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ONCOLOGY ISSUES

This publication is a benefit of membership
Association of Community Cancer Centers

Vol. 37 | No. 3 | 2022

Filling the Gap

*Integrating APPs into
a radiation oncology clinic*





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FROM THE EDITOR

Independent Oncology: An Endangered Species?

BY SIBEL BLAU, MD



of oncology practices increased significantly from 20 percent in 2007 to 54 percent in 2017, making oncology the most vertically integrated specialty.²

Before COVID-19, many physician-owned practices were already struggling financially, challenged by reimbursement cuts, buy-out pressures (especially from hospitals with access to the 340B Drug Pricing Program), competition for high-quality staff from hospitals or healthcare systems with deeper pockets, and increasing physician and staff burnout. COVID-19 has only exacerbated these challenges and exposed the vulnerability of these practices.

Today, only about half of all oncology practices in the U.S. are owned by physicians.³ These clinicians believe in the value of treating patients in the communities where they live, and they would like to remain independent. To do so, practices came together to create supergroups like the National Cancer Care Alliance and clinically integrated organizations, such as the Quality Cancer Care Alliance (QCCA).

Value-based care is a guiding principle for these organizations and should be a guiding principle for every oncology practice. Yet, with the Oncology Care Model now at end—with-out any hint about what, if anything, is to come—oncology practices are challenged to support many of the programs and systems they put in place without the MEOS (Monthly Enhanced Oncology Services) payments to help offset costs. The reality: independent physician practices do not have access to safety nets, like the 340B Drug Pricing Program, or large private equity cash flows to support their infrastructure.

Yet oncology practices are resilient. At QCCA, our member practices come together

Since 2018, the number of oncology practices that are merging or being acquired by another entity, such as a private equity firm, has increased by 21 percent.¹ Health system ownership

to find ways to remain financially solvent and still afford to bring technology and innovations to our patients. One of the key benefits for organizations like QCCA is that its members can share ideas and best practices—while simultaneously adopting innovation—through scale.

At QCCA, like-minded physician practices with deep knowledge and experience in the field of oncology are working together to solve gaps in care and brainstorm innovative and affordable solutions. We are developing programs to enhance our research network, incorporating digital tools, and building systems to accelerate value-based care and high-quality clinical research—work that is virtually impossible for an independent practice to do alone.

Despite our best efforts, independent oncology remains at risk. If vertical integration continues and independent physician practices become extinct, access to equitable healthcare is threatened. Underserved patients may have to travel longer distances or their care may be delayed. Care delays—or, worse, patients opting out of care—lead to higher acuity, increased medical costs, diminished patient quality of life, and decreased access.

Independent oncology is critical to our healthcare system. Help independent oncology stay off the “endangered species” list by supporting our adoption of new digital technologies, such as patient portals and electronic patient-reported outcomes, and ensuring adequate reimbursement for the services we provide.

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Technology and Cancer Care

BY DAVID R. PENBERTHY, MD, MBA



ACCC—the how-to organization for the multidisciplinary cancer care team—has a long and rich history of bringing forward technology-driven solutions. More than a decade ago in 2011, ACCC

created its Innovator Award program to recognize visionary ideas and compelling solutions in oncology. MultiCare Health System, MultiCare Regional Cancer Center was recognized for leveraging technology to enhance the patient experience—a significant investment that included a health system-wide electronic health record, audio-visual systems at each chemotherapy chair, wall-mounted monitors in all rooms, and more. That same year, Oregon Health and Science University, Knight Cancer Institute was honored for its telepharmacy program, which used remote medication verification technology to reduce risk, improve safety, and save millions of dollars. The next year, 2012 ACCC Innovator Award Winners Fox Chase Cancer Center implemented bed management software to streamline scheduling and resolve capacity issues and Ruttenberg Cancer Center adopted a web-based tracker to manage patient registration and reduce treatment delays.

Flash forward 10 years to 2021 ACCC Innovator Award Winners Mercy Cancer Care and Tennessee Oncology for their use of predictive algorithms to reduce emergency department visits and hospital admissions and to proactively identify patient co-morbidities.

The science of oncology is exploding, and keeping up with all the information is a daunting task. As oncology providers, we are exceptional at engaging with patients, and an opportunity exists to use technology like artificial intelligence-driven practice support tools and patient wearable devices to free up our time so we are better able to focus on critical issues like shared medical decision-making, improving care to underserved and marginalized patients, increasing clinical trial participation, and—most important—delivering person-centered care. Last year's ACCC Innovator Award Winners showed us just how to do so:

- The University of Colorado Cancer Center, UHealth-Oncology Services implemented virtual reality technology to show patients their tumor, its location, and its size, as well as how their radiation treatment plan will work, the size of the radiation beam, and where it will target.
- Wayne State University School of Medicine: Karmanos Cancer Institute developed its Discussions of Cost mobile application to improve doctor-patient discussions around costs of care.
- Inova Schar Cancer Institute used common technology like iPads to remotely monitor COVID+ patients with cancer, keeping these immuno-compromised patients safe and out of hospitals.

In addition to using technology to deliver better, smarter, and more efficient care; standardize and improve clinical decision-making; drive down costs; and deliver person-centered care, we have an opportunity to use technology to help mitigate the oncology workforce shortages we are all experiencing. At our 2022 retreat, the ACCC Board of Trustees had a lively discussion on just this topic. One board member shared how moving services like billing and prior authorization to a remote work model helped to not only retain staff but also increase productivity! Others shared how technology, such as remote check-in apps and self-serve kiosks, alleviated workforce shortages when front office staff were lured away by higher-paying jobs. From this brief conversation, it is clear that we have the opportunity—no, the need—to reimagine how we deliver cancer care.

Accordingly, on March 4, at the ACCC 48th Annual Meeting and Cancer Center Business Summit, I announced that my ACCC 2022-2023 President's Theme would be "Leveraging Technology to Improve Cancer Care Delivery and the Patient Experience."

The future is now. For the next 12 months, ACCC will inquire about pain points and opportunities for improving workflows and the patient experience to understand the current state of cancer care delivery. ACCC will then serve as a conduit to collect and disseminate large and small technology-driven solutions to help cancer programs and practices move toward an ideal future state. This journey is just beginning. 

Coming in Your 2022 ONCOLOGY ISSUES

- ▶ Auricular Acupuncture for the Treatment of Cancer-Related Pain
- ▶ Cannabis in Cancer Research and Creating a Patient Education Clinic
- ▶ An APP-Physician Model Improves Risk Stratification and Palliative Care
- ▶ Oncology Capture of ED Patients with Incidental Radiologic Findings
- ▶ A Comprehensive Oncology Program for Elders (COPE)
- ▶ Meeting NCCN Guidelines for Genetic Counseling Referrals Among Cancer Registry Patients: An Ohio Study
- ▶ Best Practices for Development of a Successful Cardio-Oncology Program in a Community Hospital
- ▶ Improving Care of Patients with Lung Cancer and COVID-19
- ▶ Meeting Women's Sexual Health Needs After a Cancer Diagnosis and Treatment
- ▶ A Study of Genetic Counseling Referrals Among Cancer Registry Patients Meeting NCCN Guidelines
- ▶ The Effect of the "Living Well After Cancer" Program on Physical and Metabolic Health: A Community-Based Feasibility Study

REPORT | **ACCC's 2021 Impact Report**

Discover resources and tools ACCC developed to support its 2021 strategic priorities: lessons learned from COVID-19, health equity, clinical research, cancer prevention and screening, quality improvement, and advocacy, among others. acc-cancer.org/impact.

PODCAST | **ICYMI: Live from AMCCBS**

ACCC's CANCER BUZZ spoke to thought leaders to get deeper insights into their sessions and top takeaways from AMCCBS 2022. These 5- to 7-minute podcasts discuss industry reconfiguration trends, effective practices for measuring new models of care, reimbursement of precision medicine, and the Cancer Moonshot Part II. acc-cancer.org/amccbs-live.

RESOURCES | **ACCC Biosimilars Education Center**

Resources include a Biosimilars Discussion Guide that answers FAQs and serves as a conversation starter between providers and patients; podcast where Miami Cancer Institute shares its approach to helping patients with cancer understand why biosimilars may be their best—and most cost-effective—treatment option; and a Biosimilars Implementation Roadmap. acc-cancer.org/biosimilars-ed.

PUBLICATION | **Business Case Studies**

Share these seven discipline-specific business briefs with your c-Suite to justify hiring staff, including genetic counselors, dietitians, financial navigators, and more. Turn to page XX to read Making the Business Case for Hiring an Oncology Social Worker. Download the entire series online at acc-cancer.org/business-briefs.

BLOG | **Congress Passes Bills to Extend Telehealth and Fund Cancer Research**

In the \$1.5 trillion spending package for FY2022, Congress extended Medicare telehealth flexibilities for 151 days beyond the end of the COVID-19 public health emergency and appropriated \$1 billion to create the Advanced Research Projects Agency for Health, part of the Cancer Moonshot relaunch. acc-cancer.org/2022omnibus.

VIDEO | **Digital Patient Assistance & Reimbursement Guide**

A pharmacist and an oncology operations manager share how this digital tool can help you find resources in less time, so patients can access—and better afford—their cancer treatments. acc-cancer.org/dpag-podcast.

fast

5 Biggest Challenges Facing the Healthcare Workforce

1. Competitive market for talent (71%)
2. Vaccine mandates (42%)
3. Employee burnout (41%)
4. Rapid employee turnover (40%)
5. Limitations to offer remote work (23%)



Source: Akasa. "No Resignation: Solving Today's Greatest Staffing Challenges in the Healthcare Revenue Cycle."



8 Goals of Psychological First Aid

1. **Contact & Engagement.** Respond to contact initiated by your co-workers from a non-intrusive, compassionate, and helpful position.
2. **Safety & Comfort.** Enhance your co-workers' immediate and ongoing sense of safety and provide physical and emotional comfort.
3. **Stabilization.** Calm and orient to the present co-workers who are emotionally overwhelmed or distraught.
4. **Information Gathering.** Identify your co-workers immediate needs and concerns.
5. **Practical Assistance.** Offer help to address their immediate needs and concerns.
6. **Social Supports.** Establish brief and ongoing with contact with primary supportive others.
7. **Information on Coping.** Provide information on stress reactions and normalize reactions.
8. **Link to Ongoing Services.** Connect co-workers with ongoing services and resources that might be helpful.

Source: Webber JM, et al. Disaster mental health counseling: skills and strategies. *Disaster Mental Health Counseling: A Guide to Preparing and Responding*. 4th Edition. Alexandria, VA. American Counseling Foundation.

facts



Survey Finds Americans Need More Education on Annual Screenings



Of the **7** most common preventative health screenings—breast cancer, colon cancer, prostate cancer, skin cancer, dental, HPV/Pap, and vision—just **2%** of respondents knew all **7** guidelines and only **16%** knew at least **5** of **7** of the guidelines.

Source. National survey of 1,078 Americans. tempus.com/study-confirms-that-americans-neglected-their-healthcare-during-covid-19-pandemic.

Puppy Love

Key findings from a Wag! Survey of More Than 1,000 Americans:

- **Dogs are the best medicine: 93%** say parenting a dog provided them mental health support, and **48%** say that dog parenting decreased their anxiety.
- **People returning to in-person work will miss their dogs: 41%** will miss their dogs more than their kids or spouses.
- **New dog parents are worried their pet will miss them:** Of people who adopted during the pandemic, **76%** are nervous about pet care challenges after returning to work in-person.
- **Puppy love is real: 37%** say the most surprising thing about parenting a new puppy was the overwhelming amount of love for their new friend.

Source. Wag! Survey. prnmedia.prnewswire.com/news-releases/wag-survey-reveals-people-returning-to-work-will-miss-their-dog-more-than-kids-or-spouse-301500827.html.

Actions to Take to Safeguard the Emotional and Psychological Needs of Healthcare Workers

- 1. These are non-normal times: adjust expectations.** Give clinicians more flexibility and autonomy, for example, work with legal, compliance, and IT to identify documentation that can be paused or eliminated.
- 2. Get rid of stupid stuff.** Partner with clinicians to identify and remove low-value work through a rapid improvement process, for example, eliminate unnecessary mandatory training requirements.
- 3. Get radical to shore up staffing.** Get frontline teams the help they need, for example, create new types of shifts to fit care needs.
- 4. Designate a well-being executive.** Appoint one person with operational authority to oversee and align all clinician well-being efforts, for example, align well-being work with diversity, equity, and inclusion efforts.
- 5. EAP is not enough! Do more.** Ensure adequate mental healthcare, including quality mental health counseling, a quality peer-support program, and psychological first aid training.

Source. National Academy of Medicine. Action Collaborative on Clinician Well-Being and Resilience. 2022 Healthcare Workforce Rescue Package. allinforhealthcare.org/pages/2022-healthcare-workforce-rescue-package.



Congress Extends Access to Telehealth and Funds Cancer Research

BY MATT DEVINO, MPH



A \$1.5 trillion omnibus spending package for fiscal year 2022 was passed with broad bipartisan support in Congress and signed into law by President Biden on March 15, 2022. In addition to providing necessary funding for federal agencies and specific allocations for cancer research, the law included a critical extension of Medicare telehealth flexibilities that are set to expire at the end of the COVID-19 public health emergency (PHE).

Prior to the pandemic, Medicare telehealth rules required patients to live in a federally designated rural area and be physically present at a doctor's office, hospital, or other specified medical facility to utilize telehealth services. Following the president's emergency declaration at the start of the COVID-19 pandemic, the Centers for Medicare & Medicaid Services was able to use its waiver authority under Section 1135 of the Social Security Act to remove these geographic and originating site restrictions for the duration of the COVID-19 PHE. Combined with other flexibilities implemented in tandem, these temporary waivers allowed Medicare beneficiaries to access telehealth services from their homes and from any geographic location across the country for the first time, resulting in the rapid uptake of telehealth over the past two years.

Given that these waivers and flexibilities are tied directly to the COVID-19 PHE declaration, they will terminate when the PHE declaration expires. The declaration itself must be renewed every 90 days by the Secretary of the Department of Health and

Human Services (HHS), and the Biden administration has indicated that it will give the healthcare community at least 60 days' notice prior to allowing the PHE to lapse. This quarterly need to reassess the continuation of the PHE has created significant uncertainty for providers and their patients since the start of the pandemic, and many stakeholder groups have called upon Congress to take action to alleviate this uncertainty. Thankfully, Congress used the spending package as a vehicle to extend Medicare telehealth flexibilities for an additional 151 days beyond the end of the COVID-19 PHE, giving Medicare patients an additional five months of predictability following the declared end of the pandemic.

Though the Biden administration has yet to determine a PHE end date, Republican lawmakers in D.C. are increasingly calling upon the president to end the COVID-19 emergency declaration. The current PHE declaration is set to lapse in July, so if it is not renewed, this new legislation would at least allow Medicare telehealth flexibilities to continue through December 2022. ACCC has advocated for the permanent removal of geographic and originating site restrictions through legislation, such as the Telehealth Modernization Act (H.R. 1332/S. 368). We are hopeful that this temporary extension will give Congress enough time to evaluate and enact permanent telehealth reform.

In addition to the telehealth provisions of the legislation, Congress appropriated \$1 billion for the creation of the Advanced

Research Projects Agency for Health (ARPA-H) through September 2024. ARPA-H is seen by many as a cornerstone in President Biden's healthcare agenda and a prominent piece of his Cancer Moonshot relaunch. Modeled from the Defense Advanced Research Projects Agency within the Department of Defense, ARPA-H would serve to accelerate the pace of breakthroughs in biomedical research to improve prevention, detection, and treatment for a range of diseases, including cancer, by bringing together academic, industry, and government partners. The administration is moving forward with plans to house the agency within the National Institutes of Health (NIH) to take advantage of the agency's resources, but HHS Secretary Xavier Becerra stated that the entity will be physically separate from the NIH's campus. The ARPA-H director will report directly to Becerra rather than the director of the NIH.

Finally, the package provides \$45 billion in continued funding for the NIH, representing an increase of \$2.25 billion over the funding level enacted for fiscal year 2021. This funding includes \$6.9 billion for the National Cancer Institute (inclusive of \$194 million specifically for the Cancer Moonshot), an increase of \$50 million for health disparities research, \$59 million for the Office of Research on Women's Health, and increased investments to enhance diversity in the biomedical research workforce.

Matt Devino, MPH, is director of Cancer Care Delivery and Health Policy, Association of Community Cancer Centers, Rockville, Md.

The ACORI Call to Action Summit

"Activating Equity in Community Oncology Research" brought together community oncology programs and practices, research team members, patient advocates, trial sponsors, industry representatives, research networks, and regulatory agencies.

The Summit highlighted the importance of diversifying clinical trials and identified concrete strategies for engaging patients, caregivers, and their communities to strengthen oncology research in communities across the United States.

Explore the Action Items Identified for Oncology Programs and Practices and Other Stakeholders.

ACORI

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acc-cancer.org/ACORI-Summit

In collaboration with Stand Up to Cancer (SU2C)

compliance

Auxiliary Personnel Involved in Comprehensive Cancer Care

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

Comprehensive cancer care is most often thought to be related to a facility's ability to use the latest technology to treat patients with cancer. This may involve cutting-edge medicines and radiation therapies that are not found in all cancer programs, except those designated as offering advanced therapies. However, as cancer care advances, the term "comprehensive" is expanding beyond standard treatments (e.g., medical, radiation, or surgical oncology) to encompass the full clinical approach, and ancillary—or supportive care—services are a key component of this level of care.

Auxiliary staff, like oncology social workers and pharmacists, directly impact patients and their cancer experience. The shift from only treating the cancer to treating the whole patient has advantages. Factors related to patient non-adherence or non-compliance include inadequate health literacy and knowledge, socio-economic status, lack of communication and transportation, and lack of family support.¹ Today, cancer programs and practices are employing and/or using auxiliary staff to address these types of unmet needs, fostering relationships and shared decision-making with patients and caregivers who find themselves now to be part of a team dedicated to their well-being and outcomes. With this comprehensive focus, patients tend to do better with adherence to their treatment plan.

Oncology Social Workers

The role of the oncology social worker in the comprehensive approach to cancer care

cannot be understated. Clinical social workers in cancer programs and practices provide a wide range of psychosocial services to patients facing a cancer diagnosis. Examples of clinical social work services can include psychological counseling, practical assistance related to transportation barriers, financial assistance to access treatment, and identification of community resources to help address social determinants of health and remove language and/or cultural barriers.

Most often, it is the social worker who helps patients and families navigate both the process of cancer care and the complex healthcare system. Social workers ensure that patients with cancer understand the care they are receiving, bridge gaps in this care by connecting them to resources, and address unmet needs—all services that improve health equity and patient compliance to treatment regimens.

Regardless of the treatment regimen prescribed for the patient or the setting in which the patient is treated, all oncology social workers adhere to a set of "Scope and Standards of Practice."² These standards ensure that all patients are treated appropriately and the education and training of the staff providing these services is appropriate and recognized.

Billing and Reimbursement of Services

One of the many questions related to the services provided by the oncology social worker is: What services can be billed to payers?

When billing for services by oncology social workers, there are several Current Procedure Terminology (CPT®) codes from the "Medicine, Psychotherapy" series developed by the American Medical Association. The ability to be paid for these services may depend on the payer, state guidelines, the setting, and timing of the services provided.

For example, if a patient is receiving radiation oncology services, there is a laundry list of services that Medicare considers part of the physician management of the patient during the course of treatment, which are billed with a dedicated CPT code. This includes nutritional counseling, pain management, and routine medical management of unrelated problem(s)—regardless of the setting in which the services were provided. Accordingly, if the services provided by the oncology social worker occur during the radiation oncology treatment course and are related to the management of the patient's cancer and treatment(s), the services provided may not be billed separately; the services are considered part of the physician management and bundled into the physician's charge.

For oncology patients who do not receive radiation treatments—or if the oncology social worker's services are provided outside the course of radiation treatment—the ability to bill for and be paid for these services depends on the payer, state guidelines, setting, and timing of the services provided, but payment is more likely because the services would not be considered bundled to other services.

When services are provided by the oncology social worker, **modifier AJ** (clinical social worker) is applied to the billing code. This identifies that the service was provided by a social worker, and Medicare will reimburse these services at 75 percent of the Medicare Physician Fee Schedule or actual rate (e.g., rates from other Medicare fee schedules or payment models), whichever is less. It should be noted that the ability to bill for other services, such as evaluation and management or procedures that include management of the patient, are typically considered outside the scope of an oncology social worker and are not billable.

Oncology Pharmacists

The oncology pharmacist is involved in all aspects of cancer care, ranging from chemotherapy dose preparation and safety checks to educating patients about side effects related to their treatment. Working closely with oncologists and other members of the multidisciplinary care team, the oncology pharmacist educates patients about treatment regimens, often bridging gaps in education about the drugs they are taking, dosing schedules, and/or administration. This education is especially critical with the growing number of oral chemotherapy medications and the importance of patient adherence to ensure best outcomes with use of these oral agents.

In addition, like the oncology social worker, the oncology pharmacist is typically aware of programs and funding that are available to patients with cancer to help offset high costs of care. Oncology pharmacists can also develop formulary management strategies that bring cost savings to the patient and facility.

Billing and Reimbursement of Services

Despite the essential services oncology pharmacists provide, billing payers for these services is problematic. Requests for the Centers for Medicare & Medicaid Services (CMS) to recognize—and reimburse—pharmacists as practitioners are not new and have

come up at different times over the last several years.

Most recently in the Medicare Physician Fee Schedule CY 2021 final rule,³ stakeholders asked CMS for clarification on whether pharmacists could provide services incident to the physician or non-physician practitioner (NPP), specifically for medication management services. According to CMS, a pharmacist is considered auxiliary personnel; pharmacists are not considered qualified healthcare professionals because there is no allowance for them to enroll in, bill, and receive direct monies from Medicare as a qualified healthcare professional would. Therefore, pharmacists cannot bill for evaluation and management services (**CPT codes 99202-99215**) for the time they spend working with patients in a consultative manner.

Medicare does continue to support services provided incident to the physician or NPP, but to support this, the physician (or NPP) must be present to supervise the work of the pharmacist at the time they are providing the service to the patient. However, CMS did indicate that pharmacists could provide services incident to the billing physician or NPP if the payment for services is not made under the Medicare Part D benefit and is within the state scope of practice and applicable state laws for the services provided.

All services provided under Medicare Part D are not billable under Medicare Part B. This includes services like medication management and Medicare Part D dispensing fees that include time verifying coverage, mixing or measuring the covered drug, filling the container, performing quality assurance, reviewing contraindications or drug-drug interactions, and dispensing the prescription to the beneficiary.

Incident-to services are limited to office-based settings and, per Medicare, these services are not available in the facility setting. Direct supervision is required of the physician or NPP for incident-to, which means they must be in the office suite and immediately available and able to respond

without interval of time. This requirement makes it challenging for many oncology pharmacists to bill for their services.

Take-Home Message

Comprehensive cancer care encompasses a wide range of services that are critical to high-quality care and the patient experience. With the move to value-based care and alternative payment models and methodologies (like bundling), it is time to ensure adequate reimbursement for all services provided to patients. Beyond reimbursement, services provided by oncology social workers and oncology pharmacists help reduce costs of care and improve patient outcomes.^{4,5} Allowing each member of the cancer care team to practice at the top of their license and focus their expertise where it is needed benefits patients and cancer programs and practices alike. 

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

spotlight

Wentworth-Douglass Hospital, Seacoast Cancer Center, Dover, New Hampshire



Seacoast Cancer Center at Wentworth-Douglass Hospital is located inland from the Atlantic Ocean and Great Bay of New Hampshire in Dover, N.H., and its full-service satellite sits closer to the coast in the beautiful and historic seaside city of Portsmouth, N.H. The cancer center's strategic location, scope, quality of services, and personalized care have gained a regional reputation stretching along the seaboard from Maine, through New Hampshire, and into northeastern Massachusetts. With Massachusetts General Hospital's acquisition of Wentworth-Douglass Hospital in 2017, both organizations work closely together to coordinate services, bringing expert oncology care to Seacoast's community and easing patient access to specialty care and research in Boston. Due to further successful mergers of Mass General Brigham Healthcare System, Massachusetts General Hospital, and Wentworth-Douglass Hospital,

the health system is emerging as a progressive academic leader, and its strategies are moving quickly to positively impact cancer care in Massachusetts and New Hampshire.

As a comprehensive community cancer center, Seacoast offers a full suite of services, including medical and radiation oncology, infusion, palliative care, navigation, lab, pharmacy, and supportive care services (e.g., nutrition, social work, and integrative therapies). It also offers specialty clinics like gynecologic oncology, genetic counseling, and multidisciplinary breast care. Both Seacoast sites have their own marquee and dedicated entrance with nearby parking and drop-offs, as new facilities are designed with patients, families, and staff in mind. "We've always focused on making sure we have everything under one roof, including the many support services patients with cancer need," says Susan Gallagher, RN, BSN, JD,

assistant vice president of Cancer Services at Seacoast Cancer Center at Wentworth-Douglass Hospital. "That's very important to us and our patients."

Seacoast's commitment to high-quality care and best practices is demonstrated by its achievements and awards. Wentworth-Douglass is a Magnet-designated hospital, and Seacoast has been accredited by the Commission on Cancer since 1986, earning it the Outstanding Achievement Award that proudly recognizes its excellence. The cancer center is also accredited by the American College of Radiology for oncology practice, evidencing its compliance with the specialty's highest standards. Primarily based on these accreditations and other national standards, cancer center leadership designed a robust and unique oncology-focused quality program that is overseen by a coordinator within its cancer registry. Through an active and well-attended cancer committee and quality subcommittees, selected measures are monitored, quality goals are established, and various studies are identified to continuously drive improvements and better outcomes.

A Robust Service Line

All cancer center staff—with the exception of its radiation oncologists, who are employed by Radiation Oncology Associates, P.A.—are employed by Wentworth-Douglass Hospital. Radiation oncology is staffed by 6 board-certified radiation oncologists, who work closely with Seacoast's 3 medical physicists, 3 dosimetrists, 15 radiation therapists, and 7 radiation oncology nurses, to provide an average of 80 treatments per day. On-site



computed tomography simulations and treatment planning with all modalities are offered, including EBRT, IMRT, and SRS, as well as HDR that is only available at Seacoast's main location in Dover. Radiation oncology staff use the latest technology, including a Varian Edge and TrueBeam in Dover and a Varian TrueBeam in Portsmouth, to treat all cancer types.

Seacoast employs 6 board-certified medical oncologists and a team of 5 advanced practice providers, with 2 new clinicians set to arrive this summer. Medical oncologists, along with their support and clinical teams, see patients in Dover and Portsmouth. Its main campus houses a 28-bay infusion suite staffed by up to 20 oncology-certified nurses, and its satellite clinic is expanding to include 10 rooms and chairs to accommodate its growing volume. Infusion bays are separated by glass walls and doors that proved to be critical during the COVID-19 pandemic, as patients were able to safely continue their treatment without having to move or change their infusion routines. Both infusion suites include a dedicated pharmacy where three full-time oncology pharmacists and several pharmacy technicians split their time, mixing patients' treatments on-site. A wide variety of treatment options are available, including chemotherapy and immunotherapy, and Dover's hospital-based campus allows for easy access to patients receiving inpatient oncology care.

Patients who need surgery as part of their care plan are referred to Wentworth-Douglas Hospital's general surgeons, who perform operations within the hospital and who have access to Massachusetts General Hospital for more complex cases.

Because Seacoast staff see more than 200 new patients a month, many cases are presented at weekly multidisciplinary conferences (e.g., general, breast, lung) that include representatives from surgery, pathology, radiology, radiation and medical oncology, genetics, clinical research, palliative care, navigation, and social work. Supported by donors, both Seacoast locations have state-of-the-art technology conference centers that support in-person

and remote tumor boards that can include other cancer centers and Massachusetts General Hospital specialists. "It's as if we are all in the same room, looking at images and pathology slides, and talking with each other," says Arul Mahadevan, MD, Seacoast's medical director of radiation oncology.

Patient Navigation is Key

At the heart of the cancer center is its Oncology Nurse Navigation program that is staffed by an elite group of oncology nurses, each with expertise in a different type of cancer. Seacoast nurse navigators provide the first touchpoint to patients as they meet with all who are newly diagnosed to answer questions, ease fears and anxiety, and ensure that all appointments are in line with their treatment plans. Nurse navigators are viewed as the point person for every patient and family who hears the word "cancer."

Survivorship Begins at Diagnosis

Another focus of Seacoast's high-quality care is survivorship and wellness. "We consider survivorship to begin the moment one is diagnosed, and our support and wellness services are available to all as an essential part of their care," explains Michael Meserve, MBA, RTT, director of survivorship and wellness at Seacoast Cancer Center at Wentworth-Douglas Hospital. The survivorship program works in collaboration with other departments and teams, from rehabilitation services and integrative therapies to social work, nutrition services, and the Patient and Family Learning Center. Funded through the hospital's foundation and donors, cancer center leadership plan to grow their survivorship services to meet patients' needs as they achieve better outcomes and more people are living with cancer. "Once patients are in our cancer center, they're really part of our entire wellness and support program," says Meserve.



Seacoast leadership see growth and expansion in the cancer center's future, because it is part of Massachusetts General Hospital and Mass General Brigham Healthcare System, and have set their sights on being the regional hub for oncology on the seacoast. "We've been around a long time—about 40 years—and we've been growing and thriving ever since. We've never stood still, and we won't stop," says Barbara Civiello, MD, Seacoast's medical director of medical oncology. "One thing for sure is that we plan to always keep our community feel and continue to provide personal attention to all of our patients. That's who we are." 

At the heart of the cancer center is its Oncology Nurse Navigation program that is staffed by an elite group of oncology nurses, each with expertise in a different type of cancer.



Approved Drugs

- On Feb. 28, the U.S. Food and Drug Administration (FDA) approved **Carvykti™ (ciltacabtagene autoleucel; cilta-cel)** (Janssen, janssen.com) for the treatment of adults with relapsed or refractory multiple myeloma after four or more prior lines of therapy, including a proteasome inhibitor, immunomodulatory agent, and anti-CD38 monoclonal antibody.
- On March 21, the FDA approved **Keytruda® (pembrolizumab)** (Merck, merck.com) as a single agent for patients with advanced endometrial carcinoma that is microsatellite instability-high or mismatch repair deficient, as determined by an FDA-approved test, who have disease progression following prior systemic therapy in any setting and who are not candidates for curative surgery or radiation.
- On March 11, the FDA approved **Lynparza® (olaparib)** (AstraZeneca, astrazeneca.com) for the adjuvant treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated human epidermal growth factor receptor 2 (HER2)-negative, high-risk early breast cancer who have been treated with neoadjuvant or adjuvant chemotherapy.
- On March 4, the FDA approved **Opdivo® (nivolumab)** (Bristol Myers Squibb, bms.com) with platinum-doublet chemotherapy for adult patients with resectable non-small cell lung cancer (NSCLC) in the neoadjuvant setting.
- On March 18, the FDA approved **Opdualag™ (nivolumab and relatlimab-rmbw)** (Bristol Myers Squibb, bms.com) for adult and pediatric patients 12 years of age or older with unresectable or metastatic melanoma.
- On March 23, the FDA approved **Pluvicto™ (lutetium Lu 177 vipivotide tetraxetan)** (Novartis, Novartis.com) for the treatment of adult patients with prostate-specific membrane antigen-positive metastatic castration-resistant prostate cancer who have been treated with androgen receptor pathway inhibition and taxane-based chemotherapy.
- On Feb. 28, the FDA approved **Vonjo™ (pacritinib)** (CTI BioPharma Corp, ctibiopharma.com) for the treatment of adults with intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis with a platelet count below $50 \times 10^9/L$.
- On April 1, the FDA approved **Yescarta® (axicabtagene ciloleucel)** (Gilead, gilead.com) for adult patients with large B-cell lymphoma that is refractory to first-line chemo-immunotherapy or relapses within 12 months of first-line chemo-immunotherapy.
- Bristol Myers Squibb (bms.com) announced that the FDA accepted its supplemental biologics license application (BLA) for **Breyanzi® (lisocabtagene maraleucel)** to expand its current indication to include earlier use of Breyanzi for the treatment of adults with relapsed or refractory large B-cell lymphoma after failure of first-line therapy.
- BeiGene (beigene.com) announced that the FDA has accepted a supplemental NDA for **Brukinsa® (zanubrutinib)** for the treatment of adult patients with chronic lymphocytic leukemia or small lymphocytic lymphoma.
- Accord BioPharma (accordbiopharma.com) announced the U.S. launch of **Camcevi™ (leuprolide)** 42mg injection emulsion for the treatment of advanced prostate cancer in adults.
- Dialectic Therapeutics, Inc. (dtsciences.com) announced that the FDA granted orphan drug designation to **DT2216** for the treatment of T-cell lymphoma. The company also announced that the FDA granted fast track designation to DT2216 for adult patients with relapsed or refractory peripheral T-cell lymphoma and cutaneous T-cell lymphoma.
- Genmab (genmab.com) announced that the FDA granted orphan drug designation to **DuoBody®-CD3xCD20 (epcoritamab)** for the treatment of follicular lymphoma.

Drugs in the News

- Mirati Therapeutics, Inc. (mirati.com) announced that the FDA accepted the new drug application (NDA) for **adagrasib** for the treatment of patients with NSCLC harboring the KRASG12C mutation who

- Taiho Pharmaceutical Co., Ltd. (taiho.co.jp/en/) and its U.S. subsidiary Taiho Oncology, Inc. (taihooncology.com) announced that the FDA accepted and granted priority review to the NDA for **futibatinib (TAS-120)** for the treatment of patients with previously treated locally advanced or metastatic cholangiocarcinoma harboring FGFR2 gene rearrangements, including gene fusions.
- Aadi Bioscience, Inc. (aadibio.com) announced the launch and commercial availability of **Fyarro™ (sirolimus protein-bound particles for injectable suspension) (albumin-bound)** for intravenous use for the treatment of adult patients with locally advanced unresectable or metastatic malignant PEComa.
- AbbVie (abbvie.com) announced the submission of a supplemental NDA to the FDA for **Imbruvica® (ibrutinib)** for the treatment of pediatric and adolescent patients one year and older with chronic graft versus host disease after failure of one or more lines of systemic therapy. An NDA was also submitted for an oral suspension formulation of Imbruvica to provide an alternative administration option for pediatric patients.
- Immune-Onc Therapeutics, Inc. (immune-onc.com) announced that the FDA granted fast track designation to **IO-202** for the treatment of patients with relapsed or refractory acute myeloid leukemia.
- ImmunoGen, Inc. (immunogen.com) announced the submission of a BLA under the accelerated approval pathway to the FDA for **mirvetuximab soravtansine** in patients with folate receptor alpha-high platinum-resistant ovarian cancer who have been previously treated with one to three prior systemic treatments.
- Bayer (bayer.com) announced the submission of a supplemental NDA to the FDA for **Nubeqa® (darolutamide) in combination with docetaxel** in patients with metastatic hormone-sensitive prostate cancer.
- Y-mAbs Therapeutics, Inc. (ymabs.com) announced that it completed the resubmission of its BLA to the FDA for **omburtamab** for the treatment of pediatric patients with central nervous system/leptomeningeal metastasis from neuroblastoma.
- Bristol Myers Squibb (bms.com) announced that the FDA accepted the supplemental BLA for **Opdivo® (nivolumab) plus chemotherapy** for the neoadjuvant treatment of patients with resectable NSCLC.
- Fennec Pharmaceuticals Inc. (fennecpharma.com) announced the resubmission of its NDA to the FDA for **Pedmark™ (a unique formulation of sodium thiosulfate)** for the prevention of platinum-induced ototoxicity in pediatric patients one month to less than 18 years of age with localized, non-metastatic, solid tumors.
- Spectrum Pharmaceuticals (sppirx.com/index.html) announced that its NDA for **poziotinib** has been accepted for review by the FDA for the treatment of patients with previously treated locally advanced or metastatic NSCLC harboring HER2 exon 20 insertion mutations.
- Servier (servier.com) announced that the FDA accepted its supplemental NDA for **Tibsovo® (ivosidenib)** as a potential treatment for patients with previously untreated IDH1-mutated acute myeloid leukemia.
- TG Therapeutics, Inc. (tgtherapeutics.com) announced that the FDA extended the Prescription Drug User Fee Act goal date to June 25, 2022, for the BLA and supplemental NDA for **ublituximab in combination with Ukoniq® (umbralisib)** as a treatment for patients with chronic lymphocytic leukemia and small lymphocytic lymphoma.

Devices and Assays in the News

- Myriad Genetics, Inc. (myriad.com) announced that the FDA approved the **BRACAnalysis® CDx** test for use as a companion diagnostic to identify patients with germline BRCA-mutated (gRBCAm) HER2-negative, high-risk early-stage breast cancer who may benefit from Lynparza.
- Foundation Medicine, Inc. (foundation-medicine.com) announced that it received approval from the FDA for **FoundationOne® CDx** to be used as a companion diagnostic to identify patients with microsatellite instability-high status solid tumors who may be appropriate for treatment with Keytruda. The company also announced that the FDA approved the FoundationOneCDx as a companion diagnostic to identify patients with NSCLC whose tumors have epidermal growth factor receptor exon 19 deletions or exon 21 (L858R) alterations and are appropriate for treatment with epidermal growth factor receptor tyrosine kinase inhibitors approved by the FDA for this indication.
- Datar Cancer Genetics Inc. (datargpx.com) announced that the FDA granted breakthrough device designation to **TriNetra-Prostate™**, a blood test to detect early-stage prostate cancer. 

NCCN Guidelines Updated

MorphoSys U.S. Inc. (morphosys.com/us) announced that the National Comprehensive Cancer Network (NCCN) Guidelines® for B-cell lymphomas have been updated, and the designation for **Monjuvi® (tafasitamab-cxix) in combination with lenalidomide** is now a preferred regimen for second-line therapy in patients with diffuse large B-cell lymphoma who are not candidates for transplant.

Filling the Gap: APP Utilization to Meet Care Needs in Oncology



A model for integrating APPs into a radiation oncology satellite clinic

In Brief

Cancer prevalence is increasing, and there is a gap between the growing number of patients and the number of oncology providers. Effective use of advanced practice providers (APPs) can help bridge this care gap. The quality improvement (QI) initiative discussed in this article involved integration of an APP into a radiation oncology satellite clinic to provide long-term follow-up care. This QI initiative demonstrated that care provided by the APP led to a 97 percent patient satisfaction rate. The APP also identified an average of 2.6 new care needs per patient—despite 70 percent of patients being seen by other oncology specialties. Though initial data suggest that this model may be cost-effective, further studies are ongoing. This model may be generalizable to any oncology program or practice to allow for growth of patient volume.

Across the United States, both cancer incidence and the number of cancer survivors are growing, increasing the demand for specialty trained oncology providers. In recent estimates by the American Society of Clinical Oncology, there was an estimated 1.8 million new cancer diagnoses and 16.9 million survivors with a cancer history in the United States in 2020.¹ In contrast, there is a downward trend in the number of oncology providers to care for this growing patient population. More than 20 percent of oncologists are nearing retirement, and less than 15 percent of oncologists are younger than 40 years of age.² Given the upward trend of cancer prevalence, there is a demand for timely access to oncologists to administer therapy, manage treatment-related side effects, and provide follow-up care. An immediate, available, and potentially cost-effective solution to address the demand for these services is to strategically deploy oncology-trained APPs to augment the existing oncology workforce. In 2019, the American Association of Nurse Practitioners reported an 8 percent increase in nurse practitioners entering the workforce.³ This increase represents a rising number of APPs who can fill workforce gaps within cancer programs and practices.

Setting the Stage

Vanderbilt-Ingram Cancer Center is centrally located in Nashville, Tenn., with strategically located satellite clinics designed to provide access to cancer care for rural portions of the state surrounding the greater Nashville area. Even with these satellite locations, many patients still commute long distances, at times across state lines, to obtain specialty care in our network.

One of our radiation oncology satellite clinics, located in Franklin, Tenn., was traditionally staffed by two radiation oncologists, with each physician attending clinic on alternating days. The recent population growth of middle Tennessee brought with it a concomitant need for radiation oncology services at our Franklin facility and other satellite locations. Due to physician staffing needs across our network and the desire to maximize access to cancer treatment for this growing population, new patient consultations were prioritized over follow-up visits in physician templates, resulting in scheduling challenges for patients needing routine post-treatment follow-up care at our Franklin location. As a result, only 22 percent of patients who finished treatment at the Franklin clinic were seen in long-term follow-up in the year prior to the initiation of our QI intervention.

Going forward, patients who complete radiation oncology treatment at the Franklin satellite location are prospectively offered the opportunity to return for follow-up in the NP-led clinic.

Though all treated patients have some oncology follow-up (e.g., with the patient's medical or surgical oncologist), staff believed that the unique needs of patients treated with radiation were not being adequately met due to lack of follow-up care availability in this satellite clinic. Recognizing that specialty-trained APPs are equipped to provide long-term follow-up care and surveillance, as well as survivorship care in partnership with their physician colleagues, our radiation oncology team proposed to use an APP to bridge this gap.

Accordingly, in 2020, our radiation oncology team of physicians, a nurse practitioner, nursing, and administrative staff developed a QI initiative with the goal of integrating an APP into the Franklin satellite clinic, thereby ensuring long-term follow-up for patients treated in radiation oncology. Additional goals were to increase patient satisfaction, identify areas of unmet patient needs, and improve new patient access by reducing follow-up burden for physician colleagues. Ideally, our radiation oncology team felt that the utilization of the APP team member would allow our physician providers to focus on addressing new patients' needs and treatment planning.

The Role of APPs in Oncology at Vanderbilt-Ingram Cancer Center

Prior to the development of this QI initiative, APPs were only employed in radiation oncology at our main campus in Nashville. Over the past few years, these team members partnered with physician colleagues in various roles. APPs played a key role in a variety of patient encounters, including urgent inpatient consults, outpatient follow-ups, and outpatient survivorship appointments. The demonstrated versatility of APPs at our main campus made these professionals a natural choice to augment the workforce in a satellite clinic.

Stakeholder Buy-In From Administrative and Physician Leadership

Our radiation oncology team compared the services offered at our main campus to those at our satellite clinics, revealing a significant gap in radiation oncology-specific follow-up care at the Franklin location. In response, our radiation oncology team proposed to develop a long-term follow-up clinic at the Franklin location. Physician leadership was open to this proposal and agreed that the integration of an APP at the Franklin satellite location was feasible and would lead to a meaningful expansion of oncology specialty services.

The inclusion of metrics for evaluation of the patient experience, feasibility, and, ultimately, cost-effectiveness was essential for implementation and stakeholder commitment to this proposal. Equally important were clear guidelines for scope of practice and physician partnership. With physician support, our team met with the Radiation Oncology Department's chief business officer, who—after seeing an unmet need and a feasibility plan—also approved the proposal. With buy-in from physician and administrative leadership, our team discussed how to implement a clinic schedule that would minimize the impact on APPs employed at our main campus. These discussions broadened to include satellite clinic management at the Franklin location, in addition to coordination of global scheduling for multiple providers. Lastly, our team met with essential staff at the Franklin satellite clinic, including front desk specialists and nursing, to prepare for an increased volume of patients on APP clinic days. Overall, stakeholders were supportive and enthusiastic to grow services and improve patient care.

Specialty-Focused Training

Vanderbilt-Ingram Cancer Center's medical director reached out to a nurse practitioner (NP) employed at our main campus who was formally trained as a family NP. With this NP on board, the next step was to provide specialty-focused training. Though there is an oncology board certification program for NPs needing formal specialty training, our radiation oncology team at the Franklin clinic provided specialty-focused training during the NP's three-month orientation process instead. The NP received additional training for survivorship appointments from an APP who was executing survivorship visits at our main campus clinic. Across the Vanderbilt network, our APPs work under the guidance of their physician partners, within their scope of practice, to refine their clinical and patient care skills with a focus on oncology.

Template Development and Schedule

Implementation began with one half day of clinic per week for six months (June 2020 to December 2020). Our team began patient recruitment by systematically calling those who had completed radiation treatment within the last six months at the Franklin facility and who were initially not scheduled for radiation oncology-specific follow up due to staffing limitations. We asked whether they would be willing to return to the Franklin clinic for their follow-up care. Going forward, patients who complete radiation oncology treatment at the Franklin satellite location are prospectively offered the opportunity to return for follow-up at the NP-led clinic. Patient volumes grew incrementally, and the NP's presence was expanded to one full clinic day per week for the next six months (January 2021 to June 2021). This resulted in a full year of data collection, and we are currently evaluating a proposal for expanding this clinic to two full days per week.

Patient Care Satisfaction Survey

To assess patients' experiences at the NP-led clinic, our team modified an existing evidence-based patient care satisfaction survey to focus on cancer-related care.⁴ Patients were provided an iPad at the end of their follow-up visits to complete the survey.

Each question presented a Likert scale that ranged from *strongly agree* to *strongly disagree*. After hearing that the survey was anonymous and meant to guide future long-term clinic modifications, as well as provide assessment of the current program, all patients agreed to complete this 15-item questionnaire.

Quality Care Assessment

As stated previously, patients treated with radiation oncology at the Franklin location did receive follow-up from providers (surgical and/or medical oncologists) at other locations. However, based on prior experience and comparison with radiation oncology services offered at our main campus, our team thought that radiation oncology patients had unique follow-up and survivorship needs and/or side effect profiles that would benefit from radiation oncology-specific follow-up care. To evaluate whether the NP-led follow-up or survivorship care offered at the Franklin location added quality care, rather than simply increasing unnecessary office visits, the NP performed a prospective assessment of unmet care needs at the time of the visit. We also retrospectively compared the number of patients who completed a course of curative radiation oncology treatment who had a follow-up visit more than 90 days after completion of treatment before this QI intervention to those who had a follow-up visit more than 90 days after completion of treatment during implementation of the NP-led clinic. Below are three patient case studies that show how quality of care was improved after implementation of the NP-led clinic.

Case Study 1: Early Lung Cancer Identified

The NP saw a 68-year-old male for a three-month follow-up visit after treatment for prostate cancer. This visit was scheduled as a survivorship consultation. One of the elements of survivorship is identifying candidacy for routine cancer screenings (e.g., colonoscopy, PAP smears, mammograms) and ensuring patients complete these screenings. It is not uncommon for patients to forget to follow through with routine health screenings during cancer treatment because these screenings are considered lower priority in the face of active malignancy. Once patients complete treatment, it is important to direct them back to the routine of regular health visits and screenings.

This patient had a significant smoking history and met lung cancer screening guidelines. To the best of our knowledge, he had not been referred for recommended annual low-dose computed tomography scans by his other healthcare providers. During the survivorship visit, the NP referred the patient to our lung cancer screening clinic where smoking cessation is discussed in detail and patients are scheduled for low-dose computed tomography screening. An early-stage lung cancer was identified in the scan. The patient did not have lymph node involvement and was not a good surgical candidate, so he had stereotactic body radiation therapy to treat his lung cancer. The patient was treated at our Franklin satellite location and remains in long-term follow-up with the NP for both his prostate and lung cancers.

Case Study 2: Survivor Fitness

A 53-year-old female presented to the NP-led clinic after breast cancer treatment for routine follow-up and a survivorship visit. Survivorship visits include assessment of mental health and patient

education about available resources following treatment conclusion. During treatment, patients commonly have profound fatigue, leading to muscle loss and an increased risk for long-term decompensation. It is not uncommon to observe weight loss or weight gain in this setting. Sometimes patients have surgeries that lead to body dysmorphia (deformity or abnormality in the shape or size of a specified part of the body). This can lead to a lack of confidence and struggles with patients' mental health in the form of depression and relationship issues if they do not feel able to be or want to be sexually intimate with their partner.

In this patient's case, she struggled with fatigue, weight gain, and body dysmorphia after bilateral mastectomies. The NP referred her to Survivor Fitness—a program directed toward cancer survivors in middle Tennessee where patients work with a personal trainer for free or at a reduced cost. By her next follow-up appointment, the patient had an intentional weight loss of eight pounds and was feeling less fatigued after routine exercise. Although this patient still has a lengthy recovery ahead, the NP noted an increase in her self-esteem and momentum in her physical and emotional healing.

Case Study 3: Lymphedema

A 47-year-old female presented for routine follow-up after breast cancer treatment. In discussion of potential side effects following treatment, the NP identified lymphedema as negatively affecting her quality of life. Additionally, the patient reported pain in her breast after radiation due to formation of significant scar tissue. The NP referred the patient for lymphedema physical therapy, and she was fitted for a compression bra, sleeve, and gauntlet. In the NP's next visit with the patient, there was noted improvement in the patient's lymphedema and scar tissue in her breast that led to better quality of life and less pain in her breast, without the use of medications. Before the lymphedema physical therapy, the patient had been unable to perform a self-breast exam because the breast was too tender for palpation, but, with the reduction in pain, she had begun performing monthly breast exams herself.

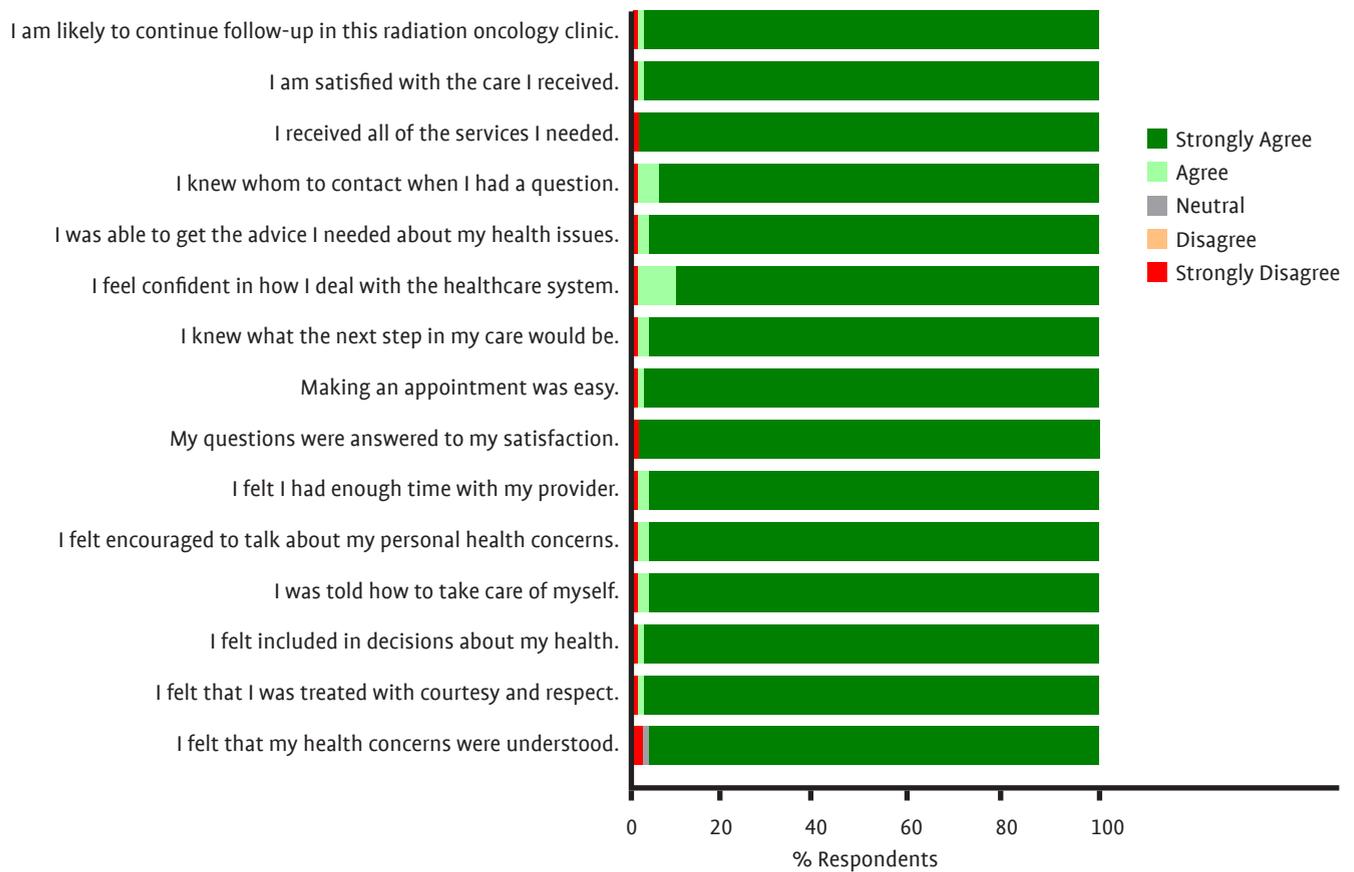
Patient Satisfaction Survey Results

Though these case studies provide snapshots of the care provided in the NP-led clinic, they are reflective of the vast majority of the patient population the NP sees. Ninety-seven percent of patients felt that they would likely continue their follow-up care in the Franklin location if given the opportunity to do so (Figure 1, page 18).

More Patients Receive Follow-Up and Survivorship Care

After implementation of the NP-led clinic, the number of patients who received long-term follow-up care (defined as 90 days or more from their last day of treatment) after completing a radiation course with curative intent increased by 45 percent, from an absolute follow-up rate of 22 percent from February 2019 to February 2020 to 40 percent from June 2020 to June 2021. Of the 222 follow-up visits over the course of the QI initiative, the NP saw 68 patients, accounting for 31 percent of all follow-up visits.

Figure 1. Patient Satisfaction Survey Results*



*Results of anonymous Patient Satisfaction Survey administered immediately after each patient’s visit with the nurse practitioner, showing the percentage of respondents with degree of agreement with each statement.

NP integration also increased survivorship care in the Franklin location. Before—and after—implementation of the NP-led clinic, physician-based follow-up visits at the Franklin location did not include survivorship visits. By contrast, 26 percent (or 18 of 68 patient encounters) of the NP’s follow-up visits were categorized as survivorship visits.

NP-Identified Care Needs

Data from the needs assessments given to patients at the NP-led clinic found that the NP met an average of 2.6 and a median of 2 new care needs per patient seen in the clinic, even though more than 70 percent of patients were seeing at least one other oncology-focused specialist (Figure 2, right). As an example, one patient had seven unmet care needs addressed by the NP. As noted in the above case studies, meeting just one of these care needs can have a significant impact on patients’ lives. Only three patients—less than five percent of those seen in the clinic—had no identified needs at the time of their follow-up with the NP. We divided the identified care needs fulfilled at the time of follow-up into distinct categories. The most common services provided by the NP were

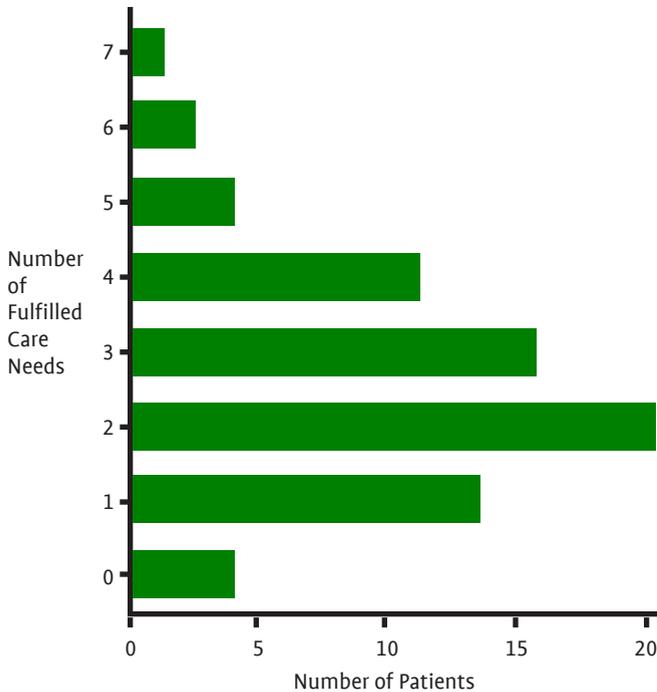
healthy lifestyle discussion, recommendations for symptom management, and cancer-related fatigue.

Limitations and Additional Benefits Initiative

The NP-led clinic was initiated during the COVID-19 pandemic. Some patients cancelled or did not want to present for follow-up care during this year of data collection. The pandemic may have contributed to a reduction in the number of patients presenting for follow up. Two patients hesitant about visiting the NP-led clinic in person agreed to a telehealth visit.

We implemented this NP-led clinic at one satellite location to serve as a pilot that would be generalizable to other oncology satellite clinics. There was a slow start to the establishment of this follow-up care clinic, which is not uncommon with similar services within Vanderbilt-Ingram Cancer Center. However, patient volumes significantly increased over the course of the year (Figure 3, right). From June to December 2020, the NP saw an average of five patients per month. From January to June 2021, the NP saw an average of 12 patients per month, with a continued upward trajectory and a fitted linear trend with an R^2 value of 0.59.

Figure 2. Care Needs Fulfilled By APP*

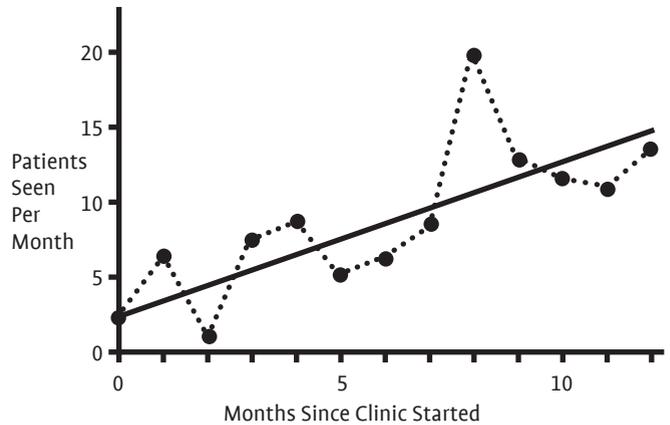


*Distribution of the number of patients (x-axis) versus the number of fulfilled care needs met (y-axis).

Although the main objective of this QI initiative was to improve patient satisfaction and establish long-term care post-radiation therapy, the NP-led clinic has the potential to deliver a significant cost benefit to our institution. In busy clinics, the use of an APP for appropriately selected follow-up patients will free up physician time for new consultation visits and treatment planning activities. As noted, the overall follow-up rate for patients treated with curative intent increased by 45 percent with the introduction of the NP-led follow-up clinic. Again, though our goal at the outset was to improve patient care, the NP visits generated revenue for our institution that would not have been captured otherwise. More detailed analyses of this model's cost effectiveness are currently ongoing to ensure sustainability and to prepare for expansion of APP services at other satellite clinics and at our main campus. 

Ellen R. Miller, MSN, FNP-BC, is a radiation oncology nurse practitioner; Anne Rajkumar-Calkins, MD, is a resident in radiation oncology; Mahmoud Ahmed, PhD, is a computational physicist in radiation oncology; Evan C. Osmundson, MD, PhD, is an assistant professor and radiation oncologist; and Heather J. Jackson PhD, FNP-BC, NEA-BC, FAANP, is a pain specialist nurse practitioner at the Vanderbilt-Ingram Cancer Center, Nashville, Tenn.

Figure 3. Patient Volume in NP-Led Clinic*



*Graph of the number of months since the NP started seeing patients at the Franklin clinic (x-axis) versus the number of patients seen by the NP per month (y-axis), with a best-fit linear.

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Disclosure of Interest

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Remote Home Monitoring of Patients with Cancer During the COVID-19 Pandemic



BY MARY STEIMER, NP; JESSICA LEABO, PA-C; HONGKUN WANG, PHD; DAVID HEYER, MD; NANCY BOWLES, BSN, MHA; LAURA MATTHEWS, MHA, MBA; TIMOTHY L. CANNON, MD; RAYMUND CUEVO, MD; WILLIAM B. ERSHLER, MD; DANIELLE SHAFER, DO; SEKWON JANG, MD; ANGELA PENNISI, MD, PHD; AMJAAD AL-HUSSAIN, MHSA; KIRBY FARRELL, BA; AND JOHN F. DEEKEN, MD



In Brief

The COVID-19 pandemic posed significant challenges in the healthcare world, especially in the care of patients with cancer. Patients with pre-existing health conditions and those with suppressed immune systems are especially vulnerable to the SARS-CoV-2 virus and are more likely to develop severe symptoms. One of the many questions under consideration in the oncologic sphere is how to manage patients who are treated on an outpatient basis and who have been exposed to or are COVID-19-positive but do not require hospitalization.

In an attempt to mitigate the risks of exposure to COVID-19, our cancer center developed outpatient screening methods and established a COVID-19 testing clinic to identify patients who may be COVID-19-positive. We also put in place a pilot program to remotely monitor patients with cancer who were either persons under investigation or COVID-19-positive with mild or no symptoms. This article describes our experience with this program.

The Inova Health System is based in Northern Virginia and comprises more than 100 outpatient clinics, including 5 acute care hospitals and 120 physician office locations. Part of this health system is the Inova Schar Cancer Institute that sees over 7,500 new cancer cases annually, with more than 850 patients receiving treatment daily across all sites.

The outbreak of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2 virus) and its infectious illness (COVID-19), has led to an ongoing pandemic that began in early 2020. At the time of this writing in December 2021, over 274 million people have been diagnosed with COVID-19, causing more than 5.3 million deaths worldwide.¹ Infection with COVID-19 can cause a wide range of symptoms, such as fever, cough, shortness of breath, and loss of smell and taste, with some individuals being asymptomatic. Severe COVID-19, which is most often observed in patients with comorbidities or various medical conditions, may eventually lead to multiple organ dysfunction and death.

The pandemic has been a major challenge for healthcare systems around the world. Healthcare providers and other hospital workers who face daily exposures are at risk of contracting the virus, which can lead to a shortage of healthy, available workers

to care for patients. In addition, the personal protective equipment required to protect these workers has not always been readily available, which has further increased their risk of exposure. The strain placed on the healthcare system to care for patients with COVID-19 has sometimes delayed the care of patients with other health conditions due to the risk of exposing them to the virus in the healthcare setting.

COVID-19 and Cancer Care

The global COVID-19 pandemic profoundly disrupted the diagnosis and care of patients with cancer. According to the Centers for Disease Control and Prevention, patients with cancer are among those who are at a particularly high risk of experiencing severe COVID-19 symptoms.² These patients who contract COVID-19 infection have higher mortality rates, are more likely to be hospitalized, and are more likely to die as a result of infection compared to the general population.³



Exterior shot of Inova Schar Cancer Institute

The reasoning behind a COVID-19 infection disproportionately affecting individuals with cancer is multi-factorial. In those with cancer, immune system function can be suppressed due to the disease itself or the therapies used to treat the disease. Some types of cancers can inhibit the immune system by suppressing bone marrow function, reducing the body's white blood cell count and, in turn, the ability to fight off infection. Cytotoxic chemotherapy and other immune-suppressing agents can have a similar effect and may increase the risk of infection by SARS-CoV-2 in these individuals. There is also ongoing research into the molecular pathways shared by oncogenesis and COVID-19 that may provide further insight into the susceptibility of this patient population.⁴ For patients with risk factors for severe disease, it is recommended that they undergo close monitoring for clinical progression with a low threshold for additional evaluations.⁵

What Is Remote Patient Monitoring

The Department of Health and Human Services has defined remote patient monitoring as “the use of connected electronic tools to record personal health and medical data in one location for review by a provider in another location, usually at a different time.”^{6,7} The aim of remote patient monitoring is to improve the care of patients through digitally transmitted health data, which can be accomplished by early detection of disease symptoms. Data suggest that remote patient monitoring can maximize patient care and treatment effectiveness in multiple areas of healthcare specialties.^{8,9} Recognizing the increased impact and potential for increased morbidity and mortality posed by the novel SARS-CoV-2

virus to our oncology patient population, our institution implemented a remote patient monitoring program for patients who were either persons under investigation or COVID-19-positive with mild or no symptoms.

Our Remote Patient Monitoring Pilot

During the early stages of the pandemic, questions arose related to the unique risks that COVID-19 posed to patients with cancer and the logistics of how to safely continue care for these patients in the outpatient clinic and infusion settings. In March 2020, our cancer center's clinical leadership team developed outpatient screening methods and established a COVID-19 testing clinic to identify patients who may be COVID-19-positive and to distinguish that from other causes of fever or respiratory symptoms.

Patients who presented to our institution with COVID-19-like symptoms and who were on active anti-cancer therapy were escorted to a COVID-19 testing clinic, separated from the rest of the cancer center and evaluated by a healthcare provider (Table 1, right). Patients were assessed and categorized as having mild symptoms if they were hemodynamically stable, with an oxygen saturation of at least 94 percent. Patients with more severe illness were ushered to the hospital's emergency department (Figure 1, right).

Persons under investigation or COVID-19-positive patients with mild symptoms were asked to take part in the pilot remote patient monitoring program. These patients continued in outpatient cancer care management in our COVID-19 clinic. This sequestered management continued until the patient had two

negative COVID-19 tests at least 24 hours apart, at which time the patient could return to the usual infusion and provider clinics.

For our pilot program, patients were offered free enrollment. Each patient was provided an iPad pre-loaded with the remote patient monitoring software. The iPads were connected to a broadband cellular network to ensure that patients without Wi-Fi could participate. Patients also had 24/7 access to the helpdesk. The entire solution (including clinical dashboards) was provided by Locus Health. Patients were educated on the program parameters and provided with the iPad and monitoring devices (Table 2, below). Patients were instructed to collect and record their data measurements into the dashboard three times daily. If patients had worsening symptoms at night, they were instructed to contact

the on-call provider or come into the emergency department. The data entered by patients were available to clinicians at the cancer center and were monitored 12 hours a day, 7 days a week. If an abnormal value was entered, the patient was prompted to call their provider’s office. The abnormal value was also automatically highlighted on the clinical dashboard and an alert was sent to the advanced practice provider team. The advanced practice provider and treating physician would make the clinical determination on the appropriate next step, and this communication and clinical recommendation was documented in the electronic health record (EHR). The institutional review board at Inova Schar approved our protocol to perform this retrospective study on the patients enrolled in this program.

Preliminary Results

Twenty-nine patients were asked to participate in the remote patient monitoring pilot program, and a total of 26 (93 percent) were enrolled between March and June 2020. Reasons for non-enrollment included the perceived complexity and stress of completing data collection/entry and the lack of a quality home internet connection. In the early days of the enrollment period, when COVID-19 tests could take 7 to 10 days to provide a result, participants were primarily persons under investigation, whose results later were negative (N = 11, 42 percent). Eventually, when test results were able to be obtained within 30 minutes, the patients who were offered remote patient monitoring were those who had

(Continued on page 24)

Table 1. COVID-19 Testing Clinic Patient Workup

Vital signs
Blood tests: Complete blood count
Rapid flu swab
SARS-CoV-2 nasopharynx swab for a polymerase chain reaction test

Figure 1. Process Workflow for Suspected COVID-19-Positive Patients

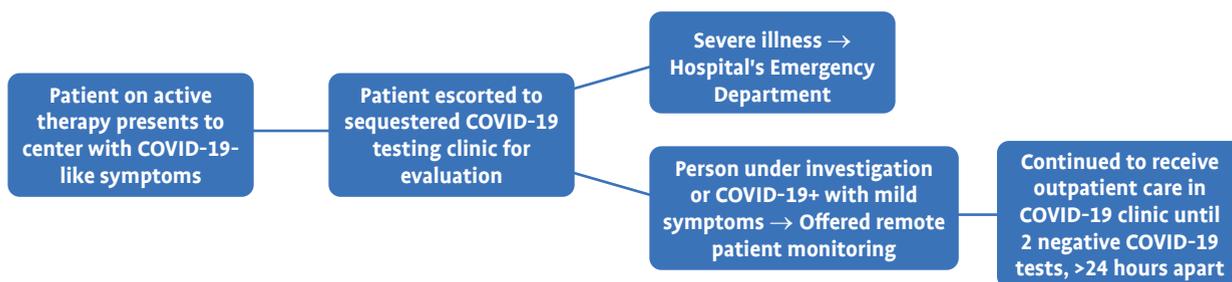


Table 2. Remote Patient Monitoring Program

Equipment Provided	Data Obtained (Three Times Daily)	Abnormal Results Prompting Alert
Automatic blood pressure cuff	Blood pressure	<100/60mm Hg
Oral thermometer	Temperature	>100.0°F
Finger pulse oximeter	Pulse Oxygen saturation	>100 bpm <93%
Configured iPad (available in English or Spanish)	Two symptomatology questions: 1. “Do you feel better, worse, or the same as yesterday?” 2. “Are you experiencing shortness of breath at this time?”	“Yes” response to the second question

(Continued from page 23)

tested positive (N = 12, 46 percent) or who were negative but where there was a high clinical suspicion given symptoms and history of close contact with a COVID-19-positive patient (N = 3, 12 percent).

A summary of patient demographics can be found in Table 3, right. The mean age of patients was 57 years old, with a range from 30 years to 88 years old. The majority were female (54 percent). The most frequent diagnoses were cancers of the gastrointestinal tract, breast, and lungs. The majority of patients were on active anti-cancer treatment (N = 22, 85 percent), including cytotoxic chemotherapy (N = 16), immunotherapy (N = 2), and targeted therapies (N = 4). In most cases, anti-cancer treatment was held until two negative COVID-19 tests were returned (N = 20, 91 percent). Two patients who were persons under investigation remained on systemic targeted therapy while awaiting their test results.

Patients remained on home monitoring for an average of 15.7 days (range, 2 to 63 days). One patient tested positive by nasal swab multiple times for more than seven weeks and was on monitoring for 63 days (or an additional 14 days after her last COVID-19-positive test). Two patients used the Spanish language version of the remote patient monitoring program. Figure 2, page 25, shows a representative example of the clinical trending dashboard of an individual patient that providers monitored centrally at our cancer center.

Patient engagement, with high compliance rates, was observed in the remote patient monitoring program. For all patients, the percentage of days during which at least one set of data was entered was 97.2 percent (range, 80 percent to 100 percent). For 65.7 percent of the days (range, 0 percent to 100 percent), data were entered all three times. No association was observed between the level of engagement and the demographic factors of age, gender, the reason for monitoring, or days in the program. When we compared patients who entered data all three times each day for every day they were in the program (N = 5) with those who did this for fewer than all of the days enrolled (N = 21), we found a relationship with age (42.2 days vs. 60.7 years; $p = 0.01$) and total days in the program (5.4 days vs. 18.1 days; $p = 0.04$).

Of the 26 patients enrolled, only 1 patient, who tested negative for COVID-19 twice, was admitted to the hospital for worsening symptoms. Two patients were admitted for reasons unrelated to their COVID-19 symptoms. Five patients reported feeling short of breath at some point during monitoring, and eight patients reported feeling worse than the day before. A total of 23 patients (88 percent) were able to be safely monitored at home and did not require hospital admission. Five patients developed worsening respiratory status (defined as 1 oxygen saturation measure below 93 percent) while on home monitoring. These patients remained hemodynamically stable on evaluation and were not sent to the emergency room or admitted to the hospital and later made a complete recovery.

Remote Patient Monitoring Challenges

Our pilot study was not without a set of challenges. Though most patients were able to easily use the equipment and technology to

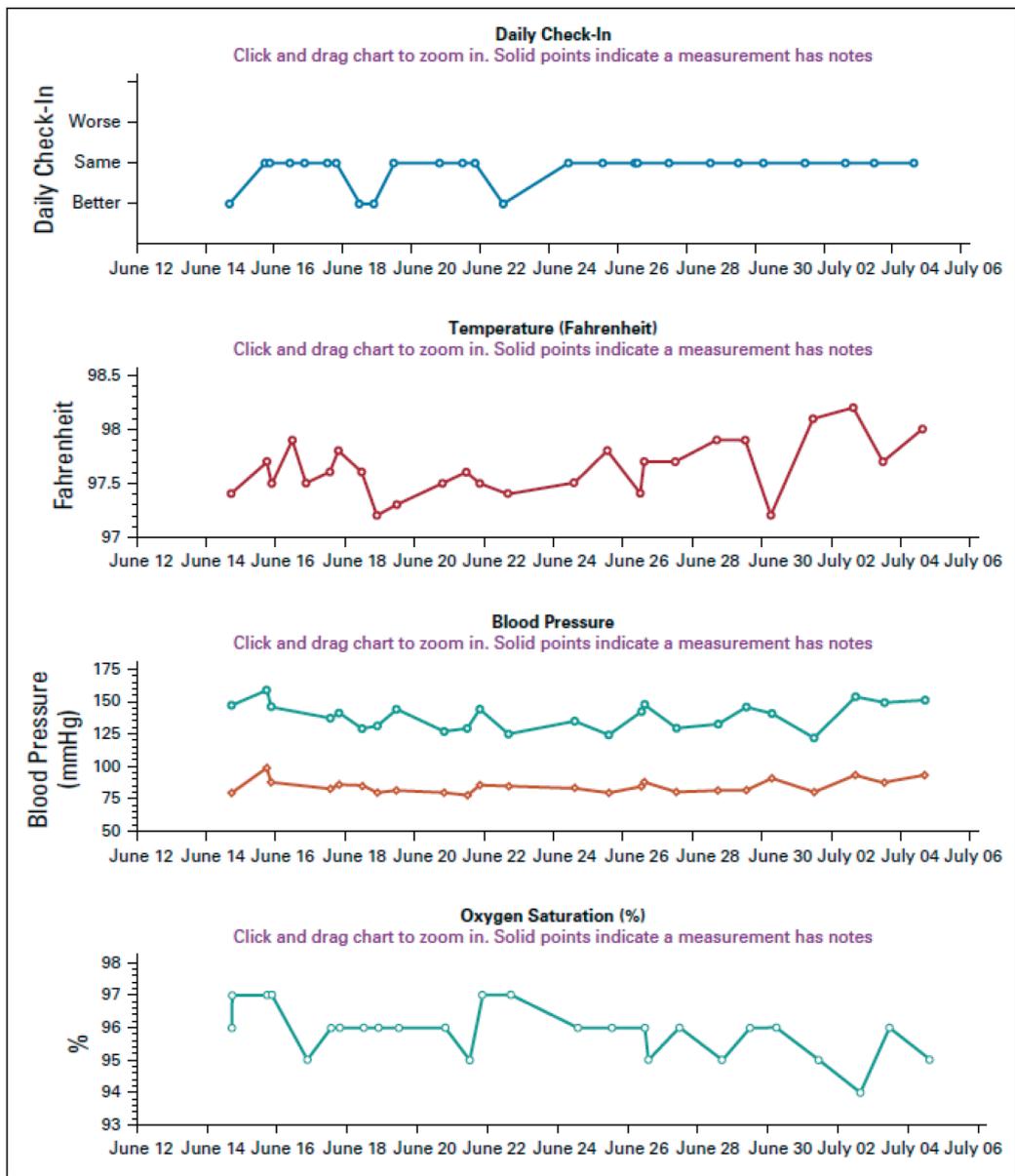
Table 3. Patient Demographics

Characteristic	N = 26	Percentage
Age (years)		
Mean	57	—
Range	30-88	—
Gender		
Female	14	54
Male	12	46
Primary cancer		
Gastrointestinal	9	35
Breast	6	23
Lung	3	11
Other	8	31
Cancer therapy		
Cytotoxic chemotherapy	16	62
Immunotherapy	2	8
Targeted therapy	4	15
No treatment or not applicable	4	15
COVID-19 status		
Positive	12	46
Persons under investigation	11	42
Clinical suspicion	3	12
Days on remote patient monitoring		
Mean	15.7	—
Range	2-63	—

remain compliant with entering their data into the dashboard, there may be selected patients who are not familiar with the technology and/or cannot operate the equipment on their own. This may be true particularly for older patients, who may not have a strong internet connection readily available. (We were able to address this by equipping the iPads with separate broadband cellular connectivity.)

Another challenge is with patients whose primary language is not English or Spanish. These two languages were available in the configuration of the iPads for patient use; however, language

Figure 2. Remote Patient Monitoring Dashboard Snapshot



interpretation was a challenge and may have prohibited the enrollment of some patients who would have otherwise participated in the program. Additionally, though levels of patient engagement generally were high throughout the program, we did see decreased participation, marked by missed repeat daily data entry points by those who were under home monitoring for longer periods of time.

At the beginning of our pilot study in the early stage of the pandemic, we faced the challenge of quickly integrating patient's entered data into the EHR system. At the time, a separate monitoring note was developed for documenting the program's data

and patient contact into their medical chart to avoid delaying the release of the program to study participants. An additional obstacle to consider is that there is a cost associated with initiating and maintaining a remote patient monitoring program. Our cancer center was fortunate to have our program funded by a generous philanthropic donation.

Looking Ahead

Given that the COVID-19 pandemic does not appear to be ending in the near term, there are opportunities to expand the remote patient monitoring program and utilize this technology to benefit

more patients. Since the early days of the pilot program, we have been able to better integrate the patient data from the dashboard into the EHR system for improved data tracking and documentation. This documentation is important for optimal patient care, as well as being able to appropriately bill insurance and receive reimbursement for these services. Due to the COVID-19 pandemic, the Centers for Medicare & Medicaid Services fast-tracked the approval of reimbursement for remote patient monitoring and remote patient monitoring-enabled services.¹⁰

There are additional potential uses for remote patient monitoring to be explored outside the sphere of a pandemic, including managing outpatients with low-risk febrile neutropenia and monitoring individuals with leukemia during their consolidation treatments. Patients who are receiving intense chemoradiation therapy may also benefit from frequent tracking of their vital signs, weight, and calorie counts. Current existing technology, such as wearable fitness devices, which some patients may already possess, could be considered for use in the future, with built-in reminders for patients to collect and record their health data. We also plan to leverage the patient education and communication (text, video) capabilities of the platform. 

Disclosure Statement

Kurby Farrell is employed by Locus Health. There are no other disclosures to report.

Author Roles

Conception and design: Mary Steimer, Jessica Leabo, David Heyer, Nancy Bowles, Kirby Farrell, John F. Deeken; Provision of study materials or patients: Timothy L. Cannon, Raymund Cuevo, William B. Ershler, Danielle Shafer, Sekwon Jang, Angela Pennisi, John F. Deeken; Collection and assembly of data: Mary Steimer, Jessica Leabo, John F. Deeken; Data analysis and interpretation: Hongkun Wang, David Heyer, Timothy L. Cannon, Raymund Cuevo, William B. Ershler, Danielle Shafer, Sekwon Jang, Angela Pennisi, Amjaad Al-Hussain, John F. Deeken; Manuscript writing: All authors; Final approval of manuscript: All authors; Accountable for all aspects of the work: All authors.

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Association of Community Cancer Centers

Developing a Cancer Care and Community Paramedicine Partnership





In Brief

The Presbyterian Healthcare Services Cancer Care program and Albuquerque Ambulance Service partnered together beginning in 2019 to develop a unique service, offering patients with cancer certain clinical interventions and wellness checks to be received at home provided by the Albuquerque Ambulance Service Mobile Integrated Health team. The goal of the initiative has been to reduce utilization of the emergency department (ED) for symptoms that could be appropriately managed in a lower level of care—in this case, patients’ homes—as well as reduce patients’ exposure to other infectious diseases while at the ED. The initiative has had the added benefit of reducing in-office visits throughout the COVID-19 pandemic for patients requiring lower acuity care. Though it is early to report on detailed findings, preliminary results suggest excellent clinical outcomes, improved patient satisfaction, and significant cost savings to both the clinical delivery system and payers.

According to a recent publication by the American Association for Cancer Research, overall national costs for cancer care in 2015 were \$183 billion and are projected to increase 34 percent to \$246 billion by 2030, based only on population growth.¹ As the cost to provide cancer care continues to skyrocket globally, there is increasing pressure to move care from hospitals and clinics into lower-cost settings.

In 2016, the Center for Medicare and Medicaid Innovation (the Innovation Center) launched the Oncology Care Model (OCM), with the primary objective stated as: “The Innovation Center is pursuing the opportunity to further its goals of improved quality of care at the same or lower cost through an oncology payment model.”² The OCM focused its efforts on “practice transformation,” which included specific metrics to reduce ED utilization and inpatient level of care. Although Presbyterian Healthcare Services did not participate in the OCM, leaders did take notice and began to explore methods to reduce costs of care.

One of these initiatives is the development of the Cancer Care and Mobile Integrated Health partnership.

About Presbyterian Healthcare Services

Presbyterian Healthcare Services is a fully integrated healthcare system that incorporates inpatient, outpatient, and community-based clinical delivery services and a commercial health insurance plan. Because of the relationships created through this integrated network, the Albuquerque Ambulance Service’s Mobile Integrated Health team can offer services aimed at providing outstanding clinical care in a model designed to prevent hospitalizations. This service model can also decrease the costs of care passed along to the health system’s health plan, whose members include a majority of the covered lives in the Albuquerque metropolitan area.

The Cancer Care program has been in place since 2007. All treatment modalities are offered, including surgical, medical, and radiation oncology, and all supportive care modalities. Services

Other low-risk clinical interventions determined appropriate for the Mobile Integrated Health team are those delivered routinely and frequently along the cancer journey. These include hydration, magnesium and other electrolytes, lab draws, antiemetics, and pain medications.

are offered at two primary locations: Jorgensen Cancer Center at Presbyterian Rust Medical Center and Presbyterian Kaseman Hospital. Surgical cases are also done at Presbyterian Hospital, which has the most developed intensive care capability. Presbyterian Healthcare Services has robust palliative, hospice, and hospital at-home programs. In 2020, approximately 2,400 patients were diagnosed with cancer in the healthcare system. Accreditations held include the Commission on Cancer, National Accreditation Program for Breast Centers, American College of Radiology's Radiation Oncology Practice Accreditation, and Quality Oncology Practice Initiative certification. Presbyterian Healthcare Services is a member of the MD Anderson Cancer Network and is seeking accreditation by National Accreditation Program for Rectal Cancer in 2022.

Getting Started

Early in 2018, various leaders within Presbyterian Healthcare Services met to discuss strategies for various service lines. In this session, several quality improvement initiatives for the Cancer Care program were discussed and are outlined below:

- Reduce ED utilization
- Reduce low-acuity hospital admissions
- Reduce risk of hospital-acquired infections by eliminating unnecessary exposure in this care setting
- Improve patient satisfaction, specifically by delivering care in the venue most convenient for patients to reduce the frequency and cost of transportation and to have continuity with clinical providers
- Reduce overall costs of care.

These became the framework for the Cancer Care and Mobile Integrated Health partnership.

The Mobile Integrated Health team's primary objective is to ensure that patients are safe in their homes. Wellness checks are part of every visit to the home and were believed to be of value to the oncology patient population. Other low-risk clinical interventions determined appropriate for the Mobile Integrated Health team are those delivered routinely and frequently along the cancer journey. These include hydration, magnesium and other electrolytes, lab draws, antiemetics, and pain medications.

At the start of the partnership, leadership from Cancer Care and Mobile Integrated Health developed a five-item initiation checklist to drive program development and implementation:

1. Determine organizational readiness
2. Assess clinical scope of practice for paramedics
3. Collect data on eligible patients
4. Receive payer endorsement and reimbursement plan
5. Design cross-training education and a competency program.

Organizational Readiness

Cancer Care and Mobile Integrated Health leadership were pivotal in gaining organizational support for this service offering. With their clarity and direction, a large group of clinical leaders on both teams became the steering committee who shared and expanded the vision. These included several medical oncologists, surgical oncologists, and radiation oncologists; the Mobile Integrated Health medical director; nursing leaders; nursing educators; Mobile Integrated Health leaders and educators; data and analytics partners; and, most important, a senior quality consultant who ensured that the team stayed on task throughout implementation and documented various measures of success.

With broad participation by this steering committee, engagement of the entire clinical team became less of a challenge. It is difficult to convince an oncologist or a nurse—who is used to seeing this subset of patients frequently—that the standard of care will not be compromised. Through a detailed orientation, competency plan, and various opportunities for social interaction, these fears were minimized.

Presbyterian Healthcare Services' senior leadership had to also understand the cost and benefit for this service offering. Most organizations are experiencing an interesting marketplace dynamic, where they seek to maximize revenue wherever possible, yet they also want to reduce costs of care. Recognizing this dichotomy, the team focused on offering the service to a cohort of patients with Presbyterian insurance, many of whom are covered by Medicare Advantage and Medicaid plans. With support and endorsement from the health plan, senior leaders understood the financial benefits as well as the exceptional patient and team satisfaction the program would bring.

To gain the trust of the clinical team, the steering committee determined that a pilot was necessary. Three patients participated in the pilot and received hydration provided by the Mobile Integrated Health team. Patients raved about the service and, as the team providing the care became comfortable, the steering committee gave the green light to expand.

Assess Clinical Scope of Practice for Paramedics

Paramedics or emergency medical technicians (EMTs) are traditionally trained to deal with acute medical emergencies. When these professionals arrive on scene, they take charge, quickly develop a plan of care, implement and execute that plan, and then move on to the next patient. This is in contrast to the world of mobile integrated health, in which clinical practice is more akin to nursing than to traditional paramedicine. However, because the Albuquerque Ambulance Service's Mobile Integrated

Health EMTs are among the senior-most staff, their ability to adapt to a different modality of care was quickly demonstrated. In addition, the Mobile Integrated Health team easily understood the value that their expertise offered the healthcare system and patients. Therefore, the staff's support for the program and their comfort level performing the required skills was high.

Although confidence was high, it remained important to ensure that the Mobile Integrated Health EMTs were more than technicians following a set of orders. Operational leaders from the Mobile Integrated Health team collaborated with oncology subject-matter experts and nurse educators to conduct a competency gap analysis to answer two fundamental questions:

1. What aspects of oncology care in the home are critical to quality but are not yet part of the Mobile Integrated Health EMTs' training, knowledge, or skillset?
2. How do we design the training required to ensure competency?

In completing the training and competency plan, it quickly became evident that the scope of practice currently approved by the New Mexico Department of Health did not include several key aspects of the treatment plan. In developing new protocols, or expanding existing ones, the relationship between program leadership and regulators at the state's lead agency that is providing oversight for emergency medical service practice (New Mexico Department of Health's Emergency Medical Systems Bureau in this case) was key to achieving the goals without substantial regulatory hurdles. Albuquerque Ambulance Service's track record in these areas has been strong for many years, so the approval process was quick.

Data Collection

A key element to achieving our desired goals included engaging Presbyterian Health System's data and analytics team at the initiation of the project. The team helped us define the target demographic, number of eligible patients, and anticipated patient volume for the appropriate care plans. Once the health plan defined the geographic coverage for services offered by the Mobile Integrated Health team, the data and analytics team



Paramedics sit with patients and provide education on their at-home treatment(s) and health.



A paramedic prepares intravenous fluids for a patient.



A paramedic arrives at a patient's home to provide care.



Patients can receive their care in the comfort of their homes and with their caregivers present.



A patient's vitals are checked.



Paramedics build close relationships with the patients they visit.

assisted in determining the number of patients who were located in the counties where services are offered. The operational plan was created with these data elements in mind.

Payer Endorsement and a Reimbursement Plan

As an integrated healthcare system, Presbyterian Healthcare Services owns and operates the Presbyterian Health Plan, which insures approximately 40 percent of the people living in New Mexico. The Presbyterian Health Plan works with both employed and other community providers to individualize patient care while optimizing outcomes, improving patient satisfaction, and managing costs. Population health works closely with the Presbyterian Health Plan to ensure goals are achieved. Oncology and Mobile Integrated Health leaders vetted the service offerings with this team. From there, the operational leaders, population health leaders, and Presbyterian Health Plan leaders collaborated to provide services to patients. Reimbursement rates were determined with the goal of covering costs, and a contract between Mobile Integrated Health and Presbyterian Health Plan was created.

Training and Competency Plan

Steering committee participants understood the need to build confidence between the two teams (Cancer Care and Mobile Integrated Health) to provide a seamless experience to patients. To that end, a social hour was held at each cancer center, where the teams met and mingled.

From there, nursing education and clinical leadership developed a detailed training plan: a didactic curriculum that included an overview of common diagnoses, complications, and care pathways. Each EMT underwent an intensive training plan (for multiple days and weeks) on-site within infusion center(s) to gain experience in accessing ports and delivery of various oncology treatment modalities. Training for the Cancer Care team included didactic sessions about EMT licensure and scope of practice.

When the pilot was conducted, an expert and certified oncology nurse went with the EMT on each clinical visit to oversee care and provide support. This was key in developing the partnership between the EMTs, oncology care providers, and patients.

Early Lessons

Though the concept and practice of home visits was not new to the Mobile Integrated Health team, we learned several lessons early that are worth considering by any oncology program or practice

looking to launch a similar quality improvement initiative:

- **Don't drive an ambulance.** This was a lesson learned prior to the Cancer Care and Mobile Integrated Health partnership that is worth mentioning here. At Albuquerque Ambulance Service, Mobile Integrated Health Team members use SUVs rather than ambulances when making home visits. This avoids the natural curiosity factor created when neighbors see an ambulance parked in a driveway for extended periods of time. It maintains a calmness for the patients and their families as well. Keep the ambulances in service for those patients who truly need emergency transportation and use a more subdued vehicle for a program like this.
- **Bring a sterile field.** The clinic environment is quite controlled and incredibly clean compared to what one might find in patients' homes. This is not judgment—just a fact. In the more traditional Mobile Integrated Health home visits to conduct medication reconciliation, diabetes management, or other less invasive treatments, this is not a significant factor—although significant health hazards may be reported through care coordination to address other social determinants of health. However, with the more invasive nature of oncology-specific treatments combined with the immune-suppressed status of patients with cancer, a clean field is important. Laying out medical supplies on the patient's table is not adequate. That said, the solution does not have to be complicated. In brainstorming this problem, staff identified that a simple, non-porous aluminum foldable camping table was a perfect solution. It is light and portable, and it is easily cleaned between patient encounters.
- **Pets are people, too.** Pets are part of the family and, therefore, part of the care team. In many cases, EMTs attempt to remove a pet from the immediate area while treating an emergency patient. Yet Mobile Integrated Health providers are in the home for extended periods of time, and patients may want their pets right by their side for comfort and companionship during the episode of care. In addition, pets may require some attention while providers are focused on patients.
- **Plan for resiliency.** Most EMTs see their patients for short bursts of time in the ambulance on the way to the hospital. As a result, there is not often a personal bond between provider and patient. EMTs become accustomed to dealing with these types of situations, as well as the cumulative stress that comes along with this type of work. The Cancer Care and Mobile Integrated Health partnership exposed EMTs to a much different environment. EMTs spend a great deal of time at each visit and make many visits over time. The relationship that is created with patients as a result is much different, as is the emotional stress that comes along with this type of care. EMTs become part of the family. Therefore, it is important to acknowledge that caregivers experience a different type of stress and fatigue, as well as the sorrow that comes along with patients whose outcomes are not as positive as we would all hope. A plan for resiliency is critical. Mobile Integrated Health is aligned with a full-time social worker, peer support team, and employee assistance group. Each of these components of

In March 2020, the Mobile Integrated Health service became critical to reducing the number of patients in the clinics and reducing exposure to those patients who are immuno-compromised.

Albuquerque Ambulance Service's employee wellness plan is available at no cost to its team members and can assist them in developing coping skills to maintain good mental health and resilience.

Additional Developments

There was no knowledge of the impending COVID-19 pandemic when this care model was developed. In March 2020, the Mobile Integrated Health service became critical to reducing the number of patients in the clinics and reducing exposure to those patients who are immuno-compromised. The Mobile Integrated Health team began to test for COVID-19 in the home and provided vaccinations. With the delay in cancer screening experienced at this facility and throughout the country, newly diagnosed patients, including those with advanced disease, caused unprecedented clinic volumes, making Mobile Integrated Health services necessary and critical.

Treatment options expanded to include common injections, such as darbepoetin alfa, filgrastim-sndz, pegfilgrastim, and pegfilgrastim-jmdb. The addition of these drugs allowed for further decongestion in the clinics and supported delivery of care in a low-cost setting.

As those intimately familiar with cancer care understand, costs are high at the time of diagnosis and are often high again at end of life. With this framework in mind, cost reduction improves over time based on comfort with this care methodology and increased program scope.

Measures of Success

At the time of writing this article, a total of 168 patients were enrolled in our program during the calendar years 2020 through 2021. We followed 98 patients who were enrolled in the Mobile Integrated Health Oncology program in 2020 and who continued into 2021. With the implementation and expansion of the Mobile Integrated Health Oncology program over that period, we found several key benefits to patients and the health system, including:

1. When looking at comparable time periods in 2020 and 2021, we found that there was a 66 percent reduction in utilization of ED, inpatient, observation, and urgent care visits (203 in 2020 compared to 67 in 2021). As initially hypothesized, the Mobile Integrated Health home visit was able to largely address the issues of electrolyte management, dehydration, nausea, and pain management in the home without having to refer patients to clinic-based care.

2. The reduction in clinic visits combined with the overall lower costs associated with paramedic care in the home translated to a 46 percent reduction in costs of providing care in 2021 (vs. 2020). We hope to follow up these findings with a more detailed and vetted financial analysis, but our initial review reveals an annualized savings to the system of more than \$1.1 million.

In addition to the clinical and financial outcomes, the improvement in patient satisfaction and clinical team engagement cannot be overstated. We know that patients prefer to be treated at home and that the providers caring for those patients found great reward in developing and expanding this innovative care model. The personal relationships that impacted care delivery became an integral part the program's success. There is no better way to summarize this than through direct feedback from our patients and staff.

Patient Satisfaction

“Every day, when the paramedics come to me at my house, is a gift that I cannot begin to explain. It’s only my life that we’re talking about here.”

- Marilyn Kirkpatrick

Team Engagement

“While participating in the training of our community EMTs, it was rewarding to witness the instant connection they were building with our oncology patients. This goes to show you that this small group of dedicated individuals are unique in their talents, and they know the importance of delivering compassionate, patient-centered care.”

- Angie Purvis, RN

“Being part of a specialized team of paramedics that get to work so closely with a group like Presbyterian Oncology has been an experience like no other. Being able to extend the oncology clinic

to the patient’s home has been one of the most rewarding and fulfilling clinical jobs I have had as an EMT. It has been a privilege to be entrusted with providing care to these patients and being a part of their oncology team.”

- Sarah Benbow, EMT-P

The connection that the community EMTs have with our patients is heartwarming. They provide care as if they were caring for their own family. Our patients have become attached to them. I know their connection and personal attention has not only improved their quality of life but has kept them from going to the hospital.”

- Chantel Tarin, RN

Future Directions

This service offering has enabled the Cancer Care and Mobile Integrated Health teams to achieve the stated goals of reduced ED utilization and unnecessary hospitalizations. Patient satisfaction with the service is outstanding, and the costs of care for patients utilizing the service were reduced. As additional data are tracked and trended to support the program, other health plans will be approached to add this service with the goal of meeting a need in the broader oncology patient community. 

Michele Goodman, RN, BSN, MBA, is vice president, Cancer Service Line and Scott A. Kasper, MS, is vice president and chief, Albuquerque Ambulance Service, Presbyterian Healthcare Services, Albuquerque, N.M.

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MAKING AN IMPACT

ASSOCIATION OF COMMUNITY CANCER CENTERS

2021 IMPACT REPORT

The oncology community grappled with significant issues in 2021, from health disparities and delayed cancer screenings to the well-being of healthcare providers and workforce shortages.

Because every cancer program and practice were impacted differently, the Association of Community Cancer Centers (ACCC) listened to its stakeholders and responded with a wealth of tools, resources, and education initiatives based on expressed member needs.

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Billing for Oncology Social Work Services



Historically, oncology social workers have not billed for their services. Common reasons include:

- Institutional stakeholders' lack of awareness that oncology social work interventions are essential to successful health and business outcomes (e.g., improved quality of care and costs savings)
- Challenges related to understanding which oncology social work services are billable and under what circumstances
- Complexity of implementing billing for oncology social work services and return on investment
- Oncology social workers' concern that billing for services might result in reducing access for those who could not afford their services.

During the past several decades, as healthcare delivery—and cancer care—have advanced and evolved, so has the field of social work. Currently in the United States, social workers comprise the greatest percentage of professionals in the mental health field. In oncology, knowledge of the ways in which biopsychosocial dimensions of a cancer diagnosis affect those living with cancer have led to important changes like the inclusion of distress screening as a component of cancer program accreditation and quality metrics.

As the U.S. continues to grapple with cost, quality, and value in healthcare delivery, the oncology ecosystem—one of the most dynamic areas of healthcare—is undergoing transformative change. Shifting demographics underway in the U.S. include a growing population of cancer survivors and an increasingly diverse

With increased recognition of the value of oncology social work services for patients, families, and providers, cancer programs and practices may benefit from a fresh consideration of billing for oncology social work services and whether this might be an appropriate next step to sustain or grow supportive care services for patients with cancer.

and aging population, with growth in patients over the age of 65 and the fastest growing cohort within that population are those who are over the age of 80.

The Institute for Healthcare Improvement's Triple Aim framework for optimizing the U.S. healthcare system calls for delivery approaches that improve the patient experience of care (including quality and satisfaction) and improve population health, while reducing per capita healthcare costs.¹ During the past two decades, significant policymaking coupled with emerging reimbursement models are transitioning the U.S. healthcare system away from traditional fee-for-service reimbursement to value-based care payment.

Disruption of the U.S. healthcare system has intensified since March 2020 when the COVID-19 public health emergency was announced. In this tumultuous environment, oncology social workers play a critical role in furthering progress toward the Institute for Healthcare Improvement’s Triple Aim.

As such, the versatile skillset of oncology social work is in growing demand in both value-based reimbursement models and fee-for-service models in which the patient experience impacts reimbursement rates. With increased recognition of the value of oncology social work services for patients, families, and providers, cancer programs and practices may benefit from a fresh consideration of billing for oncology social work services and whether this might be an appropriate next step to sustain or grow supportive care services for patients with cancer.

One caveat: medical billing is complicated no matter the provider who is billing. There are ever-changing Medicare and private insurance policies and rules, state laws, and differences in billing for hospital-based programs versus an independent community practice, to name only a few. From the outset, it is important to recognize that determining billing opportunities for oncology social work services in your cancer program or practice will take collaboration between multiple departments and experts.

Climate for Change?

As a starting point to billing, consider the following questions about the climate for change at your cancer program and/or health system:

- Is there a senior leader (e.g., chief operating officer, chief financial officer) willing to partner with oncology social work leadership to navigate culture and operational changes needed for successful innovation?
- Does the oncology social work leadership team have the knowledge and skills to engage stakeholders at multiple levels, connect with values from diverse perspectives, and build trust with stakeholders?
- Is there an understanding that reimbursement rates in current and emerging value-based models are tied to the patient experience, including quality and satisfaction?

With leadership, advocacy, and innovative problem-solving, it is feasible for oncology social work to contribute to an organization by generating revenue. The process is not simple, however. Pursuing any institutional change always requires perseverance and—most important—building trust with stakeholders.

Implementing Billing for Social Work: The City of Hope Experience

At City of Hope, a National Cancer Institute-designated comprehensive cancer center in California, oncology social work has been successfully billing for outpatient services since 2019. The goal was to create a billing roadmap for the oncology social work field. The two-year planning and implementation process (Figure 1, right) required the committed engagement of two teams of essential stakeholders. To bring the “must have” stakeholder teams on board, City of Hope used two tested engagement models.^{2,3} To engage institutional stakeholders, a values, benefits,

Figure 1. Implementation Timeline in Brief



NPI = National Provider Identifier.

outcomes model was used. For the oncology social work team, City of Hope employed a staff leadership model.⁴

Values, Benefits, Outcomes Model

Originally developed to build supportive care programs, this model starts with identifying core *values* that will motivate key stakeholders. Values connect people at their very core—highest quality medical care, patient-centered care, national recognition. *Benefits* tend to be less altruistic and relate to the reality of personal self-interest (e.g., manage a problem for me, save me time, allow physicians to see more new patients). *Outcomes* are what will be achieved together for which all stakeholders can be proud—patients living longer with higher quality of life, increased revenue, higher patient satisfaction scores, and greater levels of staff engagement. At City of Hope, key stakeholders engaged through this model included:

- Executive leadership (chief operating office and chief nursing officer)
- Revenue cycle (chief financial officer and vice president)
- Compliance officer
- Information technology support (senior vice president)
- Coding and data quality (senior manager)
- Financial department (executive director)
- Managed care (senior director)
- Credentialing (manager).

Staff Leadership Model

The underlying premise of this model is that it is the responsibility of leadership to work with their teams to 1) create a shared, long-term vision and 2) create opportunities where all colleagues have the capacity (and obligation) to make significant contributions that ensure the success of the program. In addition, in the staff leadership model, every colleague has a responsibility to openly challenge all aspects of the program. Below is a summary of how each member of the team stepped up and assumed lead-

ership roles in the implementation process for oncology social work billing:

- The oncology social work director created a vision of social work billing, developed leadership skills, and built trust with stakeholders (courage, reliability, communication).
- The oncology social work manager operationalized the vision into sustainable, feasible processes; developed training and implementation plans; and kept billing at the forefront of communication.
- Oncology social work team leads and supervisors developed easily implemented and aligned workflows, revised documentation templates to showcase clinical expertise, and supported teams through change by frontloading necessary information.
- Every oncology social work team member assumed additional responsibilities and learned new processes and talked—openly and honestly—about competing priorities, ethical dilemmas, and adjusting to change.

Billing Using Health Behavioral Codes

Licensed clinical social workers at City of Hope bill for outpatient facility charges (not professional fees) using health behavioral codes.⁵ Health behavior assessment and intervention services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems. The patient's primary diagnosis is physical in nature and the focus of the assessment and intervention is on factors complicating medical conditions and treatments. These codes describe assessments and interventions to improve the patient's health and well-being using psychological and/or psychosocial interventions designed to ameliorate specific disease-related problems.

At City of Hope, two years of billing data show that oncology social work can generate revenue; reimbursement rates for these professionals were similar to those of medical providers. Despite anticipated patient complaints about billing for social work services, City of Hope received surprisingly minimal (almost no) complaints from patients.

Pilot data from January 2019 to February 2021 show that City of Hope oncology social workers were responsible for 4,025 billing encounters. Charges generated by oncology social workers during this period totaled \$1,576,981. The revenue realized was \$297,064. This total reflects \$267,374 in line-item reimbursement from insurance providers and \$29,690 in patient coinsurance/copays. The oncology social work billing denial ratio was only 26 percent, which is in line with that of medical providers. The above financial outcomes were achieved without quality improvement efforts targeting reimbursement and denial codes, which will be a necessary next step for the team to optimize the billing program.

Key benefits to implementation of oncology social work billing at City of Hope:

- There is an increased likelihood that psychosocial services will continue to be available to patients and families.
- Increased prestige of program due to innovation and ability to overcome barriers (i.e., enhanced awareness of oncology

social work skillset and versatility) has been achieved.

- Revenue data have been used strategically (e.g., staffing, benchmarking, productivity).
- Oncology social work was able to hire and recruit during COVID-19 when many institutional divisions and roles were not.
- Oncology social work is now able to access institutional resources with other billing departments.
- The oncology social work team has the opportunity to share experience and learnings with other institutions and contribute to the field of oncology social work.

Oncology social workers are the healthcare professionals with the training and skillset to ensure the delivery of equitable quality cancer care. Oncology social workers' interventions reduce patient and family distress, resulting in improved medical outcomes, quality of life, and patient satisfaction. Exploring innovative strategies for oncology social work services to generate increased revenue can be one way to ensure sustainable delivery of quality comprehensive cancer care as defined by the National Academy of Medicine, National Comprehensive Cancer Network, American Society of Clinical Oncology, American College of Surgeons Commission on Cancer, and other leading oncology organizations.

Courtney Bitz, LCSW, MSW, OSW-C, ACHP-SW, is director of clinical social work, Department of Supportive Care Medicine at City of Hope in Duarte, California.

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Making the Business Case for Hiring Oncology Social Workers

By Krista Nelson, MSW, LCSW, OSW-C, FAOSW; Jennifer Bires, MSW, LCSW, OSW-C; Courtney Bitz, LCSW, OSW-C, ACHP-SW; Barbara Jones, PhD, MSW, FNAP; Vicki Kennedy, LCSW; Shirley Otis-Green, MSW, MA, ACSW, LCSW, OSW-CE, FNAP, FAOSW; Bradley J. Zebrack, PhD, MSW, MPH

Quality cancer care requires a comprehensive approach to addressing the wide range of biopsychosocial-spiritual needs facing oncology patients and their families. Recently, renewed attention has focused on social determinants of health as drivers of improved health outcomes, effective system utilization, and decreased healthcare and operational costs.¹ Oncology social workers are experts who have been identifying and responding to these concerns for more than a century.²

Oncology social workers are essential for a cancer program or practice to meet the Institute for Healthcare Improvement's Triple Aim: (1) the provision of evidence-based services that improve patient/family/population outcomes; (2) the improvement of patient and provider satisfaction; (3) the reduction of unnecessary utilization and costs³—and in meeting the additional imperative (i.e., the Quadruple Aim) to (4) enhance the well-being of providers in the delivery of quality care.⁴

As the primary providers of psychosocial interventions and a critical linkage to internal and external resources, oncology social workers are among the most versatile members of the healthcare team. Oncology social workers' interventions

reduce patient and family distress and improve quality of life thereby increasing patient satisfaction, improving efficiencies, and lessening the burden on physicians and healthcare teams by allowing them to do what they do best—administering innovative medical treatment to more patients.⁵

Finally, the importance of the oncology social work role is affirmed by its inclusion as a requisite to meet accreditation and quality standards such as those established by the American College of Surgeons Commission on Cancer (CoC), the American Society of Clinical Oncology's Quality Oncology Practice Initiative (QOPI), the National Comprehensive Cancer Network (NCCN), and the National Quality Forum (NQF).

THE PROBLEM

Evidence supports that the diagnosis and treatment of cancer results in biopsychosocial-spiritual distress. Research finds that, at a minimum, 30 percent of all newly diagnosed patients with cancer are identified as clinically distressed to the point of requiring psychosocial intervention.^{6,7} Other studies have found that many more patients benefit from a social work intervention during their cancer trajectory.⁸ Failure to attend to these concerns impacts outcomes, costs, system utilization, and increases moral distress for patients, families, and staff. Despite this, few cancer programs report sufficient oncology social work staffing to meet these critical needs. In fact, results from a recent ACCC survey on comprehensive cancer care revealed that 60 percent of respondents reported they had insufficient or no oncology social work staff.⁹

THE SOLUTION

Investing in the full integration of oncology social work services reflects the highest standard of quality care and is recommended by the National Academy of Medicine.¹⁰ Hiring oncology social work staff is the right thing to do for your patients, their families, and your staff, and it is cost effective.



Oncology social workers are master's-prepared specialists who contribute to your cancer program or practice by:

- Identifying and responding to psychological, social, emotional, practical, and existential distress.
- Increasing adherence to recommended treatment by identifying and reducing barriers to care.
- Facilitating complex goals-of-care conversations to ensure shared treatment decision-making and effective patient-physician communication.
- Advocating for the integration of justice, diversity, equity, and inclusion into cancer care.
- Connecting patients to local, regional, and national resources to overcome practical barriers to care, such as transportation, housing, financial barriers, and lack of adequate health insurance.
- Improving patients' and families' effective coping skills and adjustment during pivotal transition points in the cancer care continuum: diagnosis, treatment, protocol change, clinical trials, palliative care, end-of-life, survivorship, and/or recurrence.
- Addressing social and behavioral barriers to patient enrollment and retention in clinical trials.
- Developing and implementing innovative, evidence-informed programs to address unmet needs.
- Providing education, awareness, and support to mitigate moral distress; burnout; grief and loss; and compassion fatigue among healthcare staff.
- Improving patient safety by ensuring that institutions meet legal, regulatory, and accreditation standards.
- Managing complex (high-risk) psychosocial situations.

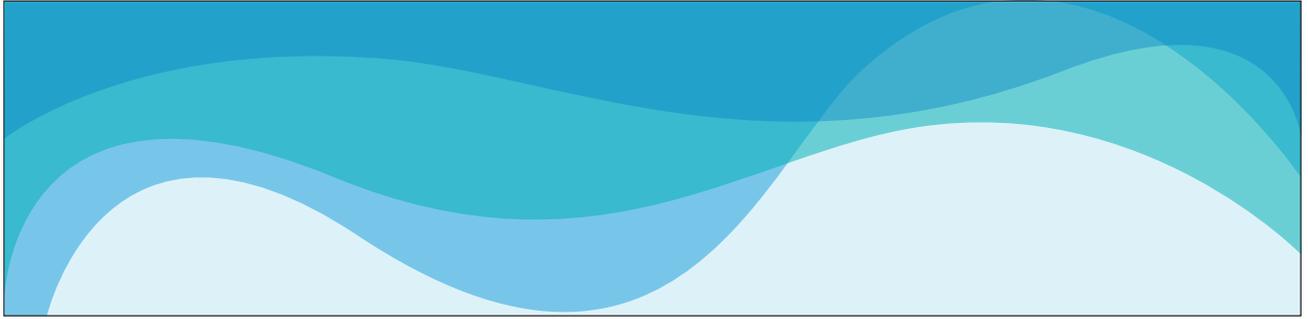
Making a solid business case for a fully integrated oncology social work staff requires a realistic assessment of programmatic and capacity needs. To optimize oncology social work impact, strategic planning and standardization of roles and responsibilities are critical.

BILLING, REIMBURSEMENT & FUNDING CONSIDERATIONS

With leadership, advocacy, and innovative problem solving, it is feasible to expand social work staffing as part of a coordinated care delivery model. Many cancer programs make a successful case for sustainable funding of FTE social work positions through their operations budget, with the understanding that these services will improve patient care and help reduce healthcare costs. Innovative value-based payment agreements that include oncology social work outcomes provide an opportunity to increase revenue and cover the cost of needed staff. It is also possible to bill for some oncology social work services both on outpatient facility charges and professional fees. Data from one National Cancer Institute-Designated Cancer Center's oncology social work team shows reimbursement rates similar to other medical providers and minimal patient billing complaints. (Look for more on the topic of billing for social work services in an upcoming *Oncology Issues*.)

SOCIAL WORK IN ACTION

The U.S. healthcare enterprise acknowledges the importance of responding to social determinants of health as essential to health equity. Increasingly there is recognition that without the delivery of equitable care we are not providing quality care. Oncology social workers are the health professionals best prepared to apply their expertise and knowledge of the social determinants of health to the full biopsychosocial-spiritual spectrum of impact on oncology patients, families, and communities. Regardless of the care delivery model, oncology social workers' versatility supports quality care through their capacity to connect and streamline resources with skill and efficiency. ●



QUALITY & VALUE

Oncology social work staff and faculty help cancer programs prepare for alternative payment model (APM) care delivery transformation. An APM Implementation Checklist developed by ACCC's Alternative Payment Model Coalition outlines three phases of readiness for APM engagement.¹¹ As oncology clinics, hospitals, and

health systems strive to improve outcomes and the delivery of equitable cancer care, oncology social workers are the health professionals best prepared to advance these efforts through community engagement, facilitating patient and family advisory councils, and conducting patient education and outreach.

DISTRESS SCREENING AND SYMPTOM MANAGEMENT REDUCE HEALTHCARE COSTS

Distress screening and response—distress management—have demonstrated effects on cost control and lay primarily within the domain of oncology social work. Since the widespread adoption and implementation of distress screening, several studies are looking at whether screening—coupled with effective distress management—is helping to improve the quality of care and reduce healthcare costs.

A recent study, commissioned by the Association of Oncology Social Work (AOSW), evaluated cancer program adherence to distress management protocols and the association between adherence and patient emergency department (ED) use or hospitalization within two months after the clinic visit that should have included screening.¹² Of 8,409 electronic health records (EHRs) reviewed across 55 CoC-accredited cancer programs in the U.S. and Canada, 5,685 patients (67.6 percent) were identified as screened and subject

to appropriate clinical response as per protocol; 2,724 (32.3 percent) were not. The EHRs also indicated that 954 patients (11.3 percent) had used the ED at the institution where they were screened, and 1,398 patients (16.7 percent) had been hospitalized at least once during the two months following the visit at which they were screened for distress.

KEY FINDINGS

Among those who were screened and responded to as per protocol, ED and hospitalization were 18 percent and 19 percent less, respectively, compared to those who were not screened and responded to according to protocol. Study authors concluded that if all patients in the study had been screened for distress and psychosocial issues addressed—a task often carried out by an oncology social worker—there would have been 172 fewer ED visits and 266 fewer hospitalizations.

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A publication from the President's Theme of 2021-2022 ACCC President Krista Nelson, MSW, LCSW, OSW-C, FAOSW, "Real-World Lessons from COVID-19: Driving Oncology Care Forward."

The **Association of Community Cancer Centers (ACCC)** is the leading education and advocacy organization for the cancer care community. Founded in 1974, ACCC is a powerful network of 28,000 multidisciplinary practitioners from 2,100 hospitals and practices nationwide. As advances in cancer screening and diagnosis, treatment options, and care delivery models continue to evolve—so has ACCC—adapting its resources to meet the changing needs of the entire oncology care team. For more information, visit [accc-cancer.org](https://www.accc-cancer.org). © 2022. Association of Community Cancer Centers. All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means without written permission.

A Model Telehealth Adolescent and Young Adult Oncology Program



Adolescent and young adult (AYA) oncology patients are defined by the National Cancer Institute as individuals diagnosed with cancer between 15 and 39 years of age.¹ According to Miller et al., an estimated 90,000 AYAs were diagnosed with cancer in the United States in 2020 and overall cancer incidence increased in all AYA age groups from 2007 to 2016.² These national data, as well as state-specific data (including low to moderately populated states, such as Wisconsin³), support the fact that AYAs make up a growing percentage of oncology patients.

In addition to representing a relatively large number of patients, AYA oncology patient care is critical given these individuals have unique oncologic diagnoses, morbidities, and psychosocial concerns that are inadequately met through conventional healthcare models. With regards to diagnoses, younger adolescents (15 to 19 years old) are more commonly diagnosed with lymphomas, germ cell tumors, and leukemias, whereas older AYAs (20 to 29 years old) are more commonly diagnosed with carcinomas.⁴ Combining these unique diagnoses with lower cancer survival rates in some AYA diagnoses,⁴ there is a crucial need to develop and implement AYA-dedicated services that take into consideration this vulnerable population's unique needs in an effort to increase patient quality of life and overall cancer survival.

Development of an AYA Oncology Program

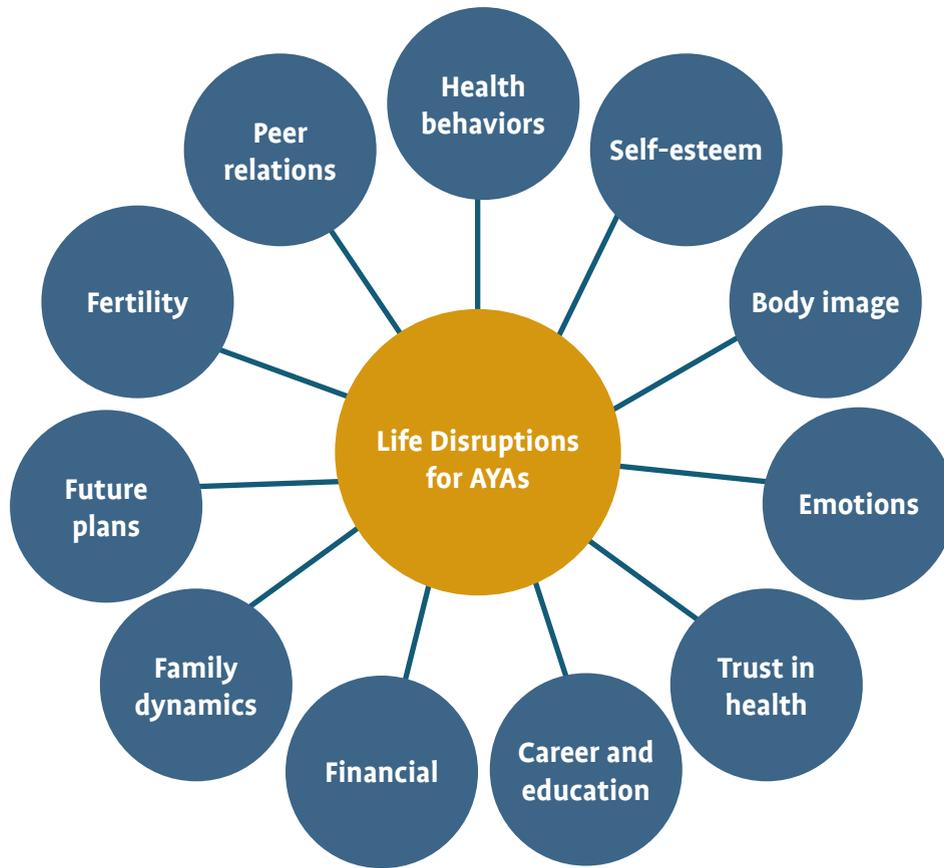
Given the intersection of age-specific developmental tasks with the complexities of cancer, AYAs have a variety of largely unaddressed needs. Unmet psychosocial needs, including those shown in Figure 1, page 46, have been associated with disparities in clinical treatment, lower survival rates, and poorer physical- and mental health-related quality of life.⁵ These challenges negatively

Using telemedicine as our foundation provided several key advantages, such as nearly eliminating the need for physical clinic space and expanding the reach of the program to AYAs from distant or rural residential locations.

impact patients' abilities to make treatment-related decisions and treatment adherence.^{6,7} Disparities in psychosocial and supportive care contribute to poorer outcomes and support the need for dedicated AYA services given the inadequate provision of psychosocial care in our current healthcare model. To meet the individual needs of AYAs, the University of Wisconsin Carbone Cancer Center sought to create a new patient-centered care model that identifies and addresses AYAs' particular needs before, during, and after treatment through the the Adolescent and Young Adult (AYA) Oncology Program at the University of Wisconsin Carbone Cancer Center. Due to resource limitations common to many cancer programs (e.g., clinic space), we developed our AYA Oncology Program using an innovative telehealth-based model.

The mission of our AYA Oncology Program is to improve the patient experience, quality of life, and long-term survival of AYAs diagnosed with cancer by providing age- and developmentally appropriate psychosocial and supportive care services from pro-

Figure 1. Common Life Disruptions for AYAs⁵



professionals with AYA expertise. This mission is addressed through three important initiatives: clinical, research, and education. The research and education initiatives meld seamlessly with the clinical aspect of the program, supporting the development of a forum to exchange multidisciplinary research to:

- Advance the field of AYA oncology
- Create training opportunities for AYA-dedicated oncology providers
- Provide clinical care to support the patient experience.

It is the authors' hope that the following description of the clinical model of our AYA Oncology Program will serve as an innovative approach to delivering AYA-dedicated care, with the understanding that many resource limitations exist among institutions and facilities everywhere.

Needs and Limitations

When approaching a new program, it is important to consider the needs that are being addressed and the possible limitations in meeting those needs. Table 1, right, shows the three critical needs we identified, along with the potential limitations in creating

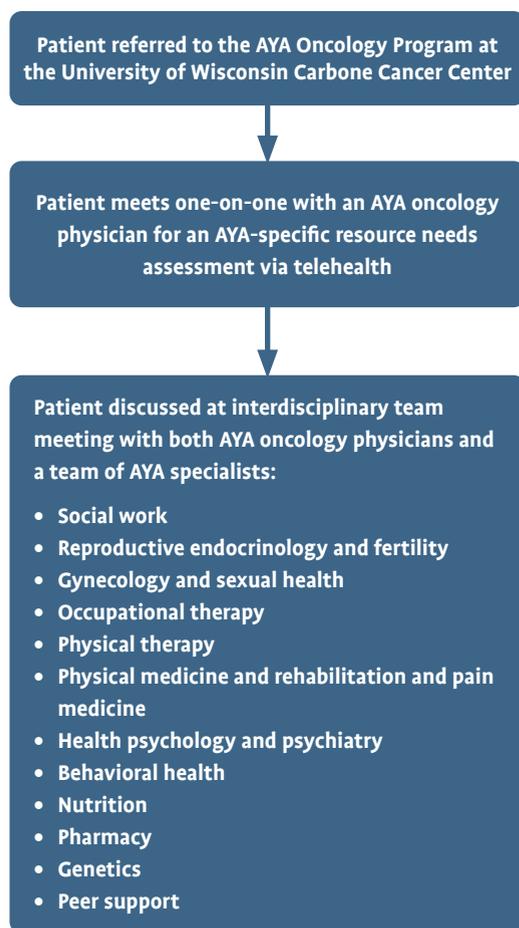
and establishing our AYA Oncology Program. First, we encountered a common limitation when conceiving the program: finite clinic space. We needed to address the physical aspects of the AYA Oncology Program within the limitations of the University of Wisconsin Carbone Cancer Center. Considering our limited physical clinic space, we followed the growing evidence amid the COVID-19 pandemic that showed that telemedicine was acceptable to AYAs⁸ and developed the first consultative AYA Oncology Program that follows a telemedicine clinical model. Using telemedicine as our foundation provided several key advantages, such as nearly eliminating the need for physical clinic space and expanding the reach of the program to AYAs from distant or rural residential locations. Patients do not need to travel to the cancer center to take advantage of the benefits of the AYA Oncology Program and can more easily fit the clinic visit in between all their other responsibilities.

A second need we identified that was imperative to program success was the participation of multidisciplinary AYA-focused providers. We needed supportive care resources tailored to AYA patients, and we made it a goal to have all supportive care services

Table 1. Needs and Limitations in the Creation of an AYA Oncology Program

Needs	Limitations
Dedicated AYA Program	Clinic space
Supportive care resources, preferably from AYA-focused providers	Limited availability of AYA-focused supportive care providers
Integration of medical and psychosocial care using interdisciplinary providers	Funding to support salary for interdisciplinary care providers

Figure 2. AYA Oncology Program Structure



provided by AYA-focused providers. Unfortunately, despite this universally identified need, we found that our current healthcare system has limited availability of AYA-focused supportive care providers. To address this limitation, we created an interdisciplinary team of diverse providers who are dedicated to AYA patient care. The establishment of our AYA interdisciplinary team allowed for the identification of AYA-focused providers within the cancer program, as well as bi-directional AYA-specific education to team members, thus allowing for the ongoing development of an AYA-specific skill set within the cancer center.

Finally, we identified a critical need for the integration of medical and psychosocial care using interdisciplinary providers. It is well established that the identification of patients' needs and the provision of services to meet those needs require interdisciplinary care. Our inability to immediately procure funding to support the salaries of dedicated interdisciplinary care providers was one of the largest limitations we faced in implementing our AYA Oncology Program. To overcome this barrier, we employed a tumor board-style interdisciplinary team meeting approach. This approach means that patients first have a telemedicine-based clinic visit with an AYA-oncology physician to complete a resource needs assessment. This visit is then followed by an AYA interdisciplinary team meeting four days later, where providers receive insight into the available resources necessary to meet patients' identified needs. This approach allows for interdisciplinary consideration of all AYA patient cases, while only requiring one hour per week from all AYA interdisciplinary team members. Resources identified by the team in this meeting are then arranged through the cancer center's standard referral pathways.

Program Launch

With this structure set, we launched our AYA Oncology Program in January 2021. Figure 2, right, shows the program's structure. Patients are referred to the AYA Oncology Program by providers in the cancer center or through external referrals. Patients are eligible to be seen at our AYA oncology clinic if they are currently

between the ages of 15 years to 39 years and have ever been diagnosed with cancer. Patients may be long-term survivors of childhood cancer, newly diagnosed, or several years off therapy. Patients are first seen by one of our two AYA-focused oncology physicians—one adult and one pediatric hematologist/oncologist. This appointment is a 60-minute telemedicine video visit that includes an AYA-specific resource needs assessment. During this visit, the patient's underlying cancer diagnosis and subsequent treatment are confirmed and the remainder of the visit is spent discussing the most frequent topics of concern for AYA patients with cancer. The goal of the visit is to explore the multitude of ways patients' lives are altered by a cancer diagnosis and work together to seek resources to address their individual needs. Four days later, all patients are presented at the AYA interdisciplinary team meeting, which is attended by both AYA oncology physicians and AYA-focused providers representing a multitude of fields, including:

- Social work
- Reproductive endocrinology and fertility

- Gynecology and sexual health
- Physical therapy
- Physical medicine and rehabilitation/pain medicine
- Health psychology and psychiatry
- Occupational therapy
- Behavioral health
- Nutrition
- Pharmacy
- Genetics
- Peer support, which includes community programs that are available to patients.

At this meeting, the AYA interdisciplinary team discusses each patient that was seen the previous week in AYA clinic. Working collaboratively, the team identifies available in-house and community-based resources that meet patients' identified needs and considers possible barriers, such as patients' residential location and insurance status. In addition to interdisciplinary consideration of each patient's unique psychosocial resource needs, the AYA oncology program also provides survivorship care plans tailored to each patient's unique exposures from their diagnosis or treatment. Our clinic can also serve as a conduit to establishing care with a primary care provider in the community.

Program Benefits

Since launch, we have seen that this innovative clinical model offers a slew of benefits to our patients. A visit with a dedicated AYA oncology physician is critical for identifying patients' needs and the supportive care services that are essential to meet those needs. With the telemedicine model, we are decreasing the resources and provider time required for such consultations. Another benefit that is critical for AYA patients who are balancing work, family, and their other priorities and responsibilities is that this program gives them flexibility, so they can better balance their medical care with their day-to-day responsibilities. Instead of adding additional travel time to the cancer center or the need to find childcare, patients can participate in our AYA Oncology Program in the location most convenient for them.

Our providers have also seen great benefits from the program. The combination of a dedicated one-on-one resource needs assessment consultation and AYA interdisciplinary team meeting helps already busy clinicians identify and support the psychosocial concerns of patients that have been shown to negatively impact patient care, including treatment compliance. Our AYA Oncology Program documents in the electronic health record all critical care components discussed in the team meeting, including fertility, contraception, and sexual health, which are key measures of quality and are supported through national guidelines (e.g., National Comprehensive Cancer Network Guidelines™).⁹ Moreover, our AYA Oncology Program creates meaningful survivorship care plans that are informed by patient visits and that help guide their ongoing survivorship care.

Program Metrics

As is true with any new program, one must use metrics to establish a program's viability and benefits to patients and the cancer center. As seen in Table 2, right, considering the first 35 patients seen in our AYA Oncology Program, we found a statistically significant increase in resource utilization. Prior to their visit with the AYA oncology physician, patients used an average of 2.51 resources per individual. After the initial AYA telemedicine consult, an additional 2.54 novel resources were identified per patient. Most notable, however, was the incredible importance of interdisciplinary team care, with an additional 1.91 average novel resources identified per patient after the AYA interdisciplinary team meeting held four days after the initial AYA telemedicine consult.

Considering the unique AYA-specific resources separately, we noticed that prior to our AYA telemedicine consultation, patients were most likely to be referred to social work and genetics, with limited connection to vocational or peer support resources. After the AYA telemedicine consultation, patients were most likely to be referred to health psychology or psychiatry and peer support, reflecting the importance of mental health services for these patients. These needs and resources are currently under-recognized and underutilized in our current healthcare system, and our AYA Oncology Program ensures that we address the mental health needs of our patients. Finally, following the AYA interdisciplinary team meeting, there was a broad representation of novel resources previously not used by patients, including physical therapy and occupational therapy, additional peer support options, and patient-specific resources (termed "other" in Table 2), such as:

- Physical medicine and rehabilitation
- Pain medicine
- Sleep clinic
- Financial resources
- Behavioral health
- Substance abuse.

These data suggest an incredible opportunity for AYA-specific programs to meet the unique needs of this patient population. Our telemedicine-based AYA Oncology Program generated an average of 4.45 new resources per patient over the course of their one-on-one visit with an AYA oncologist and case discussion with the AYA interdisciplinary team. This figure represents a statistically significant increase in resource identification and utilization ($p < 0.001$). Considering these data, our AYA Oncology Program has been both feasible and successful, despite initially facing logistic barriers common to healthcare systems and oncology programs and practices. The use of a telemedicine-based consultative model certainly helped with logistic issues related to limited clinical space, expanded the research of the program, and decreased time requirements for both patients and providers. Through this program, we have shown the critical importance of an interdisciplinary approach and added further data to support the need for AYA-dedicated patient care in oncology. Success of such novel approaches adds support to the belief that AYA-dedicated oncology

Table 2. Incremental Benefit of a Staged Approach to AYA Oncology Care: Distribution of AYA-Specific Resources Identified Before the AYA Encounter, During the Physician Visit, and at the AYA IDT Meeting

	Social Work n (%)	Fertility and Sexual Health n (%)	Genetics n (%)	Psychology and Psychiatry n (%)	Physical and Occupational Therapy n (%)	Vocational Resources n (%)	Peer Support n (%)	Nutrition n (%)	Other*	Average Novel Resources per Patient
Resources utilized pre-AYA clinic	14 (40.0)	11 (31.4)	16 (45.7)	11 (31.4)	16 (45.7)	0 (0.0)	4 (11.4)	8 (22.9)	8 (22.9)	2.51
Novel resources following one-on-one AYA physician clinic visit	5 (14.3)	11 (31.4)	8 (22.9)	14 (40.0)	8 (22.9)	4 (11.4)	19 (54.3)	10 (28.6)	10 (28.6)	2.54
Novel resources following AYA interdisciplinary teammeeting	6 (17.1)	6 (17.1)	6 (17.1)	4 (11.4)	10 (28.6)	3 (8.6)	8 (22.9)	8 (22.9)	16 (45.7)	1.91

*Other resources include physical medicine & rehabilitation, sleep clinic, financial resources, pain medicine, survivorship, behavioral health and substance abuse. AYA = adolescents and young adults; IDT = interdisciplinary team

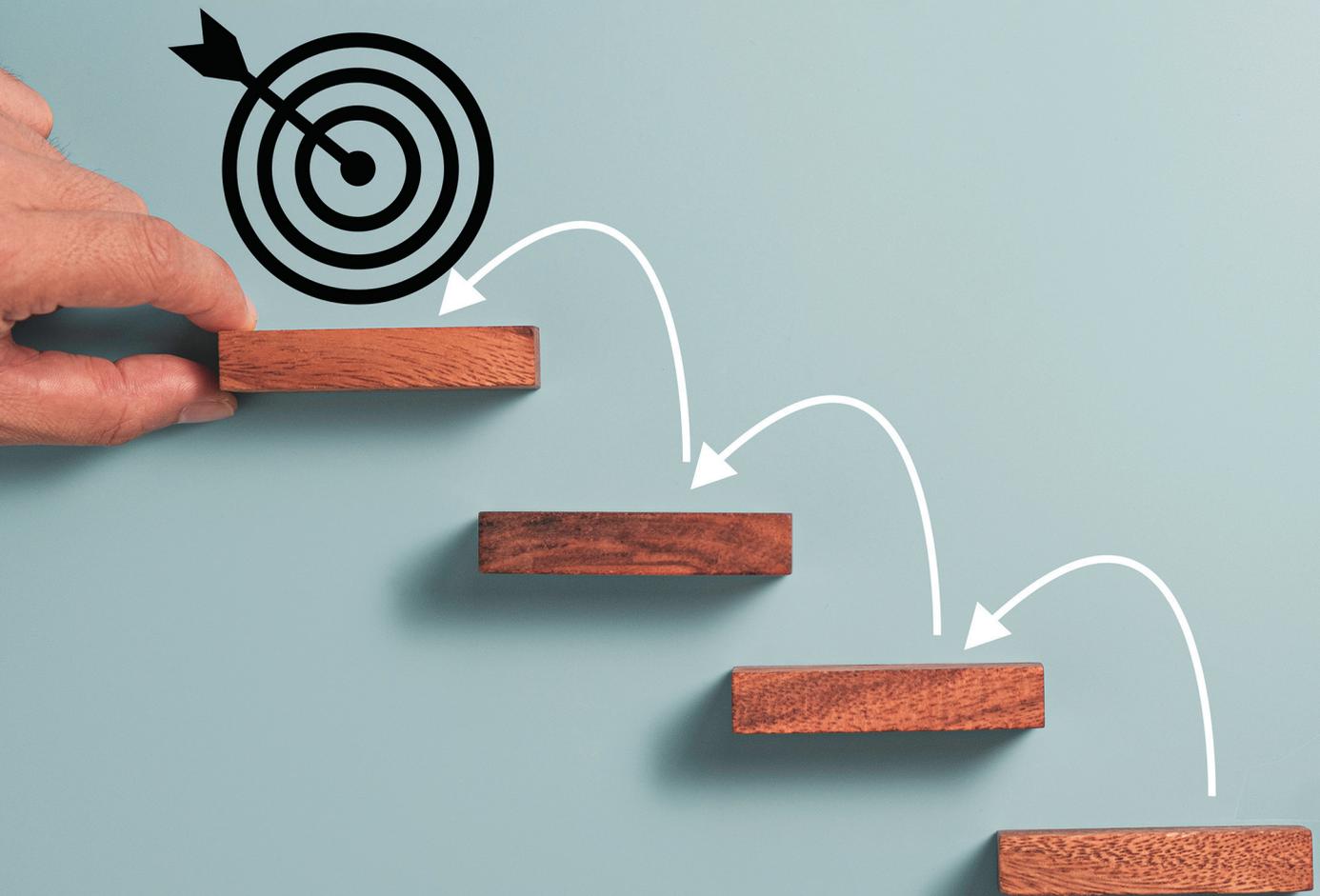
programs need not be isolated to large cancer centers and supports adoption of feasible practices to better support AYAs.

Amanda Parkes, MD, is a former assistant professor and director of the AYA Oncology Program at the University of Wisconsin Carbone Cancer Center and Cathy Lee-Miller, MD, is an assistant professor of pediatric hematology/oncology and director of the the AYA Oncology Program at the University of Wisconsin Carbone Cancer Center at the University of Wisconsin-Madison, Madison, Wisc.

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Quality Improvement Officers: Key Members of the Multidisciplinary Cancer Care Team



The concept of quality improvement (QI) in patient care dates back to Hippocrates of Kos, founder of ancient Greek medicine, who lived from 460 BC to 375 BC.¹ Over the centuries, pioneering figures have championed advances in systems of care, including:²

- Ignaz Semmelweis, the 19th-century obstetrician who championed the importance of hand washing in medical care.
- Ernest Amory Codman, a Bostonian surgeon who pioneered process-and-outcome measures to improve health safety and quality.
- Florence Nightingale, English reformer of modern nursing, whose use of basic sanitation and call to reduce human pain set standards for compassionate, patient-centered care.

In the early 20th century, American engineer, statistician, and scholar Dr. W. Edwards Deming introduced the idea of using statistics to improve quality control through systematic collection and assessment of data, emphasizing the value of total quality management.

To understand the role of QI as an integral part of cancer care today, *Oncology Issues* reached out to two experts in the field of quality and compliance. Hailing from Clearview Cancer Institute in Huntsville, Ala., Anne Marie Rainey, MSN, RN, CH, is the director of quality and value-based care, where she is responsible for quality initiatives' development, implementation, and monitoring, as well as advanced practice provider education initiatives. On the West coast, Amy Ellis was chief quality officer at Northwest Medical Specialties, a physician-run cancer care practice in Tacoma, Wash., before becoming the practice's chief operating officer (COO). As COO, Ellis is tasked with overseeing day-to-day operations, such as monitoring, strategizing, and implementing value-based care while improving quality of care for oncology patients and providers.

Clearview Cancer Institute

Not all who work in the field of oncology come from a cancer care background. That was the case with Rainey, whose background in government quality programming initially led her to oversee Health Insurance Portability and Accountability Act



Anne Marie Rainey



Amy Ellis

(HIPAA) policies and procedures at Clearview Cancer Institute as a government contractor. Over time, Rainey transitioned into the role of compliance and quality control officer at the institute, where she actively developed and organized facility policies and procedures, directed internal audit processes, and oversaw and maintained compliance programs. In her current position as the director of quality and value-based care, Rainey focuses on internal quality programming—whether directed by different departments or by the institute's physician board, in response to incidents or risk management needs, or as a component of value-based care models like the Center for Medicare & Medicaid Services' Merit-Based Incentive Payment System or Oncology Care Model (OCM).

“We have chosen to split my role, so we now have a dedicated compliance officer,” Rainey shared. “It’s hard to wear multiple hats in any situation, but compliance and quality are two very separate silos, [and] it was hard to jump between the two roles.”

When she first began at Clearview Cancer Institute, Rainey and one other staff member made up the quality and value-based care department. Eventually, as the institute grew, with enough demand for projects—both payer and internally driven—a third, full-time staff member was hired to create a dedicated department for quality control and a separate department for compliance. To justify non-reimbursed full-time equivalent positions, the practice determined it would be more cost-effective to absorb the cost by

hiring additional internal staff instead of paying great sums of money to external entities to perform the same roles—something the practice had been doing up until this point. “Because OCM was managed by the quality department, we were considered a revenue generating department,” Rainey says. “That was the argument that was made for the last five years or so because of the MEOS [monthly enhanced oncology services] dollars that came in and other performance-based payments that are potential revenue from programs we implement, oversee, and help run on a daily basis. We actually are revenue generating like many other departments or disciplines.”

In an effort to continue providing certain services at a high-quality level, Clearview Cancer Institute plans to take additional steps in implementing chronic care management and transitional care management. Although these initiatives are not comparable to MEOS, these services will provide a revenue stream, as well as much-needed services to its patients that align with the institute’s quality of care goals.

Northwest Medical Specialties

Amy Ellis has been in healthcare her entire working life. Before joining Northwest Medical Specialties, she worked at an outpatient radiology practice where one of her roles involved supporting the Northwest Medical Specialties practice and its radiology readings for oncology research, where patients enrolled in clinical trials had computed tomography scans to track the growth and response of cancerous tumors. “It was fascinating for me in my role in radiology to understand, here’s what they’re trying to do, and this is my role in it.”

Ellis experienced the devastation of cancer closer to home, having lost several family members to the disease, leading her to the realization that she wanted to be professionally involved in some aspect of oncology practice. “My first year at Northwest Medical Specialties was in the clinical research department, so that grew my passion for understanding the disease,” Ellis said. “Couple that with truly being impacted on a personal level, and it was a recipe for this is where I was meant to be.”

Ellis began her quality cancer care journey at Northwest Medical Specialties as a value-based care manager and, as the practice grew into additional programs and infrastructures, so did her role at the practice, where she transitioned to director of quality and value-based care, then chief quality officer, and currently as the practice’s COO. The practice is not only part of the OCM but also the American Society for Clinical Oncology’s Quality Oncology Practice Initiative and is certified by the National Committee for Quality Assurance. “For many years, even before my time here, the practice knew it wanted to go this [value-based care] route. Tracking [data] and the [reporting] requirements had a lot to do with it, but this was a long-term strategy the practice had put in place 10 years ago,” Ellis shared in response to whether her role was created in response to accreditation requirements. In addition to her role, the practice is staffed with a patient care coordination team, a value-based care manager, and a quality improvement coordinator. Like Clearview Cancer Institute, Ellis’s Washington-based practice relies on MEOS fees and other com-

mercial, value-based care models whose funds can be allocated to non-reimbursable staff positions.

QI in Action

To broadly address QI efforts, including staff involved in the initiatives, each practice has a distinct approach to internal quality issues. At Clearview Cancer Institute, a QI issue can get greater traction if the presenting issue is similarly perceived by multiple clinical staff. For instance, if the issue is provider related, the physician will take it to the board of physicians to determine whether it is worth investigating and addressing. “We’ll have everybody from our imaging center, lab, front desk, clinical staff, vitals, medical assistants, nurses, and physicians involved in the decision, but it depends on the project,” Rainey shares, adding, “Reimbursement is not always tied to these efforts, so we work in a different way to try to achieve buy-in from key stakeholders.” A group of advanced practice providers, nurses, and a representative from the quality department confirm the research and present it to the practice’s board of physicians, which can help find a solution.

At Northwest Medical Specialties, Ellis approaches QI efforts by holding monthly quality committee meetings with six to seven key staff to address emerging issues. The meeting lasts an hour, and the time is focused on defining root causes and strategizing the direction of the solution, after which staff will have breakout sessions to determine how to bring about an improvement. “We want the right people to be involved,” says Ellis. “I don’t want to make all the decisions because I’m not the one who, at the end of the day, is going to be delivering that care to patients.”

In both instances, Rainey and Ellis stress the importance of involving physicians who can advocate for and move issues forward. Ellis specifically identifies Sibel Blau, MD, medical oncologist and medical director at Northwest Medical Specialties, as a “partner in crime and physician champion of all things.” Rainey equally stresses the significance of involving a physician champion, particularly when researching and implementing new pilot programs.

Quality improvement touches multiple disciplines (e.g., physicians, nurses, social workers) and teams (e.g., IT, administration). Interdisciplinary and inter-departmental collaborations are key to successful QI intervention and implementation, as noted by both interviewees, and open dialogue is a key part of the process. “As quality professionals, we must be very open about communicating what we need from different departments to make an idea work, [especially] when the end goal is to improve outcomes for our patients and to benefit the clinic,” Rainey says.

In a successful inter-departmental scenario, the QI department can be the solid center of a well-oiled wheel, a resource other disciplines and departments can rely on to run a thriving, efficient program or practice. Nevertheless, some departments may be better at utilizing the QI department than others, at times necessitating QI officers to interject unsolicited intervention due to an occurrence or trend picked up in the data.

Ellis illustrated this by sharing an example of using tablets (e.g., iPads) at the front desk to administer a self-reported depres-

sion scale at Northwest Medical Specialties. Over the span of several years, it was noted that more and more patients struggled with or failed to complete the self-assessment questionnaire. To address the problem, it was crucial for staff from different disciplines to work as a team to bring about a different solution. “We had our value-based care manager, patient access specialists, nursing manager, and social workers involved in the conversation, because it’s [the solution is] going to touch several hands to make its way to the final product.”

Using data analysis and working as a team, the practice determined that technology was the key barrier in this instance, and changes were made to address patient needs. The assessment was switched to the back office, where medical assistants administer the questionnaire while rooming patients. “We now complete the distress and depression screening in the EHR [electronic health record],” Ellis says. “It’s a note template in our EHR, and we are having huge success, even though we struggled for five years to get a really solid process in place.”

Data collection and analysis are central elements of successful implementation in quality improvement. Clearview Cancer Institute under Anne Marie Rainey and Northwest Medical Specialties under Amy Ellis both rely heavily on plan-do-study-act cycles (a four-stage, problem-solving model used for improving a process or carrying out change) because it is simple, efficient, and cost-effective. “We have looked into other tools, like Lean Six Sigma,” shares Rainey. “But those require a significant monetary investment that’s not feasible for us.” Ellis concurs, adding, “There are fishbone diagrams to understand a root cause, but I’m not using fishbone diagrams weekly.”

Rainey and Ellis both endorse the use of dashboard data. Ellis additionally utilizes annual Hutchinson Institute for Cancer Outcomes Research reports³ through the Fred Hutchinson Cancer Center in Washington, and Rainey shared that Clearview Cancer Institute has recently added Microsoft Power BI⁴ to report data more frequently to stakeholders.

How Can the Association of Community Cancer Centers Support QI?

The Association of Community Cancer Centers (ACCC) is the leading education and advocacy organization for multidisciplinary cancer care teams, offering a wide range of education projects that could be considered quality or process improvement initiatives. But how can ACCC ensure that the right person at its busy member practices and programs receive this information? Ellis and Rainey provided invaluable input to help answer this question.

Ellis suggests possible modifications to the current ACCC website layout to make it easier for quality improvement staff to navigate educational resources without getting overwhelmed by the plethora of information available on the website. “I want the page to speak to them,” Ellis says. “It would be helpful if there was an easy menu for care teams, the in-the-trenches team members, with a specific bulleted hub for them to access resources.”

Chair of the ACCC Education Committee, Rainey agreed with Ellis’s suggestion, adding, “Anytime I see education that’s

available for free and [that] can benefit someone in our clinic, I’m automatically sending it on to the next person.”

Rainey frequently participates in ACCC-led educational programs, as does Ellis, who also an ACCC board member. Because of their existing relationship with ACCC, Ellis and Rainey encourage participation in experiential education programs by staff at their respective oncology practices.

To reach oncology professionals unfamiliar with ACCC educational programming, Rainey suggests being more forthright with self-promotion. “If I’m looking at a specific program, testimonials [from other oncology professionals] would sway my decision to give it a listen.”

But not all cancer programs or practices are interested in participating in pilot or value-based programs. The misconception, according to Ellis, is not realizing that there are resources across the board but instead focusing on, “How will that benefit us and our practice?” Ellis suggests marketing materials outline the target audience, highlight key takeaways, and identify benefits to participating. “It could be beneficial to point out resources that can be shared with staff as they’re trying to learn about oncology topics because we are constantly challenged to find oncology-experienced team members.”

Closing Thoughts

The overall aim of quality improvement in healthcare is to deliver high-quality care to patients through a well-managed, high-functioning system aimed at improving the overall quality of life in the general population. By providing appropriate resources and skills needed to overcome barriers, a systematic and coordinated approach is necessary to bring about measurable improvement. “The system is by no means perfect,” confides Ellis. “If you want to fix something in healthcare, there has to be resources, including financial resources, to support those changes.”

The potential to create successful healthcare delivery services is a reward unto itself, particularly for those working in the field of quality improvement. Though the work can be painstaking and time consuming, juggling multiple disciplines and departments while managing daily challenges, the work itself is unique in that it can contribute to improving quality of life for patients. Rainey puts it succinctly: “We have an opportunity to make someone’s day better and potentially make the outcomes of their health better by some of the projects that we work on. That’s what keeps me going every day.”

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Time to Get Screened!



A snapshot of COVID-19's effect on cancer screening in the United States

Early in the first COVID-19 surge of 2020, National Cancer Institute (NCI) Director Ned Sharpless warned that the pandemic could, over time, have substantial consequences for cancer outcomes. The NCI's initial modeling suggested that delayed or missed screening and treatment for breast and colorectal cancers could, over the next decade, account for an approximately 1 percent increase in deaths (i.e., an additional 10,000 deaths) from these two cancers.¹

A year and a half later, as the United States healthcare system continued to grapple with COVID-19 spikes and pandemic fallout, keynote speaker Debra A. Patt, MD, PhD, MBA, FASCO, presented her perspective on the road to recovery at the Association of Community Cancer Center's (ACCC) 38th [Virtual] National Oncology Conference in November 2021. Dr. Patt is lead author of a 2020 study examining the impact of the COVID-19 pandemic on cancer screening rates and evaluation and management services among older adults in the United States.² At the time of the study's publication (November 2020), the authors noted that disruption in screenings had continued for a minimum of six months, and most screening rates remained "diminished." In her ACCC conference remarks, Dr. Patt stressed the critical need for continued focus on cancer screenings and outreach education as the oncology care community strives to bring screening rates back to pre-pandemic levels.

For an on-the-ground perspective of how cancer programs' screening and outreach education programs were recovering from pandemic pressures, *Oncology Issues* spoke with four cancer programs around the country.

For 20 years, Mary Bird Perkins has provided education, prevention, and early detection programs to people in their home communities. In addition to a robust schedule of community events, the program features two year-round mobile medical clinics that offer free screenings for five different cancer types.

A Louisiana Perspective

During the past two years, Louisiana weathered four significant COVID-19 spikes. In July 2021 Louisiana had one of the worst COVID-19 infection rates in the country, pushing the state's healthcare resources to the limit.³ Then, in August 2021, Hurricane Ida hit southeastern Louisiana hard, with some of the storm's worst devastation affecting Terrebonne, Orleans, Jefferson, and St. John Parishes—while areas adjacent to Baton Rouge also suffered extreme damage. *Oncology Issues* spoke with Renea Duffin, MPA, vice president, Cancer Support and Outreach, Mary Bird Perkins Cancer Center, Baton Rouge, La., and here's what she shared.



Mary Bird Perkins mobile medical clinics bring free cancer screening into the communities it serves.

Duffin provided an update on “Prevention on the Go,” the organization’s award-winning screening initiative designed to reach medically underserved communities in the region. The long-standing program brings education on cancer prevention and screening services to Louisiana communities—a critical service in a state with the seventh highest rate of cancer mortality in the U.S.⁴ In 2016, ACCC recognized the program with an ACCC Innovator Award.

Mary Bird Perkins Cancer Center collaborates with various healthcare partners to deliver comprehensive, quality cancer care. For 20 years, Mary Bird Perkins has provided education, prevention, and early detection programs to people in their home communities. In addition to a robust schedule of community events, the program features two year-round mobile medical clinics that offer free screenings for five different cancer types. A third mobile unit is scheduled for delivery in summer 2022 to serve the program’s increasingly expansive service area. When an abnormal finding is identified, each patient receives follow-up from a patient navigator who helps eliminate barriers along the care path.

In 2016, through an employer grant, Mary Bird Perkins Cancer Center was able to expand the reach of its cancer prevention education to bring the mobile screening units to workplaces through its “Prevention on the Go” program. In addition, the community component of this initiative received a three-year grant from the Blue Cross and Blue Shield of Louisiana Foundation in 2020 to provide community screening and education to 12 parishes in rural northeast Louisiana.

All of these accomplishments are achieved with a relatively small staff that includes a director, nurse navigator, two outreach coordinators, two regional managers, and one workplace program coordinator.

Duffin counts among the key features of the early detection program that currently serves 30 Louisiana parishes and four southwest Mississippi counties:

- A community-based, 12-month delivery model
- Patient navigation that streamlines the process for patients and ensures follow-up of abnormal findings
- The use of national tools that monitor health outcomes by ZIP code
- Partnerships that minimize duplication and maximize smooth transitions along the care continuum.

Impact of COVID-19 on the Early Detection Program

In mid-March 2020, Mary Bird Perkins Cancer Center—like other health facilities caring for patients with cancer—swiftly adapted to COVID-19 public health emergency restrictions and requirements. As a consequence, the outreach and screening program was paused, the mobile medical units were closed, and community events were cancelled. During this period, when program staff could not travel out into the community, they regrouped, planning how best to adapt their services so that both providers and patients would be as safe as possible when screening could resume.

By July 2020, the mobile screening program was back in business—but on a more limited scale. COVID-19 safety precautions included limiting the screenings to breast, colorectal, prostate, and skin cancers. Oral cancer screenings were halted as a safety precaution. The program transitioned from a first-come, first-served basis to appointments only. When scheduling an appointment, staff would help participants complete the necessary paperwork electronically. Using a wait-list app, patients would stay in their cars until the app notified them to come to the mobile clinic unit for their appointment. No more than three individuals were permitted on the unit at one time: the patient, a nurse practitioner, and a patient navigator. The mobile medical units were equipped with air purifiers and personal protective equipment for staff, and everyone was required to be masked. To allow for thorough cleaning between each patient screening, more time was allotted between participant appointments. As a result, fewer patients were screened per day.

Screening Rates Drop

In 2020, Mary Bird Perkins Cancer Center saw an overall 30 percent decline in screening events and a 47 percent decline in screening participation compared to the previous year. The cancer center conducted 6,710 cancer screenings in 2019, a number that dropped to 3,585 in 2020. Today, screening numbers are beginning to recover. As of October 2021, year-to-date cancer screenings at Mary Bird Perkins totaled 3,786, Duffin said.

Looking at breast cancer screenings, in 2019 “Prevention on the Go” performed 2,322 breast cancer screenings and diagnosed 68 new cases of breast cancer. In 2020, the outreach and screening program screened 1,321 patients. As of October 2021, breast cancer screenings had climbed to 1,359. “The numbers are slowly beginning to tick back up,” Duffin said.

“Now, the interesting thing is that our number of cancer diagnoses did not diminish even though the number of participants diminished,” Duffin said. “In 2019, we diagnosed 68 [breast] cancers. In 2020, even though we only screened 3,585 [individuals], we diagnosed 42 cancers. Thus far in 2021 [October], we’ve

already diagnosed 31 cancers, with a number of other screening participants with abnormal findings still in follow-up.”

Engaging the Community

Duffin praised the work of the cancer center’s marketing and communications team for “doing an outstanding job of helping us promote our screening events...through social media, digital billboards, print ads, radio spots, and even television. We just finished a number of our large-scale Live Well events within the last 6 to 8 weeks [in September and October]—Live Well Ascension, Live Well North Shore, and Live Well Bayou,” Duffin said. “We did billboards for those as well as early morning news shows to make people aware. That really gets the message out to people.”

“On November 6, 2021, we held our Live Well Bayou event in Houma,” Duffin continued, “which was hard hit by Hurricane Ida.” Duffin explains that the hurricane and its aftermath resulted in cancellation of several screening events for that area as “people were focused on trying to rebuild their lives.” But by getting the word out about the rescheduled screening event, Duffin says her team did 193 screenings on that one day alone.

Mary Bird Perkins uses communication strategies to cast a wide net for its screening events. “A multi-channel approach is your best option when it comes to trying to reach as many people as possible,” said Scott Miller, communications director at Mary Bird Perkins Cancer Center. “We are targeting the underserved, but we also know there are people who have insurance who are not getting screened because of different barriers. So while we work to target communications as much as possible, we often take a mass media approach. We use all of the channels at our disposal for messaging.”

At the same time, Duffin emphasizes that relationship building and commitment over time are integral to community engagement and establishing trust. “Because we have been doing this for so long, people know who we are,” said Duffin. “They recognize us and trust us to do it [cancer screening] for them. We have so many of our participants that come year over year. And some members of our team have been doing this for so long, participants look for them. They know them by name when they call to schedule their appointment.”

Grassroots and word-of-mouth outreach is invaluable, Duffin says: “Once you become a trusted provider and you have reached influencers within the local communities, people are going to come to you. And the fact that we go out to them is even more meaningful. They don’t have to come to a brick-and-mortar facility for screening. We go into their communities and provide the service to them.”

In 2021, Mary Bird Perkins hit a milestone with more than 100,000 free cancer screenings provided, thanks to generous community support.

In the final months of 2021, the pandemic took another turn with the dawn of the omicron variant. Much more transmissible than the once-dominant delta variant, omicron swept through communities, packing hospitals worldwide. Even then, Mary Bird Perkins’ early detection program for the medically underserved continued to navigate the rocky terrain of the evolving

pandemic to bring early detection services to as many vulnerable people as possible.

Perspective from Kentucky

Next, *Oncology Issues* checked in with ACCC Cancer Program Member St. Elizabeth Healthcare in Kentucky.

Lung cancer is the leading cause of cancer deaths in the United States, accounting for nearly one-quarter (23 percent) of cancer deaths in 2019.⁵ For those at high risk for lung cancer, screening with low-dose computed tomography (LDCT) is a chance to detect disease at an early stage, when there are the most options for treatment and a potential for cure. Since 2013 the United States Preventive Services Task Force has recommended LDCT screening for lung cancer for specific at-risk patient populations. Despite this, national lung cancer screening rates are suboptimal. One recent study looking at data from 2016 to 2018 estimated that during that period fewer than 1 in 20 adults eligible for LDCT lung cancer screening received it.⁶

But there are outliers. Take Kentucky, for example. The Bluegrass State has achieved the second highest screening rate in the nation between 2019 and 2020—17.7 percent of Kentucky’s eligible patient population received LDCT lung cancer screening.⁷ This accomplishment is the result of a state-wide focus on lessening Kentucky’s disproportionate burden of lung cancer. The state has the highest incidence rate of lung cancer in the United States at 89 per 100,000 people⁸ and the highest age-adjusted lung cancer death rate.⁹ In 2018, about 23 percent of Kentucky adults (aged 18 and older) reported being individuals that smoke, compared to a national rate of 14 percent.¹⁰

Michael Gieske, MD, director of Lung Cancer Screening for St. Elizabeth Healthcare, is passionate about improving lung cancer screening and outcomes. A primary care physician and Kentucky native, Dr. Gieske leads a nationally recognized program, which received designation from the GO₂ Foundation in 2020 as a Care Continuum Center of Excellence.

Over the past eight years, St. Elizabeth’s Lung Cancer Screening Program has played an integral role in improving lung cancer screening rates in the state of Kentucky, Dr. Gieske said. “We’ve worked with the University of Kentucky through the KY LEADS Collaborative, a state-based research project aimed at improving the quality of lung cancer screening in Kentucky, and we work closely with the Kentucky Health Collaborative.” The latter comprises 10 hospital systems that encompass more than 70 hospitals and imaging centers. “Through that work we’ve helped to increase adherence with lung cancer screening. We’re looking very specifically at improving screening rates across our state right now.”

St. Elizabeth Healthcare’s stated mission is to improve the health of the communities it serves. In partnership with St. Eliz-



Michael Gieske, MD

abeth Physicians, a multispecialty physician group organization of 451 physicians, 244 advanced practice providers, and 1,500 non-provider associates, the health system delivers care to more than 380,000 patients in Kentucky, Indiana, and Ohio. The integrated network operates 6 hospitals and 169 St. Elizabeth physician specialty and primary care clinics. Lung cancer screening is offered in eight locations: Covington, Edgewood, Florence, Fort Thomas, Grant County, Herbron, and Owenton, Ky.; and Dearborn, Ind. The St. Elizabeth Healthcare Lung Cancer Screening Program participates in the White Ribbon Project, which seeks to raise awareness and to destigmatize lung cancer.

Dramatic V-Shaped Recovery

Oncology Issues asked Dr. Gieske to share his perspective on how the shifting circumstances of the COVID-19 pandemic may have affected the progress achieved through this highly successful, comprehensive cancer screening program.

In March 2020, St. Elizabeth's lung cancer screening program—like others around the country—saw a significant impact from the pandemic's initial surge. "At that time the program was providing about 350 to 400 LDCT screenings for lung cancer per month," Dr. Gieske said. With the restrictions mandated by the national public health emergency, LDCT screening dropped precipitously—13 LDCT lung cancer screens were performed in April 2020. The program rebounded quickly, however. "Once things started to return to some semblance of normalcy, we had a pretty dramatic V-shaped recovery," said Dr. Gieske. "We ended up finishing the year down just 5.8 percent in 2020 compared to what we had done in 2019. Looking at total volume of screens, we finished just shy of 4,000 screens for the year [in 2020]."

Despite the relentless uncertainty of the COVID-19 pandemic during 2021, St. Elizabeth Healthcare has seen a "significant resurgence" in cancer screening rates, Dr. Gieske said. He credits St. Elizabeth's capacity to rebound successfully to multiple factors. "We really have gone after a lot of our outstanding orders," Dr. Gieske explained, "and we've tried to impress on our patients in the community and our providers that we are returning to normal screening." With cancer screenings a system-wide priority, St. Elizabeth continues to urge patients to come in for their screening appointments. "We have a very robust program, and we're averaging 500 screens per month now," he said. The lung cancer screening program completed its 20,000th lung cancer screen at the end of November 2021.

Outreach with Multiple Touchpoints

"Taking advantage of multiple touchpoints is key," Dr. Gieske said. As was the case for the outreach and screening program at Mary Bird Perkins Cancer Center in Louisiana, the marketing team at St. Elizabeth was instrumental in spreading the word about lung cancer screenings. This included promoting cancer screening on the health system's website, communicating to patients about the COVID-19 safety precautions in place, and reaching out to the St. Elizabeth provider network. "We have a leadership meeting every month where all the managers and directors get together," explained Dr. Gieske. "Once you get the word out to that team, they get the word to their providers and

medical assistants as well. And there is also a lot of communication with our providers through either primary care leadership or through all-provider meetings."

Dr. Gieske is an advocate for engaging and involving primary care physicians from the start to develop a successful lung cancer screening program. "I'm a huge proponent of primary care input and influence, involving primary care in the process, and identifying a primary care champion for the program," he said. At the start of the lung screening process, Dr. Gieske supports a "fairly decentralized" approach, so that any provider (primary care, advanced practice provider, pulmonologist, or specialty care provider) can order the screening test. But once that test is ordered, the process transitions to a more centralized, programmatic path for managing scans and incidental findings.

A key component of this comprehensive multidisciplinary approach is nurse navigation. "We've had navigation in place at St. Elizabeth for four years," said Dr. Gieske. "If a patient presents with a lung cancer screen with a lung-RADS category 4 [i.e., highly suspicious], they are presented to our nodule review board, which meets every Monday morning at 7:00 am. If the radiologist sees something suspicious on either an incidental or a symptomatic scan, the scan is tagged [in the electronic health record with] code 'lung management,' and the patient's scan is included for nodule review on Monday morning."

An early challenge was getting buy-in and gaining the confidence of the primary care community and specialty providers. "That was a little bit of a culture change," Gieske acknowledged. "We encourage our providers, once that test has been ordered, to let the nodule review board, the panel of experts, and the nurse navigators take the reins on the care and the direction of that patient. At this point, we have gained the confidence and buy-in of our providers. We encourage them to take their hands off the wheel and allow a programmatic approach for these patients; especially patients with scans categorized as lung-RADS 4 or a significant nodule detected through the incidental or symptomatic pathway."

By the Numbers

At St. Elizabeth Healthcare, screening rates for breast cancer have not yet returned to pre-pandemic levels, Gieske noted. In contrast, screening rates for colon cancer have continued to improve year over year from 2018 through 2021 (see Table 1, right).

Among the factors that may account for the slower return to pre-pandemic breast cancer screening rates are patients' fear of coming into health facilities during the pandemic. One side effect of a patient's immune system response to the COVID-19 vaccination may be temporary swelling of the lymph nodes under the arm that received the shot. For that reason, the Society for Breast Imaging issued screening mammograph recommendations for women receiving the COVID-19 vaccine, which recommends that patients try to schedule their routine screening mammograms either before the first vaccination shot or four to six weeks after their last shot.¹¹ This, too, may account for some delays in routine breast screenings.

Remarkably, St. Elizabeth Healthcare has achieved a steady increase in colon cancer screening rates over the past four years.

Table 1. St. Elizabeth Health Care Screening: 2018-2021

Percentage of Eligible St. Elizabeth Patient Population Screened*			
Year	Lung	Breast	Colon
2018	N/A	68	63
2019	36	77.6	73
2020	29.3	72.4	74.2
2021 year-to-date October	33.5	63.4	71.8
2021 Est.	40.4	67.3	74.4
National ^{1,2,3}	6.51	66.7	68.8

*The “eligible St. Elizabeth patient population” is specific to patients in the St. Elizabeth Healthcare system who are attributed to primary care physicians in St. Elizabeth Healthcare who meet the 2015 Centers for Medicare & Medicaid Services criteria as determined in the electronic health record.

1. Fedewa SA. Chest. Aug. 3, 2021. doi:10:1016/j.chest.2021.07.030
2. CDC Health, United States, 2019;Table 33.
3. cdc.gov/cancer/colorectal/statistics/index.htm

“In 2018, we were at 63 percent [of the eligible St. Elizabeth patient population screened],” said Dr. Gieske. “In 2019, we increased to 73 percent, and in 2020, we increased that to 74.2 percent—despite the pandemic.” Improving colon cancer screening is a system-wide priority for St. Elizabeth Healthcare. The successful increase in colon cancer screening may be attributable, in part, to the health system-wide uptake of non-invasive Cologuard tests and fecal immunochemical tests that do not require individuals to come into a facility for screening, Dr. Gieske said.

The team-based approach implemented for the lung cancer screening program is now being adapted to mammography and colorectal cancer screening, along with a centralized process for outreach data collection. Under the umbrella of the health system’s value-based performance team, in August 2021, St. Elizabeth’s established an eight-person full-time team of nurse outreach specialists. By the conclusion of 2021, through this outreach, order completions total included 2,554 mammograms, 1,759 LDCT lung cancer screens, and 1,815 Cologuards, Dr. Gieske said. Each outreach effort is documented in the patient’s electronic health record. For example, a nurse may make note that an appointment is scheduled, the patient refused screening, the nurse left a message, etc.

Data on outreach results will be used to guide future screening approaches. “It’s a very orchestrated approach, and it’s going to be integral to making sure patients don’t fall between the cracks,” Dr. Gieske said. “If you schedule a patient with an appointment and you get them plugged into the system, it’s much more likely

they’ll come in for screening than if you hand them a phone number and say, ‘Call this number and schedule your appointment for a lung cancer screen.’”

A Delaware Perspective

At the end of 2021 Delaware—and many other states—saw its COVID-19-positive cases on the rise precipitously with the influx of the omicron variant. Like many hospitals nationwide, ChristianaCare in Wilmington, Del., began to experience “extraordinarily high” patient volumes and announced, “temporary postponement of some non-urgent surgeries and procedures.”¹²

When the state’s annual cancer report was released in October 2021, Secretary of the Delaware Department of Health and Social Services Molly Magarik stressed not only the importance of early screening and prevention but also her concern over the pandemic’s impact. “The data show us clearly that early screening and prevention are critical for bringing down cancer mortality rates,” said Magarik in a statement. “Unfortunately, the COVID-19 pandemic has caused many people to delay cancer screenings and other preventive chronic disease care, and economically disadvantaged communities are typically impacted the most.”¹³

The 2021 *Cancer Incidence and Mortality in Delaware, 2013-2017* report, produced by the state’s Division of Public Health, found that Delaware had the nation’s 15th highest cancer mortality rate in all cancer sites combined, unchanged from the state’s 2020 report.¹³ Despite this, Delaware is achieving progress in curbing cancer incidence and mortality rates. Comparing the periods 2003 to 2007 and 2013 to 2017, all-site cancer incidence rates decreased for most of the state’s demographic groups. Non-Hispanic Caucasian males, non-Hispanic African American males, and Hispanic males saw incidence declines of 12 percent, 22 percent, and 12 percent, respectively. Among female state residents, Hispanic women saw a 9 percent incidence rate decrease, and non-Hispanic Caucasian females and non-Hispanic African Americans saw increases of 3 percent and less than 1 percent, respectively. During the same period, there was a 26 percent decline in the all-site cancer mortality rate among non-Hispanic African American men and a 16 percent decline among non-Hispanic Caucasian men. Female all-state cancer mortality rates decreased 12 percent among non-Hispanic African Americans, 15 percent among non-Hispanic Caucasians, and 12 percent among Hispanic females.

Acting Locally

The Delaware Cancer Consortium, created by the state’s legislature in 2001, unites health, civic, government, and community-based stakeholders in statewide action to reduce the burden of cancer. The consortium focuses on overcoming barriers to cancer screenings, delivering affordable cancer treatment, and educating people about health risks and harmful behaviors to reduce cancer risk. An overarching consortium goal is to “aggressively promote screenings” for five cancers: breast, cervical, colon, prostate, and lung.¹⁴ Underpinning this goal is the aim to reduce the number of cancers diagnosed at a late stage. The Delaware Screening for Life program is integral to the consortium’s mission. The program,



Nora Katurakes, RN, Outreach Manager, talks to City of Wilmington employees about the importance of cancer screenings.



Helen F. Graham Cancer Center Community Health Outreach team handing out educational materials at an American Cancer Society breast cancer awareness event.



Charlene Marinelli, RN, Outreach Nurse and cancer survivor, with Luisa Ortiz-Marquez, Outreach Manager and cancer survivor, provide information on the importance of mammograms at the American Cancer Society's Making Strides for Breast Cancer event.

a cooperative effort of the Delaware Division of Public Health and the U.S. Centers for Disease Control and Prevention, provides free cancer screenings to eligible state residents. Nora Katurakes, RN, MSN, OCN, manager of Community Health Outreach and Education at the Helen F. Graham Cancer Center & Research Institute, has served on the consortium's Early Detection & Prevention Committee since its foundation.

With COVID-19 public health emergency restrictions and multiple studies revealing the unequal burden of the pandemic on the nation's most underserved and vulnerable populations, it is no surprise that COVID-19 had a significant impact on the Delaware Screening for Life program's screening rates from 2020 to 2021. "During that time period, we saw a 68 percent decrease in the number of cervical cancer screenings performed in [comparison to] the same time frame in 2020," said Nicholas J. Petrelli, MD, FACS, the Bank of America endowed medical director at the Helen F. Graham Cancer Center & Research Institute at ChristianaCare Health System. "From March 2020 to February 2021, colorectal cancer screenings decreased 73 percent and breast cancer screening dropped 58 percent. Now we're catching up with those [screenings], and that's pushing up the volume."

Turning Screening Rates Around

The Community Health Outreach and Education team at the Helen F. Graham Cancer Center & Research Institute at ChristianaCare is going all out to encourage return to cancer screenings and to dismantle barriers to care access. Community connections and engagement are at the core of the health system's commitment to improve cancer early detection and outcomes. Founded in 1998, the program is staffed today by eight full-time nurse navigators/educators who work closely with community-based stakeholders, including an active group of volunteer *promotoras* (lay community health workers in Spanish-speaking communities). Because relationships with diverse communities have strengthened and expanded over the years, the cancer center and health system are known and trusted providers. Bringing culturally appropriate health information and education into the underserved communities where people live and work is key to this thriving, innovative team. During the past months, however, the pandemic has shuttered most of the program's highly successful in-community events.

"But we didn't just stop," Katurakes said. "We needed to keep moving, and so we went back to some programs that we already had in place. We had to adapt." Pivoting in response to the communities' needs, the Outreach and Education team has taken cues from the communities it serves on how best to disseminate the information that the community is seeking. One example is the Health Outreach and Education Spanish-language Facebook page, which has more than 300 followers. With support from ChristianaCare's marketing and communications staff, the outreach and education team posts and responds to the concerns and questions of community members. During the pandemic's surges, many questions are understandably centered on COVID-19 and related health concerns. "If someone in the community needs information, they will message us," said Katurakes. "They may ask, 'How do I get my [access to] the Screening for Life



Helen F. Graham Cancer Center & Research Institute

back?’ or ‘How do I get my insurance [coverage] back?’” The outreach and education staff are a known source of reliable, accurate information for the community. To connect with as many individuals as possible, the team reaches out to specific communities. For example, to serve the Asian community, the outreach navigator connects with people via the WeChat social platform, which has more than 500 participants, Katurakes said.

But growing these relationships takes time, Katurakes cautions. “You have to build trust over years, not just in a week. These were relationships [developed] before COVID, and now they are continuing. We’ve elevated them and—during COVID—we’ve been communicating about vaccines, back-to-screening, and re-enrolling in the Marketplace.”

Keeping Momentum Going

Over the past 15 years, Delaware achieved remarkable success in reducing the state’s colorectal cancer incidence and mortality rates. Comparing the periods 2001-2005 to 2011-2015, the state saw a 30 percent decrease in the colorectal cancer incidence rate (greater than the 22 percent drop nationally).¹⁵ Importantly, Delaware has also been closing the disparity gap in colorectal cancer mortality rates. Comparing the years 2003 to 2017 to 2013 to 2017, data show a 37 percent decrease in colorectal cancer mortality rates among non-Hispanic African American males, compared to 20 percent among non-Hispanic Caucasian males.¹⁶ Further, in 2016, Delaware had the 12th highest colorectal cancer screening rate in the United States.¹⁵

Preventing the pandemic from upending this progress is top of mind for ChristianaCare and the Delaware Cancer Consortium. To keep the momentum going, ChristianaCare executed a long-planned colorectal cancer awareness campaign from July through December 2020. As part of this outreach, the health system debuted a new online colorectal cancer risk assessment tool, which was widely promoted via social media. The free tool gen-

erates an individual report that indicates low, medium, or high risk for colorectal cancer and encourages consumers to share their results with their primary care provider. Those identified at high risk can ask for follow-up from the cancer center’s outreach oncology nurse navigator. Also included are ChristianaCare and community resources for quitting tobacco use, finding a provider, and information on how to contact the nurse navigator.

ChristianaCare’s campaign and navigator outreach resulted in 422 completed assessments, of those, 333 individuals were identified as at risk, of whom, 97 agreed to be contacted by a nurse navigator for follow-up. The campaign was repeated in March 2021 for Colorectal Cancer Awareness Month. Christiana employees were included in screening outreach through the Caregiver Connect mobile application.

Describing the Delaware cancer screening experience in “The Cancer Letter” on Feb. 5, 2021, Dr. Petrelli, Nora Katurakes, and colleagues wrote: “As a result of COVID-19, we found individuals sometimes felt the need to reschedule or change their choice of screening option. The key,” they said, “is to have a reliable contact to help navigate through these COVID times and not stop screening.”¹⁷

Business, Not as Usual

Katurakes explains that as the outreach and education staff move forward in the still shifting context of COVID-19, they’ve been able to re-start a few community events, conduct virtual programs, and once again engage *promotoras* in educational activities. Among the established programs the Outreach and Education team conducted in fall 2021:

- “The Story of Brenda,” an education program focused on triple-negative breast cancer and health equity.
- Two community breast screening events, including one that brought 25 local senior center participants to the cancer center for mammograms.



ChristianaCare's Facebook campaign helped connect people to a new online risk assessment.

- A “pop-up” oral screening event. Katurakes explained: “We had postponed our mouth and throat cancer screening last year because of COVID. So we decided to do what I’m calling a ‘pop-up event.’ For this, we worked with our transitional housing shelters in the city of Wilmington and with our Department of Maxillofacial Surgery and Hospital Dentistry.”

Katurakes said her team went to the shelter for transitional housing, where they screened nine women. Most are smokers, and two of them needed follow-up. “It doesn’t matter how many you reach,” said Katurakes. “People need help. These are women who need help to quit smoking and also need follow-up—one for thyroid and one for thickening in the mouth. So we’re going to continue that type of pop-up oral screening and move it to two of the other shelters next year.”

As the return to screening continues to ramp up—capacity can be a challenge, said Katurakes. “We’ve found that whether it’s lung screening or breast screening—and somewhat for colonoscopy—there might be a delay in getting in and that delay can vary.” This is despite the health system expanding hours to include evening and Saturday appointments. “People want to go where they’re familiar, and they have a great trust of our healthcare system,” said Katurakes. “So we want to accommodate them.”

Given the apparent staying power of COVID-19, Katurakes adds that providers need to adjust community health outreach rather than shut it down: “You can continue to do the work you’re doing; we just need to be mindful. We can’t just stop living. We just have to follow protocol. We’re going to have to learn how to live with the COVID in our community.”

Perspective from Northern Michigan

Over the past 18 years Michigan has seen an overall downward trend in all-site cancer incidence.¹⁸ Prostate cancer is the most commonly diagnosed cancer among Michigan men, and breast cancer is the most commonly diagnosed cancer in women. Lung cancer is the leading cause of cancer death in the state. State-wide cancer control priorities target breast, cervical, colorectal, and lung cancers due to the burden of these diseases in Michigan. In its 2020 report on cancer in Michigan, the state Department of Health and Human Services highlighted “identifying and eliminating disparities within the cancer care continuum” as a state-wide priority.¹⁸ Data show disparities among diverse and marginalized Michigan populations in incidence and outcomes for colorectal, prostate, breast cancer, and lung cancers.¹⁸

Among U.S. states, Michigan ranks 20th for incidence and 15th for mortality for lung and bronchus cancer.¹⁹ According to the most recent American Lung Association (ALA) State of Lung Cancer report, 8 percent of Michiganders at high risk for lung cancer (United States Preventive Services Task Force 2013 recommendation criteria) were screened, significantly higher than the national rate of 6 percent.¹⁹ However, the ALA reports that smoking rates in the state are greater than the national rate of 15 percent, and the rate of lung cancer diagnosed at an early stage is lower than the national rate.¹⁹ The population of Indigenous peoples (American Indians/Alaska Natives) in Michigan has the highest rate of new lung cancer cases, 110 per 100,000 population.¹⁹ The ALA report notes that among Indigenous peoples in Michigan, 16 percent of lung cancers are diagnosed at an early stage, compared to the 23 percent early-stage diagnosis rate in the state’s White population.¹⁹

COVID-19 Arrived Late in Northern Michigan

Michigan’s two-peninsula geography is unique—southern Michigan includes the Detroit metro area (home to about half the state’s population) and most of the state’s larger cities, whereas northern Michigan is more sparsely populated and largely rural. Bordering on four of the five Great Lakes, Michigan is renowned for its inland lakes and unspoiled wilderness areas—most famously in the Upper Peninsula. Scenic areas of spectacular natural beauty and abundant recreational opportunities make northern Michigan a vacation and tourist mecca. Traverse City, located in lower northern Michigan, is home to Munson Healthcare, a relatively young healthcare system that serves a 30-county area. “Our population in the Grand Traverse region is about 200,000 and grows seasonally to 300,000,” explained Kathleen LaRaia, executive director of Oncology Services, Munson Healthcare, “but during the summer it attracts over a million tourists annually.” Munson Healthcare is a system of nine community hospitals located throughout northern Michigan.



Kathleen LaRaia

In response to the federal public health emergency, Michigan instituted COVID-19 safety protocols in March 2020. At that time, COVID-19 rates were surging in Detroit and some areas of the more populous southern part of the state; however, the pandemic was not yet affecting the Grand Traverse region and the more rural north-

ern areas, LaRaia said. Munson Healthcare followed state protocols and was “very proactive,” she said. “We stopped all of our elective surgeries, mammography screening, colonoscopies, low-dose CT scans.” In short, all of the usual pathways to cancer screening in the health system were halted. At the end of May 2020 the area had not yet experienced a COVID-19 surge and cancer screening services were reopened, LaRaia said. Before Munson could resume mammography and other cancer screening services, however, appointment schedules had to be reconfigured to allow more time for cleaning and social distancing, staff workflows had to be adjusted as hours were extended, plexiglass had to be installed in the reception areas, and a COVID-19-screening procedure had to be implemented.

Prior to the March 2020 shut down of services, “We were diagnosing 8 to 12 patients [with breast cancer] a week,” LaRaia explained. The cancer program holds a breast tumor conference every Tuesday at which new cases are presented to the multidisciplinary team. “Three to four weeks after we stopped our screening mammograms, there were no more patients for our tumor conference. We actually did not have a tumor conference for five weeks.”

The cancer services at Munson health system are structured in a hub-and-spoke model. The flagship Cowell Family Cancer Center in Traverse City, opened in 2016, serves as the hub for eight oncology clinics throughout northern Michigan.

Comparing the one-year period July 2019 to June 2020 to the one-year period July 2020 to June 2021, Munson Healthcare breast cancer screening rates dropped 13 percent, LaRaia said.

In late fall 2020, the Traverse City area experienced its first COVID-19 surge. “During that first pandemic year, we had the highest volume of patients [with cancer] that we’ve ever served,” LaRaia recalls. The capacity for patients to access care close to home was critical during this time. Michigan’s two NCI-designated cancer centers are located in the southern area of the state, about a four-hour drive from northern Michigan. With the pandemic surging, patients were encouraged to receive their care close to home and were able to avoid disrupted care by continuing their treatment through Munson Healthcare’s hub-and-spoke model of cancer programs.

COVID-19’s Impact on Community Outreach

As in other areas of the country, COVID-19 surges during the past two years have led to the cancellation, postponement, or downsizing of planned community outreach and cancer screening events.

“In northern Michigan, we have the highest rate of young (i.e., diagnosed before age 50²¹) female breast cancer incidence in the state,”²¹ LaRaia said. Leelanau County has the highest 5-year age-adjusted incidence rate of breast cancer in the state. Colorectal cancer diagnosed in those under age 50 is rising in Michigan and the U.S. overall. Grand Traverse County has the state’s fourth highest age-adjusted incidence rate of “young” CRC.

The area is also seeing an uptick in young colorectal cancer incidence (i.e., diagnosed before age 50).²¹ Community outreach education and screening promotion are priorities of the Munson Healthcare cancer program.

LaRaia had hoped to launch a consumer screening campaign in the summer of 2021, however, plans were modified due to a spike in COVID-19.

On Saturday, Oct. 30, 2021, the cancer center held a scaled-down version of its previous breast cancer screening blitz. “We did a similar event in 2019, and I believe we had almost 140 appointments scheduled that day,” LaRaia said. For the event in October 2021, the health system held four-hour screening blocks at several Munson locations. Forty-five breast cancer screenings were scheduled, and “we were able to fill more screening appointments throughout the month and into November,” she said. “Out of the 45, we had three call backs and one biopsy that was benign. That’s still a high percentage rate for such a small number. That’s why it’s so important for us to get out there.”

The pandemic also curtailed a long-planned colorectal cancer awareness campaign. “We had such a project scheduled,” LaRaia said. “It was titled ‘Rollin’ with the Colon.’ We had the inflatable colon coming that you would walk through as you came into the cancer center. We had a panel of physicians—a gastrointestinal physician, a colorectal surgeon, a medical and a radiation oncologist, and a genetic counselor ready to present to the community—it was scheduled for March 7, 2020, and we had to cancel.” In the interim, the health system’s multidisciplinary expert team of providers developed a standardized colon cancer screening guideline to support decision making for consumers and primary care providers in the community. The guideline, which is available on the health system’s website, explains when a home test may be appropriate and when a sigmoidoscopy or colonoscopy may be needed. “It’s guidance for the patient so that, if nothing else, they can start with a home test.”

Through its website, Munson Healthcare offers online risk-assessment tools for prostate, lung, colorectal, and breast cancers. Consumers can use these to determine whether they are at high risk for the disease. Lung cancer screening information is easily accessed on the health system’s website, which has an “Ask-a-Nurse” program with contact information so that individuals who want more information or who have questions but do not have a primary care provider have a place to turn.

Unfortunately, as budget dollars are earmarked to cover pandemic-associated costs, the budget for promotion of community outreach and cancer screening has felt the pinch, LaRaia said.

Weathering This Winter's Surge

When ACCCBuzz spoke with Kathleen LaRaia in late December 2021, the Traverse City region—like many areas around the United States—was in the midst of a spike in COVID-19-positive cases. In a message posted to the health system's website, Munson Healthcare Chief Executive Officer and President Ed Ness explained that the system was moving to pandemic response level red. "Moving to level red signals that we are prioritizing pandemic-related care and will be shifting resources to the highest areas of need," he said in his statement. At the same time, he encouraged people to "not delay necessary care or preventive screenings."

Although the health system saw more admissions than in its previous two surges, Kathleen LaRaia emphasized Munson's preparedness. "We have PPE [personal protective equipment]. We know how to treat patients with COVID-19, and we are providing monoclonal antibodies." LaRaia takes care to stress that the monoclonal antibody treatment for COVID-19, which is infused, is not administered in the cancer center infusion area. "We were not going to provide monoclonal antibody COVID treatment in our infusion clinics. We have been creative and found other areas for this so that people can come in, get their treatment, and not expose others."

Over the coming years, how likely is northern Michigan to see an increase in late-stage cancer cases as a result of the COVID-19 pandemic? LaRaia believes that—unfortunately—it is very likely. "We were already an at-risk community prior to the pandemic. We knew we needed to do more community outreach because of our high incidence rate, and so I can only imagine that this has compounded that."

Amanda Patton, MA, is a freelance writer in the Washington, D.C. area.

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ASSOCIATION OF COMMUNITY CANCER CENTERS

UNDERSTANDING AND MITIGATING DISPARITIES IN BLADDER CANCER CARE

Healthy People 2030 defines health disparities as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.”¹ Bladder cancer is the sixth most common cancer in the United States² and is primarily a disease of White males over the age of 55. However, disparities in evaluation, management, and mortality persist in patient populations where bladder cancer is less common. It is critical for multidisciplinary care teams to be aware of these disparities in order to effectively reach underserved patient populations.

This article explores disparities in bladder cancer, including data collected through a 2021 Bladder Cancer Economic Study by the Association of Community Cancer Centers (ACCC). It offers practical and operational tips for oncology care team members to manage underserved patients with bladder cancer.

Delays in Diagnosis

Blood in the urine, or hematuria, is often the first sign of bladder cancer and timely referral for urologic evaluation is considered a quality benchmark in bladder cancer management. Compared with males and White patients, females and Black patients are less likely to receive timely diagnostic evaluation of hematuria (Figure 1, page 67).

Recent ACCC analysis of Medicare claims data between 2016-2019 involving patients diagnosed with bladder cancer in 2018 (n=4,356) shows a longer time to diagnosis in early-stage bladder cancer for Black, Asian, Hispanic, and Native American patients compared to White patients (Figure 2, page 67).

Stage at diagnosis is a critical determinant of outcomes in bladder cancer and an important measure of outcome disparities. Being female, Black, Hispanic, of low socio-economic status, or poorly educated are all associated with an increased odds of being diagnosed with advanced disease at presentation.⁷ Black patients have up to 10 percent worse disease-specific survival than White patients,⁸ and are more likely than White patients to die from bladder cancer within three years of diagnosis.⁷ Compared with men, women have a greater risk of recurrence and worse overall survival.⁷

The COVID-19 pandemic reduced the number of patients presenting for symptoms suspicious for bladder cancer (e.g., hematuria), as well as for routine care.⁹ At the same time, clinicians are seeing patients from a wider geographic area, especially in relation to complications.¹⁰ These trends are likely to further exacerbate disparities in bladder cancer.

Treatment and Outcome Disparities

Disparities also persist in time to treatment and receipt of appropriate treatment. ACCC claims data research showed a longer time to initial treatment for Asian, Hispanic, North American Native, and Black versus White patients in both early- and late-stage bladder cancer (Figure 3, page 68).

Disparities also exist during treatment. Analysis of treatment patterns reveals:

- Women receive fewer cystoscopies than men in many parts of the U.S. and are less likely to undergo definitive curative radical cystectomy than men.¹¹⁻¹²

- Black patients have 21 percent lower odds of receiving guideline-based treatment compared with White or Hispanic patients.¹³
- Women, Black patients, or patients who live in regions with lower income and education levels are less likely than White patients to receive any treatment or receive treatment within 12 weeks of diagnosis.¹²
- Patients living in rural areas and with lower socio-economic status are less likely to receive neoadjuvant chemotherapy and more likely to experience delays in surgery.¹⁴

Most deaths from bladder cancer occur within the first two to four years from diagnosis, making this a critical window for treatment.⁷ The 5-year relative survival rate for bladder cancer is 77 percent overall, compared to 64 percent for Black patients.¹⁵ Women have a lower survival rate than men after radical cystectomy.¹⁶

The Financial Toll of Disparities on Patients

There are substantial all-cause healthcare and out-of-pocket costs involved in delaying diagnosis and treatment of bladder cancer. The later the diagnosis, the higher the cost to patients in terms of both financial toxicity and distress. Heather Honoré Goltz, PhD, LCSW, MEd, an oncology social worker, researcher, and health education specialist at the University of Houston-Downtown, emphasizes that patients with bladder cancer without insurance are especially likely to be distressed and anxious about practical concerns, such as the cost of treatment, transportation issues, time off from work, and an available support system for advanced treatment. She observes that when clinicians are mapping the patient’s most pressing concerns:

Oftentimes it’s not the symptomology that is the most disturbing thing to them. It really is, “Am I going to bankrupt my family? Am I going to be able to live and pay my bills? Am I going to be able to keep a roof over my head?”

Heather Honoré Goltz, PhD, LCSW, MEd

Factors Contributing to Disparities in Bladder Cancer

A cluster of factors contribute to disparities in diagnosis, treatment, and outcomes for underserved populations (Figure 2). According to studies in bladder and other types of cancer, type of insurance, the type of hospital providing care,¹⁶ provider density, and travel burden to a center of excellence or academic center are associated with a decreased likelihood of receiving critical treatment,¹⁸ regardless of insurance status. Access to care is a key factor in racial disparities in bladder cancer (Figure 4, page 69).

10 Tips to Mitigate Disparities in Bladder Cancer

Multidisciplinary and shared care management of patients with bladder cancer has emerged as a care model associated with quality improvement in oncology care.²⁶ This involves care coordination between oncology and urology practices to support timely referral, specialist evaluation, and survivorship care planning.

The following strategies can help improve outcomes for underserved patient populations and elevate equity in cancer care delivery:

1. Consider bladder cancer as a potential diagnosis in Black and female patients with hematuria who are referred to oncology via primary care, OB/GYN, and emergency rooms.
2. Promptly refer patients with hematuria to urology for timely full urologic evaluation.
3. Screen patients for financial distress at diagnosis. Refer to the ACCC Financial Advocacy Playbook for guidance.²⁷
4. Refer patients to financial advocates or navigators before treatment initiation and at treatment milestones to identify appropriate financial navigation interventions. The ACCC Patient Assistance & Reimbursement Guide can streamline this process.²⁸
5. Practice culturally competent/health literacy communication and shared decision-making to keep patients engaged in their care. Ask Me 3[®] is a great place to start.²⁹
6. Consider exploring disparities in bladder cancer in your organization via an NCI Community Oncology Research Program (NCORP), community-based participatory research study via the NCI Center to Reduce Cancer Health Disparities (CRCHD), or quality improvement project.
7. Build relationships that support access to care and reduce delays in referral through community outreach with primary care, OB/GYN, and urology providers.
8. Consider concurrent consultation with urology and medical and radiation oncology, as well as shared decision-making between patients and other members of the care team, including oncology nurses, wound ostomy and continence nurses, and oncology social workers.³⁰
9. Provide information and education to patients with cancer at the time of diagnosis about different types of treatment by type and stage of bladder cancer, options for clinical trial participation, and the roles and responsibilities of providers at different points in treatment.
10. Guide patients toward advocacy organizations, like the Bladder Cancer Advocacy Network, and resources on bladder cancer.

FIGURE 1. Disparities in Time to Diagnosis

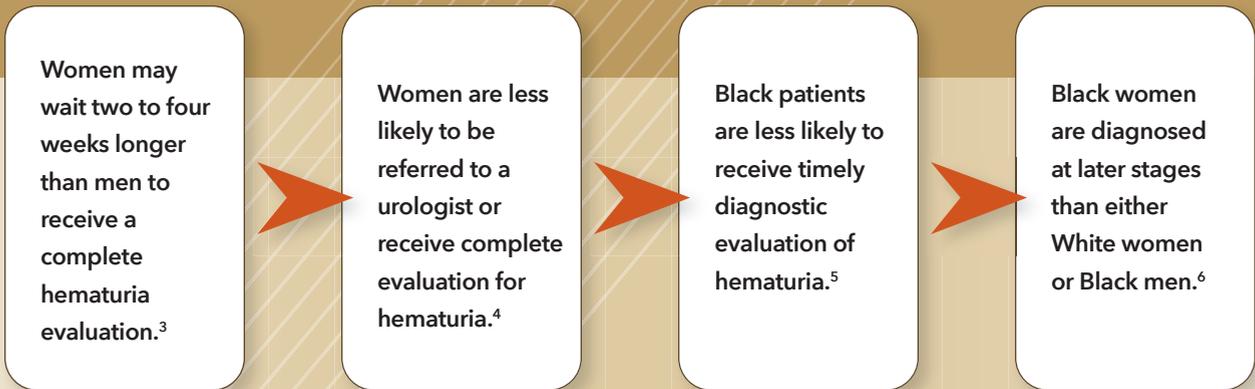


FIGURE 2. Average Time from Hematuria Diagnosis to Bladder Cancer Diagnosis (30-Day Months) by Race/Ethnicity

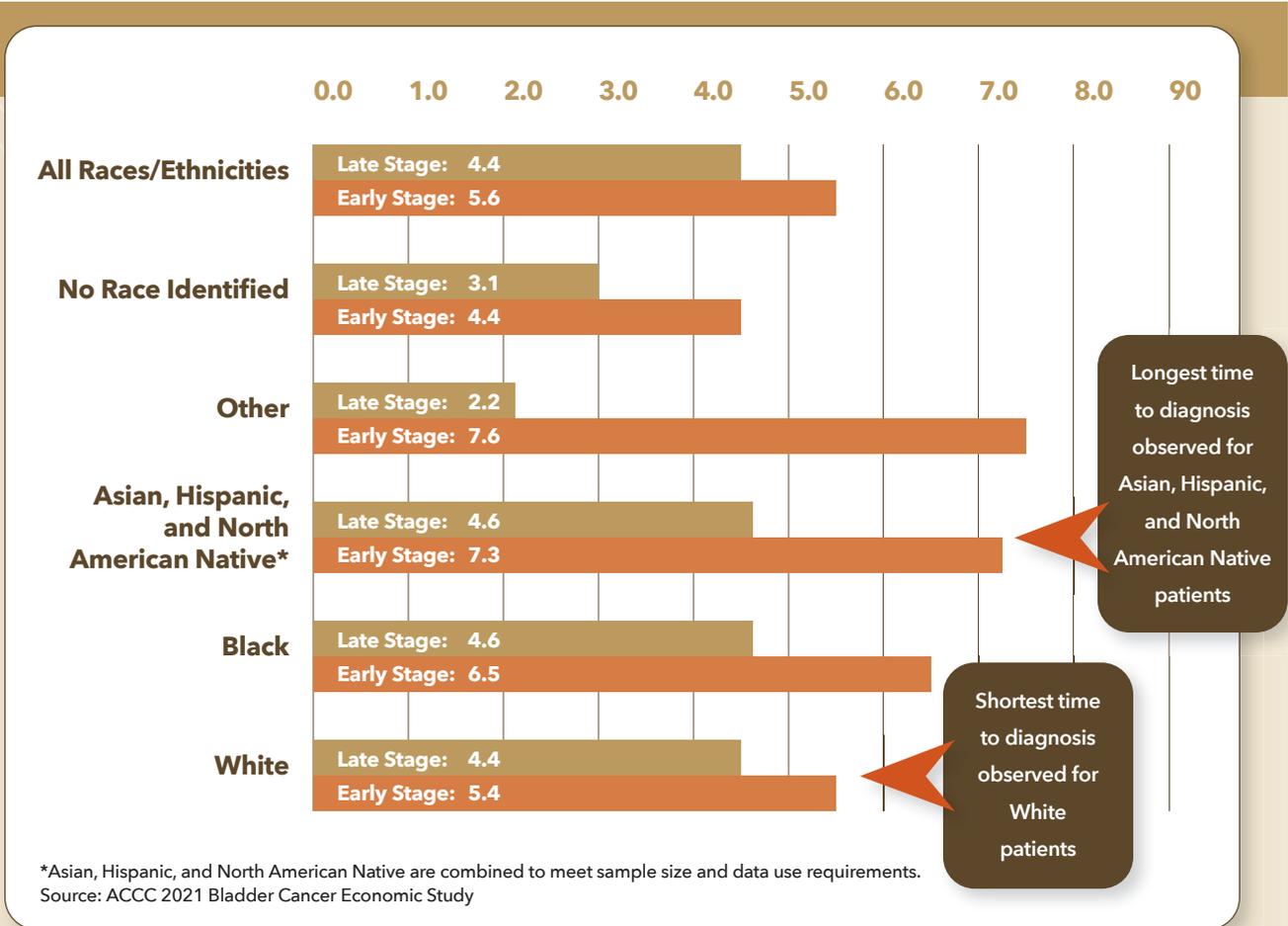
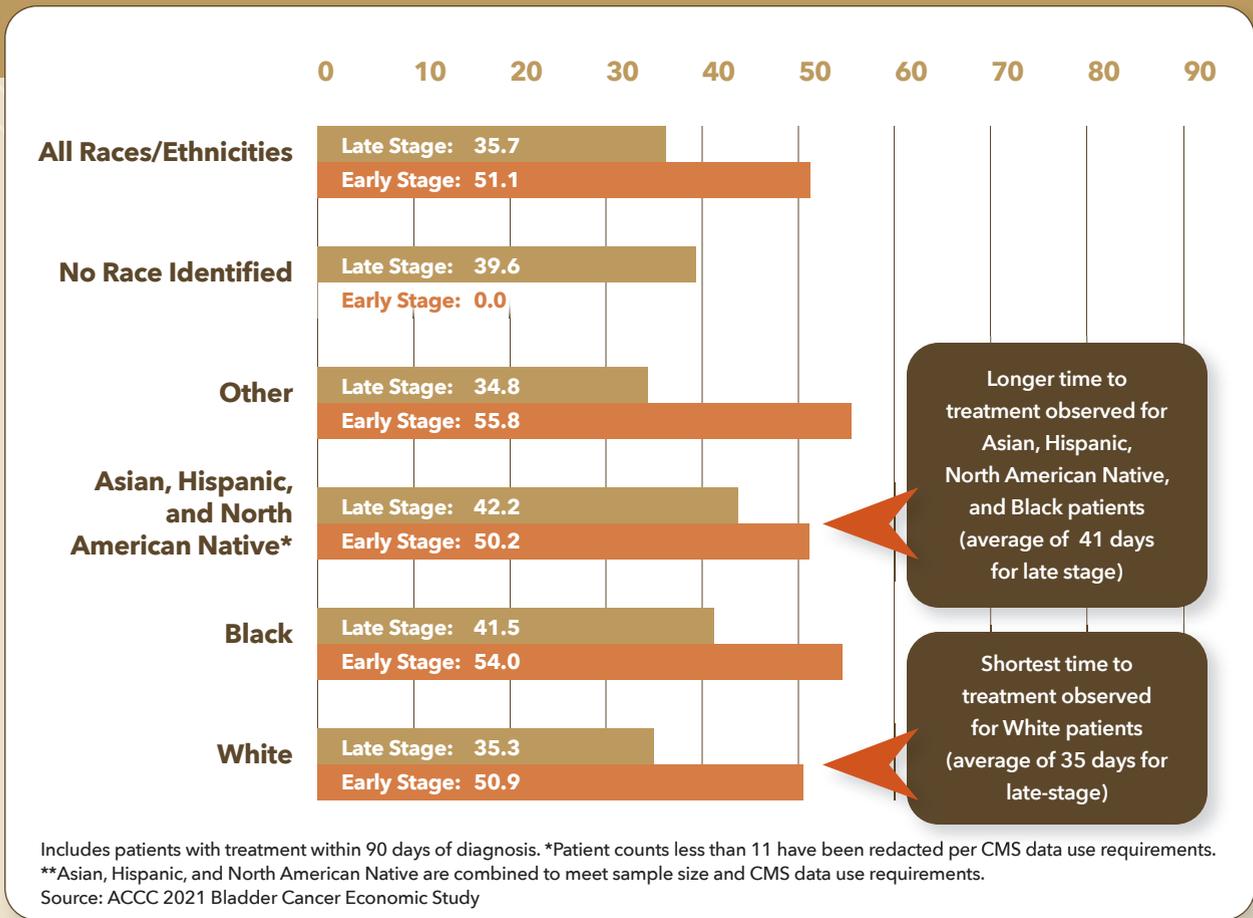


FIGURE 3. Average Days from Bladder Cancer Diagnosis to Initial Treatment



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FIGURE 4. Factors Contributing to Disparities in Bladder Cancer

Type of Insurance

- Compared with patients with bladder cancer who use private insurance, uninsured and Medicaid-insured patients are more likely to experience delays in treatment longer than 90 days and lower odds of treatment at a high-volume facility.¹⁹

Travel Burden

- Centers of excellence are concentrated in urban areas, limiting access for patients living in suburban and rural areas.²⁴
- Median travel distance has increased from 11.8 to 20.3 miles for surgical care and 6.5 to 8.3 miles for non-surgical care.²⁴

Provider Density

- The regionalization of care since the early 2000s has affected access to timely treatment.²²
- Many states experience shortages in the number of practicing urologists.²³
- Over 2,000 counties in the U.S. are without a urologist.

Type of Hospital Providing Care

- Non-White patients are more likely to be treated at community hospitals than tertiary cancer centers, where there are sometimes resource gaps, such as shortages in the availability of Bacillus Calmette-Guerin, are less likely to receive guideline-recommended treatment.²⁰
- Differences in access to treatment for muscle invasive bladder cancer account for almost three quarters of the excess risk of death among Black patients.²¹

Attitudes & Beliefs

- Primary care and OB/GYN providers often attribute hematuria to urinary tract infection in women and treat with antibiotics without undergoing further work-up.²⁵
- Many women see urologists as “doctors for men” and prefer to see primary care providers or gynecologists for hematuria.²⁵
- Implicit bias likely plays a critical role in structuring disparities in receipt of guideline-recommended care.
- Healthcare within equal-access systems does not eliminate disparities in stage at diagnosis by race/ethnicity or gender.²¹

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Survivorship Resources

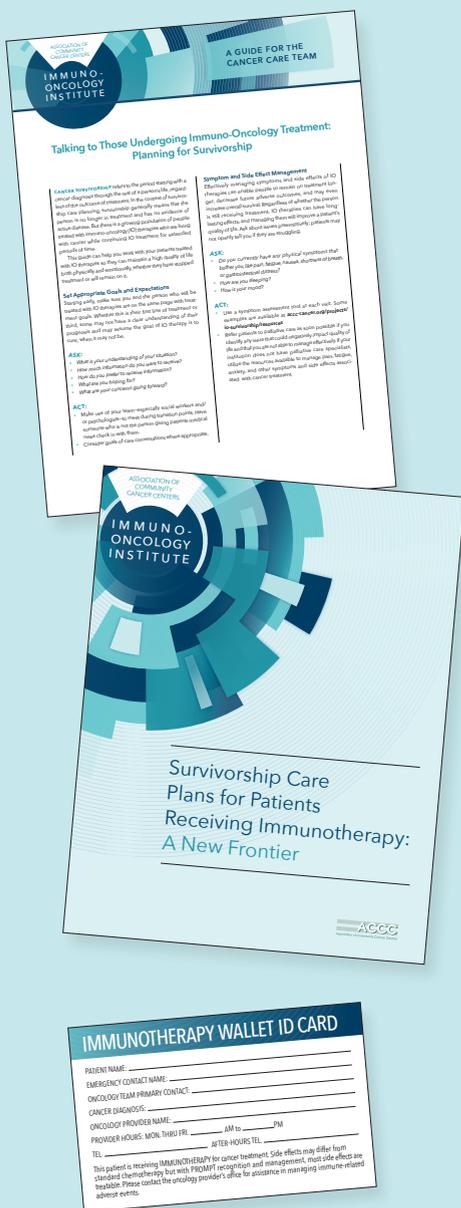
The evolution of immunotherapies have given rise to a new class of cancer survivors who require unique tools and resources.

Access this new suite of provider and patient materials today!

- **TOOLKIT:** IO Survivorship Templates
- **PUBLICATION:** Survivorship Care Plans for Patients Receiving Immunotherapy
- **PDF:** IO Medical Wallet Card
- **LECTURE SERIES:** Survivorship in the Era of IO
- **PODCAST:** Survivorship Care After Immunotherapy

Access these resources
and more at
acc-cancer.org/immunotherapy

The ACCC Immuno-Oncology Institute is supported by Bristol Myers Squibb (charitable donation) and Merck & Co. (Care Coordination educational grant).



The Association of Community Cancer Centers (ACCC) is the leading education and advocacy organization for the cancer care community. Founded in 1974, ACCC is a powerful network of 25,000 multidisciplinary practitioners from 2,100 hospitals and practices nationwide. As advances in cancer screening and diagnosis, treatment options, and care delivery models continue to evolve—so has ACCC—adapting its resources to meet the changing needs of the entire oncology care team. For more information, visit acc-cancer.org or call 301.984.9496. Follow us on Facebook, Twitter, and LinkedIn; read our blog, ACCCBuzz; and tune in to our podcast, CANCER BUZZ.

The ACCC Immuno-Oncology Institute is the leader in optimizing the delivery of cancer immunotherapies for patients by providing clinical education, advocacy, research, and practice management solutions for cancer care teams across all healthcare settings.

action

It's a Wrap! Highlights from the ACCC 48th Annual Meeting and Cancer Center Business Summit

March 2-4, 2022, ACCC convened approximately 400 members, sponsors, and industry partners in person for its 48th Annual Meeting and Cancer Center Business Summit (AMCCBS) in D.C., with an additional almost 300 individuals choosing to livestream sessions.

A day before the official opening of AMCCBS, expert panelists took to the stage to discuss the current landscape of survivorship care in oncology and how cancer programs and practices across the United States should rethink their current models of care. Panelists agreed that the key to effective survivorship care is smooth collaboration between a patient's oncologist and primary care provider. Panelists also agreed that though multidisciplinary team-based models of survivorship care are more financially feasible than others, considerable barriers exist to employing them. Resolving obstacles to obtaining reimbursement for survivorship care services and defining different provider roles (e.g., the responsibilities of primary care providers versus oncologists) are key to improving how cancer programs and practices transition their patients from treatment to survivorship care.

ACCC 2021-2022 President Krista Nelson, MSW, LCSW, (right) opened the meeting by thanking attendees for their dedication to quality cancer care throughout the COVID-19 pandemic. "I believe that the magic is in welcoming," she said, explaining, "It's not that welcoming means that we must accept everything or that we can't advocate for what is right. But we can welcome life's challenges as a part of this complex world and strive to uncover what might work for us to cultivate some sense of peace."





CANCER BUZZ



On the **CANCER BUZZ** podcast, you'll hear the brightest minds in oncology tackle topics that matter to the multidisciplinary cancer team.

- Cancer Team Well-Being
- Emergency Medicine
- Financial Health Literacy
- IO Survivorship
- Oncology Pharmacy
- Rural Cancer Care
- Supportive Care Services
- Symptom Management
- Telehealth
- And More!



Catch our mini-podcasts highlighting critical issues in health equity, diversity, and inclusion.

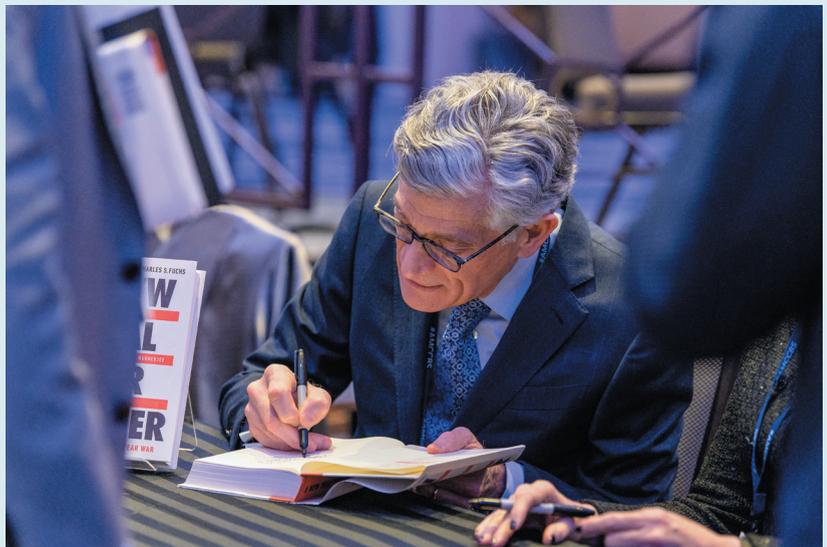
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ACCC-CANCER.ORG/PODCAST

Keynote speaker Cary Gross, MD, professor of medicine and director of the Cancer Outcomes Public Policy and Effectiveness Research Center at Yale School of Medicine, (top right) addressed the many ways in which the American healthcare system has failed patients. Our healthcare system distributes its resources inequitably, he said, leading to wide disparities in treatments and outcomes. Dr. Gross closed his keynote address by discussing what he believes is oncology's top issue when addressing poor patient outcomes: a strict focus on a cure and a skewed government-funded research agenda that does not place patients at the center. Dr. Gross suggested doubling down on prevention, developing more targeted screenings and new vaccines, lowering drug prices, and employing alternate payment models that reward payers for efficient, effective care.

Dr. Gross joined co-authors, Randall A. Oyer, MD (shown signing books for attendees), and Barbara McAneny, MD, MACP, FASCO, for a special book signing of *A New Deal for Cancer Care: Lessons from a 50-Year War*.

On March 4, 2022, ACCC announced David R. Penberthy, MD, MBA, medical director of radiation oncology at Bon Secours Southside Medical Center in Petersburg, VA (bottom right), as its 2022-2023 president. Dr. Penberthy took to the podium and announced his President's Theme, which will frame his leadership activities during his one-year term. The theme, "Leveraging Technology to Improve Cancer Care Delivery and the Patient Experience," will focus on 1) using data and digital health tools equitably to identify ways to reduce health disparities and 2) creating strategies to use technology to help mitigate workforce shortages and improve efficiency of care.





Krista Nelson, MSW, LCSW (far right), led the 2021-2022 ACCC President's Panel, Making the Business Case for Comprehensive Cancer Care Services. Nelson was joined by (left to right) Incoming ACCC President Olalekan Ajayi, PharmD, MBA, chief operating officer, Highlands Oncology Group, PA; Courtney Bitz, MSW, LCSW, OSW-C, director of Clinical Social Work and Spiritual Care, Department of Supportive Care Medicine, City of Hope; Jennifer Bires, MSW, LCSW, OSW-C, executive director, Life with Cancer and Patient Experience, Inova Schar Cancer Institute; and Al B. Benson III, MD, FACP, FASCO, professor of medicine, Robert H. Lurie Comprehensive Cancer Center at Northwestern Medicine. Although oncology programs and practices across the U.S. recognize the importance of the comprehensive cancer care that is recommended in many oncology guidelines and that is essential for some accreditations, gaps exist in all practice types and geographic locations.

New this year, AMCCBS included planned networking opportunities between providers and industry on a wide range of topics, including digital health and artificial intelligence in cancer care, oncology practice transformation, precision medicine, financial navigation, technology platforms, revenue cycle and reimbursement, workforce issues, pharmacy and infusion operations, and more.

You Asked, ACCC Responded— New and Improved ACCCeXchange is Now LIVE!



Our members love this virtual connection to ACCC’s community of multidisciplinary cancer care providers. It is a place to share knowledge, address your toughest questions, and get real-time feedback and solutions from colleagues. We have improved the platform, so you and others in the cancer care community can more easily ask and answer questions like:

- Does anyone have chemotherapy and non-chemo charging cheat sheets for your staff? Interested in how you educate your staff on coding and billing.
- My site is looking to begin doing Phase I oncology clinical trials. Looking into creating SOPs [standard operating procedures]. Does anyone have a list of SOPs they think were helpful for a successful Phase I program?
- If you are a CoC [Commission on Cancer]-accredited facility, do you have a cancer committee chair job description you can share?
- If you have gone through ACR [American College of Radiology] accreditation, was there a policies and procedures guide that you followed?
- Does anyone have a means of conducting distress screening electronically?
- Does anyone track patients per room, per hour for your oncology providers? If so, what is your average, median, or target patients per room, per hour?

Use your ACCC profile credentials to log in at:

accexchange.accc-cancer.org.

If you do not remember

your login, please contact membership@acc-cancer.org as soon as possible so that we can get you all set up.

To post a message within the ACCCeXchange community, navigate to “My Communities” in the navigation bar and click on “All Member Community,” which is the main community discussion for all ACCC and Oncology State Society members. To view all conversations, click on the “Discussion” tab. You may reply by clicking on an existing thread or to start a new conversation, click on “Post New Message.”

Most members are subscribed to receive a daily digest email of all new posts. You can change your email frequency at any time by navigating to your “Profile,” clicking on “My Account,” and selecting “Community Notification.”

We encourage you to go online and start a new conversation or reply to one of your peers. If you have not joined ACCCeXchange in the past, now is your chance to tap into the knowledge and expertise of your colleagues. It is one of the many benefits of your ACCC membership!

South Carolina Oncology Society 2022 Annual Conference



August 5 - 6, 2022
Wild Dunes Resort
Isle of Palms, SC

Complimentary Registration



Retreat to the wild for TWO days of unparalleled education and breathtaking panoramic ocean views from Charleston's most prestigious hotel!

Two miles of pristine beaches and an all encompassing Lowcountry experience, make this the premier conference destination and vacation in one. Bring your family and enjoy a lively evening event on Saturday, August 6—after the conference ends!

For details, registration, and discounted room rates, visit bit.ly/scos-events or scan the QR code.



ACCC
39TH NATIONAL
ONCOLOGY CONFERENCE

October 12-14, 2022
Palm Beach
Convention Center

DECONSTRUCTING iNNOVATION

We'll re-engineer what we know
about cancer care delivery
and reimagine the possibilities.

The past two years, the oncology community transformed its strategies, operations, and services at a groundbreaking pace.

Come together with your peers for three days of innovative sessions and hands-on workshops that will leave you with insights, lessons learned, and practical solutions to your most pressing challenges.

Start your journey of reimagination and reconnection
by registering by September 9 for a \$125 savings!

Learn more and save your seat at acc-cancer.org/NOC

Philanthropy: Funding Oncology Supportive Care Services

BY JAMIE ARENS, MSW, CSW-PIP



It amazes me that sometimes we do not see how great things are when they are right in front of us. That moment of realization hit me when I was speaking with other members of the Association of Community Cancer Centers (ACCC). I was speaking very casually to the group about the many programs my cancer institute has implemented because of philanthropy. Pretty quickly into the conversation, I became the center of attention and began receiving queries about my cancer program's philanthropy efforts, including questions on how to use funding from foundations to add dedicated programs and new staff to our oncology service line. Because philanthropy is second nature to me, I almost did not know how to answer. It was at that moment that I realized how lucky I am to have this type of support. More so, how lucky my patients and their families are to have access to a diverse offering of supportive care services at Avera Cancer Institute.

A Little About Avera

Avera Cancer Institute at the Avera McKennan Hospital and University Health Center has had philanthropic support since it opened in 1998. The cancer institute is located in Sioux Falls, S.D., and is the largest location of what is now known as the Avera oncology service line. This service line comprises 6 cancer centers, 45 rural chemotherapy sites, and a variety of telemedicine and physical outreach centers. The cancer program is part of Avera Health—a rural health ministry rooted in the gospel values of compassion, hospitality,

and stewardship. Because of its roots, our cancer institute offers holistic care in a healing environment, and leadership has used philanthropic efforts to ensure that these supportive care programs are always available to our patients and their families.

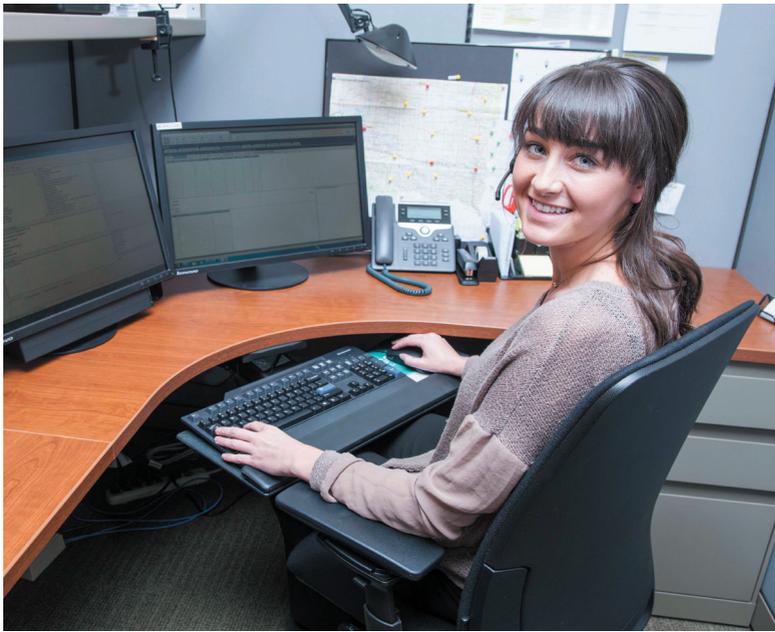
Why Philanthropy Matters

Cancer programs and practices everywhere feel the pressure of trying to do more with less these days. With the cost of cancer care in the United States reaching more than \$200 billion, we continue to see measures put in place by payers and health systems to reduce costs.¹ Ensuring coverage of the services we provide is an all-day, everyday task that is balanced between other challenges like new care delivery models, the transition to biosimilars, place of service restrictions, clinical pathways, and payer policies. On top of those tasks, we must also

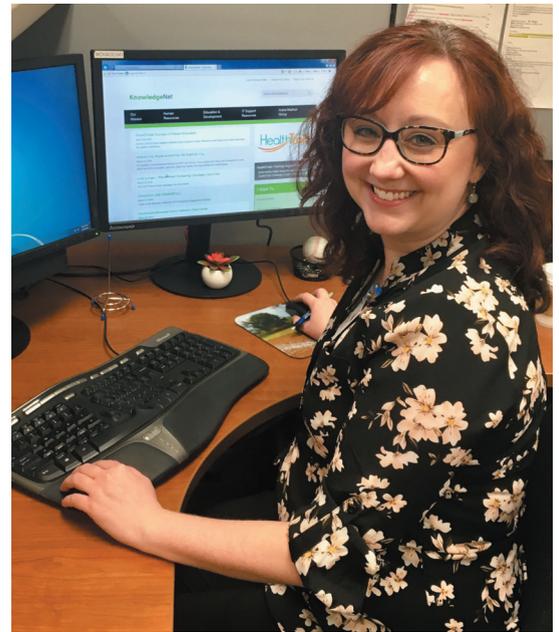
continue to meet accreditation standards and to provide quality interdisciplinary care—even though many of the services required to deliver this level of care are not reimbursed. Philanthropy is a way to support some of these needed services.

Several of our cancer institute's most impactful philanthropy efforts include coaching oncology staff to direct grateful patients to our foundation colleagues, who then have the opportunity to get to know the potential supporters of our programs. Other efforts include events like the Avera Race Against Cancer, which raises more than \$300,000 annually for our wig program and integrative medicine services. Additional efforts occur in capital campaigns. One such campaign occurred alongside the building of our new \$93 million Avera Cancer Center in 2010, which included funding for patient supportive care services like a beautiful





Jordan Jenkins, MSW, OSW-C, is a social worker at Avera Cancer Center.



Melanie Mattern, MSW, OSW-C, is an oncology social work navigator at Avera Cancer Center.

mind-body studio, meditation room, walking labyrinth, wig salon, and integrative medicine clinic. Avera leadership has also used donor funds to introduce new positions to the oncology service line, such as chaplains and music therapists. Furthermore, a \$2 million campaign funded a new navigation center—a 24-hour oncologic support center for the entire service line. The navigation center is not only a huge patient satisfier but a mechanism to appropriately educate and triage our patients in line with the cancer institute's efforts to reduce emergency department visits and hospital admissions. In just 10 years (2009 to 2019), Avera Cancer Institute raised more than \$31.4 million for oncology services, and some of these monies have been used to offset treatment-related costs for our patients.

Getting Started

Now, you may ask, how do you get started? The three simple steps below will help you begin and grow philanthropy efforts for your cancer program or practice.

1. Make friends with the fundraising staff at your institution. If you do not have fundraising development professionals at your institution, you should hire at least one dedicated staff member. You want to make sure that this point person understands the

care your institution provides to patients, so they can take these conversations back to the foundation and the public. It also helps to connect any grateful patients or caregivers to your institute's point person and/or team of professionals, so they can hear firsthand about your new program and identify whether these grateful patients want to give back to the cancer program financially.

2. Know the needs and priorities of your cancer program and be able to speak on these priorities from the patient's perspective. You and your fundraising team must know what you are raising money for, so the story of the need and potential impact can be told to others with open ears.

3. Create a long-term plan. At Avera, we do not start a new position or program using philanthropy monies until we have three years of funding in place. We set clear goals of what the new position or program is to achieve. For example, a steering committee identified the initial concept of the 24-hour navigation center, which was to provide support to anyone affected by cancer. But first we needed to develop a variety of metrics to prove the navigation center's efficacy. We track many metrics, including call volume, physical reach, barrier and intervention monitoring, types of callers,

and downstream revenue generated from those callers. Metrics like these tell the story of your new program's impact, which then support and show how pivotal the program is to patients' care. These data are helpful in proving the need to continue to fund the program permanently if philanthropic efforts end.

If you have implemented a new program or staff position using philanthropy dollars and run out of money, consider monitoring your downstream revenue, market share impact, and patient quality of life to justify transitioning that role or program into your institution's operating budget. Because patients with cancer need so many different supportive care services that may not be reimbursable, cancer programs and practices need to think about philanthropy as an important funding source. 

Jamie Arens, MSW, CSW-PIP, is the director of Cancer Clinics and Services at Avera Cancer Institute in Sioux Falls and Mitchell, S.D.

Reference

1. National Cancer Institute. Cancer trends progress report: life after cancer. Updated July 2021. Accessed February 11, 2022. progressreport.cancer.gov/after/economic_burden#:~:text=National%20costs%20for%20cancer%20care,services%20and%20oral%20prescription%20drugs

Correction

Article title: Leveraging Pharmacy Informatics to Standardize Pharmacists' Review of Oral Oncolytics for Hospitalized Patients

Authors: Saxton, M., Kisgen, R., LeBoutillier, L., & Hymel, L.

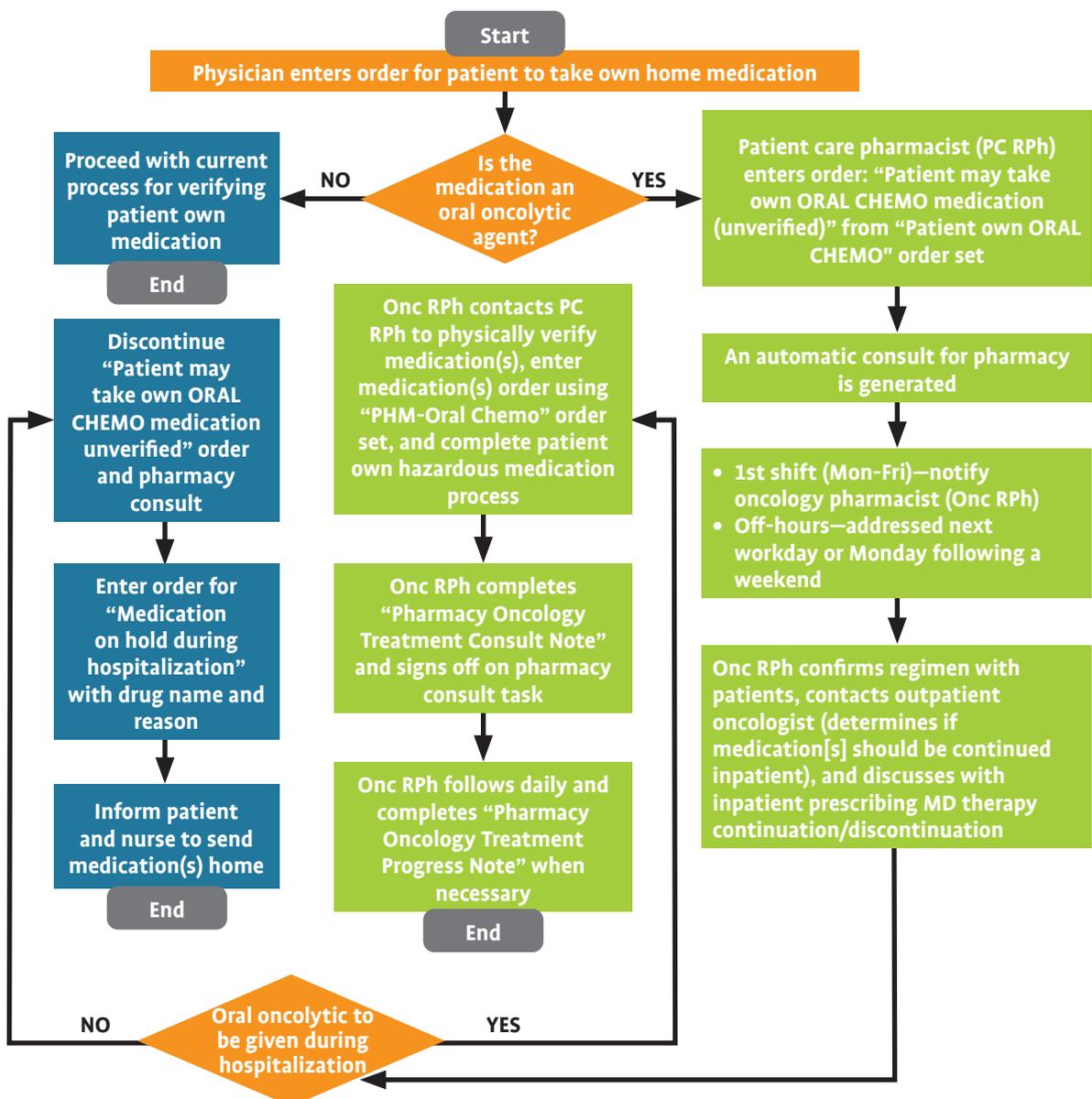
Journal: Oncology Issues

Bibliometrics: Volume 37, Number 2, pages 46-51

DOI: <http://dx.doi.org/10.1080/10463356.2021.2006016>

Figure 1 as published in the issue in print and online contained critical errors which required correction in order for the content to be clearly understood. Figure 1 has been updated in the online version of the article. The corrected image has also been reproduced below:

Figure 1. Pharmacist Workflow Process for Review of Oral Oncolytics



ASSOCIATION OF COMMUNITY CANCER CENTERS

Overcoming Prostate Cancer Disparities in Care

Find a broad range of approaches to create change and improve prostate cancer detection and treatment.



PRACTICE PROFILES PUBLICATION

ACCC conducted focus groups with four cancer programs that have developed strategies to overcome disparities in prostate cancer care. Read their practical approaches for providing equitable care that can help improve early detection and care for vulnerable patients.

Special thank you to the staff who graciously contributed:

- ChristianaCare's Helen F. Graham Cancer Center & Research Institute
- Spencer Cancer Center of East Alabama Health
- The Ohio State University Comprehensive Cancer Center (OSUCCC) Arthur G. James Cancer Hospital and Richard J. Solove Research Institute
- UCSF Helen Diller Family Comprehensive Cancer Center

ON-DEMAND WEBINAR

Hear from these four cancer sites as they highlight effective community outreach strategies to overcome disparities in prostate cancer care, including Connecting with Faith Communities, Facilitated Peer Support Groups, and more.

DIGITAL RESOURCE LIBRARY

Explore curated publications, tools, and other assets that can help support your efforts in health equity.



LEARN MORE at acc-cancer.org/ProstateDisparities2022
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In partnership with APOS, PCEC, and ZERO. Supported by an educational grant from AstraZeneca and Merck.

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