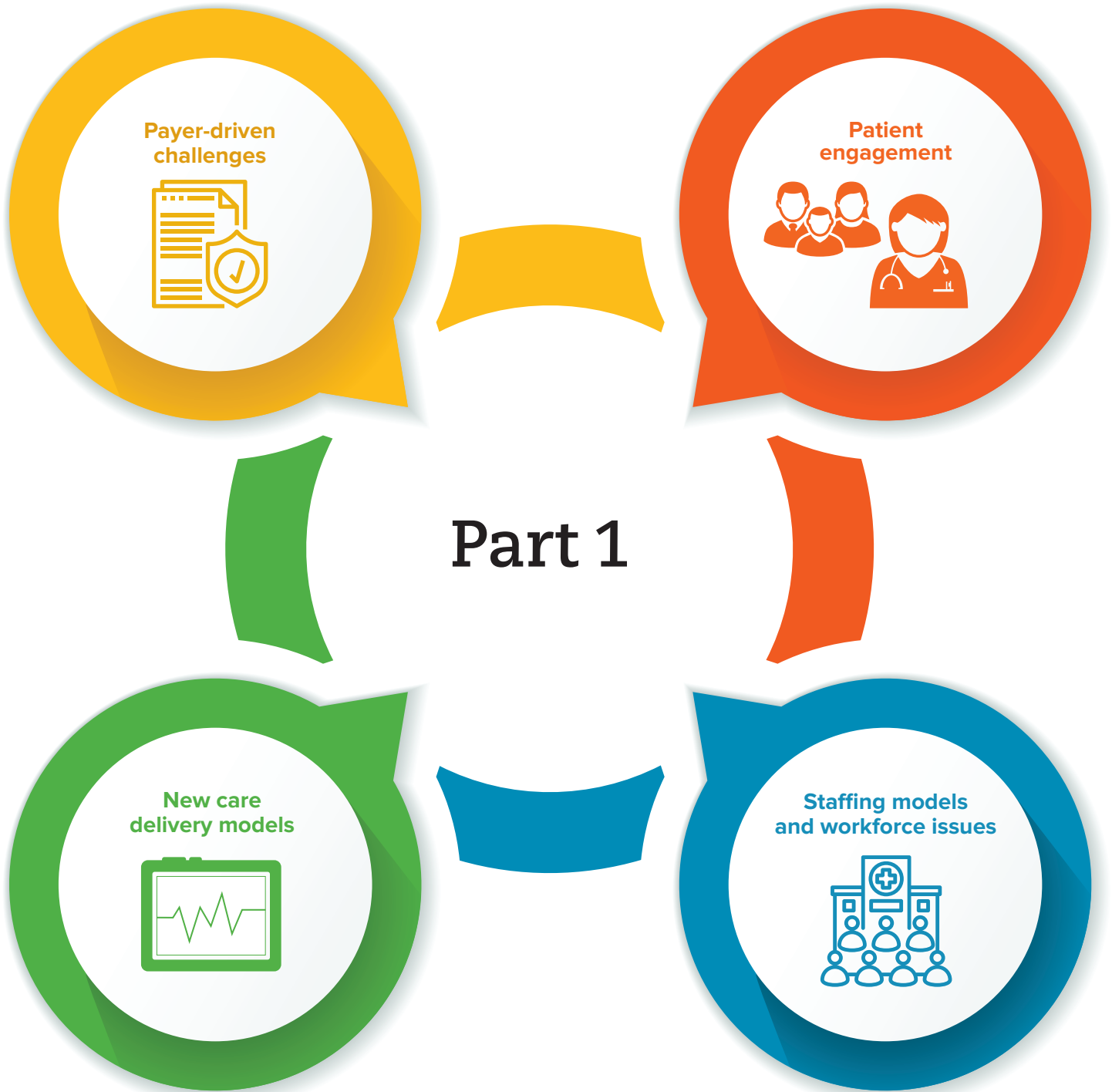


Trending Now in Cancer Care



In past years, the Association of Community Cancer Centers (ACCC) fielded an annual “Trending Now in Cancer Care Delivery” survey to its membership to gain insights into challenges they face and—most importantly—solutions to address those challenges. Unprecedented challenges from a global pandemic, a 3-plus years public health emergency, and feedback that members did not have the time and/or resources to take this annual survey led ACCC to look for alternative ways to collect these data. In 2020, ACCC conducted a series of focus groups to produce the [2021 Trending Now in Cancer](#) report. In 2023, ACCC hosted a series of interactive sessions at the ACCC 49th Annual Meeting and Cancer Center Business Summit (#AMCCBS) to collect insights and solutions into 8 key areas. Below, we take a “deep dive” into 4 of these topics. Look for “Trending Now in Cancer Care Part II” in *Oncology Issues* Volume 38, Number 5.

STAFFING MODELS & WORKFORCE CHALLENGES

With most cancer programs facing workforce shortages, improving recruitment and retention, addressing burnout, and improving morale and resiliency are top of mind for leadership at all levels.

Facilitators

- Ellen Feinstein, RD, MHA, LFACHE, Vice President, Cancer Service Line Administration, Advocate Aurora Health
- Nathalie A. Lokker, PhD, MS, then-Global Head of External Affairs, GMA, Oncology Business Unit, AstraZeneca
- Krista Nelson, MSW, LCSW, OSW-C, FAOSW, Senior Oncology Social Worker and Program Manager, Cancer Support Services & Compassion, Providence Health & Services
- Barbara Schmidtman, PhD, Vice President, Operations, Corewell Health West
- Amy Smith, BSN, RN, Cancer Center Director, Iverson Memorial Hospital, Meredith and Jeannie Ray Cancer Center

No-Cost or Low-Cost Tips for Cancer Programs With Fewer Resources

- Begin meetings with a moment of gratitude and regularly ask staff to share their “why” for working in oncology. Remember, empathy and authenticity are necessary to engage in meaningful dialogue.
- It is well-documented in the literature that most people leave an organization because of their leadership. As a leader, create time to meet regularly with each staff member. *Ask* important questions, like “share 1 thing I can help you with this month” and always enquire about job satisfaction. *Listen* to what is said. When problems arise, do not simply fix them on the backside, but let staff know the issue that is being addressed and why.

“When we have a positive mindset, it bodes well—the more positive you are, the less likely you are to have adverse health effects. Just smiling can affect a positive effect on your health.”

“We introduced birthday PTO in 2022. I got letters at home, and it was like the best thing we have ever done for our staff.”

- Regularly survey staff about what would make them feel more connected to their team members and the cancer program. Be prepared to act on what is shared; be creative in holding activities with little to no costs.
- Practice “rounding with empathy,” with staff input into the frequency of this activity. To do so, employ empathetic connection

“We use a technology platform to help run our tumor boards. It can also be used to connect patients to appropriate clinical trials. We made a promise to our physicians that once you register for this technology, learn it, and sign in and use it, it will make your lives easier. And it did.”

“You don’t always have to buy expensive technology. Sometimes you just have to be willing to listen and solve minor problems.”

questions, keep communication direct and transparent, offer personal recognition, and adopt a model that is driven by staff—not leadership.

- Recognition should be structured and ongoing; it can also be as simple as an extra day of PTO (paid time off) or an Employee Appreciation Day.
- It is widely accepted that today’s physicians have a very different set of needs. To understand those needs, meet regularly—and individually—with every physician and listen to what they need. Often these are simple, low-cost requests like tweaking the clinic schedule of advanced practice providers (APPs) to allow physicians to see more patients or adjusting clinic hours to make sure that physicians can leave the clinic on time to participate in activities like hospital rounding.

Strategies for Cancer Programs With Some Level of Buy-in and Resource Allocation

- Hire additional APPs, medical assistants (MAs), and pharmacists to help with physician shortages and/or coverage gaps. Embedded pharmacists can take over many tasks managed by physicians, including chemotherapy orders, patient education, and side effect and symptom management.
- During physician shortages, hire locum tenens to help during recruitment efforts.
- Develop a pool of floating APPs and locum tenens (retired physicians are good candidates) to travel and fill in at clinic locations so physicians can take vacation and come back to a manageable clinic schedule.
- Leverage other team members to make it easier for physicians to do their business. This could mean hiring a clinical trials coordinator to perform all the administrative paperwork; hiring a medical

“Our health care system recognizes a duty to improve the lives of our clinicians through technology. We have tools to monitor EHR use and identify those who are at risk of spending too much time in the EHR outside of clinic hours.”

assistant to be physically present in the exam and responsible for scribing; and/or ensuring that nurse navigators are screening patients before they are seen by physicians to identify potential issues and challenges and, when possible, triaging them to the appropriate staff member before the physician even enters the exam room—whether that may be a nurse for additional education or a social worker for distress or a financial navigator to help with transportation challenges. This type of staffing model and proactive planning requires process mapping.

- Adopt technology like Epic’s Signal feature, a collection of data that gives insight into the daily interactions of clinicians within the electronic health record (EHR), including how much time providers spend in the EHR outside scheduled clinic hours and how that time compares to their peers. Use technology to collect data on clinician workload and how they are managing in-baskets to better inform decisions around resource allocation.
- Improve access to mental health services. Consider partnering with an organization to offer therapy sessions. Many are available 24/7 to do an emergency assessment to make sure the individual is not in danger; others will ask what staff are looking for from therapy, identify needs, and then match these needs to vetted resources.

“I don’t have trouble getting my staff engaged—but my physicians! They tell me they are burned out, but they don’t want any strategies. I’m looking for tactics that others have employed to bring physicians into these conversations and help reduce their levels of burnout.”

“Many of our younger physicians are coming in with 6-digit educational debt—that’s a huge stressor.”

- Subscribe to apps, such as [VITAL WorkLife](#), so that providers can access features like concierge services to help arrange for family travel, childcare, eldercare, financial counseling, peer coaching, and more.
- Create funding streams to create percentages of time that staff can devote to programs and processes that address burnout and build resiliency so it’s not just activities that they work on in the evenings or on weekends.
- Develop a Narrative Medicine Program that allows clinicians and staff to talk about, journal, and then share their experiences. This type of program can improve connection and morale.

Models for Well-Resourced Cancer Programs

- With staffing shortages responsible for much of the burnout experienced by cancer care team members, cancer programs need to look for long-term solutions like establishing partnership opportunities with local high school and colleges in the community to educate young people about oncology and build a pipeline of future workers.
- Providence Health instituted a Department of Compassion. This 4-person team developed a “Strengthening Compassion Program” of mindfulness exercises; peer-to-peer support opportunities; intensive care unit (ICU)-therapeutic touch; “Connecting Conversations;” leader toolkits; and a 12-session compassion curriculum based on existing literature and resources, including videos, exercises, and guidebooks. Clinics closed for 1 hour during regular hours to participate and clinic staff was trained to facilitate curriculum to increase scalability. Outcomes: burnout dropped from 55% to 46%; engagement scores went up and disengagement scores went down; patient experience scores went up significantly; and productivity in the clinics that closed for an hour went up significantly compared to the clinics that did not close.
- Advocate Aurora Health developed a model for supporting comprehensive clinician well-being that included a chief wellness officer, a Well-Being council, and 3 core teams and programs: (1) culture of wellness, (2) personal resilience, and (3) efficiency of practice. Under personal resilience, core components included an Individual

“Our health care system developed a strategic aspiration of well-being: to embed well-being into the health system culture, so all who work here experience joy at work, feel a sense of purpose and belonging, and know that they are valued.”

Well-Being Team, a spiritual health program, an employee assistance program, a healthy living program, and an integrative medicine program. Under Efficiency of Practice, a health care informatics program looked at ways to improve efficiency of EHR interactions, improve quality and efficiency of documentation, reduce time after-hours time spent working, and reduce administrative burden.

- PeaceHealth St Joseph Medical Center hired a family practitioner as a system wellness director who then designed a physician empowerment program. Physicians are invited early in their tenure to participate in this 12-week program. Physicians participate as a cohort and there is a set curriculum ranging from improving EHR efficiency and informatics to crucial conversations to effective leadership strategies. Data have shown that this program has prevented burnout.

Along with 2 other health systems, this health system has become a financial sponsor for medical assistant education. “It has become so popular that we have 60 spots—3 to 4 times a year—completely filled. And we are beginning to look now at APPs and how our health care system can support their education.”

Participants Share What Can ACCC Do?

- ACCC could partner with members to post online some of the resources and programs shared at this AMCCBS session so that members can read about them, hold a train the trainer session, and start implementing these solutions at their own cancer programs and practices.
- ACCC could establish a mentor program where members can connect and share resources and solutions on workforce-related issues, like burnout, recruitment, and retention.
- ACCC could develop toolkits for cancer programs and practices at 3 different levels—at a service line level, at a team level, and at an individual level—along with strategies to help members prioritize their efforts or help members be intentional about how they address workforce related challenges.
- ACCC could partner with industry to offer scholarships for its members to attend its annual conferences and other in-person learning opportunities.

“As far as next steps, data show that people leave an organization because of their leadership. So, what do our leaders need? How do we equip our leaders and get them the training they so badly need and desire? Like a mentorship program, where you have a cohort, and you meet monthly. How can ACCC facilitate a cohort of people with similar situations to connect and talk about their issues and then provide a toolkit to support this work?”

“My cancer center does not have a lot of funding to come to conferences like this...many of the people here had to go to their administration and fight for funding for this educational opportunity. And these are the people who are already engaged, so how do you reach the people who are not aware of ACCC and its resources? Are there scholarships that ACCC could offer to come to this type of conference?”

“I was hesitant to come to this workshop because I am ‘burned out’ from even talking about burnout, but I really appreciate all of the concepts that were presented—not necessarily because they were anything new, but because of the message that ‘you can do it.’ I thank you all for that ridiculous optimism because I think it is contagious. And I also just wanted to say that small community organizations really struggle. As a leader of a small organization, I don’t have a ton of time and resources...so having a repository or just an area on the website with [vetted] curriculums and resources means that I don’t have to go and make one.”

“ACCC could be a repository to gather these [workforce development and support] ideas. I am sure these ideas are somewhere online, but none of us have the time to look for them, so there is real value to be able to go to ACCC and click on burnout strategies...or maybe a mentor opportunity where we can talk to someone who has implemented a specific strategy, so it’s not just something that we are reading about, but we are connecting with real humans.”

PATIENT ENGAGEMENT STRATEGIES

Educating and empowering patients so that they trust and feel connected to their cancer care team can improve access, health equity, and patient outcomes—particularly for at-risk and underserved communities.

Facilitators

- Renea Duffin, MPA, Vice President, Cancer Support and Outreach.
- Mary Bird Perkins Cancer Center – Baton Rouge
- Lailea Noel, PhD, MSW, Assistant Professor, Steve Hicks School of Social Work, and Assistant Professor of Oncology & Health Social Work, The University of Texas Dell Medical School, LIVESTRONG Cancer Institutes
- Nicole Weis, MA, Senior Service Line Director, University of Minnesota Cancer Care

Patients enter the cancer care continuum at many points, and there are opportunities to engage patients and families right where they are at—whether that’s at a community outreach and education event, through early detection efforts, after a diagnosis, during active treatment, at the transition to survivorship, upon enrollment to hospice care or palliative care, and at the end of life. Below are tips and strategies to engage with patients and families along this continuum.

Identification of At-Risk or Underserved Patient Populations

- To identify at-risk or underserved patients, conduct a marketplace needs assessment. Assign each zip code a community needs index score ranging from 1.0 (low need) to 5.0 (high need).¹ Collect social and economic data like high school graduation rates, unemployment rates, the number of adults who live in poverty, etc. Gather information on specific health behaviors, including smoking and obesity rates, alcohol consumption, and data on physical activity.² Use these data to identify high-risk and high-needs zip codes where prevention outreach, screening, and education efforts should be concentrated.
- Delivering cancer care to at-risk and underserved patients requires trust. Building trust requires asking for input from the community

“Most of us [providers] have noticed a lot more food insecurity in the past few years. My cancer program has increased its philanthropy efforts to be able to purchase food for our patients. The stipulation we have is that patients must meet with our dietitian so that we can ensure they are getting healthy food. We have a Walmart account where we have food delivered to patients who cannot go and pick it up.”

on the best locations to conduct outreach and screening and picking dates that work best for the schedules and lifestyles of those who live in that community. Start small with 2 or 3 screenings events per year.

- Delivering cancer care to at-risk and underserved patients also requires navigation. It is not enough to simply go into these communities and screen; be prepared to help individuals reach a resolution on any abnormal finding. Instead of simply providing people with a phone number to call and schedule a follow-up appointment, navigators should educate and guide people on their journey from initial screening to diagnostic testing to treatment, if necessary. More, navigators can help address any transportation or other scheduling needs.

The Role of the Community

- Conduct grassroots outreach and partner with community organizations and local businesses, including barber and beauty shops,

“There is a big push for pharmaceutical companies to play a role in improving screening rates. But how do we move the needle in reducing disparities in the community setting? It’s more complex than translating a bunch of documents into different languages. Instead, we need to educate physicians and other cancer team members on how to speak to people from different cultures. But how do you start with that type of education?”

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“The first thing that pharmaceutical companies need to do is to stop scaring people to death. When you see a commercial for a new drug, the side effects are longer than the actual commercial. It terrifies people. They walk away from that [commercial] thinking, ‘That drug will make me sicker than the cancer.’ Your information has to be in laymen’s terms. Language that people can understand. You have to explain the benefits of the treatment in a way that people can understand. Don’t just push your drug. Be a part of the solution to improve our prevention and screening efforts—especially in disenfranchised communities. I tell people all the time that I want to be put out of business. I want our cancer center to close because we’ve cured cancer.”

grocery and convenience stores, churches and other faith-based organizations, and/or civic groups. Connect with these organizations to share information about cancer prevention and schedule screening events at a time and place that is convenient for those who live in the community.

- To break down transportation barriers and reach patients who cannot get to screening events, conduct a community screening event at a bus terminal or metro hub.
- To engage with patients on skin cancer, identify and connect with key informants in the community. For example, a local Oncology Nursing Society chapter started a Hairstylist Melanoma Challenge to train local hairstylists to recognize potential skin cancer.³ After spotting a suspicious lesion, these stylists were empowered to act as “ambassadors” to encourage their client to follow up with a physician or dermatologist. The Melanoma Foundation of New England developed the “Skinny On Skin” program to offer in-person and virtual education on skin cancer to beauty industry professionals.⁴
- In patient engagement strategies, look not only to community influencers but also go directly to the individuals who live in that community. Hold focus groups and ask questions like, ‘If we were to bring a mobile van to your community, where would be a safe place for you to get screened?’ and ‘If we were to hold a cancer screening event in your community, where is a good location—one where people will want to attend?’
- When organizing a community event, use patient education tools like an inflatable colon that people can walk through. These tools make it more interesting for attendees and easier for providers to educate participants about screening procedures like colonoscopies. An inflatable colon can easily illustrate polyps and other

“Look at yourself, your own biases, and what you are bringing to the table to be able to reach your patients where they are at. If you can do that hard work—that internal work—before you go out into the community, you’ll be more successful in your community engagement because you will do so in a humble way that is more accepting of individual differences and preferences.”

chronic gastric diseases, as well as malignancies and how these growths can be removed.

- Cancer screening events should be supported by robust social media campaigns that are reflective of the communities that the cancer program is trying to reach.
- The community is key to philanthropic and fundraising efforts. One attendee shared about starting a Men’s Group that individuals pay \$1000 annually to join. “These men are engaged, and they give [join] every year.” The Men’s Group has more than 300 men enrolled and—based on that success—the cancer program started a similar Women’s Group. Both groups enjoy social events with the opportunity to hear and vote on where funds raised are spent. “We just presented to our Women’s Group last week. And they chose to fund a clinical pharmacist for the clinical trials team to the tune of \$400,000 over 2 years.”

“Providers do not have all the answers. Providers are not always experts in their communities. It’s finding those key informants in the community and partnering with them. It’s being part of the community and actively engaging with the community—not just showing up with pamphlets. Letting people know you are part of the community, and you want to make a difference in their lives.”

Shared Decision-Making

- Shared decision-making is a collaborative decision about the treatment of care that is documented and shared with relevant stakeholders. While patients are stakeholders, they do not always feel like stakeholders. It is critical to engage patients and empower them with the understanding that they are important stakeholders.
- Shared decision-making means that treatment and care options take into consideration individual values and preferences. Sometimes a patient’s preference does not look the “majority” preference. While providers can be frustrated when patients do not immediately “adhere” to their treatment recommendations, providers must make the effort to understand the “why” behind those actions and when patients want—or need—providers to work within the parameter of their preferences.

“We host community events for the 5 different cancers we screen. We offer education on nutrition and exercise through activities like a cooking demonstration or a fitness demonstration. We create a ‘festival-type’ atmosphere with children’s activities, music, and food. It makes it more comfortable for people to attend, and it makes the ‘C’ word less scary.”

“If you are going to talk about health equity, geography matters. As a health care organization, we can have the best of intentions, but the ‘ghosts’ of disparities, segregation, and structural racism barriers to care are real. We need to do the work to get patients to trust us [providers] even while we are branded with the names of places where their parents or grandparents could not receive care.”

- In shared decision-making, providers share with patients the best available evidence for treatment options, including the risks and benefits, taking into consideration health literacy. When patients fully understand the information shared, they are empowered as stakeholders in their care.
- Shared decision-making requires medical trust. To build that medical trust, adopt these best practices: (1) ensure providers are culturally aware and inclusive; (2) offer education and support to inform and empower patients; (3) identify and make available a patient advocate; and (4) identify and make available community resources.
- Hold cost of care discussions at initial visits so that patients understand if treatment needs to be delayed due to prior authorization or other payer policies. These discussions should include all key players: the patient, their caregivers, the provider care

“We do not even use the words ‘cancer screening’ at our events; instead, we brand them as ‘Live Well’ events.”

“I have said for years that my cancer program would benefit from navigation, but in our care model, oncology nurses are the social workers’ ‘eyes and ears’ because we [social workers] are ‘invited into spaces’ as opposed to primarily ‘coming into’ those spaces. We spend a lot of time having to do physician education so that we will get consults and referrals and be able to do our assessments. But we need to be brought in at the very beginning—assessing for patient needs and integrating that data into the care plan and then the discharge plan.”

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“I just completed a qualitative study on what is fueling medical mistrust. I was not expecting people to talk about patient-provider communication and the ‘elusive’ concept of shared decision-making, but that’s what was shared. Patients with cancer need to trust what they are being told by their provider team before they make decisions about how and when to begin treatment and what treatment to choose. One of the questions we asked was, ‘Who did you come into contact with throughout your treatment experience who you had a high level of trust with?’ Across the board, they said their nurse and their social workers.”

team, and, if available, a patient advocate. These discussions should also include patient education about when to call their care team and when to go to the emergency department (ED). More, when there is a choice about where to go for emergency care, patients need to be aware of which hospital is in network and which hospital is out-of-network. Patients need all this information to make an informed decision about their care.

Empowered and Informed Patients

- A multidisciplinary approach to cancer care—not just the physician or even the physician and nurse, but team members like a social worker and dietitian and, most important, patient advocate—can help empower and inform patients. This approach allows the team to effectively assess where patients are in terms of health literacy, if patients are emotionally ready to make informed decisions, and if there is anyone else who needs to be at the table, like family members.
- Education on early detection can empower patients to participate at community cancer screening events. And while statistics may *inform* patients, education about the importance of early detection and being there for their family *empowers* patients.
- Mount Sinai proactively combines its psychosocial distress screening with its social determinants of health screening to gather all key patient information in 1 location. This screening is pushed to patients through the patient portal 7 days before their second medical oncology appointment. Screenings are completed every 3 months, empowering patients, and allowing them the time and privacy to answer personal questions. Screening through the patient portal has increased the number of completed surveys. This improved engagement from patients and families has improved the cancer program’s ability to triage results. As soon as patients hit submit, information goes directly to social workers or chaplains or child life specialists, depending on specific needs. And providers are empowered to make decisions about intervention, for example, whether they meet with patients the next time they come into clinic or if it warrants an immediate phone call.
- Getting men to participate in cancer screening can present unique challenges. Men often require different strategies, including working through the women in their lives: their mothers, sisters, spouses, and significant others. Another strategy is to educate men about actions they can take that would benefit their family, for example, a healthy diet, exercise, sunscreen.
- When it comes to patients being diagnosed with cancer, especially men, providers must make sure that patients understand *all* their options—not just what the care team recommends, but all treatment options that are available to ensure patients make informed decisions.

“Patients seem to trust different individuals within the care team at different points throughout their journey. And so, we need to eliminate that hierarchy and belief that only physicians can speak up. We need to empower everyone on the care team to speak up and say, ‘I am identifying an issue, or the patient said something to me.’ And with this new information, we may need to take a step back or circle back around with patients or caregivers or advocates to ensure that patients are comfortable with their care.”

“You have to break it down for patients. We have a lot of men at our prostate cancer screening saying, ‘OK, I’ll pee in the cup for you.’ And you have to say, ‘I’m sorry sir, that’s not how this test works.’ We have women that come to our free prostate cancer screenings. And we have to tell them that they don’t have a prostate. People don’t know their bodies. We have physicians who have actually drawn on the paper on the exam tables where the prostate is to help patients understand why that type of physical examination is the only way to get to the prostate. We have a lot of people who fail to understand the importance of a colonoscopy. I always explain to them that the day before the procedure is actually much worse than the exam—you are asleep, and you don’t feel a thing.”

“My father has advanced prostate cancer. I’m an expert in prostate and bladder cancer. I’m also his daughter. Do you think my father listens to me? No. Because he hears hormone therapy. He thinks about his mother who had hormone therapy. He thinks he is going to grow breasts because he has not had the proper education on the difference between hormone therapy when you are a menopausal woman and the type of hormone therapy you get when you are a man with prostate cancer. And for many years, he based treatment decisions on this misinformation until I called into his [virtual] appointment and insisted the doctor explain the difference. And once that education happened, my father was like, ‘Oh, that’s it?’ And filled the script. Two years of my asking him to do just that—gone. Just an example of how you break through.”

The Role of Advocates and Community Health Workers

- An empowered advocate helps patients make informed decisions. Advocates understand the culture of the patient *and* the health care system. Among many critical tasks, advocates can assist with health literacy, benefit issues, social determinants of health, and barriers to care.
- Organizations such as Atrium Health Wake Forest Baptist and the University of Oklahoma Health use non-clinical navigators in their breast care programs as a best practice. At one program, non-clinical navigators had to be breast cancer survivors so that when patients were diagnosed and attached to a non-clinical navigator, they were essentially “hardwired” into the health care system, improving patient outcomes *and* patient retention.
- Cancer survivors often make highly effective advocates. Through their experience, these individuals have gained health literacy and because they have “walked the walk,” they are trustworthy to patients currently going through cancer treatment.
- Caregivers and family members of cancer survivors can also be effective advocates. Some caregivers of family members who have passed see advocacy as a way of continuing their family member’s legacy.
- Patients and families have a voice as well. Ask them what services

benefited them most and then be prepared to act on their feedback.

- Community health workers are individuals from local communities who are trained and certified to go into their communities and help health care providers build trust in that community. While not clinicians, community health workers partner with providers to educate communities about cancer, heart disease, diabetes, and other chronic health medical conditions. Community health workers can be especially useful in rural communities where providers and resources are often scarce.

“We hear over and over again from our patients that they have good resources and support while they are in the midst of their cancer treatment, but as soon as they get past that [and into survivorship], they feel like they are left on an island.”

“Cancer is so scary itself. A lot of people don’t even want to know if they have it. But if you build that trust and let them know that screening is the next step and that you [the navigator] will be stay with them until we figure out what is going on, you build that trust. They begin to recognize that you are not going to leave them.”

“In my qualitative studies, I’ve noticed that a lot of cancer survivors want to give back. Some do not want to go to support groups; these people often find their ‘support’ through giving back. If you have relationships that you’ve built with former patients and survivors—and their caregivers—that’s a great place to look for patient advocates.”

“Most of the models we’ve talked about today: navigation, patient advocates, community health workers—are not reimbursed. It’s a luxury for a community cancer program to have those services. But if your program has a development or fundraising team, these types of services sell. If you package them correctly, donors will—and want to—fund these types of services because they get at the heart of the community. Someone brought up Walmart earlier. Did you know that every local Walmart has a philanthropy arm that you can apply to for a grant? It may only be \$1000 or \$2000, but if you have 10 Walmarts in your area, that’s \$10,000. I encourage you to work with your development and philanthropy departments—not just for events—but for grants and donors who will support these critical supportive care services.”

STRATEGIES TO MITIGATE PAYER-DRIVEN CHALLENGES

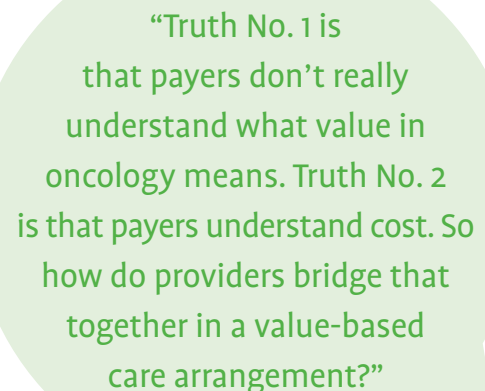
Payers continue to implement strategies, such as prior authorization, step therapy, and white- and brown-bagging, that are burdensome to providers and patients, often having a negative impact on clinical decision-making and patient outcomes.

Facilitators

- Alti Rahman, MHA, MBA, CSSBB, Practice Administrator, Oncology Consultants PA
- Susan Sabo-Wagner, MSN, RN, OCN, Executive Director of Clinical Strategy, Oncology Consultants PA
- Jorge García, PharmD, MS, MHA, MBA, FACHE, Assistant Vice President – System Oncology Pharmacy Service Line, Miami Cancer Institute, Baptist Health South Florida
- Sophia Humphreys, PharmD, MHA, BCBS, Director of System Pharmacy Formulary Management and Clinical Programs, Sutter Medical Center, Sacramento Sutter Cancer Center

Value-Based Care and Payer Contracting

- There is no one-size-fits-all value-based care model.
- Commercial payers answer and are responsible to employers. It is important to keep this mind when negotiating with commercial payers. Providers should consider if there is anything they can do or any actions they can take to better meet the needs of the employer.
- During contract negotiations, providers have the opportunity to educate payers. Educating payers about the number of new oncology drugs that are coming to market, the high price tags of these new therapies, especially with the advent of immunotherapy, and the benefits these therapies have in terms of increased life expectancy or improved quality of life is critical in provider-payer negotiations.
- Public and private payers are starting to adopt the mindset that if they are going to effectively manage high-cost specialties, like cancer, they need to think about what happens before the diagnosis. And that means primary care. So, it will be important to create payer relationships that include primary care. Cancer programs and practices with partnerships with primary care and an



“Truth No. 1 is that payers don’t really understand what value in oncology means. Truth No. 2 is that payers understand cost. So how do providers bridge that together in a value-based care arrangement?”

understanding of what happens in oncology and what happens in primary care have an advantage in payer negotiations.

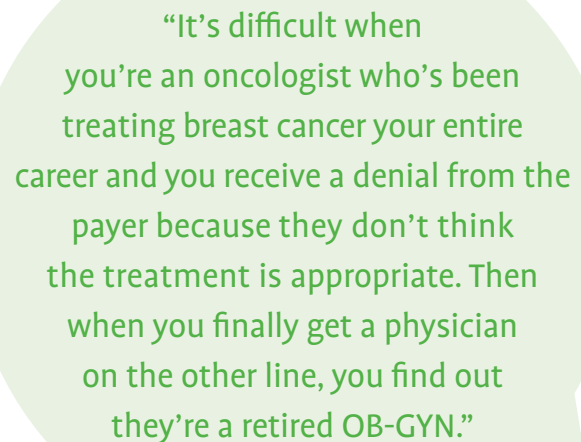
- Some value-based care models use capitation as a cost-savings tool. When providers move into risk-based models, like capitation, where they are responsible for a population and receiving a fixed per capita, per person payment, other utilization management tools, like prior authorization, are effectively minimized or even removed. More advanced capitated models use stop-loss and risk stratification, which takes a population and creates different types of risks associated with different types of disease categories, age categories, etc.
- Other value-based care models are based on episodic reimbursement, paying episodes of 4 months or 6 months at a time rather than by individual codes. That is another way of shifting risk on

to the provider as they can now choose the drugs they will prescribe. Sophisticated calculation and risk adjustment methodologies go into developing these types of episode-based models.

White Bagging

- White bagging is one of the most heavily utilized cost mitigation strategies for payers. The term *white bagging* is when a payer dispenses a drug through pharmacy benefits and delivers the medication to the cancer program or practice to administer to patients. While white bagging is an effective way for payers to cut costs, the strategy has downsides for providers. For example, from an operations standpoint, it can be challenging working with external pharmacies. White bagging can create compatibility issues with IT systems, for example, if the national drug codes (NDCs) are not file, or if it's an "infusion-able" drug and the drug is not compatible with the pump or scanning technology that the cancer program or practice uses. Most institutions have quality and safety systems in place to standardize and manage drug inventory; white bagging can circumvent or limit the quality and safety measures providers have set in place. When providers do not have supply chain records of a drug, they cannot guarantee the efficacy or safety of that the drug.
- From the patient perspective, white bagging can hinder treatment decisions. For example, payers often send drugs days in advance. Yet, when patients arrive at clinic and their most recent lab values call for a dose adjustment, providers are in the predicament of having to proceed with a dose that is suboptimal or delaying care and trying to request a different dose from the payer. White bagging often leads to other delays in care, for example, when medications are delivered after a patient's clinic visit or delivered without clear instructions of where the medication needs to go or even if the medication needs to be refrigerated.
- Data from a 2021 Vizient survey of 260 hospitals on the overall impact of white and brown bagging⁵ found that 95% experienced operational and safety issues; 83% reported instances where the drug did not arrive in time for patient administration; 66% reported instances where the drug received was no longer correct due to an updated patient treatment course or the dose being changed; 43% received a drug that was not built into their computer system; 42% reported instances when the drug delivered was inappropriate and/or the wrong dose; and 37% reported instances when the drug delivered was damaged.
- The first protection against white bagging is an institutional-level policy that describes the boundaries in which providers are willing to accept—or not accept—white bagging that is shared with payers.
- Another option is to institute a clear bagging policy where the drug comes through the pharmacy benefit, which usually means lower reimbursement to the provider compared with the amount they receive under the medical benefit. Clear bagging is generally accepted or endorsed by providers because it negates custody concerns as the drug is controlled at all times by providers.
- In the past 2 years, there has been a lot of engagement to effect policy change on a federal level; however, progress towards addressing quality, safety, and chain of custody concerns around white

bagging have been more successful at the state level. For example, Louisiana enacted a law in 2021 that allows the practice if a provider and a patient agree to it, but payers cannot unilaterally mandate white bagging.⁶ Florida has a 2-arm approach: working with state legislators and working with the Florida Board of Pharmacy. Working with the Florida Board of Pharmacy, white bagging was tied to misfills. So, if a cancer program or practice receives a drug that they did not agree to dispense, the drug is the property of the patient, but the program or practice is in custody of the drug, and the Florida Board of Pharmacy considers that a misfill. Accordingly, the specialty pharmacy that dispensed the medication is subject to Florida Board of Pharmacy disciplinary action. Florida stakeholders were purposeful not to prohibit white bagging entirely as patients who live in rural locations or those with disabilities may require a unique white bagging arrangement, but provider and patients must consent in. Support from Florida's Board of Pharmacy gives stakeholders a much better chance to effect policy change through the legislative arm.



“It’s difficult when you’re an oncologist who’s been treating breast cancer your entire career and you receive a denial from the payer because they don’t think the treatment is appropriate. Then when you finally get a physician on the other line, you find out they’re a retired OB-GYN.”

Prior Authorization

- While payers see prior authorization as an effective tool to control costs and to ensure providers are practicing evidence-based medicine, physicians who took a 2022 American Medical Association survey⁷ about prior authorizations found 93% report that they led to delay of care; 91% report that they led to a somewhat or significant negative outcome; 88% report that their associated burden is high or extremely high; 82% report that they led the patient to abandon treatment; and 1 in 3 (34%) report that they led to serious adverse events.
- Conducting prior authorization requests by phone is common; however, when care is denied, follow-up should be written and documented as this tends to be more effective on the backend. As

opposed to a phone conversation, written follow-up captures all relevant information in one place, including documentation of medical necessity and guideline adherence.

- e-prior authorization tools can streamline workflows; however, provider data is critical. Documentation of medical necessity and adherence to guidelines is key, and cancer programs should ensure these data are verified and reviewed by providers before the prior authorization is sent out.
- Robotic process automation is another tool that can help streamline the prior authorization process. Robotic process automation is the application of technology (bots) to automate business processes that involve humans interacting with digital systems. The idea is to eliminate manual tasks that do not require higher level thinking, while simultaneously creating a scalable digital process to better submit, track, and manage prior authorizations.⁸

“In oncology, there are new therapies in the neo-adjuvant and adjuvant space where time is of the essence. How will providers be able to manage these challenges? And how can a pharmaceutical company help?”

“Cancer progresses. When the prior authorization is sitting on somebody’s desk, cancer cells are multiplying. Delaying of treatment is a significant, negative impact for our patients.”

“As soon as the diagnosis is confirmed, the prior authorization is sent. Knowing how critical the treatment is, some pharmaceutical manufacturers provide free first dose, which helps. Patient assistance is also very important to helping reduce financial toxicity. Field reimbursement managers at the various pharmaceutical companies can be especially helpful with payer denials.”

- Health care systems or practices with multiple clinic locations should consider a centralized prior authorization system. In this model, all prior authorizations come into a central location and then filtered to the appropriate subject matter experts.
- “Gold carding” is a more recent strategy, although adoption has been slow. The American Society of Clinical Oncology defines gold carding as “the practice where payers waive prior authorization on services and prescription drugs ordered by providers with a proven track record of prior authorization approvals.”⁹ Several states are considering gold carding laws that would require health plans to waive prior authorization on services and prescription drugs ordered by providers with a proven track record of prior authorization approvals. Texas enacted a law whereby physicians who have a 90% prior authorization approval rate over a period of 6 months on certain services will be exempt from prior authorization requirements for those services.
- Patient co-pays are an important component of prior authorization. Any prior authorization process should include a step to confirm patient co-pay and deductibles. To help mitigate financial toxicity, providers should educate patients about their deductible

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“I’ll just add that payers have the responsibility to cover at least 1 drug per mechanism of action. And we [providers] need to hold them to it. Payers can cover more [drugs] if they want, but they cannot cover less. Providers also need to know what our patients are entitled to in terms of benefits and to effectively manage denials down the line.”

“The only model that people have really used [for prior authorizations] is to throw FTEs at the problem...just hire more and more FTEs, and the more FTEs you throw at it, the more variables you introduce into the mix and the further away you move from a standardized process... I go into practices all the time and see that they can't even pull basic reports and basic data for tracking... How much time is being spent in peer-to-peer? Benefits verification? First-level denials? First-level appeals? All those data points are critical.”

“Gold carding is kind of like finding the Willy Wonka golden ticket. We have not seen the success of it just yet...but it's important to support those conversations that are happening.”

“As providers, we need to be very invested in talking more about gold carding, not just for the 5% of our patients but beyond.”

“Forget a systemwide prior authorization process. We have a different process for the various authorizations that need to be done within oncology. Our secretaries are doing prior auths [authorizations] for PET scans, financial navigators are doing prior auth for infusion oncolytics, and practice nurses are doing prior auths for oral drugs. Can't we just treat cancer? Trust our clinicians to say, 'This is the way it is based on NCCN guidelines.' When your clinicians are doing paperwork to get paid, then they're not taking care of patients.”

“I have found it really useful to partner with field reimbursement managers at the various pharmaceutical manufacturers. Not only do they know how to deal with prior authorizations, but they are experienced in dealing with denials. Our biggest hurdle is the payers that refuse to pay. And field reimbursement managers help us deal with this. [In one instance,] I was told that there was just a particular phrase that they [payers] were looking for, and we just had to put that in the denial paperwork.”

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and their co-pay. Providers should also know if the patient can tolerate the financial burdens of their care, and if there is a patient assistance program or a co-pay card available. Resources are available to providers, including ACCC's online prior authorization clinic¹⁰ and financial advocacy toolkit.¹¹

- On the policy front, in September 2022, the US House of Representatives passed the Improving Seniors' Timely Access to Care Act.¹² While the legislation applied only to Medicare Advantage plans, it had key components that may be replicated in the future. One is to establish an electronic prior authorization program that meets specified standards. The second is to annually publish specified prior authorization information, including the percentage of requests approved and the average response time.

Step Therapy

- The Centers for Medicare & Medicaid Services defines step therapy as “a type of prior authorization for drugs that begins medication for a medical condition with the most preferred drug therapy and progresses to other therapies only if necessary, promoting better clinical decisions.”¹³ This definition can frustrate the oncology community that believes most providers are already making better clinical decisions.
- Providers see step therapy (or what is often called fail first therapy) as a utilization management tool that takes clinical decision-making out of the physician and provider's hands and putting it in the hands of people who are not necessarily specialists in the field. In cancer, if decisions are being made by someone who does not practice oncology, it may not be the best clinical decision. In the end, step therapy is typically driven by financial—not clinical—decisions.
- Step therapy creates additional barriers for patients, leading people to forgo needed medications and causing patients' medical conditions

to deteriorate; increasing the need for medical intervention in the future and, thereby, increasing health care costs; elevating frustration and incidents of depression; and increasing the risk of nonadherence and self-medication.

- Data¹⁴⁻¹⁶ has shown that 67% of patients who have initial therapy rejected due to step therapy protocols do not receive an alternative therapy within 30 days; 38.9% of drug coverage policies apply step therapy; 20% of patients on step therapy are not getting the treatments prescribed by their providers; and only 34% of step therapy policies are consistent with corresponding clinical guidelines, with more than half of step therapy policies (55.6%) more stringent than corresponding clinical guidelines.
- To effectively advocate for step therapy reform, providers need to enter into discussions with employers, which payers must answer to. Join local and state employer coalitions and educate employers, patients, and caregivers about the negative effects of this payer strategy. Although 29 states have enacted some type of legislation aimed at step therapy reform, more advocacy is needed to enact change on the federal level. On April 13, 2023, the US House of Representatives reintroduced the Safe Step Act, a bipartisan bill to make sure patients can safely and efficiently access the best treatment available to them by improving step therapy protocols.¹⁶

NEW CARE DELIVERY MODELS

COVID-19 accelerated adoption and expansion of new care delivery models, such as virtual visits and remote patient monitoring, which often allowed providers to better meet the needs of underserved patient populations (ie, those who live in rural areas or those with transportation challenges). How does our health care system permanently adopt—and be reimbursed for—models and strategies that work?

Facilitators

- Steve Grubbs, MD, Vice President of Care Delivery, American Society of Clinical Oncology
- Mark Liu, MHA, Senior Director of Oncology Strategy, Transformation & Analytics, Oncology Service Line, Mount Sinai Health System & Tisch Cancer Institute
- Christine Meek, Service Line Business Manager, Munson Healthcare

Telehealth or Virtual Care Models

This cost-effective model for cancer care delivery is becoming increasingly accepted by providers, payers, and patients. Successful implementation requires cancer programs to understand what services can best be delivered virtually, for example, palliative care and genetic counseling, and what patients can most benefit from telehealth services, for example, those residing in rural locations or those facing transportation barriers. To gain this understanding and standardize care, cancer programs can:

- Develop criteria to identify visits and services appropriate for telehealth or virtual visits
- Create consensus-driven decision trees of oncology patients who would benefit the most from this type of care
- Establish governance oversight on telehealth and virtual visits

Community Paramedicine Model

- This model allows providers to evaluate patients while they remain in their home, addressing acute symptoms before patients are sent to the more costly ED or before they come in for an urgent visit at an outpatient cancer center.¹⁷ The model shares similarities with ambulatory oncology urgent care centers.¹⁸ Successful community paramedicine models require ongoing collaboration between paramedicine, ED, and oncology to understand the patients who can safely benefit from this care model.

- Under this model, ED physicians and paramedics become a part of or an extension to the oncology care team, working together to safely and more cost effectively treat patients in their homes.
- For cancer programs with limited space (chairs, exam rooms, or inpatient beds), this model can help to meet ever-increasing patient demand.
- Most importantly, this care delivery model can create a better overall experience and improve care coordination as most patients do not want to go to the ED or urgent care clinic. It is a value-based care model governed by 2 principles: not transporting patients to more costly care locations and keeping patients at home for more cost effective treatment.

Remote Patient Monitoring Models

- Remote patient monitoring programs can enhance and extend care delivered outside the 4 walls of the cancer program.¹⁹⁻²² Remote patient monitoring programs seek to decrease health care utilization, ie, reduce hospital admissions and readmissions and ED visits; improve patient-reported outcomes and symptom management; and use this technology to improve health equity and care of underserved and marginalized groups, ie, those who live in rural locations or those who face transportation barriers.
- The remote patient monitoring program at Mount Sinai Health System focused on patients who were recently discharged from the hospital. Clinicians are engaged during the hospital admission, and staff train patients and help them set up the wearable technology. For others, Mount Sinai offers this tip: consider partnering with a single vendor to supply all components for monitoring vitals, as well as technical support for providers and patients.

- All patients initiating or already undergoing systemic anticancer therapies are eligible to participate in Ochsner Health’s Chemotherapy Care Companion.²⁰ A best practice advisory automatically appears within Epic to remind physicians to enroll the patient in the program. Opening the best practice advisory activates a smart set in Epic that allows for automatic enrollment and completion of the consent process. The patient then receives an e-consent through their MyOchsner portal, including a welcome letter and barcode, with instructions to receive and set up the devices needed to participate.
- Traditionally, patients being treated with chimeric antigen receptor (CAR) T-cell therapies require a hospital admission to manage their toxicities. To avoid these hospitalizations, Vanderbilt Ingram Cancer Center developed and implemented a remote patient monitoring and telehealth model that allowed these patients to be safely treated in the outpatient clinic setting.²²
- Patient selection is key to implementing remote patient monitoring. Cancer programs need to identify patients with the right level of acuity or a specific patient population that they feel will benefit from this technology. Staff engagement and education is also critical to success. Clinicians and staff must buy-in to this care delivery model, including being comfortable with trusting and being able to act on these data—and patient reported outcomes—that come into the cancer program.

Oncology Coordinator Model

- To help move the needle in several quality initiatives, Mount Sinai Health System developed an oncology coordinator model where coordinators (non-clinical patient navigators) help patients transition between outpatient and inpatient sites of care. These oncology coordinators reduced time to treatment and improved hospital throughput. This model allowed the cancer program to think about care design in the way patients experience their care upon admission and discharge. While most cancer programs have ambulatory and inpatient teams, patients view them as one care team. Oncology coordinators can serve as a “quarterback” for both teams, improving communication and care coordination.

Hub and Spoke Model

- To better leverage advanced practice providers (APPs), improve APP and physician partnerships, and ease transportation challenges for rural patients, Munson Healthcare’s oncology service line implemented a “Hub and Spoke Model of Care.”²³ The “hub” is Cowell Family Cancer Center, located in Traverse City on the campus of the Munson Medical Center, a 400-bed tertiary care hospital that houses most of the health system’s major oncology services, including radiation oncology, medical oncology, gynecologic oncology, cardiothoracic surgery, neurosurgery, and urologic and colorectal surgery, as well as advanced diagnostic services, a compounding pharmacy, and inpatient care. The “spokes” consist of 6 community and/or critical access hospitals that offer medical oncology clinics and infusion services and 1 outpatient health center that host therapeutic infusion services. These regional cancer clinics provide medical oncology consultation and follow-up, chemotherapy, therapeutic infusion services, and survivorship care. An APP

and nurse navigator staff all spoke clinics; a hub physician travels to spoke locations 1 to 2 times a week.

- This model allows for the delivery of care in the communities where patients live and improves standardization of care. New patients are often seen at the hub for their consult appointments, with follow-up treatment delivered at the spoke closest to home. Intake specialists at all locations check the new patient address to offer a location closer to home.
- Challenges to the hub and spoke model of care can include physician travel times, different electronic health records, inconsistent pharmacy order sets, and different Medicare carriers with different local coverage determinations for certain drugs. Specific to telehealth or virtual visits, challenges can include lack of reliable high-speed internet for rural patients and patients who may not be physically located in the state when a virtual visit is performed.
- A collaborative practice agreement with physicians and pharmacists at Munson Healthcare Cowell Cancer Center allows pharmacists to provide chemotherapy education, medication reconciliation, and adverse effect management to patients at all spoke locations. Pharmacists conduct regularly scheduled follow-up calls, and patients can contact pharmacists directly. Not only do physicians appreciate the pharmacy support, but it also frees up their time to see more patients.
- Munson’s hub and spoke physician-APP model looks to address both increased patient demand and challenges related to adequate provider staffing, retention, and compensation.²³ Under this model, APP primary responsibilities include transition of care from primary care physicians; chemotherapy education and management; symptom management; bone marrow biopsy procedures; inpatient care management; peer-to-peer prior authorization with payers; and palliative and survivorship care.

American Society of Clinical Oncology-Community Oncology Alliance Oncology Medical Home

- As of July 1, this certification program is replacing ASCO’s Quality Oncology Practice Initiative (QOPI). (Note: The QOPI Certification Program will continue for several more years.) ASCO-COA OMH (Oncology Medical Home) standards have 7 domains: chemotherapy safety, patient engagement, availability and access to care, evidence-based medicine, quality improvement, equitable and team-based care, and goals of care for palliative and end of life discussions.
- The certification program was piloted by 12 volunteer programs: 3 academic-affiliated practices, a large health system, and 8 independent practices, ranging in size from 4 to 100 oncologists. Ninety-five sites of service and 492 oncologists in total participated in the pilot, which demonstrated that programs and practices of any size can meet these standards and set themselves up for success with other alternative payment models.
- Areas of focus include the delivery of patient-centered care (patient engagement, patient education, timely access to care, etc); adherence to evidence-based medicine through the use clinical pathways; utilization and cost of care; and health equity.
- For certification, cancer programs must undergo a policy review followed by an onsite survey. These surveys will be conducted

every 3 years; surveyors will help cancer programs solve problems and identify areas for improvement.

Enhancing Oncology Model

The Enhancing Oncology Model (EOM) went into effect July 1, 2023.²⁴ Key differences between this model and its predecessor the Oncology Care Model (OCM) include as follows:

- Limited to 7 cancer types (breast, colon, chronic leukemia, lung, lymphoma, multiple myeloma, and prostate)
- A \$70 Monthly Enhanced Oncology Services (MEOS) payment per enrolled patient (down from \$160), plus \$30 for dual-eligible
- Required use of health-related social needs screening and gradual implementation of electronic patient-reported outcomes
- Required health equity assessment and plan
- Updated risk-adjustment model
- Mandatory 2-sided risk

Tips to Prepare for an Alternative Payment Model

Before entering into an alternative payment model:

- Know the specificity of included populations and covered services
- Identify if there is a good flow of patient attribution
- Make sure the episode of care you are going to be responsible for is well defined
- Consider information exchange, including data and reporting responsibilities
- Understand your performance measures and benchmarks
- Look at risk adjustment
- Understand 2-sided risk mitigation. Demonstrate ability to generate shared savings before taking risk. Establish stop loss and risk corridors. Include adjustment of shared loss if excellent quality performance.


Trending Now in Cancer Care Part II

Oncology Issues, Volume 38, Number 5 will take a deep dive into trends from AMCCBS workshops on artificial- and business intelligence solutions, precision medicine, and clinical research.



ACCC would like to thank AstraZeneca for its generous sponsorship of the Staffing Models and Workforce Issues deep dive.



For cancer programs and practices new to alternative payment models or those looking to enter into an alternative payment model arrangement, ACCC suggests using its online Alternative Payment Model Implementation Checklist.²⁵ 

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