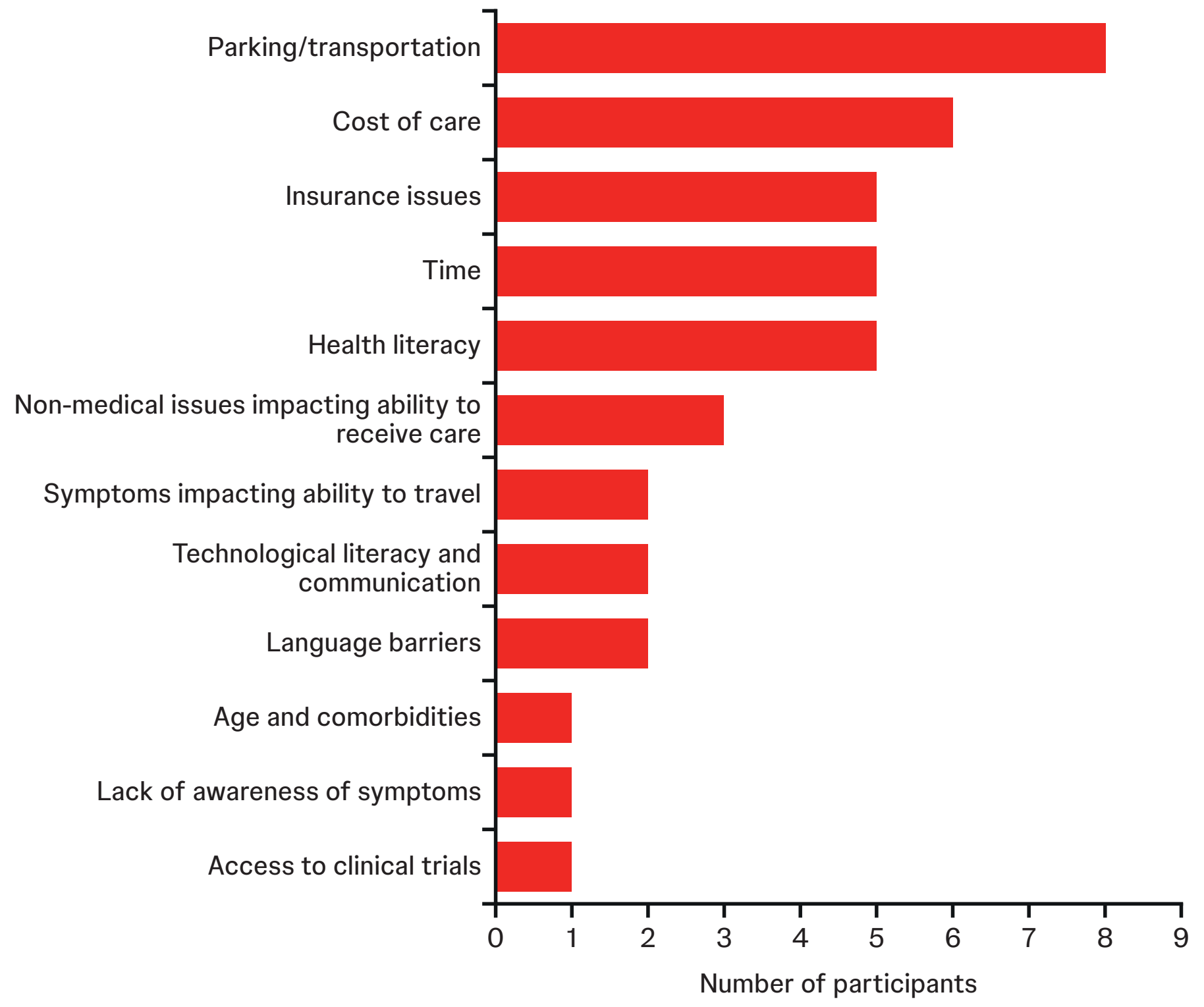
- Of 10 HCPs (5 each from NY and NC), participants included a hematology clinical leader (n=1), physicians (n=2), advanced practice providers (n=3), a pharmacist (n=1), a transplant coordinator (n=1), a patient navigator (n=1), and a social work coordinator (n=1)
- Key themes of clinician-reported barriers and root causes limiting access to SOC treatment included (**Table 3**):
  - Patient population characteristic barriers
  - Referral and treatment protocol barriers
  - Community engagement and support resource barriers
  - Care barriers (**Figure 2**)

TABLE 3: Clinician-reported barriers—themes identified from qualitative interviews with representative participant quotes

Theme	Representative participant quote
Patient population characteristics	*"Some patients have different social circumstances that make it difficult for them to focus on getting their treatment. It's hard to tell them to come in to get their treatment if they don't have somewhere to live."* **Support staff, NC**
Referral and treatment protocols	*"Time is a constraining resource … some people have to take 2–4 buses to get medication from the pharmacy."* **Clinician, NC**
Community engagement and support resources	*"We assume that everyone knows how to navigate a website, but not everyone knows … we need to meet them where they are in terms of the format they prefer."* **Support staff, NC**
Patient barriers to care	*"In the past 2 months, we've had 5 people call to say they scheduled [transportation] through insurance, and it never showed."* **Clinician, NC**

NC, Atrium Health Wake Forest Baptist Comprehensive Cancer Center, Winston-Salem, North Carolina.

FIGURE 2: Patient barriers to MM care identified during the qualitative HCP interviews (n=10)



VOICE OF THE INTERVIEWEE

*"The **majority of barriers are coming before they meet me** versus after. The **biggest thing is cost**, especially if an oral medication. The pharmacy team is great at identifying funding for meds."*

*"Patients have very little support. **They will be here without a full support system for a length of time** … they often have to work to make very big decisions with little support."*

*"We've had some patients not take their [medication] for a month **because they didn't think it was important**."*

*"Many [patients] **have not been to a hospital this large**, [and they ask] what is cancer, what is an oncologist, PCP, surgeon."*

*"There is a **lack of education** on **cancer signs and symptoms** … A lot of patients are **metastatic before they enter the door**."*

HCP, healthcare professional; **MM**, multiple myeloma; **PCP**, primary care physician.

Key takeaway

Project CoMMunity findings will help tailor approaches and interventions to improve access to and adoption of SOC and innovative MM therapies across local communities

Conclusions

- ✓ **Integrating real-world evidence with community-engaged qualitative methods can identify actionable, relevant gaps in MM care**
- ✓ **Programs striving to improve access to and adoption of SOC and innovative MM therapies need to be multifaceted and designed with local implementation in mind**
- ✓ **A local learning network with regional participants provides a robust framework to efficiently transfer insights and clinical best practices while deploying local interventions that are responsive to the needs of a diverse community**
- ✓ **A one-size-fits-all model will not succeed due to the unique needs, capacity, and existing health infrastructure of local communities**

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Multiple Myeloma

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