

Improving care of advanced cancer patients with a dedicated palliative radiotherapy team | 28

Implementing an oncology pharmacy navigator position to manage anti-cancer medications | 34

Developing an education campaign on early detection and cancer prevention | 44

# ONCOLOGY ISSUES

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

May | June 2019

## Supportive Care Just When Patients Need It

*A pilot 24-hour urgent care oncology clinic reduces ED use and cuts costs*



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**Looking for Inspiration?** Hear directly from the 2019 Innovator Award winners at the ACCC 36th National Oncology Conference, October 30 – November 1, 2019, in Orlando, FL.

# contents

Oncology Issues

May | June 2019

Vol. 34 | No. 3

**28** Improving Care of Advanced Cancer Patients with a Dedicated Palliative Radiotherapy Team  
by Kavita Dharmarajan

**34** The Oncology Pharmacy Navigator  
by Kelly Rice

**44** Cancer Crushing Prevention and Early Detection  
by Chuck DeGooyer

**54** Cost of Anti-Cancer Therapies Demands New Strategies for Decision-Making, Shared Responsibility, Communication  
by Amy Hindman

**58** Small in Stature, Large in Impact  
by ACCC Editorial Staff

**64** Elevating Survivorship: Results from Two National Surveys From the ACCC Institute of Immuno-Oncology



## Supportive Care Just When Patients Need It

The Clinical Cancer Center at Froedtert Hospital won a 2018 ACCC Innovator Award for its pilot 24-hour urgent care oncology clinic, which reduced ED use; cuts costs in radiology, EKG, and lab utilization; and improved care and patient satisfaction.

by Tina Curtis and Elizabeth Malosh

## DEPARTMENTS

**2** **From the Editor** | A Meeting of Like Minds

**3** **President's Message** | A Prescription for Sustainable Cancer Care Delivery

**4** **Fast Facts** | Docs call for overhaul of EHRs, and more

**6** **Issues** | Value-Based Care is Already Here: ACCC OCM Workshop

**8** **Compliance** | CERT Reviews Identify Need for Hard Look at Oncology Documentation

**12** **Spotlight** | Highlands Oncology Group, Fayetteville, Arkansas

**14** **Tools** | Approved drugs, and more

**71** **Action** | AACCC 45th Annual Meeting and Cancer Center Business Summit

**74** **Views** | A Patient's Best Friend



Association of Community Cancer Centers

## ONCOLOGY ISSUES

The Official Journal of the  
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## FROM THE EDITOR.....

# A Meeting of Like Minds

BY JENNIE R. CREWS, MD, MMM, FACP



One of the benefits of being an ACCC Past President is that one's official duties at a conference are limited, and one has time to take in the sessions and spend time catching up with colleagues and friends. I took full advantage of these benefits at the 45th ACCC Annual Meeting & Cancer Business Summit, held Mar. 20-22 in Washington, D.C. My list of highlights from the meeting includes a glimpse into the future of oncology care, the promise of technology in enhancing care delivery, and the newly added Deep Dive Workshops covering a variety of topics.

In the meeting's opening session, healthcare futurist Joe Flowers and Allen Lichter, MD, FASCO, showed us the potential future state of oncology care. Flowers surmised that the future of oncology will include value-based care but in potentially new models such as "spot auctions" of services and a focus on population health and community wellness. Dr. Lichter predicted seven trends that would influence oncology care over the next decade, including:

- Challenges in screening and detection, where more sensitive and less invasive tests will allow us to detect cancer earlier but require us to determine which of those cancers will be life-threatening.
- Escalating drug costs, which will challenge us to re-examine the role of pharmacokinetics in specifying appropriate dose.
- An emphasis on the social determinants of health, which will challenge us to move outside of our sphere of expertise and push us to address disparities in housing, nutrition, and education.

The future of oncology also depends on harnessing technology, and several sessions highlighted the role that advances in digital health, big data, and artificial intelligence and machine learning will play in oncology care delivery. For example, we learned how Sarah Cannon Cancer Center has leveraged technology to standardize nurse navigation and how big data can enhance efficiency in operating room scheduling. We heard about the promise and pitfalls of machine learning in guiding cancer care and how wearables and embedded devices may assist in reporting patient symptoms in real time to improve management of conditions and side effects.

My final highlight of the meeting was the smaller Deep Dive Workshops, which focused on immuno-oncology, strategic partnerships, oncology staff resiliency, and improving patient education and engagement. In small groups, participants brainstormed ideas to transform cancer care going forward and made actionable steps toward improving upon the status quo. The format of these workshops allowed for more interactive discussion and easier sharing of best practices. Be on the lookout for more Deep Dive Workshops at ACCC meetings in the future.

For me, the ability to take time away from daily duties and stressors and immerse myself in learning is one of the most valuable reasons to attend an ACCC meeting. Taking dedicated time to inform myself on the most pressing issues in cancer care delivery, as well as potential strategies and solutions for overcoming them, is crucial in providing the best possible care to our patients. The other is connecting with colleagues—to learn, to share, and to realize that the future of oncology is bright because together we are stronger.

For more from the 45th Annual Meeting & Cancer Center Business Summit, including blog posts and press coverage, visit [acc-cancer.org/amccbs](http://acc-cancer.org/amccbs).

# A Prescription for Sustainable Cancer Care Delivery

BY ALI MCBRIDE, PHARMD, MS, BCOP



I am honored to serve this year as ACCC president. Each ACCC president has the privilege of selecting a theme that is a prime focus for the Association throughout the year. In selecting a theme that resonates with

the multidisciplinary membership of the ACCC, I believe that it is important to build on the great work conducted under my predecessors, Tom Gallo and Dr. Mark Soberman, who addressed cancer care team resiliency and the next-generation cancer care team. With that in mind, I am pleased to announce the theme for my 2019-2020 presidency: **Collaborate. Educate. Compensate: A Prescription for Sustainable Cancer Care Delivery.**

Now, let me put some context to those words.


First is **Collaborate**. As our options for treating cancers grow, the cancer care team continues to innovate and expand. The advent of novel therapies, new molecular pathologic identification of cancer diseases, and cutting-edge anti-cancer treatments has engaged additional healthcare team members, including molecular pathologists, interventional oncologists, geriatric oncologists, and palliative care providers, as well as additional supportive care staff such as financial advocates, lay navigators, and home healthcare providers. It is clear that to deliver 21st-century cancer care, breaking down siloes is not only essential but salient for the future of patient care. ACCC is the “together we are stronger” organization—committed to collaboration and to creating and sharing strategies and opportunities that bring oncology care providers together as an efficient, highly functioning team.

The word **Educate** is core to ACCC’s mission as the “leading education and advocacy organization” for the multidisciplinary cancer care team. Through our meetings, publications, website, blogs, and ACCCExchange, members access resources to

help every member of the care team keep up with the rapid shifts underway in oncology—from policy and regulatory changes to the latest advances for effective delivery of immunotherapy and other emerging treatments. New technologic advancements are continually innovating cancer care, including telemedicine, biosimilars, electronic medication adherence devices for oral oncolytics, and next-generation sequencing technologies. Throughout the year, we will work with members to develop and further define the tools and resources necessary to help every team member work to the top of their license to deliver quality cancer care.

Which takes me to the most nuanced—and sometimes polarizing—word. **Compensate**. In the simplest terms: ACCC members should be compensated for the delivery of the comprehensive cancer care services they provide. And yet we all know that current compensation (or reimbursement) approaches do not in fact “compensate” for all of the services needed to provide holistic, patient-centered care. As our healthcare system moves forward with value-based compensation models that incorporate strategies such as bundled or episode-based payments, ACCC and other key stakeholders must advocate and educate on behalf of cancer care providers across all care settings.

So, what is my prescription for sustainable cancer delivery? First, we should continue to actively promote and support collaboration among all members of the cancer care team. Second, we should ensure that our staff has the resources and tools they need to succeed. And, finally, we should qualitatively and quantitatively demonstrate the value that each member of the cancer team brings to our patients, share these data with both public and private payers, and continue to make our voice heard in the development of any new payment models.

**Collaborate. Educate. Compensate.** I believe that this is a prescription for sustainable cancer care delivery that together we can make a reality. 

## Coming in Your 2019 ONCOLOGY ISSUES

- ▶ Utilizing Telehealth to Improve Survivorship Care
- ▶ Oncology Program Planning: A Framework for Your Team
- ▶ Bedside Yoga as a Nonpharmacological Intervention for Cancer Patients
- ▶ ArtsCare: Professional Artists and Musicians as Members of the Multidisciplinary Cancer Care Team
- ▶ Implementing a Clinical Assessment and Rapid Evaluation (CARE) Clinic
- ▶ Meeting the Information Needs of Veterans with Cancer
- ▶ Improving the Tumor Board Experience with Technology
- ▶ PSA Utilization at a Safety-Net Hospital Before and After the 2012 USPSTF Recommendation
- ▶ Chemotherapy Stewardship: The Evolving Role of Pharmacists
- ▶ Genetic Counselor Extenders and Telegenetics Improve Patient Access
- ▶ A Model Virtual Infusion Program
- ▶ Mt. Sinai’s Chemo Companion Program
- ▶ Leveraging Data Analytics to Develop Survivorship Care Plans
- ▶ Development and Implementation of a Patient Pathology Consult Program
- ▶ Bridging the Gap in Patient Education with Digital Communication
- ▶ Going the Distance: Bringing Cancer Care to the Navajo Nation

➔ more online @  
acc-cancer.org



### ICYMI Key Takeaways from #AMCCBS

Couldn't make it to D.C. for the ACCC 45th Annual Meeting & Cancer Center Business Summit in March? See what you missed, access key takeaways, session snapshots, videos, and more. [acc-cancer.org/accbuzz45amccbs](http://acc-cancer.org/accbuzz45amccbs).



### Case Studies in Immuno-Oncology: A Closer Look at Care Delivery

This CME/CE accredited program is available in two formats: as an on-demand audiocast and as an on-site live tumor board presentation. Five ACCC Cancer Program members have an opportunity to host this education program on-site at their facility. Apply at [acc-cancer.org/projects/io-case-studies](http://acc-cancer.org/projects/io-case-studies).



PUBLICATION

### 2018–2019 ACCC Annual Report

From a timeline of tools and resources developed last year to help members address clinician resiliency and well-being to new cancer programs that joined in the last 12 months to a recap of a robust menu of educational offerings, read how ACCC focused its time and resources in 2018-2019. [acc-cancer.org/2018annualreport](http://acc-cancer.org/2018annualreport).



WEBINAR

### Multidisciplinary Geriatric Oncology Care Webinar Series

By 2030, cancer incidence in the U.S. is expected to grow by 45 percent to 2.3 million adults. More than two-thirds of this increase will be in adults aged 65 and older. How is your program or practice preparing to meet the diverse needs of this patient population? Join in a six-part webinar series on caring for older adults with cancer. [acc-cancer.org/geriwebinars](http://acc-cancer.org/geriwebinars).



TOOL

### Downloadable IO Wallet Card

Early recognition and prompt management of immune-related adverse events (irAEs) are integral to the effective delivery of immunotherapy for cancer. For patients, knowing who call, when to call, and what immunotherapy they are receiving or have received is essential. The ACCC Immuno-Oncology Institute has developed a medical wallet card for patients on immunotherapy for cancer. Access the downloadable print-ready PDF at: [acc-cancer.org/IO-walletcard](http://acc-cancer.org/IO-walletcard).



EDUCATION

### CLL: Lunch and Learn

As part of the ACCC Multidisciplinary Chronic Lymphocytic Leukemia (CLL) Care project, ACCC is offering member programs an opportunity to host a 60-minute lunch-and-learn program that will bring expert faculty to your facility to discuss important treatment and care management updates for these cancers. Interested? Contact Monique Dawkins at [mdawkins@acc-cancer.org](mailto:mdawkins@acc-cancer.org).

# fast

## Docs Call for Overhaul of EHRs

- More than half of surveyed physicians (**54%**) say using an EHR detracts from their professional satisfaction.
- Half (**49%**) think using an EHR detracts from their clinical effectiveness.
- Nearly **3/4** agree EHRs have increased the total number of hours they work daily (**74%**) and that EHRs greatly contribute to physician burnout (**71%**).
- **59%** think EHRs need a complete overhaul.
- **40%** believe there are more challenges with EHRs than benefits.
- Only **18%** reported being “very satisfied” with their current EHR.

Source: Stanford Medicine. How Doctors Feel About Electronic Health Records National Physician Poll by The Harris Poll. [med.stanford.edu/content/dam/sm/ehr/documents/EHR-Poll-Presentation.pdf](http://med.stanford.edu/content/dam/sm/ehr/documents/EHR-Poll-Presentation.pdf).



## 3 Key Reasons Why EHRs Overwhelm U.S. Physicians

- 1. Profit.** In the U.S. a key feature of EHR use is to document charges. While charges are audited by payers, longer notes support higher charges in the current fee-for-service system.
- 2. Multiple payers.** The U.S. has dozens of payers in any given market, each with their own rules about documentation and pre-approval. Physicians must document every single data point that any given payer in their marketplace might require at every single visit.
- 3. “Quality” metrics.** Each payer requires different “quality” metrics. Because payers don’t coordinate effort, physicians must document every quality metric that any given payer in their marketplace might require at every single visit.

Source: Drummond M. Physician Burnout and EMR—It’s the Keystrokes, Silly. Documentation Overload and Four Ways Forward. [thehappyemd.com/blog](http://thehappyemd.com/blog).



# facts



## Telemedicine & Medicare Advantage Plans

While coverage of telehealth services is expanding, a survey of 781 Medicare Advantage members shows that few know about it:

- **46%** were unsure if their plan offers telehealth.
- **37%** said it is not offered.
- **17%** noted that their plan does offer these types of services.



Source: HealthMine Medicare Survey. healthmine.com.

## Data Blues

- Surveyed organizations estimate that they lose more than **\$2 million** per year because of data management challenges.
- On average, this survey found that employees lose 2 hours a day searching for data, resulting in a **16%** drop in workforce efficiency.
- Almost all of the organizations surveyed (**97%**) believe they have missed valuable opportunities as a result of ineffective data management.
- More than **one-third (35%)** admit to losing out on new revenue opportunities while 2 in 5 (**39%**) say their data challenges have caused an increase in operating costs.

Source: Veritas Research. Value of Data Study. veritas.com/form/whitepaper/realizing-the-power-of-enterprise-data.

## Secure Texting vs. Patient Portals

- When in-person conversations and phone calls are not an option, **twice as many** people surveyed prefer receiving information via secure text messages rather than through a patient portal.
- More than **90%** would like the ability to communicate via secure text messaging with a family member's care team if that loved one were ill.
- **83%** would welcome text reminders from their doctors about taking prescribed medications, checking blood

pressure, completing rehabilitation exercises, scheduling follow-up appointments, or similar tasks.

Source: DrFirst. drfirst.com/news/survey-patients-prefer-secure-texting-over-patient-portal-communication-from-their-physicians/.



## Studies suggest that U.S. physicians now spend as much time on “desktop medicine” (interacting with the computer) as they do face to face with patients.

Source: Downing NL, et al. Physician burnout in the electronic health record era: are we ignoring the real cause? *Ann Intern Med.* 2018;169(1):50-51.



## Value-Based Care is Already Here: ACCC OCM Workshop

BY BLAIR BURNETT



In the world of oncology, you often hear the phrases “transition from volume to value” and “value-based care is here to stay”—but, after countless conferences, workshops, and webinars, those phrases can lose real meaning. At the Friday, Mar. 22, ACCC Oncology Care Model (OCM) Collaborative Workshop held in conjunction with the ACCC 45th Annual Meeting & Cancer Center Business Summit, presenters and participants came together to share their experiences with the real-world barriers they have encountered as they continue forward in the OCM; their successes achieved to date; and their suggestions for proactive steps to help ensure a smooth transition to value-based care in oncology.

OCM is the first alternative payment model for medical oncology from the Center for Medicare and Medicaid Innovation (CMMI), exploring the move from fee-for-service to value-based care in cancer care from 2016 through 2021. Almost three years into the model, 180 cancer programs across the country are still participating, and more than one-third of those practices made the trip to Washington, D.C., for the March ACCC OCM workshop. As workshop moderator Basit Chaudhry, MD, PhD, pointed out, the timing for the meeting was ideal, coming at the release of Performance Period 3 data. Practices still participating in the OCM are approaching an indicative and potentially program-altering crossroads. At the end of summer 2019, these 180 practices will need to make a choice whether to assume two-sided (rather than nominal) risk. The

assumption of two-sided risk is required to continue participating in the OCM through the model’s intended end date in 2021. Currently, one-third of participating OCM practices have achieved a performance-based payment in the model, an indicator that many are viewing as a lens into who will and will not assume two-sided risk in this iteration of OCM.

With this pivotal decision point quickly approaching, the ACCC OCM Collaborative Workshop participants listened to case studies and presentations that explored approaches to deploying cost containment and utilization strategies, examined how OCM practices are operationalizing their data, and participated in in-depth discussions about assuming risk in the current OCM model.


Members of the CMMI OCM team were also in attendance to provide updates and answer some of the participants’ most pressing questions.

Implementation of this model is no small feat for these OCM practices. Tasked with increasing the value of patient care through implementation of the 13-part Institute of Medicine care plan and with driving down costs to achieve a performance-based payment, the experience of the OCM practices is being viewed as a window into the future of value-based care for oncology and is being closely watched by all oncology stakeholders.

Despite the challenges, the OCM Workshop participants recognize that this experience is conferring a level of knowledge

and empowerment that should put them ahead of the curve with the many alternative payment models anticipated from CMMI in the coming months and years. Though the future of OCM beyond 2021 is still very much up in the air, health policy experts across the country note that this model will likely lay the groundwork for the future of bundled payments and serves as a look-ahead to what all practices will be expected to implement to successfully transition to a value-based care delivery system.

Since the early days of the model, collaboration and communication have been essential to pushing the needle forward for practice transformation. The ACCC OCM Collaborative has been there from the start, with the goal of helping OCM practices connect and support each other in this groundbreaking endeavor. Plan now to attend the next OCM Collaborative Workshop in Orlando, Fla., in October. See how this workshop puts ACCC’s belief that “Together, We Are Stronger” into action.

For more information, and to join the ACCC Oncology Care Model Collaborative, visit [ocmcollaborative.org/home](http://ocmcollaborative.org/home). 

*Blair Burnett is senior policy analyst at ACCC.*

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# compliance

## CERT Reviews Identify Need for Hard Look at Oncology Documentation Practices

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

**T**he Comprehensive Error Rate Testing (CERT) for improper payment analysis was implemented by the Centers for Medicare & Medicaid Services to identify and measure improper payments in the Medicare Fee-for-Service program. To accomplish this, CERT randomly selects approximately 50,000 claims submitted to Part A and B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs during each reporting period. The size of the review allows the agency to calculate a national improper payment rate along with a service-specific improper payment rate. Because the sample of medical records reviewed is random, the calculation of the overall improper payments is considered appropriately applicable to all claims processed.

CERT has five assigned error categories to make a determination of whether the claim was paid or denied appropriately:<sup>1</sup>

- 1. No documentation.** Claims are placed into this category when the provider or supplier fails to respond to repeated requests for the medical records or when the provider or supplier responds that they do not have the requested documentation.
- 2. Insufficient documentation.** Claims are placed into this category when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the CERT contractor reviewers could not conclude that the billed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is

missing, such as a physician signature on an order or a form that is required to be completed in its entirety.

- 3. Medical necessity.** Claims are placed into this category when the CERT contractor reviewers receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage and payment policies.
- 4. Incorrect coding.** Claims are placed into this category when the provider or supplier submits medical documentation supporting (1) a different code than that billed, (2) that the service was performed by someone other than the billing provider or supplier, (3) that the billed service was unbundled, or (4) that a beneficiary was discharged to a site other than the one coded on a claim.
- 5. Other.** Claims are placed into this category if they do not fit into any of the other categories (e.g., duplicate payment error, noncovered or unallowable service).

Findings published in the calendar year 2018 CERT demonstrate that radiation oncology, medical oncology, and hematology continue to have issues with documentation.<sup>2</sup> The analysis found an overall accuracy rate of 91.9 percent, but included an 8.1 percent improper payment rate for the medical records reviewed. Within the improper rate findings for Part B, the results do not paint a flattering picture for radiation or medical oncology.

Medical oncology was the 19th highest speciality overall, with an improper payment rate of 12.7 percent of the 112 claims reviewed.<sup>2</sup> Ninety percent of those improper

claims had insufficient documentation. Radiation oncology was projected to be in the top 20 of most improperly paid claims, with a 10.3 percent overall rate; 100 percent of those improper claims were projected to be due to insufficient documentation. The actual findings showed a 10.8 percent improper payment rate on 60 reviewed claims, which had a 96.9 percent error rate due to insufficient documentation; 0.5 percent were due to medical necessity, and 2.6 percent were due to incorrect coding.

According to the fiscal year 2018 results, “oncology-radiation therapy” was listed as 20th on the list of Projected Improper Payment Rates by Service Type: Part B.<sup>2</sup> As reference, “other drugs” and “office visits-established” were listed as first and second respectively; chemotherapy was 29th, and “oncology-other” was 51st.

The results from the fiscal year 2018 CERT review are concerning for radiation oncology, because they continue to reflect data that show ongoing issues with documentation of services. On Jan. 15, 2014, CGS, the MAC for Ohio and Kentucky, published data on its website that indicated that radiation therapy had a projected error rate of 42.7 percent and was listed among the top 10 errors by type of service.<sup>3</sup> These data came from a CERT sampling period of July 2012 through June 2013.

The cases presented as an example on the CGS website indicated that medical records submitted to support codes such as treatment delivery and portal imaging (**CPT 77414** and **CPT 77417**) included no patient treatment history information, notes for dates of service other than requested, insufficient signatures, and images with no patient identifiers. Still other cases to

support IMRT treatment delivery (**CPT 77418**) submitted the prescription, plan, consult notes, and other radiation oncology notes, but no documentation that the treatment was administered or that supported IMRT over other forms of therapy. Lastly, medical records for **CPT 77427** (physician management services) were submitted but in no way supported the actual code. Records submitted included chemotherapy records, lab results, unsigned physician's notes, unsigned discharge instructions, and, upon second request, computed tomography imaging records and colonoscopy and EGD results.

CERT findings on the CGS website included the following tips for improving accuracy of submitted records:<sup>3</sup>

- The two most common errors noted among claims for radiation oncology services are failing to send supporting documentation and submitting records without a valid signature. These errors are preventable, and we encourage you to take immediate steps to ensure that your medical records staff understands what records to submit. We recommend that you review all medical records, before submitting claims, to ensure that they contain valid signatures that meet Medicare's signature requirements.
- Although the CERT process involves a very small sample of records, we have found that any errors identified in the sample are often present in other records.
- We strongly encourage you to review these errors and incorporate awareness of these errors into your practice's quality procedures.

The first tip provided by CERT and CGS to improve accuracy of submitted records is an extremely important and valid point: ensure that the staff tasked with submitting medical records know what medical records to submit in response to inquiry or denial. The findings of the CERT review reveal a lack of knowledge or training on radiation oncology documentation by the staff submitting and answering the requests. Documentation for radiation oncology services is not typically supported with consultative or procedure-type notes as commonly found with other specialties.

Much of radiation oncology documentation is image based or housed in such a way that a report can be obtained—it just requires knowledge of the system to obtain. Another key item to consider is the need for staff to have necessary access to medical record(s), including any separate radiation oncology-specific medical records that may be housed and maintained separately from a larger electronic health record.

Other findings and tips highlight ongoing issues identified routinely in medical record reviews: a lack of physician signatures or signatures that fail to meet the requirements. If a signature is illegible, an attestation or signature log can be submitted with the original approval to assist; however, many times this documentation is lacking. Documentation is not just the responsibility of the staff answering medical record requests. Signature requirements are something that all physicians should be familiar with and evaluated on to ensure compliance, because the lack of or incompleteness of a signature, no matter how complete the documentation of the service may be, can render the service improper.

Additional information about signature requirements can be found on the Centers for Medicare & Medicaid Services website, as well as Code of Federal Regulations Title 21, Part 11, Electronic Records; Electronic Signatures, Subpart B, Electronic Records, Sec. 11.50, Signature Manifestations, which states the following:<sup>4</sup>

- (a) *Signed electronic records shall contain information associated with the signing that clearly indicates all of the following:*
- (1) *The printed name of the signer;*
  - (2) *The date and time when the signature was executed; and*
  - (3) *The meaning (such as review, approval, responsibility, or authorship) associated with the signature.*
- (b) *The items identified in paragraphs (a)(1), (a)(2), and (a)(3) of this section shall be subject to the same controls as for electronic records and shall be included as part of any human readable form of the electronic record (such as electronic display or printout).*

Other findings in the calendar year 2018 CERT report identify issues with evaluation

and management visits for established and subsequent inpatient visits under the specialty of hematology/oncology.<sup>2</sup> Hematology/oncology was listed as 13th out of 13 for improper payments rates for established office visits by provider type and 11th out of 12 for improper payments rates for subsequent hospital visits by provider type.

In light of these findings on improper payment rates, it is increasingly important for providers to closely evaluate all documentation prior to any code or claim submission to ensure that the documentation is complete and appropriate. In addition, ongoing education and review of staff handling requests for medical records in response to denials or payer review is necessary to ensure that preventable errors are not inadvertently identifying specialties as problematic or requiring additional scrutiny.

Tables 1-5, pages 10-11, provide a brief synopsis of the data collected and how the specialties of radiation, medical, and hematology/oncology were valued.

*Teri Bedard, BA, RT(R)(T), CPC, is director, Client Services at Coding Strategies, Inc., Powder Springs, Ga., and Revenue Cycle, Inc., Cedar Park, Tex.*

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**Table 1. Improper Payment Rates by Provider Type and Type of Error: Part B<sup>2</sup>**

Provider Types Billing to Part B <sup>a</sup>	Improper Payment Rate	Claims Reviewed	Percentage of Provider Type Payment by Type of Error				
			No Documentation	Insufficient Documentation	Medical Necessity	Incorrect Coding	Other
Chiropractic	41.0%	388	0.0%	88.3%	7.7%	4.0%	0.0%
Medical oncology	12.7%	112	2.2%	90.0%	0.0%	7.8%	0.0%
Radiation oncology	10.8%	60	0.0%	96.9%	0.5%	2.6%	0.0%
Hematology/oncology	3.0%	355	3.2%	60.5%	1.6%	34.7%	0.0%

<sup>a</sup>Chiropractic had the highest overall improper payment rate; as a comparison, medical oncology was in 18th place, radiation oncology was in 26th place, and hematology/oncology was in 49th place.

**Table 2. Improper Payment Rates and Amounts by Provider Type: Part B**

Part B Services (BETOS Codes) <sup>a</sup>	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Provider Compliance Improper Payment Rate	Percentage Overall Improper Payments
Internal medicine	1,941	\$1,489,011,538	15.7%	9.9%-21.4%	23.1%	4.6%
Medical oncology	112	\$268,472,362	12.7%	(6.1%)-31.5%	12.9%	0.8%
Radiation oncology	60	\$151,911,093	10.8%	(0.8%)-22.3%	14.3%	0.5%

<sup>a</sup>Improper payments by provider type showing internal medicine with the highest rates, medical oncology providers in 9th place, and radiation oncology providers in 24th place.

**Table 3. Improper Payment Rates by Service Type: Part B<sup>2</sup>**

Part B Services (BETOS Codes) <sup>a</sup>	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage Overall Improper Payments
Other drugs	79	\$1,092,458,318	9.1%	(0.1%)-18.4%	3.4%
Office visits-established	1,461	\$1,050,386,680	7.1%	6.0%-8.2%	3.3%
Oncology-radiation therapy	33	\$112,699,466	10.3%	(2.2%)-22.7%	0.3%
Chemotherapy	156	\$64,081,928	2.1%	(0.3%)-4.5%	0.2%
Oncology-other	280	\$10,490,824	4.2%	(1.5%)-10.0%	0.0%

<sup>a</sup>Radiation therapy was 20th on the list of Projected Improper Payment Rates by Service Type: Part B. As reference, other drugs and office visits-established were listed as first and second, respectively; chemotherapy was 29th and oncology-other was 51st.

**Table 4. Improper Payment Rates for Office Visits-Established by Provider Type<sup>2</sup>**

Office Visits-Established	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage Overall Improper Payments
Internal medicine	1,941	\$1,489,011,538	15.7%	9.9%-21.4%	4.6%
Radiation oncology	60	\$151,911,093	10.8%	(0.8%)-22.3%	0.5%

<sup>2</sup>Improper payments by provider type showing internal medicine with the highest rates, medical oncology providers in 9th place, and radiation oncology providers in 24th place.

**Table 5. Improper Payment Rates for Hospital Visit-Subsequent by Provider Type<sup>2</sup>**

Office Visits-Established	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage Overall Improper Payments
Internal medicine	626	\$242,034,784	11.5%	9.2%-13.7%	31.6%
Hematology/oncology	31	\$8,988,060	9.3%	1.6%-17.0%	1.2%

<sup>2</sup>Improper payments by provider type showing internal medicine with the highest rates, medical oncology providers in 9th place, and radiation oncology providers in 24th place.

# spotlight

## Highlands Oncology Group Fayetteville, Arkansas



**A**lthough smoking rates have steadily decreased nationwide in recent years, Arkansas remains home to a disproportionately high number of smokers. Though smoking among U.S. adults has fallen to 14 percent, it stands at more than 22 percent in Arkansas, which ranks 47th in adult smoking prevalence among U.S. states.<sup>1</sup> That trend has taken its toll; in 2017, nearly 34 percent of deaths in Arkansas were attributable to smoking.<sup>2</sup>

### Waging a Proactive Fight Against Cancer

“The high percentage of adults who smoke in this region has added significantly to the prevalence of lung cancer in the population we serve,” says Jeff Hunnicutt, CEO of Highlands Oncology Group, a large multisite private practice with four locations in northwest Arkansas. As a participant in the Centers for Medicare and Medicaid Services Oncology Care Model, Highlands has implemented enhanced services for its patients to improve care coordination, promote patient navigation, and uphold national treatment guidelines.

As part of those efforts, Highland’s leadership has committed to proactively addressing the consequences of Arkansas’ high smoking rate with its Center for Chest Care. Established in 1999, the center was the first community-based, multidisciplinary chest cancer clinic in the United States. The clinic employs a staff of seven—including a team of oncologists and radiologists—who work with the community to identify, diagnose, and treat those at high risk of cancers of the lungs and chest.

The center launched a patient screening initiative in 2013 to detect early-stage lung cancer in the community. The program—based on the screening criteria created by the U.S. Preventive Services Task Force in 2014—offers no-cost, low-dose computed tomography scans to community members who have risk factors for lung cancer related to their smoking status and age.

“Our lung cancer screening program is a very unique offering to our patient population,” says Hunnicutt. “There are few programs in community oncology or the hospital academic setting that employ this model with a dedicated program such as ours.” Hunnicutt says that the goal of Highlands’ Center for Chest Care is to detect lung cancer at stage I or stage II, before patients exhibit any symptoms. Nationwide, only 16 percent of lung cancers are diagnosed while the tumor is still in its earliest stages of growth.<sup>3</sup>

Within the last three years, Highlands Oncology Group has detected lung cancer in 137 individuals through its free screening, of which 94 percent were at stage I or stage II—dramatically increasing the chances of survival for those individuals. “No other program that I know of is as successful in the number of patients screened annually,” says Hunnicutt, “or with the number of oncology diagnoses that are made from screening.”

### Identifying and Meeting Patient Needs

Highlands Oncology Group’s four clinical sites employ 400 staff members who collectively see nearly 6,000 patients each year. Among the staff are 11 medical

oncologists, three radiation oncologists, two supportive care physicians, two surgeons, four social workers, two physical therapists, two massage therapists, 52 registered nurses, and one genetic counselor—all directly employed by Highlands. Four oncology pharmacists work in two specialty pharmacies, and a third pharmacy is opening in 2020.

Hunnicutt says that the two largest sites—a 50,000-foot facility in Rogers, Arkansas, and a 20,000-foot facility in Fayetteville, Arkansas—offer multidisciplinary services for all major cancer types. Highlands also has a separate facility for surgical oncology—gynecological and colorectal—in addition to a building for the lung cancer screening program and the Center for Chest Care. Highlands’ oncologists work in offices that are arranged in a “hub model” that keeps them in close proximity, encouraging collaborative patient care. Oncologists also attend regular tumor boards to consult on treatment options for complex cases.

Highland’s two patient assistance representatives (or financial advocates) may also play a prominent role on a patient’s cancer care team. “When patients first come to us, we give them a survey to assess their needs outside of clinical care, including financial or spiritual concerns,” says Hunnicutt. “This gives us an opportunity to learn about any socioeconomic concerns they may have. If patients demonstrate a need for financial assistance, we refer them to our patient assistance representatives.” Those representatives work with individual patients to explore options that can help lessen their financial burden, including



co-pay assistance and drug replacement programs. Patient assistance representatives also work closely with local and regional nonprofits to help patients finance their nonclinical needs.

On-staff oncology social workers may provide supplemental assistance to patients struggling with medical expenses. Social workers are available to meet with patients before, during, or after treatment to address their emotional or financial needs. They can connect patients with resources that can help them better cope with their diagnoses and the circumstances that accompany them. If needed, social workers can also help patients with transportation, language interpretation, and tobacco cessation.


### A Standout in Research and Community Activism

Highlands' robust clinical trials program further distinguishes it from similar practices. Hunnicutt says that the practice has maintained its research program for more than 20 years. Currently, the 22 employees of Highlands' clinical trials program are working with 120 patients enrolled in more than 80 trials that cover a variety of cancer diagnoses. Highlands is the only community phase I oncology clinical site in the state of Arkansas.

Finally, Highlands prides itself on the community outreach that has made it well known in the region. "The people in northwest Arkansas are very familiar with us," says Hunnicutt. "We participate in many of the community's cancer awareness and fundraising events. If there is a breast cancer fun run, we're there. If there is a prostate cancer awareness rally, we participate. Each time our community wants to educate people about cancer detection and care, we do our best to take part in it."

The Highlands Center for Chest Care takes an especially proactive approach in educating the community and referring providers to its free lung cancer screening services. "We take advantage of being invited to community events like those sponsored by Rotary Clubs, Kiwanis, and others," says Hunnicutt.

He adds that although the breadth of Highland's clinical services distinguishes it from other cancer practices, it is the depth of its commitment to its patients that is its

crowning achievement. "There are many unique pieces of Highlands Oncology that I feel separate us from other providers," says Hunnicutt, "but the biggest thing that stands out to me is the length our providers, managers, and staff go to in order to put the needs of the patient first in everything we do. You never have to look far to find a positive patient testimony about the level of care patients have received from our practice, and that makes my job as administrator so much more enjoyable." 

### References

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# tools



## Approved Drugs

- On February 28, the U.S. Food and Drug Administration (FDA) approved **Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk)** injection for subcutaneous use (Genentech Inc., gene.com) for the treatment of human epidermal growth factor receptor-2 (HER2) overexpressing breast cancer.
- On February 15, the FDA approved **Keytruda® (pembrolizumab)** (Merck & Co. Inc., merck.com) for the adjuvant treatment of patients with melanoma with involvement of lymph node(s) following complete resection.
- On February 25, the FDA approved **Lonsurf® (trifluridine and tipiracil)** (Taiho Oncology, taihooncology.com) for the treatment of adult patients with metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least two prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and, if appropriate, HER2/neu-targeted therapy.
- On March 8, the FDA approved **Tecentriq® (atezolizumab)** (Genentech, gene.com) plus **Abraxane® (nab-paclitaxel)** (Celgene, celgene.com) for the frontline treatment of patients with unresectable locally advanced or metastatic PD-L1-positive triple-negative breast cancer.
- On March 19, the FDA approved **Tecentriq® (atezolizumab)** (Genentech, gene.com) in combination with chemotherapy (carboplatin and etoposide) for the first-line treatment of adults with extensive-stage small cell lung cancer.

- On March 11, Pfizer Inc. (Pfizer.com) announced that the FDA approved **Trazimera™ (trastuzumab-qyyp)**, a biosimilar to Herceptin, for the treatment of HER2-overexpressing breast cancer and HER2-overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma.

## Drugs in the News

- Moleculin Biotech, Inc. (moleculin.com) announced that it has submitted a request for fast track designation with the FDA for **Annamycin** for the treatment of relapsed or refractory acute myeloid leukemia.
- Aptose Biosciences Inc. (aptose.com) announced that the FDA has completed their review and granted investigational new drug acceptance for **CG-806** for patients with chronic lymphocytic leukemia or non-Hodgkin lymphomas.
- Heron Therapeutics, Inc. (herontx.com) announced that the FDA has approved a supplemental new drug application (NDA) for **Cinvanti® (aprepitant)** injectable emulsion to expand its administration to a two-minute intravenous injection beyond the approved 30-minute intravenous infusion.
- Ziopharm Oncology, Inc. (ziopharm.com) announced that the FDA has granted fast track designation for its **Controlled IL-12 program (Ad-RTS-hIL-12 plus veledimex)** for the treatment of recurrent or progressive glioblastoma multiforme in adults.
- Bayer (bayer.com) and Orion Oyj (orion.fi) have submitted an NDA for **darolutamide**

for the treatment of patients with nonmetastatic castration-resistant prostate cancer.

- Atossa Genetics, Inc. (atossagenetics.com) announced that the FDA has approved the use of **endoxifen** for “expanded access” as a postmastectomy treatment in premenopausal patients with estrogen receptor-positive breast cancer.
- Eureka Therapeutics (eurekatherapeutics.com) announced that the FDA has cleared its investigational NDA for **ET140202 ARTEMIS T-cell therapy** for patients with hepatocellular carcinoma who are positive for alpha-fetoprotein.
- Janssen (janssen.com) announced that it had submitted a supplemental biologics license application (BLA) to the FDA seeking approval of **Darzalex® (daratumumab)** in combination with lenalidomide and dexamethasone for the treatment of newly diagnosed patients with multiple myeloma who are ineligible for autologous stem cell transplant.

The company also submitted a supplemental BLA to the FDA seeking approval of **Darzalex** in combination with bortezomib, thalidomide, and dexamethasone for newly diagnosed patients with multiple myeloma who are eligible for autologous stem cell transplant.

- Imbrium Therapeutics (imbriumthera.com) announced that the FDA has granted orphan drug designation to **etoposide toniribate**, a novel topoisomerase II inhibitor, for the treatment of relapsed refractory biliary tract cancer.

(continued on page 16)

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The ACCC Financial Advocacy Network is the leader in providing professional development training, tools, and resources that will empower providers to proactively integrate financial health into the cancer care continuum and help patients gain access to high quality care for a better quality of life.

ACCC

Association of Community Cancer Centers

(continued from page 14)

- Celgene (celgene.com) announced that the FDA has accepted the company's NDA and granted priority review for **fedratinib** for the treatment of patients with myelofibrosis, a bone marrow disorder that disrupts the body's normal production of blood cells.
- The FDA has granted priority review to **Keytruda® (pembrolizumab)** (Merck & Co. Inc., merck.com) in combination with axitinib as a frontline treatment for advanced renal cell carcinoma.  
  
The company also announced that the FDA has accepted and granted priority review for a new supplemental BLA for Keytruda as monotherapy for the treatment of patients with advanced small cell lung cancer whose disease has progressed after two or more lines of prior therapy.
- Selvita (selvita.com) announced that the FDA has accepted its investigational new drug application for **SEL120**, a CDK8inhibitor for patients with acute myeloid leukemia or high-risk myelodysplastic syndrome.

- The FDA has granted priority review to **Tibsovo® (ivosidenib)** (Agiros Pharmaceuticals Inc., agios.com) for first-line treatment of patients with acute myeloid leukemia with an isocitrate dehydrogenase mutation who are not eligible for standard therapy.


The FDA also granted breakthrough therapy designation to **Tibsovo** in combination with azacytidine for the treatment of newly diagnosed acute myeloid leukemia with an isocitrate dehydrogenase mutation in adult patients who are 75 years old or older or who have comorbidities that preclude use of intensive induction chemotherapy.

- Imbrium Therapeutics L.P. (imbriumthera.com) announced that the FDA has granted orphan drug designation for **tinostamustine** for the treatment of T-cell prolymphocytic leukemia.
- Roche (roche.com) announced that it has submitted a supplemental NDA to the FDA for **Venclexta® (venetoclax) plus Gazyva® (obinutuzumab)** for patients with previously untreated chronic lymphocytic leukemia and coexisting medical conditions.

## Approved Devices

- **Paige.AI** (paige.ai), a computational pathology start-up focused on developing artificial intelligence tools for pathologists for clinical diagnosis, announced that it has been granted breakthrough device designation by the FDA.
- ViewRay (viewray.com) announced that the company has received 510(k) clearance from the FDA to market new soft tissue visualization capabilities for its MRIdian **SmartVISION MRI** system.

## Genetic Tests and Assays in the News

- Roche (roche.com) announced that the FDA has approved the **VENTANA PD-L1 (SP142) Assay** as the first companion diagnostic to aid in identifying patients with triple-negative breast cancer who are eligible for treatment with Tecentriq® plus Abraxane®. 

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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.



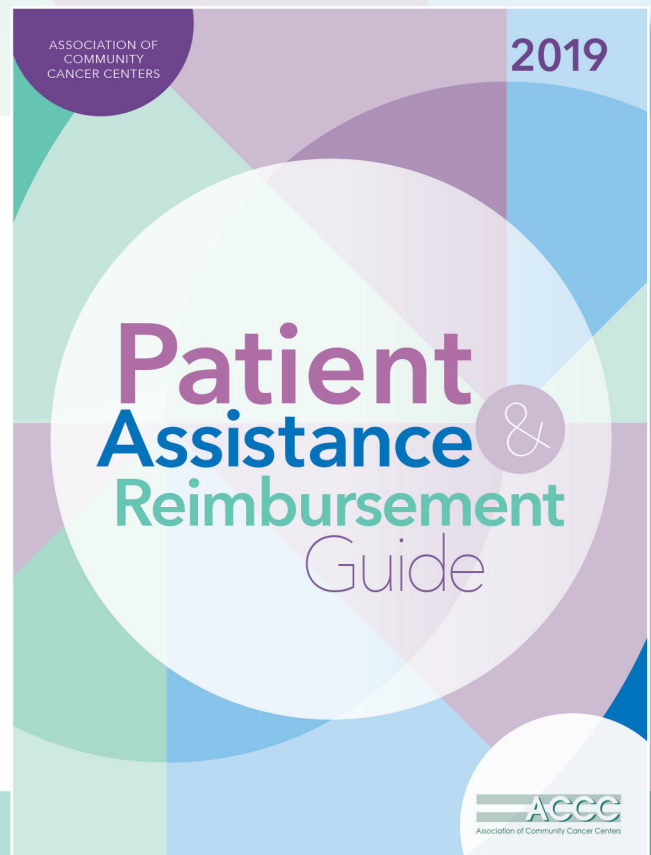
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# Supportive Care Just When Patients Need It







## *A pilot 24-hour urgent care oncology clinic reduces ED use and cuts costs*

**P**atients undergoing active cancer treatment—namely, radiation therapy and chemotherapy—can experience a variety of symptoms, including uncontrolled pain, neutropenic fever, dehydration, electrolyte imbalance, diarrhea, anemia, and thrombocytopenia. These symptoms can occur any time of the day or night, and they may require immediate or urgent clinical assessment and treatment. Same-day appointments may be available to oncology patients under active treatment, but they are often limited. Patients who experience symptoms outside of business hours, or when same-day appointments are unavailable, are often directed to seek care in the emergency department (ED) or wait until the next business day.

Receiving care in an ED is not without clinical or financial risk for oncology patients.<sup>1</sup> Neutropenic patients may be exposed to viral and bacterial pathogens from other ill patients. And ED providers may be risk averse, ordering oncology patients redundant tests and procedures, such as lab work, radiology screenings, and electrocardiograms.<sup>2</sup> ED staff may also be more likely than cancer specialists to admit oncology patients as inpatients.

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To determine the need for a 24-hour oncology-only clinic, we analyzed how oncology patients were currently using the ED by reviewing patient charts and conducting targeted interviews with key providers.

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One approach to increasing access to oncology-specific urgent care is to create a 24-hour outpatient oncology clinic. This concept is of growing interest to oncology programs across the nation, although there is currently little in the literature describing these disease-specific services. There are a variety of challenges to providing same-day care to patients experiencing acute symptoms related to their diseases or treatments.<sup>3</sup> This article describes the

creation of a 24-hour outpatient oncology clinic housed in an academic tertiary referral hospital located in a major metropolitan area.

The Clinical Cancer Center at Froedtert Hospital in Wisconsin is home to more than 4,500 patients newly diagnosed with cancer each year. The center houses eight multidisciplinary disease-specific cancer clinics that offer surgical oncology, radiation oncology, and medical oncology services. Patients also have outpatient access to an oncology lab, procedure suite, a 54-bed infusion room, and a dedicated early-phase clinical trials translational research unit. In fiscal year 2018, there were more than 297,000 outpatient visits to the cancer center.

### Analysis of Need

To determine the need for a 24-hour oncology-only clinic, we analyzed how oncology patients were currently using the ED by reviewing patient charts and conducting targeted interviews with key providers. Specifically, we examined patient arrival patterns, the types of diagnostic tests clinicians were ordering, and the frequency with which oncology patients were being admitted to the hospital. Our analysis revealed an average of 150 to 185 oncology-related visits to the ED each month, resulting in an admission rate of more than 55 percent.

An outpatient oncology nurse and an oncology nurse practitioner performed a detailed clinical chart review on a sample of 30 oncology patient visits during a six-month period. They reviewed utilization patterns, paying specific attention to the use of laboratory tests and diagnostic radiology. The nurses found that oncology patients who required urgent supportive care—such as those reporting with chief complaints of pain, nausea and vomiting, and dehydration—used diagnostic services more frequently.

We then conducted structured conversations with several high-volume oncology providers. These individuals expressed frustration with the lack of after-hours appointments for supportive care services, along with their inability to place same-day urgent patients in the hospital’s already busy infusion room.

### Laying the Foundation for a Pilot Program

Next, we brainstormed with key oncology leaders about how to best treat urgent care oncology patients in a timely manner. We discussed our vision of a 24-hour oncology clinic staffed by cancer care providers. We then conducted a literature review, which produced several examples of successful oncology urgent care models.<sup>4</sup>

Though there was interest and support for this proposal, we recognized that a permanent oncology urgent care strategy could not be implemented without definitive evidence of patient utilization. We proposed a plan to pilot test a 24-hour oncology clinic to determine its value to patients and the hospital and to gauge the extent of overall patient demand. To do this, we formed a multidisciplinary team of clinic and infusion nurses, medical oncology advance practice providers, and inpatient and outpatient nursing leaders to work out details and guide the clinic’s creation.

This team, which included key opinion leaders, helped refine our vision of the clinic, specifically outlining the operational details necessary to make the clinic successful (see Table 1, below).

Our review of ED utilization by oncology patients had revealed their most common chief complaints to be related to symptom management, including:

- Pain
- Shortness of breath
- Weakness
- Dehydration
- Uncontrolled nausea and vomiting.

Because the goal of the pilot was to create a long-term urgent care strategy for the organization, we determined that the clinic should offer services to address commonly needed supportive care treatments. We decided that the clinic’s services should include:

- Lab draws
- Fluid and electrolyte replacement
- Blood product transfusions
- Antibiotic administration
- Home infusion pump support
- Standard diagnostic services.

**Table 1. Implementation Process**

Gain pilot approval from health systems’ Healthcare Value Council
Gain approval of space planning by the hospital operations committee
Create a multidisciplinary team to determine clinic operations and patient flow
Create dedicated department in the EHR
Create and gain approval for the operating budget, including needed full-time equivalents
Determine clinical provider support
Hire and onboard clinic staff
Determine marketing and communication plan
Finalize organizational metrics for success, including measurement process
Complete construction of 24-hour clinical space, including state inspection
Finalize orientation and key EHR workflows
Open 24-hour cancer clinic
Conduct ongoing monitoring against key metrics.

## Finding a Home

Our oncology providers had a strong preference for giving the clinic dedicated space. This would allow providers to send home-based oncology patients to the clinic for triage and evaluation at any time of day. It would also provide a space for patients to have planned follow-up, or continuity of care appointments, during evening or weekend hours. These visits would enable providers to assess recently discharged patients and check their lab values outside of routine clinic hours.

We evaluated multiple locations for the pilot clinic, including the existing space used for our oncology clinic and infusion room within the hospital's outpatient cancer center. Although the cancer center is a logical place for patient care needs and it is already familiar to our patients and clinical staff, it closes on weekdays at 8 pm. After-hours staff are limited to several infusion nurses, and there is no front desk, pharmacy, or immediate provider support. Additionally, the cancer center is in a building on the edge of our large campus, several minutes away from our dedicated hematology and oncology inpatient units, in which an oncology provider is stationed in the evening. We examined the feasibility of opening the cancer center 24 hours a day, but we determined that to be too costly for the purposes of the pilot.

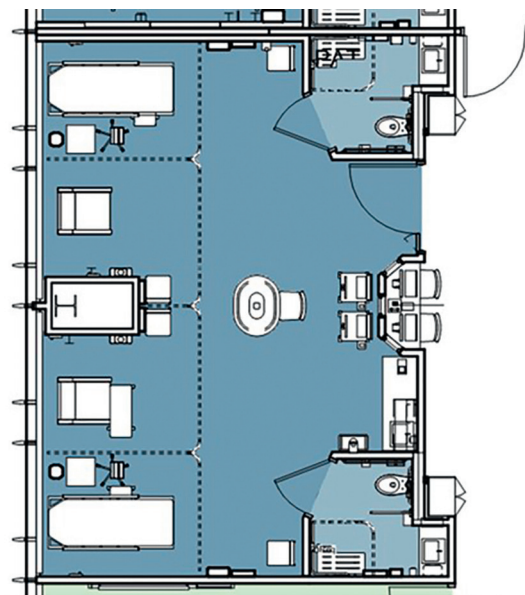
However, a new solution soon presented itself. Around the time that the hospital's Health Care Value Council approved the 24-hour oncology clinic pilot, the hospital also decided to build two additional inpatient units in the building immediately adjacent to the cancer center. The new space would house 64 hematology and oncology inpatient units and connect to the existing cancer center by way of a sky bridge. The hospital decided to reserve space in its new addition for the 24-hour oncology clinic pilot. The clinic would be housed in what was to be two inpatient rooms near the entrance to the new unit. By removing the wall between the two rooms, the hospital created one large 670-foot space for 24-hour oncology patient care. The finished space incorporates four patient bays, two 50-foot patient bathrooms, wall oxygen and suction, and a dedicated nurse charting space (see Figure 1, right). One significant advantage to having the clinic located on the hospital's inpatient unit is the ability of clinic nurses to communicate face to face with receiving inpatient nurses if a patient requires admission. This type of interaction promotes continuity of care as patients transfer from one location to another.

## Staffing the Clinic

Given the small space allotted for the pilot study and the need for nurses staffing the clinic to be comfortable with both routine outpatient care and urgent symptom management, building a nursing workforce for the clinic was challenging. Clinic nurses also had to be knowledgeable about the layout of the inpatient unit, because they would be physically stationed in the inpatient setting while working with oncology providers.

To best meet these requirements, we created a first-of-its-kind oncology nursing resource pool to train nurses for both inpatient and outpatient care environments. We cross-trained the nurses who elected to be part of this resource pool so that they would be qualified to provide care in the two dedicated hematology/oncology units, the outpatient oncology infusion

Figure 1. 24-Hour Cancer Clinic Schematic





24-Hour Cancer Clinic entrance, located on the inpatient oncology unit.

room, and the 24-hour cancer clinic. Our extended nurse orientation included training in the inpatient and outpatient electronic health record (EHR) and orientations to three nursing environments (two inpatient units and the outpatient infusion room). A dedicated nursing leader was assigned oversight of both the operations of the 24-hour cancer clinic and of the oncology nursing resource pool staff.

### Creating a Cost Structure

Because lowering the cost of oncology care is a key objective of the 24-hour cancer clinic, we designed it to be an extension of our existing outpatient daytime oncology services. This allowed us to duplicate our daytime charge structure for the new clinic, creating seamless billing for oncology providers who see patients in the 24-hour facility. Like our outpatient services, the new clinic would participate in the Oncology Care Model (OCM) program, a national five-year payment reform program sponsored by the Center for Medicare and Medicaid Innovation. The purpose of the OCM is to promote higher-quality, more coordinated oncology care with payment arrangements that include financial and performance accountability for episodes of care. Because our 24-hour cancer clinic's charge master (or fee structure) mirrors the one that we use for our daytime outpatient clinic services, the new clinic was able to serve as a potential opportunity for lowering the patient's cost of care, which is the goal of participating in the OCM. This eliminated the need for our 24-hour cancer clinic to adopt a more expensive charge master like those found in other urgent care or emergency departments.

To further simplify the new clinic's functionality, we created a dedicated EHR department that mirrors the functionality of

our daytime outpatient infusion room, making both documentation and ordering familiar to nurses and oncology providers. This dedicated EHR allowed us to track visits, arrival patterns, and other key metrics related to the 24-hour cancer clinic.

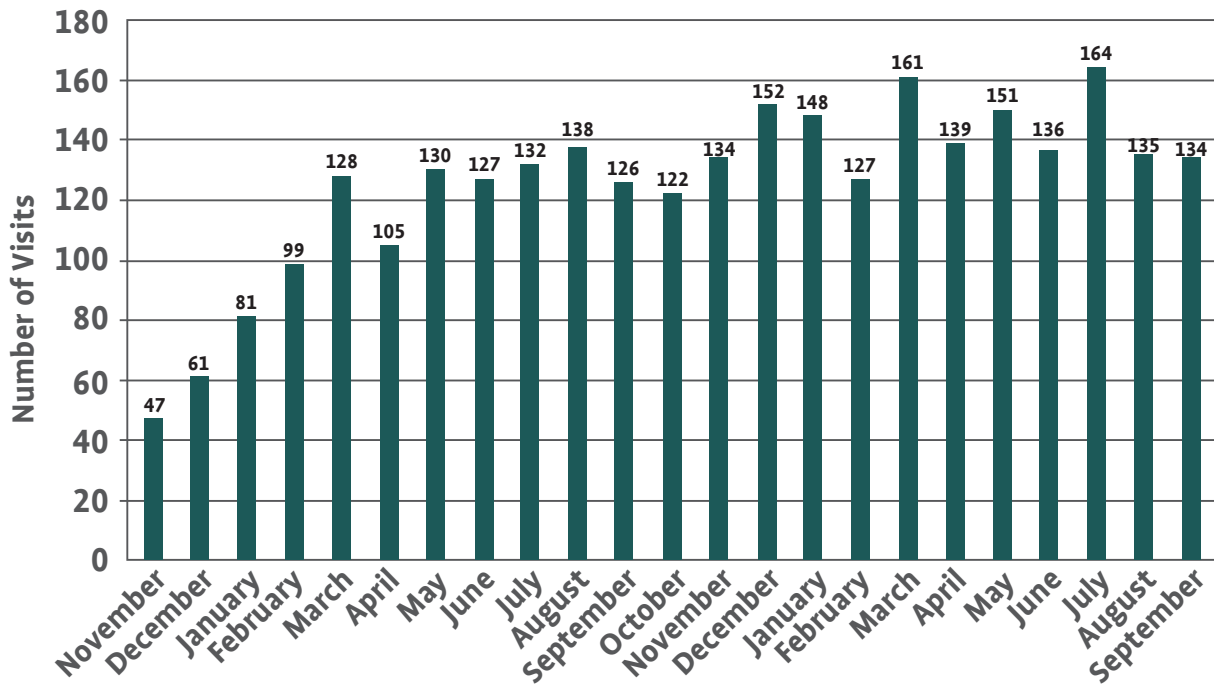
### Initial Results

Our quality improvement analysis was based on our ability to demonstrate clinically competent care that meets patients' and providers' expectations. We tracked the volume of patients presenting to the 24-hour cancer clinic, the types of services that we provided, the number of patients that we admitted (or readmitted), and the utilization of diagnostic services. We measured patient satisfaction with surveys, patient rounding, and postdischarge phone calls.

Since the Froedtert & Medical College of Wisconsin 24-Hour Cancer Clinic opened Nov. 1, 2016, it has served more than 3,000 patients—approximately 140 each month (see Figure 2, right). The cancer clinic is open to all oncology patients, including those who have been seen by our medical oncology, surgical oncology, and radiation oncology departments. Our initial analysis shows a 10.7 percent decrease in oncology patients' use of the ED from January 2016 to June 2016 compared to January 2017 to June 2017. We measured 56 percent, 32 percent, and 11 percent decreases in radiology, electrocardiogram, and lab utilization, respectively, for patients seen and discharged from the cancer clinic compared to patients discharged from the ED. The admission rate from the 24-hour cancer clinic was 18 percent, compared to a 42 percent admission rate for oncology patients treated in the ED.



Figure 2. 24-Hour Cancer Clinic Volume, November 2016 to September 2018





Patients at the 24-Hour Cancer Clinic see oncology providers who are familiar with their specific needs.

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The Froedtert & MCW Clinical Cancer Center is one of six treatment locations in the Froedtert & MCW Cancer Network.

With less ED use, direct charges to oncology patients who received care in the clinic have decreased by \$1,500 to \$2,500 per visit compared to ED charges for similar services. Patients have expressed a high level of satisfaction with the 24-hour cancer clinic, where they say that providers understand their needs, promptly address them, and, in many cases, send patients home rather than admitting them to the hospital. Patient satisfaction currently has a top box score of 92 percent for the overall rating of care, with comments that show significant appreciation for the clinic's services. Postdischarge phone calls have demonstrated that oncology patients recognize the value of an urgent care clinic that specifically serves them. Some patient comments include:

- *“You guys are great. It is so comforting to know that you are here, and you understand what I need.”*




Jessica Glaser, RN, and Chantel Relihan, RN, are nurses serving patients in the 24-Hour Cancer Clinic.

- “This was way better than having to go to the ER or urgent care. You know exactly what I need and know what to do, and you get it done.”
- “Things went perfectly. You guys took very good care of me. It is nice to have a place like this where people know what I am going through.”

### Looking Ahead

The long-term success of our 24-hour cancer clinic will depend on our ability to demonstrate a sustained reduction in the use of emergency services, diagnostic testing, and readmissions. By decreasing the need for these services, both oncology patients and government and commercial payers will benefit financially. A more efficient use of our resources will help us be more competitive in today’s oncology market, a key to the overall long-term success of our organization. Given the success of the initial pilot, discussions are in process to determine how to expand the space and services of the 24-hour cancer clinic to meet ongoing patient demands.

As the shift from volume- to value-based reimbursement accelerates, organizations must develop processes that promote efficiency and appropriate use of medical resources while also providing adequate, cost-effective disease-specific care. The Froedtert & Medical College of Wisconsin 24-Hour Cancer Clinic is an important step toward both lowering the cost of oncology care and increasing overall value for patients. 

*Tina Curtis, DNP, MBA, RN, NEA-BC, is executive director, Cancer Services, and Elizabeth Malosh MSN, RN, NE-BC, is nurse manager, Cancer Center Lab and 24-Hour*

*Cancer Clinic, Froedtert & the Medical College of Wisconsin Clinical Cancer Center at Froedtert Hospital campus, Milwaukee, Wisc.*

Thank you to the dedicated nurses, advanced practice providers, physicians, and numerous support staff from Froedtert and the Medical College of Wisconsin who worked tirelessly to make this clinic available to our cancer patients. This project would not have been possible without the assistance of Dr. Susan Breakwell and Dr. Kristin Haglund, Marquette University, College of Nursing.

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# Improving Care of Advanced Cancer Patients with a Dedicated Palliative Radiotherapy Team







Patients suffering from cancer in its advanced stages often experience symptoms of pain and discomfort. Palliative radiation therapy, or radiation therapy focused on ameliorating symptoms from metastatic disease, is a highly effective treatment modality when utilized appropriately. Palliative radiation can have lasting benefits for patients with advanced cancers with limited prognosis by reducing tumor-causing pain (and thereby significantly cutting opiate requirements, sometimes to zero), improving mobility, and consequently improving the overall quality of life.

Similar to the Sword of Damocles, two opposing sides exist within the concept of palliative radiation therapy. Despite its efficacy, at times the treatment course places an increased burden of care and responsibility on patients and their families because it can involve lengthy durations of daily treatments, lasting up to two weeks or longer. In turn, this may lead to prolonged hospitalizations for patients who are unable to travel back and forth to the radiation facility on a daily basis for treatment. Moreover, the immediate radiation-related side effects may sometimes outweigh treatment benefits in patients with short life expectancies.

Traditionally, radiation oncology programs have been disease-focused rather than person-focused and as yet have not put a high priority on creating systems of care around palliative radiation therapy for patients with advanced cancers. The consequence of this has been that palliative radiation therapy has involved lengthier courses than necessary and lengthier wait times for patients, thereby posing challenges for patients with advanced cancers in terms of financial costs, travel time, and temporary detriments to quality of life.

This innovative radiation oncology-based clinical service operates closely with the palliative medicine service within Mount Sinai Hospital. Its core mission is to care for the whole person, not merely the metastatic lesion causing the pain symptom prompting the initial radiation consultation.

Mount Sinai Hospital's Department of Radiation Oncology and the Tisch Cancer Institute in New York, N.Y., saw these challenges as an opportunity to incorporate radiation oncology within a multidisciplinary workflow that included palliative care providers and other supportive oncology services in order to improve upon the national benchmarks. Through the establishment of a specialized service model called the Palliative Radiation Oncology Consult service, the radiation oncology department was able to increase the use of shorter-course radiation treatments, reduce lengths of hospital stay, and improve access to and utilization of palliative care services for patients with advanced cancers after radiation treatment.

## Palliative Radiotherapy in Practice

It has been estimated that approximately a third of cancer patients who receive radiation therapy receive it in a palliative capacity.<sup>1,2</sup> Though treatment regimens for palliation among cancer patients with bone metastases can be two weeks or longer, shorter regimens are available and have proven to be equally efficacious.<sup>3</sup> According to a study published by Gripp et al., prolonged irradiation schedules probably reflect overly optimistic prognoses and unrealistic concerns about late radiation damage.<sup>4</sup> In light of this, shorter regimens have historically not been commonly used. For instance, in a 2013 study from Surveillance, Epidemiology and End Results Medicare data, only 3.3 percent of Medicare beneficiaries with bone metastases from prostate cancer received single-fraction treatment.<sup>5</sup>

For individuals with limited prognosis and/or severe debility, however, the length of a treatment course can be burdensome. Overall, palliative radiation for symptoms of bone metastases can effectively relieve symptoms 80 to 90 percent of the time. Notably, patients generally do not experience an immediate benefit from palliative radiation. Because radiation response is of a cumulative nature, patients will likely experience symptom relief approximately four to six weeks after completion of the radiation treatment course. Anything that providers can do to reduce suffering from symptom burden during this period is of critical importance.

## The Palliative Radiation Oncology Consult

This innovative radiation oncology-based clinical service operates closely with the palliative medicine service within Mount Sinai Hospital. Its core mission is to care for the whole person, not merely the metastatic lesion causing the pain symptom prompting the initial radiation consultation. The Palliative Radiation Oncology Consult performs its mission in three ways: first, by employing the shortest evidence-based and guideline-directed radiation treatment courses for metastases without compromising efficacy; second, by discussing individual cases in a tumor board forum attended by representatives from multiple disciplines with emphasis on symptom management; and, third, by routinely participating in goals of care conversations held often with patients, family members, palliative medicine specialists, and patients' primary oncology providers.

The Palliative Radiation Oncology Consult service is staffed by a radiation oncologist with a special interest in the needs of patients with advanced cancers, a nurse, an administrative assistant, and rotating residents and fellows representing both radiation oncology and palliative medicine disciplines. The Palliative Radiation Oncology Consult cares for patients with advanced cancers with any type of palliative radiation need. As a complement to the Palliative Radiation Oncology Consult service, a multidisciplinary symptom management tumor board exists whose role is to discuss optimal management of individual cases. The tumor board is attended by representatives from radiation oncology, palliative medicine, anesthesia, interventional radiology, social work, and nursing. In this way, radiation oncology and other

care teams are directly involved in face-to-face shared decision making, often prior to the start of radiotherapy. The Department of Radiation Oncology at the Mount Sinai Hospital treats approximately 2,000 cancer patients per year. The program utilizes five linear accelerators and two radiotherapy simulators.

The Palliative Radiation Oncology Consult was conceptualized as a cohesive team-based approach with three disciplines working in close communication: radiation oncology, palliative medicine, and primary oncology. Each discipline in the model was responsible for a different aspect of the patient's treatment (see Figure 1, right), ensuring that all of the patient's needs and concerns were addressed in a timely manner.

Individually, these teams were responsible for:

- **Radiation oncology:** Guided by symptoms, interpreting imaging and planning radiation therapy by utilizing the shortest evidence-based and guideline-directed radiation treatment courses.
- **Primary oncology:** Evaluating feasibility and efficacy of systemic treatment options given the patient's prognosis and clinical situation.
- **Palliative medicine:** Addressing new or existing physical and nonphysical symptoms of distress, providing support to patients and family members, and assisting with goals of care conversations with patients and families.

Together, the three teams were responsible for working together and gathering information from patients and families in order to incorporate it into recommendations for management that were: 1) better aligned with patients' elicited values and goals and 2) consistent with what would be reasonably achievable given the prognosis and/or clinical situation at hand.

A number of important steps were often taken in order to ensure the successful integration of the Palliative Radiation Oncology Consult service into the overall management plan. First, palliative radiation oncology was often actively involved in goals of care discussions prior to the start of radiation therapy. These conversations often helped crystallize a rationale for shorter, or longer, where appropriate, courses of palliative radiation. For example, it was important to understand the differences in purpose and potential outcomes of single-fraction radiation treatments compared to multiple-fraction courses of radiation treatments in the setting of vertebral metastases. These discussions influenced decision making and empowered patients and families to make better informed choices about where to have radiation, when to have it, how many treatments they needed to undergo, etc. We were also able to place more timely referrals to specialist-level palliative and supportive care services when necessary.<sup>6</sup>

Obtaining support from colleagues within the radiation oncology department was critical. This meant getting buy-in from departmental medical physics and therapy staff to keep slots open for patients with advanced cancers and turn around radiation treatment plans quickly. This can be difficult to do on a routine basis in many radiation oncology practices where schedules are often operating at maximum capacity.

## Results

We undertook an early assessment of the efficacy of the Palliative Radiation Oncology Consult service by comparing patterns of care and outcomes for patients with symptomatic bone metastases treated before and after the establishment of the consult service.

Demographic variables between the two studied cohorts were similar in sex, age, and the proportion receiving radiation therapy during a hospitalization (Table 1, below). We performed a propensity-adjusted score analysis to match patients on several variables, including medical insurance, which is known to affect timeliness of outpatient treatment accessibility.

Since the Palliative Radiation Oncology Consult's inception in 2014, we have seen a five-day reduction in hospital length of stay for inpatients receiving radiation; a \$20,000 cost savings per hospitalized radiation patient; a fourfold decrease in unnecessarily lengthy radiation courses; a corresponding two- to threefold increase in the use of shorter but equally efficacious radiation courses such that patients spent less of their time receiving palli-

ative radiation; and a 15 percent increase in patients who met with a palliative care provider within a month of completing their radiation. Pain improvement was not compromised (Figures 2 and 3, page 32).<sup>7,8</sup>

The increased risk of needing retreatment is often cited as a reason for patients and providers to forgo abbreviated treatment regimens in lieu of multifraction treatments. In our experience, patients who came back to our department for reconsultation were most often returning to discuss treatment at a new site, not the same site. Additionally, we found that some patients were ready to accept the possibility of needing a retreatment later if it meant coming for only one treatment now.

For patients with metastases where fracture risk or spinal cord compression was a concern, we continued to prescribe multiple-fraction radiotherapy treatments as appropriate, because these were cases of tumor control rather than palliation. The goal of the Palliative Radiation Oncology Consult program was to move the needle for patients with uncomplicated metastases who could appropriately be treated with one radiation fraction.

Figure 1. The Palliative Radiation Oncology Consult Service

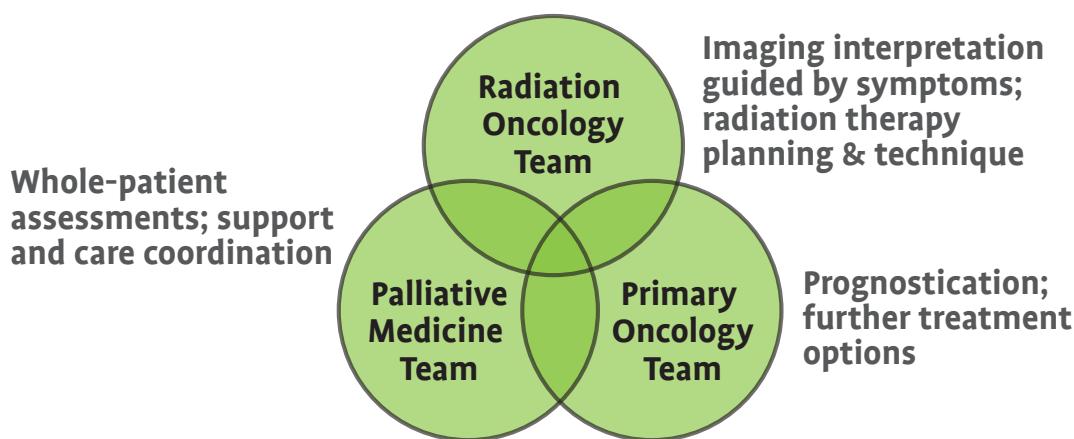


Table 1. Analysis of Study Patient Population Pre- and Post-Implementation of the Palliative Radiation Oncology Consult Service

	Pre-Implementation (n = 175)	Post-Implementation (n = 261)	p-value
Male sex	110 (63%)	97 (60%)	0.62
Median age	64	64	0.54
Median Charlson Index score	9	9	0.48
Radiation treatment during hospitalization	67 (38%)	55 (34%)	0.38

Figure 2. The Palliative Radiation Oncology Consult Service

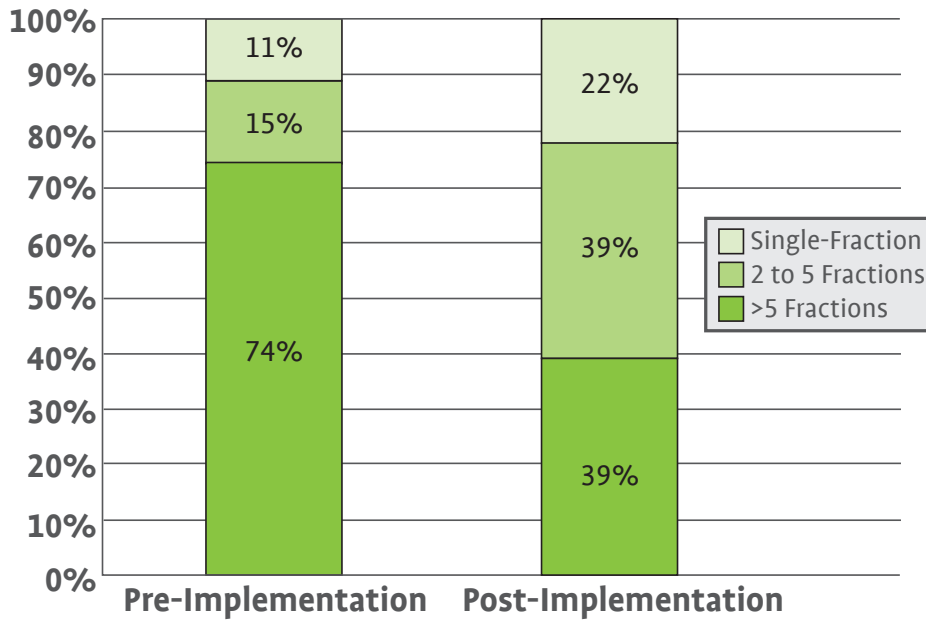
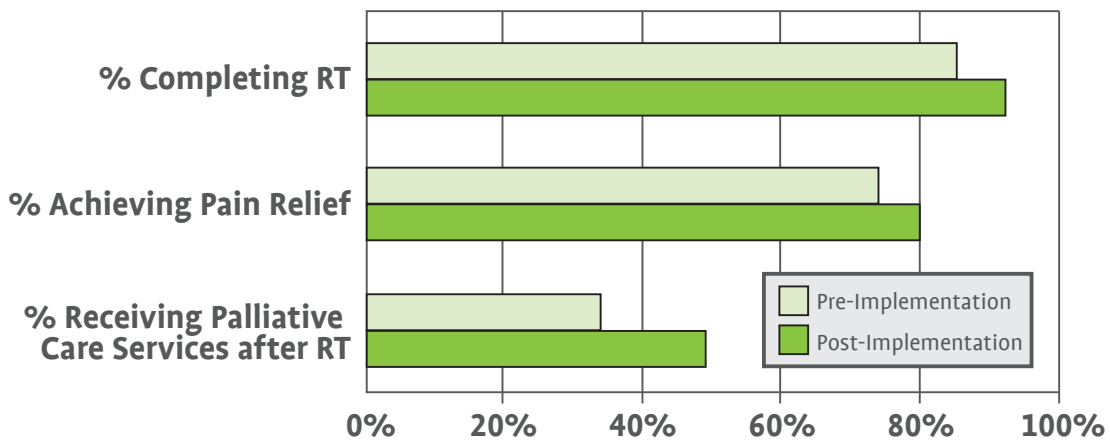


Figure 3. Treatment Adherence, Pain Relief, and Palliative Service Utilization Pre- and Post-Implementation of the Palliative Radiation Oncology Consult Service



**Closing Thoughts**

Through the implementation of a palliative oncology consult, the Department of Radiation Oncology and the Tisch Cancer Institute at Mount Sinai Hospital were able to reduce the length of radiation treatments for patients with advanced cancers, reduce the length of hospitalization, and reduce the cost of care for patients with advanced cancers. With the implementation of shorter-course radiation treatments, patients were more likely to complete their treatment, while maintaining consistently high

rates of tumor-related pain relief. They were also more likely to receive more timely support from palliative care services when needed. In our experience, radiation oncology’s approach to patients with advanced cancers can be broadened to incorporate key principles of palliative care in the real world.

Our program launched into its fourth year in 2018, proving its sustainability. The model of whole-person care that it emphasizes has encouraged many members of the care team to collaborate who previously would not have spoken to one another about a



The team of clinicians, social workers, nurses, and medical physicists who are involved in the delivery of palliative radiotherapy at Mount Sinai.

patient's management. Together we have made better decisions for our shared patients that have translated into real and measurable improvement in their outcomes.

In conclusion, we found that patients with advanced cancers benefit from a system of care that is person-focused rather than disease-focused. The dedicated palliative radiation oncology service model with a person focused mission at its core could greatly improve quality of life for patients with advanced cancers referred for palliative radiation therapy. The Palliative Radiation Oncology Consult model of multidisciplinary shared decision making highlights the fact that we cannot make complex management decisions about patients with advanced cancers in a silo. The bits and pieces of information gathered by the patient, family, and members of the disciplines on the care team are all critical in real-time decision making about palliative radiation treatment.



*Kavita Dharmarajan, MD, MSc, is an assistant professor of radiation oncology and palliative medicine at the Icahn School of Medicine at Mount Sinai, New York, N.Y. Her work involves facilitating shared decision making in advanced cancer and improving access to palliative care for patients with advanced cancers receiving radiation.*

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# The Oncology Pharmacy Navigator





## *A new best practice model for managing medications in cancer programs*

**A** woman with a new diagnosis of breast cancer does not understand how to taper off her hormone therapy. A young patient with colorectal cancer has intractable pain and cannot manage his opioid medication and side effects. An undocumented citizen without insurance requires anti-coagulation therapy for new pulmonary embolisms but has no way to pay for her blood thinner. These real-life cancer patients need an expert to manage their medications.

The oncology pharmacy navigator is a new best practice model and an integral part of our multidisciplinary program at Legacy Cancer Institute in Portland, Oregon. An oncology pharmacy navigator is a specially trained pharmacist dedicated to providing medication management by educating patients and families about prescribed medications, improving drug adherence, maintaining accurate drug lists for individual patients, addressing drug-related symptoms quickly, and improving overall compliance with treatment plans. The financial burden of a cancer diagnosis is lessened because the oncology pharmacy navigator focuses on cost-effective therapy while also decreasing barriers to medication access and addressing patients' financial concerns.

Composed of two tertiary teaching medical centers, one pediatric medical center, and four community medical centers, Legacy Health is a seven-hospital health system with locations throughout the Portland, Ore., and Vancouver, Wash., metropolitan areas. The Legacy Health Cancer Institute was the first in the United States to receive the American College of Surgeons (CoC) Network Cancer Program accreditation, identifying us as a comprehensive integrated community cancer program. The Legacy Cancer Institute ranks in the top 6 percent of all cancer programs nationally,

Studies have shown that more than 50 percent of all patients do not take their medications correctly. Medication discrepancies, adverse events, and non-adherence are leading causes of 30-day hospital readmissions among all previously hospitalized patients.

according to the American College of Surgeons Commission on Cancer. And it has received the CoC Outstanding Achievement Award for our last three survey cycles. In addition, our cancer program is the first in our region to earn the Excellence in Breast Care designation from the National Accreditation Program for Breast Centers. Legacy is an accredited blood and bone marrow transplant center, and we participate in national oncology clinical research trials.

### **From Inpatient to Outpatient Specialists**

Oncology pharmacists have long been trusted members of the medical team. Medical literature has discussed the important role they play in both inpatient and outpatient settings. However, no literature to date describes a navigation role for oncology pharmacists. Identifying the need for a pharmacy navigator in oncology was our first step toward describing the role.



Legacy Cancer Institute strives for holistic and integrated cancer care.

helped patients learn something new, and improved understanding of medication adherence.<sup>2</sup> Both patients and professionals in one survey ranked the availability of consultation with an outpatient oncology pharmacist as highly satisfying (95 percent and 98 percent, respectively).<sup>3</sup> However, more than one-half of one group of patients identified cost issues as a barrier to appropriate medication therapy. Nevertheless, the need for pharmacist navigators is evident; many practitioners say that their patients need medication intervention.<sup>4</sup> When pharmacists assessed patients using a standardized tool, they found that many patients had incorrect and duplicate therapies, avoidable side effects, and drug interactions.<sup>5</sup>

### Designing and Justifying a New Position

Once we decided to create an oncology pharmacy navigator position, we based the responsibilities of the role partly on the job description for our oncology nurse navigators. The Oncology Nursing Society has delineated core competencies for oncology nurse navigators.<sup>6</sup> Key among them are education, care coordination, and communication. We included these same competencies in the proposed functions of our new oncology pharmacy navigator (see Table 1, right). As with any new position, we had to justify this new role not only programmatically but also financially. Improved patient and staff satisfaction alone are no longer adequate to justify funding for new positions. Our task was to define not only the need but also the value. As described below, we were able to demonstrate cost savings as well as revenue generated.

We first defined the tasks and responsibilities that were not being effectively covered in our cancer program, and we wrote a draft job description that outlined the responsibilities of the oncology pharmacy navigator. Our oncology clinical pharmacist then pitched the concept to our medical and administrative directors and explained why she was uniquely qualified for the role and how our patients would benefit from her expanded responsibilities.<sup>7</sup>

Once we secured funding for the new role, we ensured that it was positioned to succeed. A key component of the success of our oncology pharmacy navigator at Legacy Health is that the person is employed directly by the Legacy Cancer Institute rather than by the hospital's Department of Pharmacy. This ensures that the navigator's commitment and focus is entirely on the cancer patients we serve, thus lessening the chance that the oncology pharmacy navigator's hours would be reassigned to the inpatient pharmacy (e.g., to cover sick calls, staff shortages, or maternity leaves).

### From Concept to Reality

The process of hiring an oncology pharmacy navigator took two years from initial concept to permanent funding (see Table 2, right). The role was assumed by our oncology clinical pharmacist. Because money was not initially available in the cancer program budget to fund this role, we submitted a grant to the Legacy Health Foundation to fund the salary of a half-time oncology pharmacy navigator. For the rest of the time, our oncology pharmacy navigator continued to work in our inpatient oncology unit.

We identified the need for our network cancer program to extend the role of our pharmacists into the outpatient setting. Although the majority of our anticancer treatments are delivered outside of our office, Legacy had no oncology pharmacist dedicated to serving our outpatients. Studies have shown that more than 50 percent of all patients do not take their medications correctly. Medication discrepancies, adverse events, and non-adherence are leading causes of 30-day hospital readmissions among all previously hospitalized patients. Because patients generally trust pharmacists and appreciate opportunities to consult with them, pharmacists are natural patient navigators.

When we reviewed the literature that supports an expanded role for pharmacists, we discovered descriptions of novel roles for outpatient oncology pharmacists. For example, one roving supportive care pharmacist was able to reduce self-reported patient scores for pain, nausea, and constipation.<sup>1</sup> Another study found that time spent with a pharmacist improved patient satisfaction,



Our new oncology pharmacy navigator began work in April 2015. It was critical for us to track and collect both quality and cost savings to justify the new position. During the first year, the pharmacy navigator tracked quality outcomes and interventions as well as the cost savings generated by her work. Our initial goal was to demonstrate savings that at least covered the cost of the oncology pharmacy navigator's salary. In the first year, we reported quarterly to our cancer program administrative team.

In the first year of this new position, the oncology pharmacy navigator was directly responsible for more than \$237,000 of cost savings (see Table 3, right). Most of those savings resulted from accessing patient support programs, grants, foundations, and free drug programs through pharmaceutical companies to help offset the high co-pays often incurred by our patients. We realized additional savings from formulary changes and the revenue generated by selling supplements in our hospital-based retail pharmacies. We currently do not bill for the services of our oncology pharmacy navigator, although other clinical pharmacists in our health system do bill and receive payment for their services. In April 2016 the oncology pharmacy navigator position was funded full-time by the Legacy Cancer Institute, and we continue to realize cost savings of more than \$200,000 annually.

### Access to All

Patient assistance programs have been instrumental in the success of our program. When our oncology pharmacy navigator receives a referral to provide financial assistance for high-cost prescriptions, we send a request to the patient's insurance company. It is not uncommon for us to do a prior authorization and/or an appeal and denial to obtain access to funds.

Luckily, many pharmacy manufacturers have excellent patient assistance programs and foundations. At times it is necessary for us to switch therapies to minimize the financial impact on a cancer patient (for example, switching between two different oral anti-coagulants). Some healthcare systems, including Legacy Health, provide charity assistance and write-offs for medications. Access to these programs varies, and our close coordination with the patients' case managers is critical. Our pharmacy navigator also writes a grant every year to the Legacy Foundation for additional co-pay assistance for our cancer patients receiving oral oncolytics or other high-cost oral therapies.

To promote understanding of our oncology pharmacy navigator's role, we have created a patient handout describing the services that she provides (see Figure 1, page 38) Written at a sixth-grade reading level, the handout accommodates those patients who struggle with general and/or health literacy. It is available in all of our oncology offices, and we give it to all patients seeing the oncology pharmacy navigator on referral.

### Referring, Tracking, and Reconciling

In the first weeks after assuming her position, our oncology pharmacy navigator met several times with our electronic health record (EHR) support team to build a referral process, amend a quality flowsheet, and develop a visit navigator. Now, any Legacy Health provider can place a referral to the oncology pharmacy

**Table 1. Roles of the Oncology Pharmacy Navigator**

Improve adherence to medications.
Maintain accurate medicine lists.
Address medication-related symptoms quickly.
Improve overall compliance with treatment plans.
Reduce the risk of drug errors and duplications.
Provide patient and family education.
Lessen the financial burden of a cancer diagnosis.
Develop new programs and formulary decisions to support patients, increase revenue, and decrease costs.

**Table 2. Timeline for Implementing Legacy Cancer Institute's Oncology Pharmacy Navigator Position**

February 2014	Develop proposal for new position, complete literature review
April 2014	Present proposal to Legacy Cancer Institute medical and administrative directors and receive endorsement
November 2014	Request foundation grant for one-year pilot position
February 2015	Receive foundation funds for 0.5 full-time equivalent position for one year
April 2015	Launch program
February 2016	Present year-to-date quality and financial results, receive approval for 0.9 full-time equivalent position with cancer institute budget

**Table 3. How Legacy's Oncology Pharmacy Navigator Achieves Costs Savings and Generates Revenue**

Coordinate all oral oncolytics for an active gynecologic oncology clinic.
Pursue drug company patient assistance foundations for patients with high co-pays and/or no prescription insurance benefit.
Sell commonly recommended supplements in outpatient pharmacies.
Write grants and receive foundation support for patients to receive free supplements and/or co-pay assistance.
Adjust drug formulary to save money (e.g., change from oral aprepitant to intravenous fosaprepitant for inpatients).

navigator using a referral entry in our EHR (Legacy’s EHR is called EPIC). We amended a flowsheet that was already built into our EHR for nurse navigation to include a section for the oncology pharmacy navigator to track interventions (see Table 4, right) We also built a visit navigator into our EHR with user-friendly buttons. The information entered into the navigator allows the oncology pharmacy navigator to quickly populate progress notes (see Figure 2, right). Tracking volume and quality benchmark information in our EHR allows us to print reports and generate data for ongoing justification of the oncology pharmacy navigator position.

To promote the new service, our oncology pharmacy navigator visited every cancer conference in our system. We also published a short article in our health system’s weekly online newsletter describing the new service. Subsequently, referrals to our oncology pharmacy navigator increased by more than 50 percent from the first year to the second year of the program (see Figure 3, page 40). Referrals come primarily from oncologists, nurse navigators, nurse practitioners, surgeons, radiation oncologists, and cancer program support staff practitioners. Our oncology pharmacy navigator attends several huddles and tumor boards each week to identify patients in need and provide medication and symptom management.

We are next planning to use our EHR to more effectively track referrals and interventions, create patient and provider satisfaction surveys, and expand patient education programs with web-based teaching and video libraries. With the use of oral oncolytics rapidly increasing in our oncology clinics, Legacy Health also plans to establish a formalized oral chemotherapy program and develop our own specialty pharmacy on site.

### Medication Reconciliation

Medication lists are often inaccurate, and medication reconciliation is a top priority for many healthcare facilities. Medication reconciliation is defined by the Institute for Healthcare Improvement as “the process of creating the most accurate list possible of all medications a patient is taking—including drug name, dosage, frequency, and route. The goal is to provide correct medications to the patient at all transition points within the hospital.”<sup>8</sup> Study data show that “an effective process can detect and avert most medication discrepancies, potentially avoiding adverse drug events and related costs of care for the affected patients.”<sup>9</sup>

Our oncology pharmacy navigator currently provides medication reconciliation for 62 percent of the referrals we receive (see Figure 4, page 41). In the first year of the program, more than 110 patients had a comprehensive medication reconciliation completed in our EHR. As shown in Table 5, right, Legacy Health cancer outpatients take between 3 and 69 medications, for an average of 13. Less than 2 percent of the patients seen by our oncology patient navigator had a completely accurate medicine list. After examining individual patient drug lists, our oncology pharmacy navigator stopped, changed, or added medications for 98 percent of our patients. Our oncology pharmacy navigator has subsequently developed additional quality targets, including

Figure 1. Oncology Pharmacy Navigator Handout

### Oncology Pharmacy Navigators

Our oncology pharmacy navigators are here to help answer all of your medication questions! Managing your medications can be a bit overwhelming, and we are trained to assist you with your medications and with managing symptoms from your cancer treatment. There is no cost to you or your insurance company to meet with us in person or by telephone or email.

Your pharmacy navigator will help you:

- Understand your medications.
- Provide a current and accurate medication list.
- Understand the side effects of your medications and help manage the symptoms.
- Make it easier to take your medications correctly through coaching, medicine schedules, and pillboxes.
- Address medication-related symptoms quickly.
- Explore financial concerns related to your medicine.

**To contact an oncology pharmacy navigator, please call (503) 413-6590**

Legacy Cancer Institute  
 Legacy Cancer Healing Center  
 Legacy Good Samaritan Medical Center  
 1130 N.W. 22nd Ave. • Portland, OR 97210  
 Phone: 503-413-6590  
 Fax referrals to: 503-413-6872  
[www.legacyhealth.org/cancer](http://www.legacyhealth.org/cancer)

Table 4. Oncology Pharmacy Navigator Quality Metrics in an EPIC Flowsheet

Medication Concerns	
Med Rec completed in Epic	
Med Rec # of Meds on Med List	
Med Rec changes made	
Med Rec deletions made	
Provided with Epic med list	
Provided with medication schedule	
Assist patient with pill box	
Med teaching provided	
Health Literacy Concerns	
Medication Adherence Concerns	
Patient on high risk medications	
Financial/Insurance concerns	

Figure 2. Example of OPN Visit Navigator in EPIC

<b>▼ Pharmacist Section</b>	
Total Meds on List prior to Med Rec?	<input type="text" value="14"/> <b>14</b> by Rice, Kelly A, RPh at 12/07/17 1547
Medication Reconciliation Completed?	<input checked="" type="radio"/> Yes <input type="radio"/> No <b>Yes</b> by Rice, Kelly A, RPh at 12/07/17 1424
Total Meds on List after Med Rec?	<input type="text" value="10"/> <b>10</b> by Rice, Kelly A, RPh at 12/07/17 1547
High risk of enhanced medication toxicity?	<input checked="" type="radio"/> No <input type="radio"/> Depression <input type="radio"/> Diabetes <input type="radio"/> HTN <input type="radio"/> HF <input type="radio"/> Hyperlipide... <b>No</b> by Rice, Kelly A, RPh at 12/07/17 1547
PIM (Potentially Inappropriate Meds)?	<input checked="" type="radio"/> None <input type="radio"/> NSAIDS <input type="radio"/> Benzos/sleeping... <input type="radio"/> Anticholinergics <input type="radio"/> Antipsychotics <b>NSAIDS</b> by Rice, Kelly A, RPh at 12/07/17 1424
Did RPh recommend DC PIMs to provider?	<input checked="" type="radio"/> Yes <input type="radio"/> No <b>Yes</b> by Rice, Kelly A, RPh at 12/07/17 1424

Note. OPN = oncology pharmacy navigator.

meeting at least 50 percent of patient referrals in person and conducting accurate medication reconciliation for at least 50 percent of all referrals (see Table 5, right).

### Setting a New Gold Standard in Accreditation

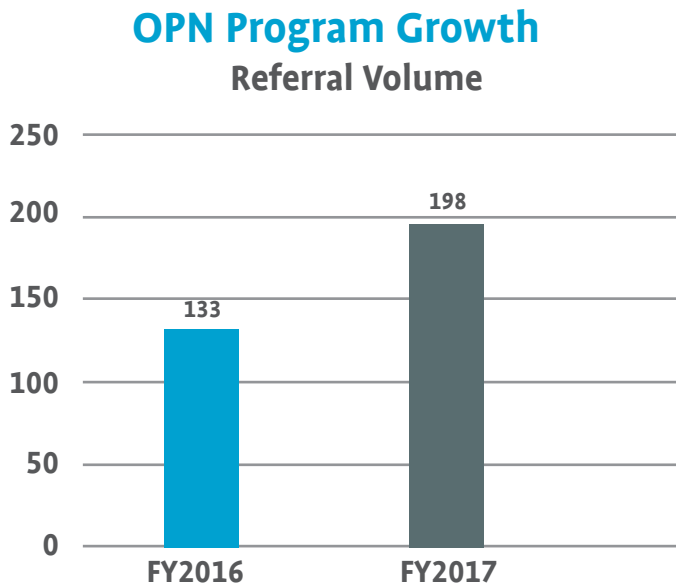
Having an oncology pharmacy navigator also distinguished us during accreditation processes. During our most recent American College of Surgeons Commission on Cancer accreditation visit, surveyors specifically cited our oncology patient navigator program as a “new best practice model.” The surveyors were impressed with our innovation and expressed hope that more cancer programs will add an oncology patient navigator to their cancer care teams.

Accreditation is critical to cancer programs, and the standards for both the CoC and the National Accreditation Program for Breast Centers (NAPBC) were evaluated in relation to our oncol-

Table 5. Medication Reconciliation as a Quality Benchmark

	Average	Low	High
Meds on EPIC List	13	3	69
Meds to ADD	2	0	9
Meds to DISCONTINUE	3	0	12
Meds to CHANGE	2	0	12

Figure 3. Oncology Pharmacy Network Program Growth



Note. OPN = oncology pharmacy navigator.

### Main referral sources:

1. Oncologists
2. Oncology Nurse Navigators
3. Nurse Practitioners
4. Non-Legacy physicians
5. Radiation Oncologists
6. Self-referred  
(fliers in every oncology office)



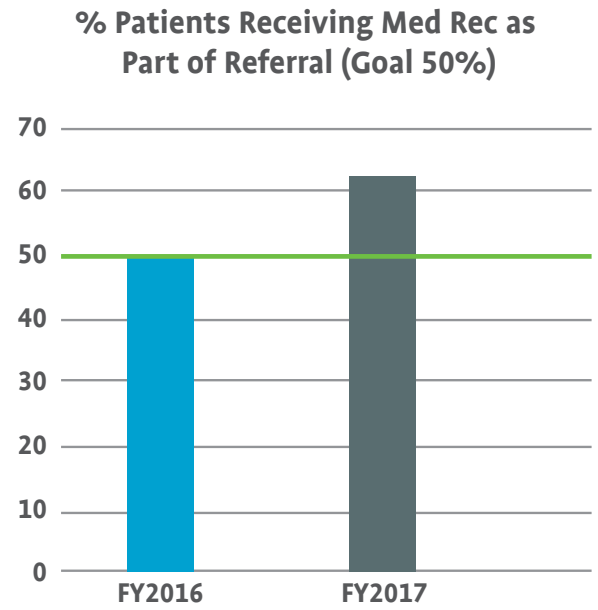
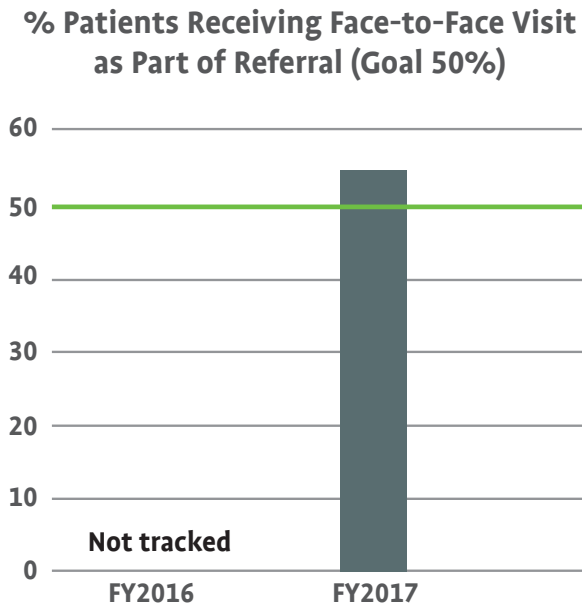
The Legacy Cancer Institute is a comprehensive integrated community cancer program.

ogy patient navigator program.<sup>10,11</sup> Both CoC and NAPBC accreditation standards contain sections on patient navigation processes. These standards aim to guide patients through provider services and address healthcare disparities and barriers to cancer care. Both CoC and NAPBC require studies of quality of care and outcomes. All of these standards were enhanced through the addition of an oncology pharmacy navigator to our cancer team.

The oncology pharmacy navigator is an innovative role that has helped distinguish Legacy Cancer Institute from other local, regional, and national cancer care programs. To evaluate the success of our navigator's interventions and outcomes, we have established quality benchmarks that we track regularly. This has enabled us to justify our oncology pharmacy navigator's salary by demonstrating how our program successfully taps drug company assistance and charitable foundations. Patient education is also an integral part of the oncology pharmacy navigator role, focusing on side effect management, hormonal therapy, and targeted oral oncolytics. Our oncology pharmacy navigator program also distinguishes us during accreditation processes and helps maintain the goals of our Center for Excellence. Most important, our oncology pharmacy navigator program has significantly benefited the patients we serve, improving medication management, lowering barriers to drug access, and addressing financial concerns.

*Kelly Rice, Pharm.D., is the Oncology Pharmacy Navigator at the Legacy Cancer Institute in Portland, Oregon. She also serves as the pharmacist in charge of an inpatient hospice facility, and oversees all investigational medications for the Cancer Research Program.*

Figure 4. Oncology Pharmacy Navigator Quality Benchmarks



Legacy Health is a seven-hospital health system with locations throughout the Portland, Ore., and Vancouver, Wash., metropolitan areas.



The Legacy Cancer Institute ranks in the top 6 percent of all cancer programs nationally, according to the American College of Surgeons Commission on Cancer.

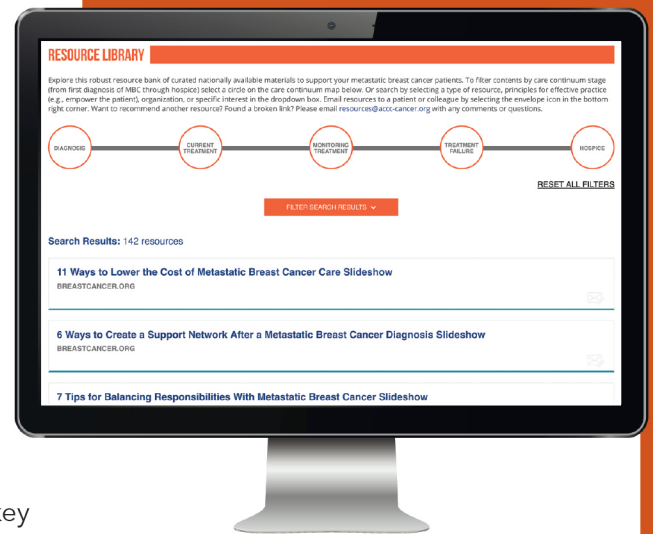
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## Tools to Help Your Team Support Metastatic Breast Cancer Patients

Recognizing the unique needs of patients with metastatic breast cancer (MBC), the ACCC Metastatic Breast Cancer Project—in collaboration with partner organizations—develops and curates resources that address gaps in knowledge, improve patient-provider communication, and support holistic, patient-centered care for patients living with MBC.

- Search the **MBC Resource Library** for over 150 nationally available materials for patients at every stage of their journey. Find resources in minutes—searchable by keywords, resource type, point of care, organization, or hot topics!
- The **Metastatic Breast Cancer: Effective Principles & Practices in Patient Support** workbook features a communication process map with six key principles to consider in a multidisciplinary workflow, helping to reframe and improve the conversation between providers and patients.
- Building upon the patient support workbook, the **Effective Principles in Action** publication explores how three cancer programs are implementing the six key principles and taking action to empower patients.



Find the resources your patients need today at [acc-cancer.org/MBCresources](http://acc-cancer.org/MBCresources)

In partnership with:



The Association of Community Cancer Centers (ACCC) is the leading education and advocacy organization for the multidisciplinary cancer team. ACCC is a powerful network of 25,000 cancer care professionals from 2,100 hospitals and practices nationwide. ACCC is recognized as the premier provider of resources for the entire oncology care team. For more information visit [acc-cancer.org](http://acc-cancer.org) or call 301.984.9496. Follow us on Facebook, Twitter, and LinkedIn, and read our blog, ACCCBuzz.

# Cancer Crushing Prevention and Early Detection







In 2015 the Tri-Cities Cancer Center, Kennewick, Wash., partnered with the Blue Mountain Oncology Program in an effort to better understand the annual number of cancer patient cases diagnosed in our area and their stage of diagnosis, with the goal of identifying opportunities for improvement. The Blue Mountain Oncology Program functions as the cancer center's local tumor registry and is responsible for collecting important patient data. In turn, these data help the Tri-Cities Cancer Center decide where to focus its efforts to prevent or detect cancer earlier so our team can save more lives by providing world-class cancer care, including survivorship support. The cancer center began to consider a new value proposition for the residents in our community by asking the question, "What matters to you?" That is, what can the Tri-Cities Cancer Center do to improve the health and well-being of its residents?

After conducting a data review, our team at Tri-Cities Cancer Center identified breast, lung, colorectal, and prostate cancer as the most prevalent cancers diagnosed in our region (see Table 1, page 46). This finding corresponds to cancer rates identified in other parts of the state and the nation. These data showed that Tri-Cities Cancer Center was doing an outstanding job in identifying breast cancer at an early stage (Figure 1, page 47). However, as we looked closer at the regional data in comparison to both state and national data, we identified the need to improve early diagnosis in lung and colorectal cancer. These data showed our region to be experiencing a higher rate of lung and colorectal cancer diagnosed at a late stage (see Figures 2 and 3, page 48). In addition, through conversations with local primary care providers, we identified an opportunity to increase patient compliance with recommended cancer screenings.

Through our innovative community education campaigns and workplace wellness program, Tri-Cities Cancer Center has sparked a community conversation to significantly impact cancer screening compliance rates.

With this information in hand, we turned our attention to increasing our community education efforts. We developed a marketing campaign that used creative messaging to highlight facts and figures related to mortality rates to bring attention to the issues. Unfortunately, this approach did not result in the desired compliance results, so our team decided to take a new approach.

### **A Dose of Education Through Humor**

Our director of strategy and business development suggested a video concept that would use humor to deliver strong messaging meant to catch and hold the community's attention. The team at Tri-Cities Cancer Center developed initial concepts and then worked with a local marketing partner to fine-tune them. The cancer center budgeted for the public outreach and education

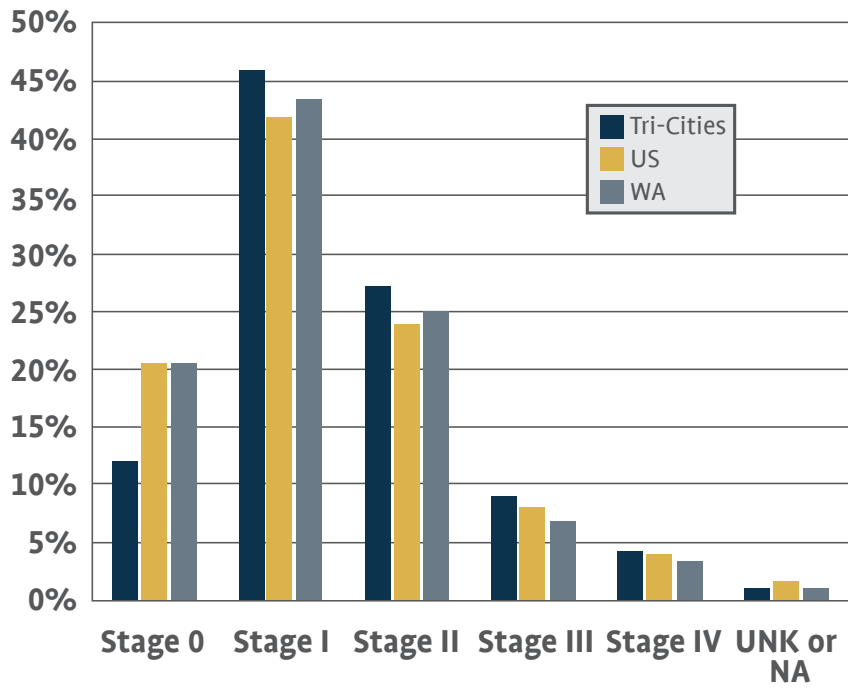
(continued on page 50)

**Table 1. Comparison of Tri-Cities and Surrounding Areas Versus Regional, Statewide, and National Data for Most Frequently Diagnosed/Treated Primary Sites<sup>a</sup>**

Number of Cases Diagnosed and/or Treated								
Primary Site	Tri-Cities Cancer Center, 2016		Blue Mountain Oncology Program Region, 2016		Washington State Cancer Registry, 2014		National Cancer Database, 2014	
	#	%	#	%	#	%	#	%
Breast	286	19.7	461	20.7	6,859	17.6	227,781	18.8
Lung/bronchus	217	16.0	288	12.9	4,373	11.2	154,723	12.8
Colorectal/anus	103	7.6	186	8.3	3,050	7.8	106,460	8.8
Prostate	115	8.5	209	9.4	4,004	10.3	95,389	7.9
Lymphomas	56	4.1	104	4.7	1,720	4.4	53,060	4.4
Thyroid	50	4.0	93	4.2	1,007	2.6	37,523	3.1
Blood/bone marrow	89	6.5	138	6.2	1,598	4.1	44,380	3.7
Bladder	77	5.7	124	5.6	1,646	4.2	48,520	4.0
Brain/central nervous system	38	2.8	59	2.6	542	1.4	26,243	2.2
Kidney/renal pelvis	51	3.8	78	3.5	1,223	3.1	45,123	3.7
Uterus/endometrium	36	2.6	70	3.1	1,071	2.7	43,940	3.6
Melanoma of skin	53	3.9	82	3.7	3,893	10.0	51,845	4.3
Other sites	206	15.2	342	15.3	8,004	20.5	276,964	22.9
Totals	1,359	100	2,234	100	38,990	100	1,211,951	100

<sup>a</sup>Latest available data from Blue Mountain Oncology Program, the tumor registry that captures newly diagnosed patient data in southeast Washington and northeast Oregon. In total, the Blue Mountain Oncology Program abstracts patient data from nine hospitals and cancer centers in the region.

Figure 1. Breast Cancer in the Tri-Cities Region by American Joint Committee on Cancer Stage. Data from Blue Mountain Oncology Program



Tri-Cities Cancer Center North Entrance

Figure 2. Lung Cancer in the Tri-Cities Region by American Joint Committee on Cancer Stage. Data from Blue Mountain Oncology Program

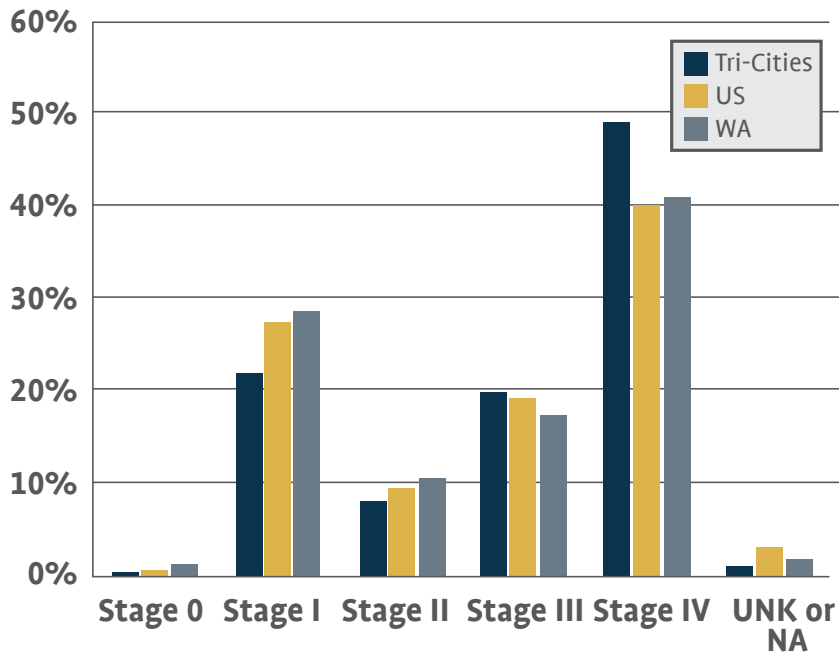
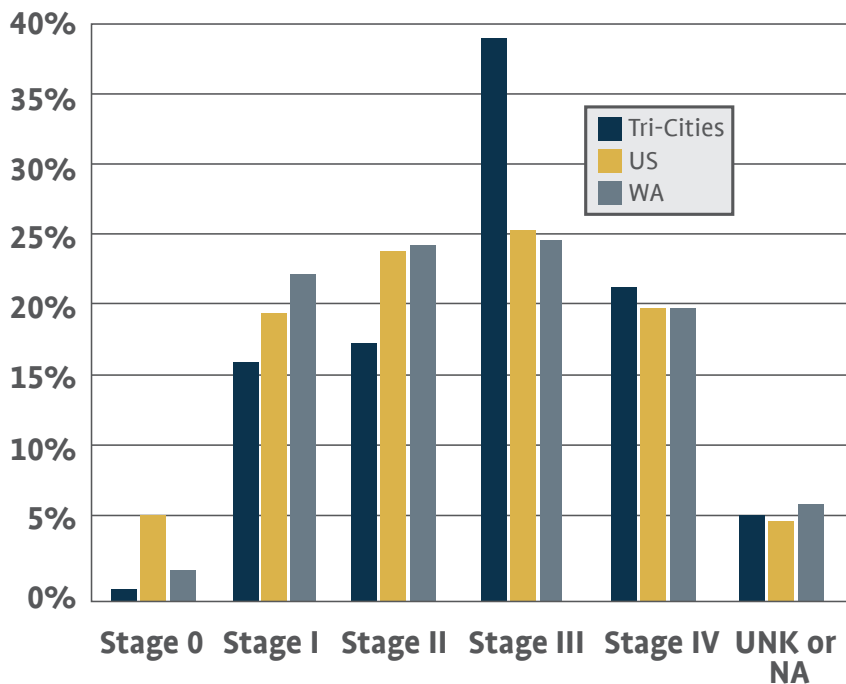


Figure 3. Lower Gastrointestinal Tract Cancer in the Tri-Cities Region by American Joint Committee on Cancer Stage. Data from Blue Mountain Oncology Program





From top left: Resource Library; Serenity Garden; Clinic Lobby; Wellness Center Donor Wall; North Entrance; Tri-Cities Cancer Center 25th Anniversary Staff Photo; Henry & Edith Smith Family Entrance.



(continued from page 45)

campaign, but money was tight and we needed to keep costs to a minimum. By leveraging the cancer center's staff and talented volunteers to bring videos to life, we were able to keep costs low. The entire process took about two months, and our main cost was for recording time with our marketing partner.

The videos produced used "tough talk" and a healthy dose of humor to educate the men and women in our local community about cancer prevention and early detection. For example, through our "BE A MAN" video campaign, Tri-Cities Cancer Center called attention to the leading cancer killers of men (and also cancers exclusive to men), such as lung, prostate, colorectal, and testicular cancers. View our "BE A MAN" video online at: [tccancer.org/men](http://tccancer.org/men). A similar message, titled "Woman Up!," highlighted serious cancerous diseases impacting women, including cervical, breast, colorectal, and lung cancers. View our "Woman Up!" video online at: [tccancer.org/womanup](http://tccancer.org/womanup).

Our cancer center received a great deal of anecdotal feedback that the humor used in our video campaigns was appreciated and helped to increase cancer awareness in our community. During 2017 and 2018, we saw a combined 29 percent increase in the number of patients treated at our facility, as well as a 25 percent increase in visitors to our website. Though this cannot be fully attributed to the video campaign, we recognize that these videos have helped us reach more people in our community with our prevention and early detection efforts, including the importance of cancer screenings.

With a rapidly growing Hispanic population, our cancer center recognized the need to broaden its reach and establish a relevant presence within our entire patient population. To do this, our team developed brief "Cancer Talks" vignettes, in both English and Spanish, to emphasize the need for breast, colon, and lung cancer screenings, and to promote our free "Quit Tobacco" program.

We strategically partnered with local media to improve the traction and frequency of our outreach and prevention education messages across all media platforms. For example, we invited the media to our campus for a free luncheon in their honor where we recognized and thanked them for partnering with the cancer center. We shared outreach and prevention education strategies and asked for the media's assistance in getting these important messages to the public. Local media outlets quickly became ambassadors to our cause, calling upon us to provide content experts throughout the year. Because of this partnership, our outreach and prevention education messages have been delivered through social media, print, television, radio, and in person at large group settings. We have now made our media luncheon an annual event.

In 2018 Tri-Cities Cancer Center partnered with the American Cancer Society and the Benton-Franklin Health District on a campaign to educate parents on the importance of vaccinating children against human papillomavirus. We are excited to be leading the promotion of human papillomavirus vaccination in our region, because it offers the opportunity to prevent many future cancers.

## A Focus on the Workplace

In addition to our community outreach and prevention education campaigns, we increased our outreach and compliance efforts by launching the Cancer Crushing Executives workplace health and wellness program in late 2017. The program promotes evidence-based practices to keep employees and their families healthy by targeting the leading causes of cancer-related death, such as smoking and obesity. In partnership with the University of Washington, the Washington State Department of Health, and senior leaders from 23 of the region's largest employers, Tri-Cities Cancer Center is developing workplace wellness programs to help decrease smoking, increase physical activity, and assist with weight control. These workplace wellness programs also help improve employee morale and promote team-building, show a concern for employee well-being, and affect recruitment and retention.

Cancer Crushing Executives gives organizations a great deal of autonomy in the structure of their wellness programs. One local city management team developed an ongoing employee walking program to encourage activity throughout the workday. Another organization is in the process of overhauling an underutilized stairwell by adding lighting and murals painted by artistic employees to encourage employees to take the stairs instead of the elevator. Several organizations have partnered with a local fruit delivery company to bring weekly fresh fruit selections to their break rooms, ensuring fresh, healthy food options. A few partner organizations have also initiated on-site health and wellness fairs to ensure that employees have easy access to available resources. The Cancer Crushing Executives program is about building healthy habits and long-term success, so developing and implementing personalized workplace policies is vital.

Collectively, organizations participating in Cancer Crushing Executives represent 30,000 employees—100,000 lives when you take family members into consideration. This represents one-third of our region's population. The program has already been a catalyst for conversations in the workplace about the need to get screened. With the senior business leaders as champions, we expect to see a shift in culture toward wellness and an increase in screening compliance from participating organizations.

## Closing Thoughts

Through our innovative community education campaigns and workplace wellness program, Tri-Cities Cancer Center has sparked a community conversation to significantly impact cancer screening compliance rates. We are looking to improve the health of our community, diagnose cancer earlier as measured through our tumor registry, and provide patients with more tools to stay healthy.

*Chuck DeGooyer is the CEO of the Tri-Cities Cancer Center, Kennewick, Wash.*

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## A Growing Region

Consisting of the cities of Kennewick, Pasco, Richland, and West Richland, the Tri-Cities is one of the fastest-growing communities in the state of Washington. Located in the heart of Washington Wine Country, it is an area known for its pleasant weather, agriculture, and outdoor recreational activities (see Figure 4, below). Thirty percent of the area’s residents are over the age of 50, with the most significant increase in residents over the age of 65 (see Table 2, page 52). According to the American Cancer Society, “Cancer can happen at any age, but nearly 9 out of 10 cancers are diagnosed in people ages 50 and older.”<sup>1</sup> We have also noted a change in the ethnic makeup of our population as seen in Table 3, page 52.

Within this growing, aging, and changing population, the Tri-Cities Cancer Center plays a vital role in providing cancer prevention and early detection, world-class cancer care, and survivorship support for the patients and families in our region. The Tri-Cities Cancer Center is located at the confluence of the Yakima, Snake, and Columbia rivers and is a joint venture of three local hospitals—Kadlec, Lourdes Health, and Trios Health—providing healthcare value to our community.

Over the past five years, in alignment with our strategic plan and in support of our owner hospitals, we have expanded our facility and acquired the latest radiation oncology technology to be able to care for patients at home, where they are surrounded by their support team. We launched our Survivorship Clinic to support our patients post-treatment (see Figure 5, below), and we were granted American Society for Radiation Oncology APEX accreditation in 2016 and National Accreditation Program for Breast Cancers accreditation in 2017 for our breast cancer program across our four locations. Tri-Cities Cancer Center was named one of Modern Healthcare’s Best Places to Work in Healthcare in both 2015 and 2017.

Figure 4. Tri-Cities Regional Snapshot. Data from Tri-City Development Council. Available online at [tridec.org](http://tridec.org)



Figure 5. Flyer Introducing the Survivorship Clinic at Tri-Cities Cancer Center

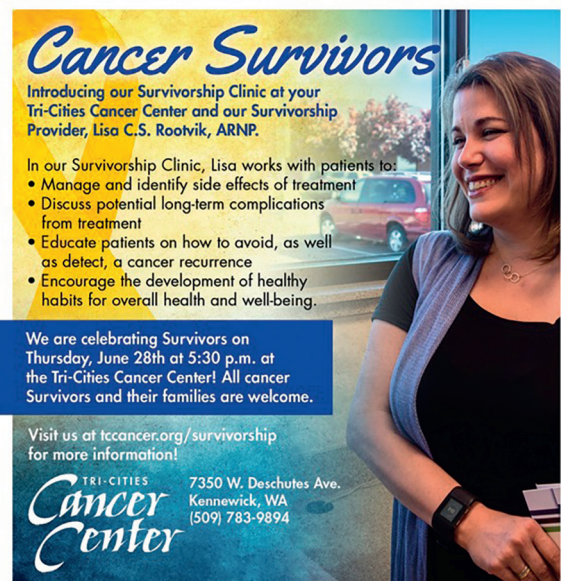


Table 2. Population of Tri-Cities Region by Age<sup>a</sup>

Population by Age	2010 Census (by Percentage of Total Population)	2018 Estimate (by Percentage of Total Population)
0-4	8.43	7.68
5-9	8.20	8.04
10-19	15.55	15.13
20-29	13.84	13.54
30-39	13.18	13.80
40-49	12.82	11.68
50-59	12.71	11.46
60-64	4.90	5.59
65+	10.37	13.09

<sup>a</sup> Data from Tri-City Development Council. Tri-Cities MSA Community Profile. Available online at [trytricitysites.org](http://trytricitysites.org). Last accessed January 30, 2019.

Table 3. Population of Tri-Cities Region by Race/Ethnicity<sup>a</sup>

Population by Race/Ethnicity	2000 Census (by Percentage of Total Population)	2010 Census (by Percentage of Total Population)	2018 Estimate (by Percentage of Total Population)
White	80.0	75.7	73.05
Black	1.3	1.5	2.23
American Indian	0.8	0.8	0.88
Asian or Pacific Islander	2.2	2.5	3.03
Other race	12.7	16.1	16.58
Multiracial	3.1	3.4	4.09
Hispanic ethnicity	21.3	28.7	31.31
Non-Hispanic or Latino	78.7	71.3	68.69

<sup>a</sup> Data from Tri-City Development Council. Tri-Cities MSA Community Profile. Available online at [trytricitysites.org](http://trytricitysites.org). Last accessed January 30, 2019.



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[acc-cancer.org/resources/virtual-tumor-boards.asp](http://acc-cancer.org/resources/virtual-tumor-boards.asp)

# Molecular Testing: Resources and Tools for the Multidisciplinary Cancer Team

Given the rapidly expanding and increasingly complex molecular testing landscape, the Association of Community Cancer Centers (ACCC) partnered with the Association for Molecular Pathology (AMP) to develop a webinar series to educate the multidisciplinary team on opportunities for collaboration to improve patient care. The 12-webinar series features case studies and robust discussions on molecular testing for breast and lung cancer, various tumor board models, and effective practices.

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Professionals in  
a Community  
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and Targeted Therapies  
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Tumor Boards

Challenging Issues  
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Management

Real-World  
Considerations When  
Implementing a Genomic  
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Key Concepts and Future  
Directions in Molecular  
Testing and Care Delivery

# Cost of Anti-Cancer Therapies Demands New Strategies for Decision-Making, Shared Responsibility, Communication



**A**s the cost of cancer care continues to climb and more costly cutting-edge therapies like chimeric androgen receptor (CAR) T-cell gene therapy are approved, finding solutions to address financial toxicity continues to challenge even the most robust cancer programs.

Although CAR T-cell therapy has shown promise in many patients who have run out of standard treatment options, the cost is often upward of \$1 million per course of treatment.<sup>1,2</sup> The side effects are extensive and sometimes severe, and the complexities of the therapy's administration require an interdisciplinary approach for success.

### The Pharmacist in Immunotherapy

Pharmacists play a crucial role in successfully implementing CAR T-cell programs. As payers push to treat CAR T-cell similarly to bone marrow transplantation for reimbursement, pharmacy directors must be well-versed in various payment models. Institutions are learning how to be more prepared when making operational changes based on new drugs entering the market.

Julie Kennerly-Shah, PharmD, MS, MHA, is the assistant director of pharmacy at The Ohio State University Comprehensive Cancer Center—Arthur G. James Cancer Hospital and Richard J. Solove Research Institute in Columbus—one of the first cancer centers in the country to use CAR T-cell therapy in clinical practice.

Though Dr. Kennerly-Shah and her team are focused on providing the best care for their patients, including using the most novel therapies, she is concerned, like most in oncology, that if the cost of immunotherapy drugs continues to increase, the trajectory is not sustainable. The larger concern, of course, is that there will be treatments that can help patients but that will be out of reach for most.

A contributor to cost is not only the price tag for the CAR T-cell therapy itself but also the cost of extended hospital stays. “It is well documented that it is much more cost effective to deliver care in the outpatient setting when possible,” Dr. Kennerly-Shah said.

### Cost-Cutting Strategies

Dr. Kennerly-Shah oversees a team of clinical pharmacists who are responsible for working directly with physicians in the inpatient and outpatient settings to determine the most clinically effective and cost-effective therapies for their patients who have been diagnosed with cancer. In addition, she facilitates the Hematology Oncology Pharmacy and Therapeutics Committee (P&T Committee) responsible for making formulary decisions determining which cancer agents will be available to providers for cancer treatments and what restrictions—if any—will be placed on those medications. The committee is actively seeking and implementing innovative solutions to keep costs down.

The P&T Committee's strategies include examining prescribed treatment plans and weighing the costs with the benefits. For example, if a drug costs twice as much but provides minimal extra benefit, should it be used? Are the treatment benefits sufficient to offset the cost? The committee looks at whether clinical



Julie Kennerly-Shah,  
PharmD, MS, MHA.

## Biosimilars and the Electronic Health Record

The P&T Committee is actively working on how the team at Ohio State University Comprehensive Cancer Center can better incorporate biosimilar medications into its portfolio of offerings by looking at how the committee can work with IT teams to enable their Epic electronic health record to better facilitate the use of biosimilars. When treatment plans are built in Epic, it needs to be easy to substitute a biosimilar for a reference product.

“When a provider wants to start a patient on a specific combination of medications, a treatment plan is pre-built in Epic to include all of those medications,” Dr. Kennerly-Shah said. “The challenge with biosimilars is that there are multiple biosimilars on the market. One insurance company may prefer one biosimilar; another insurance company may prefer another.” With generics, one can easily substitute another generic and the billing works the same, but this not true in the case of biosimilars.

For biosimilars, providers must submit a request and a bill to the insurance company that is specific to that biosimilar. Dr. Kennerly-Shah is working with the P&T Committee and with Epic to find a solution that makes it easy to interchange biosimilars based on which products a patient’s insurance may prefer.

## Patient Communication, Decision-Making

Another challenge is communicating to patients that they may be put on a biosimilar at some point during therapy. Dr. Kennerly-Shah said that, so far, they have been communicating to the patient that “there’s a biosimilar on the market. You may be put on the reference product or the biosimilar, and from the patient’s perspective, they don’t really feel a difference. From the care team’s perspective, these drugs are considered similar enough that it doesn’t make a difference in clinical outcomes.”

“Having that conversation up-front with patients is important [so] that they understand the difference between a reference product and a biosimilar and a generic, for example,” she added. “Typically, we use generics as a frame of reference for patients, acknowledging that it is not exactly the same as having a brand name and a generic substitution.”

Biosimilar education is often provided by the pharmacist who is going to be talking to patients about their regimen. “Oftentimes it comes up when the reference product is being denied by the insurance company and we are talking to patients,” Dr. Kennerly-Shah said. The pharmacist informs the patient that he or she is going to send a prescription for the biosimilar and expects it to work similarly.

Sometimes a decision is based on the cost of one cancer therapy versus the cost of another that is not a biosimilar and that is a different regimen entirely. “Say you have a new product on the market and it has a three-month difference in overall survival. Have that conversation with the patient regarding the potential cost of this therapy versus that one,” Dr. Kennerly-Shah said. “Patients are becoming much more in tune and not only receptive to those conversations, but patients are expecting those types of conversations to occur. They come in wanting to know the cost of therapy. They’re very concerned about the financial toxicity, particularly elderly patients tend to be very concerned about the

changes can be used to offset cost, asking “What can be done on an outpatient versus inpatient basis to reduce overall healthcare costs?” The committee is also focused on improving the use of biosimilars and on how best to approach the reimbursement process for these drugs.

“Historically, if you received a diagnosis of lung cancer, you received the regimen that was first-line for lung cancer. Now we use biomarkers and targeted therapies to drive a more personalized approach to cancer therapy,” Dr. Kennerly-Shah said. This targeted approach is limiting some of the physical toxicities from cancer treatment, and it is extending duration of life for patients.

One of the major challenges to accessing immunotherapy, however, is economic. “We are really excited about these novel agents, and we want to be able to offer our patients the absolute best cutting-edge therapy,” Dr. Kennerly-Shah said. “We are also faced with acknowledging that financial toxicity is real, and patients have legitimate concerns about the cost of their cancer therapy the same as they would have concerns about the cost of their cholesterol medication. Balancing the two issues has been quite the process over the last 5 to 10 years.”

## Planning for Outpatient Care

A contributor to cost is not only the price tag for the CAR T-cell therapy itself, but also the cost of extended hospital stays. “It is well-documented that it is much more cost-effective to deliver care in the outpatient setting when possible,” Dr. Kennerly-Shah said. “Each night in the hospital that we can save is significant. We have a multidisciplinary group that worked hard to develop processes and procedures where we could see these patients every day in the outpatient setting.”

“In fact, patients would prefer to be outpatient, if possible, but it does take significant infrastructure and planning on the part of the facility to be prepared to deliver CAR T-cell therapy in the outpatient setting,” said Dr. Kennerly-Shah.

burden they would be placing on their family knowing that they could have significant medical bills upon passing.”

This shared decision-making typically includes the physician, the patient, and the patient’s family members or caregivers. Pharmacists are often asked to participate in these conversations due to their unique understandings of the clinical and financial implications of one therapy versus another.


### Data and Analysis to Better Inform Care

Long-term goals for the P&T Committee include plans for a more robust economic analysis that takes into account the total cost of care. “Oftentimes we are focusing on what is the cost of the medication, which is really important, and it is a huge driver of cost in oncology care. However, it is important to also take into account the cost of toxicities as new therapies come to market,” Dr. Kennerly-Shah said. “Future plans include economic analyses that include not just the cost of the therapy, but all the other ancillary costs associated with that therapy that also contribute to the overall cost of care. And how can we then measure one therapy’s effectiveness and cost compared to another from an economic standpoint?”

The team at the Ohio State University Comprehensive Cancer Center-James tracks the cost of drugs per patient per day in the inpatient and outpatient settings, as well as reimbursement, continuously evaluating reimbursement compared to drug cost. The team also tracks the number of patients for whom they have been able to utilize patient assistance programs and the overall number of dollars associated with those programs.

“A great number is the amount of free drug, essentially, that we’ve been able to facilitate for our patients. It is an astounding number annually from working directly with manufacturers and getting patients enrolled in either a co-pay assistance program or a free-drug program with the manufacturers,” Dr. Kennerly-Shah said.

A full cost analysis is needed in every cancer program, large or small, in order to deliver cost-effective and quality care to all patients. “I would encourage all cancer programs to be actively looking at not only drug costs, but also building an infrastructure for economic analysis that looks at overall cost of care. When you think about current pending legislation and the Oncology Care Model, we are really moving toward a system that looks at how we can cost-effectively provide cancer therapy to patients as a whole. And that includes not just drug costs, but inpatient stay, outpatient stay, additional visits associated with toxicity, etc.,” Dr. Kennerly-Shah said.

“It is important for anyone who provides any amount of significant oncology care to really start thinking about the overall cost of care, and how they are going to build a team to do these economic analyses. There are references like the Institute for Clinical and Economic Review that do great economic analyses, but there’s nothing like your own data to see how much a specific diagnosis is costing within your own system.” 

*Amy Hindman is a freelance writer with more than 10 years of experience writing in technology, healthcare, and oncology.*

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### Association for Community Cancer Centers Financial Advocacy Services Guidelines

The Association for Community Cancer Centers (ACCC) has developed the Financial Advocacy Services Guidelines to support the goal of proactively addressing financial issues along the cancer care continuum to help patients gain access to high-quality care for a better quality of life. These guidelines have been developed with the input and guidance of the Advisory Committee for the ACCC Financial Advocacy Network and financial advocates working on the front lines of care. As the healthcare landscape continues to change and the role of oncology financial advocates evolves, ACCC offers these guidelines to assist programs in strengthening their financial advocacy services and to complement the resources available through the ACCC Financial Advocacy Network at [acc-cancer.org/financial-advocacy](http://acc-cancer.org/financial-advocacy).

### ACCC Immuno-Oncology Institute

The ACCC Immuno-Oncology Institute is the only initiative dedicated to educating multidisciplinary teams to go beyond a clinical understanding of immuno-oncology and tackle real-world implementation issues. With the care of patients on immunotherapies now extending beyond the cancer team, the ACCC Immuno-Oncology Institute is at the forefront of developing critical education to empower healthcare professionals across care delivery settings. Learn more at [acc-cancer.org/immunotherapy](http://acc-cancer.org/immunotherapy).

# Small in Stature, Large in Impact



## *A coastal community hospital commits to caring for both staff and patients*

Caring for patients with cancer is inherently stressful. Clinicians and support staff often form long-term relationships with their patients, whose treatment may require multiple visits over months or even years. But many oncology staff say that the difficulties associated with caring for patients in today's healthcare environment go beyond the expected emotional strain. Large numbers of staff are reporting unprecedented levels of stress.

This is the reason why Association of Community Cancer Centers (ACCC) President Tom Gallo, MS, MDA, an experienced cancer program administrator, chose *Reflect, Renew, Reignite: Building a Resilient Oncology Team in Your Community* for his 2018-2019 President's Theme. This article is the second in a series in *Oncology Issues* in which member programs share the steps they are taking to improve resiliency and combat burnout among their oncology staff.

### **Setting the Stage**

Robin Hearne, RN, MS, director of Cancer Services and Chronic Disease Care at The Outer Banks Hospital in North Carolina and chair of the ACCC Communications Committee, says that much of the stress affecting clinicians and support staff stems from the way in which medicine is delivered and reimbursed today.

To arm her staff with the tools they need to practice the best possible self-care and patient care, Hearne says that she draws on a variety of resources to create and fund leadership programs, education sessions, and community activities.

"Today's stressors are compounded because of the complexity of healthcare," says Hearne. "The financial environment in which we are trying to deliver healthcare is extraordinarily difficult these days."

Hearne says that it can be hard for her staff to see treatment decisions significantly affected by third-party payers and patients' abilities to pay. "When patient care scenarios don't line up with employees' core values, you have a situation ripe for internal conflict," says Hearne. "These scenarios often involve patient financial distress associated with the lack of access to a drug or treatment regimen due to an insurance denial."



Robin Hearne, RN, MS, Director of Cancer Services and Chronic Disease Care at The Outer Banks Hospital.

## Heads and Hearts

Though small, The Outer Banks Hospital must deal with the same challenges to modern healthcare delivery as its larger counterparts. Situated on a barrier island off the coast of North Carolina in a region that is a popular summer vacation destination, The Outer Banks Hospital is a 21-bed critical access community facility that is a joint venture between Chesapeake Regional Medical Center in Virginia and Vidant Health in Greenville, N.C. It is one of several community hospitals in eastern North Carolina that serve a local population of approximately 30,000 year-round residents. (During the summer months, the local population can reach nearly 250,000.)

“Our cancer registry has between 150 and 200 patients a year,” says Hearne, “and we are growing rapidly. Being a small program can make us nimbler when implementing change. But overall, we experience most of the same challenges as hospitals that see thousands of patients.”

To arm her staff with the tools they need to practice the best possible self-care and patient care, Hearne says that she draws on a variety of resources to create and fund leadership programs, education sessions, and community activities.

To bolster her own leadership skills, Hearne has enrolled in a one-year Integrative Leadership Program at Duke University that focuses on developing leaders to implement programs and care delivery models that do more than simply treat disease. Hearne says that by helping provide the tuition for the program, leaders at The Outer Banks Hospital demonstrate the value they place on supporting front-line staff to master the skills needed to address staff concerns and navigate the complex care their patients often require. “Our leadership committed a while ago to helping patient care staff manage stressors, starting with aligning the heads and hearts of our leadership team to implement a culture of health and well-being,” says Hearne.

Hearne says that the skills that she will acquire from the leadership program and pass on to staff at her hospital’s cancer center are mirrored in The Outer Bank Hospital’s recently opened Center for Healthy Living. Available to the hospital’s community, including both oncology patients and staff, the center is staffed by a physician trained in integrative and lifestyle medicine and a nurse practitioner certified in lifestyle medicine. The center’s health coach and chronic disease navigator work with patients and staff who want to access the center’s services.

“A lifestyle medicine provider has been trained in lifestyle therapeutic approaches to help prevent and manage chronic disease and conditions rooted in lifestyle choices,” explains Hearne. “This includes nutrition, physical activity, sleep, stress management, healthy relationships, and connectedness. The health coach helps individuals develop plans to attain the individual goals they set, which could be weight loss, getting through a cancer treatment, or a work-related goal.”

Hearne says that staff members are also invited to periodic learning salons sponsored by the Vidant Health Office of Experience. Recent salons have addressed gratitude, self-care, and

(continued on page 62)

The ever-growing number of bureaucratic tasks that clinical and support staff must complete each day to document care and be reimbursed for their services is another widely recognized source of stress for oncology staff.

“The amount of documentation required to deliver care is extraordinary, and it grows every day,” says Hearne. “The EHR [electronic health record] has the potential to improve this situation, but right now it is cumbersome and requires much support to even be operational. EHRs can become huge stressors if you don’t have the support tools to maintain them and use them profitably.”

Hearne adds that an increasing number of audits such as those required by fiscal intermediaries and internal compliance teams add to an already significant workload. “These should be good things that help us maintain high standards of patient care,” acknowledges Hearne. “But requirements like these keep growing and growing. We have to do more and more just to have care delivered and paid for.”

This growing workload can contribute significantly to caregiver stress. In a 2019 ACCC survey of its membership, 59 percent of respondents said that they either agree or strongly agree with the statement, “I feel a great deal of stress because of my job.” Fifty-six percent ranked the atmosphere in their primary work area as a 4 or 5 on a scale of 1 to 5, in which 1 is *calm* and 5 is *hectic, chaotic*. Thirty-three percent said that they are “burning out.”

This stress can take a toll on patient care. Thirty-five percent of the 15,000 physicians who responded to a 2019 Medscape survey on physician burnout, depression, and suicide said that their depression makes them easily exasperated with patients, and 16 percent acknowledged expressing their frustration in front of patients.<sup>1</sup> Fourteen percent said that their depression causes them to make errors that they would not ordinarily make.

Relationships with colleagues also suffer. Forty-seven percent said that their depression makes them more exasperated with staff and peers.





Staff at The Outer Banks Hospital celebrate the Employee of the Month.



During the holiday season, individual departments at The Outer Banks Hospital assemble gift baskets for other departments as gestures of gratitude.



The Outer Banks Hospital hosts a golf tournament fundraising event.

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(continued from page 60)



Members of The Outer Banks Hospital Frostbite 5K Team come together for an annual event.



Members of the Frostbite 5K Team relax together over puzzles.




Radiation oncologist and chair of the Cancer Committee, Charles Shelton, MD, participates in an Open House Event at The Outer Banks Hospital.

equity and inclusion in the work environment. The oncology team also leads group activities that reinforce the camaraderie cultivated in the salons by giving staff opportunities to socialize and recognize the skills and talents that each employee brings to patient care. Hearne says that during the most recent holiday season, individual departments assembled gift baskets for other departments as gestures of gratitude.

Oncology staff are also encouraged to go beyond their hospital walls and work with patients in the community. “We have an outreach department that provides opportunities for team members to participate in events in our community,” explains Hearne. “These can be breast cancer fundraisers, colon cancer or lung cancer screenings, or career days for those interested in studying medicine. We are always inviting team members to go out into the community to be part of our greater mission beyond their departments.”

Together, these efforts remind oncology staff that their work contributes to the well-being of their patients, colleagues, and entire community. In an environment in which high-quality patient care can be challenged by reimbursement issues and extensive documentation, Hearne says that a gift basket from a colleague or a break to focus on self-care can make a difference.

“We try to check our personal lives at the door, but we are human too,” says Hearne. “We try to promote mindfulness at meetings and in the clinical setting, and we actively promote employee engagement. This is not considered ‘fluff’ at our hospital; our leadership supports our efforts at the highest levels.” 

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# Elevating Survivorship: Results from Two National Surveys

## CANCER SURVIVORSHIP

### The Current Landscape

As of 2016, there were almost 16 million adults and children living with a history of cancer in the United States, a number that is anticipated to grow to more than 20 million by 2026 as the number of effective cancer treatments grows.<sup>1</sup> While for many organizations, including the National Coalition for Cancer Survivorship (NCCS), the National Cancer Institute, and the Association of Community Cancer Centers (ACCC), cancer survivorship begins at the time of cancer diagnosis, the concept of cancer survivorship is often equated with the period following treatment. However, that concept is evolving, as more people are living longer with metastatic and chronic cancers.<sup>2</sup> Following initial cancer treatment, patients are increasingly referred back to their community or primary care providers, who, ideally, share follow-up care with oncologists and other cancer specialists. Therefore, most healthcare providers (HCPs) beyond the oncology setting can expect to encounter a greater number of post-treatment cancer survivors in the coming years.

The gains in cancer treatment are considerable, especially in relation to durability of benefit associated with targeted and immuno-oncology (IO) therapies. Yet, cancer survivors continue to be increasingly exposed to a range of long-term and late side effects of treatment, including recurrent and new malignancies,

a myriad of physical effects, and psychosocial distress.<sup>3</sup> These issues, combined with the growing number of survivors across different types of cancer, create an imperative to ensure a systematic planning process for survivorship care founded on evidence-based guidance.

The survivorship care plan (SCP) is a key resource in this planning process. In 2006, the Institute of Medicine (IOM) recommended a SCP as a treatment summary and follow-up care plan that should be developed by the oncology care team for patients completing primary treatment. Proceedings from a 2018 IOM workshop endorsed the SCP as a guide to support communication and coordination of treatment among the patient, the oncology care team, and the primary care team,<sup>4</sup> and several SCP templates are available from professional and advocacy organizations to support SCP delivery.<sup>5</sup> SCPs are also required as a quality metric or accreditation standard by several bodies, including the National Comprehensive Cancer Network (NCCN), the American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI), and the National Accreditation Program for Breast Centers (NAPBC). The American College of Surgeons Commission on Cancer (ACS CoC) includes a SCP for patients who have completed 'active therapy' as Standard 3.3, required for cancer program accreditation. All CoC-accredited programs were expected to meet or exceed the delivery of SCPs to 50% of eligible patients by December 2018.

Despite the importance of survivorship care planning, community cancer programs are struggling with the process to develop and implement survivorship care planning due to lack of staffing and infrastructure. Notably, it is time consuming to prepare detailed and individualized SCPs and review their contents with patients and caregivers. The rising cost of cancer care, variation in reimbursement for survivorship care planning, increasing complexity of cancer

treatment, and rapid advancement in targeted agents and immunotherapies further exacerbate these challenges.

In order to explore experiences and needs concerning cancer survivorship from both the provider and the patient perspectives, ACCC and NCCS partnered to field two online surveys to oncology providers and cancer survivors, respectively.

**Figure 1. Sample**

ACCC SURVEY	NCCS SURVEY
<ul style="list-style-type: none"> <li>• Most respondents to ACCC's membership survey (n=93) identified themselves as clinicians in medical oncology, a majority (69%) of whom were nurses or nurse practitioners (NPs).</li> <li>• Approximately one-third of respondents (31%) practice in non-teaching community hospitals; 40% practice in academic medical centers or teaching hospitals; and 17% of respondents are in private practice. The remaining 11% work in freestanding cancer centers or prospective payment system (PPS)-exempt cancer hospitals.</li> <li>• Almost half (42%) of the institutions represented by respondents treat more than 16 new patients per month with cancer immunotherapies and 28% treat more than 21 new patients per month.</li> <li>• Lung cancer was the most common tumor type treated in the majority of settings (95%), followed by melanoma (58%), and colorectal cancer (51%).</li> </ul>	<ul style="list-style-type: none"> <li>• NCCS fielded an online survey with support from nine partner cancer organizations to a convenience sample of respondents drawn from multiple channels (n=1,380).</li> <li>• The sample was skewed female and White but otherwise well distributed across age and region, and respondents were differentiated by type and stage of cancer, treatment exposure, side effects, and demographics.</li> <li>• Respondents reflected a mix of income and education, although the sample skewed toward higher socioeconomic status (SES) than the general population.</li> <li>• Most respondents had private insurance (59%), 24% were Medicare beneficiaries, and 9% were Medicaid recipients.</li> <li>• Two-thirds of respondents were married and reflected a range of cancer types and stages; one-third were breast cancer survivors.</li> <li>• Few respondents described their health status as "excellent;" most described their health status as "good" (44%), "fair" (33%), or "poor" (12%).</li> <li>• Half the patients had completed treatment or were not in active treatment; 28% were receiving treatment for an initial cancer diagnosis; and 19% for recurrence.</li> </ul>

The surveys aimed to identify:

- Frequent and severe side effects that cancer survivors experience;
- Resources and support that cancer survivors want to manage side effects;
- Assistance and care that cancer survivors most need in post treatment;
- Challenges that providers face in planning for survivorship care;
- Technical support necessary to improve survivorship care; and
- Gaps in educational resources for both cancer survivors and providers.

### CANCER SURVIVOR PRIORITIES AND CHALLENGES Experiences Before, During, and After Treatment

Consistent with NCCS' definition of survivor, the NCCS survey included patients regardless of their treatment status and asked questions probing their experiences both during and after treatment. Survivors across the board reported experiencing a range of physical and emotional side effects during and following treatment; however, more than half of respondents reported both fatigue and anxiety as the most common and longest-lasting effects (67% and 58%, respectively). Fatigue, anxiety, nausea/vomiting or diarrhea, muscle/joint pain, and depression were the top five reported side effects, with greater severity reported by those in treatment for an initial diagnosis. Anxiety and depression were higher among cancer survivors with annual incomes under \$50,000 and those currently enrolled in Medicaid.

Even though fatigue and anxiety were top concerns for the surveyed patients, these were the very issues they felt their providers addressed the least. While 51% of respondents viewed healthcare

providers as "very helpful" in addressing nausea/vomiting and diarrhea, fewer viewed these providers as "very helpful" in addressing other physical side effects such as muscle pain (28%) or neuropathy (27%). Fewer still viewed healthcare providers as "very helpful" in addressing feeling overly tired (24%), anxiety (25%), depression (24%), and cognitive effects (14%).

Many respondents said they wished they had known more about the severity of side effects and long-term management; mental health side effects; and fertility/sexual side effects.

### Perspectives on Post-Treatment Survivorship

Although approximately half of respondents felt "somewhat" prepared for the transition from active to post treatment, few felt "very" prepared for this transition and one-third reported not feeling prepared at all. While most respondents had spoken with a healthcare provider—typically an oncologist and most commonly in a physician office—about post-treatment care, 54% reported that they initiated the discussion with their provider, and far fewer (30%) said their provider initiated these conversations. A significant proportion (16%) had no discussion at all. Few survivors report discussing financial support, survivorship plans, or emotional support prior to transitioning to post-treatment care (Figure 1).

Satisfaction with post-treatment care was mixed with just over one-quarter (28%) saying excellent, (38%) saying good, 20% saying fair, and few survivors (8%) stating poor. Indeed, some respondents felt that once they had transitioned out of active treatment, their oncology team no longer considered them a priority.

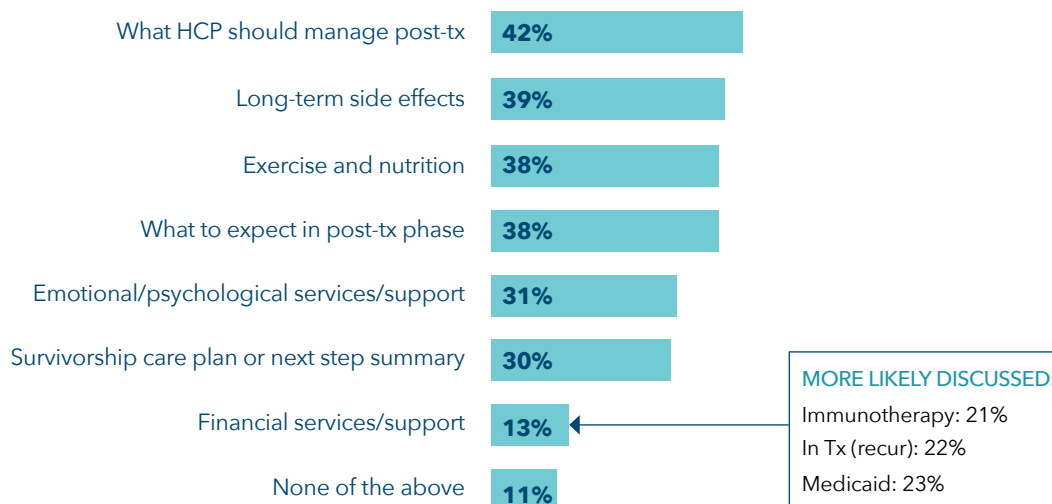
### Things that Survivors Wish They had Known Before Treatment

I think there are "survivorship" issues that should really be discussed as part of treatment, not just when treatment ends.  
[Completed treatment]

Survivorship was harder than treatments.  
[Completed IO treatment]

I wish my healthcare team would address survivorship issues and long-term effects of my cancer diagnosis. At this point I am just told to call if there are changes in the way I feel. This leaves me feeling uneasy and uncertain about the future of my health. [In IO treatment for recurrence]

**Figure 2. Topics Discussed Concerning Transition to Post-Treatment**



Note: post-tx = after treatment completion in tx (recur) = in treatment for recurrence

### Survivorship Needs

The NCCS survey explored multiple issues and challenges associated with survivorship, but the top five concerns identified were getting/keeping health insurance (45%), having the financial support that patients felt they needed (42%), managing ongoing side effects (42%), uncertainty about the future (41%), and having enough energy to get through the day (39%). Despite the high levels of concern expressed about these and other issues, less than one-third of respondents rated their healthcare provider as “very helpful” in responding to their main concerns, especially those relating to financial, insurance, and emotional issues.

**Younger (ages 18-39) and more vulnerable survivors (low income, Medicaid, in poor health) had higher levels of concern across a range of issues and were less likely to say their providers had adequately addressed these issues. Patients in treatment for an initial diagnosis had the highest levels of concerns across a range of issues.**

Many respondents expressed interest in accessing survivorship resources, especially for managing long-term symptoms, alternative medicine, insurance coverage, and exercise. Less than half (45%) of survivors relied on information from their oncologist and notably, although nurses/NPs have a role in providing post-treatment support and information, few respondents viewed them as their “go-to” resource. Instead, respondents across treatment or disease status groups relied on online sources (55%),

support groups (39%), and patient advocacy organizations (32%) for survivorship resources.

### Immuno-Oncology Patients

While IO survivors (27% of respondents) shared many of the financial and psychosocial concerns that the other respondent groups voiced, they were more likely to report major concerns about visiting a physician regularly compared with non-IO respondents (41% vs. 28%) and about starting a family/having children (25% vs. 15%). However, IO respondents were more likely to report satisfaction with their post-treatment experiences than other respondents and were more likely to report feeling prepared for the transition to post-treatment (85% vs. 66%). IO respondents also reported fewer side effects than other respondent groups and higher levels of help from healthcare providers in dealing with their challenges. For instance, compared with non-IO respondents, IO respondents were more likely to say their HCPs had been “very helpful” in addressing financial and emotional concerns (32% and 32% vs. 15% and 23%, respectively) than other respondents. Most IO respondents had also undergone multiple treatments including chemotherapy (74%), surgery (73%), and targeted therapy (70%), but overall, felt they were getting appropriate care.

Although these findings potentially suggest that more effective survivorship care is being delivered to patients receiving cancer immunotherapies, this group was significantly younger than other survivor respondents and had higher income and education levels. Therefore, this group could have been better prepared than the rest of the sample to consider, manage, and discuss survivorship by virtue of age, socioeconomic background, and education.

## Resources that Survivors Want

I am not critical of my healthcare providers for not helping with these services. I honestly don't expect them to—they need to concentrate on medicine. But I don't know where to go for help with these issues.  
[In treatment, recurrence]

Being assigned a case worker to help with insurance benefits. Being assigned someone who can help find resources for my emotional support. I feel like I don't really know what is next. Feel a bit rushed in certain cases to get out of the office and move on. Then I try to live a normal life, but I don't know what that looks like.  
[In treatment, recurrence]

Mental health counseling for anxiety about the future. Also navigating individual health insurance.  
[In initial IO treatment]

I would like to meet more cancer survivors. I feel now that I am a different person and that no one understands what I've been through. Most people think that because you survived, that you are great and not in need anymore. It would be helpful to have some friends who have taken the same journey.  
[Completed treatment for metastatic disease]

**Caveat:** The term “immunotherapy” may still not be widely understood by patients. At the time the survey was conducted 28% of respondents who indicated they had received immunotherapy (after reading a definition) had a diagnosis for which immunotherapies were not yet FDA-approved.

discussed a post-treatment care plan or next-step summary with patients transitioning from active to post-treatment care. Most respondents report they also discussed a range of other topics with patients, including what to expect in the post-treatment phase (76%), possible long-term effects of treatment (80%), and the availability of emotional or psychological support services (71%).

However, less than half of respondents said they discuss the availability of financial services and support (42%) or referrals to other providers for management of post-treatment care. Similarly, although a majority of cancer programs provide nutrition programs (74%) and mental health support groups (58%), few offer programs for managing long-term symptoms (27%), discuss integrative medicine (38%), or provide information about returning to work (43%). These findings were somewhat consistent with how respondents to the NCCS survey reported their survivorship planning discussions with healthcare providers.

## FROM THE PROVIDERS' PERSPECTIVE: PRIORITIES AND CHALLENGES

### Active Survivorship Care Planning

Several professional organizations have also developed resources or guidelines to support providers in survivorship care planning, including ACCC, NCCN, ASCO, and the Oncology Nursing Society (ONS). In ACCC's online survey of healthcare providers conducted from October to December 2018, a majority (86%) of respondents report their cancer program uses NCCN guidelines to support survivorship care, followed by ASCO (71%), ONS (47%), and ACCC (34%) recommendations. Over half (56%) of providers said they

### Survivorship Care Plans

The ACCC survey found that although a majority (83%) of the cancer programs surveyed require the use of SCPs as part of their CoC accreditation process, only 20% of respondents



reported “always” providing SCPs to cancer patients while 54% did so “very often.” Other studies similarly suggest that SCPs are being delivered to a small population of cancer survivors.<sup>6,7</sup> The ACCC survey also found that advanced practice providers (NPs or physician assistants) or navigators develop the SCP for a majority of institutions (70%), although the timing of SCP creation varied from the time of diagnosis (17%), at treatment conclusion (56%), and during treatment (11%). Similarly, recipients of the SCP varied. Almost two-thirds (60%) of institutions shared the SCP with patients; 44% shared with patients and caregivers; 65% with primary care physicians; and 13% with other treating providers.

A range of SCP templates is available from professional and advocacy organizations, including ASCO.<sup>5</sup> ACCC’s survey found that 13% of cancer programs were using the ASCO SCP template; 22% reported using a commercial electronic medical record (EMR) vendor template; and 37% of cancer programs had created their own, in-house templates. Formats for delivery of the SCP also varied. Just over half (51%) provided a print SCP; 43% printed an SCP for the patient from the EMR; 22% created a digital SCP captured in the EMR; and 16% housed the SCP in the patient portal. These findings are broadly consistent with the variation reported in a 2018 IOM workshop on survivorship care.<sup>4</sup>

### Barriers and Solutions to IO Survivorship Care Planning

Providers identified a range of barriers to survivorship care planning, especially in the context of treating patients with immunotherapies. First, for at least half of respondents, the identification of immune-related adverse effects (irAEs) and their differentiation from chemotherapy side effects posed specific challenges for IO survivorship care planning. These challenges were reflected in the irAE monitoring practices that respondents reported. Although 22% of cancer programs have a formalized follow-up procedure for patients treated with IO, 34% rely on informal follow-up, 19% on patient self-report, and 9% on reports from other physicians. Almost 16% responded that they do not monitor patients for irAEs following transition from IO treatment to post-treatment survivorship care. Unsurprisingly, one-third (36%) of respondents emphasized the importance of ongoing education for both patients and providers about the potential for irAEs and late effects of treatment.

Second, although there are general survivorship planning guidelines, the absence of specialized recommendations for IO survivorship care planning is a significant challenge for many programs (48%). For instance, the number of IO patients who transitioned to post-treatment survivorship care varied considerably across cancer programs (Figure 3).

Respondents noted that while survivorship care planning for patients with advanced disease is not yet required by NCCN and CoC standards, many IO patients with advanced disease

are living longer with stable disease. Accordingly, 21% identified targeted IO guidelines as vital to support IO survivorship care planning for patients who have not only completed treatment, but also for patients who have responded to and continue to receive IO therapy.

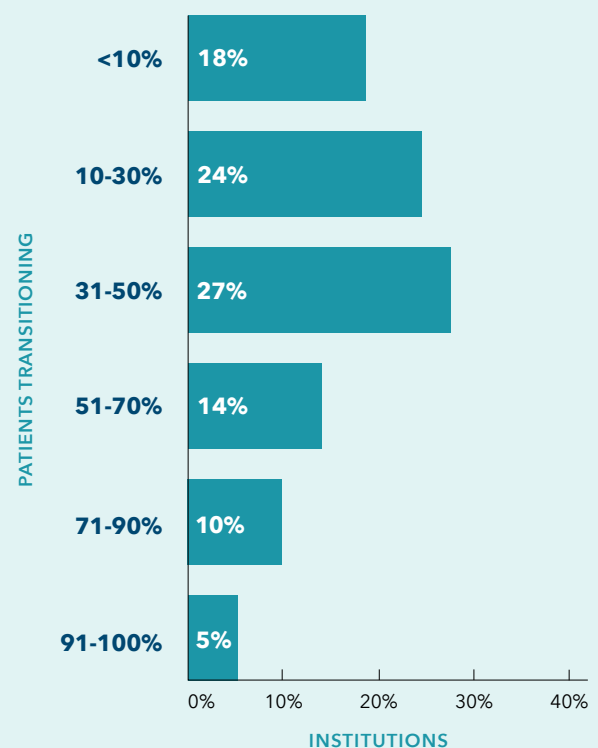
Third, respondents identified lack of staffing infrastructure (24%), a perception of low patient follow-up adherence (18%), and technical challenges (10%) as barriers to survivorship planning and, in particular, to creating SCPs.

## ELEVATING SURVIVORSHIP

### Current Survivorship Priorities

Both survivors and providers in these surveys reported having discussions about the transition to post-treatment survivorship. Yet, for a significant proportion of respondents these conversations appeared to mostly address logistics (e.g., responsibility for managing post-treatment care) versus the most urgent concerns for survivors. Insurance coverage, financial support, and long-term symptom management were priority concerns for cancer survivors, who expressed high levels of interest in accessing resources

Figure 3. Proportion of IO Patients Transitioning to Post-Treatment Survivorship



to manage these issues through their providers. However, both surveys suggest that while providers are helpful in addressing physical concerns, such as managing treatment-related side effects, few providers are currently providing information or access to financial or coverage resources.

Survivor respondents also identified post-treatment psychosocial support (e.g., counseling, support groups) as a key area of unmet need, since depression and anxiety are common mental health side effects of cancer treatment that can last well beyond treatment completion. Yet both surveys show that it remains challenging for providers to address these issues. Although some providers reported having discussions with patients about a range of topics associated with post-treatment survivorship, there was little indication of formal processes for survivorship planning, including long-term irAE monitoring in the context of IO treatment. Moreover, while advanced practice providers are more likely to be involved in planning/delivering survivorship care, few survivor respondents appeared to view nurses or nurse practitioners (NPs) as sources of information and support, relying, instead, on online and other resources.

### Implications for Elevating Survivorship

NCCS survey results clearly illustrate the emotional and financial challenges that cancer survivors face, both during and long after their treatment. While survivors feel their physical needs are being addressed, they are not getting the help they need for some of the most frequent and severe side effects. Current consensus recommendations propose that at a minimum, planning discussions for survivorship care should be initiated at diagnosis, revisited across the survivorship trajectory, and frequently reinforced via multiple formats (i.e., verbally, via a written survivorship document, and, where possible, in the presence of caregivers). In order to engage in survivorship planning and ensure that survivor concerns are addressed, all members of the multidisciplinary team, including nurses, NPs, and primary care providers, need to be aware of the importance of survivorship planning and follow-up. Moreover, given the extent to which survivors look beyond the oncology team for support and resources, findings from this study underscore the need for education that equips all members of the multidisciplinary team to provide wide-ranging post-treatment survivorship support. These findings also highlight an opportunity for cancer programs to more fully meet patient needs by integrating and prescribing non-pharmacologic

supportive care services that draw on the expertise of a range of specialties (e.g., social work, psychology, and nutrition) and to reinforce the need for payers to reimburse these services. Finally, as IO therapies are used more extensively in the adjuvant setting, the concept of survivorship will need to evolve. ▲

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An article from the ACCC Immuno-Oncology Institute.  
Learn more at [acc-cancer.org/immunotherapy](http://acc-cancer.org/immunotherapy).

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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. Access all ACCC IO Institute resources online at [acc-cancer.org/immunotherapy](http://acc-cancer.org/immunotherapy).

# action

## ACCC Welcomes Its Newest Members

### **Maryland Oncology Hematology**

Columbia, Md.  
Delegate Rep: Mary Beth Zaber  
Website: marylandoncology.com

### **Doctors Community Hospital, Doctors Regional Cancer Center**

Lanham, Md.  
Delegate Rep: Jack Nyiri, MA  
Website: dchweb.org/node/1560/

### **Columbia Memorial Hospital-OHSU Knight Cancer Collaborative**

Astoria, Ore.  
Delegate Rep: Christopher Laman, PharmD  
Website: columbiamemorial.org

## Making Our Voices Heard: ACCC Capitol Hill Day 2019

The future of healthcare is at a crossroads. In the past year, the Trump administration and Congress have made several proposals to address the rising costs of healthcare and drugs that have the potential to dramatically affect the landscape of cancer care. Now more than ever, the voices of professionals on the front lines of cancer care are crucial to shaping the direction of future legislation.

Capitol Hill Day, Mar. 20, was the first opportunity for ACCC members to meet with the 116th Congress, a diverse legislative class featuring more than 100 newly elected representatives and 10 senators. ACCC members arrived determined and ready to provide members of Congress with specific policy asks to address gaps in coverage for cancer care:

- H.R. 1730/S.741, the Cancer Drug Parity Act, requires any health plan that covers chemotherapy to provide coverage for oral chemotherapy drugs at the same out-of-pocket cost as intravenous chemotherapy drugs. Originally introduced in 2017, the bill has gained traction in the House and has been reintroduced in both houses; ACCC members urged legislators to co-sponsor and champion this legislation, which is crucial to patient access to oral therapies.
- H.R. 913, the Clinical Treatment Act, would guarantee coverage of routine participation costs in approved clinical trials for Medicaid enrollees with life-threatening conditions. Medicaid insures nearly one-fifth of the U.S. population and is the only major payer not required by federal law to provide coverage of the routine care costs of participation in an approved clinical trial for this patient population. ACCC Capitol Hill Day advocates asked their senators to support introduction of this legislation and their representatives to sign on as co-sponsors.
- ACCC recently responded to the Senate Health, Education, Labor, and Pensions Committee's Request for Information on the most pressing issues with the rising cost of healthcare and drugs. Our response was shared with every office visited on Capitol Hill Day—and many more in brief office drop-ins—and positions ACCC and its membership as a key resource for lawmakers as they prioritize legislation during the 116th Congress.

As in the past year, ACCC members were engaged and empowered by their Capitol Hill Day visits. "Representing ACCC on Capitol Hill allowed for my voice as a genetic counselor—caring for oncology patients daily—to be heard," says Carolyn Haskins, MS, CGC, of Moffitt Cancer Center in Tampa, Fla. "Additionally, I gained tremendous insight into the ever-evolving landscape of oncology care."

# Highlights of the ACCC 45th Annual Meeting & Cancer Center Business Summit, March 20-22, Washington, D.C.



At ACCC Capitol Hill Day, March 20, cancer care professionals from around the country gathered in the halls of Congress to promote meaningful, effective policy reforms. In more than 65 meetings with representatives, senators, and legislative staff, ACCC members advocated for oral parity and early phase clinical trial access and shared what they believe to be the most pressing issues facing cancer care professionals today.



On the first day of the conference, March 21, the kickoff general session featured healthcare futurist Joe Flowers, who outlined a healthcare landscape of streamlined patient-provider communication, true interoperability, and consumer-directed care. Flower invited attendees to envision how we can discard what is broken in healthcare—and retain what works—to benefit the health and well-being of patients.



More than 800 attendees came to the Renaissance Washington, D.C., Downtown hotel to learn about obstacles to optimal cancer care delivery, strategies and solutions for overcoming them, and the ever-changing healthcare landscape.



At the Exhibit Hall, more than 70 meeting sponsors and exhibitors showcased their pharmacological, technological, and clinical innovations to meeting attendees.



Attendees were encouraged to discuss their programs, projects, and methods with each other, providing a unique opportunity to share expertise across departmental and specialty lines.



ACCC was proud to showcase our education projects, which fill crucial gaps in cancer care education and provide learners with unique learning opportunities. The “Early Integration of Pathology into the Cancer Service Line” session featured information gathered from the Integration of Pathology with the Cancer Care Team project. Speakers, left to right: S. Michelle Shiller, DO, Baylor Scott & White Health; Carolyn Haskins, MS, CGC, Moffitt Cancer Center; and Nicole Braccio, PharmD, National Patient Advocate Foundation.



After general sessions, attendees separated into four unique learning tracks for smaller breakout sessions. The “NextGen Practice Management” panel in the business track included Michael L. Blau, Foley & Lardner LLP; Marcus Neubauer, MD, McKesson Specialty Health & The US Oncology Network; Brad Prechtel, MBA, American Oncology Network, and Erich A. Mounce, MSHA, OneOncology.



At the ACCC House of Delegates, March 22, Ali McBride, PharmD, MS, BCOP (left) was sworn in as ACCC president, succeeding Immediate Past President Thomas A. Gallo, MS, MDA (right). Between them: Krista Nelson, MSW, LCSW, OSW-C, BCD, ACCC secretary.



On the final day of the conference, attendees heard from Joanie Mayer Hope, MD, a gynecologic oncologist who uses the power of music to raise awareness about gynecologic cancers. Dr. Mayer Hope encouraged care team members to bridge their artistic and medicinal creativity and premiered her music video Any Mountain—a hip-hop journey through ovarian cancer—to a standing ovation from the packed ballroom.



Friday afternoon, attendees broke out into four Deep Dive Workshops—uniquely interactive, bidirectional learning opportunities that allowed participants to drill down deep into crucial issues like patient education and engagement, immunoncology, and strategic alignment. At the Clinician Resiliency and Workforce Issues workshop, Kathleen LaRaia, MS, Munson Healthcare (left), and Linda Bosserman, MD, FACP, FASCO, City of Hope (right), conducted a group activity to identify personal and organizational barriers and opportunities for alleviating cancer team burnout.

## A Patient's Best Friend

Bringing pet therapy to cancer centers

BY JULIE BULGER



**A**ndy and Cooper. Laura and Dixie. Michelle and Swoosh. These are household names at the Vanderbilt-Ingram Cancer Center, and they are just a few of our 18 famous and wildly popular pet therapy teams visiting patients who receive chemotherapy treatments.

When I first started working at Vanderbilt in 2003, I heard about a “secret” happening in the cancer clinic: there was a volunteer bringing her dog in to visit the infusion room. This volunteer was the “friend of a friend” of the charge nurse and would occasionally be allowed into the clinic. At first, I thought this meant a lot of slobbering and barking, and at a time when infusion rooms were simply recliners set in a circle, I worried that this could be disruptive to patients during treatment. But on days when the volunteer and her dog visited, the clinic was instead filled with giggles and glee.

The staff was afraid that if the “secret” of these visits got out, the program would end. But with some determination and to the staff’s delight, the opposite happened. The smiling faces of patients, their obvious joy and laughter, and the welcome distraction that the dogs and handlers created outweighed the negatives. Thus, Vanderbilt’s Pet Therapy program was born.

### The Benefits of Pet Therapy

The benefits of a formal pet therapy program are obvious—it defines personalized care. Animal visits bring joy to patients during some of their most difficult days, enhancing

social and emotional well-being and relieving stress. And though it’s all about the patient at Vanderbilt, it’s not just patients who benefit. It’s their family members, the caregivers who drive two hours each way just to spend eight hours in clinic receiving chemotherapy and seeing providers. They are scared and weary, trying valiantly to “stay strong.” Getting to play with a pet while they wait can relieve stress and reinvigorate them for the days to come.

Pet therapy is also for the nurses, medical assistants, and front desk staff, all of whom love having a five-minute reprieve from their hectic work days. Teresa Spsychalski, RN, infusion clinic charge nurse at Vanderbilt Health, says, “The vibe of the clinic changes when one of our pet teams enters the door. There is kind of a lightness felt by everyone, including the nurses and staff. Many patients come with a lot of anxiety on their chemo days, and I see how a visit from one of our furry friends just melts that away.”

“I have personally seen magical moments between my dog and a patient,” says volunteer Laura Meadors about her black Labrador retriever, Dixie. “Some have even brought me to tears. Yes, there are times when I’ve seen patients that are sad, worried, upset, or just feel bad. I am not always sure how to handle that as a volunteer, but Dixie just makes that moment easier for both sides.”

Says Victoria Harris, who visits with her dog Spanky, “When patients or a staff member say things like, ‘Y’all have really made my day’ or ‘this is exactly what I

needed today; that’s when I feel it is truly worth it. I personally know what it’s like to sit in an infusion chair; therefore, I realize how rewarding it is to have the company of a sweet four-legged animal as a visitor.”

### Formalizing Pet Therapy

I’m often asked by staff at other cancer hospitals or programs how to implement a similar program at their site or how we benchmark our program’s successes. Here are a few how-to tips for those looking to implement pet therapy:

- Your first step is to have the support of the senior leadership team. Next, begin collaborating with infection control and legal counsel. Legal will want to ensure and document the liability limits that registered pet therapy teams have.
- Ensure that pet therapy is part of your organizational animal visitation policies. Currently, many hospitals are revisiting these policies to define the differences between emotional support animals, pet therapy animals, facility animals, and service animals.
- Document clear and specific volunteer service descriptions, training requirements, and infection control practices vetted through legal, infection control, and policy development.
- Only accept pet teams that are trained and registered with national pet therapy programs. We cannot be in the business of training pet therapy teams, and they must be trained—none of our therapy dogs bark, slobber, or drool. We do not accept dogs solely on the basis of passing the American Kennel Club’s Canine Good

Citizen program or obedience training, no matter how much the handler insists that the dog is qualified. In Nashville, we are fortunate to have local affiliate organizations that evaluate and register teams with Pet Partners and Intermountain Therapy Animals. Once pet therapy teams have passed their evaluation and register, we begin the stringent screening and training process to become a Vanderbilt Volunteer Pet Team. This process takes six months; it is long, but it is critical to ensuring safety and quality.

- All teams complete Vanderbilt's Volunteer Services screening process (i.e., background checks; required immunizations; hospital-specific orientation like Health Insurance Portability and Accountability Act and confidentiality, infection control, and maintaining boundaries). Teams are scheduled to visit on the same day and time each week.
- Pet teams are placed in and only visit areas that have been pre-approved by Volunteer Services. We train volunteers how to act when an unapproved physician or family member pleads with them to come make a special visit; that can be very difficult for a volunteer who is here to help. We have areas that are strictly off-limits to pet visitation (intensive care units, myelosuppression, etc.) and areas where we have a staff member who is afraid of animals.
- As part of the volunteer training, we require a two-step shadowing process. All new volunteer handlers shadow a current team; that team then shadows and evaluates the new team on their first shift.

- It's important to support, celebrate, and recognize the invaluable contributions of your volunteer pet teams. Yes, they receive lots of immediate gratification for this work, but we can never appreciate their time and contributions enough. For example, one of our staff members is also a professional photographer and a huge fan of pet therapy. We created a photo shoot "set," and she offered a photo shoot with the handlers and their dogs. The volunteers were so grateful to have a beautiful photo just in time for holiday cards!

In 2017, ACCC invited us to bring a few pet teams to the 34th National Oncology Conference held in Nashville. After several days in high-level, heavy thinking meetings, why not end the conference by offering some on-site pet therapy for attendees?

Some of the most brilliant minds in cancer care—clinicians, researchers, administrators—immediately felt comfortable playing with these pets. Yes, there is invaluable research being done on the positive effects of pet therapy on patients in healthcare facilities, but watching conference attendees that day provided further proof of how therapy pets can bring out the best in people. They help people relax, relieve stress, and create memorable connections.



*Julie Bulger is manager of patient- and family-centered care at Vanderbilt-Ingram Cancer Center, Nashville, Tenn.*



Swoosh.



Cooper and nurses.



Yellow Lab at the 2017 ACCC National Oncology Conference, Nashville, Tenn.



Pet therapy visit with Spanky.

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