4. THE ROLE OF ACADEMIC AFFILIATION IN THE TREATMENT OF METASTATIC CASTRATE-RESISTANT PROSTATE CANCER IN THE VETERANS HEALTH ADMINISTRATION

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BACKGROUND: Cancer care in academically affiliated settings such as teaching hospitals has been associated with improved clinical outcomes. Historically, Veterans Affairs (VA) medical centers are partnered with academic affiliates; however, there have been few studies examining how this partnership affects clinical care in the Veterans Health Administration (VHA). We therefore examined the variation of first line therapy (1L) in patients with metastatic castrate resistant prostate cancer (mCRPC) in the VHA by degree of academic affiliation.

METHODS: Information from the VA Central Cancer Registry was linked to clinical data from the VA Corporate Data Warehouse to identify incident cases of mCRPC, defined as first incidence of radiologic evidence of metastasis and castrate resistance in patients with prostate cancer. Patient demographics, disease characteristics and treatment practices were extracted. The degree of academic affiliation of the treating facility was calculated using the Herfindahl-Hirschman Index (HHI), which reflects how dispersed medical residents are among different specialties and how many specialties are available within a given VA facility.

RESULTS: From 2006 to 2015, 3637 patients received an mCRPC diagnosis and were treated in 123 VA facilities. Median HHI for treating facilities was 0.374. Of these patients, 1723 (47%) were treated in a facility with higher academic affiliation (HAA; HHI $\geq$ 0.374) and 1914 (53%) were treated in a facility with lower academic affiliation (LAA; HHI $\leq$ 0.373). There was no difference in patient or disease characteristics by academic affiliation; patients with HAA and LAA had comparable Gleason scores, stage of disease at diagnosis, primary local therapy, age and median PSA levels at time of diagnosis. Patients with mCRPC at HAA facilities were more likely to receive 1L (59% vs 55%, P = 0.015). Regimens frequently used for 1L were comparable: HAA, docetaxel (29%), abiraterone (22%), and enzalutamide (6%); LAA: docetaxel (25%), abiraterone (21%), and enzalutamide (7%).

CONCLUSIONS: Patients with mCRPC had a small but significant increase in likelihood of receiving 1L if treated in HAA vs LAA facilities. Further study will focus on identifying patient, prescriber and facility factors that are associated with the likelihood of initiating 1L and the choice of 1L regimen.