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ONCOLOGY ISSUES

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Standardization of Bereavement Care Across Oncology Institutions

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Standardization of Bereavement Care Across Oncology Institutions

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By Erin King and Kristen Breault

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FROM THE EDITOR

Data Analyst: The Newest Member of the Multidisciplinary Team

BY MARK LIU, MHA



It's hard to believe that another ACCC National Oncology Conference (NOC) is in the books. Congratulations again to all the 2023 ACCC Innovator Award winners! Thank you for making the time to come to Austin, Texas, and share your work with the wider cancer care community. For those who could not attend this year's NOC, look for articles from each of the 6 ACCC Award winners starting in the next *Oncology Issues*.


Outside of these thought-provoking sessions, I always enjoy the opportunity to meet new people and reconnect with colleagues from across the country. The NOC is always such a great way to build your professional network with members across all disciplines yet working towards the same goals and facing similar challenges.

While these challenges can feel insurmountable at times, attending meetings like the NOC is where I am able to re-energize myself. There's something to be said about how helpful ACCC members are in supporting one another. A prime example is the "Women Leaders in Oncology: A Panel Discussion" on Friday, Oct. 6, which kicked off the last day of this amazing conference. Personally, I found it such an incredibly powerful session, hearing from such a diverse and talented group of leaders in healthcare and how these successful women have navigated and nurtured their own careers. They shared their diverse career paths with such honesty and vulnerability it inspired an equally open dialogue with members of the audience during the Q&A. It truly was a session that sparked overdue conversations about the importance of leadership development of women, and the 90 minutes just flew by!

As usual, there were so many takeaways from the NOC that it's challenging to zero in on one, but here goes. From my perspective, several sessions reinforced the importance and power of data and how cancer programs and practices that want to succeed under value-based care and alternative payment models should strongly

consider hiring an FTE data analyst as the "newest" member of the multidisciplinary cancer care team. While most hospitals have a dedicated information technology department, it is not just about analyzing and bringing together different data sets but also about having the oncology knowledge to translate that information into meaningful and actionable insights for cancer programs.

I heard this insight repeated at ASCO's Quality Care Symposium a few weeks later, with multiple examples of bringing together clinicians and data analysts to measurably impact and improve patient care.

I lead a small but mighty team of data analysts, and it has been profoundly rewarding to see the impact this team has made on cancer care delivery at my organization. So, when forecasting and making hiring decisions in 2024, I urge you to think outside of the traditional disciplines and specialties and bring on a data analyst(s) dedicated to your oncology service line. 

A Message of Gratitude to our Corporate Members

We wish to acknowledge and thank our corporate members for their ongoing support and commitment to ACCC throughout the year. Our annual initiatives, conferences and programs are able to thrive because your organization is an important part of our community.

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Community Collaboration in Cancer Care: A Bridge to Hope and Healing

BY OLALEKAN AJAYI, PHARMD, MBA



The journey of anyone diagnosed with cancer is daunting, but it is not a journey one must travel alone. When communities and the oncology workforce come together, they can

create a powerful support system that empowers individuals to face cancer with resilience and hope.

One of the most significant benefits of community collaboration is access to information and resources. Community organizations can serve as valuable hubs for disseminating knowledge about cancer prevention, early detection, and available treatments. This proactive approach can help reduce cancer incidence rates by promoting healthy lifestyle choices and regular screenings. Additionally, community-based programs can help patients and their families navigate the complex healthcare system, ensuring they receive timely and appropriate care.


In many cases, individuals facing a cancer diagnosis experience a sense of isolation and fear. When this happens, community support groups and networks become invaluable. Connecting patients with others who have walked a similar path can provide emotional support, reduce anxiety, and foster a sense of belonging. The oncology workforce can play a pivotal role in facilitating these connections, ensuring that patients receive not only medical treatment but also the emotional and psychological support they need.

Financial toxicity is another significant challenge for patients with cancer. The cost of cancer treatment can be exorbitant, and many struggle to cover medical expenses while maintaining their quality of life. Community-based initiatives, such as fundraising events and financial assistance programs, can alleviate some of this burden. By partnering with communities, the oncology workforce can help identify and leverage these resources, ensuring that no patient must choose between their health and financial stability.

Vulnerable populations often face barriers to accessing cancer care, including limited access to healthcare facilities, transportation, lack of health insurance, and cultural or linguistic barriers. Working closely with community leaders and organizations can help identify and address these disparities, ensuring that all individuals, regardless of their background, have equal access to quality cancer care.

In the era of personalized medicine, community engagement is critical in advancing cancer research. By involving communities in clinical trials and research initiatives, the oncology workforce can ensure that research outcomes reflect the diverse populations affected by cancer. This diversity not only enhances the generalizability of findings but also fosters a sense of ownership and participation among community members.

The importance of the oncology workforce partnering with communities in providing cancer care cannot be overstated. This collaboration goes beyond medical treatment; it encompasses a holistic approach to cancer care that addresses the physical, emotional, financial, and social needs of patients and their families.

As a cancer care provider, I encourage you to know the organizations in your community that you can partner with to make significant strides in cancer prevention, early detection, treatment, and research. You will find that your efforts will not just be about treating cancer; it will be about building a compassionate, inclusive, and equitable healthcare ecosystem where no one with cancer gets left behind. 

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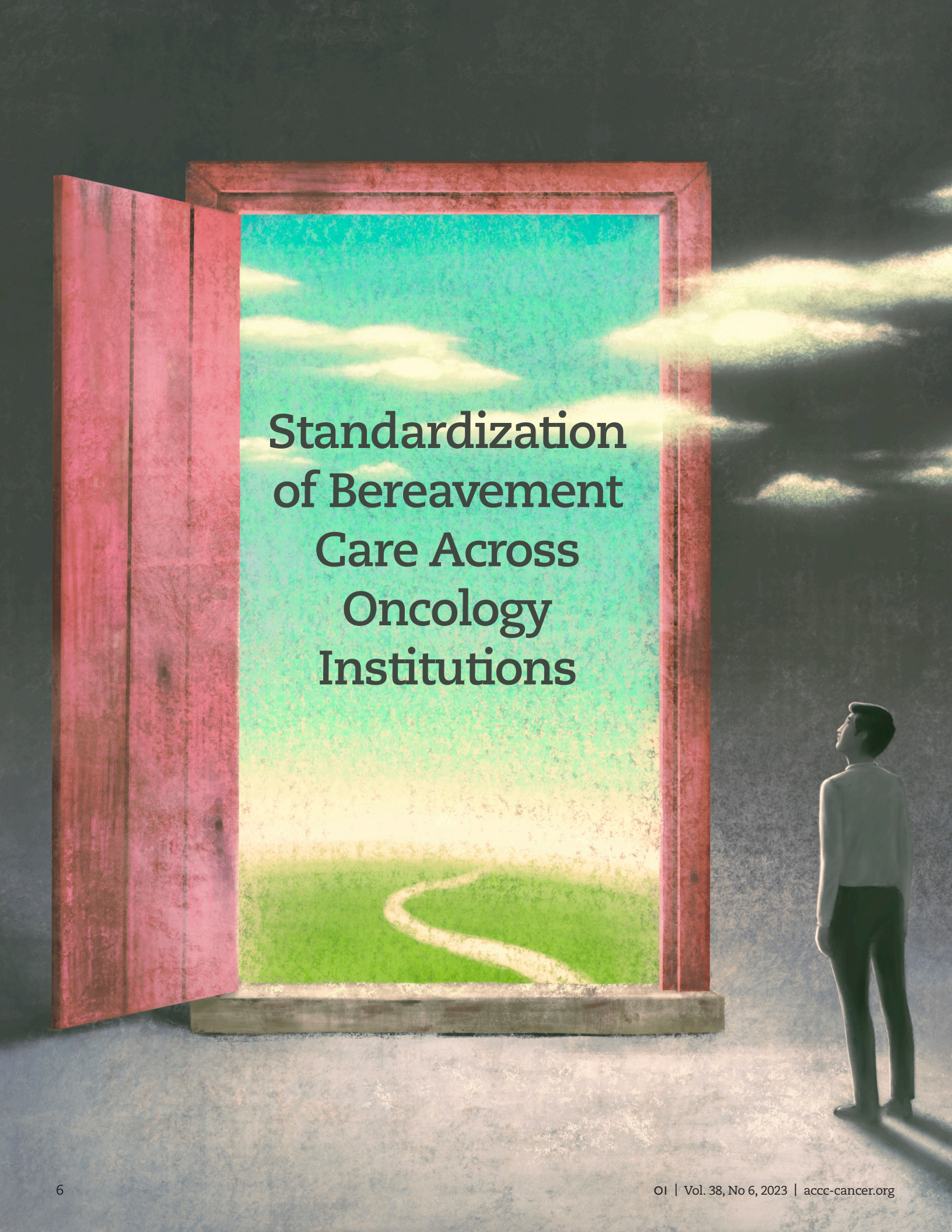
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Standardization of Bereavement Care Across Oncology Institutions

Traditionally, bereavement services are equated with individual grief counseling and support groups, yet these services do not encompass the universality of the grief experience. The implementation of bereavement services across the oncology social work field will help providers to better support bereaved clients, while also working to disrupt the delusion that health care providers are immune to loss.¹ Implementation of institutional and personal bereavement support will grant permission for professionals to tend to their own bereavement needs within the professional space. This practice is in contrast with the current notion that professionals must practice self-care on personal time. Established bereavement programs and protocols in oncology settings have been shown to support better psychosocial outcomes for clients.² Documented outcomes include a reduction in grief, depression, and anxiety.³ Despite being identified as a central component of high-quality end-of-life care, bereavement services tend to fall behind other components of palliative care and lack standardization across practice.⁴ Standardization of bereavement care across oncology institutions has the potential to increase positive connections between staff and bereaved families and promote emotional support and healing among bereaved clients and professionals alike.^{1, 2, 5}

The Dempsey Center, a nonprofit organization serving individuals impacted by cancer, has implemented a bereavement standard work process that informs, connects, and supports clients and staff. Elements of the framework include, but are not limited to:

- Individual grief counseling
- Legacy and life review
- Expressive arts workshops
- Grief after cancer loss support groups
- Intentional space made for staff members to process client deaths.

This article is designed to be a call to action for the ongoing provision of bereavement services in oncology social work. With barriers in mind, we describe in detail the key elements of the Dempsey Center's bereavement programming for practical considerations of implementation in other oncology settings.

The literature focuses heavily on bereavement care within pediatric oncology or palliative care settings, yet the delivery of comprehensive cancer care supports the provision of established programs or protocols in all oncology settings.²

The Dempsey Center as a Model

The Dempsey Center is a nonprofit organization that was founded in 2008 by the actor and Maine native Patrick Dempsey. Dempsey's mother was diagnosed with cancer and through his journey alongside her, he was inspired to create a space where the whole person would be treated, not just their illness. Through that experience, the Dempsey Center was born with the goal of providing personalized and comprehensive care at no cost to anyone impacted by cancer, at any point in their cancer experience. Populations served are those with a cancer diagnosis as well as care partners, family, and friends. Currently, most services are primarily available to those who live in Maine, but it is the active goal of the organization to expand the reach of services outside of the state in the coming years.

Service offerings for clients include individual and family counseling, support groups, nutrition-focused consultation and programming, youth-focused programming, life and legacy work, movement and fitness, massage therapy, acupuncture, and psychoeducational workshops. The program encompasses 2 physical office locations, an online platform for virtual programming, and a hospitality house, which provides lodging for clients who must travel a long distance for cancer treatment.



Remembrance flags created at the 2022 Dempsey Challenge.

Making the Case for Bereavement Care

Grief is a central component of the entire cancer experience, from the time that the diagnosis is received, throughout the course of treatment, and at any point in between and after—whatever that after may look like. Grief is most often associated with death, yet numerous nondeath losses occur throughout a cancer journey, for the person receiving the cancer diagnosis and their loved ones. The ripple effect of secondary losses may include concrete losses (eg, shifts in finances), relational losses (eg, losing friends who cannot be supportive), belief system losses (eg, questioning of faith, reimagining hopes and dreams for the future), and identity losses (eg, career termination or changes of physical abilities) (Figure 1).⁶ Oncology social workers are attuned to the vastness of grief that accompanies a cancer diagnosis and are uniquely prepared to identify those losses and respond to the bereaved.⁷

While not always absent, bereavement care is highly variable across settings. Studies of oncologists have demonstrated that bereavement care varies significantly based on factors including specialty, resource availability, and individual opinions.⁹ Some institutions have designated bereavement follow-up practices, yet there is a question of what the “right” kind of follow-up should be.⁵ The literature focuses heavily on bereavement care within pediatric oncology or palliative care settings,

yet the delivery of comprehensive cancer care supports the provision of established programs or protocols in all oncology settings.²

Barriers to implementing bereavement care may include financial, lack of systems for identifying and tracking the bereaved, and competing work demands.^{4,9} In medical oncology settings, caring for patients is, of course, the first priority, yet as one palliative care physician states, “Following people through bereavement is very important...[yet] bereavement care always ends up on the bottom of the list of things to do. It can always be put off until tomorrow.”⁵ Many oncology providers do not receive formal training on how to navigate the personal impact of client deaths and may grapple with how to be present for bereaved loved ones while also tending to their own emotional landscape and risk of burnout.⁴ Without a designated process and designated staff responsible for that process, bereavement services may easily continue to be a component of care that is seen as a desirable “bonus” as opposed to a necessity.

Bereavement services are often associated with grief counseling or support groups, but there is a wide spectrum of meaningful procedures and practices that can have a powerful impact without requiring an abundance of resources. What’s more, counseling and support groups do not encompass the provider’s grief experience. The reality is that the implementation of bereavement services is

important for any professionals working within oncology, considering the high frequency in which they are encountering death and holding other people's grief.¹ Not only are oncology social workers pivotal in addressing the bereavement needs of clients served, but also in highlighting the tendency for professionals to neglect their own mental, physical, and spiritual well-being.⁹ Establishing a standard practice for bereavement care that includes professionals who confront death in their working lives can destigmatize grief in the workplace and highlight the inevitability and universality of loss.

What Research Shows

It is estimated that 609,820 cancer deaths will occur in the United States in the year 2023.¹⁰ Extrapolating these data, it is clear that the number of bereaved individuals will surpass this number. The death of a central person from cancer can be distinguished from other types of bereavement, due in part to the reality that the bereaved are exposed to numerous sources of psychological distress throughout the cancer experience. These include observing physical and emotional changes in their loved one, witnessing traumatic events (eg, watching a loved one experience cachexia or be subject to falls), and experiencing uncertainty surrounding a loved one's prognosis.¹¹ With the number of cancer-related deaths remaining steady, it is imperative that oncology social workers recognize their position in being able to provide support and education to the bereaved as they move through grief.

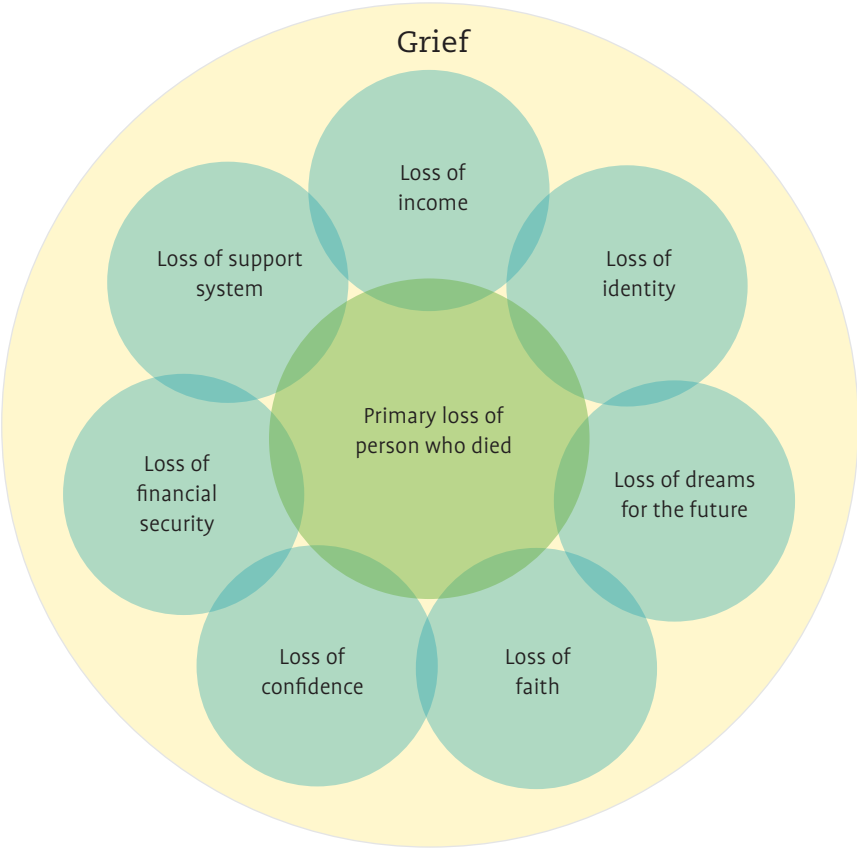
Grief does not begin at the time of death, but rather during periods of change.¹² A cancer diagnosis is marked by chaos, uncertainty, and unpredictability. Thus, individuals grieve the anticipated loss in addition to the ongoing secondary losses throughout the course of illness.¹³ With the awareness that grief is not reserved only for those whose illness ends in death, it is crucial for oncology social workers to name the experience of anticipatory grief and provide support around these feelings to anyone navigating a cancer impact.

The adolescent and young adult (AYA) population experiences unique challenges in bereavement, specifically the increased experience of loss of future with their deceased loved one. While grief is universal, the challenges that arise for younger adults (18 to 40) are different from those that can present for bereaved adults in their 50s and 60s. No person's grief can be deemed more or less intense, but the experiences are different, which highlights why grief support for the AYA population is so crucial. The death of a parent, for example, can be one of the most stressful life events a young person moves through, and the terminal phases of a parent's illness are a period of psychological vulnerability.¹⁴

Client Care

The Dempsey Center's team of oncology social workers are responsible for most of the bereavement services, all of which are offered in-person and virtually. Bereaved clients are offered 10 individual grief counseling

Figure 1. Secondary Losses Associated with Cancer⁸





Collages created from an expressive arts workshop.

sessions as well as grief after cancer loss support groups. Most Dempsey Center bereavement groups are general, meaning they are open to anyone who has experienced the death of a loved one to cancer. Others are tailored to a topic, such as navigating grief during the holidays. Given the special considerations for the AYA population, several age-specific groups are offered in rotation: general grief after cancer loss, loss of partner, and loss of parent. Support groups have been shown to encourage members to share their experience while working towards restoration of their current lives. To grieve with others normalizes the grief experience and promotes healing in community.⁶

Expressive arts healing workshops are another option for bereaved clients. Often the experience of grief goes beyond what words can describe and therefore processing it through other media such as writing, drawing, or collage can be powerful and healing. As social creatures, humans possess an innate drive to express themselves outwardly. The inability to do so has been shown to promote poor physical health.¹⁵ Meanwhile, engaging in expressive acts, even solitary activities such

as writing, has been shown to promote well-being.¹⁶ Human existence is full of uncertainties, and it is a natural inclination to want to understand the world and all that it encompasses. To create is a natural response to wanting to make sense of the sensory stimuli people receive daily. Art allows for the nonverbal aspects of an experience to be displayed, to step in and translate when words are not enough.¹⁶ Workshops at the Dempsey Center have included curricula featuring writing, collage, and drawing. These groups are limited to 10 participants and have a mix of solitary work and community discussion.

The psychosocial team also offers legacy and life review filming, a process in which an oncology social worker and a client who has been given a terminal prognosis work together to come up with questions and answers that reviews the client's life, takeaways, and sentiments they would like to express. The results are compiled into a professionally edited film for the individual to share as they wish. This interview process allows for a meaning-making opportunity for the client, validating their personal experience, taking control over what they want to leave behind, and how they want their life to "end."¹⁷ The film is a meaningful keepsake for loved ones after the client dies, serving as a way to maintain an enduring bond with their person, which we know to be a healthy, productive, and normal part of the grieving process.¹⁸

Beyond the psychosocial team at the Dempsey Center, massage, reiki, fitness classes, and nutrition support are all open to bereaved clients. All are reminded and encouraged to use these offerings to promote self-care and tend to the physical responses to grief. Bereaved clients often express feeling surprised or even frightened by the ways that grief manifests physically, but studies in neurobiology have proven how losing a loved one can literally change biochemistry, impacting our respiration, heart rate, and nervous system responses.¹⁹ Viewed in that light, these integrative services are yet another way to validate and normalize the entirety of the grief experience.

Staff Care

While the impact grief has on clients is clear, grief also impacts oncology social workers and other oncology providers. To support staff members, the Dempsey Center psychosocial team regularly discusses individual practices that clinicians can engage in after a client's death, whether it be lighting a flameless candle, reciting a poem or blessing, or spending time in quiet contemplation.

On a larger scale, the Dempsey Center staff members have found that sharing the names of recently deceased clients at monthly all-staff meetings provides the opportunity to reflect on and honor clients who have died. Speaking to her experience as a member of the Advancement team, a staff member states, "As a staff member...with limited interaction with clients, I am often shielded from the grief that many of our counselors and providers see daily. Incorporating the reading of names into staff meetings has been a powerful way to be reminded of the mission of the organization and the gravity of loss happening to our clients and care partners. I'm grateful this process was introduced as a way for us to honor those that have passed and as a collective group to virtually wrap our arms around one another in show of support." This ritual encourages all employees, regardless of role, to recognize and appreciate the magnitude of the work and the impact on those served.

Having a designated team to track and report client deaths allows the Dempsey Center to be efficient and mindful. Upon learning of a client’s death, staff members who have regularly seen that individual are contacted, which can allow for emotional processing, but also helps to ensure the bereaved are not receiving any potentially now-unnecessary communications from the center. A group of Dempsey Center volunteers is then responsible for sending a sympathy card to the bereaved, offering condolences and a reminder that the center continues to be a place of support. The Dempsey Center also heavily prioritizes the well-being of psychosocial team members. For example, individual and group supervision is provided on a biweekly basis, with additional individual opportunities readily available. The support group model includes scheduled time for group facilitators to center together prior to group and to debrief afterwards.

What the Dempsey Center Is Doing for Clients and Staff

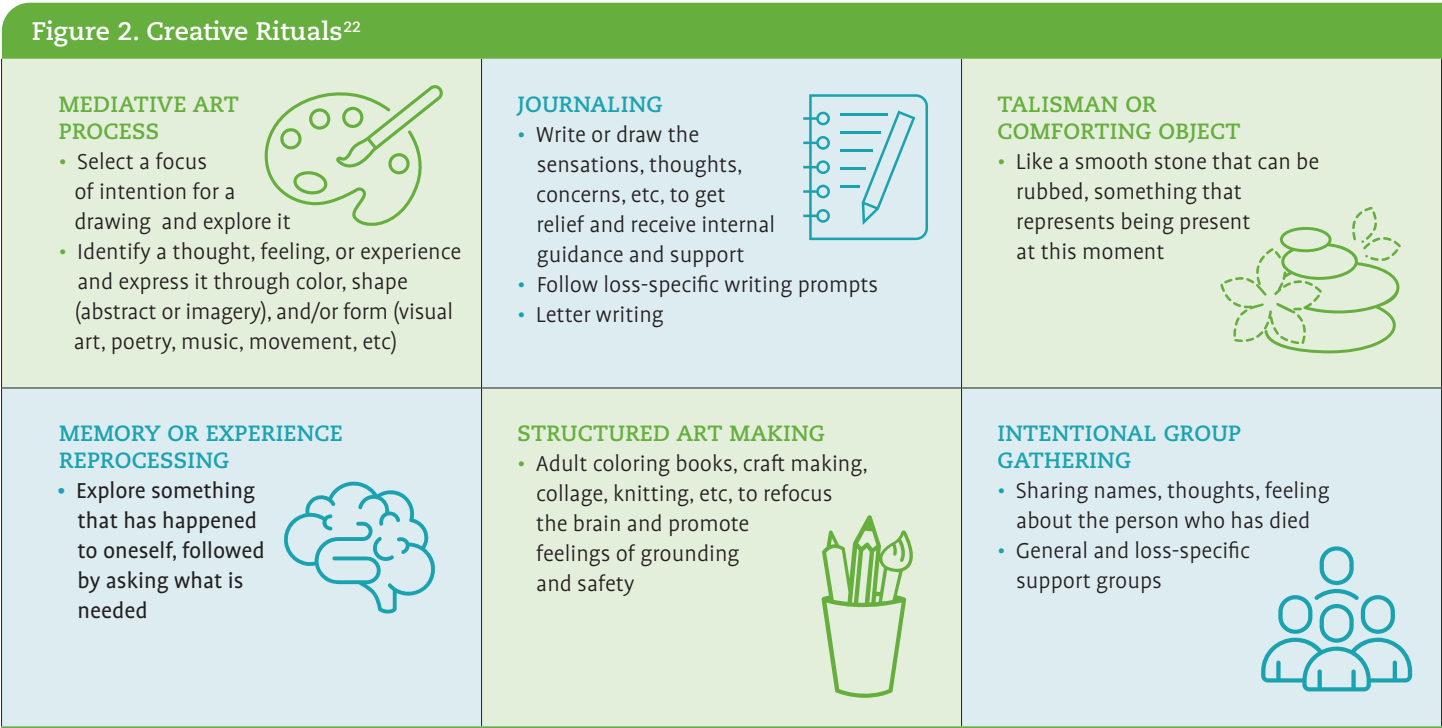
The Dempsey Challenge is an annual run/walk/ride event; bereavement activities are intentionally incorporated into the fundraiser. These events are always open to clients, registered participants, and staff. Prior to the Dempsey Challenge, families and individuals are invited to design “Signs of Hope and Healing,” memorial road signs to go along the racecourse. These signs offer a profound race experience, encouraging participants to acknowledge those who have died and those who continue to be impacted by cancer. During the 2022 Dempsey Challenge, a remembrance flag activity was introduced. A special tent was designated for anyone to gather and take time to decorate and then hang a flag in honor of someone who had died of cancer or someone who was amid their cancer journey.

Meaning-Making and Creative Rituals

Rituals are acts committed with intention and often represent far more than the act itself. Rituals can come from families, culture, higher power beliefs, and personal reasoning. Individuals engage in rituals daily: removing shoes before entering a home, prayer at mealtimes, wearing specific jewelry for special occasions, wearing the same jersey at certain sporting events, and/or a bedtime or wake time routine, just to name a few. Big or small, these rituals can be grounding and give people a sense of safety and direction.²⁰

Mourning rituals have occurred for centuries—decorated burial grounds, community gatherings, wearing black, lighting candles, sharing a meal with the dead, burying the deceased with items they loved, and so on. The urge to create symbolic ways to continue bonds with the deceased has existed beyond what recorded history shows. Grief rituals have historically been highly organized social gatherings intent on encouraging the bereaved to be present with the intensity of their feelings. This path is still true for many, but it is not the only way grief rituals can be carried out.²¹

While large gatherings are still practiced mourning rituals, the understanding of such practices has expanded, with recognition of *meaning-making* being a pivotal part of the experience. Authors and grief professionals Rando, Laird, Schnell, and Neimeyer have all contributed to this understanding of grief rituals, “a specific series of actions, grounded in meaning about death and mourning, that gives symbolic expression to thoughts and feelings about a particular loss.” Personal grief rituals, in turn, are essential when satisfactory opportunity has not been provided by the culture.²¹




Personal grief rituals can be rooted in creativity, incorporating practices of meditation, writing, creating art, intentional gatherings, or performing music (Figure 2). All these activities are relatively low-barrier, cost-effective ways for oncology social workers, and any oncology care provider, to create personalized bereavement rituals. For others, quiet contemplation and remembrance may be all that is needed. The important reminder is that rituals can be as elaborate or as simple as they need to be. When reflecting on her own grief ritual after learning of a client's death, a Dempsey Center staff member shares, "While often I can't remember what I ate for breakfast, it is amazing what comes back to me about individuals—where I met them, who they were connected with, what their struggles and joys were. I guess that *is* my ritual: remembering who they were. We have the privilege of meeting people at their most vulnerable, and that essence stays with me. So: no rocks, candles, thoughtful times of reflection...but they are *always* remembered."

Oncology social workers are in a unique position to forge connections with individuals during a most vulnerable and intense time. The learning of a client's death is absorbed, consciously or unconsciously, and personal grief rituals can provide a way for clinicians to acknowledge and sit in the weight of that honor.

Concluding Thoughts

The presence of grief and loss throughout the entirety of the cancer experience supports the importance of awareness of this topic. Oncology social workers can help develop a new way of practicing bereavement care through the promotion of healing in community, artistic expression, and an emphasis on the well-being of the physical and emotional body for both clinicians and clients. The Dempsey Center framework serves to offer potential elements of bereavement care that individual providers and institutions might use to enhance or establish their own bereavement protocols.

It is the authors' hope that other cancer programs and practices will consider conducting more research on understanding and helping to establish standardization of bereavement care services across the oncology social work field. 

Erin King, LCSW, APHSW-C, OSW-C, is an oncology counselor and Kristen Breault, LCSW, is a young adult oncology counselor at the Dempsey Center in Maine.

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Pioneering a Cancer Program for the Future

Novel approaches
to optimize the patient
experience



Achieving the Cancer Moonshot goal¹ of reducing the national cancer death rate by 50% over the next 25 years will require improved interventions and increased access to cancer care. Emerging research is fostering paradigm-altering improvements to cancer diagnosis and treatment, and innovative technologies are expanding access to cancer services to broader patient populations. At the same time, many programs face capacity and resource constraints—which will continue to rise as demand for cancer services grows in the coming years. The aging US population is predicted to drive an increase in cancer incidence of almost 50% by 2050.²

Many cancer programs are facing significant challenges to maintaining access to care. By focusing on core operational imperatives, cancer programs can deliver advanced care and expand access to that care while maintaining a focus on the patient experience.

As cancer programs look to the next decade, administrative and clinical leaders will need to implement novel approaches to cancer care to support increased patient access, improved operational efficiency, and equity for all patients. While strong, subspecialized physicians and excellent clinical outcomes remain fundamental to maintaining a competitive cancer program, this article does not address those topics, as it is assumed that cancer programs have focused their development efforts in those areas over the past 10 to 20 years. Instead, this article explores 4 pillars for creating a differentiated patient experience:

1. Optimization of performance to increase patient access.
2. Incorporation of strong patient navigation services across the program.
3. Integration of digital health tools into the patient care experience.
4. Dedicated focus on improving health equity.

While each pillar must be understood on its own, cancer leaders who recognize how the pillars overlap can position their programs to reap the full rewards of investing in these initiatives—ensuring their programs can continue bringing cutting-edge, patient-centric care to their communities and drive financial improvement for their organization.

Given the complexities associated with cancer care, there are 2 key patient navigator roles that cancer programs should prioritize to coordinate care for patients throughout the oncology care continuum: the new-patient coordinator and the clinical nurse navigator

Patient Access

The Problem

In addition to expecting high-quality cancer care, patients increasingly want rapid access to appropriate oncology specialists following diagnosis and the ability to initiate treatment quickly. Many high-performing programs strive to arrange new patient appointments within 5 to 7 calendar days, or even less (eg, best-in-class breast programs see new patients within 24 to 48 hours).

These shifting patient experience expectations around access present increasing challenges for cancer programs that are already facing high patient volumes, staffing limitations, and/or physical footprint restrictions. For many patients, the ability to access care quickly and seamlessly is a key factor in determining where to seek care. Cancer programs without well-designed patient access processes are at a competitive disadvantage.

In today's resource-constrained operating environment, providers need strategies to expand access and optimize capacity without adding new space, chairs, or staff so that they can more effectively serve their patient populations. Patient and provider priorities should also be considered when designing and implementing operational changes within a clinical program. Additionally, alternative care strategies

need to be considered as methods of using existing infrastructure in different ways.

Solutions

To improve new-patient access, programs need to prioritize capabilities that will support a seamless patient experience while decreasing time to first appointment. Key among these capabilities is refining referral intake processes while understanding the overall demand for new-patient appointments, enhancing program capacity management to meet that demand, and optimizing provider work standards to free up capacity and enable operational efficiency.

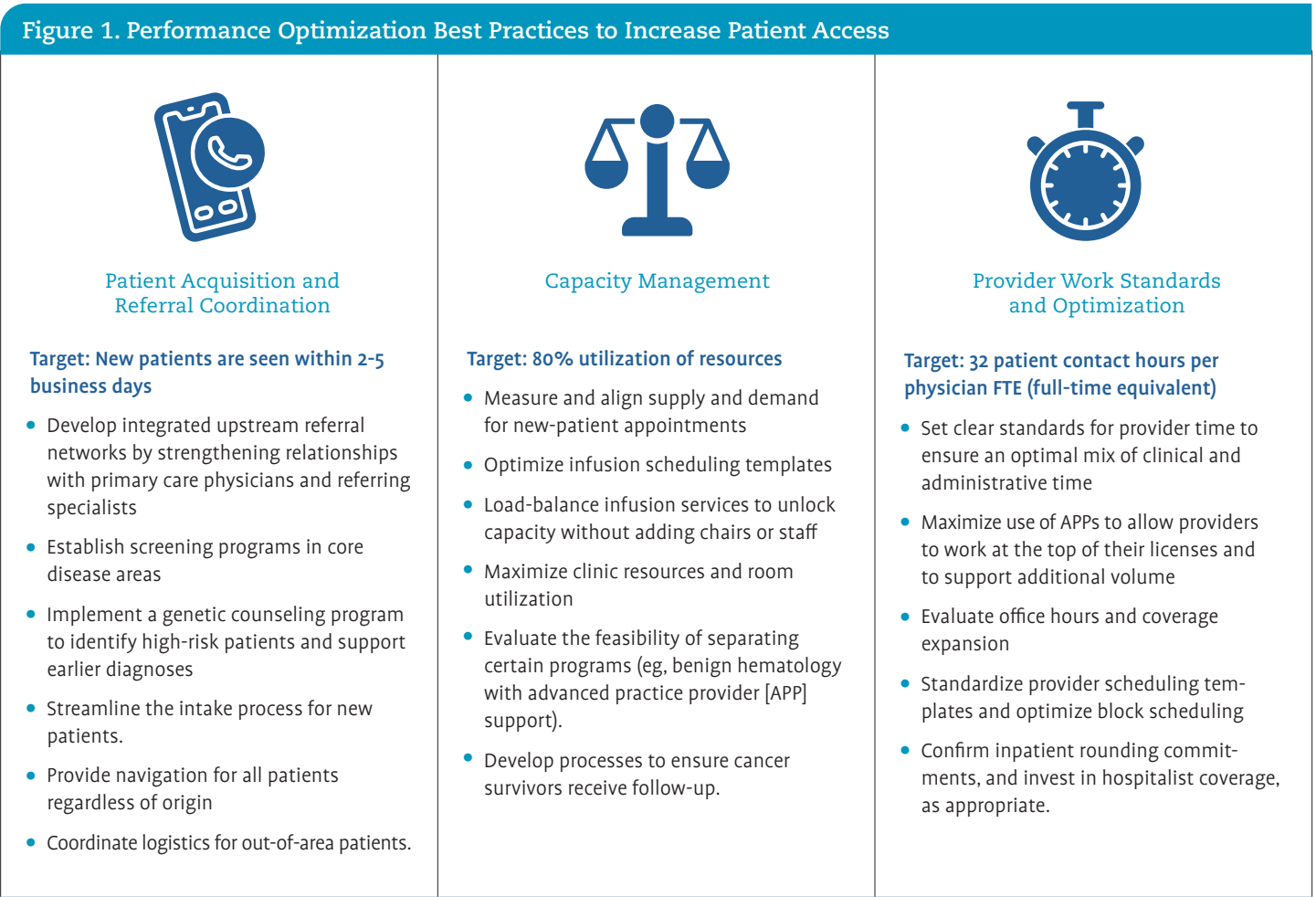
High-performing programs approach these 3 issues using standardized processes that allow all providers to work at the top of their licenses while reducing variation in workload across individual providers. Once providers’ available time is optimized, capacity management and clinical coordination efforts can be more effectively implemented. Best practices, such as those found in Figure 1, can help increase capacity without adding resources, which will in turn reduce wait times for new patients.

Along with optimizing referral coordination, capacity management, and provider work standards, ensuring that patients utilize the right care setting will improve overall patient access. Oncology urgent care centers and home infusion programs are 2 methods for utilizing existing program infrastructure in different ways (Figure 2).

Oncology Urgent Care Centers

Providing on-demand access to the right care setting for patients is key to both reducing health care costs and meeting patient experience expectations. Three of the most common frameworks for oncology urgent care centers include:

- Dedicated space in a medical office building or existing oncology clinic space
- An oncology-specific clinic within an emergency department (ED) that avoids general ED triage and provides oncology-specific emergency care
- A standalone ambulatory clinic that patients can visit directly from home or after visiting the ED if their medical needs do not warrant an inpatient stay.



FTE=full-time equivalent.

Figure 2. Benefits to 2 Common Alternative Payment Models



Oncology Urgent Care Centers

- Address adverse effects of treatment and symptoms before they become significant issues
- Reduce unnecessary hospital admissions
- Avoid exposure to the general population for immunocompromised patients
- Provide a venue for unscheduled visits, without disrupting the flow of outpatient clinics.



Home Infusion Programs

- Improve patient access, particularly for patients who may have challenges related to comorbidities, cancer-related symptoms, or transportation limitations
- Address clinic capacity issues by providing treatment in an alternative setting.

In addition to establishing the right clinical setting and structure for an oncology urgent care center, the center should offer patients:

- A way to communicate with a triage nurse who can direct them to the proper setting for their needs
- Same-day and/or walk-in visits and extended hours of operation
- Access to oncologists familiar with cancer treatment-related issues and adverse effects (AEs)
- Ability to treat common AEs (eg, hydration) on site.
- Alignment with value-based care strategies that reduce ED or inpatient admissions to create a supportive care environment.

Home Infusions

Although chemotherapy infusions have traditionally been delivered in a clinical setting, certain therapies can be delivered to patients at home. This approach has been demonstrated to improve patient satisfaction and has the potential to create financial savings for both patients and health systems.^{3,4} Patients who have demonstrated tolerance of a treatment in an infusion center are candidates for home infusion.⁵ Treatments can include intravenous and subcutaneous medications, as well as biologics, which are administered either by a nurse or by the patient themselves.⁶ Nurses also provide patients with education, apply dressings to the infusion site, and check for adverse reactions. As a relatively new model for delivering cancer treatment, home infusion programs face several challenges that should be considered during design and implementation, including:

- Regulatory approval and/or state requirements for licensures
- Insurance reimbursement
- Availability of appropriately trained nurses
- Logistical issues related to geography and patient/provider safety
- The need for a high degree of coordination between patients, care teams, home infusion pharmacies, and home health agencies.

Patient Navigation

The Problem

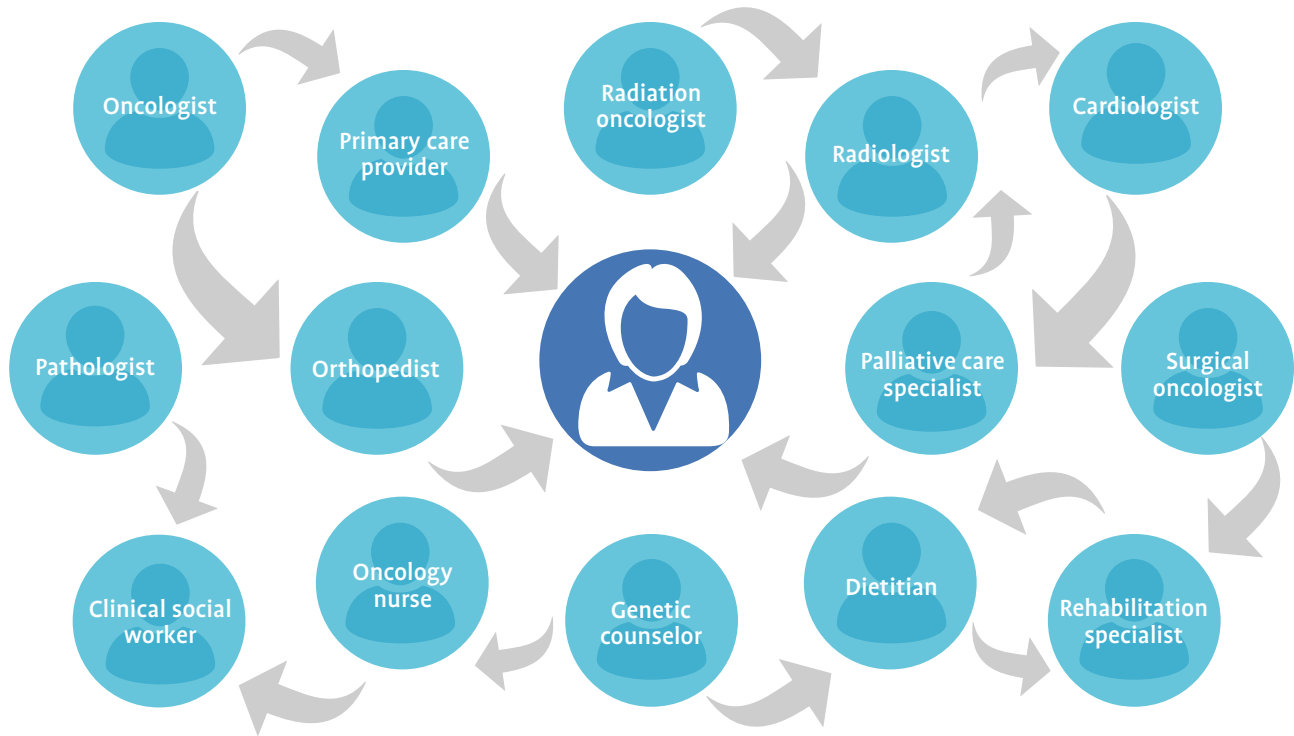
Cancer is a complex disease that requires multidisciplinary care (Figure 3). What makes it even more challenging is that the care pathway (both the unique care providers required and the sequence of events) varies by patient and is dependent on their clinical diagnosis and treatment plan. This complicates most programs' efforts to implement a standardized set of care coordination protocols for their entire patient population, and therefore, patients often struggle to coordinate care between specialists during their cancer journey. Patient navigation programs are commonly used to bridge this gap and are designed to facilitate a patient-centered care experience by reducing barriers and ensuring access to timely cancer care. These services make the cancer care journey more manageable for patients and their loved ones.

While most cancer programs offer some fragmented patient navigation services, high-performing cancer programs offer a comprehensive patient navigation experience serving all patients, regardless of disease site or geographic location, beginning at the point of intake and continuing through the duration of the patient's cancer journey. There are a variety of areas where enhanced navigation services can buttress existing clinical and operational practices and/or help minimize other patient-specific barriers to care (eg, related to language, income, geography, education) and drive financial improvement for their organization. These services are particularly important for programs to have in place to efficiently manage patients' needs as the demand for cancer services increases.

The Solution

Given the complexities associated with cancer care, there are 2 key patient navigator roles that cancer programs should prioritize to coordinate care for patients throughout the oncology care continuum: the *new-patient coordinator* and the *clinical nurse navigator*. New-

Figure 3. Complexities of Cancer Care



patient coordinators are the first point of contact for all oncology patients. They assist throughout the patient journey and are responsible for scheduling appointments and treatments, managing referrals, and assisting with financial matters. Prior to the first patient visit, these coordinators are responsible for the following duties:

- Ensure patients have the information they need about the location(s) of their appointment(s)
- Help patients complete required documentation, including collecting records required to guide treatment (eg, results of diagnostic testing, such as lab and radiology reports)
- Assist with transportation and parking
- Help identify lodging for patients traveling from out of town
- Facilitate transfer of clinical information to the treatment team
- Help schedule appointments with financial counseling, social work, and other support services.

During cancer treatment, new-patient coordinators are responsible for the below tasks:

- Ensure patients remain connected to support services as needed and assist with scheduling
- Provide individual or family counseling and emotional support
- Connect patients to peer support (cancer support groups).

Once a patient has decided to pursue the treatment plan from their oncologist, the new-patient coordinator will connect the patient to the clinical nurse navigator, who then begins to coordinate appointments with the patient's care team. The clinical nurse navigator has the following duties:

- When possible, accompany patients to initial appointments
- Coordinate diagnostics, procedures, and specialist appointments
- Assess patients' physical, emotional, psychosocial, spiritual, and financial needs
- Initiate referrals to ensure patients are connected with community resources
- Provide patient education
- Assist in arranging treatment closer to home when available and appropriate.

In addition to having capable navigators overseeing patient volume (at a ratio of approximately 200 patients per 1.0 FTE navigator for either the new-patient coordinator or clinical nurse navigator), a number of different components must be in place to ensure the patient navigation program is successful. There must be a strong vision and clearly articulated scope for the program, clarity on roles, robust electronic health record (EHR) documentation tools, and a high level of physician and organizational commitment.

Figure 4. Patient Navigation Performance Metrics

ORDER OF FUNCTIONS	METRIC	DESCRIPTION
Diagnosis	Cancer screening follow-up to diagnostic workup	Number of navigated patients with an abnormal screening referred for a diagnostic workup
	Completion of diagnostic workup	Number of navigated patients with an abnormal screening who completed a diagnostic workup
Treatment and care transitions	30-, 60-, and 90-day readmission rates	Number of navigated patients readmitted to the hospital at 30, 60, and 90 days
	Navigation caseload	Number of navigated patients per month
	Patient retention	Percentage of navigated patients retained for treatment services
	ED utilization	Number of navigated patients who visit the ED per month
	Treatment compliance	Percentage of navigated patients who adhere to institutional treatment pathways
	Clinical trial education	Number of patients educated on clinical trials by the navigator per month
	Diagnosis to treatment	Number of business days from diagnosis (date of pathology result) to initial treatment (first date of treatment)
Patient experience	Patient experience	Patient experience or satisfaction survey results per month
	Patient goals	Percentage of new cancer cases per month for which patient goals are identified and discussed with a navigator
	Caregiver support	Number of caregiver discussions about needs/preferences with a navigator per month
Survivorship and palliative care	Survivorship care plan	Number of navigated patients (curative intent) per month who received a survivorship care plan and treatment summary
	Referrals to support services	Number of navigated patients per month referred to appropriate support service at the survivorship visit
	Palliative care referral	Number of navigated patients per month referred for palliative care services

For individuals responsible for operating the navigation program, there are multiple ways to evaluate its success. Oncology leadership will need to determine the most appropriate performance indicators for their specific program. Performance can be evaluated utilizing metrics in both clinical and nonclinical categories as illustrated in Figure 4.

While the direct return on investment (ROI) is difficult to measure, a strong patient navigation program drives an estimated 10% improvement in patient retention.⁸ Other factors to consider when evaluating the ROI for patient navigation include improved patient compliance with treatment plans and reductions in hospital admissions, readmissions, and ED visits.

Digital Health⁹

The Problem

Patients expect to find the same flexibility and ease of navigation in health care as they experience in other industries. Consumers want better products, higher-quality service, and a better overall experience, all enabled by technology. These expectations for seamless and quick access are driving providers to reevaluate their digital capabilities to be as patient-centric as possible.

To achieve this goal, organizations must thoughtfully evolve their use of digital health care tools while understanding that digital trans-

formation is not about simply adopting the latest technology. Cancer programs must carefully consider how they can best utilize digital health tools to drive improvements in patient access, patient experience, care coordination, and program differentiation. Considerations regarding the application of artificial intelligence (AI) should also be evaluated as AI-assisted technologies rapidly enter the healthcare space. These technologies are predicted to become a mainstream tool for providers within the next 10 years.

Solutions

It is crucial to establish a foundation of digital health tools before venturing into more innovative technological capabilities. All cancer programs should have the following 4 patient-centric elements in place today:

- **Integrated telehealth.** Synchronous video visits integrated into the EHR
- **Patient portal access.** Full patient access to the EHR, including the ability to upload and download information
- **Patient communication.** Multiple access points, including phone and portal messaging; coordinated and personalized survivorship communication
- **Triage services.** On-demand digital nurse triage capabilities available through multiple access points.

With these capabilities in place, cancer programs can explore pioneering approaches to digital health that improve the patient experience while automating routine clinical tasks in a manner that allows providers and clinic staff to more efficiently attend to a larger patient population. One crucial digital health application that drives improved patient experiences and reduces the need for unnecessary clinic visits is remote monitoring of patient vitals and symptoms. The continuum ranges from basic electronic patient-reported outcomes (ePROs) to remote monitoring and, ultimately, AI-assisted monitoring solutions. These advanced digital tools enable the gathering and reporting of patient data to the care team and facilitate better symptom management, reduce travel burdens, minimize emergency visits, and improve cancer survival rates.¹⁰

Although implementing remote monitoring necessitates changes in staff skills, systems, and workflows, introducing ePROs in the short term will help patients adapt to remote monitoring, paving the way for the adoption of more innovative tools. Establishing a strong ePRO capability today will position cancer programs to transition to more advanced remote monitoring (including AI-assisted) solutions as technologies evolve and gain industry approval.

ePROs

ePROs utilize tools such as smartphones and web-based platforms to collect patient-reported data on vital signs, symptoms, and quality of life. Patients provide information about their health status by manually logging information into a system at preplanned intervals, allowing their providers to receive timely data outside of routine clinic appointments. This approach empowers patients to actively participate in their care and has been shown to improve patient outcomes, satisfaction, and compliance with clinical therapies. Additionally, ePROs can enable more timely interventions from clinic staff when serious issues arise.

Remote Monitoring

Remote monitoring involves the use of technology to automatically track a patient's health status. It typically involves the use of wearable devices, Bluetooth-enabled medical devices, or mobile applications that enable real-time collection and transmission of data such as heart rate, weight, blood pressure, or physical activity. In other cases, data are collected and pushed to the clinic on a scheduled basis or downloaded when the patient visits the clinic.

This data collection and transmission process allows healthcare providers to detect any potential issues or changes in the patient's condition and provide timely interventions or adjustments to their treatment plan to reduce adverse treatment-related events, ultimately lessening the need for frequent in-person visits (eg, clinic visits, ED visits, hospital admissions) and improving patient outcomes.

AI-Assisted ePROs and Remote Monitoring

Further into the future, remote monitoring technologies will incorporate AI algorithms to assist providers in making timelier and more data-driven decisions. Unlike humans, AI algorithms can analyze longitudinal patient data in real time, potentially incorporating data from the patient's EHR. This technology enables the identification of trends to support taking preemptive (and remote) measures to avoid adverse events or making rapid adjustments to the patient's course of treatment.

Examples of where AI-assisted technologies are already being tested include:

- **CANKADO PRO-React.** A digital system of patient-generated daily health documentation and symptom questionnaires that predicts impending adverse incidents at earlier stages and shares the patient-generated data with physicians in real time. This technology also provides recommendations to patients regarding how urgently they should seek medical care.¹¹
- **BioIntelliSense.** A rechargeable sensor that adheres to the chest and passively measures more than 20 vital signs, recording 1440 measurements daily. The AI software component manages, monitors, analyzes, and interprets the daily data points and alerts the healthcare team and patients when the vital signs fall outside personalized ranges.¹²

Economic returns for digital health technology investments are measured through direct and indirect ROI. Direct ROI includes cost reduction or avoidance (eg, through reduced hospital readmissions). Indirect ROI is measured through an increase in the customer lifetime value of a patient driven by 3 factors:

- **More total patients served** (eg, patients switch from competitors, patients are attracted from outside the current market, reduced time to treatment allows for more patients to be treated)
- **More revenue per patient** (eg, fewer appointment no-shows, new digitally enabled services such as genomics counseling, payment reminders to improve collection rates)
- **More time caring for patients** (eg, patient loyalty increases because of high-quality and convenient experience, survival rates improve through consistent care delivery and personalized medicine).

Health Equity

The Problem

Although the US has made tremendous progress in treating cancer in recent decades, advances in detection, diagnosis, and treatment have not benefited all populations equally. Cancer incidence rates and mortality are declining steadily across all population groups; however, disparities across the cancer continuum remain a major public health challenge. People of color and other medically under-

served populations continue to bear a disproportionate burden for cancer when compared to White Americans (Figure 5). At a general population level, approximately 40% of cancers are considered preventable, and 60% of patient outcomes are correlated directly with environmental factors and patient behavior¹⁴—statistics that are closely tied to social determinants of health (Figure 6).

Although social determinants of health factors function upstream from traditional health care interventions, they often have as much, or more, of an impact on health outcomes for individual patients
(Continued on page 21)

Figure 5. US Cancer Disparities¹³

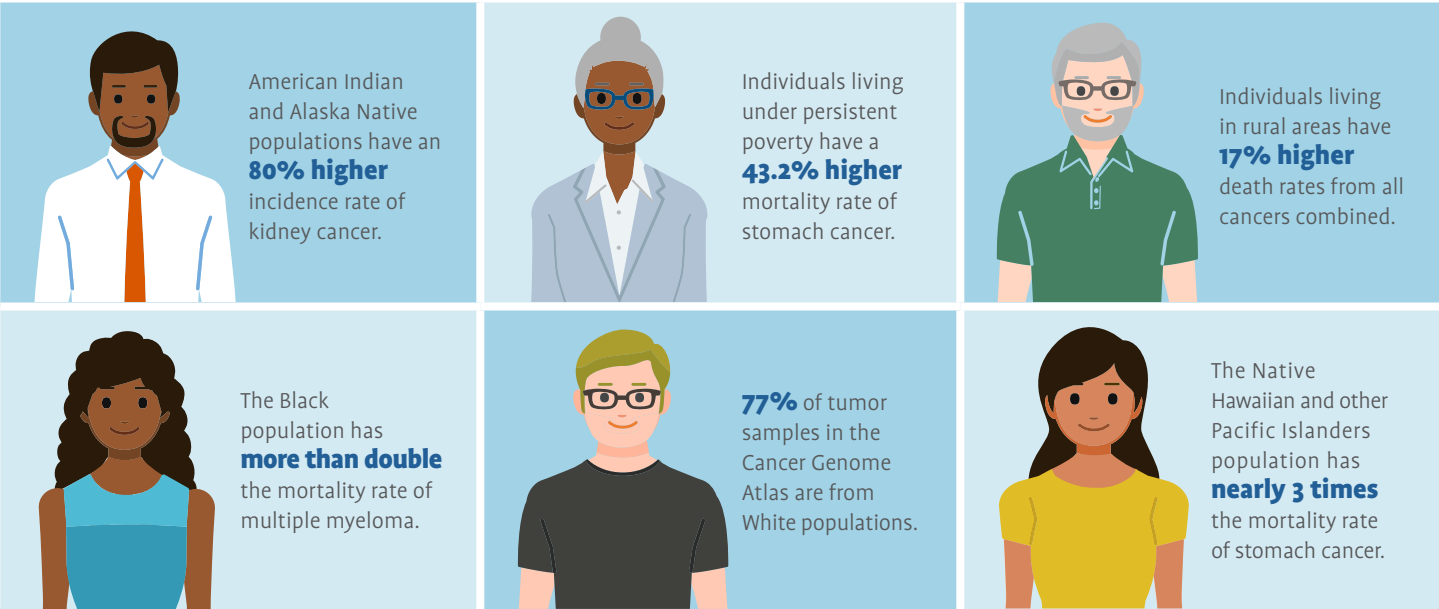


Figure 6. Key Social Determinants of Health¹⁵

Economic Stability	Neighborhood and Environment	Education	Food	Community, Safety, and Social Context	Health Care System
Factors Driving Health Outcomes					
<ul style="list-style-type: none">• Employment• Income• Expense• Medical bill debt support	<ul style="list-style-type: none">• Housing• Transportation• Parks• Playgrounds• Walkability• Zip code and geography	<ul style="list-style-type: none">• Literacy• Language• Early childhood education• Vocational training• Higher education	<ul style="list-style-type: none">• Food security• Access to healthy options	<ul style="list-style-type: none">• Social integration• Support systems• Community engagement• Stress• Exposure to violence• Policing	<ul style="list-style-type: none">• Health coverage• Provider and pharmacy availability• Access to linguistically and/or culturally appropriate care• Quality of care

Health outcomes: mortality, morbidity, life expectancy, health care expenditures, health status, functional limitations

(Continued from page 20)

and communities as the provision of health care services themselves. Accordingly, providers and programs seeking to improve health equity must adopt a comprehensive view of patients and their communities, looking beyond efforts to simply improve access to care within the clinical setting.

Solutions

There are generally 4 practical methods that cancer programs can use to begin improving health equity:

- 1. Proactively identify patient care gaps within the community to understand both clinical and nonclinical vulnerabilities across the social determinants of health spectrum
- 2. Expand access to cancer screening within communities, increase outreach by bringing care closer to home, and improve health literacy in a socioculturally tailored manner
- 3. Increase diversity in the workforce and in clinical trial participation
- 4. Improve provider and staff education to facilitate the delivery of culturally appropriate care, free of implicit bias and medical discrimination.


Specific examples of tactics within these groupings are found in Figure 7.^{16,17} When implemented thoughtfully, these methods can help cancer programs build connections and develop trust within their communities.

Patients and communities want to know that their health care providers understand their needs and are committed to empowering individuals to be engaged in both their general health care and cancer care journeys. Over time, deploying the tactics outlined in Figure 7 will enable cancer programs to improve access to care and build connections

to the local community that drive increased patient volumes. Moreover, by actively engaging with the community, health care organizations will eventually be able to treat diseases such as cancer at earlier stages, which often results in better treatment outcomes at lower total systemic costs. As health care trends toward population health and risk-based contracting models, this shift to reduced costs and improved outcomes will have a meaningful financial impact for provider organizations. In particular, cancer programs can indirectly realize ROI from health equity measures by fulfilling regulatory requirements for Certificate of Need applications and by meeting clinical research requirements to expand participating patient populations.

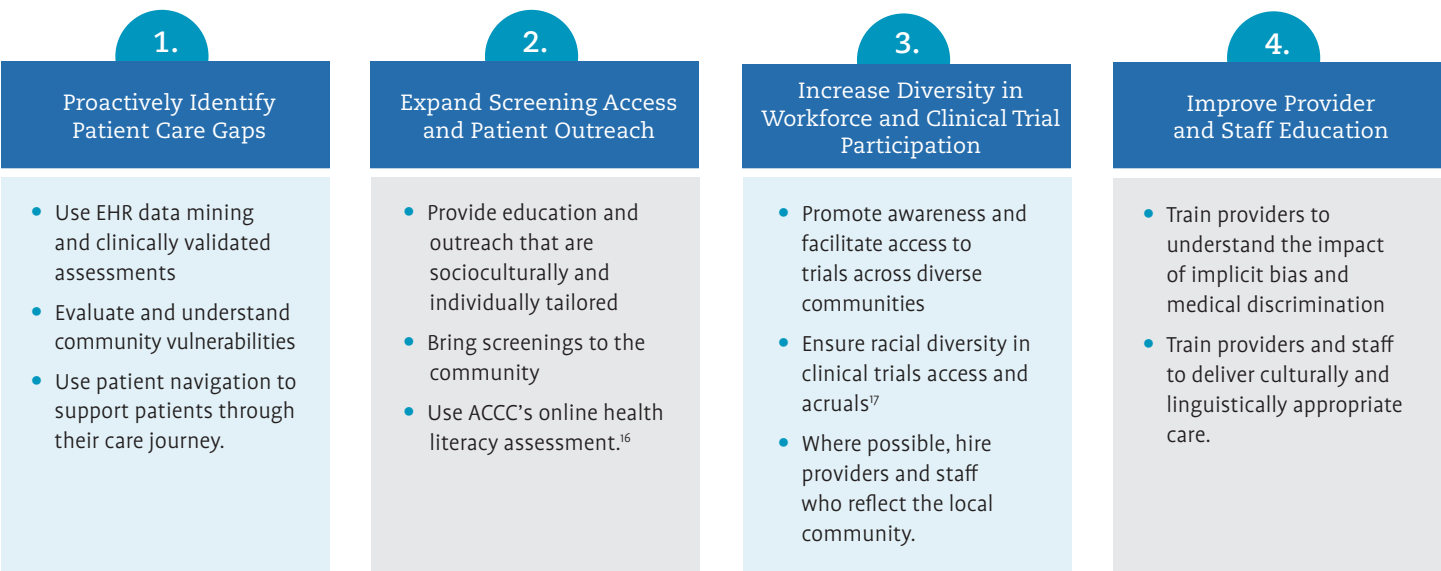
A Forward-Looking Approach

As the demand for high-quality, patient-centric cancer care continues to increase over the next decade, cancer programs that have prioritized the strategies described in this article will be best positioned to continue meeting the needs of their diverse communities, maintain competitive success, and realize programmatic volume growth. This success includes pursuing elements that could be considered more foundational (adoption of industry best practices for navigation services, overall program optimization, continued evolution of digital health capabilities), as well as proactively addressing more complex issues (health equity) and incorporating innovative approaches to better meet patient needs and expectations (alternative care models).

Just as successful clinicians take a holistic view of their patient’s needs, administrators and leaders should adopt an expansive perspective of their roles as stewards of community cancer care into the future. 

Monica DeNault and Lili Hay are Managers; Matt Sturm, MBA and Jessican Turgon are principals at ECG Management Consultants, a Siemens Healthineers Company.


Figure 7. Tactics to Improve Health Equity^{16,17}



ACCC=Association of Community Cancer Centers.

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A Virtual Reality Intervention for Anxiety Relief During Initial Chemotherapy Treatment

In Brief

Patients with cancer often experience significant anxiety and fear with their first chemotherapy treatment. Nurses at this NCI-designated Comprehensive Cancer Center piloted an evidence-based project that provided an immersive virtual reality (VR) experience with the goal of reducing this anxiety. After initial pretreatment education, nurses administered the State-Trait-Anxiety Inventory Scale short version (STAIS-5) to new patients receiving cycle 1, day 1 of their chemotherapy regimen. Patients then participated in an 8-minute immersive VR experience using the [TRIPP VR app](#) and the [Meta Quest VR headset](#). The program focused on mindful awareness and breathing techniques. After viewing the video, patients completed the STAIS-5 questionnaire to reassess their state of anxiety and provided qualitative feedback in a comment field. The results of this evidence-based pilot project demonstrated that VR-based mindfulness applications (apps) are a feasible, holistic, nonpharmacologic modality that may be used to provide anxiety relief during chemotherapy infusion. The findings further support the benefits of integrating technology into oncology care.

The high levels of stress and anxiety experienced by oncology patients during their first chemotherapy treatment can stem from multiple factors, including coping with a new diagnosis, having existing pain, processing an overwhelming amount of information, and experiencing overstimulation from an unfamiliar environment. Treatment-related anxiety is thought to create apprehension and increase the potential for anxiety-related adverse events. In 2021, The Infusion Center at Moffitt Cancer Center at Wesley Chapel piloted an evidence-based project using VR technology and an immersive mindfulness meditation app to provide a relaxing experience for patients receiving chemotherapy treatment. Integration of innovative, nonpharmacologic means of symptom management is a cutting-edge way to offer support for those who are adjusting to the difficult nuances of anticancer treatment, honoring their need for comfort in a holistic manner.

Our Literature Review

VR has been successfully used in infusion centers to mitigate the effects of treatment anxiety by creating an immersive experience. The brain can only respond to 1 source of stimuli at a time; therefore, creating an environment where the patient can focus on pleasant, nature-related imagery can distract patients from the stressful clinical environment, create positive emotions, and induce a relaxed state. The Attention Restoration Theory shows that involvement in environments with peaceful stimuli creates a *soft fascination* effect, where attention is restored in a therapeutic fashion using nature-related

Patients experiencing the lifting of mental fatigue have improved processing capabilities and the ability to perform tasks with a higher level of cognitive function, which may be helpful in retention of knowledge about self-management of symptoms.

environments that have been shown to have a restorative effect.¹ Reducing anxiety can also help improve the patient's ability to recall information and engage with the nurse in discussions about symptom management and the treatment regimen.

In a recent study of patients in an outpatient cancer center receiving chemotherapy over a consecutive 30-day period, patients reported feeling less distracted and more relaxed after viewing a brief nature video prior to treatment, as evidenced by their stress and anxiety scores and open-ended responses on preintervention and postintervention surveys.² VR programs showing nature scenes were provided to patients during their infusion treatments. Participants self-reported their anxiety to be lower, and strongly agreed to feeling immersed in

the environment. Qualitative feedback revealed that patients appreciated and valued the intervention, feeling less anxious, worried, and more relaxed.¹ In another study, patients receiving immunotherapy for irritable bowel syndrome were provided with a VR experience via a headset during their treatments.³ Using the STAIS tool, the patients self-reported an improvement in their sense of well-being and decreased anxiety while waiting for medication administration. This study determined that further research was needed in terms of VR reducing anticipatory anxiety prior to infusion, as it was administered prior to the start of their treatment.³

In terms of the more concrete, quantitative measures of the physiologic response, studies that provided patients with exposure to nature scenes for 10-minute intervals showed a noticeable shift from a state of *fight or flight* to a parasympathetic nervous system response, as evidenced by electromyography studies and pulse. Functional MRIs of patients exposed to nature scenes reported increased blood flow to the cingulate cortex, an area of the brain that promotes stability of thought processes. Restorative effects were noted, especially when patients viewed a scene containing water.⁴

The Stress Reduction Theory supports the use of *green* nature-based environments to reduce stress and adverse emotions. By creating a nature-based environment, we not only improve the environment of care, but adhere to the theoretical basis that changing the environment virtually can have a positive effect on one's mood.⁵ Nature-based scenes have been shown to have a lower level of stimuli, therefore, while Stress Reduction Theory focuses on reducing psychological stressors, the Attention Restoration Theory is geared more

towards the resolution of mental fatigue due to stress.⁶ Patients experiencing the lifting of mental fatigue have improved processing capabilities and the ability to perform tasks with a higher level of cognitive function, which may be helpful in retention of knowledge about self-management of symptoms.⁷ In this theoretically based way, this can promote patient self-efficacy.

Our Methodology

In planning the intervention, our project team reviewed Press Ganey patient satisfaction data, which reflected an opportunity to improve upon staff's concern for the patient's comfort during their infusion treatments. A main component of the patient's comfort is anxiety management; thus, the STAIS tool was chosen. STAIS is widely considered to be the *gold standard* for this measurement; however, it is lengthy, leading our team to use the adapted STAIS-5 tool. This 5-question measure, developed by Zsido, et al,⁸ is a validated tool measuring factors indicative of anxiety on a 5-point Likert-type scale. The tool was selected because of its abbreviated nature to reduce the *paperwork fatigue* and overwhelm that often manifests during new patient appointments.

This project was an exploratory venture, testing different VR apps and products. The study compared a cardboard-based, low-tech system to an advanced VR gaming device to determine which process would be most cost-effective, conducive to nursing workflow, and produce positive patient outcomes. The Infusion Center at Moffitt Cancer Center at Wesley Chapel served as the pilot site, averaging anywhere from 35 to 40 patients per day. Initially, our project team purchased 40 cardboard headsets in anticipation of surveying 40





patients undergoing their first chemotherapy treatment during this time. Cycle 1, day 1 patients were selected due to the high degree of stress and uncertainty during the first exposure to treatment in an unfamiliar environment.

The cardboard headsets were selected due to low initial costs and their reduced risk of transmitting pathogens. As the COVID-19 pandemic presented a high risk at the time of initial planning, our project team felt that a computerized headset would not be advisable, as it would need to be cleaned between each patient. Due to the variability of cleaning practices, the risk of potential infection was thought to be higher than with a single-use headset.

In December 2021, our infusion nurses underwent an in-service training to provide information about the intervention process and purpose and orient them to the device. At the start of the intervention, the nurse assessed the patient's level of anxiety using the STAIS-5 tool. Patients were asked to rate common symptoms of anxiety on a 5-point Likert-type scale. Nurses explained the rationale for the survey and educated patients about the intervention. If patients agreed to participate, they were provided with a cardboard VR headset for use with their own cell phone. Because the devices are single use, they could be taken home and brought to each appointment. The nurse assisted patients with setting up the device and choosing a VR video from a YouTube playlist. Patients then watched a 10- to 15-minute nature-themed video during their infusion. After the intervention, nurses reassessed patients again using the adapted STAIS-5 tool.

After 2 months of initial data collection in May 2022, our project team conducted a PDCA (plan, do, check, act) cycle to evaluate progress. Comments from patients and nurses revealed that the initial cardboard headset did not fit a variety of phone types and required separate earphones for sound. Patients had to choose their own YouTube video; it was challenging to find a high-quality 360-degree video that showed clearly through the headset. Patients reported blurry visuals, as the lenses

were not adjustable to accommodate different pupillary distances. There was low patient participation due to an overwhelming number of steps in the process, creating an additional stressor instead of a relaxing experience as planned. Additionally, nurse workflow was affected due to the complicated set up, creating delays in patient care. To mitigate these barriers, our project team applied for an evidence-based practice grant through the Florida Organization for Nursing Leadership (formerly the Florida Organization of Nurse Leaders) and was granted funding towards purchasing a Meta Quest headset for the infusion suite. Nurses ceased the use of cardboard headsets after the Meta Quest headset arrived. TRIPP VR was chosen as the primary app for delivery of mindfulness content.

This pilot project illustrated the process of pivoting to a more advanced system, supporting that more complex VR technology is a worthy investment.

After the pivot was made to the Meta Quest system in June 2022, additional in-services were held with the infusion nurses, and flyers were created to promote use. Our project team found that the padding and head strap made the headset much more comfortable for patients and presented a clearer image and sound. Nurse workflow became more streamlined, as the TRIPP VR app was preloaded, and nurses only needed to provide a brief tutorial prior to use. The simplicity greatly improved the patients' degree of autonomy in the use of the technology and garnered increased interest from patients due to ease

of use. Our team created a guide to orient patients to the features and processes, including wearing the headset, adjusting the view, safety precautions, and an overview of the app.

Participation greatly increased during the months following implementation of the electronic system, generating positive responses from both patients and nurses. The video was limited to 15 minutes to prevent cybersickness, potential nausea, dizziness, and vomiting due to dysregulation when readjusting to the real-world environment. The same process was followed using the STAIS-5 tool preintervention and postintervention, with a comment feature that allowed patients to share their perception of the intervention in their own words.

Our Data Analysis

Twenty-five surveys were collected from March 2022 to October 2022 for the initial intervention period. Figures 1-3 provide data from these surveys. We would like to note that prior to implementation of Meta Quest, patients responded with negative comments related to difficulty with the cardboard set-up, audio, and visuals. After June 2022, patients responded favorably to the Meta Quest headset:

- “I tried VR immersion to see if it would help distract from the side effects, and I can tell you it does. The only time I received those insane shivers and my fingers going ice cold was when I went to the bathroom. When I came back and put that VR headset on and got immersed in that light, I felt that my concentration was elsewhere other than the way I was feeling and even when I took

- the headset off, I never regained the tremors.”
- “...the experience did make me laugh and distract me from the infusion, so I think it helped with my anxiety.”
- “In the short time I viewed the calm experience, I can see how beneficial it can be. Truly enjoyed it.”
- “Absolutely recommend VR for anyone that is nervous. Extremely relaxing.”
- “This is my first chemo treatment, and I find this very helpful. I know how potent it is to have a good distraction at times to help you relax and refocus.”
- “Very interesting and different kind of experience thanks!”
- “Good distraction from the normal setting.”
- “I love it!”

Our Current State and Future Directions

The pilot project has been sustained as the standard of care in the Infusion Center at Moffitt Cancer Center at Wesley Chapel since October 2022. In January 2023, the intervention was opened to all patients undergoing infusions, regardless of type or cycle phase. By expanding the patient population, our project team has noticed enthusiastic interest from patients of all ages and diagnoses. Eventually, VR will be disseminated as standard of care across multiple infusion centers throughout the health care system. Additional data are being collected as part of continued efforts to pilot implementation
(Continued on page 29)

Figure 1. Virtual Reality Patient Survey: STAIS-5 Results, March-October 2022

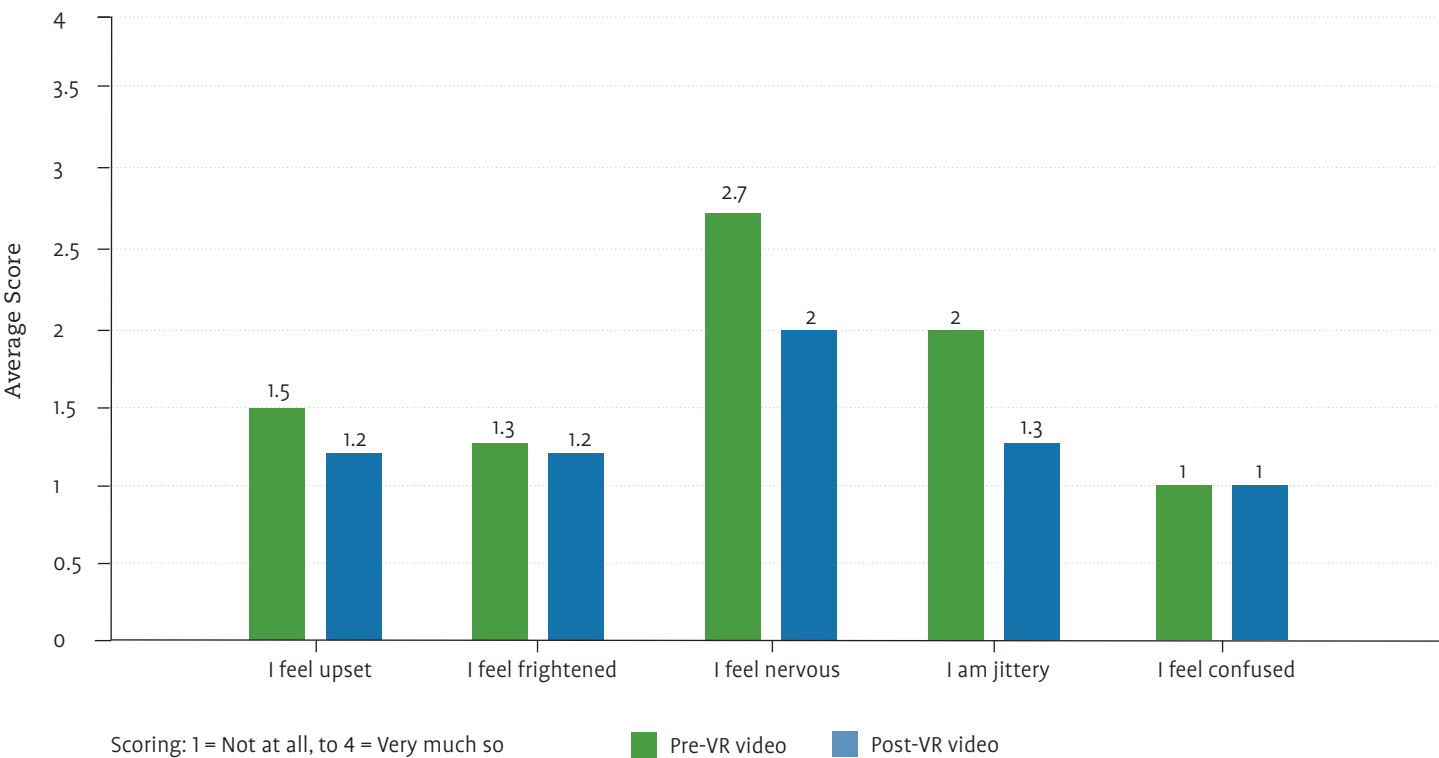


Figure 2. Percentage of Patients With Improved Symptoms

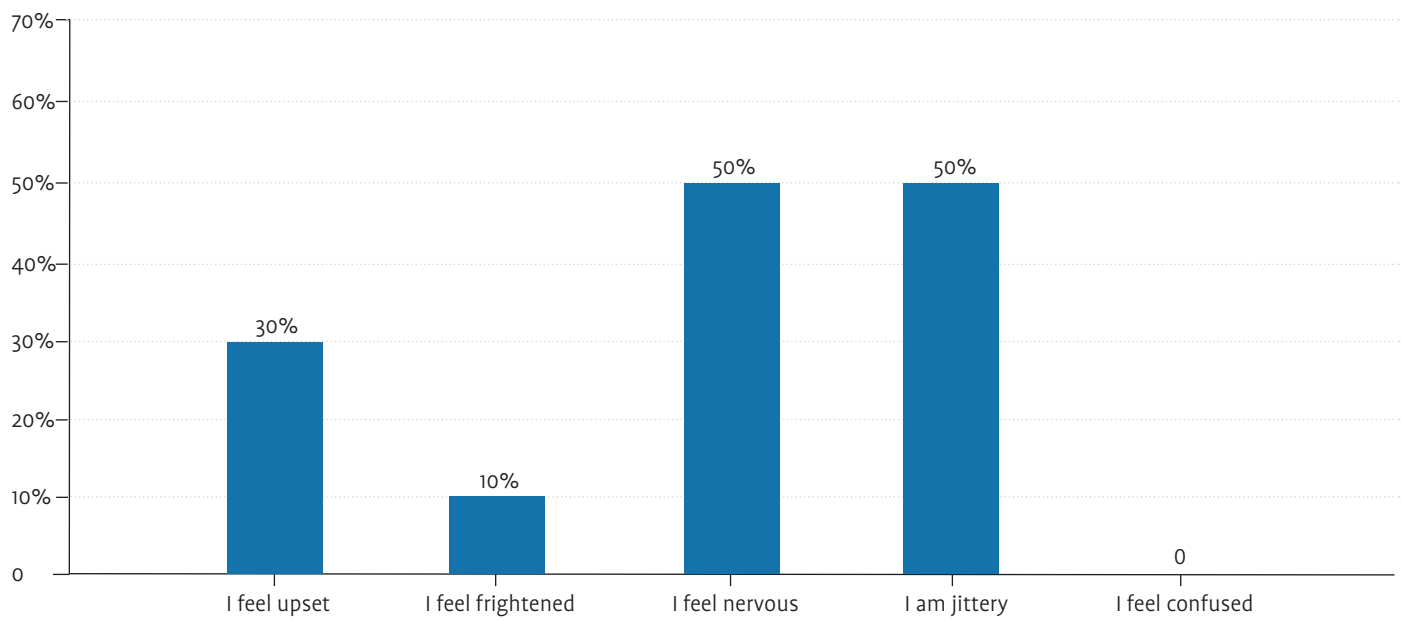
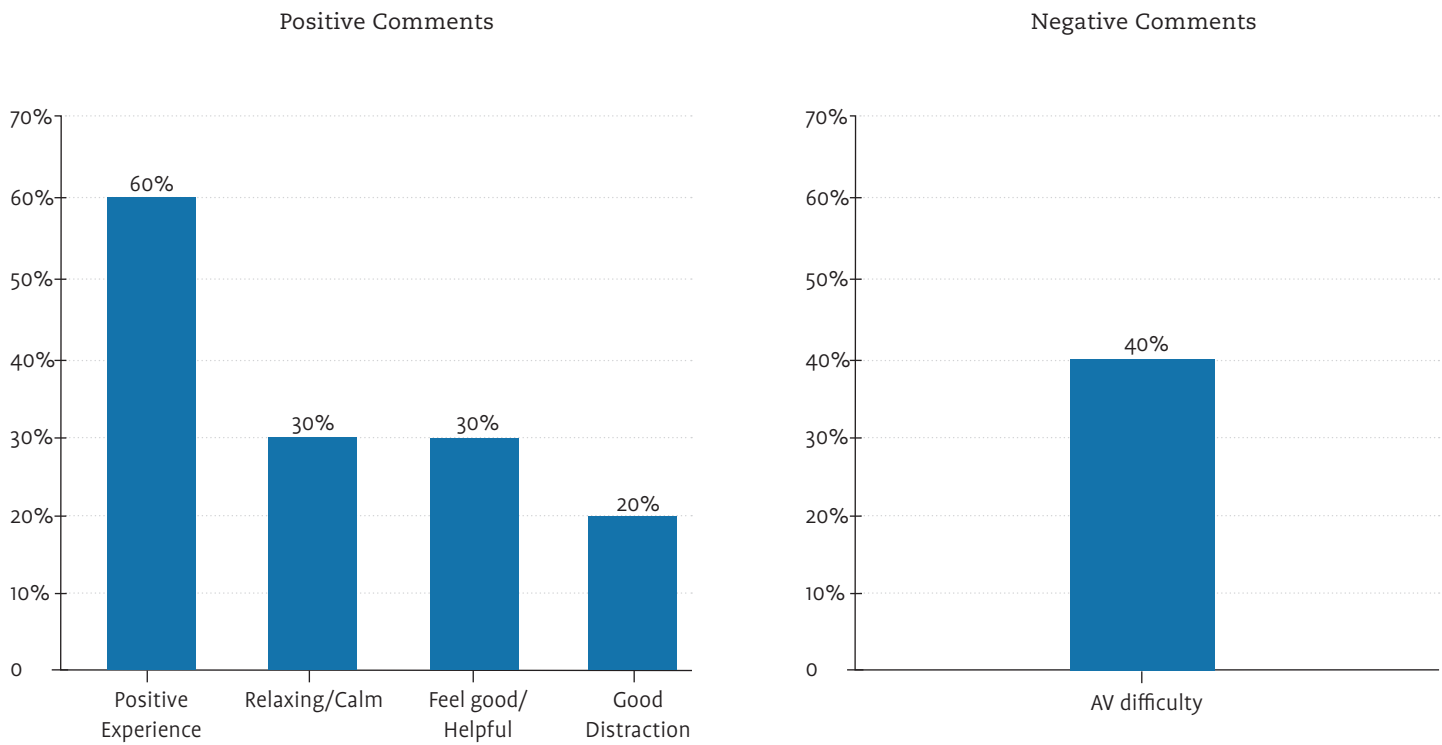



Figure 3. Qualitative Feedback



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of science-based research on use of virtual reality.

This pilot project illustrated the process of pivoting to a more advanced system, supporting that more complex VR technology is a worthy investment. Subsequently, this technology empowered patients—young and old—to expand their comfort with using technology in the health care environment. Although this technology was easily adopted by participants, additional exploration into other VR devices and apps should be carried out to evaluate ease of use. Information on age and diagnosis was not collected during this project; however, comparison of usage between patients of varying ages and diagnoses would be beneficial in creating future systems that are adaptable to meet individual needs and challenges. While state of anxiety and patient satisfaction were the sole metrics for this pilot project, biologic feedback using heart rate could provide an additional indicator of parasympathetic nervous system activation during the intervention. Future studies are needed to investigate integration of technology into nurse workflow and ease of use from a nursing perspective. 

Emery Bergey, MSN, RN, OCN, HNB-BC, is a clinical specialist in oncology and holistic nursing who supports the ambulatory clinics at Moffitt Cancer Center. Caroline Stallings, BSN, RN, is the manager of the Infusion Center at Moffitt Cancer Center at Wesley Chapel. Jennifer George, BSN, RN, OCN, is an oncology certified clinical lead nurse and VR project lead, and Stefanie Young, BSN, RN, OCN, is an infusion nurse with 16 years of experience (13 years in oncology outpatient infusion) and VR project colead at the Infusion Center at Moffitt Cancer Center at Wesley Chapel; Lisa Lapanus, BSN, RN, OCN, is an oncology certified infusion nurse with 9 years of oncology experience, and Jennifer Little, BSN, RN, is a clinical lead nurse with 20 years of infusion oncology experience at the Infusion Center at

Moffitt Cancer Center at Wesley Chapel. Recently recognized as a 2022 Nurse of the Year at Moffitt Cancer Center, Veronica Pabon-Amador, MHSA, BSN, RN, OCN, is an infusion nurse at the Infusion Center at Moffitt Cancer Center at Wesley Chapel with experience in navigation, dialysis, and infection control.

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TRIPP VR is an evidence-based application for VR headsets. Although used in this intervention, Moffitt Cancer Center does not promote this product, or the Meta Quest. Neither the project leads nor Moffitt Cancer Center have received any financial compensation or incentive for the use of these products.

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PHOTOS OF PATIENTS AND PROJECT TEAM HAVE BEEN USED WITH PERMISSIONS.

Developing and Implementing a Comprehensive Tobacco Cessation Program



Tobacco use has declined over the years, but there remain over 50 million tobacco users in this country, and tobacco use continues to be a major health care concern.¹ Tobacco use remains the leading cause of preventable disease, disability, and death in the United States.¹ The use of tobacco products has a ripple effect and causes a strain on the health care system. In 2018, nearly \$240 billion was spent on health care costs associated with smoking.² Additionally, 20% of deaths in the United States are directly linked to cigarette smoking, accounting for more deaths than caused by HIV infection, car accidents, alcohol, drugs, and firearms combined.³

People who use tobacco or who have secondhand exposure are at increased risk of developing cancer. Tobacco use is associated with 40% of all cancers diagnosed in this country.⁴ Tobacco use may also negatively impact a patient's outcomes after a cancer diagnosis. For example, worse response to treatment, increase in cancer recurrence, development of new primary cancers, decreased survival rates, and death from other health complications may occur due to tobacco use.³ Quitting tobacco at any point in the cancer journey can improve prognosis, survival rate, and quality of life.³ The understanding that people are more likely to quit smoking or to stop using tobacco if a health care professional provides information on tobacco cessation was an underlying reason for the development and implementation of the tobacco cessation program at Dorcy Cancer Center at St Mary-Corwin Hospital in Pueblo, Colorado.³

Community Background

The Dorcy Cancer Center at St Mary-Corwin Hospital serves the southern part of Colorado and parts of northern New Mexico and western Kansas. Pueblo is a working-class town that is known as the *Home of the Heroes*. The nickname was given in recognition of the numerous Medal of Honor recipients who call Pueblo home. As with many small communities, available resources are limited. Smoking and tobacco use are more common among populations with greater disparities; this is no different in our community, where it is estimated that the median household income in 2021 was estimated to be just over \$40,000, the percentage of people with a college education was around 20%, and members of minority groups make up approximately half of the population.⁵ These socioeconomic and educational demographics, when combined with a large population of veterans,

puts our community at high risk of being targeted by the tobacco industry, leading to higher tobacco use rates when compared with the rest of Colorado. To help fill gaps in care and reduce disparities, the cancer center has developed resources that include an integrative therapy program, a patient resource center, a cancer survivorship program, cancer screening events, a generous financial foundation to help patients overcome barriers to cancer care, and, now, a smoking cessation program.

Program Development

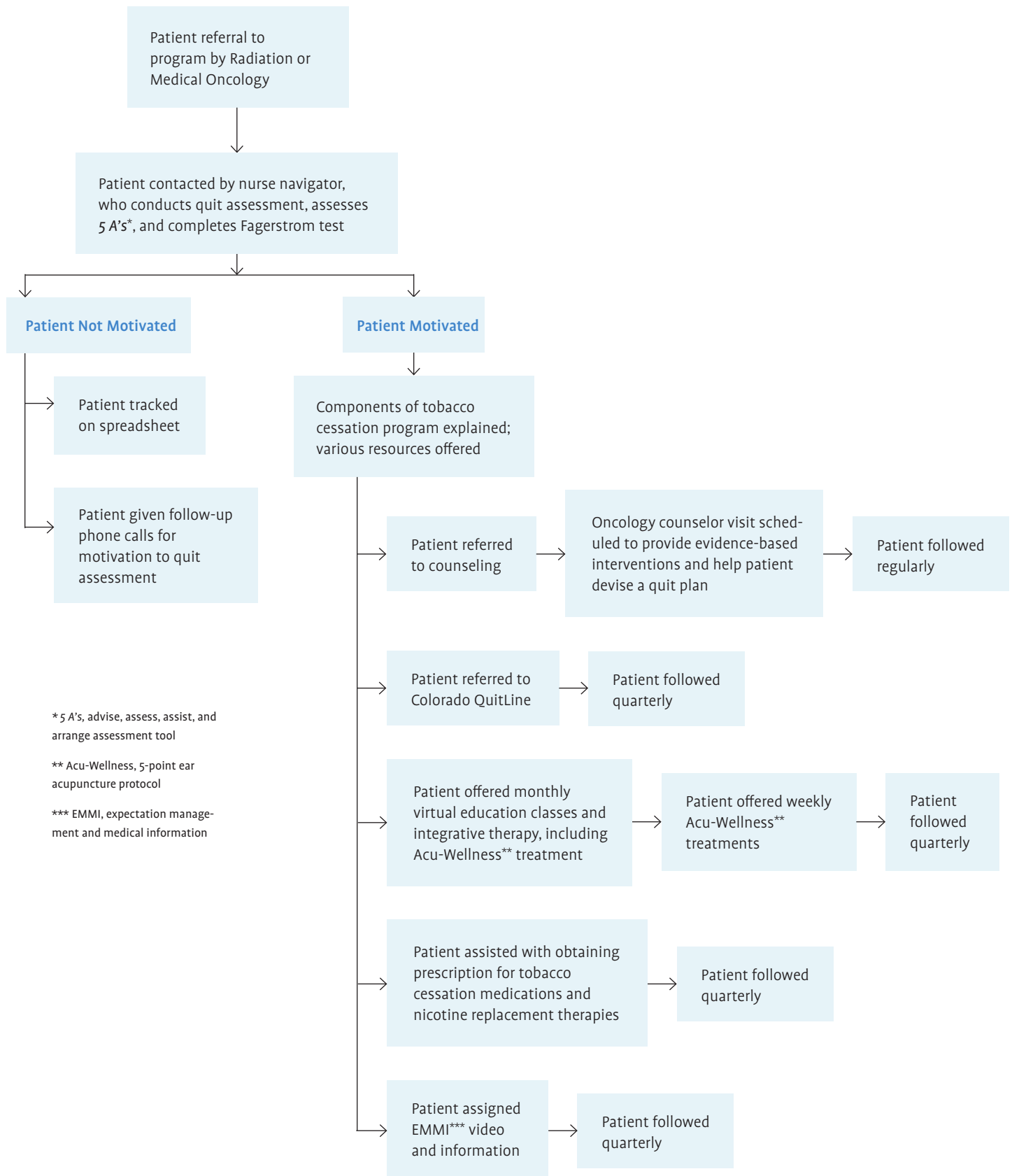
In April 2022, the Dorcy Cancer Center at St Mary-Corwin Hospital piloted its tobacco cessation program to address a lack of tobacco cessation programming available to its oncology patients. The creation of a smoking cessation program also aligned with the cancer center's mission to care for those who are ill by nurturing the health of the people in our communities. Perhaps most importantly, evidence shows a clear correlation in increased cancer survival rates, positive outcomes, and tobacco cessation.⁶

One of the initial steps in the development process was to gain buy-in from administration. This buy-in included obtaining approval for tuition reimbursement for our nurse navigator and oncology counselor to become tobacco treatment specialists through The University of Texas MD Anderson Cancer Center's Certified Tobacco Treatment Training Program. Once this training was complete, our nurse navigator and oncology counselor met to strategize the next steps in program development, feasibility, and implementation. During these meetings, the 2-person team analyzed evidence-based programs, conducted a thorough literature review to determine characteristics necessary for successful tobacco cessation programs, identified possible barriers, and brainstormed solutions to meet those barriers. Once key components of the program were defined, the team gained endorsement from key stakeholders, including referring nurses, radiation and medical oncologists, and department managers.

One important component of a successful tobacco cessation program is access to smoking cessation medications and nicotine replacement therapies. Our radiation oncologist agreed to be the prescribing physician for smoking cessation medications and nicotine replacement

(Continued on page 33)

Figure 1. Workflow for the Dorcy Cancer Center Tobacco Cessation Program



(Continued from page 31)

therapies for patients who chose these courses of action. Once a patient is no longer followed in the oncology setting, our team works with primary care providers to continue this prescription support.

Most tobacco users acknowledge that tobacco is harmful to the body, yet the impulse to use nicotine is greater than the realization of the consequences of smoking, because nicotine is a highly addictive substance.⁷ In fact, nicotine dependence is a recognized disorder in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*. Stigma is strongly associated with tobacco use, and people who use tobacco and are diagnosed with cancer often feel guilt and shame that they caused their disease.⁸ Recognition of this stigma can help clinicians build rapport with patients who use tobacco.

Referral Process

The team understood that a simple, yet effective, process for sending and receiving referrals was key to getting the program off the ground. The nurse navigator and oncology counselor collaborated with referring clinicians on issues regarding timing, eligibility, frequency of contact, and a referral method that would work well with existing workflows. By consensus, it was determined that the best time for a referral to this program would be at the time of the initial medical consult—prior to the start of treatment. While the clinical team, namely nursing, takes the lead for initiating most referrals, any associate within the cancer center can provide a referral to the tobacco cessation program at any time.

Program Components

Our comprehensive tobacco cessation program includes various components and interventions, as outlined in Figure 1. The program was designed to give patients the flexibility to participate in all or

If in-person or virtual tobacco cessation counseling sessions are needed, the oncology counselor uses evidence-based interventions, including motivational interviewing, solution-focused therapy, cognitive behavioral therapy, and acceptance and commitment therapy.

- some of the programming, depending upon their preference. We wanted to ensure that our program was accessible for all learning types, and we included these interventions:
- In-person counseling
 - Virtual monthly education presentations
 - [QuitLine referral](#)⁹
 - Patient resource folders
 - EMMI (expectation management and medical information) education videos
 - Nicotine replacement therapies
 - Prescription for tobacco cessation medications

Table 2 shows the number of patients who received these interventions between April 2022 and June 2023.

After the referral is received, our nurse navigator contacts the patient by phone or in person at their oncology appointment to conduct

Table 2. Number of Patients Receiving Various Interventions Between April 2022 and June 2023	
INTERVENTION	NUMBER OF PATIENTS
Packet	35
EMMI Video Assigned	35
Quitline Information	35
Nicotine Replacement Therapy	16
Cessation Medication	10
Counseling	9
Acu-Wellness (implemented June 2023)	2

a quit assessment and gauge their motivation to stop using tobacco products. The initial assessment includes the evidence-based [5 A's \(ask, advise, assess, assist, and arrange\) assessment tool](#) and the [Fagerstrom Test for Nicotine Dependence](#). Upon completion of the assessment, patients are given the details of the tobacco cessation program and asked to select the therapeutic methods that are best for them.

If in-person or virtual tobacco cessation counseling sessions are needed, the oncology counselor uses evidence-based interventions, including motivational interviewing, solution-focused therapy, cognitive behavioral therapy, and acceptance and commitment therapy. The first session is scheduled to last 60 minutes; it includes an assessment of motivation to quit, tobacco use history, medical and mental health history, other substance abuse history, and general psychosocial support. The initial session also includes development of a quit plan that is agreed upon by clinicians and patients. After the initial session is completed, subsequent 30-minute sessions are scheduled either weekly or biweekly, depending upon patient preference, to assess and support the smoking cessation journey. Follow-up sessions cover topics like relapse prevention, coping strategies, problem solving, motivation to quit, change talk, and encouragement techniques.

The virtual monthly presentations are led by a multidisciplinary team that includes a dental hygienist, a dietitian, the oncology counselor, the nurse navigator, an oncology nurse, a patient care coordinator, and auricular acupuncture technicians. These presentations are offered during the lunch hour for easy access by patients who are employed. The presentations cover various tobacco-related topics such as:

- Nicotine replacement therapies
- How to pack a healthy lunch and snacks
- Tobacco use and oral health
- The cost of tobacco use
- Acu-wellness treatments and how they help with addiction
- Relapse prevention
- Risks of using tobacco while on treatment
- Complimentary therapies
- A question-and-answer panel session.

Access to the Colorado QuitLine is also offered during this time if patients prefer such support. The QuitLine offers a telephone assessment of readiness to quit, a customized plan to quit, motivation and problem-solving advice, up-to-date information about nicotine replacement therapies, and a *quit kit* tailored to the patient's needs. The QuitLine is appropriate for tobacco users in any state of readiness to quit.

Tobacco cessation folders are provided to every patient; they include a welcome letter with handouts about the Colorado QuitLine, substance use resources in the community, and a general list of online tobacco resources. The folders include handouts with titles such as:

- "Look What Quitting Does Over Time"
- "It's Never Too Late to Quit Smoking or Vaping"
- "Tobacco Withdrawal Symptoms"
- "When Triggered to Use Tobacco-Tip Sheet."

A tobacco journal is given with the folder to help the patient track successes, tobacco use, a plan for moving forward, and time for reflection. Also included is the cancer center's monthly Integrative Therapy Program calendar, which provides various programming

and stress coping tools. Furthermore, EMMI education videos and handouts are assigned to each patient. Information on how to access the EMMI videos is included within the folder.

We plan to extend the program by expanding the catchment for referrals to include tobacco cessation at time of oncology surgery, referral acquisition from the low-dose CT lung screening program, and increased referrals from in-network primary care physicians.

Quarterly phone calls are made to patients no longer connected to the tobacco cessation program and to patients who were not ready to engage with the tobacco cessation program at the time of initial contact. During these phone check-ins, patients report on progress with their quit plan and indicate whether they need to reconnect with the program for support.

Our Tobacco Treatment Specialists (nurse navigator and oncology counselor) also participate in Project ECHO (Extension for Community Healthcare Outcomes) from The University of Texas MD Anderson's [Project TEACH](#) (Tobacco Education and Cessation in the Health System). This weekly tobacco cessation telemonitoring program provides a comprehensive educational platform for clinicians to assist individuals who desire freedom from nicotine addiction.¹⁰ We use this program to enhance our skill set, provide evidence-based care and interventions, and continue professional growth. Furthermore, the program provides an opportunity for networking, peer consulting, continuing education credits, and evidence-based strategies to assist.

Looking Ahead

The development of our tobacco cessation program has been rewarding and well received by administration, the multidisciplinary cancer care team, physicians, and patients. These stakeholders supported the program from the onset, because they understood the value in providing support to patients who want to quit, and they knew that the program would improve treatment outcomes and overall quality of life. Radiation oncology nurse Sheila Gomez said, "It has been nice for me as a nurse to have a program to refer patients to...where I know they will get the support and guidance they need. I recognize the importance [that] a comprehensive smoking cessation program provides to our patients."

We are always looking for professional growth opportunities that provide value to our patients and community. In 2023, the nurse navigator and oncology counselor became certified auricular acupuncture technicians; they began performing Acu-Wellness treatments for tobacco cessation patients in May of that year. Acu-Wellness is a 5-point ear acupuncture protocol in which 5 needles are placed in

5 specific points in the ear. This treatment can be used for a wide range of indications, including tobacco cessation. When people use this technique in combination with education, their success for quitting tobacco increases exponentially.¹¹ Patients embrace Acu-Wellness as part of their tobacco cessation journey. Michael Snyder, a tobacco cessation patient, said, “Acu-Wellness has really helped me deal with stress, relaxation, anger, and quitting smoking.” We hope to offer an ongoing Acu-Wellness program as part of the Integrative Therapy Program at the cancer center to provide access to free treatments and help patients desire to quit tobacco use.

Now that the tobacco cessation program has been implemented for a more than a year, we have identified ways to improve and augment the program. Our next steps include standardizing the follow-up care that is provided, enhancing the interdisciplinary team, expanding the referral base, and tracking data for the program.


We plan to improve follow-up care through the standardization of protocols. For example, we follow up with patients quarterly after they are no longer connected to the tobacco cessation program. Standardizing this step includes developing a script so that each patient receives the same information and contact numbers. It also includes identification of a multidisciplinary team member who is comfortable with making the follow-up calls. We believe that these 2 changes will create consistency within the tobacco cessation program, allowing us to make positive connections with patients, permit those who have not yet met their goal to gain program re-entry, provide an extra layer of support to those who may not be aware that they can re-enter into the program, and increase the number of people who succeed with becoming free of tobacco use.

We plan to extend the program by expanding the catchment for referrals to include tobacco cessation at time of oncology surgery, referral acquisition from the low-dose CT lung screening program, and increased referrals from in-network primary care physicians.

Lastly, it will be important to track the effectiveness of the tobacco cessation program’s interventions by collecting and measuring outcomes. We hope to capture whether the interventions provided were successful, whether 1 intervention had more success than another, and whether all individuals who were current tobacco users at the time of consultation were reached. In addition, we hope to discover how many patients have quit tobacco use successfully. To accomplish these goals, we need to document within the patients’ electronic health records so that we can pull reports to reflect work being done.

Final Thoughts

While tobacco use has decreased overall, it remains a foremost health concern today because it is the number one cause of preventable disease, disability, and death in this country, including cancer. Providing a comprehensive tobacco cessation program within our community cancer center has allowed us the opportunity to provide support to patients at a vulnerable time in their life. As clinicians,

developing this program has allowed us to find meaning in the work that we do. We were able to advocate for change within our healthcare system, develop a supportive multidisciplinary team, and build relationships with providers and patients to provide support to those who have a cancer diagnosis and a desire to quit tobacco. We are excited for the future and will continue to grow, develop, and implement a tobacco cessation program that will encourage, support, and advocate for those who wish to be tobacco free. 

Corinth Baxter, MSN, RN, OCN, TTS, is RN lung navigator & oncology program manager and Brenda Biggerstaff, LCSW, TTS, AAT, is oncology program manager, counselor, and Survivorship chair at Dorcy Cancer Center at St. Mary-Corwin Hospital in Pueblo, Colorado.

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Navigation:

A Critical Component
in a Comprehensive Approach
to Dismantling Health Inequities

This Academy of Oncology Nurse & Patient Navigators (AONN+) Leadership Council's Health Inequities Statement was published in August 2023, serving as a call to action for the integration and sustainability of navigation within the health care team.

Navigation: A Critical Component in a Comprehensive Approach to Dismantling Health Inequities

There has never been a more optimal time to embrace and move toward widespread implementation and sustainability of the patient navigation role to address individual health equities.^{1,2} Health equity is the attainment of the highest level of health for all people³ and the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality.⁴ Health inequities are unfair, unjust, avoidable, and unnecessary. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health care disparities.⁵

Cancer Disparities

The root causes of racial disparities in cancer care are complex, including implicit bias, poor communication and potential language barriers in care delivery, lack of representation in the oncology community, mistrust of the health care system and clinical trials, and social drivers of health. Disparities in cancer care persist, with marginalized communities facing significant barriers to accessing and receiving quality oncology screening and treatments, which lead to more advanced stage presentation and worse oncologic outcomes. Despite recent progress toward reducing disparities in the burden of cancer, ethnic or communities of color, which make up 40% of the US population, continue to experience cancer inequities. Below are just a few examples:

- Compared to Caucasian men, cancer incidence in African American men is 6% higher and cancer mortality is 19% higher. This disparity is even more notable in African American women, who have 8% lower cancer incidence than Caucasian women but 12% higher cancer mortality.⁶



- American Indian/Alaskan Native people also have higher incidence rates for kidney (80% higher), liver (2 times higher), and lung cancers (5 times higher for those living in the Northern Plains), as well as increased mortality from these diseases, when compared to Caucasian patients.⁶

Cancer disparities are not limited to racial disparities; inequities also are present in rural communities. Compared to those individuals living in urban areas, rural communities show 17% higher death rates from all cancers combined.⁷ Numerous studies highlight socioeconomic and racial/ethnic disparities present in oncologic care, and further identify access to timely cancer screening and treatment, as opposed to biologic differences, as a major driver of health inequities.

Patient Navigation

One of the only evidence-based interventions that has effectively been able to address disparities in cancer care is patient navigation.^{8,9} Patient navigation is an evidence-based solution to dismantle health inequities, helping patients overcome health care system barriers and providing them with timely access to quality medical, logistical, and psychosocial care from before cancer diagnosis through all phases of their cancer experience. Navigation encompasses both clinical and nonclinical navigators who are critical members of the multidisciplinary team who provide important perspectives on logistical, structural, and social needs of the patient as well as cultural considerations, patient values, and care preferences.

Patient navigators:


- Promote health equity and its benefits in improving oncologic screening and treatment, especially for traditionally marginalized communities.
- Improve the lives of those in greatest need, specifically those who have experienced systemic and institutional injustices and inequities.
- Impact health literacy through patient education and the value of trusted relationships between patients and patient navigators.
- Demonstrate sensitivity and responsiveness to a diverse patient population, including, but not limited to, race, ethnicity, gender and gender identity, age, culture, religion, abilities, and sexual orientation.
- Expose health inequities and find solutions to ensure that all people have the opportunity to live healthy, fulfilling lives.
- Can expose and increase awareness of bias against underrepresented populations in cancer care, particularly as it applies to their unequal representation in clinical trials.
- Identify solutions appropriate for communities that lack resources and/or infrastructure.
- Exhibit cultural humility with diverse communities, cultural norms, beliefs, or practices.

Effectiveness and scope have been studied in relation to cancer screening, diagnosis, treatment, clinical trial enrollment, survivorship, and palliative care. One study, the Patient Navigation Research Program, a multisite, randomized controlled trial conducted in heterogeneous settings, compared patient navigation to usual care with outcomes that included time to diagnosis and treatment, patient satisfaction, and cost-effectiveness.¹⁰ Within this cohort of more than 7500 patients, African American patients who received help from a navigator experienced the greatest reduction in time from abnormal cancer screening to resolution, suggesting that navigation has the most profound impact on historically marginalized communities.¹¹

Interventions, such as the Accountability for Cancer Care through Undoing Racism and Equity (ACCURE; NCT01954641) trial, demonstrated the impact of patient navigation in reducing racial disparities and improving care for all cancer patients. The trial used a multifaceted, system-based intervention to improve treatment completion for both African American and Caucasian patients and to reduce racial disparities.¹² The 5-year observed survival for Caucasian and African American breast cancer patients increased from 91% and 89%, respectively, to 94% for both races. For Caucasian and African

American lung cancer patients, 5-year survival rates went from 43% and 37%, respectively, to 56% and 54%, respectively, after the navigation intervention.

Call to Action

Efforts should be made to integrate sustainable patient navigation services into standard oncology care, expand their reach to underserved populations, and strengthen collaboration among health care providers, community organizations, and policymakers. Future reimbursement models for oncology, including value-based and alternative payment models, should prioritize access to navigation services specifically designed for marginalized communities to ensure that these oncologic outcome disparities do not continue to persist or worsen. Only through a collective effort can we work toward achieving health equity for all individuals affected by cancer along the care continuum. To see how this call to action aligns with the Association of Community Cancer Centers' efforts to stand up its Comprehensive Cancer Care Services Institute, see the last page of this article. 

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The Association of Community Cancer Centers' Comprehensive Cancer Care Services Institute

COMPREHENSIVE CANCER CARE encompasses a broad range of services that are commonly referred to as supportive oncology care. These [services](#)—which encompass the care continuum from patient navigation and fertility preservation to spiritual support and palliative care—are not just help that is “nice to have.” The delivery of comprehensive cancer care is essential to person-centered care and has been found to greatly improve patient quality of life and outcomes.

Although supportive oncology care services are recommended in guidelines and required by accreditation bodies, such as the American College of Surgeons Commission on Cancer, significant barriers prevent consistent delivery of and access to these services. Two major obstacles are inadequate reimbursement and workforce shortages in many of the specialties that provide these services. Challenges are especially pronounced in community programs and practices where there is limited access to philanthropy and other funding to supplement supportive oncology care.

The Association of Community Cancer Centers (ACCC) recognizes the need for action. In response, the ACCC is launching a new strategic initiative: the [Comprehensive Cancer Care Services Institute](#). ACCC past president Krista Nelson, MSW, LCSW, OSW-C, FAOSW, program manager of Quality & Research, Cancer Support Services and Compassion, Providence Health & Services, highlighted the importance of this initiative at ACCC's 40th National Oncology Conference, in Austin, Texas. She explained that “Development of this institute is critical as we know that the needs of patients with cancer exceed the standard treatment of their disease and transcend into mental, social, physical, and other unique supportive care needs. In addition, these comprehensive cancer care services need to be accessible to all patients with cancer and their care partners.”

The Comprehensive Cancer Care Services Institute will build on ACCC's robust portfolio of cancer care [resources and tools](#), including:

- Information to support [patient navigation](#) services
- Support and [empowerment for caregivers](#) and family members as crucial members of the cancer care team
- [Business briefs](#) to justify hiring the staff necessary to provide comprehensive cancer care services
- Resources to support [psychosocial care](#) of patients with cancer and their family members
- Tools to improve and support [health literacy](#) in oncology care
- [Nutritional support](#) to improve patient outcomes
- Resources to implement and grow [financial navigation services](#)
- Models and tools to incorporate [shared decision-making](#) in treatment conversations with patients
- Resources to ensure providers are integrating [survivorship care](#) plans into the continuum of care

ACCC seeks to further develop these resources to incorporate new information, identify effective practices, and address new challenges in the post-COVID cancer care community. Special focus will be placed on the improved delivery of [emotional distress and mental health](#) screening and support services, improving access through new care delivery models like [telehealth](#) and [virtual visits](#), and advocacy for adequate reimbursement for comprehensive cancer care services.

ACCC's Comprehensive Cancer Care Services Institute will be led by a diverse, multidisciplinary team of cancer care service providers.



If They
RECUR,
You Should
Refer

A Community Oncologist Patient ID Roundtable Summary

Chimeric antigen receptor-modified (CAR) T-cell therapy has become a critical part of the armamentarium for the treatment of relapsed and refractory hematologic malignancies. As our experience with CAR T-cell therapy grows and new data emerge, however, identification of suitable patients has become more complex. The Community Oncologist Patient ID Roundtable, held on May 16, 2023, brought together 3 professional societies: the Association of American Cancer Institutes (AACI), the Association of Community Cancer Centers (ACCC), and the American Society for Transplantation and Cellular Therapy (ASTCT) with the aim of developing a standardized framework to enable community oncologists to easily assess patients for CAR T-cell therapy, with a focus on large B cell lymphoma.

The main objectives of this discussion were to:

- Achieve consensus on a framework for rapid identification of patients with large B cell lymphoma who are suitable for CAR T-cell therapy
- Discuss potential channels, partners, and next steps for dissemination of information and community education.

When considering a patient for referral to a CAR T-cell therapy specialist, important factors include the disease indication, clinical fitness (including cardiac, pulmonary, renal, hepatic, neurological immune dysfunction, or other significant or other significant comorbidities; clinical deterioration; and performance status), and nonclinical factors, such as the time required for treatment and recovery, distance from the authorized treatment center, out-of-pocket costs and other financial barriers, caregiver status, and employment status.¹ Rapid identification and consultation, ideally at the earliest indications of first-line treatment failure, can increase the likelihood that patients will receive CAR T-cell therapy expeditiously and benefit from treatment.^{2,3} For many oncologists, however, it may be difficult to ascertain the appropriateness or optimal timing of referral.

An effective framework for patient identification should reflect the clinical and nonclinical patient factors that influence suitability for CAR T-cell therapy. It should provide clear guidance that is not overly restrictive and includes timing and actions for rapid decision-making. Such a framework should be adaptable as clinical guidelines and the treatment landscape evolve over time, serve as a

Early patient identification increases the chances of referring eligible patients with large B cell lymphoma to CAR T-cell therapy specialists in time to optimize treatment response and improve outcomes.

readily applicable educational resource for community oncology care teams and patients, and withstand pressure-testing by multiple stakeholders in the CAR T-cell therapy community.

Early patient identification increases the chances of referring eligible patients with large B cell lymphoma to CAR T-cell therapy specialists in time to optimize treatment response and improve outcomes. One key discussion at the roundtable centered around challenges faced by community oncologists in identifying patients who are appropriate for CAR T-cell therapy. These included a lack of central guidance; insufficient awareness of patient resources; minimal real-world CAR T-cell therapy experience, including feedback on CAR T-cell therapy outcomes; and limited exposure to patients with large B cell lymphoma. In this context, a streamlined framework would empower community oncologists to confidently refer potential patients for consideration of CAR T-cell therapy and strengthen their pivotal role in expanding access to this potentially curative treatment.

A factor prioritization exercise identified 5 key factors to optimize CAR T-cell therapy and access:

1. Relapsed and refractory disease, which is the minimum criterion and consensus trigger for referral
2. Availability of support for patients, including financial support, across the continuum of care
3. Communication across multiple levels, including bidirectional communication between CAR T-cell therapy centers and community oncologists

CAR T CONSULT CONSIDERATIONS FOR PATIENTS WITH LARGE B-CELL LYMPHOMA (LBCL)

"IF THEY RECUR, YOU SHOULD REFER"



ASTCT®

AACI Association of American Cancer Institutes

ACCC Association of Community Cancer Centers

- An understanding that comorbidities would be evaluated on a case-by-case basis by cell therapy specialists and are not necessarily a contraindication to CAR T-cell therapy
- An understanding that advanced age in general should not be a barrier to consultation.


Participants universally agreed that the presence of large B cell lymphoma that has relapsed after or is refractory to first-line standard-of-care treatment is the most critical consideration. Dr. Peter Riedell of AACI deemed relapsed and refractory disease “the most important consideration when considering a CAR T-cell therapy consult.” Similarly, Dr. David Porter of ASTCT cited “anyone with relapsed or refractory disease” as the “key determinant” for consult eligibility.

Roundtable participants next discussed the role of psychosocial and financial challenges for patients under consideration for CAR T-cell therapy and stressed the importance of caregivers and support for essential needs. Dr. Riedell reminded the group, “It is not just the drug cost. It is the parking, other costs to support treatment [such as] caregiver accommodation...so [cumulative cost] is certainly a significant factor.” While cost is admittedly a major obstacle, it was emphasized that it should not prevent any patient from being considered for a consultation with a cell therapy specialist. As stated by Judy Ebmeier of ACCC, “It is important to connect the patient with services for psychosocial support [and] transport...it is key for these patients.”

Comorbidities and age were also cited as important factors in

overall decision-making around CAR T-cell therapy but, importantly, not contraindications to consultation. As Dr. Porter stated, “Age—no [it should not be a barrier]...I personally don’t think age should be highlighted as a limiting factor. Leave that up to the treatment center.” In real-world experience, axicabtagene ciloleucel, for instance, has demonstrated a 57% improvement in overall response rate (ORR) over standard chemoimmunotherapy among patients aged 65 or older, versus a 46% improvement among those younger than 65, underscoring the potential benefit for the older cohort.⁴ Similarly, comorbidities are an important consideration for specialists when evaluating and counseling patients about CAR T-cell therapy but should not preclude referral; even patients with severe comorbidities such as end-stage renal disease who are receiving dialysis treatments are being successfully treated with CAR T-cell therapy.⁵ Multidisciplinary collaborations with case workers, social workers, advocacy foundations such as the Leukemia & Lymphoma Society or the Lymphoma Research Foundation, and patient financial counselors should be explored to potentially mitigate financial toxicity, and issues surrounding transportation, and psychosocial distress.

In a survey among participants, the slogan “If they RECUR, you should refer,” was deemed most effective, with RECUR representing Relapsed and refractory large B cell lymphoma, Every age and comorbidity, Caregiver support, Urgency to recommend consult, and Receive patients who return post-CAR T-cell therapy. “If they RECUR, you should refer” encapsulates the roundtable’s conclusions and

provides a framework for oncologists to identify patients suitable for CAR T-cell therapy consultation and, in turn, allow providers to facilitate access to potentially curative therapy for relapsed and refractory large B cell lymphoma. 

Peter Riedell, MD, is with the Association of American Cancer Institutes, Pittsburgh, Pennsylvania. Christian Downs, JD, MHA; Leigh Boehmer, PharmD, BCOP; and Judy Ebmeier are with the Association of Community Cancer Centers, Rockville, Maryland. David Porter, MD, and Andre Williams are with the American Society for Transplantation and Cellular Therapy, Chicago, Illinois.

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The Hospital of the Future 2.0



The concept of the hospital of the future envisions a health care facility that includes advanced technologies and innovative approaches to improve patient care and health outcomes. It will leverage technology to provide a more personalized, efficient, and patient-centered experience. Recently, *Modern Healthcare* hosted a virtual briefing, bringing together industry leaders to discuss the concept of the hospital of the future.

“In the hospital of the future, the focus will be on technology-enabled care (that is, digital transformation), staffing, and an aging population,” said keynote speaker Mark Kandrysawtz, MBA, vice president and chief innovation officer at WellSpan Health. Kandrysawtz also emphasized the struggle that health care organizations have faced in the wake of the COVID-19 pandemic. He noted that the pandemic was enormously disruptive and served as a catalyst for a changing workforce, economy, and customer expectations.

Speakers highlighted 2 key strategies as vital for the future of health care:

- Advancing digital transformation
- Fostering health equity and eliminating health disparities

“Innovation occurs in problem-rich environments.”

MARK KANDRYSAWTZ

WellSpan Health, headquartered in Pennsylvania, is a clinically integrated network of 2600 physicians and advanced practice providers, 8 hospitals, more than 220 patient care locations, and 20000 employees. WellSpan Health recently earned 5 MyChart Diamonds—the first health care organization in the world to achieve this designation.¹ Epic’s diamond program recognizes organizations with technology that is working well and is widely used by patients.

“Think of it [digital transformation] as a marathon, not a sprint.”

MARK KANDRYSAWTZ

Digital Transformation

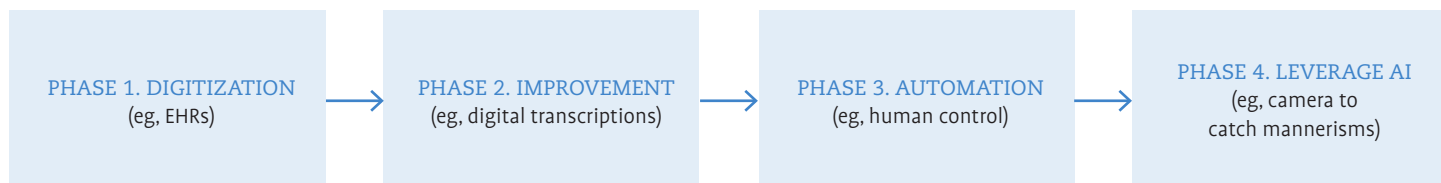
For decades, many health care tasks have been automated and digitized, such as electronic health records (EHRs) and the provision of medical care through telemedicine. These innovations have arguably made health care more efficient and effective. Through telemedicine, patients have access to virtual consultations with health care professionals anywhere in the United States, and remote patient monitoring (tracking vital signs and health parameters) allows for early detection of potential health issues from the comfort of patients’ homes.

And yet, this increased use of technology can create as many, if not more, headaches than it aims to cure. The barriers to digital transformation are not technological. They are, instead, based on organizational culture, structure, and governance.² It will take a concerted effort by all stakeholders to prepare for changing customer expectations and advanced levels of virtual care.

Postpandemic, patients continue to seek opportunities for virtual care. “And with huge advancements in electric vehicles, it leaves us asking the question of how health care might take advantage of this proliferation?” Kandrysawtz asked. For example, health care systems could learn how to source and acquire products, how to move these products to get them at the right time, and in general, change the way we think about the purchase, procurement, and storage of materials.

Artificial intelligence (AI) and machine learning have the potential to play a significant role in various aspects of health care, including assisting in diagnosing diseases, analyzing medical images, and predicting patient outcomes. They can also help streamline administrative tasks, optimize resource allocation, and improve operational efficiency.

Figure 1. The 4 Phases of Digital Transformation



Overall, the hospital of the future will leverage technology and data-driven approaches to deliver more-efficient, personalized, and patient-centric care. It will seek to improve health care outcomes, enhance patient experiences, and optimize resource utilization. Figure 1 illustrates how digital transformation occurs through 4 phases.

Fostering Health Equity and Eliminating Health Disparities

Speakers examined health equity and health disparities through the lens of surgical patients. In a panel discussion, speakers discussed how health disparities affect a patient's ability to access and recover from surgery. In defining health equity, the speakers explored variations on a similar theme: to remove barriers to ensure everyone has access to the highest quality care, regardless of social constructs.

Two speakers discussed how they utilized robotic surgery to tackle health equity. Morehouse School of Medicine, based in Atlanta, Georgia, shared its experience in implementing robotic surgical education. It chose to tackle health equity because the community and patients deserve the best possible care, and it is fully capable to educate and train learners. Shaneeta M. Johnson, MD, MBA, FACS, FASMB, professor of surgery, shared that after implementing robotic surgery, it saw significant cost savings, and improvements in patient length of stay, shorter recovery times, decreased patient pain levels, decreased mortality rates, and increased patient satisfaction.


"Inequities that exist are very relevant, whether we are referring to rural or urban America."

JOSEPH V. SAKRAN

Comparably, the University of Utah's Huntsman Cancer Institute shared its experience in implementing advanced minimally invasive robotic surgery. Brian Mitzman, MD, MSc, FACS, FCCP, director of robotic thoracic surgery, noted it is the only NCI-designated institution for the Mountain West Region. Meaning, patients come from hundreds of miles away to get care. The institute's focus on health equity includes building affiliations with local hospitals across its service area to provide care to patients where they live.

At Johns Hopkins Medicine, minimally invasive robotic and laparoscopic surgery is the standard of care for many patients. In fact, the integration of robotics has proven to improve patient outcomes, including patient length of stay and minimizing the number of conversions to open surgery. "Surgery is a time when people are at their most vulnerable," said Joseph V. Sakran, MD, MPH, MPA, FACS, executive vice chair of surgery and director of clinical operations of surgery, "we look to provide the best possible care to all patients." The robotics program at Johns Hopkins boasts a safer, reproducible approach to surgical procedures that is available 24/7 to patients.

Lessons Learned

The speakers also shared lessons learned from their work combatting health disparities and promoting health equity. Sakran noted, "health equity cannot be addressed in a silo. Try to understand that to be successful, you have to break down silos and work together across sectors." Mitzman said, "referring doctors don't know what they don't know; patients need enhanced recovery pathways. [It is important to] go into the community to inform physicians and patients about what to expect from their care, including the updated standards of care." And, finally, Johnson stressed the importance of collaboration. "Collaboration allowed us [at Morehouse] to gain resources to keep pace with others in the area." 

Stephanie Helbling, MPH, MCHES, is associate editor, Oncology Issues.

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ICYMI: *Oncology Issues* covered Modern Healthcare's 2022 virtual briefing on the Hospital of the Future, which focused on access and staffing challenges.³ Read about it [here](#).

Examining Health Care Workforce Needs in Hawaii

BY STEPHANIE HELBLING, MPH, MCHES®

Introduction

For years, the United States health care workforce has struggled to keep pace with burnout, retirement, or finding people with the specialty training needed to do the work. In fact, staffing shortages have been identified as the biggest challenge facing hospitals and health care providers nationwide.¹ Recent national estimates of physician supply indicate the current shortage is between 40,000 and almost 60,000 practicing physicians in the United States, and the shortage is expected to grow to 139,000 physicians by the year 2033.¹

The COVID-19 pandemic, a major public health catastrophe, exacerbated the strain on the health care workforce worldwide.² Effects of COVID-19 included morbidity and mortality of the public and health care workforce, economic impacts, as well as psychological

effects. Disaster response and substantial shortages of personal protective equipment resulted in feelings of fear and isolation.³ As a result, providers have been taxed both physically and psychologically. This is concerning because a health care workforce that is fatigued and burnt out can lead to medical errors, lack of empathy, decreased productivity, and higher turnover.²

Recently, the Association of Community Cancer Centers (ACCC) partnered with the Hawaii Society of Clinical Oncology (HSCO) to define workforce challenges in Hawaii and provide policy recommendations to address defined barriers and gaps. A landscape analysis was conducted to provide an overview of current regional activities, barriers, and interventions around the health care workforce shortage in Hawaii.

Why is there such a problem in Hawaii?

A 2022 report from the Healthcare Association of Hawaii found a 76% increase in the number of job vacancies for health care workers, from 2,200 in 2019 to 3,873.⁴ In recent years the COVID-19 pandemic played a major role, however there were factors at play

in Hawaii well before. For example, Hawaii's general excise tax, stringent licensing requirements, and high cost of living all make it difficult for health care providers to work in Hawaii.⁵

Workforce Challenges

Critical Staffing Shortages

The physician shortage in Hawaii is dire. Statistics show demand is greater for physicians and other health care workers than what is available, especially on neighbor islands.⁵ It is estimated that there are approximately 1,000 too few providers.⁶ Demand stretches across positions from providers and nurses who provide direct care, to administrators who support operations.

In a 2023 report titled, "Annual Report on Findings from the Hawaii Physician Workforce Assessment Project," the University of Hawaii examined supply and demand numbers based on a voluntary relicensure survey, queries of local community contacts, internet searches, and direct calls to physician offices, as well as the purchase of a demand model to support the analysis of physicians in relation to the population.⁷

Table 1. Statewide Supply and Demand Estimates by Medical Specialty⁷

Specialty (Medical Specialties)	Demand	Supply	Difference	w/o Overage	% Shortage
Allergy and Immunology	20.6	10.0	10.6	10.6	51.7%
Dermatology	34.7	49.6	-14.9	0.7	2.0%
Infectious Diseases	38.5	20.8	17.7	17.7	45.9%
Neonatology	25.5	21.8	3.7	7.8	30.4%
Nephrology+	47.5	32.1	15.4	15.4	32.5%
Adult Cardiology	102.6	78.3	24.3	24.3	23.7%
Pediatric Cardiology	7.1	6.3	0.8	1.2	17.3%
Adult Critical Care+	19.1	41.4	-22.3	5.6	29.5%
Pediatric Critical Care	2.7	5	-2.3	0.8	29.6%
Adult Endocrinology	28	13.9	14.1	14.1	50.3%
Pediatric Endocrinology	7.8	2.5	5.3	5.3	67.9%
Adult Gastroenterology	63.7	57.2	6.5	8.7	13.7%
Pediatric Gastroenterology	8.2	2.5	5.7	5.7	69.5%
Adult Hematology and Oncology	44.2	27.8	16.4	16.6	37.6%
Pediatric Hematology and Oncology	7.3	6.3	1.1	1.8	24.7%
Adult Pulmonology	57.3	19.8	37.5	37.5	65.4%
Pediatric Pulmonology	5.5	1.3	4.2	4.2	75.8%
Adult Rheumatology	22.5	20.6	9.5	9.5	42.2%
Pediatric Rheumatology	1.3	2.2	-0.9	0.4	30.8%
Medical Specialties Total	544.1	411.7	132.4	187.9	34.5%

The Physician Workforce Report found a 38% and 25% shortage for adult and pediatric hematology and oncology statewide, respectively.⁷ Primary care remains the area of greatest need across all islands. However, the greatest statewide shortage of subspecialties includes pediatric pulmonology, pediatric gastroenterology, pediatric endocrinology, adult pulmonology, colorectal surgery, thoracic surgery, allergy and immunology, and adult endocrinology (see Table 2).⁷

The numbers tell a very different story when examined on a county-level. Hawaii County is experiencing a shortage in both adult and pediatric hematology/oncology providers.⁷ While neighboring Kauai and Maui counties are experiencing a shortage in pediatric providers of hematology/oncology.

Table 2. Greatest Subspecialty Shortages, Statewide⁷

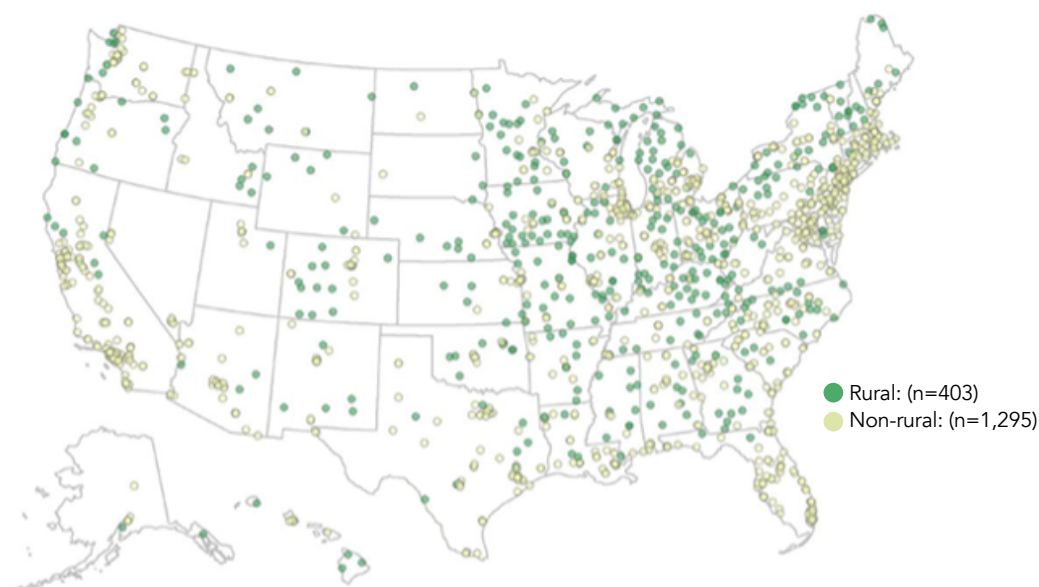
Specialty	FTE Shortage	Percent short
Pediatric Pulmonology	4.2	75.8%
Pediatric Gastroenterology	5.7	69.5%
Pediatric Endocrinology	5.3	67.9%
Adult Pulmonology	37.5	65.4%
Colorectal Surgery	6.4	60.0%
Thoracic Surgery	11.7	57.1%
Allergy and Immunology	10.6	51.7%
Adult Endocrinology	14.1	50.3%

FTE, full-time equivalent.

Table 3. Physician Supply and Demand Estimates for Hematology/Oncology, County-Level⁷

Oncology Shortages by County	Demand	Supply	Difference	w/o Overage	% Shortage
Adult: Hawaii County	0.9	0.0	0.9	0.9	100.0%
Pediatric: Hawaii County	6.5	0.0	6.5	6.5	100.0%
Adult: Honolulu County	29.0	23.2	5.8	5.8	19.9%
Pediatric: Honolulu County	5.5	6.3	-0.8	0.0	0.0%
Adult: Kauai County	1.9	2.1	-0.2	0.0	0.0%
Pediatric: Kauai County	0.3	0.0	0.3	0.3	100.0%
Adult: Maui County	7.4	2.2	5.2	5.2	70.3%
Pediatric: Maui County	0.6	0.0	0.6	0.6	100.0%

Figure 1. A Look at Rural and Non-Rural Oncology Practices



Sources: Medicare Physician Compare (April 2020 update), US Census Bureau Gazetteer Files, USDA Rural-Urban Continuum Codes

Comparatively, a look at oncology providers across the Nation show a similar pattern seen in Hawaii. Non-rural areas show higher numbers of oncology providers when compared to rural states. While rural states and Hawaii's outer islands reflect shortages (**Figure 1.**).⁸

Impact of COVID-19

Hawaii continues to deal with surges of COVID-19. As late as June 2022, the Hawaii State Health Department reported case numbers for a 1-week period in the thousands and 8 deaths.³ A recent study of Hawaii's nursing workforce revealed that of 421 respondents, 23% considered leaving nursing during the pandemic.⁹ Reasons provided include safety (39.2%), family/caregiver strain (32.0%), job fatigue (24.7%), retiring (21.6%), not wanting to be a health care provider (21.6%), and economic strain (9.3%). Even after the pandemic has been declared over, the effects are persisting on the health care workforce.

Burnout and Depression

Burnout has long been a problem nationally for physicians, nurses, and other health care professionals. Hawaii considers health care worker burnout from the pandemic an important public health problem.¹⁰

Burnout refers to a stress reaction marked by emotional exhaustion, depersonalization, and a lack of sense of personal accomplishment.¹¹

The pandemic heightened the crisis. Factors affecting burnout include workload, supply shortages, and pressure, among many others. Burnout is difficult to combat. It can cause increased risk to patients, lead to potential malpractice claims, increase absenteeism, and cause substantial losses financially.¹¹

Limited Training Opportunities

The University of Hawaii John A. Burns School of Medicine in Honolulu is the state's only medical school.¹² It provides 19 accredited programs that are run by a nonprofit organization, Hawaii Residency Programs, Inc.¹³ The school of medicine cites approximately 230 physicians receive training annually in specialties such as internal medicine, surgery, psychiatry, and pediatrics. Oncology and radiation oncology are not on the list of training specialties offered.

Because medical school and residency positions are so few and so competitive, many local Hawaiians end up completing their training elsewhere in the United States.

Why are providers not moving to Hawaii?⁶

There are a host of reasons, but the state's high cost of living, licensing requirements, and general excise tax all make it harder to be a health care worker in Hawaii.

Cost of Living

Hawaii is the most expensive state to live in the United States.¹⁴ As one of the most remote places in the US, most resources need to be shipped in from the mainland.

- Ninety percent of food and 95% of energy resources are imported to Hawaii annually.¹⁵
- Average cost of a home in Hawaii is over \$1 million.
- Restaurants often charge more for food and drinks in areas of high tourism.

Licensing Requirements

Every state (commonwealth or district) in the United States has licensing requirements for providers to practice medicine. In recent years, states have begun creating compacts with other states to allow providers licensed in other states to practice within their state.¹⁶ Hawaii does not allow for such compacts. Any provider practicing medicine in Hawaii must be licensed by Hawaii.

General Excise Tax

Hawaii does not have sales tax. Instead, they use a general excise tax (GET).¹⁷ A GET is a tax imposed on a business for the privilege of doing business in Hawaii. Often, this cost can be passed through to customers. In the case of physicians and patients, however, this cost cannot be applied to Medicare, Medicaid, or TRICARE (insurance for US armed forces).¹⁸ As a result, physicians can make more money practicing in other states.

Recommendations

There are many groups across the state that are examining barriers and defining interventions to combat the workforce issues. It is in the best interest of all involved to coordinate these and other efforts to address workforce issues affecting Hawaii.

Some solutions already being implemented include⁷:

- **Recruit the future physician workforce:** Hawaii's Area Health Education Center (AHEC) receives federal grant funding to provide mentoring, counseling support and activities to promote careers in health professions.
- **Physician recruitment:** AHEC hired a statewide physician recruiter to support physician recruitment in Hawaii.
- **Educational loan repayment:** Hawaii's Loan Repayment Program (HSLRP) has supported 76 recipients since the program began in 2012. Additionally, the Innovative Loan Repayment Program has been introduced to support providers in areas of need who do not meet federal criteria for loan repayment.
- **Housing costs:** AHEC is working with banks to provide physicians with low interest, low down payment loan packages for purchasing homes.
- **Physician mentoring program:** Hawaii's physician recruiter has created the Alakai program for mentoring and providing cultural awareness to new physicians moving to Hawaii to practice.

Additional recommendations to consider include:

- Increase health care provider compensation.
- Establish residency and fellowship programs at health care practices on neighboring islands.
- Partner with mainland health care institutions to provide clinical care on neighboring islands.
- Work with other organizations to petition for exemption of medical services from Hawaii's GET.

In addition to initiatives focused on recruitment and retention of physicians, stakeholders should examine the incorporation of Advanced Practice Providers (APPs) into the oncology community. Studies show employing APPs such as nurse practitioners and physician assistants can help to improve the workforce issues in cancer care.¹⁹ While APPs can support clinical care, they also can contribute to administrative and operational tasks as well as patient education, genetic counseling, prevention, and survivorship care.²⁰

Conclusion

Hawaii's workforce shortage is real, and there are clear causes. It will take collaboration among many organizations within and outside of health care to address the underlying issues. Luckily for Hawaii, there are many groups already working on solutions. Major issues that will need to be addressed in the very near future include the cost of living, provider salaries, and reimbursement. The longer these major issues go unaddressed, the longer the workforce shortage will persist.

Stephanie Helbling, MPH, MCHES® is an associate editor, Oncology Issues, Rockville, Maryland.

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In partnership with:



Association of Community Cancer Centers

A publication from the ACCC education program, "The Future of the Healthcare Workforce in Hawaii."

Learn more at accc-cancer.org/HSCOWorkforce.

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

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fast facts

Survey Finds Telemedicine Consistently Outperforms In-Person Visits for Cancer Care When Both Are Available

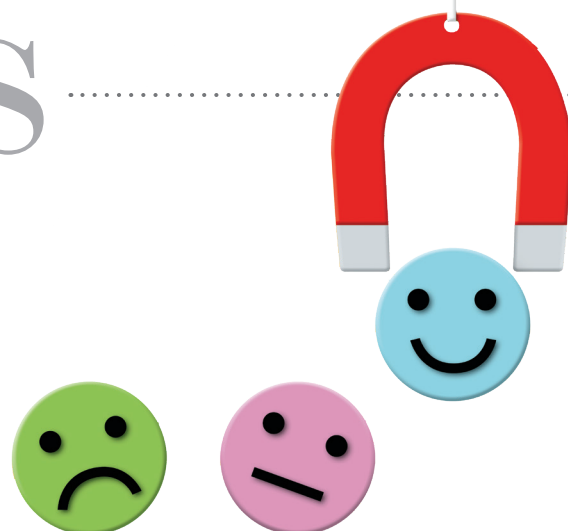
- **62.5%** of in-person visits were rated as “highly satisfying,” versus **75.8%** for telemedicine.
- When asked about the response and amount of concern demonstrated by their care provider, **84.2%** in-person visits and **90.7%** of telemedicine visits received “high satisfaction” scores



Source. Patel KB, Tabriz AA, Turner K, et al. Telemedicine adoption in an NCI-designated cancer center during the COVID-19 pandemic: a report on patient experience of care. *J Natl Compr Canc Netw.* 2023;21(5):496-502. doi: 10.6004/jnccn.2023.7008

Report shows more than 75% of hospitals still not complying with Hospital Price Transparency Rule.

Source. Fourth Semi-Annual Hospital Price Transparency Report: February 2023. patientrightsadvocate.org/february-semi-annual-compliance-report-2023



5 Strategies to Improve Employee Attraction and Retention

1. **Ensure onboarding is a part of your overall engagement strategy.** Guide new employees through the entire range of benefits and support services, ensuring they understand not only their health benefits but also financial assistance, family planning, and disability support.
2. **Create meaningful connections in that critical first year.** Assign mentors or buddies to new employees, provide regular check-ins, and organize team-building activities to help employees feel supported and valued.
3. **Educate frontline supervisors and managers.** Equip these staff with comprehensive knowledge so that they are better positioned to recognize employees' needs and direct team members to the appropriate resources.
4. **Understand engagement and value feedback.** Engagement goes beyond an explanation of benefits; it encompasses a broader sense of connection, purpose, and influence. Create an environment where employees not only comprehend their benefits but also feel that they have a voice in determining what is offered to them.
5. **Emphasize connection and community.** Facilitate genuine connections between employees, their colleagues, and the organization. While virtual communication is essential, employers should also organize in-person meetings, team-building events, and/or collaborative projects.

Source. A press release from the Integrated Benefits Institute. <https://www.ibiweb.org/resources/attraction-and-retention-in-a-post-covid-19-era?hsLang=en#>.



Survey Finds Most Americans Satisfied with Health Plans

- **90%** of those surveyed said they were satisfied with their current health insurance plan, compared to **9%** who said they were dissatisfied.
- Respondents were split on the subject of universal health care, with **43%** opposed and **40%** in support of banning private health insurance and everyone being enrolled in a government plan.
- When asked how they would rate their current health insurance coverage, **75%** rated it as good, compared to **19%** who rated it adequate, and **6%** who rated it poor.

Source: [Pacific Research Institute](#).



The Pitfalls of Prior Authorizations

- More than **4 in 5** physicians (**86%**) report that prior authorization requirements led to higher overall utilization of healthcare resources, resulting in unnecessary waste rather than cost-savings
- About **2/3** of physicians report resources were diverted to ineffective initial treatments (**64%**) or additional office visits (**62%**) due to prior authorization policies
- Almost half of physicians (**46%**) report prior authorization policies led to urgent or emergency care for patients

Source: American Medical Association. 2022 AMA Prior Authorization Physician Survey. ama-assn.org/system/files/prior-authorization-survey.pdf.

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Strategies to Address Disparities in Patients with Acute Myeloid Leukemia

While there are many factors why patients with acute myeloid leukemia are ineligible for allogeneic stem cell transplant, such as age, financial hurdles, or other comorbidities, these factors are often compounded by social determinants of health, which can act as a significant barrier to consolidation therapy and long-term remission for these patients. In this [episode](#), CANCER BUZZ speaks with Keri Maher, DO, Director of the Acute Leukemia Program, and assistant professor at Virginia Commonwealth University's Massey Cancer Center about strategies to address these disparities and optimize care and treatment options for patients with acute myeloid leukemia who do not receive a transplant.



A Roadmap for Newly Diagnosed Patients with Pancreatic Cancer

In this [blog](#) by [Let's Win Pancreatic Cancer](#), learn more about the organization's guide, [What to Do If You Are Newly Diagnosed with Pancreatic Cancer](#). Information, resources, and recommendations are organized into 3 steps: After Diagnosis, Beginning Treatment, and Helping Patients Care for Themselves.



There is No One-Size-Fits-All Care Plan for Caregivers

The rapid evolution of cancer care delivery toward multi-agent regimens, oral and/or combination therapies, and at-home treatment administration has made cancer caregiving extremely complex. The Caregiver Clinic at Memorial Sloan Kettering provides support to people who are having difficulty coping with the demands of being a caregiver. Hear how this [clinic](#) helps individuals maximize their ability to provide care to loved ones while attending to their own self-care, needs, and other important responsibilities.



The Value of Financial Advocacy

This [infographic](#) shows how financial navigators help improve health outcomes of patients, increase patient and caregiver satisfaction, improve the cancer program's financial strength, and help streamline operational processes related to tasks like prior authorizations, denials, and appeals.



Patient Navigation Services Promote Equitable Access to High-Quality Care

[Read](#) about the recent Centers for Medicare & Medicaid Services proposal to reimburse "Principal Illness Navigation" services under Medicare to help patients navigate treatment for serious illnesses such as cancer. These benefits would include person-centered assessments; identifying or referring the patient (and caregiver or family if applicable) to appropriate supportive services; practitioner, home, and community-based care coordination; health education; building patient self-advocacy skills; and access to comprehensive and equitable care.

CAR T-Cell Therapy: A Significant Advance for Patients With Hematologic Malignancies

BY NICOLE TAPAY, JD



First approved in 2017, chimeric antigen receptor (CAR) T-cell therapy is a type of immunotherapy that has altered the way many hematologic malignancies are treated.¹ To date, 6 CAR T-cell therapies have been approved by the FDA for the treatment of blood cancers, including lymphomas, some forms of leukemia, and, most recently, multiple myeloma.² These therapies have produced remarkable responses in some patients for whom other treatments had stopped working, which has led to growing interest in the potential of CAR T-cell therapy beyond the particular blood cancers it is currently approved to treat. More than 600 active CAR T-cell therapy trials are currently ongoing worldwide.³ Despite this significant clinical progress, access to CAR T-cell therapy raises several challenges, including but not limited to issues relating to geographic access, caregiving, and coverage and affordability.

How CAR T-Cell Therapies Are Administered¹

Current CAR T-cell therapies are customized for each patient. T-cells are collected from the patient and re-engineered in a laboratory to produce proteins on their surface called chimeric antigen receptors, or “CARs,” which recognize and bind to specific proteins, or antigens, on the surface of cancer cells. The revamped T-cells are “expanded” into the millions in the laboratory and then infused back into the patient. If the treatment progresses as planned, the CAR T-cells will continue to multiply in the patient’s body and—guided by their engineered receptor—recognize and kill any cancer cells that harbor the target antigen on their surfaces.

Improving Access to CAR T-Cell Therapy in the Community Setting

CAR T-cell therapy is complex and, to date, has generally only been available at select treatment centers. Hence, distance to a treatment center may be a barrier for some patients. Nevertheless, most of the US population resides within a reasonable driving distance from a hematopoietic cell transplantation center. One study found that nearly half (46.7%) of the US population lives within 30 minutes of a transplant center and 65.9% to 77.1% of the population resides within a 60- or 90-minute travel time, respectively.⁴ Additional concerns include whether these centers are certified to provide some of these therapies. For example, fewer than 100 centers were certified to give axicabtagene ciloleucel (Yescarta®) in the United States, as of 2020.⁴

Furthermore, FDA Risk Evaluation Mitigation Strategy programs for CAR T-cell therapies may require patients to remain within a specified travel time to the treatment center (between 30 minutes to 2 hours), restrict driving, and frequently require a caregiver to be present for 30 days post infusion. While these processes are critical for monitoring safety post infusion, these requirements can pose substantial challenges for patients and caregivers.⁵

Some cancer programs and practices with fewer resources are wary about offering CAR T-cell therapy, given the skills and infrastructure required to administer the treatment. Many smaller community cancer programs indicate that they prefer to refer patients who are (or may be) candidates for CAR T-cell therapy to larger cancer programs and academic medical centers. Some of the reasons for this hesitation include unfamiliarity with the therapy;

inadequate reimbursement; insufficient infrastructure; and the potential for unfamiliar adverse events, such as life-threatening toxicities, to affect patients.⁶

The Association of Community Cancer Centers (ACCC) is helping community cancer programs and practices of various sizes to become educated about building their own CAR T-cell therapy programs. This requires an understanding of the operational infrastructure, such as care coordination and patient support, that is required for timely identification of patients who are good candidates for CAR T-cell therapy and improving referral relationships between noncertified and certified centers.^{3,6} These educational projects are supported by Kite Pharma, Janssen Oncology, and Bristol Myers Squibb.

Coverage and Affordability Challenges

CAR T-cell therapy is costly. For example, the most recently approved CAR T-cell therapy costs more than \$450,000.² This poses unique challenges for patients, caregivers, providers, and payers.

Many cancer programs and practices offer financial navigation services to patients to help them obtain available coverage and financial assistance. In fact, coverage is often a prerequisite before treatment can be initiated. For example, even Medicare beneficiaries may not be assured full coverage. If a traditional Medicare beneficiary does not have a supplemental plan (or is not covered by a Medicare Advantage plan), the significant cost-sharing under traditional Medicare (20%) may be prohibitive for patients and it may mean that some patients cannot afford their out-of-pocket

responsibility, thus deterring them from receiving the treatment.⁷ Additionally, many insured patients face reimbursement restrictions. Approximately two-thirds of US health plans have restrictive coverage policies relating to cell and gene therapy, likely due to the high costs of treatment.⁵ Treatment center and payer processes can add a week or more to CAR T-cell therapy timelines. These delays in treatment may be detrimental for patients with active and rapidly progressing disease.

Innovative Payment Models

CAR T-cell therapies have the potential to save or significantly prolong many patients' lives. Yet the cost and reimbursement of these therapies pose some formidable challenges for the health care system. New payment models are emerging that seek to address patient mobility across payers over time and/or to create risk-sharing mechanisms whereby payments to the manufacturer are tied to certain treatment milestones. The following are some mechanisms that have been identified to help structure payments for cell and gene therapies:⁸

- **Milestone-based contracts.** Up-front payment with requirement for refund if certain milestones are not met. Generally, these contracts have a 1-year term.
- **Multi-year milestone-based contracts.** Performance-based agreement for the longer term with requirement for rebate if certain milestones are not met.
- **Reinsurance.** Insurance for insurance companies to reduce the impact of unexpected high costs for a patient or group of patients.
- **Stop-loss insurance.** A product that provides protection against unpredictable costs for a patient above a specified threshold. It is purchased by employers who have decided to self-fund their employee health plans.
- **Risk pools.** Federal or state government programs or coverage-specific insurance products in which a premium is set and paid for coverage of a defined treatment for a group of individuals, thereby creating cost predictability.

- **Performance-based annuities.** A multi-year payer-developer agreement in which the payer makes an up-front payment for part of the price of the therapy, as well as a commitment to further periodic payments as specific patient performance milestones or outcomes are met.
- **Payment over time or installment financing.** Paying for a treatment over multiple years rather than in one upfront payment.

Looking Forward

CAR T-cell therapies have ushered in a new era of treatment options for patients with certain hematologic malignancies and have saved the lives of many. Yet, these treatments raise logistical and financial challenges for many patients. It is, therefore, important to increase the number of cancer programs that offer these therapies, as well as to develop innovative payment mechanisms. ACCC will continue to work with its members and the broader provider, patient, caregiver, and stakeholder communities to provide educational background about—and help develop possible solutions to—some of the opportunities and challenges attendant to CAR T-cell therapies. 

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Managing Chronic Conditions in Oncology Patients

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

Although providers and oncology programs focus on the latest proven technologies for the effective treatment of cancer, the human body is complex and the task of addressing so many different diagnoses is not easy. To treat the whole patient and to mitigate and manage their response to treatment, oncology providers also must address a patient's other conditions. This requires developing a comprehensive plan of care to heal the mind, body, and soul of the patient.

For many patients, the prevalence of multiple chronic conditions is a significant challenge. At a recent Michigan Society of Hematology and Oncology meeting, a Contractor Medical Director for Wisconsin Physician Services (WPS) Health Solutions gave a presentation on 2021 claims data. It indicated that in the 2 jurisdictions (6 states) that WPS serves, 63% of Medicare patients reported 2 or more chronic conditions. Reviewing other Medicare data available since 2010 supports the prevalence of chronic conditions for Medicare beneficiaries. Consequently, many oncologists find themselves managing more than just their patients' responses to cancer treatment. Instead, oncology providers often become the constant in a patient's ongoing health care routine, which requires them to manage the patient's multiple conditions, some of which may be severe.

It is possible for providers and clinical staff to charge for the work and the resources that are necessary to manage patients with chronic conditions. However, 2021 claims data indicate that very few oncologists actually bill for these

services. In 2021, the specialty Hematology/Oncology represented anywhere from 0.1% to 1.1% of the claims submitted using chronic care management codes.¹ Compare this to the internal medicine specialty, which billed for nearly 40% of these services.¹ In my recent discussions with oncology providers, some indicated that the lack of billing was due to the administrative guidelines for documentation and concerns about the added patient co-pays such invoices would generate. Oncology providers agree that this work is routinely being done, and even though cancer is a chronic condition that is often covered by payers, the work required to bill for management of chronic conditions is overly burdensome. Other oncology providers seem unaware of the codes that would allow them to capture and bill payers for this work.

Defining Chronic Care Management

Chronic care management and complex chronic care management are time-based services that can be reported and paid by Medicare once per calendar month. Note: Medicare will only pay for one or the other of these services during a given month. According to the American Medical Association (AMA) manual, *CPT® (Current Procedural Terminology)* 2023, patients who receive chronic care management have "two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline."²

Both physicians and non-physician

practitioners (NPPs) are considered to be eligible providers of these services, but they must be working and billing for the services under their respective National Provider Identifier (NPI) if they are developing the care plan. NPPs or clinical staff working under the direction of the physician must be physically present in the United States and must meet the criteria for incident to; providing the services that they are trained to provide under general supervision of the physician. Typically, services provided incident to the physician require direct supervision, but Medicare has adjusted this for work specific to chronic care management services.

The oncologist must develop a care plan (eg, comprehensive direction for the clinical staff to address all the patient's health problems) and the patient must give written or verbal consent to proceed with this care. It is expected that this plan will require periodic review and may require substantial revisions for the duration of the care. In addition, the plan will include some, if not all, of the following: a problem list; expected outcome and prognosis; measurable treatment goals; a description of how symptoms will be managed; who is responsible for any planned interventions, medication(s) management, and any ordered social services; and how any services provided by outside organizations will be coordinated and managed in support of the care plan.

Per the AMA CPT manual, any cancer program or practice that decides to provide and report this level of care must have the following capabilities to meet the needs of the patient and required work elements:²

- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients and caregivers with a means to contact health care professionals in the program or practice to address urgent needs, regardless of the time of day or day of the week.
- Provide continuity of care with a designated member of the care team with whom the patient can schedule successive routine appointments. Provide timely access and management for the follow-up after an emergency department visit or facility discharge.
- Utilize an electronic health record system so that care providers have timely access to clinical information.
- Use a standardized methodology to identify patients who require chronic complex care coordination services.
- Have an internal care coordination process whereby a patient identified as meeting the requirements for these services starts receiving services in a timely manner.
- Use a form and format in the medical record that is standardized within the program or practice.
- Be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

Available CPT Codes

Chronic care management services are billable with 4 CPT codes; 2 are the primary or initial time provided each month (**99490** and **99491**) and 2 that are considered add-on (+) codes (**99439** and **99437**) and are only billable in addition to the primary code when conditions of the code are met. See **Table 1** for full definitions of these codes. The primary codes, **99490** and **99491**, require at least 20 or 30 minutes, respectively, of staff time over the course of 1 calendar month and must be directed by a physician or other qualified health care professional who is carrying out the direction of the care plan.

Complex chronic care management services are billable with 2 CPT codes; 1 is the primary

Table 1. Chronic Care Management CPT Codes	
CPT CODE	DEFINITION
99490	Chronic care management services with the following required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
+99439	Chronic care management services with the following required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for primary procedure.)
99491	Chronic care management services with the following required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.
+99437	Chronic care management services with the following required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for primary procedure.)

Table 2. Complex Chronic Care Management CPT Codes

CPT CODE	DEFINITION
99487	Complex chronic care management services with the following required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
+99489	Complex chronic care management services with the following required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for primary procedure.)

or initial time provided each month (**99487**) and 1 is an add-on (+) code (**99489**) and is only billable in addition to the primary code when conditions of the code are met. See **Table 2** for full definitions of these codes. Code **99487** represents the first 60 minutes of clinical staff time and add-on code **+99489** represents each additional 30 minutes.

Complex chronic care management requires moderate or high complexity of medical decision-making by the physician. In addition to the previously mentioned eligibility criteria for chronic care management services, complex chronic care management services are typically provided to patients who are being treated with 3 or more prescription medications, require other services such as physical or occupational therapy, and meet at least 1 of the following criteria:

- Require the coordination of a number of specialties and services
- Are unable to perform activities of daily living and/or cognitive impairment, which would result in poor adherence to the treatment plan without substantial assistance from a caregiver
- Have psychiatric and other medical comorbidities
- Need social support or experience difficulty accessing health care

For time-based codes, if the physician

personally provides any of the services normally carried out by clinical staff, their time may be counted toward the total time necessary to meet the criteria of the code. Hospital outpatient departments (HOPDs) can report chronic care management codes for the time clinical staff spend in support of the services. Documentation would include identification of the supervising physician and time spent by both physician and clinical staff. Both the HOPD and the physician would bill for their respective services, as is the case for services provided in the inpatient setting.

The CPT 2023 manual provides a table similar to **Table 3** to assist providers in understanding which of the care management services is billable based on criteria and staff, as they differ between chronic care management and complex chronic care management.

As happens with many of the management codes created by the AMA, the Centers for Medicare & Medicaid (CMS) is not always in agreement and the agency creates its own codes to be used specifically for Medicare beneficiaries. If a patient is new to the physician or practice or the patient has not been seen by the physician within the past year, the physician must provide a face-to-face initial evaluation and management (E/M) visit, annual wellness visit, or the initial preventive physical examination. This service is a separately billable item. If the patient requires extensive

face-to-face assessment and care planning for initiation of care management, the provider can report an add-on code to Medicare:

- Healthcare Common Procedure Coding System (HCPCS) **G0506**: Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service).

The code is billable only once, at the outset of chronic care management or complex chronic care management services and only includes the time spent by the provider—no clinical staff time can be counted.

CMS has also created a code specific to rural health clinics and federally qualified health centers to capture and bill for the services provided in many difficult-to-staff facilities:

- HCPCS **G0511**: Rural health clinic (RHC) or federally qualified health center (FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, nurse practitioner, physician assistant, or certified nurse-midwife), per calendar month.

Note: HCPCS code **G0506** is not billed in these settings. Documentation of discussion is not required at initial visit and **G0511** is paid under

Table 3. Care Management Services Coding Examples

CHRONIC CARE MANAGEMENT		
UNIT DURATION (TIME SPENT)	STAFF TYPE	CODE & UNIT MAX PER MONTH
Less than 20 minutes	Clinical staff	Not separately reported
20-39 minutes	Clinical staff	99490 x 1
40-59 minutes	Clinical staff	99490 x 1 and 99439 x 1
60 or more minutes	Clinical staff	99490 x 1 and 99439 x 2
Less than 30 minutes	Physician or other qualified health care professional	Not separately reported
30-59 minutes	Physician or other qualified health care professional	99491 x 1
60-89 minutes	Physician or other qualified health care professional	99491 x 1 and 99437 x 1
90 minutes or more	Physician or other qualified health care professional	99491 x 1 and 99437 x 2
COMPLEX CHRONIC CARE MANAGEMENT		
Less than 60 minutes	Not separately reported	
60-89 minutes	99487 x 1	
90-119 minutes	99487 x 1 and 99489 x 1	
120 minutes or more	99487 x 1 and 99489 x 2 and 99489 for each additional 30 minutes	

the non-facility rate of the Medicare Physician Fee Schedule (MPFS).³

To help providers use and bill these codes correctly, CMS has developed an online informational pamphlet entitled *Connected Care Toolkit, Chronic Care Management Resources for Health Care Professionals and Communities*.⁴

Real-World Application

It is one thing to know the codes for chronic

care management and complex chronic care management services, but applying them in the real world can be challenging. Below is a case study that illustrates how providers can ask or discover critical patient needs and concerns. This example includes time spent asking questions, establishing goals for the patient, measuring progress, developing actions to move in the direction of the goal, and assessing and evaluating progress.

Case Study

A man, aged 55 years, is diagnosed with cancer at the base of his tongue. The patient has a history of and mentions current substance abuse while also on medication for depression. The patient is currently employed in the custodial services department of a school. The patient's support is limited. He has an aunt with dementia who lives in a local nursing home. He receives occasional assistance from friends, but he is unsure how

he will manage everything.

The provider begins by developing a care plan to manage the 3 chronic conditions (cancer, depression, and substance abuse). During the initial meeting with the patient, the provider asks the following questions to assess current and future needs, with the understanding that as time progresses and the patient's situation changes, the care plan will need to be updated and revised:

- What does the patient identify as his immediate need(s)?
- Does the patient plan to work while undergoing anti-cancer treatment?
- Before the patient was diagnosed with cancer, was he experiencing any financial difficulties that may be exacerbated if he is not able to work or must reduce the number of hours worked?
- What causes the patient to feel stress? How does he manage stress and/or factors related to his depression?
- Does the patient have concerns related to his home environment, health, or substance abuse?
- Does the patient understand everything that has been explained regarding his cancer? Does he understand how the disease will be treated and the potential adverse effects he may experience?

After talking with the patient, the provider identifies several of the patient's immediate needs, which must be addressed:

- The patient does not fully understand what the treatments will do.
- The patient is unsure whether he will be able to continue working during cancer treatments.
- The patient does not have a regular dentist; he is not well versed in the need for dental care during treatment for tongue cancer. He is not sure whether his insurance covers dental visits.
- The patient does not have a mortgage; he inherited his home after his mother died 2 years ago.
- The patient is still dealing with grief from the loss of his mother and tends to drink alcohol to cope. He would like to try a 12-step program but is hesitant to attend and unsure of what to expect.
- For this patient, dealing with stress means "just doing whatever needs to be done."


- The patient eats when hungry but has been losing weight over the past year due to disease progression and depression.

The provider develops the following care plan to address this patient's needs and concerns:

- The provider gives the patient some materials that explain head and neck cancer, chemotherapy, and radiation treatments. The provider specifically selects and personally reviews them with the patient to explain the process and to give the patient a sense of what to expect.
- A staff member makes an appointment for this patient with a local dentist who is in-network and familiar with what head and neck cancer patients must do to prepare for radiation treatments.
- The clinic has a staff member who actively attends alcoholics anonymous (AA) meetings; this individual spends some time with the patient and explains how the program works and arranges to attend a meeting with the patient that evening.
- A local business creates premade meals that require minimal cooking and can be tailored to certain dietary needs. The patient is given a few vouchers to try out this service. To ensure the patient maintains his weight and calorie intake, he completes a weekly food log to monitor his nutrition.

The clinical staff member meets with the patient and enters everything into the medical record. As this is a time-based service, the documentation will need to include the time spent working with the patient throughout the month, even when the work is not face-to-face, so it can be appropriately billed.

An assessment will be made to gauge how the patient is doing post implementation of the care plan. As he continues through the course of care, the plan will be updated according to any new goals, measurements, or interventions that may be necessary. For any additional needs that may impact his care and the management of his chronic conditions, the care plan will be updated. It will reflect any new goals, specific interventions, metrics for success, and methods of patient assessment. The care plan is ongoing and customized to each patient. Resources and educational materials may be standardized, but no 2 patients are expected to require the exact

same management and resources to manage their chronic conditions. 

Teri Bedard, BA, RT(R)(T), CPC, Executive Director, Client & Corporate Resources at Revenue Cycle Coding Strategies in Des Moines, Iowa.

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The Impact and Importance of a Care Coordinator in Community Oncology

BY WENDY COLLINS



When a patient is diagnosed with cancer, the ensuing treatment plan becomes the highest priority. However, care coordination is just as important as the treatment a patient receives during their cancer journey. Care coordination comes in many forms:

- Improving access to care
- Ensuring continuity of care
- Transitioning patients between care settings
- Planning for discharge
- Connecting patients to supportive care services.

Care coordination is crucial for managing the adverse effects of cancer treatment and navigating patient challenges such as emotional distress, isolation, financial toxicity, and lower quality of life. The care coordinator at an oncology clinic assists patients in identifying barriers to care and then works to remove those barriers and ensure the patient achieves the best health outcome possible. In doing so, care coordinators promote health equity, and contribute to patients receiving comprehensive cancer care. That is the goal I am focused on achieving.

My Story

I am the care coordinator at the Beacon Clinic, a boutique cancer center in Coeur d'Alene, Idaho. The Beacon Clinic is committed to providing holistic patient care. I created the care coordinator role at the cancer center when I saw the stress caused by a cancer diagnosis in our patients' lives. My degree in crisis counseling has prepared me to walk alongside patients with cancer in a difficult season

of their lives. People present to the clinic from different walks of life. When they meet with their physician, they are focused on their overall outcome and treatment options. Often, the ability to discuss the issues that keep them awake at night does not happen in the exam room. That is where I come in.

I discover the psychosocial challenges a patient is experiencing by creating a space they are comfortable in. We also discuss the financial impact of cancer treatment on them and their families. This is a crucial step, as most patients underestimate or are underinformed about the impact of financial toxicity. As many as 51% of patients with cancer in the United States report catastrophic levels of financial hardship and are carrying medical debt due to their cancer treatment.¹ Therefore, a greater commitment to establishing health equity across the cancer care continuum is more important than ever.

Identifying a patient's needs is not enough. These issues must be addressed by actionable resources and community relationships to assist that patient. Because I understand this, I have been committed to creating partnerships in the community for referrals that our patients can utilize in their time of need. I apply for grants that ensure patients have access to medication when they cannot afford it. This helps reduce the financial burden that uninsured and underinsured patients bear. In addition, I refer patients to mental health professionals in the community when their needs are more than I can address. At the Beacon Clinic, we have community meal delivery services, as well as lodging and transportation assistance, to make life easier for patients experiencing a challenging situation.

Effective Tools

In my experience, the most useful tool in my arsenal to help improve health equity is the National Comprehensive Cancer Network (NCCN) Distress Thermometer. This tool has been invaluable in helping me identify the needs of our patients. It is a 10-point scale; 0 represents no distress, 10 represents severe distress, and a score of 5 or 6 indicates moderate distress. Patients who score a 5 or higher may benefit from immediate intervention to address the factors contributing to their distress. As a result, the front desk staff report all distress thermometer forms where patients have self-reported a 5 or higher, which allows me to identify patients who are feeling stressed. Once their challenges are addressed, these patients are asked to complete a new distress form a few weeks later. Then the care team and I address any other issues they may have and tackle those. We observe the results and impact of the interventions we have implemented.

On average, there is a 4-point reduction on the NCCN Distress Thermometer once we implement an intervention. Some of the tangible items patients require based on their self-report are easier to accommodate. Our local nonprofit organization provides volunteer drives to assist patients with cancer in getting to and from appointments. I have secured reduced lodging at some area hotels for our patients who are undergoing treatment. Through community partnerships such as this, we have found creative ways to address the unique needs of our patients.


Bridging Communication Gaps

The care coordinator is an integral part of the care team and often serves as a medical interpreter between their colleagues and patients. The relationship I have with patients and their families allows me to have conversations that patients—by their own admission—are uncomfortable having with their provider. Patients often overstate their wellness to their providers, and it takes an attentive and deliberate staff member to inquire about how patients are really doing—both mentally and physically. The level of attention a care coordinator pays to a patient is essential today, as many health care professionals are consumed with trying to obtain treatment reimbursement from insurance companies. Additionally, the care coordinator role can provide a “lift” to the clinic by taking on patient-centered administrative duties and supporting other departments.

Cancer does not wait for a convenient time to come into a person's life. A patient may be grieving a loved one before being blindsided by a cancer diagnosis. One of our patients poignantly stated, “It is impossible to plan for cancer financially.” At the Beacon Clinic, the care coordinator has positively affected patient treatment adherence by removing barriers to care that may have otherwise gone

unnoticed. Committing to the health equity of our patients allows us to treat patients holistically and will enable them to experience the best health outcomes possible.

In Closing

To comprehensively treat a cancer patient, a cancer program or practice must intentionally assess their patient's needs. Because of the relationships care coordinators build with their patients, they can help improve treatment adherence and can minimize treatment disruptions. I deliberately create the necessary space to identify how patients' needs relate to their roles in their families and communities. Being intentional in forming community partnerships also is imperative for the patient's success. Ultimately, a cancer program or practice must be able to do more than simply identify a patient's needs—they must deliver actionable strategies to rectify those deficiencies. 

Wendy Collins lives with her husband of 25 years in beautiful North Idaho where they have raised 4 children. Wendy has a natural love for walking with people through difficult seasons. She has been a care coordinator at the Beacon Clinic for 3 years. This role allows her to share her compassion with others and relieve some of the burden experienced by patients with cancer.

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spotlight

Highlands Oncology North Arkansas



As the only diamond producing state in the United States, Arkansas is home to many gems. Among them is one of the largest physician-owned cancer programs in the country—Highlands Oncology. Established in 1996, the founding physicians sought to bring comprehensive cancer care to Northwest Arkansas, so that patients would not have to leave the comfort of home to receive cutting-edge treatment. Highlands Oncology Group is a multidisciplinary cancer center featuring medical, radiation, and surgical oncology; supportive care; and an oncology rehabilitation program. Further, they have a full-service infusion center in each clinic, as well as state of the art diagnostic imaging, a cancer

assessment and risk education clinic, a free lung cancer screening program, a center for chest care, and a robust research program that participates in over 100 active clinical trials.

Access: The Crown Jewel

Access is at the core of Highland's founding philosophy. The practice currently has 5 locations in Northwest and Northcentral Arkansas. "Before opening the flagship location in August 2020, we were spread around in a variety of different small buildings. Administration would be in 1 building and the business office would be in another building, therapists in another, and so forth," said Jeff Hunnicutt, CEO at Highlands Oncology Group. "So, the

level of teamwork and collaboration has improved because you have people who are just down the hall, as opposed to a mile away or so." According to Hunnicutt, this location ensures the cancer program is well placed to accommodate the demands of future patients as the population of the state grows. "It gives us plenty of space for expansion in the future. As this area continues to grow so rapidly, we want to make sure that we were staying ahead of that trend and accommodate that growth."

Developing and maintaining strategic partnerships designed to improve cancer care continues to be a major part of the program's model. This spirit of collaboration fueled the development of their location in Mountain Home. The multi-story, 33,000-square-foot facility, which opened in May 2023, is the product of a partnership between Baxter Regional Medical Center and Highlands Oncology Group. The center is located adjacent to the hospital, and this allows patients with cancer to access inpatient treatment services.

Although patients can self-refer, the majority of the Highland Oncology's referrals come through individual physician practices. When patients walk through the doors of their Springdale facility, they will find radiation oncology and imaging services on the first floor. The infusion suites are located on the second floor and contain 43 infusion chairs which are staffed by 18 nurses. The location at Rogers adopts a similar layout, with an infusion suite equipped with 37 chairs and staffed by 20 nurses.

Their Fayetteville and Mountain Home locations have 20 and 24 chairs and are staffed by 13 and 9 nurses, respectively. Further, there is a dedicated retail and sterile compounding pharmacy at each location. The radiation and



medical oncology departments in the Rogers and Fayetteville clinics are staffed by 4 medical physicists and a team of dosimetrists.

The cancer program offers a range of robust treatment options including external beam radiation only using photons or electrons with a range of different modalities: 3D, IMRT/VMAT, SBRT, and SRS/SRT. In addition, patients have access to surface-guided radiation therapy (SGRT), deep inspiration breath hold, atypical partial breast irradiation, and image-guided radiation therapy. Highlands Oncology also provides patients with breast cancer access to the DigniCap® Scalp Cooling System, a US Food and Drug Administration approved computerized cooling unit that reduces hair loss from certain chemotherapy treatments.

Center For Chest Care

In 1999, Highlands Oncology Group launched its Center for Chest Care—the brainchild of a few local physicians eager to improve the diagnosis and treatment of cancers in the lung and chest. It was the first community-based, multidisciplinary chest cancer clinic in the US and remains the longest, continuously active multidisciplinary lung cancer clinic in the country.

In October 2020, the cancer program decided to incorporate other cancer types into the program. Each month, it hosts over 30 multidisciplinary clinics or after-hours medical conferences which include diagnostic radiologists, medical oncologists, pathologists, pulmonologists, radiation oncologists, thoracic surgeons, breast surgeons, neurosurgeons, and urologic surgeons. The clinics also include colorectal surgeons, oncology trained head and neck surgeons, research coordinators, genetic counselors, patient navigators, social workers, a registered dietitian, and tobacco treatment specialists. This initiative allows multiple specialties to be present in a single place, thus facilitating real-time collaboration for the development of comprehensive, timely, personalized treatment plans for patients. Valmarie Blasucci, a former patient at the program who was diagnosed with lung cancer, attests to the efficacy of this model.

“When we came down and talked to all the doctors at the Center for Chest Care, I don’t

think we even wanted to go and get a second opinion anywhere else. We knew what we were going to do in 1 day. I mean, with the 7 of them, that would be better than us [having] to go to 7 different doctors,” she said. According to Blasucci the program made her feel welcome and ensured she received her lung cancer screening early. “If I hadn’t had the lung screening done and taken care of myself, I wouldn’t have been around for the birth of my great-grandson,” she said. “This little guy is the world. Truthfully, I don’t have a bucket list. I’m just glad to be alive every day.”

Blasucci’s story is just one of many. According to Hunnicutt, the cancer program screens nearly 4,000 patients a year. “It is completely free to the patients, but it allows us to reach people who may have a higher chance of getting cancer and may not know anything about it at the time of the actual scan,” he explained. “It allows us to find some of those in advance.”

Clinical Trials Close to Home

Thaddeus Beck, MD, a founding member of Highlands Oncology, expressed his desire to be involved in clinical trials from the beginning. His intellectual curiosity and desire to make a difference in patient outcomes was a driving

force in the creation of the Research program at Highlands. As medical director, Dr. Beck created one of the largest and most successful community-based clinical trial programs in the country. At any given time, he oversees over 120 active clinical trials, 30 physicians, advanced practice providers, and data managers. Even with this load, Dr. Beck still takes the time to sit



with his patients, draw up a plan, and ensure that they understand and are prepared for the journey ahead. He uses his exceptional expertise and years of experience to hand pick clinical trials he believes will be relevant and helpful for the patients in this community.

Connecting patients with advanced clinical trial services is an important part of the cancer program's mission. "A lot of people don't know what a robust research program we have here in Northwest Arkansas," Hunnicutt said. "Frequently, patients who are diagnosed with cancer immediately start thinking about looking outside the region for an innovative clinical trial. Then they are redirected back to us because we have the same trial right here in Northwest Arkansas." Hunnicutt takes great pride in being able to deliver innovative medicine and treatment to people close to home. In doing so, the program offers a beacon of hope for patients with cancer in Arkansas, working to ensure they receive the best outcomes. A fitting commitment, for in a state full of diamonds, only the best and brightest shine. 📺

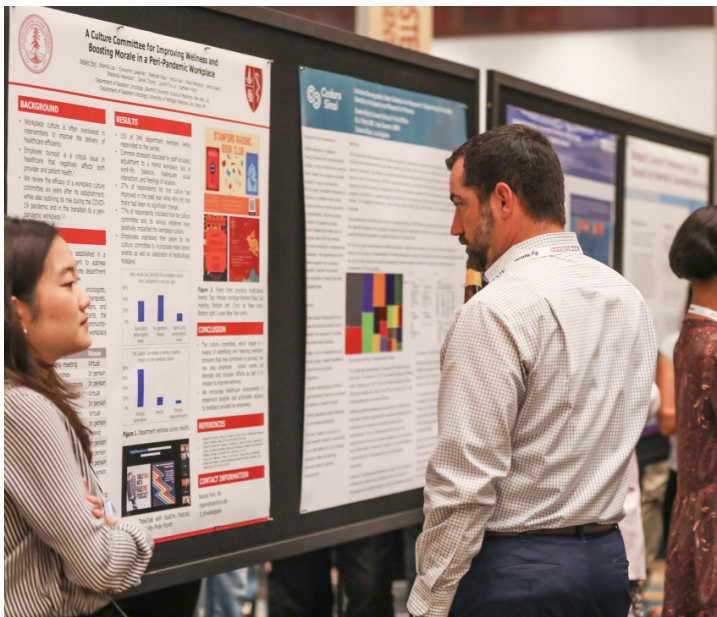


action

ACCC 40th National Oncology Conference



The Association of Community Cancer Centers (ACCC) welcomed more than 600 attendees over a 3-day span (October 4-6) in Austin, Texas, for its 40th National Oncology Conference. Day 1 of the meeting included a pre-conference focused on the ACCC Financial Advocacy Network (left), an enlightening discussion on the importance of delivering value-based care while juggling alternative payment models, and an invite-only summit on electronic health record (EHR) integration to facilitate timely and comprehensive biomarker testing (right).



For the first time in its history, ACCC hosted poster presentations at the Opening Exhibit Reception on October 4. These presentations, which covered a wide range of topics from employee engagement programs to strategies to decrease medical mistrust to steps to take to improve compassion fatigue and quality of life for cancer care providers, were well-received by attendees, generating conversation and networking opportunities.



Innovation was the major theme on the second day of the conference. The opening keynote speaker of the day, Ted A. James, MD, MHC, FACS, medical director and vice chair of Beth Israel Deaconess Medical Center, New York, New York, (left) delivered an insightful session on driving innovation and excellence in cancer care. “We can’t deliver cancer care the same way we have always done. Times are changing. It is the age of information, convenience, and control,” Dr. James said. “Change is hard, and I believe it’s because it requires energy and action, and it also takes a lot of effort from a leader to effect change.” Immediately following the opening keynote were presentations from the 6 2023 ACCC Innovator Award winners (right).



After lunch, attendees had 2 tracks of content to choose from, including a series of workforce development sessions developed as part of ACCC President Lekan Ajayi’s 2023-2024 President’s Theme: (Re)Building the Oncology Workforce to Deliver Next Generation Care. Topics ranged from developing an oncology pipeline for the oncology workforce to recruitment and retention strategies to leadership sustainment and engagement during challenging times.



The last day of the ACCC 40th National Oncology Conference kicked off with a powerful session on “Women Leaders in Oncology.” The rapt attendees listened as panelists discussed the challenges they had experienced as women leaders in a stratosphere largely inhabited and dictated by men. “As a woman of color in a leadership role, one of my biggest challenges has been being the only one at the table,” said Renea Duffin, MPA, vice president, Cancer Support and Outreach, Mary Bird Perkins Cancer Center (right, speaking). “But I’ve learned to be confident in myself.”



Approved Drugs

- On September 11, the US Food and Drug Administration (FDA) approved **Aphexda® (motixafortide)** in combination with **Neupogen® (filgrastim)** (BioLineRx Ltd., biolinerx.com) to mobilize hematopoietic stem cells to the peripheral blood in patients with multiple myeloma for collection and subsequent autologous transplantation.
- On September 26, the FDA approved **Bosulif® (bosutinib)** (Pfizer Inc., pfizer.com) for pediatric patients 1 year of age and older with chronic phase Ph+ chronic myelogenous leukemia that is newly diagnosed or resistant or intolerant to prior therapy.
- On October 11, the FDA approved **Braftovi® (encorafenib)** in combination with **Mektovi® (binimetinib)** (Pfizer, pfizer.com) for adult patients with metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation, as detected by an FDA-approved test.
- On October 16, the FDA approved **Keytruda® (pembrolizumab)** (Merck, merck.com) with platinum-containing chemotherapy as neoadjuvant treatment, and with continuation of single-agent **pembrolizumab** as post-surgical adjuvant treatment for resectable NSCLC.
- On October 27, the FDA approved **Loqtroz® (toripalimab-tpzi)** in combination with **cisplatin and gemcitabine** (Coherus BioSciences, coherus.com) for the first-line treatment of adults with metastatic or recurrent, locally advanced nasopharyngeal

carcinoma. The FDA also Loqtroz as a single agent for adults with recurrent unresectable or metastatic nasopharyngeal carcinoma with disease progression on or after a platinum-containing chemotherapy.

- On October 13, the FDA approved **Opdivo® (nivolumab)** (Bristol Myers Squibb, bms.com) for the adjuvant treatment of completely resected Stage IIB/C melanoma in patients 12 years of age and older.
- On August 28, the FDA approved **Reblozyl® (lusparcept-aamt)** (Bristol Myers Squibb, bms.com) as a first-line treatment for anemia in adults with low to intermediate risk myelodysplastic syndromes who have not previously received erythropoiesis-stimulating agents and may require regular red blood cell transfusions.
- On October 20, the FDA granted accelerated approval to **Rozlytrek® (entrectinib)** (Genentech Inc., gene.com) for pediatric patients older than 1 month with solid tumors that have a neurotrophic tyrosine receptor kinase gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity and have progressed following treatment or have no satisfactory standard therapy.
- On September 14, the FDA approved updated labeling for **Temodar® (temozolomide)** (Merck, merck.com) under Project Renewal, an Oncology Center of Excellence initiative aimed at updating labeling information for older oncology drugs.

- On October 24, the FDA approved **Tibsovo® (ivosidenib)** (Servier, servier.us) for adult patients with relapsed or refractory myelodysplastic syndromes with a susceptible isocitrate dehydrogenase-1 mutation, as detected by an FDA-approved test.

Drugs In the News

- Daiichi Sankyo (daiichisankyo.com) announced that the FDA has granted two additional breakthrough therapy designations for **Enhertu® (fam-trastuzumab deruxtecan-nxki)** for the treatment of adult patients with unresectable or metastatic HER+ solid tumors that have progressed following prior treatment and who have no satisfactory alternative treatment options, and for the treatment of patients with HER2+ metastatic colorectal cancer who have received 2 or more prior regimens.
- Geron Corporation (geron.com) announced that the FDA has assigned a standard review and a prescription drug user fee act action date of June 16, 2024, for Geron's new drug application (NDA) for **imetelstat** for the treatment of transfusion-dependent anemia in patients with lower risk myelodysplastic syndromes.
- Merck (merck.com) announced the FDA has accepted for priority review a new supplemental biologics license application (BLA) seeking approval for **Keytruda®** in combination with external beam radiotherapy and concurrent chemotherapy, followed by brachytherapy for newly diagnosed patients with high-risk locally advanced cervical cancer.

- Regeneron Pharmaceuticals ([regeneron.com](https://www.regeneron.com)) announced that the FDA has accepted for priority review, the BLA for **odronextamab** to treat adult patients with relapsed/refractory follicular lymphoma or relapsed/refractory diffuse large B-cell lymphoma, who have progressed after at least two prior systemic therapies.

- AstraZeneca ([astrazeneca.com](https://www.astrazeneca.com)) announced that the FDA approved a supplemental NDA for **Tagrisso® (osimertinib)** in combination with chemotherapy for the treatment of adult patients with locally advanced or metastatic epidermal growth factor receptor-mutated NSCLC.

- Servier ([servier.us](https://www.servier.us)) announced the FDA has accepted a sNDA and granted Priority Review for **Tibsovo® (ivosidenib tablets)** in the treatment of patients with isocitrate dehydrogenase 1-mutated relapsed or refractory MDS.

- Day One Biopharmaceuticals ([dayonebio.com](https://www.dayonebio.com)) announced the FDA accepted a NDA for **tovorafenib** as a monotherapy in relapsed or progressive pediatric low-grade glioma.

- Merck ([merck.com](https://www.merck.com)) announced the FDA has accepted and granted priority review for a supplemental NDA seeking approval for **welireg**, the company's oral hypoxia-inducible factor-2 alpha inhibitor, for the treatment of adult patients with advanced renal cell carcinoma following immune checkpoint and anti-angiogenic therapies.

- Pfizer Inc. ([pfizer.com](https://www.pfizer.com)) and Astellas Pharma Inc. ([astellas.com](https://www.astellas.com)) announced that the FDA has accepted and granted priority review for the companies's NDA for **Xtandi® (enzalutamide)** for the treatment of patients with non-metastatic castration-sensitive prostate cancer with high-risk biochemical recurrence.

Approved Diagnostic Tests and Assays

- On October 24, the FDA approved the **Abbott RealTime IDH1 Assay** as a companion diagnostic device to select patients for Tibsovo® (ivosidenib) (Servier, [servier.us](https://www.servier.us)).

- On October 26, the FDA granted breakthrough device designation for **Paige Lymph Node** (Paige, [paige.ai](https://www.paige.ai)) an artificial intelligence application used to detect breast cancer metastases in lymph node tissue. 