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ONCOLOGY ISSUES

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Leveraging Technology to Achieve Excellence in Oral Oncolytic Management

ACCC
Association of Community Cancer Centers

contents

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Leveraging Technology to Achieve Excellence in Oral Oncolytic Management

This interdisciplinary team of clinic nurses, nurse navigators, pharmacists, and pharmacist technicians evaluated existing processes and leveraged technology to improve oral oncolytic compliance through education, consent, and adherence standards. After this quality improvement initiative, oral oncolytic education and consent compliance increased from 60 percent to 100 percent, with 96 percent occurring on the same day an oral oncolytic was prescribed.

By Morgan Nestingen and Marguerite Rowell

DEPARTMENTS

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ACCC is proud to recognize these Cancer Program Members for their significant achievements in creating compelling solutions in oncology care.

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ONCOLOGY ISSUES

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FROM THE EDITOR

#AMCCBS, the 2023 ACCC Innovator Award Winners, and More

BY MARK LIU, MHA

I have always found the Association of Community Cancer Centers (ACCC) Annual Meeting & Cancer Center Business Summit (#AMCCBS) to be an energizing and inspiring meeting, where attendees discuss the latest trends and challenges and share best practices. This year's meeting was no different, and, outside of the general sessions, the afternoon's facilitated breakout discussions allowed attendees to get into the details of their own processes and workflows around specific focus areas. It was clear that everyone enjoyed leaving the virtual meeting setting behind and getting back to the in-person meetings, where we could share dialogue, laughter, and collegiality. Also, being in D.C. to catch some of the early cherry blossoms is always a nice perk!

The healthcare workforce is evolving, and the 2023-2024 theme of ACCC President, Olalekan Ajayi, PharmD, MBA, could not be timelier: *(Re)building the Oncology Workforce to Deliver the Next Generation of Cancer Care.* You can read more about this theme and what Dr. Ajayi is planning in his "President's Message" on page 4.

I have personally experienced and heard from many ACCC members about the retention and recruitment challenges they face across various disciplines and specialties. We will likely all benefit from future programming that ACCC is putting together to support its members in these areas.

And on the topic of future programming, I would personally like to thank all the ACCC member programs that submitted applications for the 2023 ACCC Innovator Awards. This year's winners are listed on page 2 of this issue (immediately preceding this column). These award-winning cancer programs and practices are also recognized on the ACCC website at accc-cancer.org/Innovator. I look forward to hearing and learning from these peer-selected winners at the ACCC 40th National Oncology Conference on Oct. 4 to 6, in Austin, Texas. The ACCC Innovator Award program has been such a wonderful way to highlight the visionary and compelling ideas implemented in oncology programs and practices across the country.

Yet there is plenty of great information for you in this issue. Our cover article features 2022 ACCC Innovator Award Winner Baptist Health's Miami Cancer Institute and its efforts to improve oral oncolytic compliance through a vigorous overhaul of its education, consent, and adherence processes and standards. Then read about the experience of two other 2022 ACCC Innovator Award winners—Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (OSUCCC – James) and Ochsner Health, Ochsner Cancer Institute—as they discuss the creation of a rapid cancer diagnostic clinic and the development of a digital chemotherapy remote monitoring program, respectively. One of the greatest benefits to ACCC's membership is the ability to learn about these types of innovations and then replicate similar successes at our own cancer programs and practices.

Finally, I would be remiss if I did not mention that I was selected to be one of 40 lifetime Fellows of ACCC, who were recognized at #AMCCBS. What an honor—for the recognition of our hours (sometimes years!) of volunteer service and efforts to advance education and advocacy in cancer care.

ACCC PRESIDENT'S MESSAGE

(Re)Building the Oncology Workforce

BY OLALEKAN AJAYI, PHARMD, MBA

It is an exciting time to be in oncology. We are learning from new therapies and technologies, such as CRISPR and artificial intelligence-enabled pathways and algorithms, and they are revolutionizing the way we will care for our patients in the future. As a pharmacist, I remember 15 years ago when we were just beginning to scratch the surface of immunotherapy treatments. Look at how far we have come, and now imagine what the next 15 years will bring.

Yet these advances are tempered by a sobering realization, which the global COVID-19 pandemic only confirmed. One of the greatest challenges we face over the next decade is related to our oncology workforce. Specifically, will we have enough providers and staff to support and deliver these lifesaving treatments to patients? It is a question that keeps me up at night and one reason my 2023-2024 ACCC President's Theme will focus on *(Re)Building the Oncology Workforce to Deliver Next Generation Cancer Care.*

To accomplish this goal, over the next 12 months, ACCC will focus time and resources in three areas.

First, the Association will identify, develop, and deliver educational and advocacy resources to expand the capacity of the cancer care workforce, exploring innovative ways to deliver the highest quality of care. This means helping our workforce access the tools, information, and technology necessary to unlock their ability to deliver care at a higher level.

Second, ACCC will collaborate with thought leaders and key stakeholders across multidisciplinary organizations to identify, foster, and mentor future leaders in cancer care delivery.

Fifteen years ago, as a pharmacist from Nigeria—the most populous Black nation on earth—living in Wyoming, arguably the least diverse state in America, I knew that in addition to my training and education, I had to adapt my style to successfully care for my patients. I was trained in the British system and spoke British English, but soon realized that to succeed as a practitioner, I had to speak in a way my patients could relate to, and to learn and understand what they cared about and what they valued. My experiences in Wyoming and now in Arkansas have shown me that we must meet and develop leaders where they are. This will require us to think differently about what a leader looks like, where our leaders come from, and what formal training our leaders need.

Third, we must broaden the coalition of the oncology workforce to reflect the growing complexity of cancer care and to realize more equitable cancer care delivery. This will require all of us working together to add new disciplines, diverse educational backgrounds, distinctive community voices, and unique experiences and perspectives into our cancer care delivery teams.

Making healthcare—particularly lifesaving care like cancer treatment—accessible to everyone should be our calling. Whether we are talking about race, geography, age, socioeconomic status, or other any other individual characteristics, what is better than having providers who reflect the communities where they live and work, providers with cultural humility and the desire to understand what their patients value, and providers who can walk a mile in their patient's shoes? Those are the providers we need to rebuild our oncology workforce; those are the providers who will succeed in delivering next generation care.

I invite you to be a part of this movement. Join me for informal fireside chats; read the articles in this journal and the ACCC Buzz blog; listen to the CANCER BUZZ podcast; attend in person educational opportunities like the ACCC 40th National Oncology Conference this October; and then pay it forward and share what you have learned with your colleagues. We can—and must—effect positive change in our oncology workforce. Join me in recognizing and raising up the next generation of leaders who will spearhead efforts to improve the provider and patient experience and the quality of care we deliver.

Coming in Your 2023 *ONCOLOGY ISSUES*

- Machine Learning and Predictive Analytics Platform Transforms Infusion Center Operations
- Trending Now in Cancer Care Part I
- e-Consults for Immune-Related Endocrine Toxicities Reduce Appointment Access Time and Prevent Hospital Admissions
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- Supportive Oncology in Lung Cancer: Program Development for Patients and Care Partners
- Comprehensive Cancer Risk Management Clinic for Families with Hereditary Cancer Syndromes
- Coordinating RECIST 1.1: A Community Hospital Perspective
- Therapeutic Art: Transforming Self-Awareness for Those Impacted with Cancer
- Increasing Clinical Trials Accrual Through the Implementation of a Clinical Trials Nurse Navigator
- Using Virtual Reality for Anxiety Relief in Oncology Patients during Initial Chemotherapy Treatment
- Development of a Model Tobacco Cessation Program

Leveraging Technology to Achieve Excellence in Oral Oncolytic Management

BY MORGAN NESTINGEN, PHD, APRN, AGCNS-BC, NEA-BC, OCN, ONN-CG, AND
MARGUERITE ROWELL, MSN, MBA, MSM/HM, ONC, SCRN, NEA-BC

A confirmed cancer diagnosis can be an emotional, all-consuming, and devastating circumstance for patients and their families. While this is a too frequent occurrence in the United States, cancer survival rates are improving due to early diagnosis through screening and the increased availability of new anti-cancer treatments and targeted therapies.[1] According to the American Cancer Society's 2022 statistics,[2] the impact of cancer is profound and continues to grow with last year's projections being forecast as:

- 1,918,030 new cancer cases
- 609,260 cancer deaths
- Approximately 5,250 individuals newly diagnosed with cancer per day
- Lifetime invasive cancer probability of 38.5 percent in women and an even higher rate of 40.2 percent in men, based on life expectancy and risk.

For these patients, access to state-of-the-art anti-cancer treatment and services is integral to their survival and quality of life.

The Landscape of Oral Oncolytics

Oral oncolytic treatment is the fastest growing form of anti-cancer therapy in newly approved clinical trials. In the U.S., the prevalence of oral anti-cancer agents ranges from 25 percent to 35 percent of all antineoplastic agents on the market, and approval by the U.S. Food and Drug Administration has exploded exponentially over the last three to four years.[1,3,4] According to 2019-2020 ACCC President Dr. Ali McBride, "More than 3,500 novel approaches have been evaluated clinically or pre-clinically in the last decade. Currently, more than 10,000 clinical trials with novel and approved agents, alone or in combination, are ongoing, with over 12 percent having entered Phase III status…Of the more than 800 new oncology therapies currently in the pipeline, 25 [percent] to 35 percent are oral agents."[1]

Oral oncolytics are often preferred by patients and clinicians for their comparative administration ease, convenience, flexibility, and reduced burden of care.

Oral oncolytics are often preferred by patients and clinicians for their comparative administration ease, convenience, flexibility, and reduced burden of care.[1,3,4] Specific ad-vantages of oral oncolytics over standard chemotherapy infusions include:[3–6]

- Fewer oncology clinic or office visits
- Less patient monitoring
- Increased patient convenience
- Fewer expended healthcare resources and lower administration and management costs
- Patients' ability to maintain a quality of life that closely resembles their life before cancer

- Reduction in financial burden on patients due to frequent transportation, childcare, and other out-of-pocket costs that are not usually covered by insurance.

Conversely, there are also disadvantages to oral oncolytic therapy, including:[3–6]
- Increased knowledge burden on patients, who must understand how to self-administer their medications, which can challenge even highly educated patients
- Side effect management and treatment adherence, particularly when patients may experience forgetfulness as a side effect of their anti-cancer treatment
- The high costs of oral oncolytics
- The safe handling and storage of these medications.

To address these factors and harness the potential of oral oncolytics to transform cancer care, oncology programs and practices must build systems to support patients through all phases of oral oncolytic management—from prescription to adherence. A multifactorial, multidisciplinary approach is needed to educate, support, and improve patient adherence and outcomes when taking an oral oncolytic. According to Dr. McBride, "Developing an oral chemotherapy workflow that includes financial assistance, high-quality patient education, side effect self-management support, and monitoring and follow-up is critical. This complex workflow involves many members of the cancer care team, including pharmacists, pharmacy technicians, financial navigators, physicians, advance practitioners, and nurses."[1]

Getting Started

In early 2021, Baptist Health's Miami Cancer Institute entered its survey window for the American Society of Clinical Oncology's (ASCO) Quality Oncology Practice Initiative (QOPI®) re-certification. This was a critical re-certification for the cancer institute because our 2018 survey highlighted a few opportunities for improvement, including oral oncolytic patient education and consent. Miami Cancer Institute implemented several improvements after the 2018 survey; however, an understanding of our current performance could not be assessed due to staff and leadership turnover. The 2020 QOPI standards[7] set forth strict criteria for education, consent, documentation, and management of any form of anti-cancer therapy, including oral oncolytics (Table 1, below).

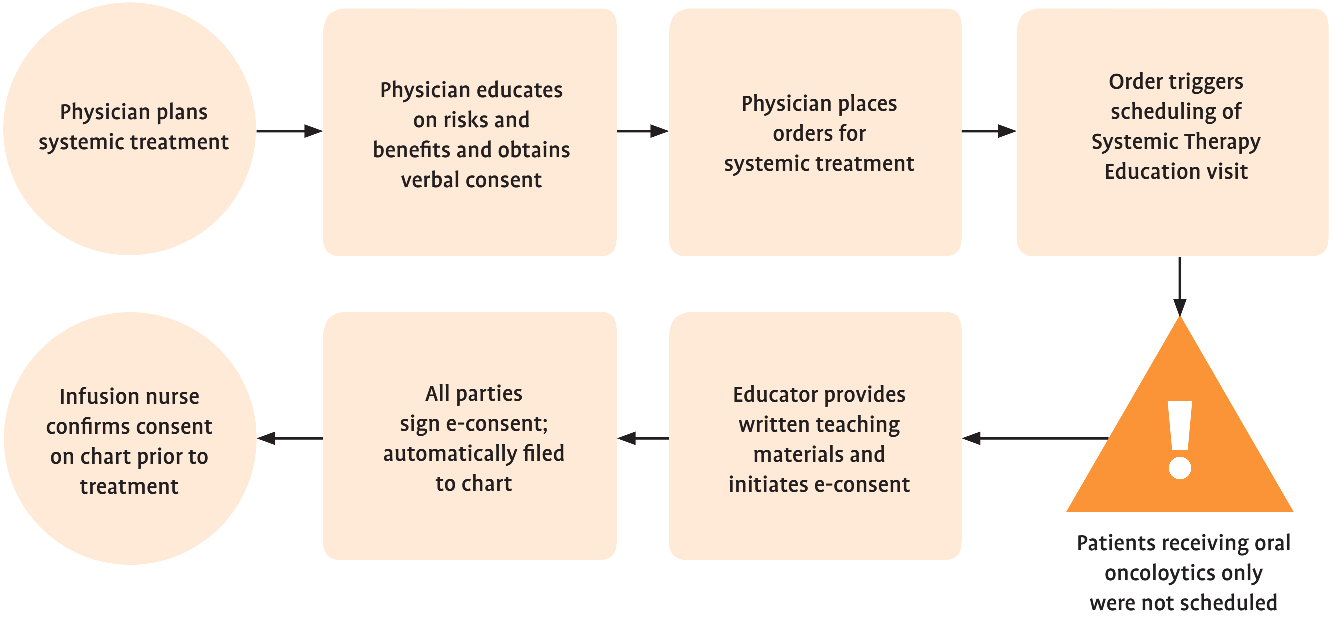
To understand our then baseline performance, our pharmacy team completed an initial consent audit, which demonstrated that only 26 percent of our oncology patients had evidence of documented and signed consent for oral oncolytic treatment in the electronic health record (EHR) prior to April 2021. At the time, the process relied on provider teams, who would provide informed consent and comprehensive patient education. Following this, Miami Cancer Institute pharmacists would provide additional follow-up education and adherence monitoring. These results were a call to action that our process needed to be fixed, and immediate interventions were needed to improve our performance to ensure patients were educated on and consented to their oral oncolytic treatment appropriately. Our assessment showed that patients on an oral-oncolytic-only

Table 1. 2020 QOPI Standards for Education & Consent Documentation of Chemotherapy Initiation[7]

STANDARD NUMBER	2020 STANDARD DEFINITION	REQUIREMENTS
2.1	Domain 2. Treatment Planning, Patient Consent, and Education: This domain describes the requirements for obtaining and documenting patient consent or assent for chemotherapy, and patient and family education prior to the initiation of treatment.	The healthcare setting has a policy that documents a standardized process for obtaining and documenting chemotherapy consent or assent. Informed consent and assent (optional) is documented prior to initiation of each chemotherapy regimen. The consent process should follow appropriate professional and legal guidelines. The content of informed consent is the discussion with the patients; it is the education and understanding of the patient. The documentation is evidence that the legal obligation of obtaining informed consent has been fulfilled; it is evidence that the discussion occurred, the patient was educated, and the patient understood. Informed consent for chemotherapy is an essential prerequisite to the administration of a chemotherapy agent by any route in any healthcare setting. Informed consent needs to be documented.

QOPI = Quality Oncology Practice Initiative

Figure 1. Simplified Systemic Therapy Education and Consent Process with Observed Failure Mode in Oral Oncolytic Regimens



regimen were not being referred to a standard systemic chemotherapy education visit, which was the norm for parenteral and combination therapies. Hence, there was no education being provided, and the subsequent consent process did not occur. There were no referral orders in our EHR to trigger an oral oncolytic education referral and consent initiation (Figure 1, above).

In April 2021, we created an "Oral Oncolytics Patient Education Referral" order to be placed by the oncologist, which would trigger a task to schedule patients for a comprehensive systemic therapy education session and close the loop on the consent process. After educating the patient on their oral oncolytic therapy, the systemic therapy educator would also enter a "Consult to Pharmacy Order: New Oral Oncolytic Education" order in the EHR to trigger follow-up pharmacy education and adherence monitoring. Providers and staff were educated on the workflow, and the new referral orders for May 2021 went live.

We monitored the workflow for the next three months (May 2021 to July 2021), seeing improvements in patient education, consent documentation in the EHR, and referral order use. Figure 2, page 9, compares the pharmacy teams' oral oncolytic consent documentation in the EHR prior to April 2021 to post-implementation, using the new workflow for clinical and medical staff and referral orders to the systemic education and pharmacy teams. Over the following three months, we saw an improvement of 33 percent in overall consent compliance. In addition, our audit demonstrated 60 percent compliance with referral order usage, 59 percent compliance with patient education documentation, and 60 percent compliance with signed patient consent. Figure 3, page 9, illustrates our audit's results, demonstrating utilization of the provider's referral order for comprehensive systemic therapy patient education, documented and informed consent, and patient education in the EHR. These results suggest that when the referral order is used as intended, patients are educated and their consent is obtained.

From Good to Great: A Call to Action and Multidisciplinary Approach

In August 2021, despite these initial improvements, Miami Cancer Institute executive and operational leaders remained unsatisfied with these results. Not only did 59 percent consent compliance fall far below our internal benchmarks, but the complexity of prescribing, authorizing, and fulfilling an oral oncolytic—combined with patients' ability to independently start oral medications—meant that we could not ensure patients were properly educated and provided consent prior to starting treatment. Our team was strongly aligned on the belief that our patients deserved a higher standard of oncology care that better met the 2020 QOPI standards. Further improvements would require a multifaceted, collaborative, and interdisciplinary team approach, patient-centered education, and use of intensive and creative non-reimbursable resources, including technology, to meet the needs of our diverse patient population.[1,3–6,8]

To that end, we assembled executive and operational leaders,

(Continued on page 10)

Figure 2. Percentage of Oral Oncolytics Consent Compliance

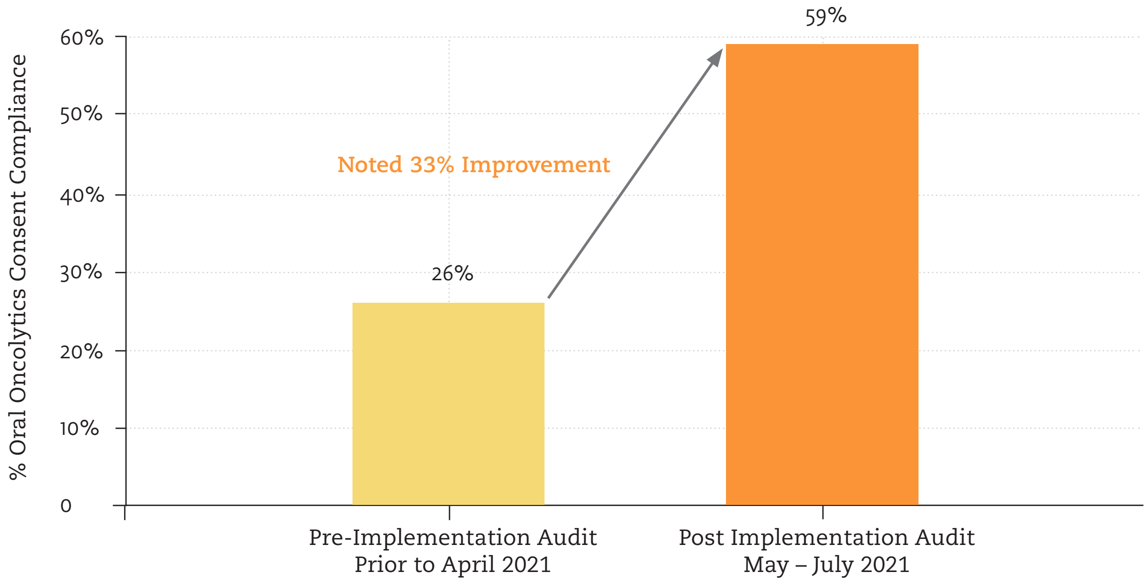


Figure 3. Percentage of Overall Process Improvement

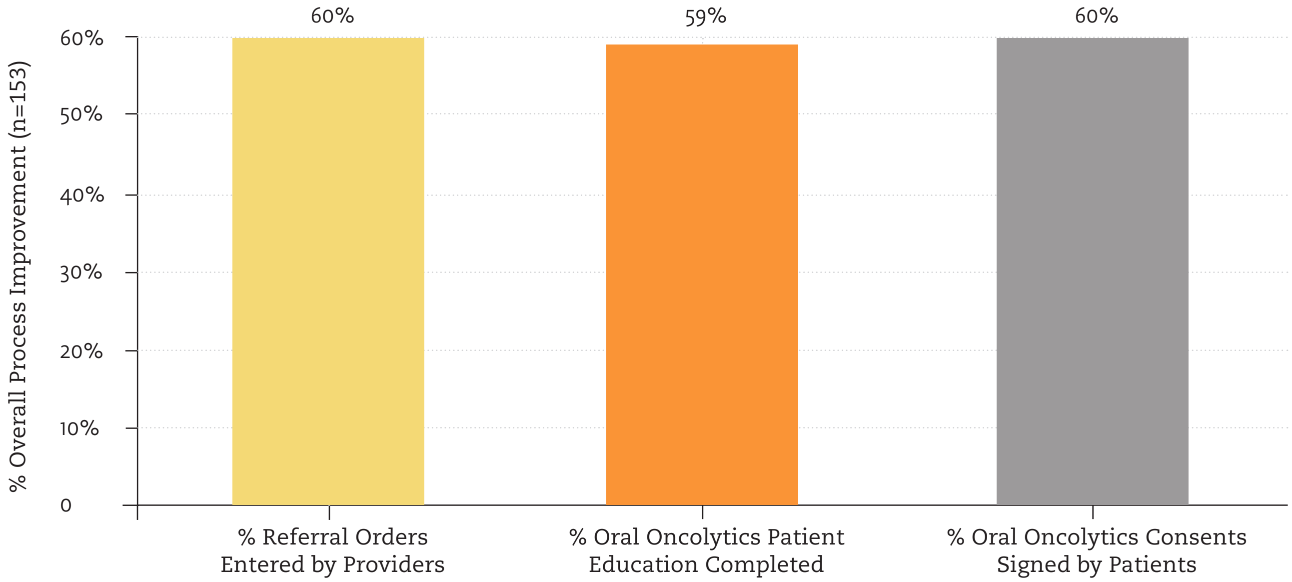


Table 2. Provider and Pharmacist Oral Oncolytic Responsibilities by Role

PHYSICIANS AND ADVANCED PRACTICE PROVIDERS	PHARMACISTS
Identify patients, who are appropriate for treatment with oral oncolytics	Review prescribed oral oncolytics for appropriateness of therapy and missing lab work or clearances
Provide initial patient education regarding oral oncolytic treatment, including risks, benefits, and side effects	Obtain insurance authorization
Obtain verbal, informed consent	Submit insurance appeals and coordinate application for co-pay assistance
Order lab work and clearances, as well as coordinate start of oral oncolytic regimen	Perform patient education and counseling on treatment initiation
Manage patient symptoms	Track adherence at key intervals
Prescribe refills	

(Continued from page 8)

who have oversight of key areas that would impact oral oncolytic management. The team transparently evaluated initial and ongoing data and outcomes associated with the oral oncolytic workflow at the cancer institute.

Reviewing Our Existing Workflow

We found that the initial, patient-facing tasks performed by providers in the clinic and the downstream education and coordination provided by pharmacists worked well (Table 2, above). However, these two expert groups operated in siloes, communicating through messages within the EHR. The cohesiveness of the overall workflow hinged on the systemic therapy education session and support provided by nurse educators. Unfortunately, this visit often occurred too late to capture patients' education and informed consent needs prior to treatment initiation. In addition, patients receiving oral oncolytics did not benefit from an infusion nurse's final check for documented consent and education prior to treatment administration (see Figure 1, page 8). When this process failed, there was no mechanism to identify missing care or evaluate quality on an ongoing basis.

The COVID-19 pandemic introduced additional challenges in the form of decentralized teams, staffing shortages, and remote platforms. Providers and clinic support staff rotated between on-site and remote work, adding complexity to interdisciplinary communication. Technology solutions designed to work in on-site applications did not translate to webinars, video calls, and phone consultations. Many clinics continued to rely on paper consents and written education that were delivered in-person by providers during a routine medical oncology visit. It quickly became clear that our workflow needed to evolve.

Revising Our Workflow

Over the next month, our team set out to revise and optimize our oral oncolytic workflow to overcome these observed challenges and make best use of our existing resources. The team crafted a new workflow that included three key innovations:

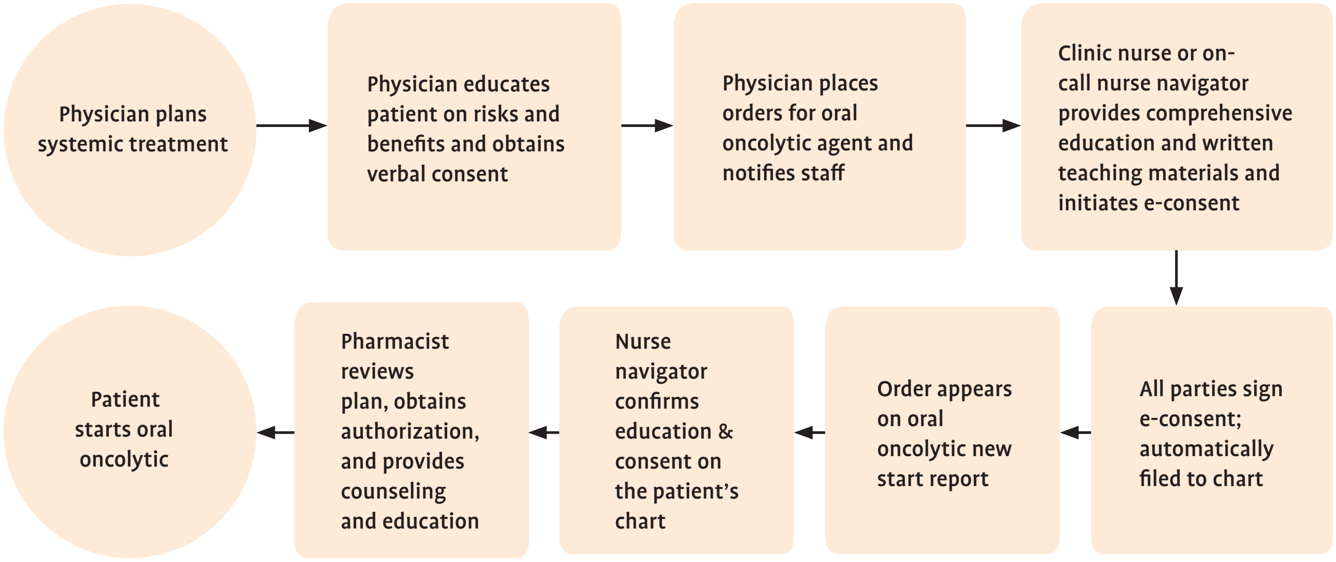
1. Support of local clinic nurses or an on-call oncology nurse navigator to improve overall compliance and ensure quality
2. Technological changes, including expansion of e-consenting, web- or phone-based patient education, and informed consent during telehealth visits
3. Quality oversight and care coordination that is provided by the oncology navigation team (Figure 4, page 11).

These changes ensure patients receive the same quality of care whether they are being seen in-person or via telehealth.

Training Our Staff and Providers

We began implementation by hosting training sessions for our physicians, advanced practice providers (APPs), registered nurses, nurse navigators, and medical assistants. These sessions were led by informatics educators, clinical educators, team champions, and leaders. Training focused on changes to the workflow and technology support. For medical oncology teams, these changes represented minor revisions to the existing process and added resources. For others, most notably nurse navigators, the new workflow involved increased partnership with clinical teams and tasks that were not traditionally considered in scope for their role. On-call nurse navigators were included in the process to address gaps in nursing support in some clinics. This necessitated more detailed education on the workflow, familiarity with patient education materials, and a

Figure 4. Revised Oral Oncolytic Workflow



learning curve as nurse navigators adjusted to the new process. Staff and providers alike voiced that, when possible, patient education and care coordination should be performed by local clinic nurses.

During this phase, stakeholders contributed key observations and potential challenges based on their expertise. For instance, the revised workflow originally included a final check performed by the pharmacy team prior to dispensing to ensure each step of the process was documented appropriately. Pharmacists noted that many payers mandated the use of off-site, third-party pharmacies, which would make a quality check at this step impractical. It became clear that nurses must play a crucial role in ensuring compliance and quality—both during the patient's treatment planning visit and subsequent auditing.

Technology & Tools

Prior to this implementation, Miami Cancer Institute relied on e-consent software embedded within the EHR. Clinicians would initiate and sign an English or Spanish version of the e-consent using a digital tablet. This consent, when completed and signed, would be automatically filed in a designated consent folder within the EHR. Unfortunately, although the pandemic made remote e-consenting a priority request, our EHR is still working to implement this function. As a result, some medical oncology clinics reverted to paper consents, which were emailed or faxed during telehealth visits and eventually scanned into patients' health record. This approach was highly manual and prone to failure.

Instead, our team promoted the use of an approved third-party software to allow remote e-signatures. Project leaders partnered with the cancer institute's technology and digital team to build new, digital consent templates. These templates could be initiated during a telehealth visit, sent to patients or caregivers via a secure email, and automatically returned to the clinic once completed. This new process required additional staff training and minor revision of our health records process. More importantly, it necessitated a recommitment by medical oncology teams to perform all patient consents electronically.

Oncology informaticists also collaborated with clinicians and our technology and digital partners to build a real-time report of all new oral oncolytic regimens that Miami Cancer Institute providers prescribed. This report supported nursing efforts to capture education and consent needs throughout the day within individual clinics and perform an institute-wide daily audit.

Evaluating the Impact of Our Innovation

Our quality improvement efforts continued at the executive and operational leadership levels. Stakeholders met weekly to evaluate the success of the revised workflow. The team established initial measures of overall compliance with clinic education and consent standards.

Initial data demonstrated a rapid improvement in overall education and consent compliance (90 percent, n=146) over the course of two months versus the 60 percent audit benchmark. Despite these data, leaders identified a persistent gap between our performance and aspirational goal of 100 percent compliance. To address this gap, we reviewed several key factors, including the prescribing physician, clinic specialty, type of visit, timing of prescription order, and nurse roles within the clinic. We identified

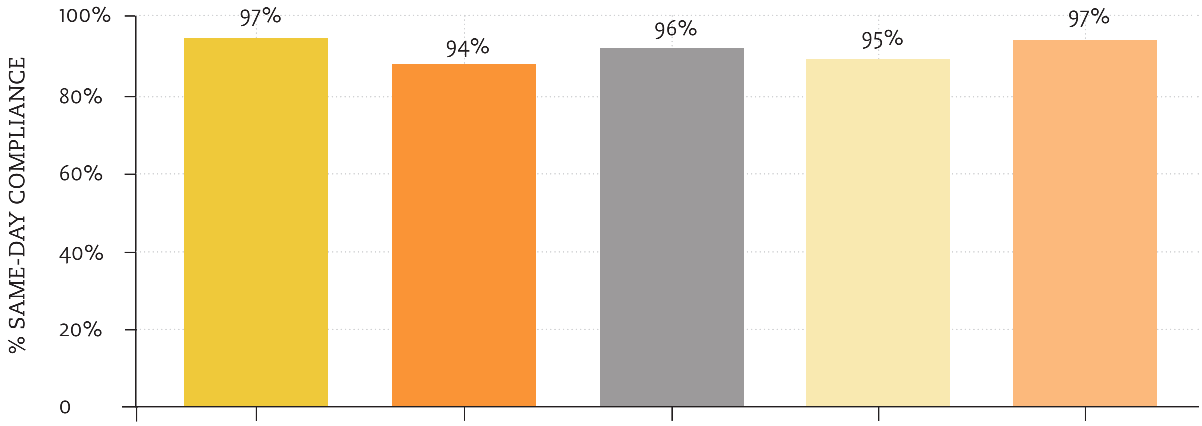
(Continued on page 13)

Table 3. Reasons for Non-Same-Day Compliance for Patients Prescribed Oral Oncolytics

REASONS FOR NON-SAME-DAY COMPLIANCE	NUMBER OF CASES
No provider notification	251
Infusion and oral oncolytic	218
Virtual consult	95
Scheduled APP consent/education visit	49
Rx written on the weekend/after hours	32
Rx written in the inpatient setting	30
Other	18
TOTAL	**693**

APP = advanced practice provider; Rx = prescription

Figure 5. Same-Day Compliance with Oral Oncolytic Standards



	CY21Q4	CY22Q1	CY22Q2	CY22Q3	CY22Q4
% Same-Day Compliance	97%	94%	96%	95%	97%
# Same-Day Compliant	185	154	156	137	146
# Same-Day Prescriptions	191	164	162	144	151

CY = calendar year; Q = quarter

(Continued from page 11)

several operational and clinical challenges (see Table 3, page 12) with one common theme: non-compliance was more likely to occur when patients did not receive their oral oncolytic prescription and required education and consent at the same time. Consequently, we modified our key performance indicator to reflect same-day compliance—a measure that better ensures all requirements, including education, consent, and prescription order, occur during the same clinic visit.

We included additional process metrics to measure key steps in our revised workflow, particularly those deemed potentially prone to failure in busy clinic settings. We measured provider documentation of the informed consent discussion, nurse-led review of patient education materials, and all parties' signatures on the completed consent form. These measures captured related requirements and provided some redundancies in case of process failure. These process metrics allowed us to identify and address specific opportunities.

Fortuitously, Miami Cancer Institute had previously migrated to a suite of web-based applications and reporting tools. This technology allows providers, staff, and leaders to share data in real time. Teams met weekly to review the audit dashboard and transparently discuss performance, opportunities, and recommended actions needed for improvement. Overall and same-day compliance quickly improved to 90 percent (n=1,614) and 96 percent (n=867), respectively (Figure 5, page 12). Patients who were not targeted for same-day compliance were monitored daily by nurse navigators, who were reviewing the oral oncolytic dashboard, until compliance was achieved. These nurse navigators also facilitated communication and care coordination with clinics to ensure patients received education and consent before starting their treatment.

In February 2022, Miami Cancer Institute successfully completed QOPI re-accreditation with zero deficiencies cited and a perfect survey score. Members of our oral oncolytic process improvement team, including a prescribing provider, nurse educator, nurse navigator, clinic nurse, and pharmacist, were on-hand to present our new workflow to QOPI surveyors. Operational leaders shared our project outcomes and ongoing efforts to improve clinical quality for patients receiving oral oncolytics. The surveyors complemented the team's interdisciplinary collaboration and patient education materials, noting that Miami Cancer Institute was unique in achieving the same high-quality care for patients on infusion and oral oncolytic treatments alike.

Challenges & Solutions

Our team faced many challenges during this project. To address these, we employed a key tenet of quality improvement: resisting the tendency to oversimplify. During our weekly meetings, we identified several reasons clinical teams could not reasonably achieve same-day compliance (Table 3, page 12). We tracked these reasons and measured non-same-day cases by examining overall compliance. This allowed us to respond to operational challenges within individual clinics and further refine our workflow.

Most often, same-day compliance was not feasible because the ordering physician did not notify the clinical team of the new oral oncolytic start. This occurred during clinic peak times, when

physicians were covering for one another or when an unusual regimen was ordered. Team members reviewed outcomes at the individual, physician level, and leaders sought physician buy-in through rounds and provider education.

Some oral oncolytic medications were ordered in combination with an infusion. When this occurred, comprehensive education included patient teaching on all prescribed agents. This task was deemed best handled by our expert systemic therapy educators, and the visit was scheduled prior to the patient's intended treatment start date.

Although remote e-consent signatures played a key role in this project, the entire process of obtaining and scanning signed consents into patients' chart could not practically be achieved during a single telehealth visit. Instead, remote consent was initiated during the virtual treatment decision-making visit, and patients' consent was subsequently scanned into their health record once complete.

One medical oncology clinic employed a unique approach to physician and APP collaboration. The physician planned and ordered all new treatment regimens, and the APP scheduled a subsequent follow-up visit to complete a detailed assessment, additional work-up, patient education, and informed consent. These providers felt that this was the best approach for their patient population and consistently delivered education and consent prior to treatment. Our project team acknowledged this practice preference and audited new prescriptions to ensure that the follow-up education and consent visit was scheduled and that compliance was achieved before treatment.

Not all oral oncolytic prescriptions were written during operating hours. Some were written after hours by physicians managing busy clinics or those working ahead in anticipation of authorization delays. In some cases, oral oncolytic regimens were planned during an inpatient hospitalization; when this occurred, the inpatient team or APP was responsible for providing written education and initiating the consent process. However, inpatient units often used paper consents and retained them for scanning at a later time. The assigned nurse navigator monitored these orders to ensure compliance was achieved once the clinic opened or the patient was discharged from the hospital.

Many other challenges impacted our oral oncolytic workflow. Clinical teams partnered to address unique circumstances as they arose; these included sudden Wi-Fi outages, the absence of a patient proxy or legal decision-maker, and many other unique patient- and clinic-specific challenges. The key ingredients to resolving project challenges were the multidisciplinary team's commitment to best practice and their willingness to transparently examine and learn from failures.

Sustaining the Change: Updates in Staffing, Roles, & Responsibilities

As we transitioned to project maintenance, we needed to build in mechanisms to sustain our progress. Clinic staffing gradually recovered as COVID-19 numbers improved. Nurses within each clinic now provide adequate support during treatment decision-making visits without leveraging on-call nurse navigators. Instead, nurse navigators use their increased familiarity with oral oncolytic regimens to proactively identify symptoms and adherence issues during routine navigation follow-up encounters. Designated nurse navigators are now assigned to perform the daily house-wide audit and quality review of the oral oncolytic workflow. Ongoing leadership review transitioned from the executive and operational leadership level to the manager level, and outcome measurement shifted from weekly to monthly intervals.

Sustaining the Change: Identifying Next Steps

During this phase, stakeholders shifted their attention to potential next steps for further improvement. This includes optimization of oral oncolytic reporting tools, e-consent software, and an improved e-signature workflow between physicians and APPs. Leaders and staff defined requirements for an automated audit tool and oral oncolytic reporting dashboard. The oncology informatics team worked with our technology and digital, as well as EHR specialists to provide customer feedback and request updates to the embedded e-consent functionality.

> ...successful management of patients on oral oncolytic regimens is a team sport. Cancer programs and practices interested in improving oral oncolytic management should build upon...opportunities for increased collaboration between team members.

Practice Implications

Oral oncolytic treatment regimens pose unique challenges to cancer programs and practices and require an interprofessional approach to ensure optimal patient outcomes. In our innovation project, each team member contributed disciplinary and specialty expertise to our combined efforts. Physician buy-in was an especially crucial factor in each clinic's success since our revised workflow began with the prescribing physician. Clinic nurses played a key role in breaking down siloes between providers, pharmacists, and patients to ensure compliance with quality care standards. Nurse navigators provided on-call support, care coordination, and quality oversight to the process. Pharmacists bridged gaps between patients and their insurance companies, assistance programs, and dispensing pharmacies. APPs efficiently addressed urgent symptoms, follow-up visits, and refills. Educators, informaticists, and leaders provided critical support and guidance to the clinical team. In short, the successful management of patients on oral oncolytic regimens is a team sport. Cancer programs and practices interested in improving oral oncolytic management should build upon interprofessional team members' specialty knowledge, top-of-license practice, and opportunities for increased collaboration between team members.

Great teamwork can be further enhanced with the right technology. Seamless integration of smart tools, such as automated EHR tasks and alerts, can help clinicians deliver the best possible patient outcomes. Although our team faced many challenges, we continually sought better approaches to work via innovative technology solutions. Often, this required us to partner with informaticists, our technology and digital team, as well as our EHR vendors to articulate clinical goals and propose future digital enhancements. This ongoing partnership is key to furthering oncology innovation.

Finally, our team is committed to continuous improvement and includes several stakeholders with formal quality improvement experience. These individuals help us approach process changes in a systemic manner, strive for standardization, and maintain transparency and exacting standards. Cancer programs and practices can leverage well-established quality improvement methods and resources to continually improve the quality of their care delivery.

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Our Program At-a-Glance

Miami Cancer Institute, a community-based ambulatory cancer center in Miami, Fla, opened its doors in January 2017. The institute is a 405,000-square-foot, next-generation, anti-cancer treatment center built with one goal: that no patient with cancer in south Florida would ever have to leave home to receive innovative, comprehensive, and lifesaving treatments. Miami Cancer Institute is an alliance partner with Memorial Sloan Kettering Cancer Center, which allows for the expansion of clinical trials and knowledge-sharing with some of the most prominent and pre-eminent oncology/hematology experts in the world, benefiting patients in south Florida, Latin America, and the Caribbean.[9]

In six short years, Miami Cancer Institute has grown exponentially and is now recognized for its leading clinical care, research, compassionate patient experience, and state-of-the-art technology. The institute treats more than 9,000 new patients with cancer annually, with approximately 1,000 patients accessing care and services daily. The cancer institute is a renowned center of excellence and part of the Baptist Health South Florida system—the region's largest healthcare provider. In its 2022 to 2023 report, *U.S. News & World Report* ranked Miami Cancer Institute's oncology program in the top 10 percent of all high-performing cancer centers in America.[9]

Miami Cancer Institute is a hybrid academic center accredited and certified by the American Society of Clinical Oncology Quality Oncology Practice Initiative, Commission on Cancer, and Foundation for the Accreditation of Cellular Therapy. The institute offers a wide range of specialized clinical care and patient services to patients and their families, including radiation oncology, proton therapy, blood and marrow transplant, clinical trials and research, medical and surgical oncology, prevention and multidisciplinary specialty clinics, support services, and a well-known oncology patient navigation program.

Acknowledgments

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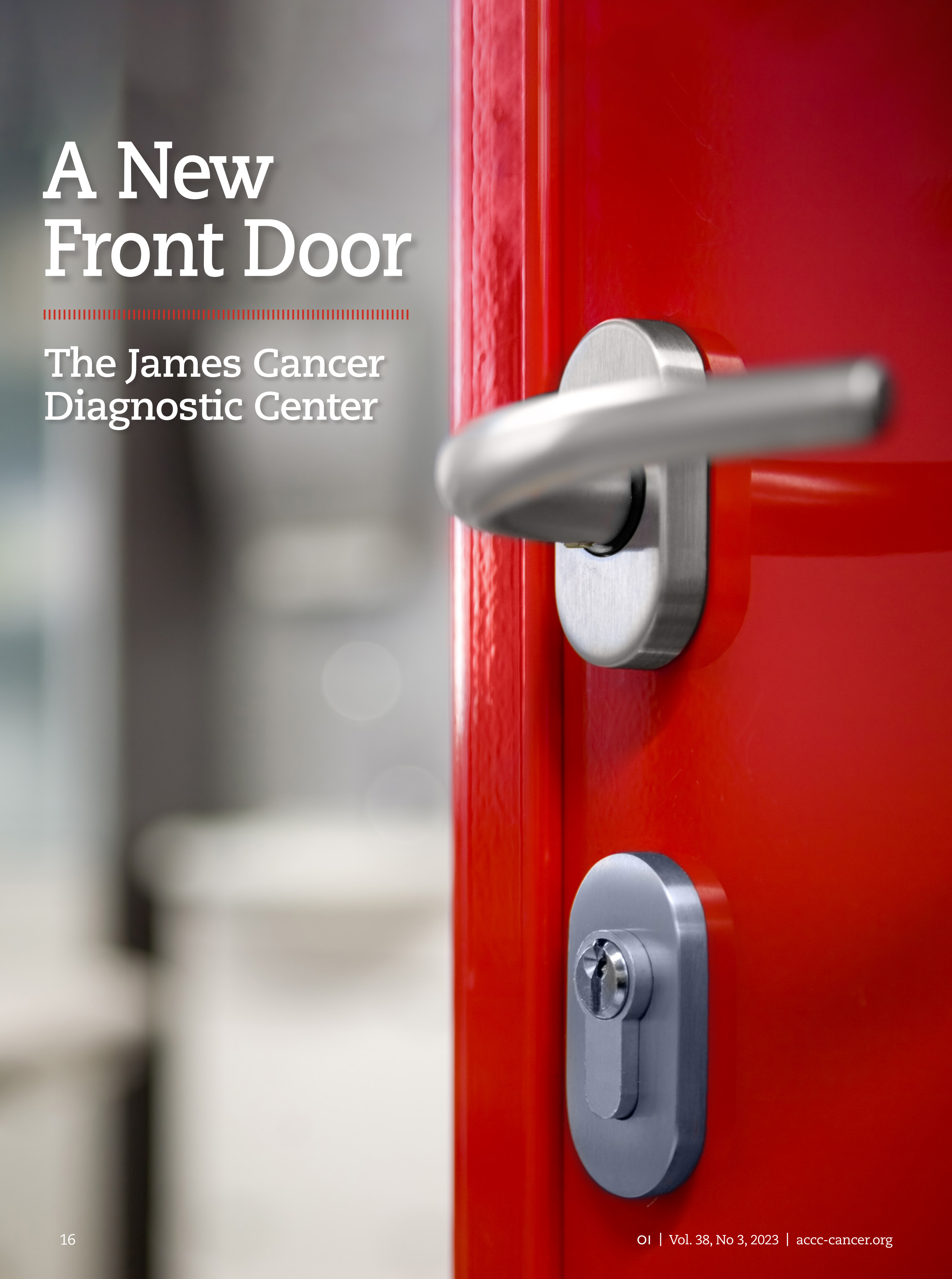


A New Front Door

The James Cancer Diagnostic Center

BY RAQUEL E. REINBOLT, MD; DARETH GILMORE, APRN-CNP; SCOTT ROWLEY, DNP; VICTORIA KROGG, DNP; RUPA GHOSH-BERKBILE, DNP, APRN-CNP; TORI STUCKE; CHRISTINE MAURER, MHI, RN, OCN; TINA SOWERS, FACHE; DAVID COHN, MD, MBA, FACHE; AND ERIN HEUSER, MBOE, RT(R)(T), LSSBB, CCMP

2022 ACCC INNOVATOR AWARD • ASSOCIATION OF COMMUNITY CANCER CENTERS •

The cancer population continues to grow, with an estimated 1.9 million new cases to be diagnosed in 2022.[1] A cancer diagnosis is challenging. At times, patients' symptoms may prompt urgent or emergent evaluation; other times, the disease is more insidious. In many instances, presenting signs or symptoms also mimic features of benign disease states, necessitating a comprehensive investigation to tease out cases that are truly indicative of malignancy versus those of other etiologies. These investigations often require complex care coordination with cancer-specific experts and a variety of imaging and laboratory testing modalities, all of which can be challenging to facilitate in a timely fashion. Furthermore, studies indicate that diagnosis at a later stage of disease is a contributor to poor health outcomes.[2,3] As such, it is imperative to prioritize efforts to expedite a cancer diagnosis whenever possible.

In addition to evaluations driven by patients who are experiencing symptoms, many cancer diagnostics are pursued in response to abnormal cancer screening results. Established screening methodologies, such as those for breast, cervical, colorectal, and lung cancers, are estimated to save hundreds of thousands of lives.[4] Unfortunately, the COVID-19 pandemic significantly impacted routine cancer screening, resulting in decreased rates of cancer screening, diagnosis, and treatment.[5] Downstream sequelae of this phenomena will likely include worse survival statistics for an extended period of time, particularly among vulnerable populations.[6,7] Despite the pandemic's negative impact on cancer screening and detection, it has positively spurred the healthcare enterprise to rethink current diagnostic strategies for patients. Novel methods to deliver care to the right patient at the right time and in the right place are required.

> The premise of this clinic is to leverage the expertise of our providers...to deliver a comprehensive assessment of signs and/or symptoms that are concerning for malignancy in a timely fashion and in a single location—virtual or in-person—that is convenient for patients.

In recognition of these needs, The Ohio State University Comprehensive Cancer Center – The James, located in Columbus, Ohio, formed a multidisciplinary workgroup in November 2019 to develop a clinic that would provide direct, expedited access to diagnostic testing for patients that have a suspicion of cancer via radiographic imaging, lab finding, or physical exam. The premise of this clinic is to leverage the expertise of our providers at The James to deliver a comprehensive assessment of signs and/or symptoms that are concerning for malignancy in a timely fashion and in a single location—virtual or in-person—that is convenient for patients. This clinic would ultimately come to be known as The James Cancer Diagnostic Center.

Figure 1. The Six Sigma DMADV Process

D DEFINE	M MEASURE	A ANALYZE	D DESIGN	V VERIFY
• Reviewed current referral pathways for undiagnosed patients with cancer.	• Identified gaps in our decision tree algorithms that limited patient access at The James.	• Sought out existing evidence-based diagnostic oncology pathways. • Partnered with radiology and interventional radiology to define pathways for expedited imaging.	• Defined referral pathways (provider and self-referral). • Planned physical space. • Created dashboard to monitor success. • Conducted sub-specialist review of clinical guidelines for diagnostics.	• Held regular tumor boards with subspecialists to review cases. • Hosted bi-weekly team huddles to monitor workflows and barriers. • Monitored dashboard metrics to ensure process is in control.

Opening a New Clinic During a Global Pandemic

The James is a National Cancer Institute (NCI)- and National Comprehensive Cancer Network (NCCN)-designated cancer center. It is also the third largest cancer hospital in the nation and home to more than 200 oncologists. In 2019, leadership at The James identified the need to better serve its community and share its cancer expertise through the development of a rapid cancer diagnostic pathway. With the help of a process engineer team, The James deployed the Six Sigma DMADV (define, measure, analyze, design, verify) methodology to design a focused diagnostic clinic that would fit seamlessly into current patient intake workflows (Figure 1, above). The James assembled a team of cancer center leadership, including the chief medical officer, nursing and service line administrators, advanced practice providers (APPs), the new clinic's medical director, and representatives from the departments of Informatics, Marketing, Operations Improvement, Outreach, and Patient Access. The workgroup was tasked with deploying this novel diagnostic process by November 2020.

During the define phase, the workgroup identified the opportunity to improve how patients first entered The James for their cancer care. The workgroup observed that some patients could not be scheduled to see our experts because they did not have a confirmed, pathologic cancer diagnosis. In the measure phase of this project, the workgroup identified the specific patient populations that were denied appointments due to gaps in decision tree algorithms that mandated a pathologic diagnosis prior to treatment scheduling. Through this process, the workgroup confirmed the need for a dedicated clinic to accommodate patients without a definitive cancer diagnosis. As decision trees were recreated to include referral opportunities to this novel diagnostic center, the workgroup realized that the inclusion of a self-referral option for patients, who are not established with primary care and/or those with limited healthcare access, is critical to the health equity mission of the new clinic and The James.

In the analyze and design phases, the workgroup sought out existing evidence-based diagnostic oncology pathways. The workgroup also partnered with radiology and interventional radiology to discuss workflows that would permit patients to receive same-day imaging and expedited biopsies if clinically appropriate. These conversations took place in March 2020, right as the COVID-19 pandemic accelerated, prompting a temporary pause of the workgroup's efforts to better prioritize pandemic-related operations at The James.

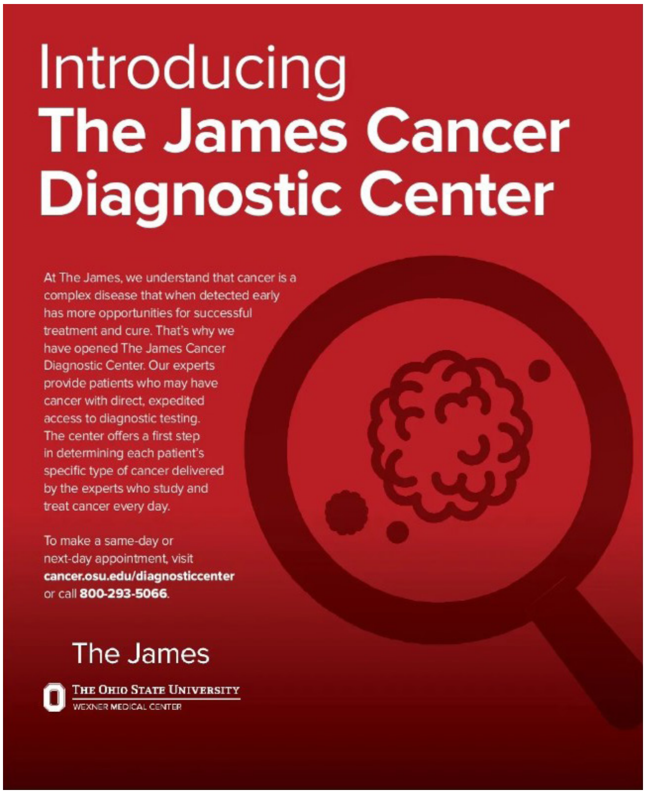
The original target date to open the diagnostic center in November 2020 was placed in jeopardy, while The James faculty and staff continued to navigate COVID-19-related challenges. In mid-May 2020, as a response to the deleterious impact of the pandemic on cancer screening rates and many canceled appointments for symptom assessment, The James' leadership recognized the urgent need to elevate opportunities that would enhance patient access. Consequently, efforts related to the diagnostic center were reinvigorated, and the workgroup was charged with opening the clinic by mid-June 2020.

With the target date to open its doors rapidly approaching, the workgroup jumped to action and quickly outlined the necessary steps to operationalize the diagnostic center. Subject matter experts were consulted to ensure each operational element was addressed. Tasks included:

- Setting up the physical space for the diagnostic center
- Identifying nurses and providers to staff the diagnostic center
- Establishing appointment types (virtual and in-person) and provider templates for scheduling
- Creating a dashboard for metric capture
- Developing a new department and referral pathway in the electronic health record
- Obtaining necessary equipment and supplies
- Developing and carrying out internal and external communication and outreach.

Upon completion of this whirlwind of activity, The James Cancer Diagnostic Center ultimately opened its doors on June 15, 2020 (Figure 2, page 19).

Figure 2. The James Cancer Diagnostic Center Introductory Announcement



Introducing
The James Cancer Diagnostic Center

At The James, we understand that cancer is a complex disease that when detected early has more opportunities for successful treatment and cure. That's why we have opened The James Cancer Diagnostic Center. Our experts provide patients who may have cancer with direct, expedited access to diagnostic testing. The center offers a first step in determining each patient's specific type of cancer delivered by the experts who study and treat cancer every day.

To make a same-day or next-day appointment, visit **cancer.osu.edu/diagnosticcenter** or call **800-293-5066**.

The James
The Ohio State University
Wexner Medical Center

The Diagnostic Center's Staffing Model

The James Cancer Diagnostic Center is currently staffed by doctoral-prepared, certified nurse practitioners with advanced oncology certification through the Oncology Nursing Certification Corporation. Given the clinical complexity of the diagnostic center, APPs with several years of solid tumor and hematologic malignancy experience in both the inpatient and ambulatory settings, as well as a strong foundation in internal medicine, were targeted to staff the clinic. Additional backup staffing is provided by The James' medical oncology consult team. At inception, the diagnostic center was staffed by rotating APPs until a full-time position could be filled by a dedicated provider with the aforementioned experience. Due to increases in clinic volume and the amount of care coordination required for each patient, a second APP was added more recently to support the diagnostic center. It is also staffed by three nurses with more than 30 years of oncology experience in both the inpatient and outpatient setting. Nursing plays an invaluable role in guiding patients and providing reassurance through the diagnostic journey and its associated uncertainties. The diagnostic center's medical director is a board-certified internist and medical oncologist; she offers case review and clinical support to the team, when needed.

Feedback from APPs and nursing staff early in the development of the clinic was instrumental in capturing the productivity of the clinical team and included suggestions to restructure the diagnostic center template to optimize the time required for care coordination, follow up, subspecialty consultation, and documentation. The number of new patient visits per day was restricted to allow for telemedicine return visits to discuss diagnostic results and next steps in a patient's plan of care.

The Diagnostic Center Visit

The James Cancer Diagnostic Center offers evaluations five days a week and currently operates in two locations to better serve those living in the surrounding communities. Patients with a suspicion for cancer via radiographic, laboratory, or physical exam findings are invited to be seen in the diagnostic center. External and internal provider-initiated referrals, as well as self-referrals, are accepted. Once the evaluation request is received, the clinic team screens the consultation to ensure The James Cancer Diagnostic Center is the appropriate clinic for upfront evaluation. The goal of the diagnostic center is to streamline the cancer diagnostic journey for patients as much as possible. If an initial consultation with a different specialty clinic would result in a more direct care experience, that referral would be appropriately re-triaged. Given the highly specialized nature of their exams and/or imaging, patients with suspected non-metastatic, primary breast, gynecologic, or central nervous system malignancies are also generally triaged directly to their respective specialty clinics within The James. Upon screening clearance, every effort is made to see the patient promptly within two to four business days or, if clinical urgency necessitates, on an urgent or same-day basis.

Prior to a patient's first appointment, the clinic and scheduling teams diligently work to obtain any prior, completed diagnostic evaluation(s) and other relevant collateral. Given the typical complex nature of any presenting signs and/or symptoms, approximately one to two hours are expected for each new patient visit. Providers review the patient's medical history, reason(s) for referral, and other pertinent clinical information prior to their arrival for the appointment. During the visit encounter, the clinic team will obtain a thorough history and physical and, based on the findings to date, formulate a diagnostic plan of care. The diagnostic work-up may include:

- Labs
- Same-day ultrasound
- Same-day CT (computed tomography)
- Urgent MRI or PET (positron emission tomography)
- Same-day FNA (fine needle aspiration) biopsy
- Urgent referral to specialty teams or interventional radiology for biopsy.

APPs collaborate with physicians, proceduralists, and other APPs within The James and larger academic institution to decide on a tailored and expedited plan of care for each patient. After undergoing workup, the patient is contacted within one to two days via telehealth to review their results and discuss next steps, as indicated. Clinic staff place referrals to oncology specialists and coordinate with the patient and scheduling teams to ensure the care plan is quickly enacted. If the patient does not have a cancer diagnosis, every effort is made to refer them to the appropriate specialty team, such as gastroenterology, neurology, rheumatology, pulmonary, or back to their primary care provider. Closed-looped verbal or written communication with the referring provider is a clinic standard. Once a patient is successfully established with their oncology team (or other appropriate provider), APPs review and then formally sign-off on the final plan of care.

Results Matter: Throughput and Output

Since the James Cancer Diagnostic Center opened in June 2020 and through September 2022, the clinic saw nearly 1,100 new patients and almost 1,000 return patients for visits (Figure 3, below). The majority of these visits were conducted in person (54 percent), although a significant amount of telemedicine (video visit or telephone encounter) appointments were employed (46 percent), particularly for return visit encounters. Most referrals (47 percent) were from internal providers; 31 percent came from external sources, and 22 percent of patients self-referred. The median lag time for new patients to be seen in the diagnostic center was three days.

The James Cancer Diagnostic Center evaluates a myriad of signs and symptoms (Figure 4, page 21); generalized or localized enlarged lymph nodes is one of the most frequently seen concerns. The clinic also uses a variety of diagnostic tools to evaluate patients. To date, clinic staff have ordered more than 13,000 discrete laboratory studies, imaging, or procedures. During this same time, over 550 subspecialty visits for ongoing care have directly resulted from patients' evaluation at the diagnostic center, including referrals to subspecialized hematology and medical oncology clinics, among others.

Enterprise Impact at The James

In some instances, The James Cancer Diagnostic Center represents the first point of contact a patient may have with The James. In fiscal years 2021 and 2022 combined, we estimate that more than 230 new patients made their entry into The James via the doors of this diagnostic center; many of these patients were also entirely new to The Ohio State University Wexner Medical Center—the overarching healthcare program at the university. Based on these statistics and experiences to date, we believe The James Cancer Diagnostic Center is well positioned to contribute to The James' greater vision: offering access to world-class diagnostic and cancer care to the larger community.

Like other large academic medical centers, The Ohio State University's emergency and inpatient care sites typically operate at full or near-full capacity. To ensure that emergency and inpatient bed usage is optimized, The James Cancer Diagnostic Center has partnered with the university's hospital emergency department and transfer center, which coordinates patient flow for the entire enterprise and referring hospitals. The diagnostic center collaborated with these teams to develop workflows that identify patients with a concern for cancer, who might not require emergency or inpatient-level care, and may be more appropriate for the diagnostic center. Prompt appointments are offered to these patients who meet established criteria. Efforts to refine appropriateness criteria and streamline the referral process to The James Cancer Diagnostic Center are actively being pursued.

The Patient Experience

The James Cancer Diagnostic Center prides itself in offering personalized care and a "concierge" feel to patients. Clinic providers closely monitor and maintain contact with patients from the time of referral to when they are handed off to

Figure 3. The James Cancer Diagnostic Ceneter's New Patient Volumes

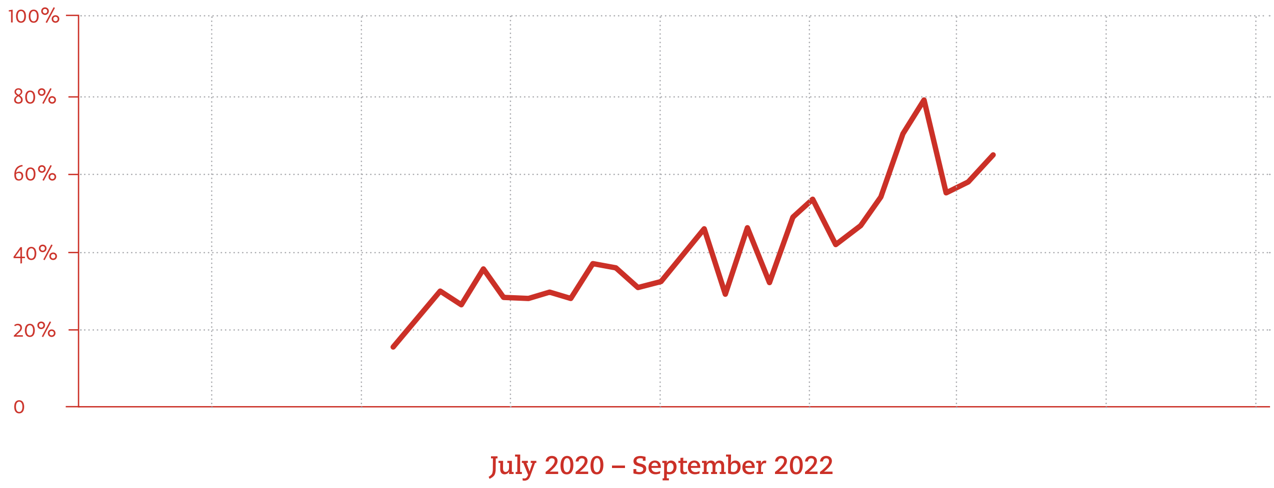
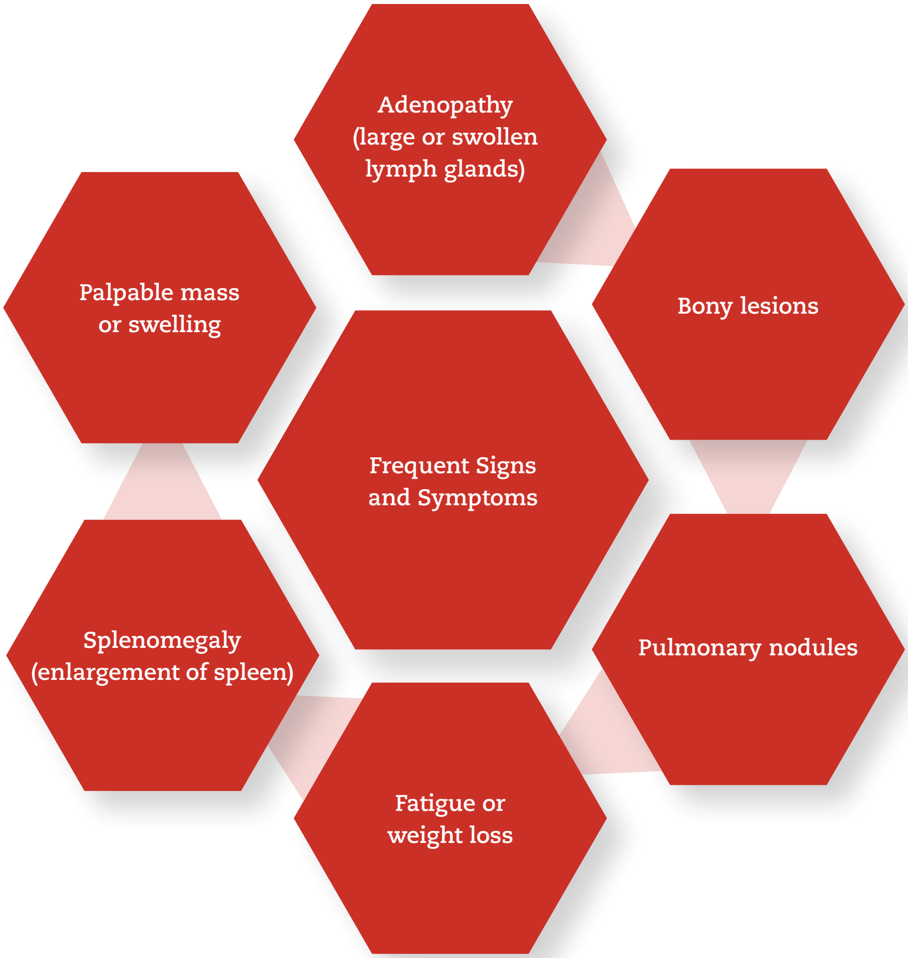


Figure 4. Frequently Evaluated Signs and Symptoms



a subspecialty provider or back to their primary care provider. This new "front door" to The Ohio State University Comprehensive Cancer Center—The James is the first impression many patients have of the university's larger cancer hospital. As such, it is a clinic priority to ensure patients feel welcome and well cared for throughout their diagnostic experience. Comments received to date from patients, caregivers, providers, and staff, alike, highlight the warmth and compassionate care the clinic strives to deliver.

Education and Research: Maintaining High Standards and Creating a Cancer-Free World

From inception, subspecialty providers were engaged to confirm cutting-edge care and the most up-to-date diagnostic methodologies are used at The James Cancer Diagnostic Center. Subspecialists directly informed many of the initial clinic diagnostic pathways and helped identify the types of pathologies most appropriate for clinic evaluation. This close collaboration continues today to ensure the delivery of high-quality care. The James Cancer Diagnostic Center provider team holds regular tumor board reviews with subspecialty providers to discuss challenging cases or identify opportunities to strengthen the diagnostic pathway. When a cancer diagnosis is confirmed, the clinic's team works hard to ensure all necessary diagnostic information is obtained so that subspecialists can rapidly move to treatment planning when they first meet a newly diagnosed patient.

Committed to advancing The James' mission of creating a cancer-free world, The James Cancer Diagnostic Center actively partners with several research teams to contribute to our current understanding of cancer. Patients with a suspicion for a new lymphoproliferative disorder are offered the opportunity to participate in The James' Leukemia Tissue Bank Shared Resource. This research team seeks to better characterize lymphoproliferative disorders, like lymphoma and leukemia, by studying biospecimens obtained prior to treatment initiation. The James Cancer

Diagnostic Center's patients may also enroll in The James' Total Cancer Care© Protocol, which studies patients and their tissues to advance understanding of the differences between patients so that the prevention, detection, and treatment of cancer may be better tailored to the individual.

Looking Forward

The James Cancer Diagnostic Center and The James' leadership teams continue to refine and further grow this innovative care delivery model through a variety of quality, operational, and scholarly initiatives. For example, the diagnostic center is actively developing partnerships with primary care providers to enhance support for when diagnostic uncertainty arises and to lead complex care coordination. Collaborations to better streamline the diagnostic process, such as offering same-day diagnostic center and interventional radiology appointments to expedite tissue biopsies, are also under consideration. The James has recognized that this APP-led provider clinic model is unique; as such, it is reviewing opportunities to extend the diagnostic center's expertise to other medical learners. Finally, The James also seeks to highlight the diagnostic center's impact on enterprise resource utilization by providing measurable contributions to triage the right patients at the right time to the right place and promote emergency- or inpatient-bed avoidance if clinically appropriate.

When a suspicion for cancer arises, The James Cancer Diagnostic Center represents a novel "front door" for the community to access The James' cutting-edge diagnostic and cancer care. This model promotes efficient use of resources and, most importantly, the delivery of high-quality, patient-centered care. The changing healthcare climate necessitates innovative and effective care delivery models, like the diagnostic center, which demonstrate value while prioritizing the patient.

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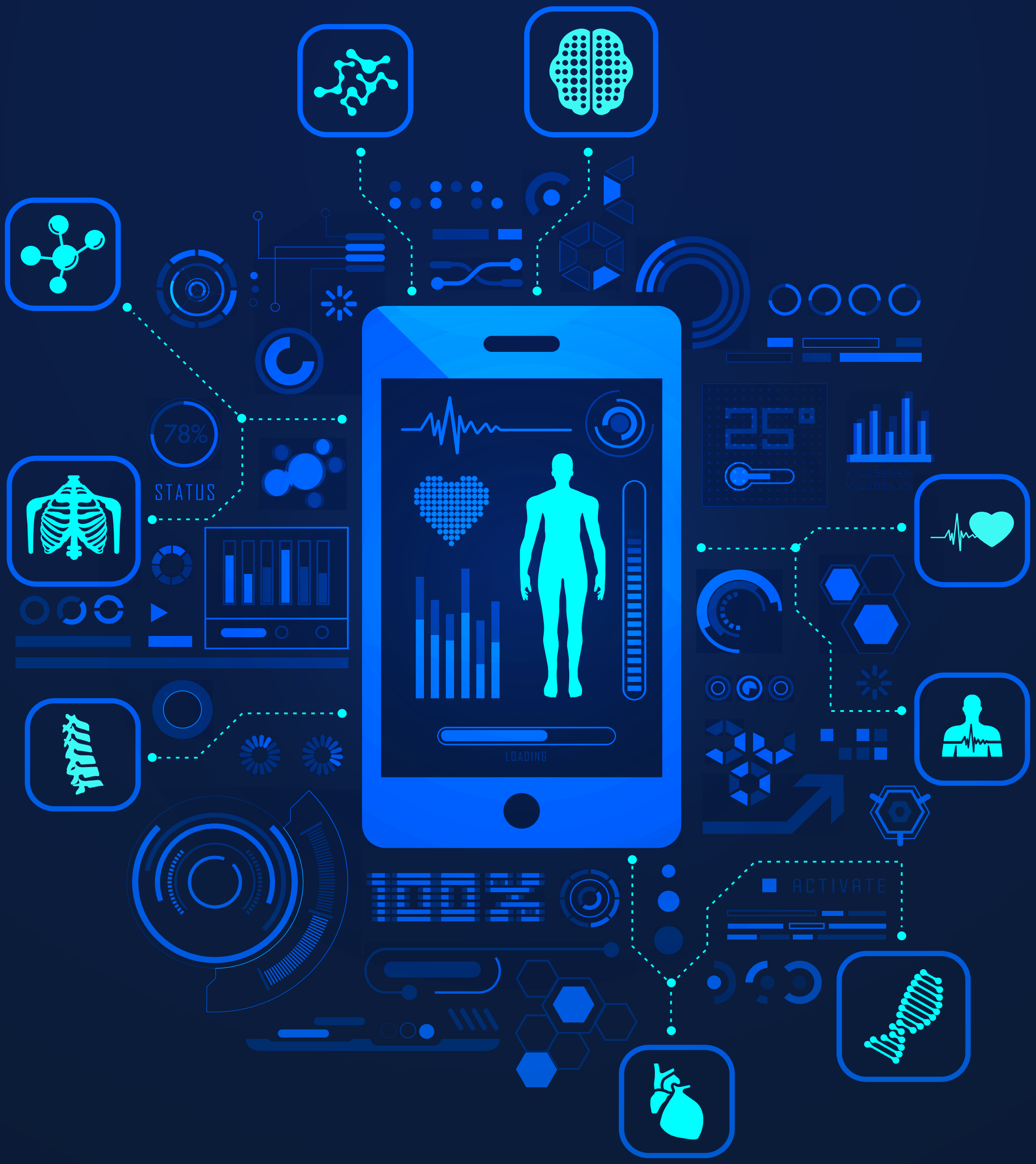
Ochsner Chemotherapy Care Companion

Improving Outcomes through Digital Medicine



BY ZOE LARNED, MD AND
ERIN PIERCE, MSN, APRN, FNP-C

Telehealth platforms continue to grow and offer innovative health access options for patients outside the traditional clinic and hospital settings. These platforms have proven to be beneficial to hematology/oncology patients because they facilitate expanded access to care and monitoring.[1,2] Patient benefits of this improved monitoring include decreased hospitalizations and dehydration events, as well as improved fitness levels and performance status.[3-6]

Oncology is increasingly recognizing the importance of patient-reported outcomes (PROs), which have shown significant associations with key health outcomes, such as performance status and treatment adherence. Digital telehealth platforms have the potential to facilitate PROs data capture and may afford additional benefits, such as real-time and remote monitoring with automated interventional triggers.

Patients receiving oncologic care are predisposed to disease- and treatment-related issues, many of which have shown to be preventable through proactive monitoring and management. In 2019, Ochsner Health's Department of Hematology/Oncology developed a digital chemotherapy remote monitoring program called Chemotherapy Care Companion. Preliminary program results showed a decrease in emergency department (ED) visits and hospitalizations through the tracking of patients' vitals and questionnaire responses. Earlier recognition and intervention also improved quality of life indicators and patient satisfaction for those enrolled in the program.

What is Digital Remote Monitoring?

Digital remote monitoring is a merger of software and hardware technologies within healthcare delivery and management. Electronic devices are used to collect health data from individuals in one location and electronically transmit that information to healthcare providers in a different location for assessment and recommendations.

> Patients receiving oncologic care are predisposed to disease- and treatment-related issues, many of which have shown to be preventable through proactive monitoring and management.

Since 2021, interest in remote patient monitoring has rapidly expanded, as shown by the increase of venture capitalist investments in this technology.[7]

Rationale and Configuration

For patients with cancer, the most common diagnoses for ED visits are related to infection and sepsis, dehydration, pain, and hypertension. Cancer-related ED visits account for 3.7 percent of all patients seen in the ED in 2021; approximately, 27 percent of patients with solid tumors had at least one ED visit while on treatment.[8-10]

In 2019, Ochsner Health developed its Chemotherapy Care Companion program to monitor and manage patients' therapy complications. The program was designed to help providers identify issues earlier and mitigate any symptoms that could lead to ED visits and/or hospital admissions. It works by monitoring patients' vital signs and escalating any variations from baseline vitals data and normal range data to providers. These data, including escalations, are shared via patients' personal devices through the Chemotherapy Care Companion platform, which was designed and integrated within the electronic health record (Epic). Ochsner Health initially piloted its Chemotherapy Care Companion at the Gayle and Tom Benson Cancer Center. The program has since expanded to two additional regional cancer centers and several community oncology care clinics within the Ochsner Health system.

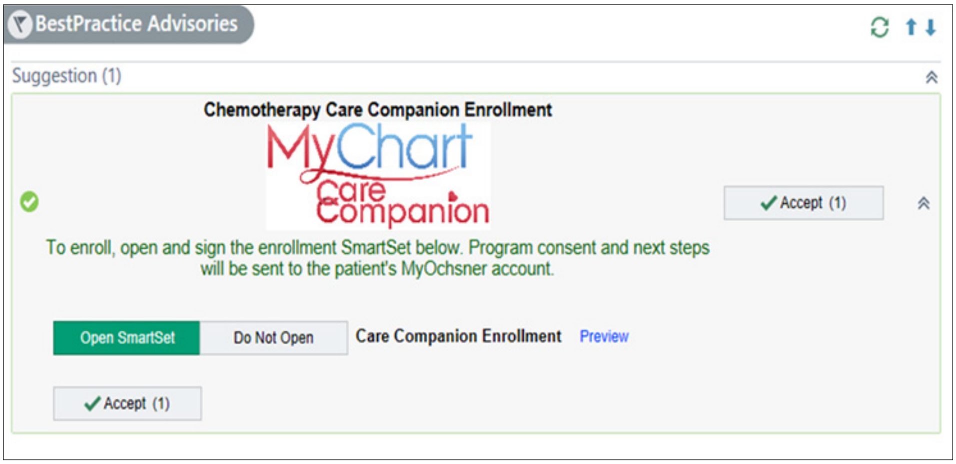
Ochsner Health employs 33 hematology/oncology physicians and 17 oncology advanced practice providers (APPs) across the system, encompassing 3 regional cancer centers and 6 additional clinic and infusion sites. In 2022, Ochsner Health provided care to more than 35,000 unique patients with cancer.

Nuts and Bolts

Chemotherapy Care Companion went live in January 2020 and is used to monitor Ochsner Health oncology patients in the outpatient setting by tracking vital signs and questionnaire responses to help identify issues caused or exacerbated by systemic therapy. All patients initiating or already undergoing systemic anti-cancer therapies (chemotherapy, immunotherapy, or oral tyrosine kinase inhibitors [TKI]) are eligible to participate. The monitoring kit includes a digital blood pressure cuff, digital scale, and digital thermometer. (The original kit included a pulse oximeter, which was removed during the COVID-19 pandemic, as these tools needed to be prioritized for COVID-19-related virtual monitoring programs.)

(continued on page 27)

Figure 1. Best Practice Advisory in EHR

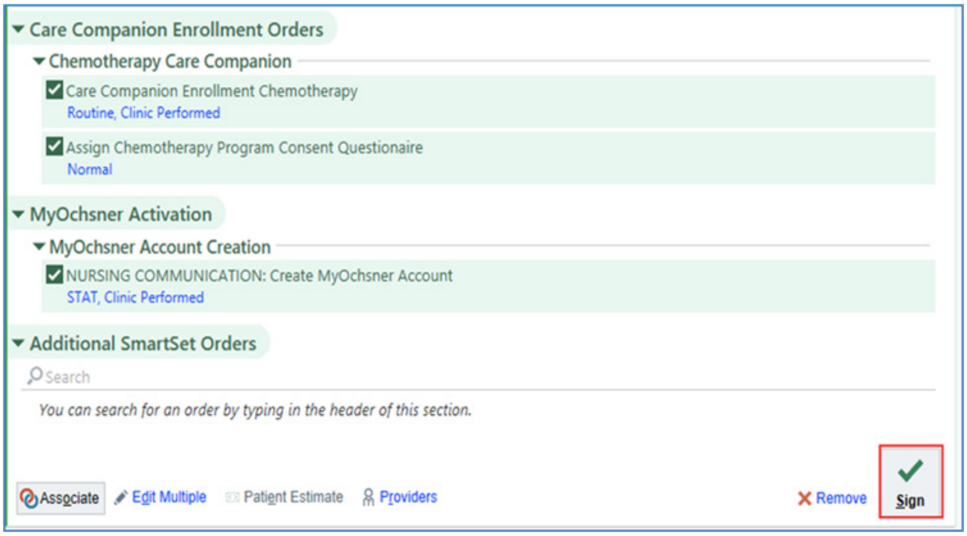


Chemotherapy Care Companion Enrollment

To enroll, open and sign the enrollment SmartSet below. Program consent and next steps will be sent to the patient's MyOchsner account.

Care Companion Enrollment

Figure 2. Enrollment Order



Care Companion Enrollment Orders
- Chemotherapy Care Companion
  - ☑ Care Companion Enrollment Chemotherapy — Routine, Clinic Performed
  - ☑ Assign Chemotherapy Program Consent Questionaire — Normal

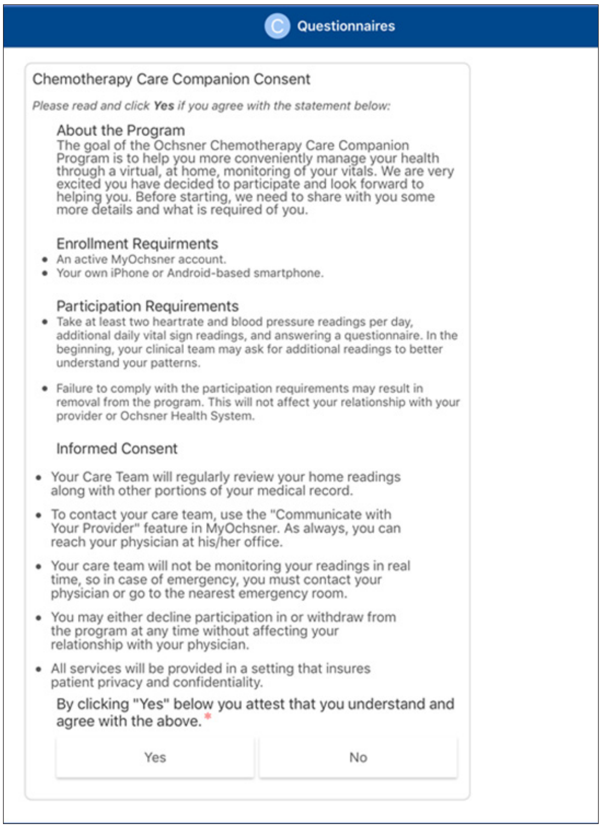
MyOchsner Activation
- MyOchsner Account Creation
  - ☑ NURSING COMMUNICATION: Create MyOchsner Account — STAT, Clinic Performed

Additional SmartSet Orders

You can search for an order by typing in the header of this section.

Ochsner Health introduced its retail “O Bars” at its hospitals and clinics, allowing patients to access innovative, interactive health technology. O Bars are staffed full time by technology specialists and have now been placed in all of its cancer centers to support its digital programs.

Figure 3. e-Consent in Patient Portal



Chemotherapy Care Companion Consent

*Please read and click **Yes** if you agree with the statement below:*

About the Program

The goal of the Ochsner Chemotherapy Care Companion Program is to help you more conveniently manage your health through a virtual, at home, monitoring of your vitals. We are very excited you have decided to participate and look forward to helping you. Before starting, we need to share with you some more details and what is required of you.

Enrollment Requirements

- An active MyOchsner account.
- Your own iPhone or Android-based smartphone.

Participation Requirements

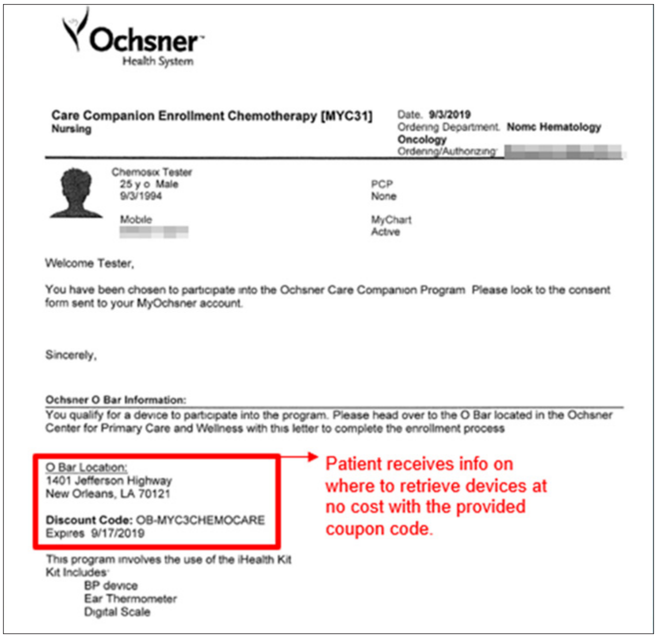
- Take at least two heartrate and blood pressure readings per day, additional daily vital sign readings, and answering a questionnaire. In the beginning, your clinical team may ask for additional readings to better understand your patterns.
- Failure to comply with the participation requirements may result in removal from the program. This will not affect your relationship with your provider or Ochsner Health System.

Informed Consent

- Your Care Team will regularly review your home readings along with other portions of your medical record.
- To contact your care team, use the "Communicate with Your Provider" feature in MyOchsner. As always, you can reach your physician at his/her office.
- Your care team will not be monitoring your readings in real time, so in case of emergency, you must contact your physician or go to the nearest emergency room.
- You may either decline participation in or withdraw from the program at any time without affecting your relationship with your physician.
- All services will be provided in a setting that insures patient privacy and confidentiality.

By clicking "Yes" below you attest that you understand and agree with the above. *

Figure 4. Enrollment in Patient Portal



Ochsner
Health System

Care Companion Enrollment Chemotherapy [MYC31]
Nursing

Date. **9/3/2019**
Ordering Department. **Nomc Hematology Oncology**
Ordering/Authorizing: [redacted]

Chemosx Tester
25 y o Male
9/3/1994

Mobile
[redacted]

PCP
None

MyChart
Active

Welcome Tester,

You have been chosen to participate into the Ochsner Care Companion Program Please look to the consent form sent to your MyOchsner account.

Sincerely,

Ochsner O Bar Information:

You qualify for a device to participate into the program. Please head over to the O Bar located in the Ochsner Center for Primary Care and Wellness with this letter to complete the enrollment process

O Bar Location:
1401 Jefferson Highway
New Orleans, LA 70121

Discount Code: OB-MYC3CHEMOCARE
Expires 9/17/2019

Patient receives info on where to retrieve devices at no cost with the provided coupon code.

This program involves the use of the iHealth Kit
Kit Includes:
BP device
Ear Thermometer
Digital Scale

Table 1. Daily Tasks for Completion in Patient Portal App

TASK	DUE TIME
Daily questionnaire	9:00 AM
Daily weight entry	9:00 AM
Daily temperature entry	9:00 AM
Morning blood pressure & heartrate reading	9:00 AM
Evening blog pressure & heartrate reading	3:00 PM

(continued from page 25)

Enrollment Process

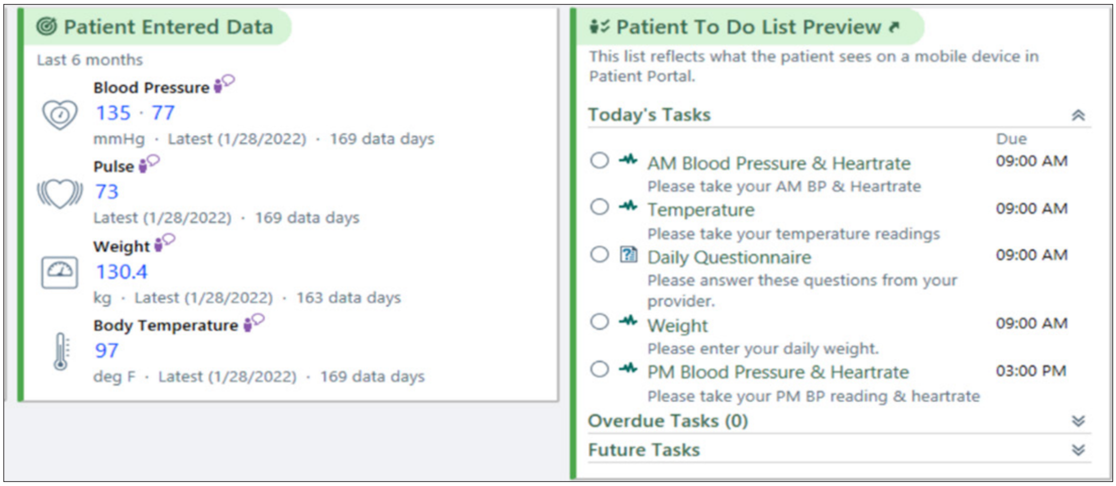
For all patients with orders to initiate any chemotherapy, immunotherapy, or TKIs, a best practice advisory automatically appears within Epic to remind physicians to enroll the patient in Chemotherapy Care Companion (Figure 1, page 25). Opening the best practice advisory activates a smart set in Epic that allows for automatic enrollment and completion of the consent process (Figure 2, page 25). The patient then receives an e-consent (Figure 3, page 26) through their MyOchsner portal, including a welcome letter and barcode, and visits the Ochsner O Bar to receive and set up the devices needed to participate (Figure 4, page 26). Ochsner Health introduced its retail "O Bars" at its hospitals and clinics, allowing patients to access innovative, interactive health technology. Ochsner Health's O Bars are staffed full time by technology specialists and have now been placed in all of its cancer centers to support its digital programs.

Once enrolled and consented to Chemotherapy Care Companion, patients are assigned a series of daily tasks, including a symptom survey, weight entry, temperature entry, AM/PM blood pressure, and AM/PM heart rate reading (Table 1, left), and the system can send automatic push notification reminders to patients for PROs (patient reported outcomes) completion in the patient portal app. Vital signs are then uploaded automatically from the integrated Bluetooth devices to the patient portal and into Epic for provider review. Figure 5, below, provides examples of patients' responses.

Patient escalations can be triggered by questionnaire responses (Figure 6, page 28) or vital sign changes and are sent to a monitoring pool via Epic in-basket messages (Figure 7, page 28) that are monitored from 7:00 AM to 5:00 PM by APPs. Figures 8 and 9, page 29, show flowsheet reports of a patient's vital signs. If variations in vitals from baseline are detected or concerns are raised on questionnaire responses, patients are then contacted by APPs to be triaged and offered care recommendations. All data are permanently stored in the patient's records. If an intervention is required because of triggered escalations by a patient's results, APPs respond and document their responses and treatment recommendations via an Epic smart phrase (Figures 10a and 10b, page 29).

The length of enrollment in this program varies by patient and regimen, but Chemotherapy Care Companion generally concludes when the clinician documents an end-of-treatment date under the patient's treatment plan (Figure 11, page 30). Patients can also opt out of Chemotherapy Care Companion at any time.

Figure 5. Examples of Patient Responses



Patient Entered Data

Last 6 months

Blood Pressure
135 · 77
mmHg · Latest (1/28/2022) · 169 data days

Pulse
73
Latest (1/28/2022) · 169 data days

Weight
130.4
kg · Latest (1/28/2022) · 163 data days

Body Temperature
97
deg F · Latest (1/28/2022) · 169 data days

Patient To Do List Preview

This list reflects what the patient sees on a mobile device in Patient Portal.

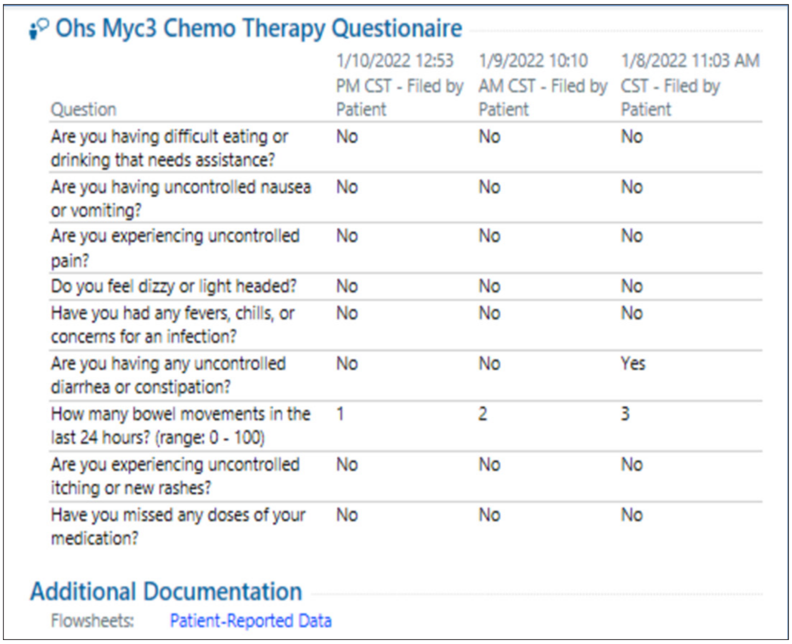
Today's Tasks

	Due
○ AM Blood Pressure & Heartrate Please take your AM BP & Heartrate	09:00 AM
○ Temperature Please take your temperature readings	09:00 AM
○ Daily Questionnaire Please answer these questions from your provider.	09:00 AM
○ Weight Please enter your daily weight.	09:00 AM
○ PM Blood Pressure & Heartrate Please take your PM BP reading & heartrate	03:00 PM

Overdue Tasks (0)

Future Tasks

Figure 6. Chemotherapy Questionnaire



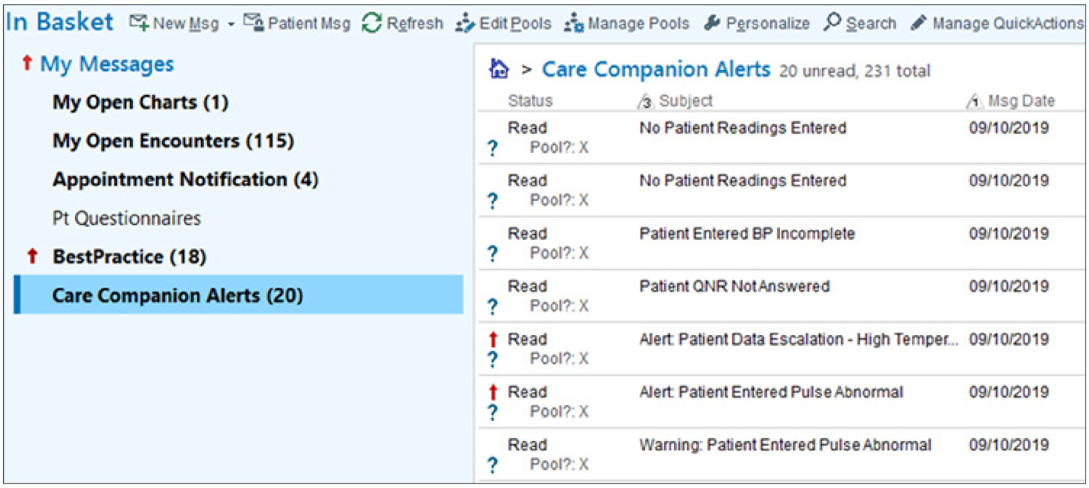
Ohs Myc3 Chemo Therapy Questionaire

Question	1/10/2022 12:53 PM CST - Filed by Patient	1/9/2022 10:10 AM CST - Filed by Patient	1/8/2022 11:03 AM CST - Filed by Patient
Are you having difficult eating or drinking that needs assistance?	No	No	No
Are you having uncontrolled nausea or vomiting?	No	No	No
Are you experiencing uncontrolled pain?	No	No	No
Do you feel dizzy or light headed?	No	No	No
Have you had any fevers, chills, or concerns for an infection?	No	No	No
Are you having any uncontrolled diarrhea or constipation?	No	No	Yes
How many bowel movements in the last 24 hours? (range: 0 - 100)	1	2	3
Are you experiencing uncontrolled itching or new rashes?	No	No	No
Have you missed any doses of your medication?	No	No	No

Additional Documentation

Flowsheets: Patient-Reported Data

Figure 7. EHR In-Basket Message



My Messages
- My Open Charts (1)
- My Open Encounters (115)
- Appointment Notification (4)
- Pt Questionnaires
- BestPractice (18)
- Care Companion Alerts (20)

Care Companion Alerts 20 unread, 231 total

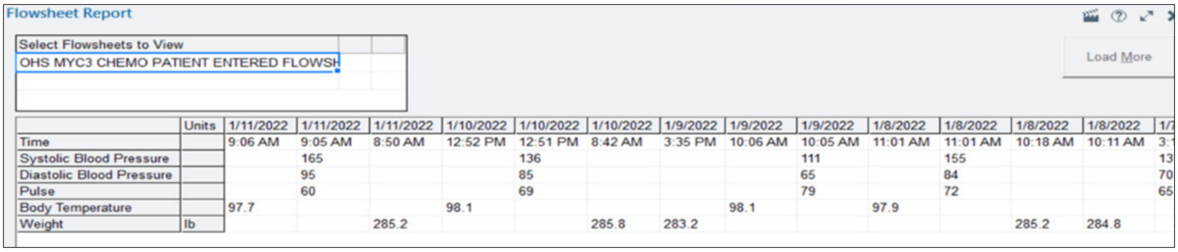
Status	Subject	Msg Date
Read Pool?: X	No Patient Readings Entered	09/10/2019
Read Pool?: X	No Patient Readings Entered	09/10/2019
Read Pool?: X	Patient Entered BP Incomplete	09/10/2019
Read Pool?: X	Patient QNR Not Answered	09/10/2019
Read Pool?: X	Alert: Patient Data Escalation - High Temper...	09/10/2019
Read Pool?: X	Alert: Patient Entered Pulse Abnormal	09/10/2019
Read Pool?: X	Warning: Patient Entered Pulse Abnormal	09/10/2019

Additional System Support: Urgent Care

In 2018, prior to the development of Chemotherapy Care Companion, Ochsner Health's Department of Hematology/Oncology embedded an urgent care clinic within the cancer center. The goal of this specialized clinic is to improve the quality of cancer care by increasing patient access to specialized providers and reducing the burden of ED visits. This clinic proved to be a major support to the success of Chemotherapy Care Companion because it facilitates same- or next-day patient access to the clinic when alerts trigger a need for the patient to be seen by a provider. All APPs at the urgent care clinic have two one-hour slots that are blocked daily on their schedule to accommodate any patients needing to be triaged, including those who need to be seen within 24 hours for assessment and intervention, either in person or on the virtual platform. Patients also have access to the infusion room for intravenous fluids, pain management, antiemetics, and antibiotics.

(continued on page 30)

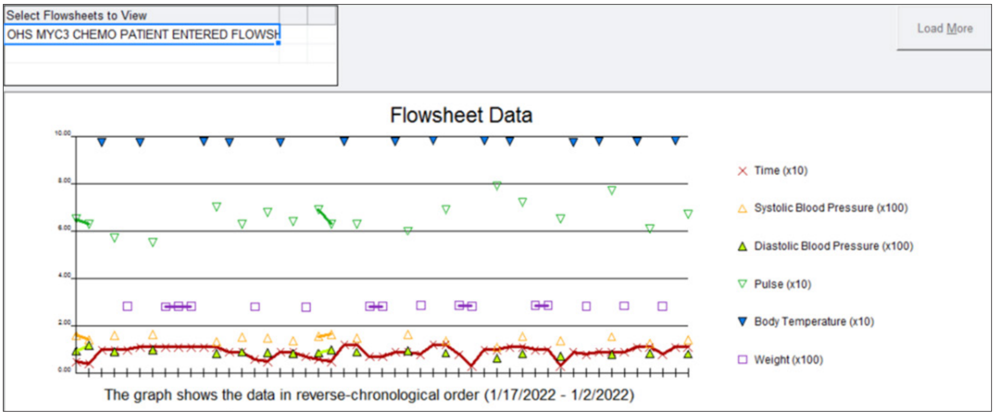
Figure 8. Flowsheet Report of Vital Signs



Select Flowsheets to View
OHS MYC3 CHEMO PATIENT ENTERED FLOWSH

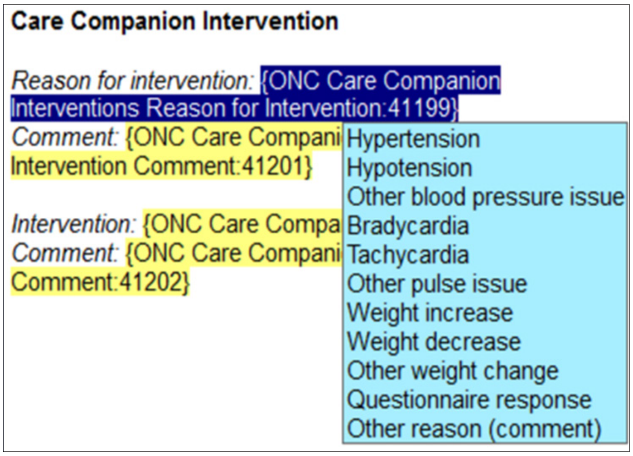
	Units	1/11/2022	1/11/2022	1/11/2022	1/10/2022	1/10/2022	1/10/2022	1/9/2022	1/9/2022	1/9/2022	1/8/2022	1/8/2022	1/8/2022	1/8/2022	1/
Time		9:06 AM	9:05 AM	8:50 AM	12:52 PM	12:51 PM	8:42 AM	3:35 PM	10:06 AM	10:05 AM	11:01 AM	11:01 AM	10:18 AM	10:11 AM	3:
Systolic Blood Pressure			165			136				111		155			13
Diastolic Blood Pressure			95			85				65		84			70
Pulse			60			69				79		72			65
Body Temperature		97.7			98.1				98.1		97.9				
Weight	lb			285.2			285.8	283.2					285.2	284.8	

Figure 9. Flowsheet Report of Vital Signs 2



The graph shows the data in reverse-chronological order (1/17/2022 - 1/2/2022)

Figure 10a. Epic Smart Phrase Documentation

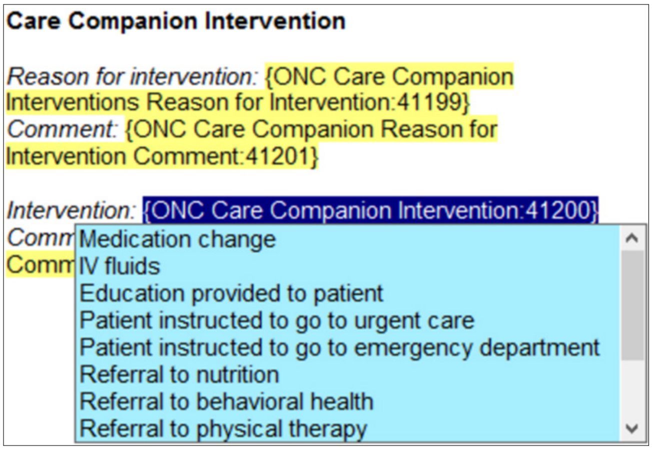


Care Companion Intervention

Reason for intervention: {ONC Care Companion Interventions Reason for Intervention:41199}
Comment: {ONC Care Compani
Intervention Comment:41201}

Intervention: {ONC Care Compa
Comment: {ONC Care Compani
Comment:41202}

10b. Epic Smart Phrase Documentation



Care Companion Intervention

Reason for intervention: {ONC Care Companion Interventions Reason for Intervention:41199}
Comment: {ONC Care Companion Reason for Intervention Comment:41201}

Intervention: {ONC Care Companion Intervention:41200}
Comm
Comm

(continued from page 28)

Epic Information Technology

Ochsner Health's Epic information technology (IT) team was invaluable in providing program support and design enhancements throughout the development of Chemotherapy Care Companion. As mentioned above, in the two years since the program went live, Ochsner Health expanded the use of Chemotherapy Care Companion from the Gayle and Tom Benson Cancer Center to all regional cancer centers and most oncology clinic and infusion sites through local O Bar sites within the Ochsner Health system. Each site provides onboarding support, device distribution locations, and patient navigation workflows. Each site also developed their own, local APP monitoring pools and provided training and education to all providers and clinical staff.

Moreso, Chemotherapy Care Companion has expanded beyond just patients being treated by medical oncology to include those in the bone marrow transplant program, patients with acute inpatient leukemia who are on discharge, and those being seen by palliative care, gynecologic oncology, and the cardio-oncology program.

Ochsner Health created a monthly enhancement committee with its IT/Epic partners to discuss and design program updates and create an operational alliance across all Ochsner Health sites. The many successes of this committee included the development of an interactive patient storyboard as a response to patient feedback, allowing for reminders so patients enter data, and the ability for patients to engage with providers more actively while in the program.

Preliminary Results and Outcomes

To date, Chemotherapy Care Companion has been funded entirely through philanthropy dollars, with all patients receiving free monitoring devices when participating in the program. The future goal is to advocate for insurance coverage for this program based on successful results.

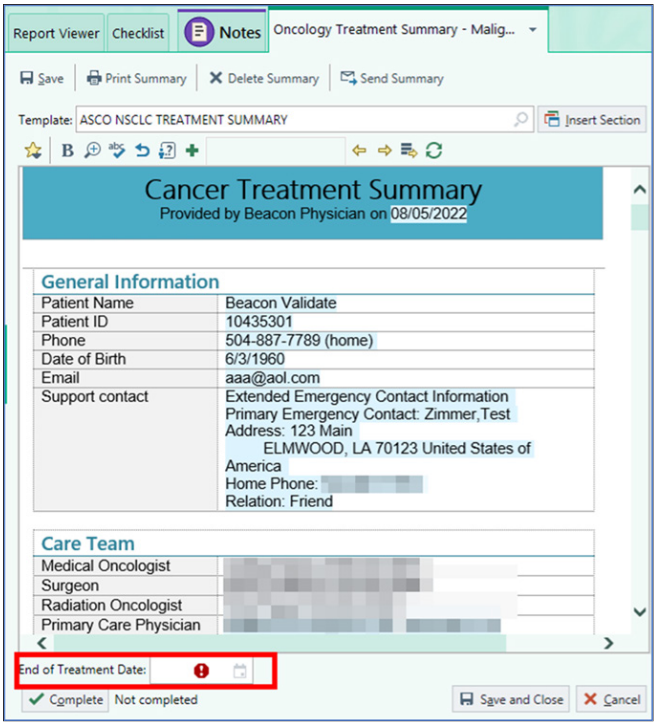
As of October 31, 2022, Ochsner Health enrolled more than 500 patients in Chemotherapy Care Companion. Patients ranged in age from 23 years to 86 years and represented all cancer stages, with 50 percent being Stage 4 diagnoses (Figures 12, right, and 13, page 31).

Ochsner Health began tracking interventions in August 2021, and more than 130 patient interventions occurred in 2022. Chemotherapy Care Companion had a 70 percent compliance rate, which is defined as successful completion of at least 50 percent of daily tasks by patients. Preliminary data show a 33 percent reduction in ED visits, from 4.9 ED visits for non-enrolled patients to 3.3 ED visits for patients enrolled in Chemotherapy Care Companion.

Patient Satisfaction

In August 2022, all actively enrolled Chemotherapy Care Companion patients received a nine-question survey. Ochsner Health received 131 responses, with the following results:

Figure 11. End of Treatment Summary



Template: ASCO NSCLC TREATMENT SUMMARY

Cancer Treatment Summary

Provided by Beacon Physician on 08/05/2022

General Information

Patient Name	Beacon Validate
Patient ID	10435301
Phone	504-887-7789 (home)
Date of Birth	6/3/1960
Email	aaa@aol.com
Support contact	Extended Emergency Contact Information Primary Emergency Contact: Zimmer,Test Address: 123 Main ELMWOOD, LA 70123 United States of America Home Phone: [redacted] Relation: Friend

Care Team

Medical Oncologist	[redacted]
Surgeon	[redacted]
Radiation Oncologist	[redacted]
Primary Care Physician	[redacted]

End of Treatment Date:

Not completed

Figure 12. Participation in Chemotherapy Care Companion by Disease Stage

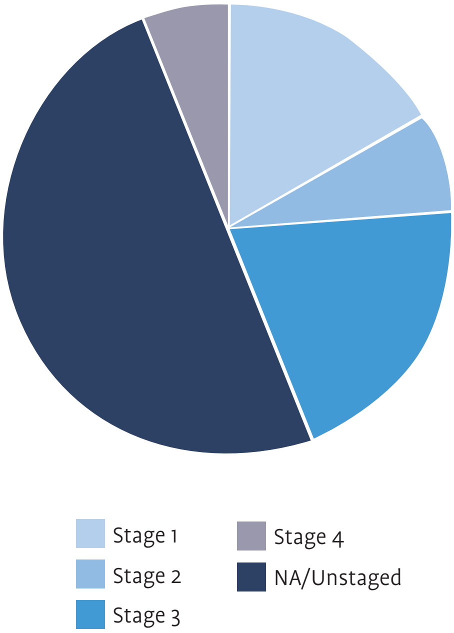
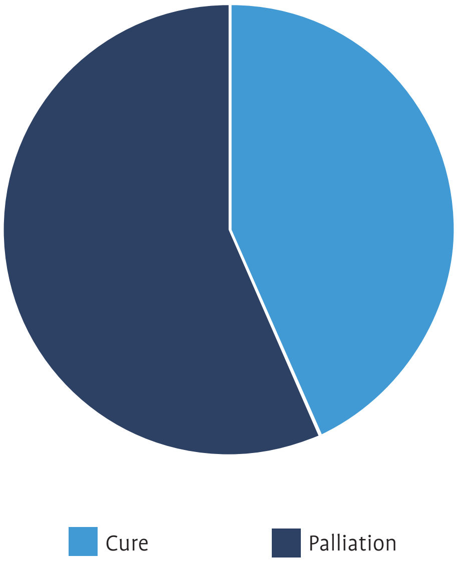


Figure 13. Participation in Chemotherapy Care Companion by Curative vs. Palliative Intent



- 90 percent of patients are "very satisfied" or "satisfied" with Chemotherapy Care Companion overall
- More than 90 percent of patients would recommend Chemotherapy Care Companion to a friend or colleague
- Nearly 90 percent of patients are "very satisfied" or "satisfied" in their understanding of why they were enrolled in Chemotherapy Care Companion
- 90 percent of patients think Chemotherapy Care Companion's instructions are clear and easy to understand
- 70 percent of patients are "very satisfied" and 20 percent are "satisfied" with the O Bar help
- 85 percent of patients are "very satisfied" or "satisfied" with the ease of the daily questionnaires and submission of vitals
- More than 80 percent of patients state that Chemotherapy Care Companion gives them a sense of security and well-being when knowing they are actively being monitored
- 85 percent of patients are "very satisfied" or "satisfied" with booking an appointment when they need to be seen.

Looking Ahead

Ochsner Health is now looking to incorporate additional devices, including wearable options, to allow for additional patient support and data metrics. The success of Chemotherapy Care Companion has furthered Ochsner Health's commitment to offering home monitoring to all patients on active treatment regimens, and Ochsner Health has been fortunate to have philanthropic support to meet these needs. Moving forward, it is hoped that data results will support insurance coverage of these devices based on cost savings through earlier interventions. Ochsner Health also plans to continue to develop unique patient-specific educational resources and questionnaires based on individual diagnoses and treatment plans. With grant support, Ochsner Health is initiating a pilot to support patients with sickle cell anemia through the digital monitoring platform, improving support to another vulnerable patient population. OI

Zoe L. Larned, MD, is system chair, Hematology Oncology, and Erin Pierce, MSN, APRN, FNP-C, is manager of the Precision Cancer Therapeutics Program, Ochsner Health System in Louisiana.

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An Interprofessional EHR Collaboration Optimizes Oncology Navigation Efficiency and Value

BY LAURI LEDBETER, MSN, RN, NPD-BC, CNE, OCN;
WHITNEY DAWS; LINDSAY SHIMIZU;
AND REBEKAH HART

In Brief
Identifying a lack of integrated tools to support oncology navigators, an interprofessional, multi-state collaborative team optimized navigation efficiency and value using the health system's electronic health record (EHR).

Since the development of the first patient navigation program in 1990, oncology navigation has evolved;[1] the Commission on Cancer (CoC) updated its standards in 2016[2] to include patient navigation as a means to address barriers to cancer care, with a more recent focus on supporting care coordination, the patient experience, and care value.[3] Navigators, including oncology registered nurses, social workers, and unlicensed (or lay) patient navigators, have nationally recognized competencies in:[4–6]

- Care coordination
- Communication
- Advocacy
- Psychosocial support
- Evidence-based practice
- Quality improvement
- Interdisciplinary and inter-organizational collaboration
- Assessment, education, and intervention
- Metrics and outcomes tracking and monitoring.

For nearly 20 years, the National Academy of Medicine (formerly the Institute of Medicine) has advocated for all healthcare professionals to work in interprofessional teams, apply quality improvement and evidence-based practice, provide patient-centered care, and utilize informatics to improve care outcomes.[7] Interprofessional collaboration among healthcare professionals and informaticists, who are skilled in leading the design, development, and application of data collection tools, creates synergy to improve care.[8]

Materials and Methods

Recognizing a gap in oncology navigation tools within the EHR, an informaticist at Providence Health & Services—a large health system across seven states in the United States—submitted a project request in February 2020, followed by a system leader competitive vetting process in November 2020, resource allocation in January 2021, and a plan set for February 2021. This plan called for the formation of an interprofessional team to develop and implement an EHR suite of tools to support navigation efficiency, transparency, productivity, and care value.

In February and March 2021, identified stakeholders, including nurse navigators, social workers, leaders, and informaticists, collaborated virtually in discovery sessions and found significant variations in roles and processes when it came to oncology navigation, as well as a lack of formal navigation governance structures across Providence Health & Services. Stakeholders voiced consistent challenges (Table 1, page 34), including:

- Documentation inefficiency and duplication within and outside the EHR
- Gaps in identifying newly diagnosed patients
- Inefficiency in tracking patients for follow-up needs
- Inefficiency in locating oncology-related staging information.

To help prioritize interventions and resource allocation to optimize care coordination, patient and staff satisfaction, and health outcomes, the interprofessional team identified a need for data visualization in the form of a one-stop-shop dashboard. Team

Table 1. Identified Navigation Needs within the EHR

DOCUMENTATION
Discrete navigation-related fields
Patient-based workspace for health overview, results, and documentation
Navigation-related documentation and assessments for accreditation capture
PATIENT IDENTIFICATION
Newly diagnosed
Newly referred
PATIENT TRACKING
Next outreach/tasks
Disease-specific navigation
Acuity-guided navigation
Urgency-guided navigation
ORGANIZATION OF NAVIGATION WORK
Dashboard to aggregate patients and plan daily work
Communication and coverage by navigation teams
Consistent care team-based workflow

EHR = electronic health record

members believed this dashboard could be developed using a suite of tools available in the EHR. This process improvement effort would not only transform navigation efficiency, but it would also support CoC accreditation efforts and (potentially) improve care outcomes.

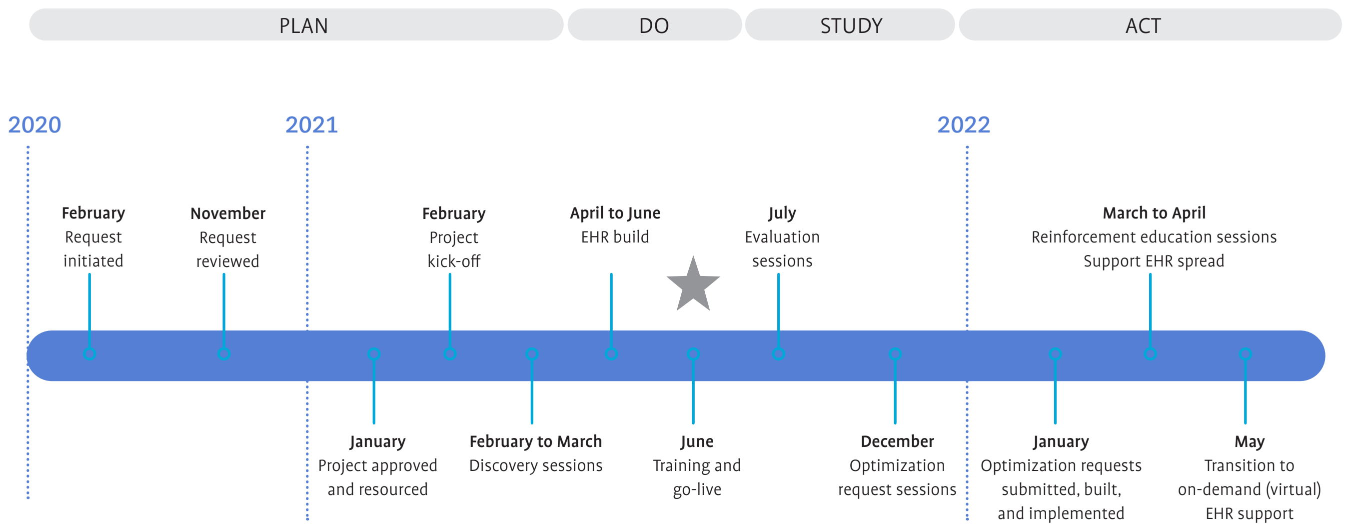
Accordingly, in April through June 2021, analysts facilitated a system-wide build across key EHR applications. This build was followed by virtual collaborative learning sessions to educate stakeholders about the new EHR tools, provide handouts, and encourage independent practice in a virtual learning environment. Super-users and informaticists supported the implementation of these new EHR tools.

In July 2021, the interprofessional team reviewed feedback and evaluations from these virtual sessions, leading to a number of improvements. Ad-hoc governance sessions held in early December 2021 shaped further optimization changes. In March 2022, the interprofessional team held focused, virtual reinforcement teaching sessions, followed by a report-focused virtual teaching session in April 2022 to support user confidence and enhanced use of these tools. In May 2022, the interprofessional team transitioned user support to a virtual, on-demand clinical informatics team for sustainability. Figure 1, below, outlines the timeline of this process improvement effort.

Results

Based on the plan-do-study-act quality improvement model, this interprofessional approach to developing and implementing a new suite of EHR tools to support oncology navigation was successful in several areas. Nearly 60 percent of the health system's navigators are now using the tools, representing 6 states of 7 total

Figure 1. Project Timeline



EHR = electronic health record

states covered by the health system, and identifying approximately 900 patients monthly for navigation services. Navigators using these tools report greater efficiency in key areas (Table 2, below), including:

- Identifying and tracking patients
- Documenting provided care, acuity, and education in discrete data fields
- Responding to high distress screening scores
- Measuring allocation of navigation time and resources by disease type
- Communicating with patients electronically.

The enhanced EHR optimizes the interprofessional care team's ability to locate navigation documentation, communicate electronically, and refer to navigation services, therefore, supporting care coordination and value. Navigators also report less use of non-EHR calendars and spreadsheets for patient and data tracking, reducing inefficiencies and the risk of privacy breaches.

Dashboard and report capabilities with task lists, patient-specific oncology overview indices, productivity, and more (Table 3, below) support efficiency and transparency in metrics to direct navigation resources to best serve patients in optimizing care outcomes. There is additional navigator interest in learning how to better use these reports. One unanticipated benefit of the interprofessional project is the desire for regular and strengthened collaboration among regional teams of navigators, as well as between system informaticists and navigators.

Discussion

Interprofessional collaboration and subsequent EHR transformation have positively improved teamwork within the Providence Health & Services health system; increased the efficiency of navigation services; and enhanced data analytic functionality to prioritize services and improve patient outcomes and care value. Other lessons learned include:

- Additional outreach and training are needed at locations where navigators are not yet using the tools.
- While data analytic and reporting functions are available, they are under-utilized, which is reflective of navigators' want for additional knowledge and training on how to best use these reports.

Table 2. New Navigation Documentation Features
Assigned navigator
Disease type
Treatment stage
Referral source
Date(s) of care (e.g., oncology consult, chemotherapy start)
Date(s) of tumor board presentation
Patient messaging
Barriers identified and resources offered
Referrals made for services
Education provided
Acuity
Time spent navigating
Visit type (telephone, in-person, location of services)
Care team identification

Table 3. Sample EHR Dashboard, Reports, and Data Analytic Features
Assigned task list reminders by due date
Active navigation patients by navigator(s) or department
Incomplete task list reminders for more than one navigator
Navigation enrollment and disenrollment
Productivity
Distress screening and barriers
Recent and upcoming oncology new patient visits
Recent admissions, discharges, and demises
Recent emergency department visits
Upcoming/recent appointments
Timeline-to-treatment initiation
Patient-specific oncology overview index

EHR = electronic health record

- Additional promotion, training, and ongoing development of EHR features are needed to support more robust uptake of the tools and should help with CoC reporting requirements, as well as capturing navigator-influenced patient and return-on-investment outcome metrics, such as no-show rates, diagnostic workup, time-to-treatment efficiency, referrals for cancer prevention, emergency department utilization, and patient retention within the health system.
- Value-based care payment models, like the Enhancing Oncology Model that is going into effect on July 1, 2023,[9] require patient navigation services, and an optimized EHR can be instrumental in understanding a cancer program or practice's weaknesses, reducing emergency department visits and hospital admissions, identifying and addressing health-related social needs, leaning into health equity, and improving patient care.

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ASSOCIATION OF
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ACCC'S CALL TO ACTION: DELIVERY OF PSYCHOSOCIAL CARE IN ONCOLOGY SUMMIT

EXECUTIVE SUMMARY

Program Background

The burden of cancer is far greater than the diagnosis of a single tumor. When patients receive a cancer diagnosis, every facet of their life—physical, mental, emotional, social, financial—is impacted and without appropriate psychosocial support, that burden can be extremely heavy. While psychosocial distress screening is mandated in cancer programs by the American College of Surgeons Commission on Cancer,[1] service delivery models vary and are largely dependent on the availability of staffing and funding. Furthermore, in the post-COVID-19 healthcare landscape, the need for psychosocial care in oncology has transcended the needs of patients and their families, as supportive care to address emotional distress and burnout is urgently needed for cancer care professionals.

To explore the current state of oncology supportive care, the Association of Community Cancer Centers (ACCC)—with its partners, the Association of Oncology Social Work (AOSW), the American Psychosocial Oncology Society (APOS) and with support from BeiGene—held a multistakeholder meeting, *A Call to Action: Delivery of Psychosocial Care in Oncology Summit*, on March 8, 2023, in Washington, DC. Invitations were extended to key leadership representatives of advocacy organizations, academic medical centers, and community care programs. Its aim was to develop priorities and actions to address barriers to access and delivery of psychosocial care in oncology.

Summit goals included:

- Providing a forum for healthcare leaders, cancer care team members, and patient advocates to discuss the current state of mental health in oncology
- Building a collaborative dialogue amongst interested stakeholders to identify action plans that address ongoing mental health issues for patients, caregivers, and cancer care professionals
- Identifying effective screening tools, training, resources, and policies to address psychological distress in patients, caregivers, and cancer care professionals
- Identifying barriers to providing and accessing timely and appropriate care for patients and caregivers experiencing psychological distress
- Promoting strategies to foster resilience and a healthcare culture that mitigates burnout among all members of the cancer care team.

The following executive summary highlights findings from the summit and will guide post-summit action planning efforts and the creation of enduring deliverables to support improvements to the psychosocial care in oncology landscape.

About Psychosocial Care in Oncology

A cancer diagnosis is undeniably stressful. Patients experience fear, uncertainty, anger, sadness, and despair, and while many will recover, approximately 25 percent of survivors will have continued issues, such as anxiety, depression, and other psychological and social (psychosocial) stressors.[2] Moreover, in a 2022 survey conducted by Cancer Support Community as part of its Cancer Experience Registry, a research study that evaluated 600 cancer patients and survivors who self-identified as having experienced emotional or mental health concerns, 60 percent of respondents were not referred to a mental health professional by their cancer care team.[3] Untreated psychosocial distress can contribute to poorer treatment outcomes and a worsening of comorbidities, as well as lead to higher healthcare costs.

With the onset of the COVID-19 pandemic, existing psychosocial services became overburdened by the emotional and occupational distress experienced by providers caring for patients with cancer and helping patients and families make difficult treatment choices. During the height of the pandemic in 2021, 60 to 75 percent of clinicians reported symptoms of exhaustion, depression, sleep disorders, and post-traumatic stress disorder, and approximately 20 percent of healthcare workers quit, resulting in staffing shortages nationwide.[4] Existing disparities in access to services for underserved populations also worsened during this period.

In 2019, ACCC surveyed its membership to assess the level of burnout across multidisciplinary cancer care teams utilizing the American Medical Association's clinically validated Mini Z survey; the results revealed high levels of dissatisfaction and occupational stress—pre-COVID. ACCC repeated this survey in 2022; physicians, advanced practice providers, and nurses were found to be the disciplines most at-risk. Today, cancer care providers across the multidisciplinary spectrum continue to experience record high levels of burnout, due to increasingly complex treatment options, a rapidly increasing aging population, growing financial toxicity, and an overstrained healthcare system. Social workers, who have been on the front lines of the public and mental health crisis during and post-COVID-19, continue to suffer as they struggle to support patients with job losses, housing issues, food insecurities, and other critical challenges.

Psychosocial care can be instrumental in alleviating the burden of stress not only for patients, but for the care teams that play a critical role supporting patients and their families. Psychosocial care focuses on the whole-person in addressing any social, psychological, emotional, spiritual, and functional aspects of care.[5] By identifying and promoting effective distress screening tools and resources, as well as developing strategies that promote a healthcare culture of resilience, patients, caregivers, and cancer care teams can be better prepared to face the daily challenges of cancer.

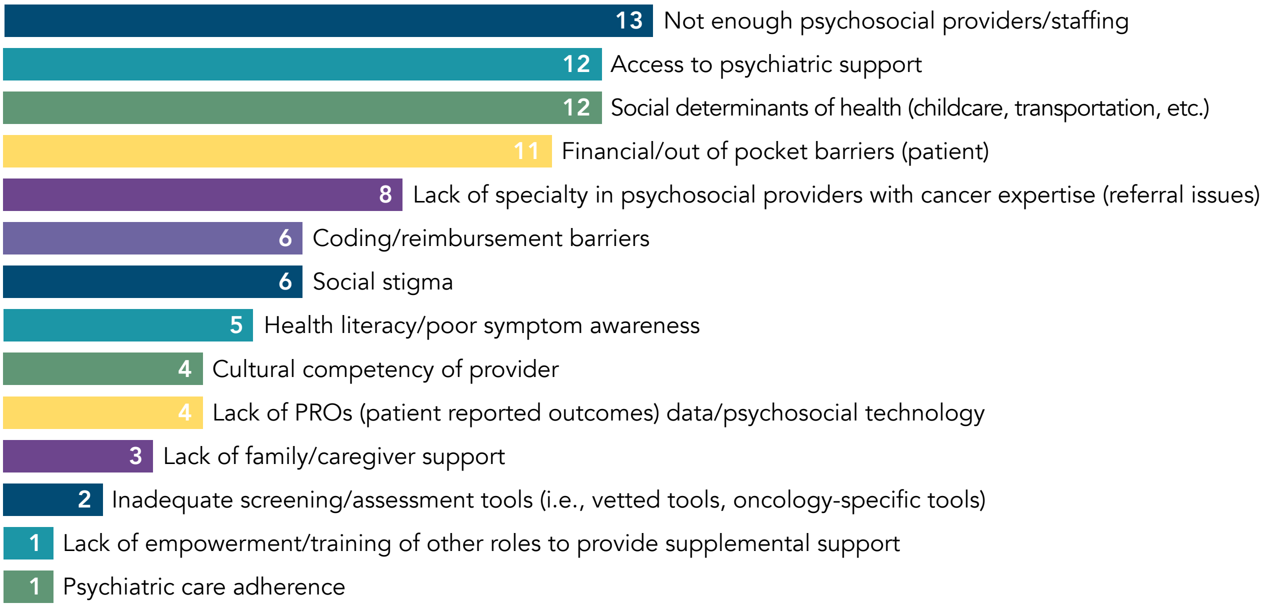
Pre-Summit Survey

Summit participants were asked to complete a brief, pre-summit survey to provide a snapshot of the current challenges and barriers to access and delivery of psychosocial care in oncology. All participants responded to the survey (n=18). The survey explored what practices/service models have been effective, and asked respondents to identify and rank the top barriers to accessing support. Participants were also asked to consider and share feedback on what organizations, such as ACCC, AOSW, and APOS could do to advance diversity, equity, inclusion, and access in psychosocial care.

Roles represented included licensed clinical social workers (LCSWs), licensed independent clinical social workers (LICSWs), clinical psychologists, board of oncology certified social workers, nurses, advanced practice providers (APPs), and one physician.

Figure 1. Pre-Summit Survey: Top Barriers to Access and Delivery of Psychosocial Care (n=18)

(Participants selected their top 5 barriers.)



Other barriers included: *poor utilization of screening tools, hierarchy of need (they present with other significant needs that their psychological distress is not often high on the scale and cannot be addressed until the others are), and poor screening adherence.*

Of the participants, the majority (72 percent) identified the lack of psychosocial providers/staffing as the most critical barrier to care. Social determinants of health (e.g., childcare, transportation, internet access), access to psychiatric support, and financial and out-of-pocket barriers were also identified by participants (approximately 60 percent) as major hurdles, among numerous other barriers (see Figure 1).

Strategies That Work

Raising awareness about psychosocial services, incorporating community health workers, and utilizing technology were among the strategies and service models that participants were most proud of. In one cancer program, oncology psychology services are introduced during meet and greet sessions with physician and clinical team members during their onboarding week. Another cancer program raises awareness among oncology providers about clinical social work training and skills set, which has enabled LCSWs to practice at the top of their license.

Utilizing telehealth, one cancer program has been successfully conducting telehealth therapy groups for the last three years. Some cancer programs have integrated distress screening within their electronic health record (EHR) systems and others utilize private messaging through the EHR to communicate and consult on patients' needs.

Another important strategy to expand access has been collaboration with community health workers. Several cancer programs are incorporating community health workers to address the need for adequate staffing, which has proven helpful, and in one program, has even served to increase the diversity of its team.

Key Challenges

The obstacles and barriers current cancer programs face are numerous. Funding and under-staffing topped the list, as nearly all participants highlighted challenges surrounding adequate financial and leadership support to ensure psychosocial programs are equipped with the necessary staff and funds needed for operations. As a result, LCSWs are often asked to take on additional roles and functions that limit their ability to work at the top of their license and contribute to role strain and burnout. Logistics around distress screening is also compounded by these challenges, as screening workflows are difficult to maintain due to frequent staff turnover and space limitations.

Lack of understanding and awareness of the scope and functions of psychosocial services among hospital administration was also reported as a key barrier. Often seen as extensions of outpatient behavioral therapy, psychotherapists, and/or care managers have presented challenges related to clinical expectations and billing and/or reimbursement issues.

The pre-summit survey also explored the greater challenge of advancing diversity, equity, inclusion, and access in psychosocial care, which was later identified as one of the key priorities for discussion during the summit. **Opportunities and suggestions shared by survey participants were numerous, and included:**

- Forging partnerships with communities and advisory groups to target outreach programming for communities
- Identifying funding to support specialty training and creating scholarships for Black, Indigenous, and People of Color (BIPOC)/people from diverse backgrounds to pursue the field of oncology
- Increasing advocacy, public policy work, and changing the national conversation around psychosocial care, cultural humility, and other diversity, equity, and inclusion topics
- Integrating cultural humility and competence in patient care and interdisciplinary team communication and collaboration
- Acknowledging the ways (direct and indirect) that structural racism, implicit bias, and other inequities continue to impact care
- Increasing equity, diversity, and inclusion training for providers, integrating cultural humility and competence in patient care, increasing diversity of staff, and advocating for diverse and inclusive leadership
- Advocating for healthcare payment models that include psychosocial care and clinical social work
- Supporting research dedicated to assessing social determinants of health, as well as evidenced-based interventions appropriate for minority groups.

Summit Highlights

The summit included a a general session, two 30-minute breakout sessions, and a call-to-action wrap-up. The framework was designed to utilize experts to develop priorities and potential actions while onsite, then use these recommendations as a catalyst for a greater, national discussion over the coming months. Prior to the summit, participants were provided with a series of pre-read materials and resources (see box on last page) to supplement the discussion. A visual recorder was also provided onsite to capture the ideas and strategies voiced during the summit.

To open the dialogue, participants were asked to share their vision for psychosocial care in a perfect world. Overarching themes that emerged were a call to change the national conversation around psychosocial care and to build awareness among providers, hospital leadership, and administrators on what psychosocial care means and the impact it can make when fully funded and integrated. There was also a resounding call for increased diversity, equity, and inclusion in psychosocial care staffing, as well as ensuring greater access to care for underserved populations.

Eucharia Borden, MSW, LCSW, OSW-C, FAOSW, and vice president of Programs and Health Equity at Family Reach, stated, **"It's time to change the national conversation. We need a movement—it should not take a tragedy to get action."**

Kauser Ahmed, PhD, and director of Psychosocial Care at the University of California Los Angeles-Simms Mann Center added, **"In my ideal world, administrators would recognize psychosocial care as necessary and valued in the same way physicians and nurses are viewed, moving [psychosocial care] out of the realm of charity and into necessity."**

Following a high-level discussion of the current state of care, participants were divided into four groups to explore the following barriers (selected as key priorities based on survey results) during the first breakout session:

- Social determinants of health (e.g., transportation, childcare, internet access)
- Financial barriers and/or out of pocket expenses for patients
- Lack of psycho-oncology specialists
- Cultural competency; diversity, equity, inclusion, and access.

Groups were instructed to brainstorm and develop actionable solutions related to their designated barrier and rate these solutions in terms of impact and level of difficulty to implement. Groups were then asked to select the top three actionable ideas to share during their report-out to the general session.

Key action ideas that emerged included:

Group 1. Social Determinants of Health

- Partner across organizations to access and/or obtain federal funds (underutilized funds)
- Collaborate on research; influence = policy change
- Ensure all patients have adequate Internet access so that they can receive telemedicine
- Address transportation needs
- Provide psychosocial support that is proactive vs. reactive (for example, distress screening catches issues reactively)
- Share best practices across multiple platforms, like webinars and podcasts
- Standardize licensure to have reciprocity across the U.S.
- Work with standard setting organizations to improve equity and access; lobby Medicare.

Group 2. Financial Barriers

- Provide more cost transparency to patients; track and address indirect costs
- Engage policymakers to address inconsistent insurance coverage from state to state and lack of knowledge on how other states are handling coverage
- Measure health-related outcomes; high impact but difficult to find quantitative measurements for qualitative metrics.

Group 3. Lack of Psycho-Oncology Specialists

- Advocate for national supervision hours
- Develop additional training opportunities
- Create short-term national programs

- Launch a marketing campaign to educate people about these professions
- Institute a national licensure, rather than a state licensure, to allow professionals to work across state lines.

Group 4. Cultural Competency, Diversity, Equity, Inclusion, and Access

- Build advocacy/policy training and methods/skills training into the curriculum across disciplines (R25 Sim Lab could be a pathway)
- Utilize professional societies and accrediting bodies to support/influence changes to the curriculum
- Train early and often—take a proactive approach, rather than reacting when psychosocial practitioners are already in the role
- Change the national conversation through macro efforts like Cancer Moonshot and the state of education across various professions
- Develop a structure to hold organizations and providers accountable for diversity, equity, and inclusion in the workplace.

During the second breakout session, participants were divided into three action groups:

- Screening tools (e.g., use of technology, telemedicine, PROs)
- Delivery models, reimbursement, and billing and coding
- Provider and healthcare team burnout.

Groups used this breakout session to develop actionable ideas related to the question, "What could our associations produce that would address [the designated barrier] that would have an impact on institutions, policies, or providers?" Again, groups were instructed to rate actionable ideas in terms of impact and level of difficulty to implement. Groups were then asked to select the top three action ideas to share during their report-out to the general session.

Key themes that emerged included:

Group 1. Screening Tools

- Create screening goals: organizations can work together to do research on why, when, how, and where screening should be done
- Further develop standards for policies and procedures for screenings
- Develop guidelines for responding to screenings.

Group 2. Delivery Models

- Unify organizations to promote collaborative care and integrated behavioral health models
- Conduct training to help providers be more engaged in psychosocial care
- Create a playbook with education around billing codes for psychosocial staff so that administrators have more transparency on costs and financial implications of psychosocial care.

Group 3: Provider and Healthcare Team Burnout

- Develop clearinghouse of best practices to reduce burnout
- Evaluate and adjust staffing to meet current needs; end practice of pulling staff to support teams, roles, and/or tasks outside of scope
- Educate administrators to develop national standard on culture of care for providers—not just patients
- Advocate self-care for providers (e.g., proposed model one-third individual's responsibility and two-thirds the organization's responsibility to provide time and opportunities to practice self-care)
- Develop leadership ladders for social workers in psychosocial care (i.e., social workers need to be supervised by social workers rather than nurses, administrators, or psychologists)
- Speak shared language around whole person care and delineate roles so patients understand each providers' role in care
- Utilize tumor boards to as an opportunity to develop care plan for the whole patient—not just the tumor

Call to Action

Following the breakout sessions, participants reconvened to view the results of their work: 21 actionable ideas that spanned the top challenges of access and delivery of psychosocial care in oncology. While these ideas will lay the groundwork for future planning of education and advocacy initiatives, as a group, summit participants voted and selected the following top two priorities to develop into an immediate call-to-action: **promote collaborative care and integrative models** and **develop standards for a culture of care.**

Promote Collaborative Care and Integrative Models

Summit participants identified several initial steps that could be taken immediately to create a sense of urgency and bring attention to this need. These included issuing a joint statement by ACCC, AOSW, and APOS calling for a collaborative care model, as well as holding additional workshops and webinars (or partnering in upcoming ACCC/AOSW/APOS conferences) to target oncologists and additional medical associations to raise awareness of this need.

Identified next steps included: defining and developing the model, ensuring that the model considers the needs across all settings (e.g., rural areas, community hospitals caring for underserved populations, etc.); educating organizations and providers about the model; and developing a group of early adopters to implement the model once developed. Participants also discussed creation of an administrator engagement roadmap, recruiting the involvement of other relevant associations (e.g., American Society of Clinical Oncology, Association of Cancer Executives, patient advocacy organizations, and others) or the creation of a new consortium or alliance to guide the initiative.

The impact of the collaborative care model initiative would serve to ensure oncology patients and providers receive the appropriate psychosocial care they need, address current logistical and operational challenges with an effective model, and reduce role strain and staff burnout.

Develop Standards for a Culture of Care

To create an effective action plan for developing standards to create a culture of care and reduce staff burnout, participants agreed on the need to identify current best practices among cancer programs.

Suggested steps included:

- Acknowledging and broadening a greater understanding of toxicities
- Normalizing healthcare professionals seeking mental health care (e.g., virtual fireside chats modeling vulnerability, creating safety in conversations)
- Connecting patient satisfaction to provider well-being
- Including self-advocacy skills in curriculums across all disciplines
- Developing proposed reporting requirements
- Removing current licensure requirements to disclose mental health issues.

Discussions also included the need to involve multiple professional oncology associations, organizations focused on mental health and wellness, and medical schools and universities.

The impact of this initiative would create healthier staff, which in turn would reduce staff burnout and promote staff retention; it would also produce happier patients. This important work would also reduce the stigma associated with mental health in healthcare workers.

Path Forward

This summit marks the start of a movement to create real change in psychosocial care delivery in oncology. To continue the momentum post-summit, ACCC shall disseminate a series of high-level, relevant resources to the ACCC membership and the broader oncology community across multiple platforms with the aim of beginning a national conversation on this important issue. The path forward is clear, and the improvements needed are many; however, with partnerships and collaboration with key stakeholders, the goals and actions outlined in this summary are within reach.

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Pre-Read Resources

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Thank you to our project supporter:

BeiGene

ACCC
Association of Community Cancer Centers

The Association of Community Cancer Centers (ACCC) is the leading education and advocacy organization for the cancer care community. Founded in 1974, ACCC is a powerful network of more than 30,000 multidisciplinary practitioners from over 2,000 hospitals and practices nationwide. As advances in cancer screening and diagnosis, treatment options, and care delivery models continue to evolve—so has ACCC—adapting its resources to meet the changing needs of the entire oncology care team. For more information, visit **accc-cancer.org**. Follow us on social media; read our blog, **ACCCBuzz**; tune in to our **CANCER BUZZ podcast**; and view our **CANCER BUZZ TV channel.**

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An Innovative Approach to Navigating Patients Through Cancer Diagnostics

Precision Medicine Stewards: Applying Precision Principles to Biomarker Testing Processes to Improve Patient Access

Precision medicine is all about the details. It is stepping away from a one-size-fits-all approach for cancer diagnostics and when implemented correctly, ensures each patient has access to the most appropriate biomarker testing and associated treatment options. Therefore, it is only natural that with the transition to more complex testing, cancer programs can benefit from customizing their staff as well, by designating a precision medicine expert to navigate the labyrinth of biomarker testing processes and results.

With a marked increase in recommendation for somatic genomic testing for patients with metastatic or advanced cancer[1] and an increase in U.S. Food and Drug Administration (FDA) approval of biomarker-directed therapies and clinical trials in recent years,[2] cancer programs have been exploring new ways to meet the demands of guideline-concordant biomarker testing. Precision medicine stewards—defined as a member of the multidisciplinary team who is focused exclusively on biomarker test ordering, biopsy samples, coordination of logistics for tissue transport, and delivery/receipt of results—are gaining momentum as the ideal solution for improved care coordination workflows.

In early 2022, the Association of Community Cancer Centers (ACCC) embarked on a mission to make the case for implementation of precision medicine stewards through education and awareness-building about the unique role and value of these dedicated navigators. ACCC's *Precision Medicine Stewardship* education program, in partnership with the Academy of Oncology Nurse and Patient Navigators (AONN) and the American Society for Clinical Pathology (ASCP), and supported by AstraZeneca and Blueprint Medicines, showcases oncology programs that have successfully integrated these stewards into their respective centers and shares expert insights on this role as an important member of the multidisciplinary oncology team.

In August 2022, as interest continued to grow among providers, ACCC brought together experts from oncology programs nationwide (representative of academic and community-based programs who had successfully implemented any type of precision medicine stewards, as well as those who were considering the addition of one) to participate in a series of three focus groups to examine the mechanics, the advantages, and the feasibility of this undertaking. ACCC shares an inside look at these discussions and paves the way for integrating precision medicine stewards in programs nationwide.

Mechanics of the Role

One of the first issues the focus groups considered was what, exactly, a precision medicine steward could do that would make an immediate impact on care coordination, as well as how the role can be differentiated from existing roles, such as nurse or patient navigators.

Stewards act as the central liaison between oncologists, patients, nursing teams, pathology teams, and external reference laboratories.

Discussions revealed that while essential tasks for the role can vary across cancer programs, stewards share core responsibilities related to testing coordination—from test ordering to results reporting and all tasks in between. Stewards also act as the central liaison between oncologists, patients, nursing teams, pathology teams, and external reference laboratories. Additional responsibilities could be added depending on the specific needs of the cancer program, the clinical background of stewards (e.g., nurse navigator, laboratory professional, etc.), and order volumes.

In cancer programs that have been successful in implementing precision medicine stewards, such as Sanford Health in Sioux Falls, S.D., TriHealth Cancer and Blood Institute in Cincinnati, Ohio, and Astera Cancer Care in East Brunswick, N.J., the role has taken on different models and titles (oncology nurse navigator genomics, precision medicine test coordinator, and molecular processor, respectively) with varying qualification requirements. However, customizing the role, selecting the appropriate individual, and laying the groundwork to ensure that individual would be successful in their role was not without its challenges.

Courtney Rice, MS, LGC, manager of Precision Medicine and Genetics Services at TriHealth Cancer and Blood Institute explained. "Trying to standardize, and finding the right individual, was a challenge—we are a community-based system, so the test coordinator [must] support all specialties and all cancer diagnoses. What is unified about this role…we actually have two [precision medicine testing coordinators] and they job share to cross cover for each other…is that they could help coordinate testing from a colon cancer and then a lung cancer and then a breast cancer, [as long as it was] a molecular order that the physician wanted to place. To help streamline the process, we had our key physician champions in all areas of our Cancer Institute meet and vet different lab vendors so that we could select a preferred lab; that decision really helped standardize the initial process for getting samples sent out and returned, and then we built upon that process with our one-offs for whenever a provider wanted to use a different laboratory. So, getting the clinical staff to agree and standardize some parts of the role and the way this individual would work with the rest of the team was important."

Nearly all successful precision medicine steward models have encompassed the following key responsibilities related to biomarker testing:

- Evaluates insurance coverage (which reference labs are in-network vs. out-of-network); completes necessary prior authorization paperwork; assists eligible patients to complete patient financial assistance applications offered by reference labs
- Enters patient information into the reference lab portal when the order is placed; streamlines and simplifies test ordering process for ordering providers (most often the oncologist)
- Contacts appropriate pathology group (if diagnostic tissue involves external institution) and coordinates logistics for tissue transport and tracking to the reference lab
- Coordinates liquid biopsy orders if ordering concurrent liquid and tissue testing, or if the sample quantity is not sufficient to complete tissue-based testing; tracks both tissue and liquid biopsy test results
- Retrieves the test results from the lab portal; informs the ordering provider of results and/or scans into the EHR.

Depending on the institution and clinical background of the precision medicine steward, other tasks may include:

- Meets with the patient to discuss the clinical importance of biomarker testing and how results can impact treatment planning; engages in shared decision-making conversations
- Works with IT to develop electronic order sets for send-out biomarker tests; creates different order sets for each reference lab
- Works with reference labs and hospital IT to integrate electronic health record (EHR) modules (e.g., the Epic Genomics Module) for test results to be viewed as discrete data fields in the EHR
- Tracks the status of financial assistance applications; contacts patients to gather missing information to minimize assistance decision delay
- Prepares patient case summaries for molecular tumor board discussions
- Identifies potential clinical trials based on test results
- Coordinates with genetic counselors to identify opportunities where both hereditary and somatic testing is needed.

Benefits to Cancer Care Programs

As the road to biomarker testing in real-time has been bumpy for some community cancer programs facing operational challenges with test ordering, insurance approvals, and lengthy turnaround times for results, the concept of a precision medicine steward and its benefits was both highly relevant and welcomed by clinical staff.

Crystal Enstad, MBA, BSN, RN, OCN, Sanford Health's oncology nurse navigator-genomics (Sanford's equivalent of a precision medicine steward) explained. "Connecting with our nurse navigators and clinic nurses, as well as listening to the oncologists themselves, they really needed one point of contact, an efficient workflow, and timely results. The patient needed to be educated on their out-of-pocket expenses, what the testing was for and why, and why we [providers] needed those results. And so, I really set out to be that one-stop-shop."

With the addition of a steward, the test ordering and results processes, which can be complex and time-consuming for oncologists and clinical staff, are streamlined. Administrative tasks, such as entering patient demographics into the reference lab portal, coordinating logistics associated with tissue transport, and tracking test results, can be centralized and managed by the steward, freeing the clinical staff to focus on clinical tasks and direct patient care.

Conversations and administrative processes that may have been previously handled by nurse navigators or genetic counselors, such as pre-authorizations, financial assistance paperwork, and patient education on the importance and role of biomarker testing, can also be moved to precision medicine stewards. Moreover, as significant disparities in NGS (next generation sequencing) testing rates have been observed among Black and White patients with lung, breast, and colorectal cancer,[3] cancer programs that treat underserved populations who face unique challenges around biomarker testing[4] can utilize stewards to help patients overcome barriers to access.

Rice described the positive reception by clinical staff at TriHealth. "Once we spoke to the primary nurses and the oncologists and explained the role, they were so thankful to hand over all the work that was falling to the primary nurses in clinic that was viewed as administrative."

Furthermore, through the power of technology and the addition of this single role, TriHealth's turnaround time from order to results decreased from an average of 24 days to 12 days and the quantity not sufficient (QNS) rate of testing decreased by five percent (unpublished, internal data).

> **Connecting with our nurse navigators and clinic nurses, as well as listening to the oncologists themselves, they really needed one point of contact, an efficient workflow, and timely results. The patient needed to be educated on their out-of-pocket expenses, what the testing was for and why, and why we [providers] needed those results. And so, I really set out to be that one-stop-shop.**

Building Support for Stewards

While the advantages of centralizing tasks with one steward is ostensibly more efficient, focus groups expressed concerns with the potential challenges and financial implications associated with adding more full-time employees (FTEs) to programs that are already stretched thin. As staffing shortages nationwide continue, many cancer programs have become accustomed to utilizing multiple members of the cancer care team to handle various aspects of biomarker testing processes, such as oncology nurses, navigators, or pathology lab assistants. In addition, for cancer programs with lower biomarker test volumes or programs where tissue-testing is performed by in-house pathology teams, the value-added benefits may not be as easily discernable.

Therefore, cancer programs that have been successful in implementing the precision medicine steward model stressed the importance of gaining leadership support at the outset, through establishment of a precision medicine steering committee or similar group. They also emphasized the critical role metrics can play in supporting implementation and sustainability, and gave examples highlighted below.

Other focus group participants, who do not yet have this type of role in their cancer program, shared suggestions on what they believed would help to move precision medicine stewards from idea to implementation.

Pablo Gutman, MD, medical director of Holy Cross Cancer Institute and medical director of Holy Cross's clinical laboratories, brought the perspective of community-based hospitals. "Buy-in from medical oncology is fundamental in developing biomarker testing at the community level. Hospitals are concerned with the costs associated with these types of tests, and medical oncologists are in a unique position to explain and help develop algorithms for efficient and cost-sensitive testing. The hospital pathology department cannot do this on its own."

Participants from academic medical centers shared another perspective. With the push to increase enrollment in clinical trials, particularly from underserved populations, investigators (i.e., medical oncologists) can be instrumental in advocating for biomarker testing. As an efficient system and quick turnaround times are essential to enabling more patients to undergo biomarker testing, which is often an eligibility requirement for clinical trials, precision medicine stewards can streamline workflows and in turn, impact enrollment rates.

Metrics, Metrics, Metrics

Nearly all cancer programs with successful precision medicine stewards in place emphasized the value of developing and tracking key performance metrics for success. Being able to break down data and track biomarker testing statistics to prove efficiencies, identify quality gaps, and opportunities for improvement, is pivotal to building justification, support, and sustainability for the role.

Some of these **key performance metrics** include:

- Time from test ordering to result delivery
- Time from diagnosis to treatment with a targeted therapy
- Percentage of patients (for whom testing is clinically indicated) who receive complete biomarker testing
- Percentage of patients who apply for financial assistance and receive aid
- Percentage of patients who receive a surprise medical bill from a reference lab
- Percentage of patients who receive an insurance denial for testing coverage
- Patient experience scores (e.g., patient satisfaction)
- Patient retention
- Provider satisfaction scores

Enstad described the early days of implementation, before using metrics. "When I first started my role, we had no way to harness or identify who or how many genomic tests we were sending out to anyone…we would describe it as the wild, wild west. Everyone just kind of did their own thing."

> **Buy-in from medical oncology is fundamental in developing biomarker testing at the community level. Hospitals are concerned with the costs associated with these types of tests, and medical oncologists are in a unique position to explain and help develop algorithms for efficient and cost-sensitive testing.**

Once Sanford and other cancer programs with precision medicine stewards began tracking performance metrics that justified the role, highlighting successes, and identifying gaps, the game changed. In fact, Sanford Health has already begun exploring ways to expand this role, evaluating the feasibility of deploying oncology nurse navigator genomics at all Sanford locations or alternatively, centralizing the role and utilizing telehealth to serve multiple locations.

In addition to these metrics, successful cancer programs suggested measuring the frequency (and types) of quality improvement projects that result from biomarker testing data, such as the percentage of eligible patients from underserved populations who receive testing, thereby improving health equity. Another important success metric, measuring the number of patients identified for clinical trials based on biomarker results, would serve to increase patient enrollment in clinical trials.

Final Thoughts

Paving the way for precision medicine stewards is about more than simply adding another FTE to the cancer care program roster. The steward can play an integral role on the multidisciplinary team to streamline and improve operational processes, increase efficiency, reduce turnaround times, and make significant headway towards increasing patient participation in clinical trials and improving health equity. In the rapidly evolving precision medicine landscape with multiple players, the precision medicine steward is the key player who can help drive the game and keep the biomarker ball moving.

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Examining Colorectal and Cervical Cancer Care in Appalachia

A review of barriers and interventions to cancer screening, genetic services, and continuity of care

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Appalachia encompasses 13 states, spanning 206,000 square miles.[1] It is home to nearly 26 million people. A fourth of Appalachia's 423 counties are rural, characterized by generational poverty and a lack of key resources, such as adequate healthcare. This is evidenced in an overall Appalachian cancer mortality rate that runs 10 percent higher than the national average.[2] Appalachia's most rural populations experience cancer death rates more than 15 percent higher than the rest of the nation. In central Appalachia, the mortality rate is 32 percent higher than the rest of the U.S. In fact, Appalachian Kentucky has the highest rates of cancer burden, exceeding the national average by 35 percent.

Lung, cervical, and colorectal cancer incidence and mortality are higher in the Appalachian areas of Ohio, Kentucky, Pennsylvania, Virginia, and West Virginia than any other parts of the U.S.[3] In addition, there is a general lack of genetics professionals in Appalachia, and services tend to be clustered around major cities resulting in barriers of distance, transportation, and time.[4-6] Other barriers to genetic screening and counseling include lack of awareness about genetic testing and potential benefits, low demand, perception of high cost, low prioritization, lack of physician recommendation, and lack of insurance coverage.[4,5]

With multiple providers delivering care to patients with cancer, there are increased opportunities for gaps in communication and role confusion among primary care providers (PCPs) and cancer specialists. The transition from active treatment to survivorship care is a critical piece to patients' long-term health outcomes. Barriers faced by patients during this transition of care may include fragmented care, poor communication (especially among providers and patients), and a lack of understanding of future risks or a follow-up plan.[7]

The Association of Community Cancer Centers (ACCC) has joined with state oncology societies from throughout the region to create the Appalachian Community Cancer Alliance (the "Alliance"). The Alliance seeks to provide residents of Appalachia and beyond with interdisciplinary, patient-centered approaches to cancer care from prevention through survivorship, with an emphasis on enhanced quality-of-life. A landscape analysis was conducted to inform the Alliance's strategic planning by providing an overview of current locoregional activities, barriers, and interventions around colorectal and cervical cancer screenings, genetics services, and continuity of care along the cancer continuum.

Barriers

Barriers to care, and especially cancer screenings, are well documented in all patient populations. There are often multiple, confounding factors, for example, patient fear, community distrust, cost, and lack of transportation. Some barriers are out of patient control, such as distance to a healthcare facility, inconvenient clinic hours, or limited capacity. Reducing such structural barriers leads to increased access to cancer screenings.

ACCC's literature review identified the following barriers to screenings and related services.

Cervical Cancer

Incidence and mortality rates of cervical cancer are higher in Appalachian areas of Ohio, Kentucky, West

Virginia, and Virginia when compared to other parts of the U.S.[8] Similarly, this area has lower screening and vaccination (for Human Papilloma Virus) rates, and high smoking rates. These rates are attributed to a region that is rural, often described as geographically isolated, with above-average poverty rates, low household income, and below-average educational attainment.[9]

Identified barriers to cervical cancer screening include:

- Preference for a female provider[10,11]
- Competing priorities, such as caregiving and lack of childcare[11,12]
- Lack of patient-centered communication: demeaning or discriminatory attitudes towards women (language, culture, low socio-economic status)[11]
- Lack of accommodation for women's logistical needs around clinic hours and location[11]
- Human papillomavirus infection (HPV) self-sampling-specific: forgetting, fear, lack of time, worry about using test incorrectly.[13]

Colorectal Cancer

Colorectal cancer is preventable with routine screenings. However, it remains the second leading cause of cancer mortality in the United States. In Appalachia, colorectal cancer incidence and mortality rates are higher when compared to the U.S.[14] There are many factors attributable to the high mortality and incidence rates including unfamiliarity and lack of adherence to screening guidelines, feelings of worry about colorectal cancer, and poor overall health.

Identified barriers to colorectal cancer screening include:

- Lack of knowledge about stool-based testing options (e.g., FIT, FOBT) and appropriate frequency of each, doubt about the quality of tests, incorrect completion, inconvenience (e.g., some need multiple samples)[15]
- Colonoscopy-specific: perceived discomfort of prep and/or procedure, sense of violation (especially among men), embarrassment, and privacy and/or confidentiality concerns, especially in rural areas where people may personally know healthcare staff[15,16]
- Some in primary care (especially pre-pandemic) recommended colonoscopy over home-based stool-testing, or only offered stool-based testing if colonoscopy was refused, instead of engaging in shared decision-making.[15]

Genetic Services

Generally, genetic services are more available around major cities, which creates a problem for those living in rural Appalachia. Tele-genetics, or the provision of remote genetics services, is a promising strategy for extending reach into rural areas and addressing distance-related access barriers. Further unintended access challenges may occur, however, for some rural, older, etc. patients in Appalachia due to lack of equipment or connectivity issues.[17]

Identified genetic services barriers include:

- Distance, transportation, and/or time barriers[18-20]
- Technological access, literacy, and infrastructure limitations, such as lack of internet and mail service coverage[5,18,21]
- High cost perceptions[18]
- Low prioritization[19,21]
- Lack of physician recommendation (in part because of lack of physician skills and knowledge around genetic risk assessment, referral, and guidelines)[18,21,23]
- Lack of insurance coverage and/or costs.[18,21]

Interventions

Cervical Cancer

Numerous factors appear to facilitate cervical cancer screening. These factors include prior screening participation, referral by a healthcare professional, experience of positive symptoms, perceived need, prior HPV diagnosis, perception of convenience, interest in health status, and having family or friends who had cancer experiences.[20,23,24]

Specific facilitating interventions and strategies include:

- HPV self-sampling

- Patient navigation and/or community health workers
- Community outreach
- Patient education
- Material supports
- Clinic-level interventions
- Community and/or systems-level interventions
- Policy interventions.

Colorectal Cancer

Colorectal cancer screening rates are affected by provider recommendation, family support and encouragement, perceived risk, family history of colorectal cancer, and knowing people with this type of cancer.[11,13,20]

A systematic review found these interventions were associated with increased colorectal cancer screening completion: outreach, patient navigation, patient education, patient reminders, clinician interventions of academic detailing, clinician reminders, repeated mailed FOBT (fecal occult blood tests) with navigation.[16]

In fact, interventions designed to remove barriers for patients have increased colorectal cancer screenings by 37 percent.[25] Interventions specifically focused on patient navigation services provided through healthcare systems. Patient navigation services target populations experiencing greater disparities in cancer screening, including historically disadvantaged racial and ethnic populations, as well as those with lower incomes.

Specific facilitating interventions and strategies include:

- Test choice
- Community outreach
- Community outreach
- Patient education
- Material supports
- Clinic-level interventions
- Community and/or systems-level interventions
- Policy interventions.

Continuity of Care

As diagnosis and treatment options evolve in cancer care, so too do the number of providers patients see for their care. The cancer care continuum spans primary care through specialty and sub-specialty care providers. Collaboration between PCPs and specialty care providers can be challenging, and there are many opportunities to develop issues around care transitions. Continuity of care, therefore, becomes imperative to ensure quality outcomes for patients. The focus for continuity of care is around care transitions early in the cancer continuum, interactions between primary care and oncology, and follow-up after an abnormal cervical or colorectal screening.

Primary Care and Cancer Specialist Team Interactions

Primary care providers interact with specialty providers regularly. Those conversations and interactions are important regarding patient care. The landscape analysis found the following concerns among providers:

- Primary care providers prefer more communication from cancer specialists and report a significant gap between diagnosis through end of treatment. Oncologists also report infrequent communication and see room for improvement.[27]
- Primary care providers prefer a shared-care model, oncologists prefer specialist-based care.[28]

Cervical Cancer

There were logistical and psychological barriers identified for follow-up care after an abnormal (positive) Pap test result.[29]

Colorectal Cancer

The main barrier under continuity of care for colorectal cancer was follow-up care after an abnormal (positive) FIT test result.[30] Secondary barriers included cost concerns, lack of insurance, lack of transportation, and psychological state after a positive screen.

Interventions

Strategies identified to mitigate care continuity issues and improve provider communication include:

- Using a memorandum of understanding (MOU) between primary care and local cancer programs to formalize workflows and shared care processes

- Examining feasibility of shared electronic health records (EHR) or communication systems
- Agreeing to a referral system among providers
- Piloting embedding an oncologist in the primary care setting, or vice versa
- Examining opportunities for informal rapport-building between multidisciplinary care teams
- Identifying and sharing primary contact information for ease of ongoing contact
- Ensuring clear documentation including follow-up recommendations[31]
- Sharing data on cancer volume and stage to encourage collaboration among oncology programs
- Engaging with cancer care networks to collaborate on funding.

Interventions identified in the landscape analysis for cervical and colorectal cancer focus on provider-to-provider communications (examining how specialists such as cardiologists or endocrinologists interact with primary care providers), medical centers providing rural sites with technical assistance and services, and patient navigation.[32]

Next Steps

The Alliance has chosen to focus its efforts on optimizing colorectal cancer screenings in Appalachia for 2023. The Alliance will prioritize relationship building among multidisciplinary providers through an e-newsletter, local, regional, and/or national meetings, and educational webinars. In addition, the Alliance will use an implementation framework to map evidence-based solutions to identified barriers and leverage existing resources and Alliance expertise to develop new solutions. Information and materials created will be disseminated amongst ACCC member programs and partners. Organizations or individuals interested in staying informed or participating in the Alliance can **sign up on the website accc-cancer.org/acca.**

Key Highlights from the Landscape Analysis

- Incidence rates for colorectal cancer in Appalachia range from 19.9 per 100,000 in Virginia to 29.5 in Mississippi (2015 to 2019) compared to the U.S. national rate of 21.8. Four Appalachian states (Mississippi, Kentucky, West Virginia, and Pennsylvania a) fall within the highest late-stage incidence, and five (Mississippi, West Virginia, Kentucky, Tennessee, Alabama) fall within the highest mortality quintile of states in the U.S.[31]
- Parts of Appalachia have been identified as early onset colorectal cancer hotspots.32 Colorectal cancer screening prevalence among people aged 50 and above ranged from 68.97 percent in Mississippi to 74.83 percent in Pennsylvania, compared to 71.9 percent in the U.S, with nine states above the national average.[31]
- Incidence rates for cervical cancer in Appalachia range from 2.6 in Virginia to 5.1 in Kentucky compared to the U.S. national rate of 3.6. Mortality rates range from 1.9 in Virginia, New York, and North Carolina, to 3.4 in Mississippi compared to the U.S. national rate of 2.2.[31]

For more information on the **Appalachian Community Cancer Alliance** and the Rural Appalachian Lung Cancer Screening Initiative, visit **ACCC's website accc-cancer.org/acca.**

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ACCC

Association of Community Cancer Centers

The Association of Community Cancer Centers (ACCC) is the leading education and advocacy organization for the cancer care community. Founded in 1974, ACCC is a powerful network of 30,000 multidisciplinary practitioners from 2,000 hospitals and practices nationwide. As advances in cancer screening and diagnosis, treatment options, and care delivery models continue to evolve—so has ACCC—adapting its resources to meet the changing needs of the entire oncology care team. For more information, visit **accc-cancer.org**.

This publication is a benefit of ACCC membership.

Integrating Oral Oncolytics into Chronic Lymphocytic Leukemia Practice

Case Studies Highlight Barriers and Successes

Introduction

In recent years, treatment for patients with chronic lymphocytic leukemia (CLL) has undergone a dramatic transformation, shifting from intravenous chemotherapy to oral chemotherapy. Oral oncolytic treatment for CLL offers many benefits, including convenience, better outcomes, and improved effectiveness. However, oral treatments also come with drawbacks to consider, including side effects, patient adherence, and financial toxicity.

Effective integration of oral oncolytics into community practice requires:[1]

- Multidisciplinary collaboration
- Accurate and efficient medication dispensing
- Patient education and adherence
- Thorough data capture.

A multidisciplinary team that includes physicians, advanced practice providers (APPs), nurses, pharmacy staff, financial navigators, and social workers are essential to providing patients with optimal clinical, financial, and psychosocial support throughout their treatment journey.

Delays in medication administration impact patient outcomes. Factors that attribute to delays include prior authorization, access to specialty medications, and insurance processing. Establishing insurance coverage is often the rate-limiting step to filling oral oncolytic prescriptions, particularly when prescriptions must be filled at an outside specialty pharmacy based on insurance requirements. Additionally, having processes in place to navigate the potential financial barriers for patients is an important operational component of oral oncolytic dispensing.

Patient medication adherence greatly impacts treatment success. Medication adherence is strongly linked to health literacy (i.e., the patient's comprehension of their disease and treatment). Effective patient education is vital to establishing adherence and compliance.[2] While prescribers are often the first to educate patients and their caregivers about CLL, other care team members, such as nurses and pharmacists, can help counsel patients about the importance of treatment, how to take medications, treatment duration, common side effects, and potential drug interactions.

Lastly, data capture and outcomes reporting are important to assess the success of oral oncolytic programs. Concrete outcomes data is needed to gauge the impact of specific interventions and process changes, as well as to identify areas of opportunity. Cancer programs should continuously consider how they can measure outcomes when implementing oral oncolytic programs into their practice.

Current Practice

ACCC has developed an educational initiative Integrating Oral Oncolytics into Chronic Lymphocytic Leukemia Practice. The goal of this work is to raise awareness about programs that have effectively integrated oral oncolytics into the cancer care continuum, inclusive of tools and resources, as well as process improvement strategies that have been used to successfully integrate oral oncolytics.

In early 2022, ACCC conducted a survey across its provider network to evaluate current practice patterns in integrating oral oncolytics into the care and treatment of patients with CLL. The survey received 130 responses. Results showed approximately 23 percent of programs treat between 26 to 50 patients with CLL per year, and 22 percent treat more than 100 patients per year. Nearly half of all respondents reported their program does not have an established workflow for integrating oral oncolytics into the care and treatment of patients with CLL.

For the 40 percent of programs that do have established workflows, the most referenced workflows were:

- Multidisciplinary team coordination
- Coordination with specialty pharmacy
- Assessment of coverage and financial assistance programs
- Patient education
- Processes for monitoring adherence and adverse events.

Through the *Integrating Oral Oncolytics into CLL Practice* initiative, three case studies were examined to highlight barriers and interventions to support effective treatment of CLL with oral oncolytics.

Penn Medicine Lancaster General Health

The Ann B. Barshinger Cancer Institute of Penn Medicine Lancaster General Health is a comprehensive community cancer program servicing Lancaster County, Pa., which treats more than 100 patients with CLL per year.

Lancaster General Health has its own specialty pharmacy through which CLL oral oncolytics are processed and dispensed. Oral oncolytic prescriptions are ordered by physicians through Epic (the electronic health record), then routed to the specialty pharmacy. Once the medication is processed through insurance, it is dispensed and delivered to the patient.

While the oral prescription is being processed through the specialty pharmacy, several efforts are happening behind the scenes. After the initial prescribing, the nurse navigator and clinic triage nurses consult with the physician regarding relevant labs, electrocardiogram, and other necessary monitoring, relaying this information to the appointment scheduler team. Simultaneously, oral oncolytic pharmacists review the prescription for appropriateness, document the regimen in the chart, and schedule the patient for an oral chemotherapy education session.

> Lancaster General Hospital's medically integrated pharmacy helps to streamline communication between the dispensing pharmacy and the clinic staff, while also reducing delays between medication prescription and dispensing to patients.

Coordination among the cancer care team is based on an estimate of when the medication will arrive to the patient. The care team at Lancaster General Hospital primarily communicates via EPIC in-basket messages and chart notes. In the best-case scenario—and if insurance authorization is obtained the same day—patients receive their medication within 24 to 48 hours of the prescription being written.

American Oncology Network

American Oncology Network (AON) is a network of healthcare providers within community oncology settings who partner together to optimize community-based oncology care. Currently, AON's platform consists of 107 physicians and 89 APPs across 18 states in more than 70 clinics. AON covers all areas of hematology and oncology in addition to some non-oncology services. The network treats more than 100 patients with CLL per year.

As a network of community-based practices, many patient services are centralized to streamline care, including specialty pharmacy and pathology and diagnostics services. AON's specialty pharmacy manages oral oncolytics prescriptions from approximately 70 clinics and ships the medications directly to patients. When AON providers are ready to prescribe an oral oncolytic, they send the prescription to the AON pharmacy via their electronic health record (most commonly OncoEMR).

Upon receipt of the prescription, multiple steps occur to process the oral oncolytic in the following order:

1. A clinical pharmacist reviews the prescription for appropriateness
2. Benefit investigation is conducted for active coverage
3. Prior authorization is submitted (if necessary)
4. Patient financial assistance is consulted, as needed
5. The patient is contacted to schedule delivery
6. The prescription is filled and shipped
7. Pharmacists provide patient counseling for oral oncolytics
8. Nurses review the EHR prior to subsequent refills to evaluate appropriateness for continuation of treatment and to reduce waste.

> AON prioritizes a proactive approach on ongoing annual renewal of applications for medication grants and patient assistance programs to secure financial assistance for patients and reduce the administrative burden for network clinics.

The typical turnaround time from when the prescription is initially written, to when the patient receives the medication is around 72 hours. Some medications can even be delivered the same day if there are no insurance issues. All patients who receive oral oncolytics are enrolled in a care management program that provides structured patient outreach calls and education. In addition, AON provides patient educational materials translated to multiple languages to reduce health literacy barriers.

Pontchartrain Cancer Center

The Pontchartrain Cancer Center is a private community practice located in Hammond, La., that services a rural population with an average of 1 to 10 patients with CLL per year.

At Pontchartrain Cancer Center, the oral oncolytic process starts with the provider prescribing the oral medication to the in-house pharmacy. After the order is placed, a separate treatment plan visit is scheduled for patient education and consent. Prescriptions filled in-house are done within 24 to 48 hours if there are no prior authorization issues. The average turnaround time for outside prescriptions is five to seven days.

All oral oncolytic prescriptions—internal and external—are tracked in a log to ensure that patients are obtaining their medications within a week or less. Providers at Pontchartrain Cancer Center find that having the medication available at the time of the initial oral oncolytic educational session on hand greatly enhances the effectiveness of patient education.

> One unique aspect of patient education at Pontchartrain Cancer Center is that the center has cultivated a robust "binder" of information for patients and caregivers ranging from typical drug information to practical tidbits, including patient medication and appointment calendars, suggested home remedies for adverse event management, contact information on who and when to call, and a glossary of medical terminology for cancer patients.

Once a patient starts on a medication, a nurse will follow up with the patient within several days of initiation, as well as weekly or monthly calls to ensure compliance.

After an intervention (i.e., dose reduction), patients are followed up within 24 hours. Even with monthly compliance calls, patients are also scheduled to come to the clinic once a month for evaluation. As with prescription turnaround time, compliance is tracked, and reasons for non-compliance are reviewed by upper management.

Resources

To help cancer programs and practice implement oral oncolytic programs into the care and treatment of CLL patients, ACCC designed a *patient journey infographic and an Effective Practice Guide* that highlights various aspects of the oral oncolytic process, from the point of treatment decision-making to long-term monitoring. The goal of these tools is to outline the general workflow and considerations for oral oncolytics that can be adapted for any practice setting. ACCC aims to support cancer programs and practices as they navigate through the complexities of oral oncolytic treatment.cancer centers navigate through the complexities of oral oncolytic programs with this effective practice guide.

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A publication from the ACCC education program, "Integrating Oral Oncolytics into Chronic Lymphocytic Leukemia Practice." Learn more at **accc-cancer.org/integrating-oo-cll**

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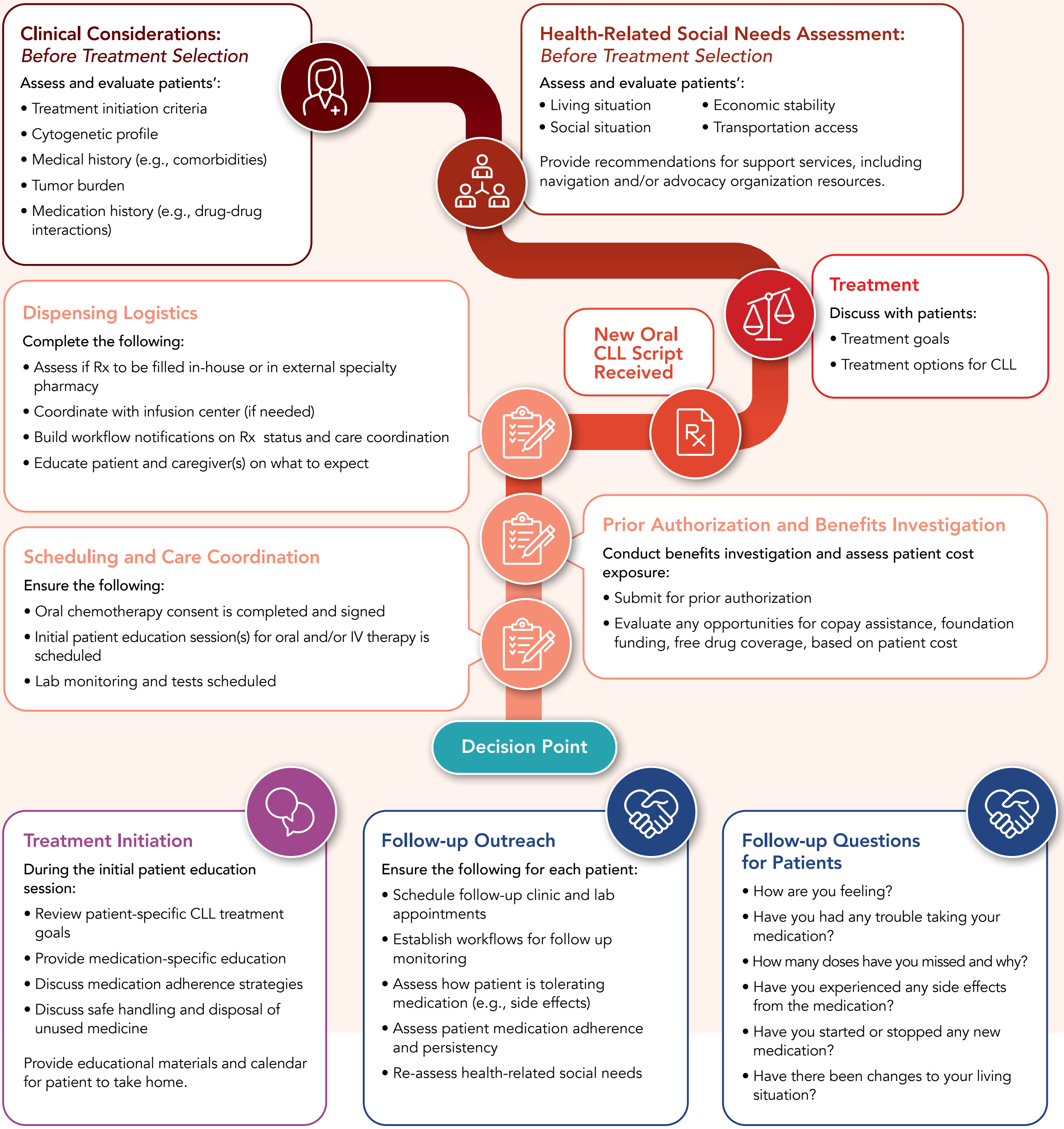
Oral Oncolytic Clinical Workflow for Treatment of Patients with Chronic Lymphocytic Leukemia



Clinical Considerations: *Before Treatment Selection*

Assess and evaluate patients':

- Treatment initiation criteria
- Cytogenetic profile
- Medical history (e.g., comorbidities)
- Tumor burden
- Medication history (e.g., drug-drug interactions)

Health-Related Social Needs Assessment: *Before Treatment Selection*

Assess and evaluate patients':

- Living situation
- Social situation
- Economic stability
- Transportation access

Provide recommendations for support services, including navigation and/or advocacy organization resources.

Treatment

Discuss with patients:

- Treatment goals
- Treatment options for CLL

New Oral CLL Script Received

Dispensing Logistics

Complete the following:

- Assess if Rx to be filled in-house or in external specialty pharmacy
- Coordinate with infusion center (if needed)
- Build workflow notifications on Rx status and care coordination
- Educate patient and caregiver(s) on what to expect

Prior Authorization and Benefits Investigation

Conduct benefits investigation and assess patient cost exposure:

- Submit for prior authorization
- Evaluate any opportunities for copay assistance, foundation funding, free drug coverage, based on patient cost

Scheduling and Care Coordination

Ensure the following:

- Oral chemotherapy consent is completed and signed
- Initial patient education session(s) for oral and/or IV therapy is scheduled
- Lab monitoring and tests scheduled

Decision Point

Treatment Initiation

During the initial patient education session:

- Review patient-specific CLL treatment goals
- Provide medication-specific education
- Discuss medication adherence strategies
- Discuss safe handling and disposal of unused medicine

Provide educational materials and calendar for patient to take home.

Follow-up Outreach

Ensure the following for each patient:

- Schedule follow-up clinic and lab appointments
- Establish workflows for follow up monitoring
- Assess how patient is tolerating medication (e.g., side effects)
- Assess patient medication adherence and persistency
- Re-assess health-related social needs

Follow-up Questions for Patients

- How are you feeling?
- Have you had any trouble taking your medication?
- How many doses have you missed and why?
- Have you experienced any side effects from the medication?
- Have you started or stopped any new medication?
- Have there been changes to your living situation?

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Advanced Non-Melanoma Skin Cancers: Effective Practices in Multidisciplinary Care

LEVERAGING MULTIDISCIPLINARY NETWORKS TO IMPROVE CARE

Collaborative multidisciplinary relationships and bi-directional referrals play an integral role in oncology, but for disease types that are rare or at high risk to develop into more aggressive forms, these networks can make a critical difference in the delivery of expert cancer care and improved patient outcomes. While basal cell and squamous cell carcinomas of the skin represent more than 80 percent of non-melanoma skin cancers, management of patients with high-risk features associated with advanced cutaneous squamous cell and basal cell carcinoma as well as more rare types, such as Merkel cell carcinoma, cutaneous lymphomas, cutaneous adnexal tumors, Kaposi sarcomas, and others, can be complex and often requires collaboration with multiple specialists.

As patients trust the relationships established with their own healthcare providers, often in community-based care settings, transitioning patients with advanced skin cancers to specialty sites or to a multidisciplinary care team of dermatologists, dermatopathologists, cutaneous oncologists, surgeons, and radiation oncologists, can be challenging. Building clear referral pathways and establishing a network of advanced non-melanoma skin cancer specialists can facilitate this process and ensure patients receive timely, comprehensive care.

In 2019, the Association of Community Cancer Centers (ACCC), with advocacy partners Skin Cancer Education and Research Foundation, Cancer Support Community, and CancerCare, and with support from Regeneron and Sanofi, launched a multi-year education program, *Advanced Non-Melanoma Skin Cancers: Effective Practices in Multidisciplinary Care*, to explore the work of multidisciplinary programs treating patients with cutaneous squamous cell carcinoma, basal cell carcinoma, and Merkel cell lymphoma, and highlight effective practices in multidisciplinary care. This initiative included site visits to three community cancer centers, Ellis Fischel Cancer Center in Columbia, Mo., The George Washington University Cancer Center in Washington D.C., and The Knight Cancer Institute in Portland, Ore., which formed the foundation for a comprehensive **best practices guide**, as well as a series of peer-to-peer education sessions held around the country.

Building upon this important work, in 2022, ACCC conducted a series of virtual workshops designed to engage members of the multidisciplinary care team as well as non-oncology specialists on effective practices for supporting, treating, and managing patients with advanced cutaneous non-melanoma skin cancers. ACCC shares a look at the culmination of this education program and its suite of resources that multidisciplinary teams can leverage to expand connections with advanced non-melanoma skin cancer experts and improve multidisciplinary care coordination.

Real-Time Lessons Learned: Visiting Experts Program

The goal of ACCC's Advanced Non-Melanoma Skin Cancers Visiting Experts Program was to bring together specialists in the field of non-melanoma skin cancer to support cancer programs in identifying barriers and developing action plans to improve care for this patient population. Through a series of three, virtual platforms, program participants—which included Community MD Anderson Cancer Center in Indianapolis, Ind., Inova Schar Cancer Institute in Fairfax, Va., and the University of Nebraska Medical Center in Omaha, Neb.—had the opportunity to discuss complex case studies, exchange opinions in real-time, discuss current challenges and barriers to care, and create action plans to address and overcome these challenges. Participants were also provided with a series of three, 30-minute eLearning videos curated by ACCC prior to the program, to provide a deeper dive into cutaneous squamous cell carcinoma, basal cell carcinoma, and Merkel cell lymphoma.

Visiting Experts faculty included Sunandana Chandra, MD, MS, associate professor of Hematology and Oncology at Northwestern University; Carlo Contreras, MD, associate professor of Surgical Oncology at The Ohio State University Wexner Medical Center; Mark Faries, MD, FACS, co-director of Cutaneous Oncology at Cedars-Sinai The Angeles Clinic and Research Institute; and Emily Smith, MD, clinical associate professor of Pathology and Dermatology at the University of Michigan-Michigan Medicine.

Experts shared several best practices cancer programs could immediately implement to improve care for patients and better facilitate bi-directional referrals. These included key recommendations like scheduling concurrent operations between Mohs, reconstruction, and resection; ensuring communications with referring providers include reporting of high-risk features and identification of patients who are immunosuppressed; and leveraging multidisciplinary tumor boards to discuss patients with high-risk features.

Common themes discussed across workshops included:

- Importance of communication; building close relationships across the multidisciplinary team, with dermatopathologists/pathologists to ensure reporting of high-risk features, as well as enhanced patient/provider communication
- Identification of high-risk non-melanoma skin cancer and patients who may be at high-risk for recurrence
- Psychosocial impact of diagnosis of advanced non-melanoma skin cancer; the social, emotional, physical, and financial burden patients can face
- The role of chemotherapy, immunotherapy, radiation therapy, and adjuvant therapies for advanced non-melanoma skin cancers
- Importance of adjuvant clinical trials and challenges related to enrollment of patients with cutaneous squamous cell carcinoma
- Concurrent operations between Mohs, reconstruction, and resection
- Leveraging multidisciplinary tumor boards to review cases and discuss patients with high-risk features.

Opportunities for improvements and action plans identified across workshops included:

- Standardization of Mohs protocol (i.e., debulking) for referring surgeons to ensure accurate risk stratification of patients
- Creation of a standard checklist for referring providers to guide patient intake (e.g., available debulking specimen, presence of high-risk features, etc.)
- Leveraging tumor boards to review cases with high-risk features
- Agreement on a universal staging system to channel cases automatically to tumor board
- Creation of a list of commonly seen high-risk scenarios to guide referring providers
- Creation of a contact list for general practitioners to facilitate contact with dermatology experts
- Monitoring of the number of high-risk patients seen and length of time (i.e., number of days) between referral and dermatology visit
- Increase patient awareness and access to dermatology for skin checks.

For more about lessons learned and specifics on the action plans developed by each cancer program, visit the **Visiting Experts Program Spotlight series**.

Tips from the Experts: Webinar on Building Multidisciplinary Capacity to Care for Patients with Advanced Non-Melanoma Skin Cancers

Expanding upon the success of the Visiting Experts Program, ACCC developed a webinar, *Building Multidisciplinary Capacity to Care for Patients with Advanced Non-Melanoma Skin Cancers*, accessible to providers seeking opportunities to expand multidisciplinary care collaboration and coordination to improve care for patients with non-melanoma skin cancers. The webinar features expert Dr. Faries, along with special guests Jennifer DeSimone, MD, specialty care physician of Dermatology at Inova Schar Cancer Institute and Rachel Saks, MSS, LSW, OSW-C, senior director of Education at Cancer Support Community, who lead a discussion on identifying strategies to cultivate multidisciplinary collaboration, conduct quality improvement initiatives, and resources available to providers to improve quality care for this patient population.

Sharing Insights: CANCER BUZZ Podcast

Through its official podcast channel CANCER BUZZ, ACCC explored current challenges advanced non-melanoma skin cancer care providers face in practice. These include navigating difficult conversations with patients facing advanced-stage cancer, as well as addressing barriers to care, particularly for patients who live in rural areas.

In a podcast with Dr. Chandra and Rachel Saks (**Podcast Episode 98**), ACCC explores how to engage patients in shared decision-making, particularly when it comes to palliative and supportive care, sharing tips and resources that can help guide patient discussions.

Through a conversation with Dr. Smith (**Video Podcast Episode 25**), ACCC shares how to leverage the skills of a multidisciplinary team to better support patients in rural areas and address other social and emotional determinants of health.

Building a Network: 360 Connect

To facilitate multidisciplinary relationships with ease, ACCC has also curated an online tool, **360 Connect**, which enables providers to locate and connect with experts and non-melanoma skin cancer centers of excellence across the United States. The database is searchable by state and includes specialists in surgical oncology, dermatology, radiation oncology, and medical oncology, with a focus on advanced cutaneous malignancies.

Strengthening Partnerships for Improved Patient Care

Leveraging multidisciplinary networks to better manage care of patients with high-risk features associated with advanced non-melanoma skin cancer or other rare types of skin cancer can be a valuable means to ensuring patients gain access to comprehensive specialty care and improved outcomes. As providers continue to seek new ways to improve patient care, establishing these collaborative relationships, defining clear referral pathways, and calibrating internal processes can create a more seamless transition for patients as they move between providers throughout their cancer care journey.

A publication from the ACCC education program, "Advanced Non-Melanoma Skin Cancer Care." Learn more at **accc-cancer.org/advanced-NMSC**.

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Thank you to our advocacy partners:

This project is supported by:

Building Multidisciplinary Care Capacity for People Impacted by Hepatocellular Carcinoma

According to the American Cancer Society, in 2023 there will be 41,210 people diagnosed with new cases of liver cancer, and, of this total number, 29,380 people will die from their disease. Further, the American Cancer Society notes that both incidence and mortality rates have significantly increased in the last 40+ years.[1]

Hepatocellular carcinoma is the most common primary liver cancer[2] and requires highly coordinated cross-specialty screening, diagnosis, treatment, and management. Patients with hepatocellular carcinoma often present with chronic liver disease, underlying comorbidities, and complex psychosocial needs. This patient population is increasingly being diagnosed and treated in the community setting, yet few resources exist to support the multidisciplinary management of hepatocellular carcinoma in this setting. Therefore, the Association of Community Cancer Centers (ACCC), launched a multi-year program (2018 to 2022) to support multidisciplinary providers in the care of patients with hepatocellular carcinoma. This article highlights key program components, lessons learned, and available resources.

Data to Inform Interventions

Race, ethnicity, socio-economic status, and geography disproportionately impact access to treatment and health outcomes for people with hepatocellular carcinoma.[3,4] To help identify which areas of the country are facing higher access challenges and mortality rates, ACCC developed a Liver Cancer Heat Map,[6] utilizing 2012 to 2016 data from the United States Cancer Statistics,[5] which includes data from the Surveillance, Epidemiology, and End Results Program (SEER) and National Program of Cancer Registries. The map is searchable by age-adjusted incidence rate, crude incidence rate, number of cases, mortality, and mortality-to-incidence ratio. In addition, National Cancer Institute-designated cancer centers and ACCC Cancer Program members are overlaid to show where these treatment facilities exist within each state.

Lastly, data capture and outcomes reporting are important to assess the success of oral oncolytic programs. Concrete outcomes data are needed to gauge the impact of specific interventions and process changes, as well as to identify areas of opportunity. Cancer programs and practices should continuously consider how they can measure outcomes when implementing oral oncolytic programs into their operations.

There are multiple ways to use the data from the heatmap, including:

- States with high incidence might consider interventions to decrease risk of hepatocellular carcinoma, such as broad public awareness campaigns and developing education materials for use with higher risk patients being seen by their primary care and/or gastroenterology provider(s).
- States with high mortality rates may look at interventions that result in earlier diagnosis or better access to treatment. The number of cases can help users understand resource allocation needs, and the mortality to incidence ratio can indicate disparities in access to care.

However, when reviewing state-level data, it is important to remember that barriers to accessible care can be related to several factors, including race, socio-economic status, and geography. More research is needed to understand disparities and their causes, while ensuring that community cancer programs and practices can provide access to hepatocellular carcinoma specialists may help bridge the gap between incidence and mortality rates.

Effective Practices in Multidisciplinary Hepatocellular Carcinoma Care

To further support cancer programs and practices in the care of patients with hepatocellular carcinoma, ACCC collaborated with its advisory committee and partner organizations to develop an effective practices guide.[7] The guide was informed by an environmental scan,[8] expert recommendations, and practical insights from three programs: Emory Healthcare, Atlanta, Ga.; Mercy Medical Center, Baltimore, Md.; and Sharp HealthCare, San Diego, California.

The six effective practices that emerged were:

1. Follow national hepatocellular carcinoma guidelines for testing, staging, and treatment.
2. Work with a dedicated hepatobiliary and transplant multidisciplinary team or collaborate with an external, expert tumor board.
3. Conduct regular multidisciplinary evaluations of hepatocellular carcinoma cases.
4. Establish operational pathways to document adherence to guidelines and quality of care metrics.
5. Promote and support screening through communication and education with community clinicians.

In addition, the guide offers extensive practical insights and strategies to address disparities, screening, disease management, navigation/coordination, care models, and patient-centered communication.

Resources to Support Patients with Hepatocellular Carcinoma

As part of providing patient-centered care, it is critical to connect patients and their loved ones to education and support resources. Blue Faery (bluefaery.org) and the Cancer Support Community (cancersupportcommunity.org/liver-cancer) offer a number of free services, including education, peer support, and a helpline. In addition, the Global Liver Institute (globalliver.org) is open to anyone who is interested in advocating for policy changes to improve access to care, increasing research to expand prevention and treatment options, and ending disparities.

Peer-to-Peer Insights

To help build capacity for multidisciplinary care, ACCC delivered a Hepatocellular Carcinoma Visiting Experts Workshop to Ascension SE Wisconsin - Cancer Care in 2022.

The goals of the workshop were to:

- Educate multidisciplinary providers through an interactive, virtual discussion on effective practices for supporting, treating, and managing patients with hepatocellular carcinoma
- Support the cancer program in identifying a barrier to care for patients with hepatocellular carcinoma, which could be addressed through a tailored action plan.

Faculty for the workshop included: Debashish Bose, MD, PhD, FACS, surgical oncologist, Mercy Medical Center; Angela Majied, RN, CCRN, nurse coordinator, Tumor Clinic, Emory University Hospital; and Philip A. Philip, MD, PhD, medical oncologist, Gastrointestinal and Neuroendocrine Oncology, Henry Ford Cancer Institute, Wayne State University.

Ascension SE Wisconsin - Cancer Care

This private healthcare company with a network of cancer specialists provides care to people throughout southeast Wisconsin (i.e., Milwaukee and surrounding areas). Ascension has a strong commitment to improving outcomes for patients with hepatocellular carcinoma. They treated 30 patients with hepatocellular carcinoma from October 2020 through September 2021. Of the 30 patients with hepatocellular carcinoma cared for, 3.2 percent are Asian, 10 percent are Hispanic, 42 percent are Black, and 45.2 percent are White. More than half of patients (55 percent) presented to the emergency department, while the remainder (45 percent) presented to a facility in the outpatient setting.

Key Takeaways

The Ascension team was interested in learning best practices for establishing a multidisciplinary clinic to optimize care.

Faculty shared that the goals of a multidisciplinary clinic are to:

- Optimize the patient experience with seamless access to and discussions with specialists
- Balance discussion of the case among various disciplines (e.g., interventional radiologist, surgeon, and medical oncologist
- Accelerate care delivery.

Based on these goals, the faculty provided recommendations from their experience and offered suggestions on how to tailor these recommendations to fit within Ascension SE Wisconsin – Cancer Care system.

To accelerate patient identification and intake, faculty offered the below recommendations:

- Create pathways to identify hepatocellular carcinoma earlier in patients. For example, breast, lung, pancreatic, and gastrointestinal screenings could trigger further assessments for hepatocellular carcinoma
- Obtain and review as much information as possible (e.g., imaging and lab results) before seeing the patient for their initial multidisciplinary clinic consultation. Faculty members and participants also identified the value of a 15-minute. "huddle" among multidisciplinary team members to review materials together
- The multidisciplinary team should meet patients within a week to accelerate care. Consider scheduling patients on days/times when all specialists are in the same setting.

To improve ongoing management of patients with hepatocellular carcinoma, faculty offered the below recommendations:

- Convene at tumor boards to discuss treatment options
- Meet virtually to overcome hurdles, such as specialists being in different locations and challenges with scheduling
- Develop mutually beneficial relationships and agreements with external providers (e.g., transplant centers) to retain patients after referrals.

To improve ongoing management of patients with hepatocellular carcinoma, faculty offered the below recommendations:

- Confirm all imaging and lab results are available and have been reviewed prior to the first consult to ensure smooth intake
- Provide continuity of care through involvement from the time of referral to the creation of the treatment plan and/or through the transplant process
- Equip the care team with information needed for decision making, empowering them to perform at the top of their license(s)
- Identify a main point of contact for the care team.

Workshop Outcomes

Participants rated the workshop highly and valued its candid multidisciplinary discussions and practical guidance from other successful settings. As one participant described the workshop, "It brings us together as a team....It helps us look at our program differently and provides an outside perspective." This convening benefit was echoed by another participant who expressed that "participation of the other departments allows us to share a common understanding of where our gaps are." Post-event survey results indicate practical hepatocellular carcinoma knowledge gains, increases in skills and self-efficacy for care improvement, and strong commitment to advancing multidisciplinary care.

From Opportunities to Action

The Ascension team identified opportunities to improve care, and then created an action plan with the following goals:

- Create an institutional guideline or algorithm for which patients are a candidate for surgery vs. liver-directed therapy
- Establish a referral framework for mutual patients receiving services within the institution and transplant services outside the institution to ensure continuity of care
- Increase early identification of high-risk patients requiring intervention
- Define management of patients with cirrhosis within the organization.

At the three-month follow-up, the team made the following strides toward their identified goals:

- Drafted a treatment algorithm for potentially curable hepatocellular cancer
- Identified next steps for opening channels of communication with a local transplant center
- Conducted initial outreach to gastrointestinal physicians in the catchment area to discuss clinic services and referral pathways
- Audited patient charts and identified pain points and opportunities to potentially leverage software for patient identification.

In addition, the team planned to vet the treatment algorithm with other specialties for further refinement and to obtain buy-in, while continuing to explore software solutions and marketing to and building relationships with external organizations. Finally, the team felt they had a clear vision and understanding of gaps, strengths, and next steps and are poised to elevate care for their patients with hepatocellular carcinoma.

Call to Action

To address the substantial disparities in access to quality care faced by people with hepatocellular carcinoma, cancer programs and practices must urgently assess and build their capacity to coordinate the many clinical and supportive care services that are key to hepatocellular carcinoma prevention, screening, diagnosis, treatment, and survivorship.

Using ACCC's resources outlined above, multidisciplinary care team members can:

- Use state- or region-specific gaps in access to care, as evidenced by high mortality-to-incidence ratios to identify at-risk patients and opportunities to improve care
- Identify local hepatocellular carcinoma experts to coordinate care with
- Apply effective practices in multidisciplinary care coordination and patient engagement to build program capacity.

Thank you to our patient advocacy partners: the American Cancer Society, Blue Faery, Cancer Support Community, and Global Liver Institute. This program is made possible in thanks to funding from Bristol Myers Squibb and Eisai.

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The Association of Community Cancer Centers (ACCC) is the leading education and advocacy organization for the cancer care community. For more information, visit **accc-cancer.org**.

In partnership with:

This project is supported by:

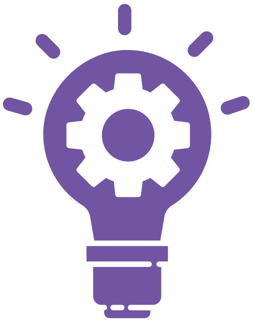
fast facts

New study finds that the total cost of adolescent and young adult (AYA) cancer diagnosed in 2019 was $23.5 billion, a lifetime cost of nearly $260,000 per person, while the total well-being cost of AYA cancer was $96 billion, a lifetime cost of $1 million per person.

Source. Parsons SK, Keegan THM, Kirchhoff AC. Cost of Cancer in Adolescents and Young Adults in the United States: Results of the 2021 Report by Deloitte Access Economics, Commissioned by Teen Cancer America. J Clin Oncol. Published online February 24, 2023. Doi: 10.1200/JCO.22.01985..

10 Questions to Inspire Innovation

1. Where are we wasting time?
2. How could we generate revenue from our idle assets?
3. We only have half our current staff. What should we prioritize and simplify?
4. Money is no object. What is the first thing we would fix and what's the cheap version of that?
5. What could we offer staff that would make them rave about us to their friends?
6. What would [INSERT COMPANY OR INDUSTRY] do if they were us?
7. What could we add to our service line that would make it premium?
8. How could our business help our community and/or environment?
9. What is one way we could personalize our patients' experience to make them feel special?
10. What is frustrating our patients and how can we change it, so they love it?

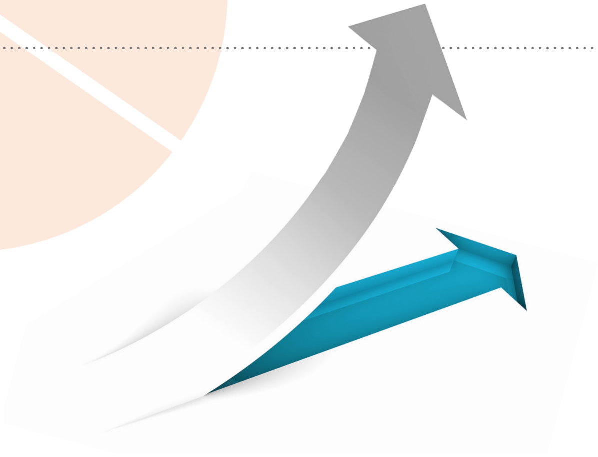


Source. Julie Holmes. ACCC 39th National Oncology Conference. julieholmes.com.

3 Key Takeaways from the Future of Rural Health Summit

1. Adoption of digital health in rural markets offers challenges and benefits. While small, rural hospitals could lead adoption of digital health technologies because there are fewer barriers to implementation when compared to large, academic research hospitals, many advanced platforms require broadband internet that can be sparse in rural communities.
2. While the market continues to deliver solutions, the market is saturated with options. The boom of new digital health companies seems to have ended and will likely be a followed by an increase in merger and acquisition activity.
3. Artificial intelligence is here to stay. Younger clinicians have quickly adopted and largely embraced AI-based platforms. Those platforms range from business intelligence tools to clinical decision support.

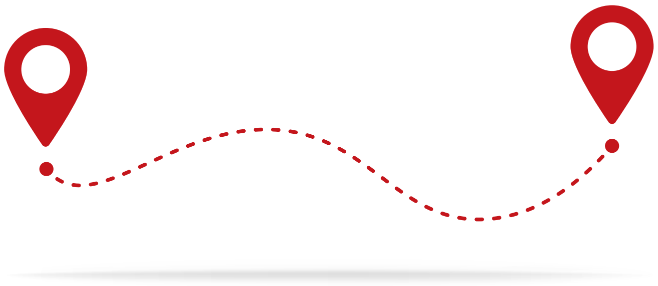
Source. Turner BEW. 5 takeaways from the Future of Rural Health Care Summit. digitalhealth.modernhealthcare.com/transformation/5- takeaways-future-rural-health-care-summit?utm_source=the-digital-health- deal&utm_medium=email&utm_campaign=20220826&utm_content=article3-readmore



Survey Finds Use of Advanced Practice Providers Continues to Rise

The use of APPs in combination with physicians is a growing strategy. Hospitals see the benefits of integrating APPs into the care model to improve access, lower costs, and bring flexibility to staffing. In a recent Locum Tenens.com survey, **74%** responded affirmatively to the question, "Do you plan to expand APP coverage?"

Source. Locum Tenens.com. Innovation & Flexibility: Journey to Sustainable Healthcare Report. locumtenens.com/media/4qcdoyjs/innovation-flex-report.pdf.



How Far Americans Are Willing to Travel for the Best Price in Medical Care

- 10 to 20 miles: **51%**
- 21 to 50 miles: **31%**
- 51 to 100 miles: **13%**
- 101 to 200 miles: **2%**
- 201 to 400 miles: **3%**

Source. A YouGov survey, commissioned by AKASA. prnmedia.prnewswire.com/news-releases/new-survey-highlights-what-americans-are-willing-to-pay-more-for-in-healthcare-301615701.html.

more online @ accc-cancer.org

VIDEO

Mitigating the Financial Burden of Cancer Diagnostics

As soaring testing costs, coverage challenges, and heavy administrative overhead continue to impact access to guideline-concordant screening and biomarker testing, hear from an expert panel how to reduce financial hurdles and increase patient access to cancer diagnostics. Listen to this CANCER BUZZ vodcast at accc-cancer.org/financial-burden-cancer-diagnostics.

WEBINAR

Navigating Radiation Authorizations and Denials

A discussion of radiation authorization submissions before treatment and strategies on how to work radiation authorization denials and appeals after treatment. Learn more at accc-cancer.org/radiation-authorizations.

BLOGS

Addressing Health Equity Among American Indians and Alaska Natives

In 2019, Tuba City Regional Health Care Corporation in Tuba City, Ariz., developed the first cancer clinic on any American Indian reservation in the United States. Read how this partnership is helping to achieve health equity and bridge gaps in healthcare at accc-cancer.org/health-for-all.

PODCAST

Treatment Options for Patients with Multiple Myeloma Who Are Ineligible for Transplant

Over half of patients newly diagnosed with multiple myeloma are not eligible for transplant due to age or other major health problems. Hear treatment planning options available to patients who are ineligible for transplant. accc-cancer.org/multiple-myeloma-podcast.

RESOURCE

ACCC's 2022 Impact Report

From leveraging technology to transform cancer care delivery and the patient experience to championing equitable access to care through partnerships like the Cancer Moonshot and the Appalachian Community Cancer Alliance, read how the Association spent its time and resources in 2022. accc-cancer.org/impact-report.

ACCC Announces Its 2023 Advocacy Agenda

BY CHRISTIAN DOWNS, JD, MHA

The Association of Community Cancer Centers (ACCC) is truly "a community of cancer centers," representing members nationwide from all care delivery settings: health systems, comprehensive cancer programs, academic centers, community cancer programs, and private practices. ACCC educates and advocates on behalf of its members to ensure they can provide high-quality, comprehensive, and equitable care for patients with cancer and their caregivers.

Each year, ACCC is active at the state and federal level, advocating on behalf of its members to ensure that the rules and regulations in place do not, in any way, impede the delivery of cancer care. These efforts can include advocating equitable access to new therapies and innovative technologies, adequate reimbursement for services and treatments, and equitable access to care and clinical trials. For 2023, ACCC members have identified four core areas of focus, among a larger set of issues and concerns, that the association will be supporting.

1. Protect adequate and stable reimbursement for oncology providers. Year after year, increasing cuts to Medicare reimbursement continue to threaten the financial viability of our nation's cancer programs and practices. ACCC supports payment policies that adequately and sustainably cover the costs of delivering comprehensive cancer care, while accounting for ongoing inflationary pressures. Any reimbursement changes should not undermine oncology providers' ability to deliver high-quality, affordable, and equitable cancer care to their communities.
2. Reduce delays in care due to utilization management. Health plan utilization management policies, including prior authorization and step therapy, can act as a barrier to patients with cancer, who are seeking access to necessary treatments in a timely manner. When combined with a lack of transparency in the approval process, utilization management requirements create significant burdens for oncology providers and can delay critical care for their patients. ACCC champions federal utilization management reform that improves health plan transparency and protects patients from unnecessary and harmful delays in care.
3. Preserve provider and patient choice in anti-cancer treatment. Health plans and pharmacy benefit managers (PBMs) are increasingly restricting provider and patient options when deciding where patients can receive care, how anti-cancer drugs can be dispensed, and which drugs will be covered by the health plan. To improve accessibility and affordability of therapeutic options to patients, while maintaining clinical quality and safety standards, ACCC believes that patients and their providers must retain the autonomy to make treatment choices that consider the patient's unique circumstances and any barriers to care.
4. Improve access to and coverage of supportive oncology services. Comprehensive cancer care delivery is recommended in clinical guidelines and considered essential for delivering high-quality care. ACCC seeks to promote policy solutions and value-based payment reform that increase access to—and reimbursement for—supportive oncology services, including but not limited to, social work, psychology and psychiatry, physical and occupational therapy, nutrition and dietetics, genetic counseling, spiritual services, navigation, integrative medicine, financial advocacy, palliative care, fertility services, and critical services provided by other specialty service professionals (i.e., oncology pharmacists).

In addition to these core areas, ACCC will continue to advocate on issues related to the following themes:

- Increase diversity in cancer clinical trials
- Ensure continued access to care through telehealth
- Support the development of a resilient oncology workforce
- Advance the value journey in oncology

For more information about the association's 2023 advocacy priorities, visit accc-cancer.org. OI

Christian Downs, JD, MHA, is executive director, Association of Community Cancer Centers, Rockville, MD.

Returning to "Normal"

The End of the COVID-19 Public Health Emergency

BY TERI BEDARD, RT(R)(T), CPC

On May 11, 2023, the COVID-19 public health emergency (PHE) officially ended, signaling the return to the pre-pandemic "normal" and the application of the asterisk (*) next to calendar years 2020 to 2023 when performing data analytics. Since January 31, 2020, when the Secretary of the Department of Health and Human Services (HHS) declared the PHE, and March 30, 2020, when the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule in response to the COVID-19 pandemic, healthcare providers have been working under many waivers and extensions that softened regulatory guidelines.

But before we look at what's ahead, let's first take a step back. When a PHE is declared, it is enacted for 90 days and can be renewed as necessary. Additionally, the HHS Secretary can also adjust the PHE length to be shorter than 90 days if needed. Since January 31, 2020, the COVID-19 PHE has continually been extended; however, on January 30, 2023, it was declared to end on May 11, 2023. This timing provided the required 60-day notification to state governors to prepare for the end of many of the COVID-19-related waivers and extensions. It also means that cancer programs and practices, as well as their providers, must prepare to return to "normal" or pre-pandemic practice standards.

Where to Go for Help

Due to the volume of changes enacted over the last few years, CMS has updated its website to provide direction on the policies and processes that are ending, changing, or remaining. One CMS resource, "Coronavirus Waivers & Flexibilities," includes fact sheets by medical setting or entity type.[1] For example, there are separate documents for physicians and other clinicians, hospitals, and CAHs (critical access hospitals, teaching hospitals and teaching physicians, and hospice). On February 13, 2023, CMS also updated its telehealth list, removing the column that identified the expiration dates of non-permanent telehealth services.[1]

Originally outlined in the Consolidated Appropriations Act of 2022, all telehealth services and many waivers and extensions were supposed to continue for 151 days after the COVID-19 PHE ended; however, the Consolidated Appropriations Act of 2023 made changes to telehealth.[2,3] Specifically, changes to non-permanent waivers and extensions—that were enacted by CMS over the last three years—will occur on one of three dates: May 11, 2023, December 31, 2023, or December 31, 2024.

To better understand what will be changing or ending and when, listed below are many of the primary waivers and extensions that impact oncology providers. Note: this is not a comprehensive list, and I recommended healthcare professionals visit the CMS website for additional information.

Waivers and Extensions That Ended or Changed on May 11, 2023

- Virtual check-ins and e-visits for new patients will no longer be allowed; these visits will only apply to established patients. Healthcare Common Procedure Coding System (HCPCS) codes **G2010** and **G2012** (for physicians), as well as **G2251** and **G2252** (for non-physician practitioners), for remote evaluation of patient video/images and virtual check-in services can only be provided to established patients.
- Telehealth via any non-public facing application. Telehealth visits will continue until December 31, 2024; however, the technology used to conduct a visit must be HIPAA compliant beginning May 12, 2023.
- State laws will continue to govern whether a provider needs to be licensed in the state in which they practice. There is no CMS-based requirement that a provider must be licensed in their state of enrollment.
- Telemedicine services furnished to a hospital's patients through an agreement with an off-site hospital will end.
- If a beneficiary's home was designated as a provider-based department of the hospital for purposes of receiving outpatient services paid under the Hospital Outpatient Prospective Payment System (HOPPS), this designation will end.
- The process of allowing the addition of services to the Medicare Telehealth Services List on a sub-regulatory basis will end. Any requests for services to be added must be done through the rulemaking process.
- Subsequent inpatient visits provided via telehealth, without the limitation of the telehealth visit being once every three days (Current Procedural Terminology [CPT®] codes **99231–99233**), will end.

- Teaching physicians, who are only in residency training sites located outside a metropolitan statistical area, may direct, manage, and review care furnished by residents through audio/video real-time communication technology.
- The locum tenens provision to provide coverage longer than 60 consecutive days during the PHE, whether the arrangement is reciprocal billing arrangements or fee-for-time compensation arrangements, will revert to the original guidelines. On the 61st day after the PHE ends, the regular provider must use a different substitute (locum tenens) provider or return to work at their practice.

Waivers and Extensions That Will End or Change on December 31, 2023

- Physician treatment management visits (CPT **77427**) for radiation oncology will no longer be on the telehealth list of services. Radiation oncologists will be required to see patients for external beam radiation therapy in-person in their office or department where they work to bill for services.
- Prolonged outpatient office visits (HCPCS code **G2212**) will no longer be allowed as a telehealth service. For Medicare beneficiaries, prolonged outpatient services will need to be furnished in-person beginning January 1, 2024.
- CMS currently allows providers to be in their home to provide telehealth visits and report the address of their office or Medicare enrolled location on the claim form. This practice will be discontinued; starting January 1, 2024, CMS will require providers to be physically present in their office or department where they are enrolled with Medicare to bill for any telehealth services. The address and place of service will reflect where the provider is physically present, when providing the work that is billed for during the telehealth visit.
- CMS has allowed for the direct supervision of diagnostic tests; physicians' services, including those services provided incident to and in the office setting; and some hospital outpatient services to be provided using real-time audio/video capabilities. CMS reiterated in the calendar year 2022 Medicare Physician Fee Schedule final rule[4] that after December 31st of the year the PHE ends, providers will be required to be physically present to meet direct supervision guidelines—just as they were required prior to the PHE.

Waivers and Extensions That Will End or Change on December 31, 2024

- Telehealth services that are available to patients in any geographic area and originate in the United States will end. All telehealth services will revert to pre-pandemic guidelines. Patients will need to be present at an originating site—not their home—unless specifically designated for allowance. The House of Representatives bill H.R.134[5] was introduced on January 9, 2023, which would allow patients to be in any originating site located anywhere geographically to receive telehealth services, not only the limited locations as part of pre-pandemic requirements.
- Telehealth services that are provided to patients in their home will end. Prior to the Consolidated Appropriations Act of 2023,[3] CMS determined that only certain designated patients could continue to receive telehealth services while in their home. This was predominantly limited to behavioral health and the treatment of end-stage renal disease and acute stroke. The extension set through the end of 2024 is not diagnosis specific. Beginning January 1, 2025, patients will need to be at an originating site to receive telehealth services, as required pre-pandemic. Audio-only encounters via telephone evaluation and management services (CPT **99441–99443**) will be discontinued; CMS will no longer reimburse or accept these codes for services. The expansion of healthcare professionals, who can furnish distant-site telehealth services and include all those who are eligible to bill Medicare, will end and no longer include many non-physician practitioners.
- Medicare's payment of telehealth services at the same rate as in-person services will end. At this time, it is unknown what payment for telehealth services will look like beginning January 1, 2025. Prior to the PHE, telehealth services were reimbursed by Medicare but not at the same rate as in-person services.

As the PHE response to the COVID-19 pandemic continues to winddown, oncology providers will need to review the various extensions and waivers they implemented throughout the last three years. It is possible that some providers have already reverted to delivering care and services as they did pre-pandemic. For those who are still providing telehealth services, it is extremely important to review CMS' varying phases of change to provide a smooth transition for patients and staff.

For now, CMS is limited in the changes it can enact. Any provisions defined by Congress can only be changed by Congress. If Congress does not address what has yet to be outlined, then CMS will move forward with its changes or endings as defined within the Medicare final rules. Providers should find out what CMS proposes and finalizes for calendar years 2024 and 2025, including how any of these changes could impact their oncology services. OI

Teri Bedard, RT(R)(T), CPC, is executive director, Client & Corporate Resources at Revenue Cycle Coding Strategies in Des Moines, Iowa.

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3. Congress.gov. H.R.2617—Consolidated Appropriations Act, 2023. Accessed April 17, 2023. https://www.congress.gov/bill/117th-congress/house-bill/2617

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5. Congress.gov. H.R.134—To amend title XVIII of the Social Security Act to remove geographic requirements and expand originating sites for telehealth services. Accessed April 13, 2023. https://www.congress.gov/bill/118th-congress/house-bill/134?s=1&r=28

tools

Approved Drugs

- On February 9, the U.S. Food and Drug Administration (FDA) approved **Jemperli® (dostarlimab-gxly)** (GSK, gsk.com) for adult patients with mismatch repair deficient recurrent or advanced endometrial cancer, as determined by an FDA-approved test, that has progressed on or following a prior platinum-containing regimen in any setting and who are not candidates for curative surgery or radiation.
- On March 30, the FDA granted full approval to **Keytruda® (pembrolizumab)** (Merck, merck.com) for treating adult and pediatric patients with unresectable or metastatic microsatellite instability-high or mismatch repair deficient solid tumors, as determined by an FDA-approved test, that have progressed after treatment, leaving patients no good alternative treatment options.
- On April 3, the FDA granted accelerated approval to **Padcev® (enfortumab vedotin-ejfv)** (Astellas Pharma, astellas.com) **in combination with Keytruda** (Merck, merck.com) for patients, with locally advanced or metastatic urothelial carcinoma, who are ineligible for cisplatin-containing chemotherapy.
- On March 16, the FDA approved **Tafinlar® (dabrafenib) in combination with Mekinist® (trametinib)** (Novartis, novartis.com) for pediatric patients 1 year of age and older with low-grade glioma, a BRAF V600E mutation, and who require systemic therapy.
- On March 6, Coherus BioSciences (coherus.com) announced that the FDA approved the single-dose, prefilled autoinjector presentation of **Udenyca® (pegfilgrastim-cbqv)**, a biosimilar of **Neulasta® (pegfilgrastim)** (Amgen, amgen.com).
- On March 3, the FDA approved **Verzenio® (abemaciclib)** (Eli Lilly and Company, lilly.com) **in combination with endocrine therapy (tamoxifen or an aromatase inhibitor)** for the adjuvant treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive, early breast cancer at high risk of recurrence.
- On March 22, the FDA granted accelerated approval to **Zynyz® (retifanlimab-dlwr)** (Incyte Corporation, incyte.com) for adult patients with metastatic or recurrent locally advanced Merkel cell carcinoma.

Drugs In the News

- Pfizer Inc. (pfizer.com) announced that the FDA accepted for review its supplemental new drug applications (NDAs) for **Braftovi® (encorafenib) and Mektovi® (binimetinib)** for patients with metastatic non-small cell lung cancer with a BRAF V600E mutation, as detected by an FDA-approved test.
- Pfizer (pfizer.com) announced that the FDA granted priority review to its biologics license application (BLA) for **elranatamab** for the treatment of patients with relapsed or refractory multiple myeloma.
- Fore Biotherapeutics (fore.bio) announced that the FDA granted orphan drug designation to **FORE8394** for the treatment of primary brain and central nervous system malignancies.
- Hutchmed Limited (hutch-med.com) announced that it completed the rolling submission of an NDA to the FDA for **fruquintinib** for the treatment of refractory metastatic colorectal cancer.
- Accord BioPharma (accordbiopharma.com) announced that the FDA accepted its BLA for **HLX02** (a proposed trastuzumab biosimilar) for the adjuvant treatment of HER2-overexpressing breast cancer, HER2-overexpressing metastatic breast cancer, HER2-overexpressing metastatic gastric, or gastroesophageal junction adenocarcinoma.
- Telix Pharmaceuticals (telixpharma.com) announced that the FDA approved its supplementary NDA for **Illuccix®** (kit for the preparation of gallium Ga 68 gozetotide injection) for the selection of patients with metastatic prostate cancer for whom lutetium-177 (177Lu) PSMA-directed therapy is indicated.
- Lumicell (lumicell.com) announced it submitted an NDA to the FDA for **Lumsight™** for intraoperative breast cancer detection and removal.
- SpringWorks Therapeutics, Inc. (springworkstx.com) announced that the FDA accepted its NDA for **nirogacestat** for the treatment of adults with desmoid tumors.
- Bristol Myers Squibb (bms.com) announced that the FDA accepted its supplemental BLA for **Opdivo® (nivolumab)** as a monotherapy in the adjuvant setting for the treatment of patients with completely resected Stage IIB or IIC melanoma.
- Deciphera Pharmaceuticals, Inc. (deciphera.com) announced that the FDA

granted breakthrough therapy designation to **Qinlock® (ripretinib)** for the treatment of adult patients with unresectable or metastatic second-line gastrointestinal stromal tumor, who received prior treatment with imatinib and harbor a KIT exon 11 mutation and co-occurring KIT exon 17 and/or 18 mutations (KIT exon 11 + 17/18 mutations).

- Mesoblast Limited (mesoblast.com) announced that the FDA accepted its BLA resubmission for **remestemcel-L** for the treatment of children with steroid-refractory acute graft versus host disease.
- Ymmunobio (ymmunobio.com) announced that the FDA granted orphan drug designation to **YB-200** for the treatment of hepatocellular carcinoma.
- Janssen (janssen.com) announced the submission of its NDA to the FDA, seeking approval of **Zejula® (niraparib)** (GSK, us.gsk.com/en-us/) **in combination with Zytiga® abiraterone acetate** (Janssen) **plus prednisone** for the treatment of patients with BRCA-positive metastatic castration-resistant prostate cancer.

Devices and Assays in the News

- Roche (roche.com) announced that the FDA approved its **VENTANA PD-L1 (SP263) Assay** as a companion diagnostic to identify patients with non-small cell lung cancer, who are eligible for treatment with Libtayo® (cemiplimab) (Regeneron, regeneron.com). OI

Ivinson Memorial Hospital, Meredith and Jeannie Ray Cancer Center, Laramie, Wyoming

For the residents of Laramie, Wyo., there is only one source of local cancer care—Ivinson Memorial Hospital, Meredith and Jeannie Ray Cancer Center. When Meredith Ray was diagnosed with prostate cancer in the 90s, he and his wife Jeannie were forced to travel 60 miles south of their hometown to Fort Collins, Colo., to receive treatment. "They drove down there five days a week, and the highway to Fort Collins [U.S. Route 287] is one of the most dangerous highways in the United States," said Amy Smith, director of Ivinson Memorial Hospital, Meredith and Jeannie Ray Cancer Center. "That highway has more accidents than any other two-lane road in Wyoming."

Determined to ensure that patients with cancer in Laramie did not encounter a similar barrier, Meredith Ray and his wife Jeannie began collaborating with the administrative staff at Ivinson Memorial Hospital to develop a cancer center. "We live in such a rural area that it so hard for patients to get care. I am grateful that Meredith and Jeannie Ray took the first step to get a cancer program in our town," Smith said. "Thinking that we didn't even have a cancer center before that—I can't even wrap my head around it."

The Meredith and Jeannie Ray Cancer Center is now one of eight in Wyoming. Built as a single-level facility, it is connected to the Ivinson Memorial Hospital via a hallway—allowing patients with cancer to access hematology, medical oncology, and radiation oncology services.

Delivering High-Quality Cancer Care

"When patients enter our building's main lobby, it branches off, so they can go directly into the infusion suite, medical oncology clinic, or radiation oncology clinic," Smith explained. "Our linear accelerator is right off the front entrance."

The cancer center strives to see patients within seven days of their referral, which involves coordinating care with a hybrid-set of staff. The radiation oncologist lives in Casper, Wyo., which is a three-hour drive from Laramie, and is onsite once a week. Two physicists and one dosimetrist are also present once a week, working remotely from Casper on all other days. Finally, the radiation oncology clinic is staffed full-time by a nurse and 2 radiation therapists, as the clinic offers brachytherapy, IMRT, SBRT, and SRS treatments to patients.

Patients in medical oncology can receive outpatient infusion treatments. The cancer center's infusion suite sees an average of 50 patients a day, using 9 chairs. It is staffed by 5 nurses and 1 patient care technician.

"The walls of the infusion suites are decorated with art from Wyoming," Smith shared. "Our rooms are private bays with glass doors, heated and massage seats, and televisions."

The cancer center also staffs 1 oncology clinical pharmacist, a medical oncologist, and an internal medicine provider—each of whom are supported by a nurse and patient care technician. All staff, except the radiation oncologist, are employed by Ivinson Memorial Hospital.

To further treat patients' disease, the cancer center implemented a nurse navigation program, and a nurse navigator was hired to assist patients with all cancer types. According to Smith, approximately

25 percent of the patients who present to the center are uninsured or underinsured. As such, a financial navigation program was also implemented to assist with patients' financial needs. Their goal is to have every patient meet with the financial navigator prior to beginning treatment, and Smith hopes this practice will ensure patients do not experience financial toxicity. Further, patients have access to two support groups, one of which is dedicated to those with advanced-stage breast cancer. Patients also have access to dietitian services,advanced care planning, and massage coupons.

Through Jeannie's Boutique, a grant-funded program, the cancer center offers specialty services and products to all patients with cancer at no cost. This program offers wigs, head coverings, prosthetic fittings, bras, and lymphedema sleeves. "Jeannie's Boutique was designed with the idea to help cancer patients gracefully adapt to life during and after cancer," Smith said. "With a wide variety of products available to choose from, patient's will be able to find the best look for them." All supportive care services are free and available to patients through self-referral.

Developing Strategic Partnerships with the Community

For rural centers like the Meredith and Jeannie Ray Cancer Center, developing strategic partnerships with the community is key to delivering comprehensive cancer care locally to patients. One of those partnerships is with the University of Colorado Denver – Anschutz Medical Campus. "A lot of the doctors at Anschutz Medical Campus have Wyoming licenses now, and so they're able to consult with our patients via telehealth," Smith said.

Through this partnership, residents of Wyoming can access clinical trials, bone marrow and stem cell transplants, and treatment for acute leukemia. This collaboration allows staff at the Meredith and Jeannie Ray Cancer Center access to tumor boards. "That partnership was developed within the last five years, and it continues to grow," Smith said. "When you have doctors in those big clinics, they don't really have the confidence in rural clinics to provide the care they want for their patients. So, it took a lot of persistence for them to have the confidence that they have in us now."

Further, the cancer center maintains a fundraising partnership with the Wyoming Breast Cancer Initiative. This partnership provides financial resources to breast cancer patients at the center.

Addressing Access Barriers to Care

Though grants with the American Cancer Society, the cancer center provides gas cards, as well as travel and hotel vouchers, to patients in need of this assistance. Additionally, the cancer center built a guest house a few blocks away that is made available to its patients, who must stay locally for treatment, at no cost. "When patients are coming for radiation treatments, they often must stay in town the whole week. The guest house gives them a place to stay and not have to pay for a hotel all week," Smith said. "We are always looking for programs that we can partner with to help our patients with their expenses."

While development of the Meredith and Jeannie Ray Cancer Center resolved many patient access issues, it did not eliminate them all. Smith surmises that travel to and from treatment is still one of the greatest barriers patients with cancer face in Wyoming, with some still having to travel several hours to get treatment. "The cost of fuel, as well, and the time they have to be away from work is a huge burden," Smith said. "In addition, oral medications are often unable to be delivered on time with the remote areas our patients live in."

According to Smith, harsh winters also prevent patients from receiving their medication. "Winter is exceptionally long here—the snow starts in September and does not end until May," she explained. "This past year, the interstate was closed for over a week due to winter conditions and accidents."

The staff at Meredith and Jeannie Ray Cancer Center understand the effects of this problem more than most. Therefore, they ensure that every patient who walks through their doors receives compassionate, patient-centered care. The kind of care that is unique to cancer programs and practices in small towns, where everyone knows everyone. OI

ACCC Welcomes its Newest Members

The Cancer Center of Hawaii
Honolulu, Hawaii
Delegate Rep: Carolyn Voulgaridis RN, JD, MBA
Website: tccoh.com

Ferguson Cancer Center at FHN Memorial Hospital
Freeport, Ill.
Delegate Rep: Risa Tyler BSN, RN
Website:
fhn.org/specialtyCareFeatCancer.asp

ACCC Hosts Pre-Conference Events

On March 8, the day before the ACCC 49th Annual Meeting and Cancer Center Business Summit (#AMCCBS), ACCC held two events: the Best of Community Cancer Care Workshop and the Delivery of Psychosocial Care in Oncology Summit. More than 100 people attended the Best of Community Cancer Care Workshop in-person and online to learn from invited subject matter experts, with 33 participants attending the invite-only summit dedicated to addressing mental health needs in oncology.

Featured Clinical Oncology/Hematology Updates

Natalie Rizk, MD, breast surgical oncology specialist at Ascension Michigan Van Elslander Cancer Center -Ascension St. John Providence and assistant professor at Wayne State University School of Medicine, opened the Best of Community Cancer Care Workshop pre-conference with detailed updates on the multidisciplinary management of breast cancer. In highlighting the evolution of breast cancer surgery from a radical mastectomy (whether halsted or modified) to breast conservation lumpectomy, the treatment of breast cancer has evolved to consider patients' preferences and dedicated improvement to their quality of life. Yet further advancements must be made to address health disparities, use of locoregional management after neoadjuvant chemotherapy, and de-escalation of treatment across disciplines when treating patients with breast cancer.

In quoting June Goodfield, Dr. Rizk closed her session by stating: "Cancer begins and ends with people...It is sometimes possible to forget this one basic fact. Doctors treat disease, but they also treat people, and this precondition of their professional existence sometimes pulls them in two directions at once."

Pedro Barata, MD, MS, director of the Genitourinary Medical Oncology Research Program at University Hospitals Seidman Cancer Center and associate professor of medicine at Case Western Reserve University, then took the stage to discuss emerging targeted therapies for the treatment of prostate cancer. In doing so, Dr. Barata emphasized the need to understand patient's cancer through genetics. "Germline information complements somatic information and vice versa," he said. Further, Dr. Barata believes that genetic test results—whether somatic or germline—are expected to be increasingly used by providers to inform treatment decisions and that molecular profiling holds great potential as a biomarker for response assessment.

Lastly, Farrukh Awan, MD, professor of internal medicine and director of the Lymphoid Malignancies Program at UT Southwestern Medical Center, Harold C.

Krista Nelson, MSW, LCSW,OSW-C, FAOSW, Past ACCC President and senior oncology social worker and program manager, Cancer Support Services & Compassion Providence Health & Services.

Simmons Comprehensive Cancer Center, spoke on the current landscape for treating patients with hematologic malignancies and patient selection for novel cellular therapies. From targeted therapies to immunotherapies, Dr. Awan shared how the evolution of anti-cancer treatments have positively impacted patient outcomes (survival vs. progression) and improved patients' quality of life during and after treatment, with more advancements to come in this space.

Supporting the Well-Being of Patients and Staff

The Best of Community Cancer Care Workshop also featured two sessions dedicated to the operational side of oncology care. Much anticipated, the ACCC Financial Advocacy Network released its Financial Advocacy Services Guidelines. Speakers Lori Schneider, oncology operations manager at Green Bay Oncology, and Meredith Doherty, PhD, LCSW, assistant professor at the University of Pennsylvania - School of Social Policy & Practice, discussed the current landscape of the field and shared strategies to best implement these guidelines in any cancer program or practice. Both speakers emphasized the importance of clinical and operational staff collaboration when building comprehensive financial advocacy programs and addressing financial hardship for patients with cancer. "Please don't push yourselves on this. We know building programs takes time, and we want to help you build a good program," Schneider said. Further, the network will be spending much of its 2023 agenda to identify and disseminate strategies to help cancer programs and practices—of any resource, size, or patient volume—put these guidelines into practice.

Kamakshi Rao, PharmD, BCOP, interim director of pharmacy, Clinical and Academic Enterprises at the University of North Carolina Hospital, then spoke on oncology pharmacy workforce issues that have been severely impacted by the COVID-19 pandemic. With a rapid increase in rate and prevalence of burnout among healthcare providers, including pharmacists, Dr. Rao suggested that cancer programs and practices provide support to their pharmacy staff in the form of professional development, additional training, and protected time to engage in activities outside core business. "We have work to do both from an institutional and organizational level to engage and retain the workforce," Dr. Rao said. And by appropriately supporting, advocating, and recognizing their oncology pharmacy workforce, as Dr. Rao shared, cancer program and practice leaders will be one step closer to retaining a happier and more satisfied workforce.


#AMCCBS participants gather at a networking event.

Delivery of Psychosocial Care in Oncology Summit

Patients with cancer and their circles of support are not the only ones to benefit from psychosocial care. The burden of COVID-19—coupled with the emotional distress associated with caring for patients with cancer and helping patients and families make difficult treatment choices—has brought to light the urgent need to provide comprehensive psychosocial care to the healthcare workforce as well.

Therefore, ACCC hosted its invite-only Delivery of Psychosocial Care in Oncology Summit to convene experts in the field to discuss the current state of mental health in oncology; build a collaborative dialogue among all interested stakeholders to identify action plans that address ongoing mental health issues for patients, caregivers, and the cancer care team; review and identify effective screening tools, training, resources, and policies to address psychological distress among individuals; and identify barriers to providing and accessing timely and appropriate care for patients and caregivers experiencing psychological distress. Next steps identified by the group in this space includes incorporating rural health systems into the process to better fill gaps and increase access, education on what collaborative care is, better support for those implementing collaborative care in practice, and identifying a group of early adopters—needed to convince others to develop collaborative care models with a focus on psychosocial care, too. Stay tuned for more information from ACCCBuzz, the CANCER BUZZ podcast, and the association's official journal, *Oncology Issues*.

The ACCC 49th Annual Meeting and Cancer Center Business Summit

On Thursday, March 9, about 500 participants convened in Washington, D.C., at the ACCC 49th Annual Meeting & Cancer Business Summit for a day and a half of general sessions, deep dive workshops, and networking opportunities. Below are highlights from #AMCCBS.

Stories From CRISPR

Kevin Davies, PhD, referred to CRISPR as a “cutting-edge technology with miraculous benefits,” adding that “this is not just science fiction anymore. There are patients walking around today that have been cured by this technology. This is why we fund basic research.” Dr. Davies described the current healthcare landscape as being characterized by an “arms race for drugs,” thus technologies like CRISPR will be key in the future of delivering equitable, high-quality cancer care to patients everywhere.

Cancer Moonshot Update

“I want to start where the president and first lady usually start—hope. We don’t mean hope in the abstract. We mean hope grounded in reality,” said Danielle Carnival, PhD, coordinator for the White House Cancer Moonshot, as she opened her session. “Taking on cancer is one the life missions for the president and first lady because of the impact it has had on them, but it is a presidential priority because of the impact it has on every one of us—cutting short too many Americans’ lives. That is why the president and first lady relaunched the Cancer Moonshot program.”

According to Dr. Carnival, access and health equity are major components of the relaunched Cancer Moonshot Initiative. “The tools we have and those we develop along the way must reach all Americans,” she said. “To address inequities, we must ensure that every community in America—rural, urban, tribal, and everywhere else—has access to cutting-edge cancer diagnostics, therapeutics, and clinical trials.”

Dr. Carnival described these goals as a “shared agenda” that every member of the healthcare community must focus on achieving. “The president called on everyone to do their part: the scientific community to bring its boldest thinking to the front, and the medical community to improve their outreach and support for underserved people around the country,” she said, adding that “the private sector must step up and develop new treatments.” Further, Dr. Carnival highlighted President Biden’s desire for patients with cancer to share their stories. “The president respectfully called on people living with


Meeting participants enjoyed the opportunity to learn from and ask questions of expert presenters.

Keynote speaker Kevin Davies, PhD, executive editor of *The CRISPR Journal* and author of “Editing Humanity: The CRISPR Revolution and the New Era of Genome Editing.”

cancer, their caregivers, family, and those who have lost someone to share their perspectives and experiences and to keep pushing for progress," she said. Patients with cancer and their loved ones can share their experiences on the Cancer Moonshot's website.

Dr. Carnival then discussed the goals of the first ever Cancer Cabinet:

- To set up priority actions to close the screening gap
- To understand environmental and toxic exposures
- To decrease the impact of preventable cancers
- To bring cutting-edge research through the pipeline to patients and their communities
- To better support patients and caregivers.

Dr. Carnival went on to discuss the work that has been done within the Department of Veteran Affairs: "1.5 million veterans have already received screening for toxic exposures as of January, and in November, the VA [Veteran Affairs] announced it would expedite veteran's claims for cancers associated with toxic exposure," she said. The commitment of the U.S Food and Drug Administration (FDA) and National Cancer Institute (NCI) were also highlighted. "The FDA is moving forward on making sure that we have regulations in place that make cigarettes and tobacco products less attractive and addictive," Dr. Carnival said. "The NCI launched new efforts to connect clinical trials more extensively to underrepresented groups."

Dr. Carnival wanted attendees to leave with two primary messages. "The first is we need to bring the cancer care system to people," she said. "And the second is, so much is being asked of a family with a cancer diagnosis—cancer brings a financial, emotional, and medical burden. We need to find better ways to support them." Dr. Carnival concluded by discussing the primary points from President Biden's 2023 State of the Union address, regarding the Cancer Moonshot. These points include:

Bringing America's Cancer Moonshot mission into the 21st century—an initiative centered around the reauthorization of the National Cancer Act.

Meeting attendees packed the deep dive sessions and participated in lively and timely discussions.

Providing patient navigation to support every American facing cancer.

Tackling smoking, the single biggest driver of cancer-related deaths in the U.S.

"The president often says that his dad had [an] expression, 'Don't tell me what you value. Show me your budget, and I will tell you what you value.' I am glad to say the budget [which was published on Thursday, March 9] will show the value the President places on the Cancer Moonshot," Dr. Carnival said. "America will lead by the power of its example—this is the framework in which [the] Cancer Moonshot sits."

Diving Deep into Oncology Care Challenges

ACCC hosted eight deep dive workshops throughout the day, allowing invited expert facilitators and attendees to partake in interactive conversations to identify challenges its members are experiencing today and help generate practical solutions to mitigate or resolve those challenges. Areas of focus included:

- New care delivery models
- Business intelligence and artificial intelligence technology solutions
- Precision medicine
- Payer-driven challenges
- Research and clinical trials
- Staffing models and workforce strategies
- Patient engagement.

Discussion from these workshops will be captured and used to develop a comprehensive report for ACCC-members post-conference, scheduled for publication in the Volume 38, Number 4 *Oncology Issues*.

The 2023-2024 ACCC President's Theme

Friday, March 10, #AMCCBS began with the ACCC House of Delegates Meeting and the announcement of Olalekan Ajayi, PharmD, MBA, chief operating officer at Highlands Oncology Group, PA, as the 2023-2024 ACCC President. "It is a privilege and an honor to serve as ACCC President," Dr. Ajayi said. "My President's Theme will be *(Re)Building the Oncology Workforce to Deliver Next Generation Cancer Care.*" (Read more on page 4). As his first official duty as ACCC President, Dr. Ajayi introduced opening keynote, Andre Harvin, PharmD, MS, MBA, executive director of pharmacy, Oncology Services, at Cone Health Cancer Center.

Robotics in the Oncology Pharmacy

Andre Harvin, Pharm D, MS, MBA, previewed his keynote for ACCCBuzz—sharing the major highlights of his address. And during his live session, Dr. Harvin discussed how incorporating robotics into the oncology pharmacy facilitated efficiency at Cone Health Cancer Center. "By leveraging robotics and improving collaboration with nursing, we reduced average patient waiting time by 30 percent," he said. "We also used robotics to compound medication ahead of time—this strategy saved 143 hours in [patient] wait time each month."

According to Dr. Harvin, growing healthcare costs pose a significant challenge to cancer programs and practices around the country. Further, Dr. Harvin believes that healthcare has been affected by the inflation rates that have and are still sweeping the nation. "High contract labor expenses, in addition to high salaries, are required to keep qualified employees," he said. "Healthcare has not been immune [to inflation rates, as] a lot of people exited the healthcare field." By leveraging robotics at Cone Health, Dr. Harvin and his team were able to devote their time to more pressing issues. "Now, I can have that pharmacist focusing on what they do that is unique, and that is being a drug expert who can answer questions for providers and patients," he said.

2023-2024 ACCC President Olalekan Ajayi, PharmD, MBA

Attendees at the 2023 ACCC House of Delegates Meeting.

Friday's keynote speaker Andre Harvin, PharmD, MS, MBA.

The NYC Nursing Strike

"There was moral distress. The nurses that had to walk away from that baby at 6:00 AM, the nurses that knew that patients were going to come in for chemotherapy that day and they were not going to be there to see them—there was so much distress," said Una Hopkins, DNP, RN, FNP-BC, director of research at Montefiore Einstein Center Cancer Care, as she discussed the nursing strike that occurred in New York City earlier this year. "It is upsetting because I am nurse."

Mark Liu, MHA, senior director of oncology strategy, transformation, and analytics, Oncology Service Line at Mount

Sinai Health System & Tisch Cancer Institute, echoed Hopkins's sentiment on the issue—where more than 7,000 nurses in NYC walked off the job and went on a three-day strike in early January. "We aim for perfection, but, in moments of crisis, there is a lot to handle," he said. According to Liu and Hopkins, burnout, stress, and a reduced workforce contributed to the NYC nursing strike. "It wasn't about salary. It was about fighting for safer staffing ratios and not wanting to take care of patients in hallways," Hopkins explained.

Liu and Hopkins also asserted that the COVID-19 pandemic created a lasting strain among nurses that may have contributed to the strike. "COVID[-19] really did a lot to the nursing workforce," Hopkins said. And Liu adding: "During COVID[-19], there were long, incredibly intense days. We were home for maybe four hours on some days. The uncertainty of not knowing when it would end—it was very tough."

To supplement the gap in care created by the strike, Hopkins' team sought the services of travel nurses. "We knew we were going to add travel nurses, but they are expensive," she said. "I onboarded 485 nurses in three days." Her team also employed specialty nurses to assist in care delivery at her cancer program.

The impact of the NYC nursing strike also affected different members of the multidisciplinary cancer care team. "Our respiratory therapists, our nurses' aides, who were not in the same contract, our unit secretaries, they were all impacted," said Hopkins. "The impact was real for everyone. It wasn't just nurses."

Moving forward, Liu and Hopkins believe it is incumbent for health systems and/or hospitals' leadership to ensure workplace satisfaction—thereby reducing the risk of a strike among other groups within healthcare.

Creating a Real Impact

"This conference [#AMCCBS] will have an impact on improving cancer care delivery on Monday morning," said ACCC Immediate-Past President David R. Penberthy, MD, MBA, medical director, Radiation Oncology at Penn State Health Milton S. Hershey Medical Center, at the conclusion of #AMCCBS. The inclusion of small-group deep dives and expert-driven general sessions gave attendees unique insights and strategies to take home to improve operations at their program or practice. Looking forward, ACCC will continue to provide resources and tools based on the conversations at #AMCCBS that cancer programs and practices everywhere can use to facilitate the delivery of comprehensive, high-quality, and equitable cancer care to patients. OI

Ben Jones, vice president, Government Relations & Public Policy, The US Oncology Network, McKesson (far right) interviewed Mark Liu, MHA, senior director of Oncology Strategy, Transformation & Analytics, Oncology Service Line, Mount Sinai Health System & Tisch Cancer Institute, and Una Hopkins, RN, FNP-BC, DNP, director of Research, Montefiore Einstein Center Cancer Care, about the recent nursing strike in New York City.

#AMCCBS attendees returned to their cancer programs and practices with insight into the emergent issues facing the oncology community.

Medical Hypnosis: Where Cancer & Hypnotherapy Meet

BY MARY B. BATTAGLIA

Medical hypnosis can help support people diagnosed with cancer. As a clinical hypnosis practitioner, I have used hypnosis techniques to alleviate pain, remove fears, stay calm, and help prepare for surgery during my own cancer journey.

I have been practicing clinical hypnosis for 10 years, working with clients to address many different issues like anxiety and stress. I have supported individuals with different medical issues, including brain, breast, lung, prostate, and skin cancers. Some patients with cancer came to me because of their fear of needles or for preparation before chemotherapy and blood work. Others need support pre-surgery, with relaxation techniques, or for healing purposes. I have found that with hypnosis I am able to help people in a way that creates a wholeness in their healing.

Hypnosis is a relaxed state like a meditative state; it is like a daydream but deeper. Many of us can experience hypnosis on our own, usually while getting lost in our thoughts. I guide people through hypnosis to let go of thoughts by entering the subconscious where your memories and imagination exist. People usually remember these sessions, and we will have conversations while they are in that state. In deeper states of hypnosis, we can look within to see if there is information about one's illness. An individual can hold on to traumas, pain, or emotions from their past, and we can release these via hypnosis, helping in the healing process.

There are many different techniques to help people though hypnosis, including visualizing the healing of one's body or using processes to reduce pain or discomfort. For people with a deep faith, they can find comfort in the hypnotic space. For example, I had one client who was getting ready for a lumpectomy for breast cancer, and—through hypnosis—she saw all these angels surround her in the treatment room and felt comforted. It removed all her fears, and she knew she would be okay. She left her procedure feeling elated and called me after to share how calm she felt and how everything went well. You never know what someone will experience in hypnosis because it truly is unique to the individual.

Last year, I learned firsthand just how valuable and supportive hypnotherapy can be for those with a cancer diagnosis.

My Story

In November 2021, I was diagnosed with chronic myeloid leukemia. For me, that year was challenging and not just because of my diagnosis, but because my mom's health also declined. She passed from congestive heart failure in May. After she passed, my sister and I had to clean out our family home, filled with years of memories and personal belongings to review. So, when I saw that my body was bruising more than usual, I wrote it off as a side effect of the packing and moving.

Once the house sold, I went on a five-hour drive to Maine to decompress. I was amazed at how tired I was and how much time I spent in bed. I thought that between the moving and grief I was just exhausted. But then I noticed that I was starting to have shortness of breath when walking up hill. Putting the pieces together, I decided that it was time for me to get a physical, which I scheduled in November. A few days before the appointment, I noticed that my stomach was tight and that I was experiencing some discomfort.

Two nights after my check up, my doctor called and provided me my blood work results: my liver panel was off, I was very anemic, my white blood cells were elevated, and my spleen was very enlarged. I asked how high my white blood cell count was, and she told me the normal range was from 4,000 to 10,000; mine was at 90,000. She proceeded to tell me that I needed to go see a hematologist because I could have leukemia.

I remember hanging up the phone and wondering if I really had leukemia. It took a few days for me to get an appointment scheduled with a hematologist for the following week. I also did some research and saw that I had many of the symptoms for leukemia. It took about two days for all of this to sink in and for me to accept that leukemia was a possibility. In that moment, I also remembered the advice I would give to the patients with cancer I would see. I told them how important it is to keep an optimistic mind set and not let the fear of cancer take control. This is a mindset I knew I needed to keep as well.

Hypnotherapy

After the initial shock, I decided to create a hypnosis script about my body's ability to produce healthy white blood cells. I wrote a script about my blood cells being healthy and read it into my phone recorder, along with visualizing of all my white blood cells as being healthy. I also created a night-time ritual of listening to the recording for daily relaxation and positive reinforcement. I would repeat parts of it, as well, to reinforce the idea within that I am healthy.

I also did self-hypnosis during the day if I needed to feel calmer. This is similar to a meditative process. I would focus on one spot, taking a few breaths in and closing my eyes. I would then let go of my thoughts to clear my mind and stay in that quiet space for as long as I needed. My whole body would relax, and all the mindless chatter would dissipate, creating calm. I did this before my appointments or if I felt my stress or anxiety level increasing, and it really helped me. It made me feel like I had some control, even before I went to see the hematologist. Taking action to help myself was empowering and removed some of the helplessness I was experiencing.

Over the next few days, I felt deep sadness. It felt like I had been on the highway of life and that this looming threat of leukemia had sideswiped me and put me on the shoulder of the road. I was in shock. The thought of a cancer diagnosis created fear and uncertainty in me. I did not fear death, but I feared the treatment and how I would respond to it.

Ten years before (in 2011), I watched my sister, who was diagnosed with breast cancer, go through chemotherapy for a year and a half until she passed. And the memories of that experience came flooding back to me. I had not yet realized how my sister's cancer journey impacted me. I always told myself that "I would never do chemotherapy." Lesson learned; never say never.

Powerful Tools to Build Strength

As I entered the cancer center for my appointment, I paused and said a little prayer to give me strength and help me heal. This is a routine I continue to this day any time I go back to the cancer center for lab work or a medical appointment. Pausing and saying a blessing is how I create a positive intention, which gives me strength and peace as I walk into my appointment. During challenging times in life, having tools to help comfort and support you are empowering.

They needed to do blood work to determine if I had leukemia, as my white blood count increased to 130,000. The hematologist wanted me to take an oral chemotherapy medication to lower my white blood count. I told him that I did not know if I could take the pill, stating that I would get the prescription filled, but I was not sure I would take it. It all felt like it was happening so quickly.

> Being mindful of our words and how we say something creates a shift in the mind in how we receive information in the brain. Our mindset and how we absorb the information being shared makes a difference in how we respond to it.

In the days leading up to my lab results appointment, I used hypnotherapy to do inner work on myself—to release and let go of the fear I had toward chemotherapy. By releasing the blocks and fears I had, I freed myself to welcome the healing component of the medicine.

I went back to the doctors and found out I had Philadelphia chromosome-positive chronic myeloid leukemia—a disease that occurs due to an abnormal fusion gene called BCR-ABL1, which results from a change in chromosomes in the body. I felt relief knowing that my disease was a more manageable cancer.

I then went to a new hematologist to get a second opinion. I appreciated that this hematologist could give me some suggestions when I asked how I could visualize combatting the cancer. Throughout my career, I have created many pre-surgery recordings for my clients, allowing them to feel love and support. I acted and did this for myself before my bone marrow biopsy. The nurse practitioner let me listen to the recording during the procedure. The verbiage I used—being calm, relaxed, safe, and secure—is what gave me comfort. After the procedure I was stiff but did not feel any pain or have any swelling the next day.

Taking Back Control

When I started sharing my diagnosis with friends, I was careful with how I communicated it. I did not want the leukemia to take over my life. I used the phrase, "I have been diagnosed with leukemia," verses, "I have leukemia." To me, being diagnosed creates a barrier between me and the disease. Being mindful of our words and how we say something creates a shift in the mind in how we receive information in the brain. Our mindset and how we absorb the information being shared makes a difference in how we respond to it. My goal was to have my mind be strong, in control, and positive, so I could support myself on my healing journey.

It just so happened that I received a new oral chemotherapy on a day that my friends were over for lunch. I opened the packaging and said a blessing (or sent positive thoughts) over the medication. I expressed my gratitude for the medicine to enter my body and help me heal, removing the bad white blood cells. I said out loud, "I am open and ready to receive your healing." I then asked the medicine to leave my body quickly after it does its job. I visualize this happening as I speak. My friends also said positive things to me about the medicine and how it would help me. It was moving to feel such love and support from them. It also felt empowering and supportive to take action and control over what I was putting into my body. Every night when I take the pill, I express gratitude for it helping me heal.

Everyone experiences side effects differently. I get swelling in my face, and my skin is more sensitive to lotions.

Left: For some patients with cancer, meditation has been shown to help relieve anxiety, stress, fatigue, and improve sleep and mood.

Right: Mary poses with singing bowls (also known as sound bowls) that are used to promote relaxation and offer healing properties.

My stomach often feels tight and sometimes nauseous. I have lost weight, and I eat smaller meals. Because of the leukemia, I changed my diet to eat more vegetables and small amounts of protein, while trying to avoid sugars, processed foods, and white flour products. When the tightness in my stomach gets too uncomfortable, I use hypnosis to visualize the tightness and unwinding the knots, so it feels more relaxed.

Besides listening to my hypnosis recording, I create my own personal hypnotherapy sessions where I visualize a hand scooping the bad white blood cells out of my bone marrow. I then envision a healing light coming into the bone marrow and spreading throughout my body. I feel calm, I feel the healing, and I believe that I am getting additional benefits from this work.

Going Forward

When a cancer diagnosis occurs, I believe that it is a wake-up call that we should make changes in how we approach life. I have made dietary changes and rebalanced my work and life. I experienced a lot of fatigue in the first few months, and I have honored my time by slowing down to heal and doing more of my hypnosis sessions via Zoom. I am grateful for my arsenal of tools (e.g., practicing hypnotherapy, positive affirmations, mindfulness, etc.) that help me heal in conjunction with the medical treatment. Now that my energy is back, I am focusing on creating a new addition to my work: hypnosis tools for people with cancer to have the same support that I had.

As we journey through life and face its challenges, we need to create a good mind space for ourselves.

Hypnosis helped me take back control over the cancer, instead of the disease making me feel as if I had no other options. It helped me keep an optimistic mindset, even during sad times; stay motivated to make the right nutritional choices; and create positive thoughts so I can feel like I am truly supporting my healing. Today, my body is barely making any more of the bad white blood cells, and I have two years of treatment left. I believe that I will heal quicker in that time and that is what I tell my body every day. In the meantime, I focus on living a full and complete life. OI

Mary B. Battaglia is a certified clinical hypnosis and sound practitioner, speaker, and the author of Transformation Through Hypnosis: Relax, Clear Your Mind & Step Into Your Power. *Mary helps people reduce stress, heal, remove fears, clear blocks, and tap into their unlimited potential. She is trained in medical hypnosis and helps people with illnesses, pain-reduction techniques, side effects of medicine, reduce anxiety, insomnia, and other health-related issues.*