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ONCOLOGY ISSUES

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

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Carrie's TOUCH: Supporting Black Women with Breast Cancer

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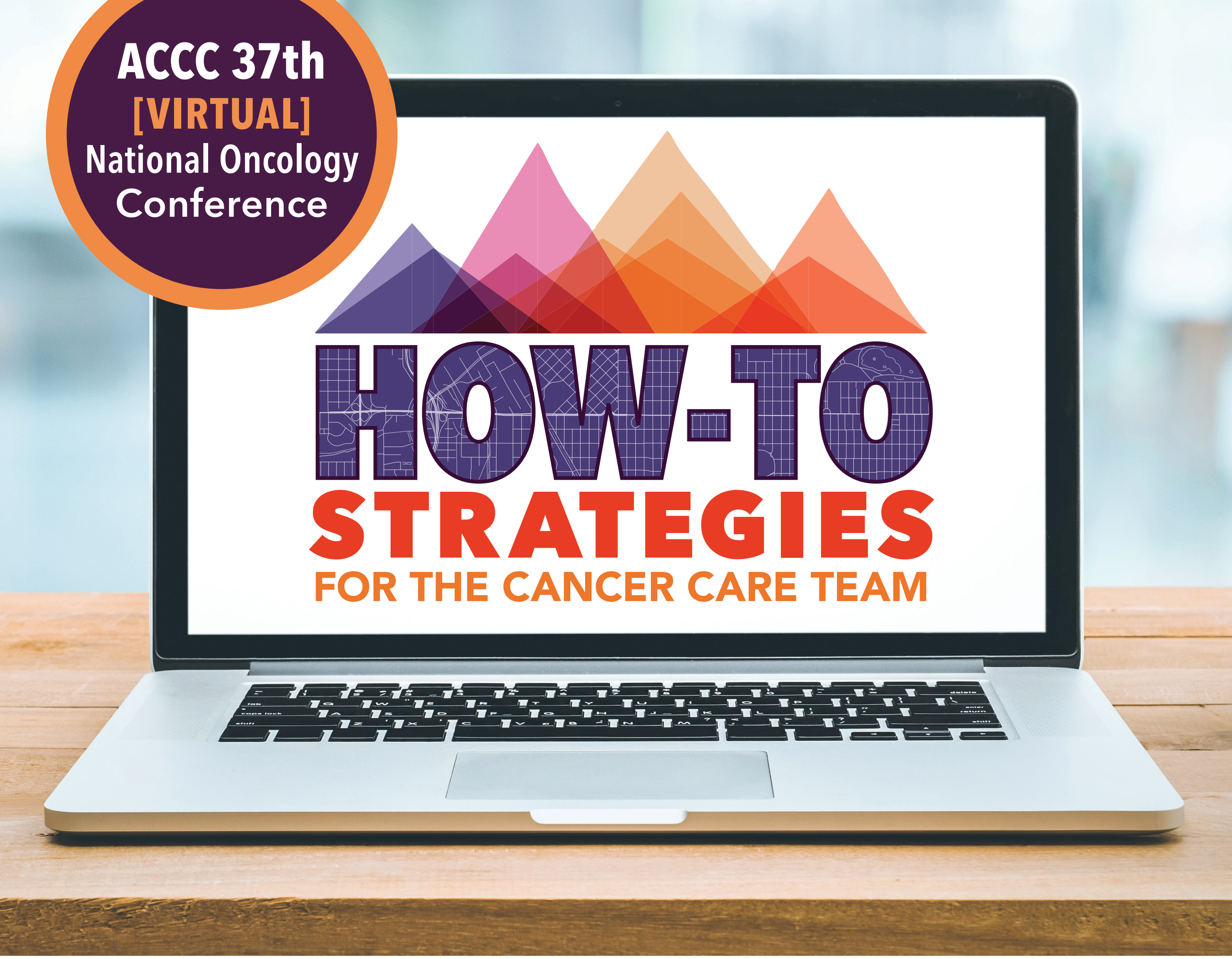
ACCC 37th
[VIRTUAL]
National Oncology
Conference
HOW-TO
STRATEGIES
FOR THE CANCER CARE TEAM

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Oncology Issues
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DEPARTMENTS

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Association of Community Cancer Centers

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FROM THE EDITOR

How Oncology Can Help Improve Vaccination Rates

BY SIBEL BLAU, MD

About 90 days have passed since the first vaccine against the novel coronavirus SARS-CoV-2 arrived in the United States, fueling new hope nationwide for the fight against the virus. Vaccine rollout has been a top priority and millions of individuals in this country have been vaccinated thus far. Rates of diagnoses and mortality have decreased significantly since the beginning of the year.

Despite these recent wins, make no mistake—we are still in a race against a virus that is so clever it mutates even faster than a typical coronavirus. A recently published *New England Journal of Medicine* article finds the relative resistance of variants, including the B.1.351 variant that surfaced in South Africa, to be an ongoing feature of this virus. With these variants, we can expect transmission despite immunity with vaccinations or natural infection. Of course, efforts are ongoing to develop more effective vaccines, but time is limited. The good news: at least we know vaccines protect people from severe cases and death.

Because many of our patients with cancer are eligible to get the vaccine, most of us ask whether they have received their vaccines during clinic visits. Most patients with cancer are enthusiastic about getting a vaccine, yet some decline it due to concerns over side effects, religious beliefs, or misinformation about the vaccine itself. I often find myself in the position of explaining the benefits and risks and the scientific approach to vaccine development.

Oncologists may not be on the frontline taking care of patients with COVID-19 in intensive care units or emergency departments, but we do have the chance to advocate for vaccination to win the race against this deadly virus. For the most part, our patients trust us with their lives, so our voices can be an important tool for promoting vaccine compliance across the nation. This may take time and effort, but it is worthwhile even if we gain only one patient at a time.

As I walked into my clinic to work for the second long day in a row on a Sunday morning, a patient of mine stopped me at the entrance. She thanked us for providing vaccines to the community, and she also told me that this experience helped her fully realize the effect that oncologists can have on their patients. She said, "We look to our oncologist to tell us this vaccine is important. We believe you come from a scientific background and that you care about us. I am here today because you told me I should get this vaccine. Thank you for advocating for me."

To alleviate concerns and find answers to frequently asked questions, our practice developed educational materials for patients and staff, which are updated as new information and data become available.

As the new vaccines arrive and side effects are made publicly available, we will likely see growing confusion and perhaps more resistance to vaccination. Patient education takes time. The fact that oncologists, alongside nurses, are administering COVID-19 vaccines on the weekend at my practice has had an important psychological effect on patients. Our patients see how much we care about this issue, and they truly sense that we are all in this fight together.

At the end of the day, oncologists care for one of the most vulnerable patient populations, and therefore, it is our duty to continue advocating for these vaccines. To help, I have made my practice's patient education tools, including our COVID-19 Vaccine Clinic flyer and a Frequently Asked Questions sheet, available to all ACCC members at: accc-cancer.org/journal. OI

ACCC PRESIDENT'S MESSAGE

Driving Oncology Forward

BY KRISTA NELSON, MSW, LCSW, OSW-C, FAOSW

I want to start by sharing my gratitude for the honor of serving as your 2021-2022 ACCC President. I have loved every opportunity I've had to lead and develop programs that have their members and the cancer community (including our patients with cancer) at the forefront, so working with ACCC is a natural fit. One of my favorite things about ACCC is the ability of this organization to bring the cancer community together in one place. To me, ACCC represents how we care for our patients—we need every member and every discipline, leader, payer, industry partner, and innovator working together to provide the best care possible in a sustainable way. My experience is grounded in oncology social work, my field of work for more than two decades. This experience has shaped my ACCC President's Theme and the lens in which I view cancer delivery and care.

This next year, as we emerge out of COVID-19's shadow and into a landscape that has been forever altered by the worldwide pandemic, it is important that we reflect on what we witnessed this past year—not only the suffering but the "wins." Though we saw suffering among our patients, our communities, and our cancer care teams, we also saw innovation, resilience, and heroism within these same groups. As we heal and hopefully start to recover from the COVID-19 pandemic, we must capture and learn from the important lessons of the past few years. To help us in this effort, I am pleased to announce my 2021-2022 ACCC President's Theme, *Real-World Lessons from COVID-19: Driving Oncology Care Forward*.

Lesson 1. Health equity and social justice are critical drivers of quality cancer care. Practice-based solutions are needed to reduce barriers to access and treatment and improve health outcomes. During the last year, ACCC worked with its members to reduce cultural and ethnic barriers and improve access to care, which includes an ongoing collaboration with the American Society of Clinical Oncology to improve racial and ethnic minority representation in clinical trials. The ACCC Board of Trustees is committed to continuing its focus on equity, diversity, and inclusion through education programs, such as health literacy and shared decision making, and advocacy efforts moving forward.

Lesson 2. The escalating need for high-reach, high-impact psychosocial and supportive care services requires innovative care delivery models that demonstrate measurable value to the oncology ecosystem. ACCC will grow its existing series of discipline-specific business briefs, which demonstrate to internal (cancer programs and practices) and external (public and private payers) stakeholders the value of offering comprehensive cancer care services. This year we will focus on the critical need for oncology social workers and oncology pharmacists. ACCC will use the results of its 2019 Comprehensive Cancer Care Survey to guide policy, advocacy, and educational initiatives and inform value-based payment reform discussions.

Lesson 3. A culture that supports professional well-being and resilience is essential to practice sustainability and both provider and patient satisfaction. Distress and moral injury among the healthcare workforce are nearing catastrophic levels. Strengthening—and mobilizing—a culture that supports professional well-being and resilience is critical. We must use our experience throughout COVID-19 and the Black Lives Matter movement to 1) tackle practice-based disparities, attitudes, and processes that impede equity; 2) create efficient and effective delivery of state-of-the-art psychosocial and supportive care that brings measurable value to care delivery; and 3) acknowledge that the oncology workforce is hurting at every level—personally and professionally. Trauma runs deep and requires immediate interventions that create a culture focused on compassion and resilience. Our cancer programs and practices cannot go on without recognizing and supporting those that care for patients with cancer and their communities.

As ACCC members, I hope that these lessons resonate with you and the work you do. This work is a partnership. Please let us know what you need and, most important, whether you are interested in being involved in developing solutions. Consider this an open invitation to join us in this important work to drive oncology forward. I thank you for all you do to support patients with cancer, the care team, our communities, and ACCC.

Coming in Your 2021 *ONCOLOGY ISSUES*

- Onboarding Experienced Non-Oncology Nurses to Address Staffing Shortages
- Improve Oral Oncolytic Workflow and Reduce Treatment Delays with a Pharmacist Collaborative Practice Agreement
- Reducing Readmissions After Chemotherapy with Predictive Modeling of Risk Factors
- Integration of Prehab, Rehab, and Prospective Surveillance into Interdisciplinary Teams
- Shifting Chemo Administration from Inpatient to Outpatient Setting Improves Care and Reduces Costs
- Integrating Spiritual Care in the Outpatient Oncology Setting
- Use of Pharmacy Informatics to Standardize Pharmacist Review of Oral Oncolytic Medications for Hospitalized Patients
- Medication Transitions in Hematologic Malignancy Patients at a Safety Net Hospital
- Timing Distress Screening in Surgically Resectable Esophageal Cancer
- An Investigation of Self-Determined Work Motivation Among Young Adult Central Nervous System Cancer Survivors
- This Lyrical Life: Music Therapy in Oncology
- Mixed-Method Study Examining Initial Interactions of Oncology Patients with Multidisciplinary Cancer Care

2020 Trends in Cancer Care Delivery

fast

Source. 2020 Trending Now in Cancer Care Survey.

Acceleration of Telehealth

Cancer programs and practices ramped up telehealth efforts virtually overnight. In spring 2020, virtual visits accounted for about **40%** of patient volume, falling to about **10%** in the summer, and increasing to almost **50%** during the fall. Congress acted quickly to expand access to telemedicine services by increasing reimbursement for Medicare beneficiaries and changing regulatory requirements to ease adoption. If this flexibility remains in place, and connectivity inequities are addressed, telehealth may help improve patient access and remove transportation barriers, particularly in rural and underserved communities.

Top Telehealth Barriers

- Lack of IT staff to implement telehealth solutions
- Using off-the-shelf telehealth resources (like Zoom and Doxy) with little technical support or training
- Physician comfort levels with telehealth
- Lack of equipment (cameras, microphones, and speakers)
- Initial lack of codes for reimbursement; initial lag of parity for telehealth and in-person services
- Lack of access to technology, connectivity, and/or privacy.

Financial Navigation Goes Virtual

- Navigators were largely unable to have face-to-face conversations with patients onsite, instead relying on phone calls or virtual platforms.
- Many patients did not have access to the necessary technology, or even adequate Internet connection.
- Patients were hard to reach by phone. Unfamiliar with navigator cell phone numbers, many did not answer calls, adding to navigators' workload.

facts

Cancer Screening Drops Sharply

Cancer screening volumes (e.g., colonoscopy, PAP smear, mammogram) decreased either because screening sites closed, or primary care providers did not offer screening. Patients canceled regular exams and avoided the ER, reducing the potential for incidental findings. Cancer programs and practices combatted this with a focused effort to educate patients that it is safe to return to the clinic and not to postpone these critical preventative visits.

U.S. Healthcare System Took a Financial Hit

Some health systems stopped outpatient or scheduled appointments and suspended entire service lines. Reductions in overall patient volume and elective procedures adversely impacted revenue. Because patients with cancer in active treatment kept their clinic visits, oncology programs often shored up health system revenue. The drastic dip in screenings contributed to fewer new patient visits. Revenue-protecting strategies included:

- Furloughing and laying off staff.
- Flexing staff to patient volume.
- Freezing and/or eliminating merit increases.
- Implementing voluntary and involuntary salary cuts.
- Putting matching IRA contributions on hold.

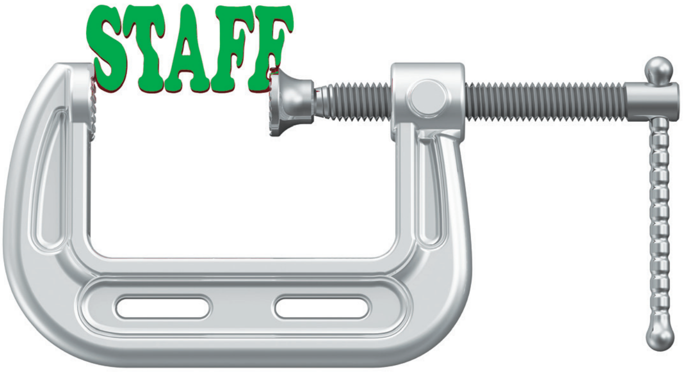
Delayed Screenings Pose Risk to Patients

Many believe that the dramatic reductions in screening and preventative appointments may lead to cancers being diagnosed at later stages. While the overall impact on cancer diagnoses has yet to be calculated, focus group participants shared these insights:

- One program noted a **50%** reduction in new breast cancer diagnoses in the second quarter of 2020 and a **20%** reduction of new breast cancers in 2020 overall.
- A similar pattern is likely for other staging- or screening-detected cancers.
- Tumor registries will likely record more advanced cancers in 2021 and beyond.

2020 Trends in Cancer Care Delivery

Source. 2020 Trending Now in Cancer Care Survey.



Staffing During the Pandemic

In spring 2020, staffing cuts and furloughs were widespread and staff were redeployed to support COVID-19 operations or cover the shortfall for other services. Over the summer, cancer programs and practices continued to experience staffing shortages when inpatient volumes rebounded, and new COVID-related clinical and administrative roles were created to screen patients prior to clinic visits. During the second surge in late 2020, short-staffing remained a significant problem as elective surgeries increased to offset severe revenue shortfalls. The pandemic increased staff workloads and reshaped roles and responsibilities. Staff juggled multiple roles and absorbed new responsibilities during furloughs and redeployments. Virtual patient visits increased expectations about patient volume.

Innovative Ways to Support Staff

As the pandemic evolved, cancer programs and practices developed a heightened awareness of staff burnout. To bolster resiliency, service line leaders employed solutions like:

- Repurposing conference rooms and other areas as designated staff spaces.
- Getting innovative with staff recognition or perks in times of financial hardship, such as hosting milkshake and ice cream bars.
- Implementing robust Buddy Systems.
- Sending daily supportive messaging.
- Sharing positive stories and accomplishments.
- Reinforcing a "speak up" culture, especially when issues and challenges arose.

A Heavy Toll on Cancer Care Staff and Providers

The impact on staff morale and health was severe.

- Many staff contracted COVID-19 or experienced financial hardship due to furloughs and layoffs.
- Those working reported burnout, exhaustion, fatigue, and stress.
- Institutional support for remote work varied and was mostly used for service line leadership and supportive care staff.
- In addition to increased workloads, staff contended with their own personal health concerns and additional home responsibilities.

Moving the Needle on Health Equity

COVID-19 exacerbated existing disparities in oncology along socioeconomic, racial/ethnic, age, gender, and geographic lines. The very real digital divide meant that telehealth did not benefit all patients equally. Many patients in rural or impoverished areas lacked cell phone minutes, cell phone service, connectivity, and privacy. The pandemic stimulated a nationwide discussion to address health inequities. Cancer programs and practices responded by:

- Scheduling flexible clinic and treatment hours for working patients.
- Increasing transportation support for treatment visits, e.g., gas cards and public transportation and rideshare vouchers.
- Identifying areas of additional patient support, including addressing food insecurity and childcare needs.
- Understanding that patients with cancer and their families often want to give back in a meaningful way and engaging them to help develop strategies to improve health equity.
- Partnering with community organizations to reach at-risk people, offer tailored education and resources, and identify and reduce disparities.

Clinical Research Reimagined

Flexibilities emerged in 2020 that have long-term potential to reshape the design and conduct of clinical trials; increase patient access, enrollment, and retention; and improve health equity, including:

- Decentralizing care based on FDA guidance.
- Implementing remote consent and trial eligibility screening.
- Clarifying which tests are essential.
- Amending studies to eliminate lab test times or lengthen testing intervals.
- Using virtual visits for clinical assessment and patient-reported symptoms.
- Leveraging biometric devices to support patient evaluation (e.g., sleep, movement).
- Shipping oral drugs directly to patients and deploying pharmacists to counsel and monitor adherence by phone.

Recent Trends in White Bagging and Brown Bagging

BY KRISTIN FERGUSON, DNP, RN, OCN

Over the last several months, ACCC members have experienced a rising trend of payer-mandated white and brown bagging.

"White bagging" is the term used when payers require certain drugs to come from a specific specialty pharmacy and be shipped directly to a practice, hospital, or clinic for administration. Often these drugs are billed under pharmacy benefits instead of medical benefits, as is generally the case under the buy-and-bill model where providers purchase and stock drugs that they then administer to patients after physician orders are entered.

"Brown bagging" is the term used when payers mandate that drugs be shipped directly to patients' homes. Under this model, patients are required to bring the drug to the infusion center, clinic, or practice for administration; self-administer the drug at home; or have home health nursing administer the drug in their home.

Payers say these two models improve utilization management; however, many oncology providers and support staff believe that due to the complexity of anticancer drugs, which often require dose adjustments and treatment delays, white bagging and brown bagging can:

- Delay patient care.
- Increase safety concerns about drug quality.
- Result in drug waste.
- Create unnecessary administrative burden.
- Have a negative impact on care coordination.

Concerns also exist around drug integrity, home infusion, and patient burden.

Workflow and Patient Safety Concerns

Many patients visit with their medical oncologists and have labs drawn on the same day they receive treatment in an infusion center or physician's office. This practice ensures that their body is healthy enough to receive the next dose of chemotherapy or immunotherapy. Sometimes, due to a new side effect observed or an abnormal lab, a physician may decide to hold or reduce the dose of a drug. If the drug is coming from an outside specialty pharmacy directly to the clinic or to the patient first, the drug may go to waste if the physician determines that the patient cannot safely receive the drug that day. Due to expiration requirements, drugs cannot always be saved for the next treatment date.

Many ACCC members report that white bagging can increase patient wait times when the drug is not delivered on the treatment date or the drug is delivered to an area of the clinic or hospital where oncology staff is not present. When this happens, drugs can sit in temperatures not recommended for viability or not reach the correct department at all.

With white and brown bagging, because the drug is not initially overseen in a program's oncology pharmacy, providers who must administer the drug may have concerns about how the drug was mixed and whether the correct drug is in the bag or syringe. Liability concerns, should patients have a reaction, are prevalent. With white and brown bagging, clinic staff do not have control over drug handling, temperature, how long ago a drug is mixed, and the drug's expiration date, leading to potential safety implications for patients.

Specialty pharmacies typically do not have full access to patients' medication histories and electronic health records, resulting in situations where drugs are sent to or for patients without necessarily having undergone safety checks and balances.

Specific to home infusions, revenue loss is of concern as well to cancer program and practice administrators, who budget for staff, equipment, and other costs based on revenue generated from drug administration.

Looking at home infusion from the patient perspective, though many believe that patients prefer receiving therapy at home (one reason why more brown bagging has been emerging during the COVID-19 pandemic), most oncology drugs cannot be given safely at home due to fear of an infusion reaction, as well as risk to other individuals in the home who may potentially be exposed to hazardous drugs.

Recent Trends

Members in several states have sent ACCC different payer notifications about changing requirements for certain drugs, many of them supportive therapies, requiring that these drugs come from specialty pharmacies prior to delivery to the clinic (white bagging) or requiring that these drugs be delivered directly to patients' homes (brown bagging).

John Montville, executive director, Oncology Service Line at Bon Secours Mercy Health in Paducah, Ky., worries that payers are "launching these requirements in sporadic places first" and fears that their goal is to roll out these requirements nationwide. How health systems and oncology practices respond to these increasing payer requirements will likely determine whether the increase in white and brown bagging continues.

The delivery of oncology care in the home is another concerning and related trend. For providers, home oncology care shares many of the same concerns of white and brown bagging, in addition to unique challenges, such as home staff not having adequate oncology training and a lack of supportive care in the home if an infusion reaction or adverse event occurs during or immediately after drug administration.

So, What Can Providers Do?

Some cancer programs are refusing to accept payer contracts or to treat patients whose insurance has white and brown bagging requirements, which, unfortunately, decreases access to care for patients with cancer. However, with concerns over drug safety, integrity, and liability, many cancer care providers feel they have no choice.

Others are using legislative means to fight these payer requirements at the state level. Jorge Garcia, PharmD, MS, MHA, MBA, FACHE, assistant vice president at Baptist Health Florida and member of the ACCC Board of Trustees, states:

"We are currently organizing to advocate about this in Florida through professional organizations and state boards. We want to establish guidelines for promoting safer pharmaceutical procurement practices. A letter from the Florida Society of Health System Pharmacies will be presented at the Board of Pharmacy in Florida outlining our various concerns with these [white and brown bagging] practices, specifically quality and safety concerns. As a healthcare leader, I do not feel these practices are in the best interest of quality patient care, timely care, or patient safety."

ACCC will continue to monitor and update members about issues related to white and brown bagging. Meanwhile, if your cancer program or practice is experiencing workforce, reimbursement, or cancer care delivery trends, issues, and/or challenges, please feel free to email me at kferguson@accc-cancer.org. I look forward to hearing your thoughts and learning more about how ACCC can help. OI

Kristin Ferguson, DNP, RN, OCN, is senior director, Cancer Care Delivery & Health Policy, Association of Community Cancer Centers, Rockville, Md.

compliance

Behavior Health Assessment and Intervention for Oncology Patients

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

As the public health emergency continues, recognition of the importance of mental health and health behavioral services is ever more present. For anyone who has worked in the oncology setting, this understanding is not new.

A cancer diagnosis invokes fear, anxiety, uncertainty, and confusion in patients, their families, caregivers, and friends. Responses vary, depending on the type of cancer, age, socio-economic status of the patient or their family, and how a patient can and does cope with difficult life situations. Fear or concern of cancer recurrence can be just as impactful as the initial diagnosis on patients and their support system.

Patients having difficulty accepting their diagnosis, those fearful of how they will pay for treatment (even with insurance), and/or those feeling depressed or anxious about the effectiveness of treatment can experience sub-optimal outcomes due to appointments or follow-ups that go unscheduled, missed treatments, and/or non-compliance with medications. The literature finds that patients with a healthy support system in place or those who receive health behavioral services tend to do better and experience better outcomes.

A 2019 article published in *BMC Psychiatry* found that the incidence of psychological disorders in patients with cancer is very high, somewhere between 30 and 60 percent.[1] The most encountered problems were depressive symptoms associated with anxiety, adjustment disorder, depressive moods, or major depression. However, of those patients less than 10 percent are referred to health behavior services.[1]

Coding and Billing for Health Behavior Services

The idea of billing for health behavior services began in 1998 by the American Medical Association (AMA). In 2002 these services were expanded to allow for more widely available billable services, including the addition of Current Procedural Terminology (CPT®) codes (**96150-96155**) for Health Behavior Sciences. The introduction of these codes made health behavior services available to more patients and, more important, recognized the impact that physical illness may have on patients who have not been diagnosed with a mental illness but who have some other primary illness. The AMA explained the 2002 addition and intention of these by stating:[2]

"Many services performed by psychologists and other non-physician (i.e., non-MD/DO) practitioners are performed to enhance a patients overall health. This includes but is not limited to a number of types of psychotherapy

services, as well as other mental health procedures intended to treat designated, diagnosed mental illness. Sometimes, however, these services are offered to a patient who presents with established illnesses or symptoms who are not diagnosed with mental illnesses. Instead of treating a particular illness, these services are intended to assess and address certain factors related to the patient's physical health. These factors can include modification in a patient's behavior towards prevention, treatment, or management of the physical health problem, or other factors that do not directly treat a diagnosed illness but affect recovery or its progression."

Effective in 2020, the AMA deleted the six codes that had been available since 2002 and replaced them with nine new codes (**96156-96171**). According to the AMA 2020 CPT manual, the intention of the new health behavior assessment and intervention codes "…describe assessments and interventions to improve the patient's health and well-being utilizing psychological and/or psychosocial interventions designed to ameliorate specific disease-related problems."[3]

The AMA goes on to further define a health behavior assessment and health behavior intervention as follows:[3]

- **A health behavior assessment** "includes evaluation of the patient's responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment. Assessment is conducted through health-focused clinical interviews, observation, and clinical decision making."
- **A health behavior intervention** "includes promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery, and management of and improved coping with medical conditions. These services emphasize active patient/family engagement and involvement. These interventions may be provided individually, to a group (two or more patients), and/or to the family, with or without the patient present."

Below is the list of behavior health assessment and intervention CPT codes added in 2020 that are still current in 2021. Note: Codes denoted with a "+" are add-on codes and must be reported with the primary service on the same claim.

- **96156**. Health behavior assessment or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making).
- **96158**. Health behavior intervention, individual, face-to-face; initial 30 minutes.
- **+96159**. Health behavior intervention, individual, face-to-face; each additional 15 minutes. (List separately in addition to code for primary service.)
- **96164**. Health behavior intervention, group (two or more patients), face-to-face; initial 30 minutes.
- **+96165**. Health behavior intervention, group (two or more patients), face-to-face; each additional 15 minutes. (List separately in addition to code for primary service.)
- **96167**. Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes.
- **+96168**. Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes. (List separately in addition to code for primary service.)
- **96170**. Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes.
- **+96171**. Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes. (List separately in addition to code for primary service.)

According to the American Psychological Association Services, Inc., components of the health behavior assessment reported with CPT **96156** will vary and may include but are not limited to:[4]

- Relevant medical history
- Adjustment to the medical illness or injury
- Psychological and environmental factors affecting management of the medical condition
- Health beliefs, perceptions, and outlook
- Understanding of treatment plan, benefits, and risks of procedures
- Healthcare decision-making skills
- Coping strategies, patient strengths
- Motivation and self-efficacy beliefs
- Treatment adherence and expectations
- Daily activities, level of behavioral activation, and functional impairment
- Sleep, diet, physical activity, and other health risk behaviors
- Mental health and substance use (including tobacco and alcohol use)—current and past
- Social support, family, and interpersonal relations
- Academic and vocational histories
- Mood
- Quality of life.

Medical documentation should include clear rationale supporting why the assessment was performed, the frequency and duration goals of the intervention(s), and the patient's compliance with the medical treatment plan.

Although these codes are not defined as to which specific physical illnesses they may be used for, they do include some required billing elements, which should be evident and supported in the medical documentation:

1. There must be a health-focused clinical interview of the patient by the qualified healthcare professional (QHP). This includes face-to-face interviews with the patient. If the interviews or assessment is not completed on a single date of service, the billing date is the date documented as the completed date of the assessment.
2. There must be behavioral observations by the qualified healthcare professional on how the patient responded throughout the clinical interview.
3. There must be clinical decision making documented by the qualified healthcare professional. This includes the incorporation of data, interviews, discussions with

other QHPs about the patient, as well as the information gathered during the interview with the patient.

Payer Requirements and Considerations

Payer coverage varies. Some payers may not cover services that are not provided directly to the patient; others may have limited coverage for group work. In addition, there are further limitations to coverage or support for who can report the behavior health assessment and intervention codes and the quantity or maximum amount of time per date of service for interventions. The patient must have a suspected or established underlying physical illness, such as cancer. There must also be some indication of psychological and/or psychosocial factors significantly impacting or affecting the treatment and management of the physical illness. Lastly, the patient must have the cognitive capacity to understand and respond during the face-to-face interview with the QHP.

It is important to note that the behavioral health assessment and intervention CPT codes (**96156-96171**) are *not* billable with evaluation and management (E/M) codes on the same date of service *by the same* provider. If a QHP performs behavior health assessments and/or interventions and another provider who can bill for E/M services provides an E/M service on the same date to the same patient, both services can be billed. For the add-on CPT codes, which have a time threshold of at least 15 minutes, a minimum of 8 minutes must be spent with the patient, family, or group to support use of these codes. For the codes with a 30-minute threshold, a minimum of 16 minutes must be spent with the patient, family, or group.

In the era of precision medicine and patient-centered care, it is no longer enough just to treat the physical illness. Instead, providers must embrace a balanced and comprehensive approach to patient care to help ensure the best possible outcomes. This means incorporating a multidisciplinary team approach to treat the whole patient, including behavior health assessments and interventions that address the mind, body, and spirit.

Teri Bedard, BA, RT(R)(T), CPC, is executive director of client and corporate resources at Revenue Cycle Coding Strategies, LLC, Des Moines, Iowa.

References

1. Anuk D, Özkan M, Kizir A, Özkan S. The characteristics and risk factors for common psychiatric disorders in patients with cancer seeking help for mental health. *BMC Psychiatry*. 2019;19(1):269.
2. American Medical Association. CPT assistant, March 2002. Available online at: ama-assn.org/practice-management/cpt/need-coding-resources. Last accessed March 22, 2021.
3. American Medical Association. AMA releases 2020 CPT code set. Available online at: ama-assn.org/press-center/press-releases/ama-releases-2020-cpt-code-set. Last accessed March 22, 2021.
4. American Psychological Association Services, Inc. What is APA Services, Inc.? Available online at: apaservices.org. Last accessed March 22, 2021.

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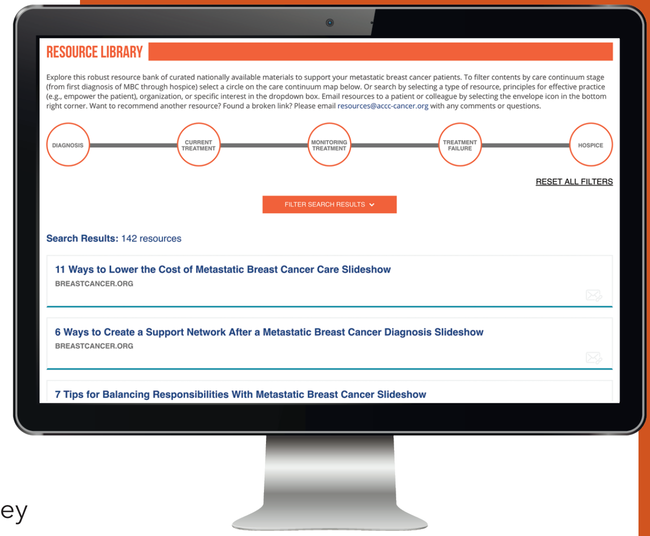
Tools to Help Your Team Support Metastatic Breast Cancer Patients

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.



RESOURCE LIBRARY

Explore this robust resource bank of curated nationally available materials to support your metastatic breast cancer patients. To filter contents by care continuum stage (from first diagnosis of MBC through hospice) select a circle on the care continuum map below. Or search by selecting a type of resource, principles for effective practice (e.g., empower the patient), organization, or specific interest in the dropdown box. Email resources to a patient or colleague by selecting the envelope icon in the bottom right corner. Want to recommend another resource? Found a broken link? Please email resources@accc-cancer.org with any comments or questions.

Search Results: 142 resources

11 Ways to Lower the Cost of Metastatic Breast Cancer Care Slideshow
BREASTCANCER.ORG

6 Ways to Create a Support Network After a Metastatic Breast Cancer Diagnosis Slideshow
BREASTCANCER.ORG

7 Tips for Balancing Responsibilities With Metastatic Breast Cancer Slideshow

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tools

Approved Drugs

- On Feb. 12, G1 Therapeutics, Inc. (g1therapeutics.com) announced that the U.S. Food and Drug Administration (FDA) approved **Cosela™ (trilaciclib)** to decrease the incidence of chemotherapy-induced myelosuppression in adult patients when administered prior to a platinum/etoposide-containing regimen or topotecan-containing regimen for extensive-stage small cell lung cancer.
- On March 10, the FDA approved **Fotivda® (tivozanib)** (AVEO Pharmaceuticals, aveooncology.com) for adult patients with relapsed or refractory advanced renal cell carcinoma following two or more prior systemic therapies.
- On March 22, the FDA approved **Keytruda® (pembrolizumab)** (Merck, Merck.com) in combination with platinum- and fluoropyrimidine-based chemotherapy for patients with metastatic or locally advanced esophageal or gastroesophageal carcinoma who are not candidates for surgical resection or definitive chemoradiation.
- On Feb. 22, the FDA approved **Libtayo® (cemiplimab-rwlc)** (Regeneron Pharmaceuticals, regeneron.com) for the first-line treatment of patients with advanced non-small cell lung cancer (NSCLC; locally advanced who are not candidates for surgical resection or definitive chemoradiation or metastatic) whose tumors have high programmed death ligand 1 expression as determined by an FDA-approved test, with no epidermal growth factor receptor (EGFR), anaplastic lymphoma kinase (ALK), or C-ros oncogene-1 (ROS-1) aberrations.
- On March 3, the FDA granted regular approval to **Lorbrena® (lorlatinib)** (Pfizer, pfizer.com) for patients with metastatic NSCLC whose tumors are anaplastic lymphoma kinase ALK-positive, detected by an FDA-approved test.
- On Feb. 26, the FDA granted accelerated approval to **Pepaxto® (melphalan flufenamide)** (Oncopeptides, oncopeptides-us.com/en) in combination with dexamethasone for adult patients with relapsed or refractory multiple myeloma who have received at least four prior lines of therapy and whose disease is refractory to at least one proteasome inhibitor, one immunomodulatory agent, and one CD38-directed monoclonal antibody.
- On March 5, the FDA granted accelerated approval to **Yescarta® (axicabtagene ciloleucel)** (Kite Pharma, kitepharma.com) for adult patients with relapsed or refractory follicular lymphoma after two or more lines of systemic therapy.

Drugs in the News

- Novartis (novartis.com) announced that **asciminib (ABL001)** has been granted breakthrough therapy designation by the FDA for the treatment of adult patients with Philadelphia chromosome-positive chronic myeloid leukemia in chronic phase, previously treated with two or more tyrosine kinase inhibitors and for the treatment of adult patients with Philadelphia chromosome-positive chronic myeloid leukemia in chronic phase harboring the T315I mutation.
- Merck (merck.com) announced that the FDA accepted and granted priority review for a new drug application (NDA) for the hypoxia-inducible factor-2 alpha inhibitor **belzutifan (MK-6482)** for the potential treatment of patients with von Hippel-Lindau disease-associated renal cell carcinoma not requiring immediate surgery.
- BeiGene (beigene.com) announced that the FDA has accepted a supplemental NDA for **Brukinsa® (zanubrutinib)** for the treatment of adult patients with Waldenström's macroglobulinemia.
- Exelixis (exelixis.com) announced that the FDA granted breakthrough therapy designation to **Cabometyx® (cabozantinib)** as a potential treatment for patients with differentiated thyroid cancer that has progressed following prior therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate).
- Celsion Corporation (celsion.com) announced that it has received FDA fast track designation for **GEN-1** for the treatment of advanced ovarian cancer.
- Incyte (incyte.com) announced that the FDA accepted for priority review the supplemental NDA for **Jakafi® (ruxolitinib)** for treatment of steroid-refractory chronic graft-versus-host disease in adult and pediatric patients 12 years and older.
- Merck (merck.com) has voluntarily withdrawn the U.S. indication for its checkpoint inhibitor **Keytruda® (pembrolizumab)** in metastatic small cell lung cancer.
- Seagen (seagen.com) and Astellas Pharma (astellas.com) announced the

completion of two supplemental biologics license application (BLA) submissions to the FDA for **Padcev® (enfortumab vedotin-ejfv)**. One submission seeks to convert Padcev's accelerated approval to regular approval, and the second submission requests an expansion of the current label to include patients with locally advanced or metastatic urothelial cancer who have been previously treated with a programmed cell death protein 1/ programmed death ligand 1 inhibitor and are ineligible for cisplatin.

- Steba Biotech announced that the FDA granted orphan drug designation to **padeliporfin** for the treatment of adult patients with upper tract urothelial cancer.
- On Target Laboratories (ontargetlabs.com) announced that the FDA accepted its NDA for priority review for **pafolacianine sodium injection** as an adjunct for identifying ovarian cancer during surgery.
- Spectrum Pharmaceuticals (sppirx.com) announced that the FDA granted fast track designation for **poziotinib** for the treatment of NSCLC in previously treated patients with human epidermal growth factor receptor 2 (HER2) exon 20 mutations.
- Amgen (amgen.com) announced that the FDA has granted priority review for **sotorasib (AMG 510)** for the treatment of patients with KRAS G12C-mutated locally advanced or metastatic NSCLC, following at least one prior systemic therapy.
- Roche (roche.com) announced that the company is voluntarily withdrawing the U.S. indication for **Tecentriq® (atezolizumab)** in prior platinum-treated metastatic urothelial carcinoma.
- Seagen (seagen.com) and Genmab (genmab.com) announced the submission of a BLA to the FDA seeking accelerated approval for **tisotumab vedotin** for the treatment of patients with recurrent or metastatic cervical cancer with disease progression on or after chemotherapy.
- Shanghai Junshi Biosciences Co., Ltd. (junshipharma.com/en/AboutUs.html) and Coherus Biosciences (coherus.com) announced the initiation of the rolling submission of the BLA for **toripalimab** to the FDA for the treatment of recurrent or metastatic nasopharyngeal carcinoma.
- Sesen Bio (sesenbio.com) announced that the FDA accepted for filing and granted priority review its BLA for **Vicineum** for the treatment of high-risk, bacillus calmette-guerin (BCG)-unresponsive non-muscle invasive bladder cancer.

Devices, Genetic Tests, and Assays in the News

- Agilent Technologies (agilent.com) announced that the FDA approved the company's **PD-L1 IHC 22C3 pharmDx** assay for expanded use in patients with NSCLC.
- Natera, Inc. (natera.com) announced that the FDA granted two breakthrough device designations covering new intended uses of the **Signatera™** molecular residual disease test. Its performance has been clinically validated in multiple cancer types including colorectal, NSCLC, breast, and bladder cancers.
- Roche (roche.com) announced FDA approval of the **Ventana ALK (D5F3) CDx Assay** as a companion diagnostic to identify patients with ALK-positive NSCLC eligible for treatment with Lorbrena® (lorlatinib).

Other Oncology-Related Products in the News

- Boston Scientific Corporation (bostonscientific.com) announced it has received FDA approval of the **TheraSphere™ Y-90 Glass Microspheres** for the treatment of patients with hepatocellular carcinoma.
- Optellum (optellum.com) announced it received FDA 510(k) clearance for its **Virtual Nodule Clinic**, an artificial intelligence-powered clinical decision support software for pulmonologists and radiologists managing patients with small lesions in the lungs (nodules) that could represent early-stage lung cancer.

Cancer Centers of Colorado at SCL Health St. Mary's

Grand Junction, Colorado

Serving a catchment area of more than 150 miles, the Cancer Centers of Colorado at SCL Health St. Mary's is a hospital-based community cancer center located just west of the Rocky Mountains in Grand Junction, Colo. Its 16-year-old building sits across the street from the SCL Health St. Mary's Hospital in an outpatient pavilion. Through a suite of multidisciplinary cancer care services, the Cancer Centers of Colorado at SCL Health St. Mary's provides high-quality cancer care under one roof to its rural population. St. Mary's is the only cancer center in the region with dual accreditations—one from the Commission on Cancer as a designated community cancer center and another from the America Society of Radiation Oncology.

The SCL Health St. Mary's location serves as the main site for cancer care for the Cancer Centers of Colorado in the western region of the state. Through partnerships with other community and critical access hospitals in the region, St. Mary's also provides care at three outreach clinics and offers radiation oncology services at a second location. At the main location, the cancer center offers medical, radiation, and surgical oncology services, as well as a variety of supportive care services. Its clinical and non-clinical staff are employed by SCL Health St. Mary's Hospital.

"We try to be as much of a one-stop shop for our patients as possible," says Kevin Dryanski, director of the oncology service line at the Cancer Centers of Colorado at SCL Health St. Mary's. "We know that many of our patients travel an hour or more to get to us, and we want to limit the number of places they have to visit to receive the high-quality care that we provide."

St. Mary's provides outpatient oncology services on the first floor of the cancer center. Medical oncology is staffed by four medical oncologists, three advanced practice providers, six nurse navigators, and five medical assistants. The medical oncology clinic is set up in a pod-style structure, where each medical oncologist has their own pod made up of one provider office, a medical assistant and nurse navigator station, and three exam rooms. Each pod is staffed by one medical oncologist or nurse practitioner, one medical assistant, and one nurse navigator.

A 25-chair infusion suite located on the same floor provides oncology and non-oncology infusions for SCL Health St. Mary's Hospital. The infusion suite employs a staff of 14 oncology-trained or certified nurses and two medical assistants, and the clinic sees approximately 40 to 50 patients a day. Many infusion chairs face a long wall of windows through which patients can view trees, foliage, and the Colorado National Monument during treatment. Patients also have the option of receiving treatment outside on a patio when weather permits. The oncology pharmacy—staffed by three oncology certified pharmacists and two pharmacy technicians—is down a hallway from the medical oncology clinic.

As its accreditations suggest, St. Mary's provides a suite of high-quality radiation oncology services, including IGRT, VMAT, SABR, SRS, and HDR, via two TrueBeam linear accelerators. Its radiation oncology department is staffed by three radiation oncologists, three physicists, two dosimetrists, and seven radiation therapists. The cancer center also provides gynecologic surgical oncology services in the hospital through a partnership with the University of Colorado physicians group. Other surgical oncology services are performed by the SCL Health St. Mary's employed cardiovascular thoracic surgery group or local independent general surgery and other subspecialty groups, which are both closely aligned with St. Mary's providers.

Treating Patients Close to Home

St. Mary's partners with the Radiation Oncology Physician Group and Montrose Memorial Hospital to provide full-service radiation oncology treatments in Montrose, Colo., via one TrueBeam linear accelerator. It operates two medical oncology outreach clinics in the state: an in-person clinic in Rifle, Colo., and a telehealth-based clinic in Craig, Colo. The Craig location is run in partnership with Memorial Regional Health, a critical access hospital, as St. Mary's medical oncologists and nurse practitioners conduct remote visits with patients through telehealth in the presence of the partner hospital's infusion nursing staff. St. Mary's staff in Grand Junction alternate telehealth coverage at this location. Staff then travel to the Rifle location once a month to run a full-day clinic. A third outreach clinic in Moab, Utah, offers in-person clinics once a month and telehealth services once per month from staff in Grand Junction. Each of these locations offer patients infusions, follow-up care, and oncology pharmacy services, while its partner hospitals provide infusion nursing staff, clinic staff, and onsite pharmacy staff.

"The purpose of the three outreach clinics and second radiation oncology location is really to increase access to specialized care and to limit additional need for patients to drive, anywhere from an additional two to four hours, to get to Grand Junction to receive care," explains Dryanski.

Care Coordination is Essential

Staff at the Cancer Centers of Colorado at SCL Health St. Mary's take pride in their care coordination model, which begins with the new patient nurse navigator at the start of a patient's referral. At this first meeting, the new patient nurse navigator answers the technical and sensitive questions patients may have prior to their multidisciplinary consult.

"It was a big push of ours a few years ago to ensure that we had not just a clinical person but a highly trained clinical person who would be the first voice patients would hear when they received a notice that they needed to be referred to an oncologist," says Dryanski. The new patient nurse navigator walks patients through the initial consult process to ensure that patients have all of the information they need to be prepared for their consult and works closely with oncologists to ensure that providers have everything they need to have a meaningful consult.

After the initial consult, patients are introduced to their oncology nurse navigator, who supports them throughout treatment and into survivorship. When patients and their oncologists determine a plan of treatment, the oncology nurse navigator follows up with patients to go through a teaching session where they can answer any questions patients and their families might have about treatment. Oncology nurse navigators then outline a treatment schedule, so patients know what to expect at the start and after their treatment course. At St. Mary's, the new patient nurse navigator and oncology nurse navigators are key members of the cancer care team who provide support to patients and ensure continuity of care.

The cancer center also offers social work, nutrition, financial counseling, spiritual and chaplaincy services, and genetic counseling. All supportive care services are provided on-site and are free to patients. Patients can also participate in support groups that are now remote due to COVID-19, and St. Mary's hopes to bring back massage therapy, yoga, and art therapy once it is safe to do so.

Treating Patients in the Rockies

As a regional community cancer center west of the Rocky Mountains, St. Mary's sees a large percentage of patients who are veterans—about 5 to 10 percent of its entire patient population. With this patient population comes certain challenges, such as coordinating care between the cancer center and the local Veterans Affairs (VA) hospital. To better support these patients, St. Mary's is enhancing the communication with its local VA hospital to improve coordination of care and the patient experience.

Due to the many mines spread out across western Colorado, the cancer center also sees a higher prevalence of lung cancer, especially diagnosis at late-stage disease. Dryanski likens these rates to the rural area St. Mary's services, which impacts patients' access to care and health education. To address these needs, the cancer center educates its community through monthly interviews with television stations across its catchment area, providing education on all types of cancer. It also offers lung cancer screening via low-dose computed tomography that is available to its entire community.

"It's a robust program that we've been doing for the last several years, which has led to decreases in our percentage of total advanced lung cancer," says Dryanski.

Improving Access to Clinical Trials

The Cancer Centers of Colorado at SCL Health St. Mary's also offers its patients the opportunity to participate in state-of-the-art clinical trials that fit their diagnostic, health, and treatment history. Its Clinical Research Team employs a director, two research nurses, a research pharmacist, a research coordinator, a financial coordinator, a data coordinator, and a regulatory administrator. The team collaborates with the cancer care team to identify potential clinical trials for patients and coordinates care for patients who choose to enroll in a clinical trial. Its research program also recently joined the SWOG Cancer Research Network, a global cancer research community funded by the National Cancer Institute (NCI). Through this network, St. Mary's offers patients access to 36 NCI-sponsored Phase II and Phase III clinical trials, currently open to accrual. In 2020 St. Mary's accrued 156 patients to clinical trials—approximately 17 percent of the total number of new patients seen at the cancer center.

To improve patient care at the pace St. Mary's has seen, Dryanski takes pride in cancer center leadership's ability to listen to its front-line staff members and enact change when needed, while also ensuring that all staff are engaged in continuous improvement efforts.

"St. Mary's ability to engage everyone to enact improvement and change certainly accelerates the rate at which we can improve what we do and how we do it," he says. "But the thing that really defines us is our people. We have staff and providers who genuinely care about helping others. We care about people first and foremost and that is central to everything we do." The Cancer Centers of Colorado at SCL Health St. Mary's brings high-quality cancer care to its rural community by quickly adapting to the needs of its patients as cancer care continues to advance at a rapid pace, putting them at a competing level with large academic cancer centers. OI

Carrie's TOUCH: Supporting Black Women with Breast Cancer

BY MADDELYNNE PARKER AND TAMMIE DENYSE, M. DIV., MCL

Editor's Note: In this edition of *Oncology Issues*, 2021-2022 Association of Community Cancer Centers President Krista Nelson, MSW, LCSW, OSW-C, FAOSW, announced her President's Theme: "Real-World Lessons from COVID-19: Driving Oncology Care Forward." One of the key lessons learned is that health equity and social justice are critical drivers of quality cancer care delivery. Although cancer incidence and mortality overall are declining in the United States, certain underserved patient populations continue to be disproportionately impacted by certain cancers. To help ensure equitable access and quality cancer care for *all* patients—regardless of race, ethnicity, age, gender identity, income level, sexual orientation, and/or geographic region—the Association of Community Cancer Centers is shining a spotlight on pioneering organizations and individuals, like Reverend Tammie Denyse, who are moving the needle on health equity.

Tammie's Story

Tammie Denyse, MDiv, MCL, co-founder and president of Carrie's TOUCH, was diagnosed with stage 2B invasive ductal carcinoma breast cancer 16 years ago. At the time, she was 39 years old and a single mother of three children. "When I was diagnosed, I knew there was going to be something different about my journey," Rev. Tammie explains. "That there was going to be a greater intention with the work I would do following my diagnosis."

Accompanied by her support system, which included six of her closest friends, Rev. Tammie met her oncologist, who shared with her a clinical trial opportunity that could potentially save her life. He said to Tammie, "This trial is perfect for you."

Even though this was Rev. Tammie's first experience with cancer and cancer research, she knew to ask one key question:

> With disparate breast cancer outcomes, lack of messages of hope, and limited available support for Black women, Rev. Tammie and her late sister were inspired to co-found Carrie's TOUCH in 2006.

Carrie's TOUCH helps women digest the news of their cancer diagnosis and prepare for their consultation so that in the limited time frame they have with their cancer care team patients leave informed and ready to participate in shared decision making.

Tammie Denyse, M. Div., MCL. Photo courtesy of April Taylor.

How are Black women responding to this new treatment? Her oncologist did not know. "That just stunned me," she says. "I literally said unacceptable—it is unacceptable for you [my oncologist] to come into this office and present a treatment we are looking at that could save my life, and you don't know how women who look like me are responding."

This inspired a dynamic patient-doctor relationship between Rev. Tammie and her oncologist. She was determined to participate as much as she could in her treatment decisions. After she was sent home with a 32-page document of information about the trial and possible side effects, Rev. Tammie requested a meeting with the identified clinical trial's head researcher. Carrying with her a laundry list of questions, she met with the researcher for more than four hours. With all of the information she received, still no one could tell Rev. Tammie how Black women were reacting to the treatment being studied in the trial.

"Needless to say, the decision I made wasn't a decision for me," Rev. Tammie explains. "I said to myself: if I enter this trial, at least they will have information on one Black patient."

Her response to the treatment was one of the worst cases her oncologist had seen in his 20 years of practice. After she began participating in the clinical trial, Rev. Tammie's support system, which she affectionately calls, her "Tribe," became concerned for her quality of life due to the serious side effects she was experiencing. "I just refused to stop the trial because I knew it was going to serve a greater purpose at some point," she says. "Every decision I made wasn't necessarily a decision for my own personal journey or my own personal comfort, but it really was a decision made with others in mind. I was bold enough to believe that my journey with breast cancer could actually affect future advancements in medicine. Navigating the murky waters of a breast cancer journey is complex. Therefore, it is my greatest desire that people will look at my life, my experiences, and my journey to find hope."

Carrie's TOUCH

With disparate breast cancer outcomes, lack of messages of hope, and limited available support for Black women, Rev. Tammie and her late sister were inspired to co-found Carrie's TOUCH in 2006.

"As I was fighting to figure out next steps with my own healing process, I wanted and needed a support group with women who understood my perspective as a Black woman. Disturbingly and sadly, there were none in my area," Rev. Tammie explains. "My oncologist was concerned about my survivorship. My cancer was aggressive and had already spread, and he wasn't confident I would make it to the coveted five-year anniversary disease free."

With this news, she began searching the Internet for any information on breast cancer, Black women, and survival. Rev. Tammie found only one study, from the American Cancer Society, that shared information on Black women with breast cancer. Yet the findings of the study did not offer much hope. Instead, it only perpetuated the narrative of the disproportionately high mortality rates for Black women. "I was appalled and became determined to make a difference, effective immediately. I needed to create a space curated by Black women for Black women battling breast cancer," she says.

Thus, Carrie's TOUCH was born. Along with 12 women who wanted to be part of the change, the work began to communicate a message of hope, inspiration, and survival to better support Black women with breast cancer. "We understood the importance of creating a culturally sensitive and safe space: a space that felt familiar, where women felt comfortable being vulnerable enough to share their most intimate stories about breast cancer, and a space where sharing expanded beyond conversation to removing uncomfortable wigs and/or prosthesis at times," Rev. Tammie explains.

Carrie's TOUCH dedicated its mission to breaking the silence that adversely impacts Black women with breast cancer. "The statistics of Black women still dying, 16 years later, at an approximately 41 percent higher rate than our Caucasian sisters is exasperating. It's long overdue for that number to change. It's time to close the gap," she says. "This organization began as a voice to fight for those who cannot, will not, or who do not know how to fight for themselves. We do that through our TOUCH: Teaching, Outreach, Understanding, Caring, and Healing. Our framework includes advocacy, awareness and education, research, and support."

Supporting Black Women Everywhere

One of the most vital initiatives of Carrie's TOUCH is educating Black women on breast cancer and what to do when diagnosed, which is often realized by meeting with patients before their oncology consultation and accompanying them as an advocate to the consult. This is one of the ways the organization stays in touch with its patients.

"We meet women where they are. Pre-COVID we would go to places where other organizations wouldn't. We'd go into their homes, their doctors' offices, on their jobs, or wherever they needed us," Rev. Tammie explains. "Our goal is to educate and empower women to know their rights as patients and to use their voice to be their own advocates."

Carrie's TOUCH helps women digest the news of their cancer diagnosis and prepare for their consultation so that in the limited time frame they have with their cancer care team patients leave informed and ready to participate in shared decision making. "We give these women new perspectives on how to look at their diagnosis. Instead of asking, 'Am I going to die?' consider asking, 'What treatment options are available to help me live?'" Rev. Tammie adds.

COVID-19 has greatly impacted the organization's ability to meet patients where they are, as the in-person touch that Rev. Tammie and her team take pride in has been put on hold to keep patients safe. "We always want to give that human interaction as a personal touch," Rev. Tammie says. "We've had to reimagine what that looks likes in this climate. With COVID-19, that just does not happen because our women are immuno-compromised. Now, we rely more on that face-to-face and one-on-one we have with patients over Zoom. We've reinvented how we conduct our support groups, too. We now have multiple online opportunities for survivors to connect."

Though COVID-19 has impacted the organization's ability to work in person with women, Carrie's TOUCH uses its voice on social media to continue its mission. The social media campaign #BreastCancerBeLike was released Oct. 15, 2020. Part one of the three-part video series portrays two women—one White and one Black—who receive a breast cancer diagnosis and the traditional doctors' visits and support these women receive. With the same breast cancer diagnosis, Carrie's TOUCH shows that White women are often flooded with support from their cancer care team and by other breast cancer organizations, whereas Black woman and their needs are ignored, and they are often left alone to understand and navigate next steps. This video highlights the unfortunate truth that Rev. Tammie has seen Black women experience time and time again, including the lack of support she received from her own doctor upon delivering her diagnosis of breast cancer. The second video in the series helps women by highlighting common terms and experiences patients face, while also putting Black women in the spotlight so viewers can see themselves and their stories told. Using humor as a teaching tool, Carrie's TOUCH highlights the reality Black women face during their cancer treatment journey. These videos educate the general public and they help build a sense of community for Black women who may feel ignored and alone by showing women that others face the same struggles and needs.

"#BreastCancerBeLike continues to advance the necessary conversation on Black women with breast cancer by illuminating the racial injustices and inequalities," says Rev. Tammie.

Cancer Research

Because of Rev. Tammie's experience with a clinical trial, she wanted to include cancer research as an important component of Carrie's TOUCH. In partnership with the University of California Los Angeles, Carrie's TOUCH initiated Project SOAR: Speaking Our African American Realities.

"We began this project almost four years ago when there was nothing in the literature that looked at the Strong Black Woman concept and its impact on Black women diagnosed with breast cancer," explains Rev. Tammie. "Our goal with Project SOAR is to literally break the silence. We are listening to the unique stories of Black women with breast cancer. Stories some women have only shared with us. Their stories matter. Their stories deserve to not only be heard but their stories need to be considered when developing oncology pathways. We want the patient voice in the driver's seat of shared decision-making. It was lifesaving for me to know I was making informed decisions with my oncologist and medical team, about my life."

Project SOAR gave Black women diagnosed with breast cancer the opportunity to share their story and the experience of their cancer journey. Project SOAR has since finished data collection for Phase II and reached its minimum goal of participants. Data is now being analyzed in preparation for documenting Project SOAR findings.

"As we were in the final days of recruitment for Phase II of Project SOAR, we looked to the future of developing ethnocentric, patient-centered care pathways," explains Rev. Tammie. Carrie's TOUCH is unpacking what the pathway is that would adequately accommodate a Black woman while she is on her breast cancer journey, leaving her whole instead of fragmented on the other side. "We're considering the whole woman—mind, body, and soul before, during, and after treatment. We are acknowledging the complexities of the new normal these women face. As she reinvents herself, we want the woman to embrace her mental, physical, emotional, spiritual, and financial well-being," says Rev. Tammie.

The political and social justice issues and conversations sparked again in 2020 around the experiences of the Black community in the United States were not new to Rev. Tammie and her team. She experienced the racial disparities and insensitivity that exists in the U.S. healthcare system firsthand and has since dedicated her work to changing that narrative through Carrie's TOUCH. As Carrie's TOUCH dedicates its mission to improving the lives of Black women everywhere who may feel isolated and unsupported upon receipt of a breast cancer diagnosis, Rev. Tammie wants all Black women with breast cancer to know one thing: "Black women can and do survive breast cancer." OI

Maddelynne Parker is associate editor, Oncology Issues, *Rockville, Md. Tammie Denyse, MDiv, MCL, is president and co-founder of Carrie's TOUCH and co-principal investigator of Project SOAR, Sacramento, Calif.*

CENTER FOR INDIGENOUS CANCER RESEARCH AT ROSWELL PARK COMPREHENSIVE CANCER CENTER

BY AMANDA PATTON, MA

In pre-colonial America, five Native Nations came together with the goal of living peacefully.

The Haudenosaunee Confederacy united the Mohawks, Oneidas, Onondagas, Cayugas, and the Senecas in a common governance known as the Great Law of Peace, administered by the Haudenosaunee Grand Council. Haudenosaunee communities in the United States and Canada today continue to reflect the tenets of the Great Law. Spiritualty is foundational to Haudenosaunee culture, as is consideration for the generations to come.[1]

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Development of the Center for Indigenous Cancer Research

Over the course of 2020, the effects of health inequities were made evident by the unequal burden of COVID-19 on racial and ethnic minorities in the United States. The inequities exposed by the virus focused national attention on persistent health disparities, including gaps in care access and health outcomes. Although the oncology community has made progress in reducing disparities for some cancer types, racial and ethnic minority populations continue to bear a disproportionate burden from cancer. Among these are the diverse, heterogeneous, culturally distinct Indigenous peoples of this country, including Native Americans, Alaska Natives, Native Hawaiians, and Pacific Islanders. One important step toward supporting the health of Indigenous Peoples was the opening of the Center for Indigenous Cancer Research (CICR) at Roswell Park Comprehensive Cancer Center in January 2020. Its mission: to reduce the impact of cancer on Indigenous com-

> Although the Haudenosaunee culture helped shape the Center for Indigenous Cancer Research and its mission, the center intends to conduct research and education that will benefit Indigenous Peoples from across the United States and around the world.

Center for Indigenous Cancer Research Staff

munities regionally, nationally, and internationally. The CICR mission is aligned with a foundational value of the Haudenosaunee, “the duty of preparing for the seventh generation,”[1] and represents the vital role of the local and regional Haudenosaunee communities.

“Roswell Park understood that it is sitting right in the original territories of many of the Native Nations of the Northeast and New York,” said Rodney Haring, PhD, MSW. Dr. Haring, director of the CICR and an enrolled member of the Seneca Nation/Beaver Clan, credits Roswell Park’s Inter-Tribal Community Advisory Board with helping to shape the center’s mission and inform its community-based participatory research model.

In a recent conversation with *Oncology Issues*, Dr. Haring was joined by CICR team members Will Maybee, BS, CSCS, community relations coordinator, member of the Seneca Nation/Turtle Clan, and radiation oncologist David Mattson, MD, associate professor of Oncology, Department of Radiation Medicine, CICR clinical advisor. A Native Hawaiian, Dr. Mattson advises on Roswell Park’s Inter-Tribal Community Advisory Board.

“Our community advisory board was formed by looking at both our Native American urban population and different tribes in the region,” said Dr. Haring. The center team holds quarterly meetings with the community advisory board. These community members have a voice both in the process and in sharing the results of the center’s work, which focuses on relevant research and education along the continuum of cancer care from education, prevention, and screening, through treatment, survivorship, and palliative care.

“We are taught to look forward seven generations, so what we are creating [at the CICR]—we consider how that will affect our future generations. Education is part of that—for instance, we are developing opportunities and working with Roswell Park's education team for summer research programming or internships, and we encourage post-docs to look at the opportunities that are available at Roswell Park with a forward look to what impact this will have for clinical care and research," said Dr. Haring.

Although the Haudenosaunee culture helped shape the CICR and its mission, the center intends to conduct research and education that will benefit Indigenous Peoples from across the United States and around the world. As of January 2020, the United States had 574 federally recognized Native tribes in 37 states.[2] About 2.9 million people, or 0.9 percent of the U.S. population, identified as American Indian or Alaska Native alone in the 2010 decennial census.[3] About 5 million people (1.7 percent) identified as American Indian or Alaskan Native alone or in combination with another race.[3] The Indian Health Service (IHS) reports providing services to 2.56 million American Indians and Alaskan Natives.[2] The Native Hawaiian and Pacific Islander population, which includes people with origins in Hawaii, Guam, Samoa, and other Pacific Islands, is an estimated 1.5 million and growing.[4]

The CICR team is made up of professionals from across disciplines who contribute their diverse skill sets to the center's initiatives. "Our current members are clinicians, surgeons, researchers, community health educators, and soon we hope to add navigators," said Will Maybee. "I think we [team members] will be integrated into nearly every aspect of Roswell Park." Drs. Haring and Mattson also sit on Roswell Park's Diversity Action Committee. In addition to Dr. Haring, Dr. Mattson, and Will Maybee, the team includes:

- Whitney Ann Henry, BS, research assistant, enrolled member Tuscarora/Deer Clan
- Josie Raphaelito, MPH, research coordinator, enrolled member Diné/Navajo Nation
- Michelle Huyser, MD, Surgical Oncology Fellow, Department of Surgical Oncology, CICR clinical advisor, enrolled member Diné/Navajo

Sharing of Knowledge

Collaboration and the sharing of knowledge are integral to the CICR mission. These activities advance the center's goals while fostering bidirectional learning that, in turn, strengthens community engagement. Before the COVID-19 public health emergency curtailed travel, Dr. Haring and team members visited different regions of the country to present on and learn from Indigenous communities about their health concerns and research interests.

In February 2020, the team visited Arizona to conduct a tribal institutional review board training for several tribes in the Arizona and New Mexico region. The team visited nearby Native Nation communities to introduce themselves and the CICR at Roswell Park. Federal treaties and tribal governance policies differ, so there is no one standard process for creating sovereign Nation to Nation agreements, Dr. Haring notes, but such collaborations are a keystone of the center's work. "We are open to collaboration with Native Nations in the mainland U.S. and Alaska, as well as Indigenous communities in Hawaii. We are always trying to keep the collaborative hat on for both research and team science."

One barrier to care common to many traditional Indigenous communities is geography. In Hawaii, for example, "the majority of the population is on the main island of Oahu, but the population is spread out across six major islands," said Dr. Mattson. "Among the neighbor islands there's a fair proportion of Native Hawaiians, especially in rural areas. The availability of healthcare and access to quality care on those neighbor islands is definitely disproportionately wanting compared to the main island of Oahu." For specialized cancer services, such as specialized surgery and in some instances for radiation therapy, many patients need to travel to Oahu. "So, there is that obstacle of expense that comes with travel and lodging and those costs that are harder to quantitate, like being away from family and not around the social support network they would have on their home island. Financial costs are definitely an obstacle, too, because native Hawaiian incomes are less than many other ethnicities in Hawaii."[5]

The 2010 Census reported that 78 percent of American Indians and Alaskan Natives live outside of tribal statistical areas; 22 percent live on reservations and other trust lands.[6] According to the Office of Minority Health, U.S. Department of Health and Human Services: "Typically, this urban clientele has less accessibility to hospitals, health clinics, or contract health services provided by the IHS and tribal health programs. Studies on urban American Indian and Alaska Native populations have documented a frequency of poor health and limited health care options for this group."[6]

As of 2017, the following states had the largest populations of American Indians and Alaskan Natives: California, Oklahoma, Arizona, Texas, New Mexico, Washington, New York, North Carolina, Florida, and Alaska.[6] Reservations and trust lands are often in geographically remote regions. For specialist care such as medical oncology, surgical oncology, and radiation oncology, long-distance travel is often required. Hazardous weather conditions, cost, and lack of transportation are additional barriers to care. Access to subspecialist care at a major academic medical center may be even more difficult. "We pinpointed all the NCI [National Cancer Institute]-designated cancer centers across the U.S. and overlaid on a map of all the Native Nations," said Dr. Haring. When cross-referenced with the IHS area on the map, Dr. Haring and colleagues found that many tribes in the Great Plains region are at great distances from NCI-designated cancer centers. For example, the nearest NCI-designated cancer center for Native Alaskans living in Alaska is in Seattle, Wash.

Prioritizing Needs

Since its inception, the CICR has participated in research to identify disparities, shared research findings with affected communities, and engaged community members on how best to close the gaps. "We recently did an epidemiology-type study[7] looking at what the cancer mortality disparities might be in our region, and we pinpointed some of areas of concern from that data," Dr. Haring said. For both Haudenosaunee and Whites, colorectal and lung cancer were the leading causes of cancer deaths and rates were similar. However, comparison of liver cancer mortality in the populations revealed significantly higher rates of liver cancer mortality among both Haudenosaunee men and women than in Whites and American Indian/Alaska Natives in the IHS East region.[7] The study also revealed disparities in liver disease, colorectal, and lung cancers. "We brought that data back to our communities and shared [the information], and [we are] creating programs around this for our communities," Dr. Haring said. In response to the study findings, the CICR developed health promotion intervention education focused on liver disease and has brought that into the community.

As cancer care advances, biomarkers are playing an increasing role in targeted therapies that require companion diagnostics. Understanding of the cultural concerns related to data sovereignty and the use of biological data for testing is important for cancer clinicians caring for Indigenous Peoples.

Other areas of need are emerging. Through NCI grant-funded community-based participatory research, the center is studying the full cancer care continuum among the Haudenosaunee in its region. These communities have expressed the need for an Indigenous patient navigator to help in accessing care along the often-fragmented path from diagnosis through treatment and into survivorship. "It's a prime example of how we take the concerns and the knowledge directly from the community and apply it to research to address gaps in healthcare," said Will Maybee.

Another identified gap is a lack of genetic counseling. "We've heard this in other studies that we've done, too, that there have not been any Indigenous genetic counselors," said Dr. Haring. "On the clinical side that's probably a huge gap across cancer centers. Education [of this kind] is always key to what we do."

Increasing Clinical Trial Accrual

The cascade of events throughout 2020 has focused national attention on the effects of structural and institutional racism—both explicit and implicit. The importance of achieving greater diversity in clinical trials accrual is recognized across the healthcare enterprise.[8,9] The barriers to clinical trial accrual for ethnic and racial minority patients are many. "Across Native culture there are additional layers of challenges," Dr. Mattson said. "Whether it is in identifying patients who would be eligible [for trial participation] or actually gaining the trust and the understanding of the culture in order [for them] to be comfortable enrolling these clinical trials." Educating the communities and, especially, younger community members is essential, added Dr. Haring. "Getting them the information to understand the importance and benefits of clinical trial participation," agreed Dr. Mattson. "There's more than one reason for this [lack of accrual]. Some [factors] center around the Native population, others center more around administrative processes that would aid us in identifying candidates for trials who are Indigenous Peoples."

The CICR is developing culturally appropriate content on clinical trials and will make these materials publicly available. "It is a very polarizing topic," Will Maybee said. "There is historical distrust of research for many reasons. One of the ways we work directly with the community is to field those concerns and start to cultivate a new narrative about clinical trials." Even as researchers at Roswell Park, the CICR team members acknowledge, it can be challenging to identify Native Americans who may be eligible for clinical trials among the patient population. The center has already implemented an NCI-funded program, Screen to Save.[10] One objective of this grant is to identify Native American patients at Roswell Park and offer not only an introduction to the CICR but also to clinical trial education. Maybee explains: "This is important because ultimately that may be a conversation that patients have with their physicians or the research teams at Roswell Park. We've met people in our communities who were participants in clinical trials, yet prior to being a participant had minimal knowledge of what clinical trials were."

"We're taking this model gathered from our communities and starting to offer solutions to address gaps in cancer care, and I think that's really our most pressing need—filling in those gaps," Maybee added. "There are clearly some logistical gaps in terms of identifying Native American patients, and we credit that solely to the community to bring those problems into focus because we don't always know what those problems are."

Cultural Humility, Traditional Values, and Clinical Advances

Though beliefs, customs, and cultures are distinct among Indigenous populations, a holistic (mind-body-spirit) model for well-being is found in many traditions. This holistic approach finds alignment in the 2008 Institute of Medicine consensus report, *Cancer Care for the Whole Patient*, which recognized the need to address the psychosocial effects of living with cancer.[11]

For example, in the Haudenosaunee tradition both male and female healers cared for the sick and fostered wellness in the community. Healing is in equal measures a spiritual process and a natural process complemented by traditional medicines and practices.[1] In a similarly holistic approach, traditional concepts of health for Native Hawaiians place emphasis on *lokahi*, or balance.[12] Wellness occurs when the physical, mental, and spiritual are united in balance.[12]

As cancer care advances, biomarkers are playing an increasing role in targeted therapies that require companion diagnostics. Understanding of the cultural concerns related to data sovereignty and the use of biological data for testing is important for cancer clinicians caring for Indigenous Peoples. Challenges may arise along the continuum of care: in cancer diagnosis, in shared decision making, in determining clinical trial eligibility, in conversations on palliative care, end-of-life care, and more. “In the research context, this means working with the tribal nations on what they feel is best for the community,” said Dr. Haring. “Do they need more information? What does this mean in terms of partnership from Nation to cancer center?”

Growth Through Understanding

To conclude the conversation, Dr. Haring, Will Maybee, and Dr. Mattson were each invited to share a key takeaway about the CICR with *Oncology Issues*’ readers.

Seven Generations—A Legacy of Sustainable Change

Dr. Haring. “For me it’s always the seven generations philosophy. We are honored and thankful that Roswell Park has supported our efforts, that we’ve showcased that these are some of the needs in our communities, and really put a team science approach to it at Roswell Park. We are working across disciplines and across team members not only on our campus but with our partners that are on reservations, in the cities, and across borders. Our Indigenous team is building strength on campus; however, our success is only through the collaborative efforts of our other team members at Roswell Park. In this way, we are creating this platform to be sustainable not just for my generation as a Roswell Park employee, my generation as a cancer scientist, or my generation of oncologists—we are really looking forward seven generations so our children’s children’s children have a place and a voice at the table to continue that change for wellness.”

“The Center for Indigenous Cancer Research at Roswell Park has a cancer-specific MOU [memorandum of understanding] in place with the federal Indian Health Service office. The MOU is a blueprint of sorts, and having that partnership in cancer with the Indian Health Service is important to us. It can also be important to cancer centers across the U.S. that they know what IHS clinic is in their service or catchment area and that they really connect with them.”

Indigenous Models of Wellness—Caring for the Whole Person

Will Maybee. “The Indigenous model of wellness that encompasses everything holistically was traditionally used to complete the individual—which in turn completed the entire community. I believe those values have a direct impact on both the research as well as the value structure of our community. As it turns out, food, physical movement, mindfulness, emotional well-being, spirituality—these are of tremendous value in many different biological systems. We know that to be inherently true now. These are all values deeply embedded in most—if not all—Indigenous cultures and values. It’s important for our voices to be heard, to have a seat at the table because our traditional values can directly impact the amount of suffering that all communities endure from cancer. What I know from our communities is that these [traditional] activities, this knowledge, is still very, very strong. My belief is that ancestral knowledge combined with modern medicine holds the key to the best outcomes as it relates to the cancer burden in our communities. I believe there is a lot of untapped potential there.”

Dr. Rodney Haring

Will Maybee

Dr. David Mattson

A New Perspective on Research Endpoints

Dr. Mattson. "With a holistic perspective, there are a lot of important endpoints that Western remedies do not address. Some of these endpoints aren't things that we normally measure in Western medicine. For example, with cancer care, we measure local control of disease and survival with cancer, but there is also the quality-of-life component, the spiritual well-being. These are things that traditional remedies can address that chemotherapy or radiation therapy or surgery would not. So, it's that holistic approach that is important, and the endpoint—striving for more holistic well-being and spiritual healing in addition to the physical healing—that is something that is important."

Amanda Patton, MA, is a freelance healthcare writer. She worked as a senior writer and editor for the Association of Community Cancer Centers for more than 15 years.

References

1. Haudenosaunee Confederacy. About the Haudenosaunee Confederacy. Available online at: haudenosauneeconfederacy.com. Last accessed December 9, 2020.

2. U.S. Department of Interior, Indian Health Service. Indian Health Service fact sheet. Available online at: ihs.gov/newsroom/factsheets/ihsprofile. Last accessed December 9, 2020.

3. National Congress of American Indians. Demographics. Indian Country demographics. Available online at: ncai.org/about-tribes/demographics. Last accessed December 9, 2020.

4. American Cancer Society. Cancer facts & figures 2016. Special section: Cancer in Asian Americans, Native Hawaiians, and Pacific Islanders. Available online at: cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2016/special-section-cancer-in-asian-americans-native-hawaiians-and-pacific-islanders. Last accessed December 28, 2020.

5. U.S. Department of Health and Human Services, Office of Minority Health. Profile: Native Hawaiians/Pacific Islanders. Available online at: minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=65. Last accessed December 28, 2021.

6. U.S. Department of Health and Human Services, Office of Minority Health. Profile: American Indians/Native Alaskans. Available online at: minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62. Last accessed December 28, 2021.

7. Haring RC, Jim MA, Erwin D, Kaur J, et al. Mortality disparities: a comparison with the Haudenosaunee in New York State. Cancer Health Disparities. 2018;2. Available online at: pubmed.ncbi.nlm.nih.gov/31777774. Last accessed December 29, 2020.

8. Bierer BE, White SA, Meloney LG, Ahmed HR, et al. Achieving Diversity, Inclusion, and Equity in Clinical Research. Version 1.0. Cambridge, MA: Multi-Regional Clinical Trials Center of Brigham and Women's Hospital and Harvard (MRCT Center); 2020. Available online at: mrctcenter.org/diversity-in-clinical-research. Last accessed April 3, 2021.

9. American Association for Cancer Research. Cancer Disparities Progress Report 2020. Available online at: cancerprogressreport.aacr.org/disparities. Last accessed December 29, 2020.

10. U.S. Department of Health and Human Services, National Cancer Institute. Connect with Screen to Save. Available online at: cancer.gov/about-nci/organization/crchd/inp/screen-to-save/connect. Last accessed December 9, 2020.

11. Adler NE, Page AEK, eds. Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs. Washington, DC: National Academies Press; 2008. Available online at: nap.edu/catalog/11993/cancer-care-for-the-whole-patient-meeting-psychosocial-health-needs. Last accessed December 9, 2020.

12. Stanford School of Medicine. Ethnogeriatrics. Traditional health beliefs: Native Hawaiian values. Available online at: geriatrics.stanford.edu/ethnomed/hawaiian_pacific_islander/fund/health_beliefs.html. Last accessed December 9, 2020.

How Can *Your* Cancer Program Participate?

Suggestions from the Center for Indigenous Cancer Research Team:

Step 1. Connect with the population of Indigenous Peoples in the communities you serve. If no partnership exists with Native Nations, Dr. Haring suggests reaching out to the Office of the Tribal Chair or the president or chief's office as a starting place.

Step 2. Sign up for the Center for Indigenous Cancer Research newsletter and webinars and follow the center on social media. The center has Indigenous-specific podcasts; Indigenous-specific, relevant virtual grand rounds; and a quarterly newsletter.

Step 3. Share information about the Center for Indigenous Cancer Research and its outreach and education programs with your providers and patients. "We want to make sure that our communities are aware that we have information to share," said Dr. Haring.

Step 4. Visit the Center for Indigenous Cancer Research website at https://www.roswellpark.org/research/center-indigenous-cancer-research. Education content developed by the CICR will be available through the Native CIRCLE initiative, which is currently in progress. "Our goal is to not only share content from across our Native Nations but also to provide our audience with all the research and content that we're creating," Will Maybee said.

ASSOCIATION OF
COMMUNITY CANCER CENTERS

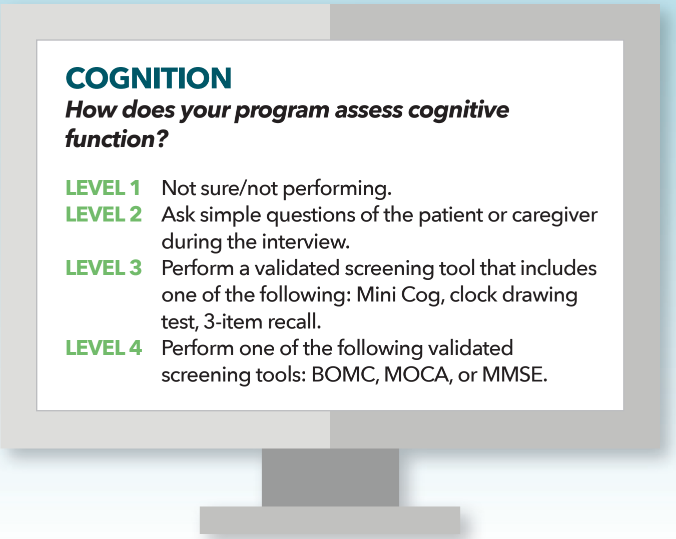
Transform Care for Older Adults with Cancer

Practical Resources for the Multidisciplinary Oncology Team

Geriatric Oncology Gap Assessment

Assess your program's performance against validated measures and best practices related to older adult care.

Nine domains offer four levels to help identify current practices of care. A personalized report provides a score and recommendations for improvement.



COGNITION

How does your program assess cognitive function?

LEVEL 1	Not sure/not performing.
LEVEL 2	Ask simple questions of the patient or caregiver during the interview.
LEVEL 3	Perform a validated screening tool that includes one of the following: Mini Cog, clock drawing test, 3-item recall.
LEVEL 4	Perform one of the following validated screening tools: BOMC, MOCA, or MMSE.

ASSOCIATION OF COMMUNITY CANCER CENTERS

Practical Application of Geriatric Assessment:

A How-To Guide for the Multidisciplinary Care Team

ACCC

How-To Guide

Offers practical solutions for implementing geriatric screening and assessment without investing significant resources. The key is to start with something simple and feasible.

Online Resource Library

Explore validated assessment tools, offering solutions in all care delivery settings.

Search by Featured Domains including:

- Cognition
- Comorbidities
- Functional Status
- Nutrition
- Pharmacy/Medication Management
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100+ TOOLS!

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Association of Community Cancer Centers

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Pfizer

Thank you to Pfizer Oncology for their collaboration and support in developing these resources.

Implementing a Transportation Hub

A Holistic Approach to a Systemic Problem

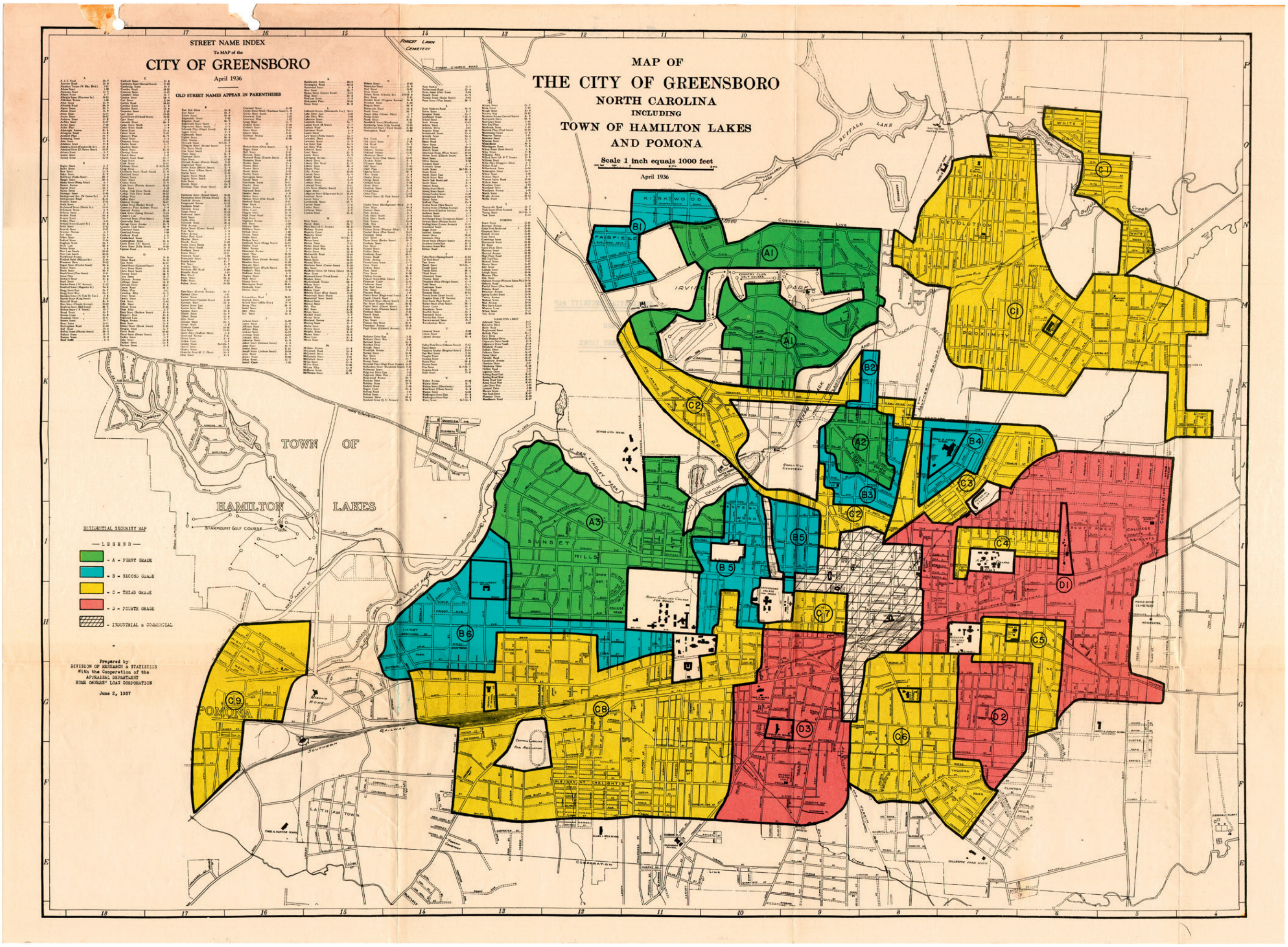
BY RACHEL MARQUEZ, BS, MPH

Editor's Note: In this edition of *Oncology Issues*, 2021-2022 Association of Community Cancer Centers President Krista Nelson, MSW, LCSW, OSW-C, FAOSW, announced her President's Theme: "Real-World Lessons from COVID-19: Driving Oncology Care Forward." One of the key lessons learned is that health equity and social justice are critical drivers of quality cancer care delivery. Although cancer incidence and mortality overall are declining in the United States, certain underserved patient populations continue to be disproportionately impacted by certain cancers. To help ensure equitable access and quality cancer care for *all* patients—regardless of race, ethnicity, age, gender identity, income level, sexual orientation, and/or geographic region—the Association of Community Cancer Centers is shining a spotlight on pioneering organizations, like Cone Health below, that are moving the needle on health equity.

In Greensboro, N.C., there is a stark divide between those who have access to resources and those who do not. Like many other metropolitan cities, Greensboro has historically been divided and segregated along racial lines. To this day, the southeast portion of the city reflects the original outlines of redlined areas (i.e., those declared as hazardous and unsuitable for government investment). This area continues to be devoid of resources and is predominately home to Black individuals (Figure 1, page 32).[1] Residents of these areas are three times more likely to suffer from adverse health outcomes due to chronic disease, are 70 percent less likely to have higher than a high school education, and live roughly 18 years fewer than their White counterparts only a few miles away.[2]

> In our deep dive into the disparate outcomes experienced by our patients, several factors continued to surface. Generally, these patients were part of a racial minority group, had a low-socio-economic background (or were living in poverty), and had a high school education or less.

Figure 1. Home Owners' Loan Corporation Historical Redlining Map of Greensboro, N.C.[1]



Additionally, Greensboro is the site of the famous 1960 sit-ins, notably the Woolworth lunch counter sit-in.[3] These sit-ins marked an important milestone in the Civil Rights Movement and were a catalyst for many of the other sit-ins and peaceful protests that took place throughout the South.

What is lesser known about Greensboro is the prominent role that the city and the Moses H. Cone Memorial Hospital played in the desegregation of healthcare. In 1962, George Simkins, Jr., a Greensboro dentist, Alvin Blount, Jr., MD, a physician, and seven other black dentists, physicians, and patients brought forward a lawsuit against Moses H. Cone Memorial Hospital claiming that they had been denied "the admission of physicians and dentists to hospital staff privileges, and the admission of patients to hospital facilities, on the basis of race."[4] The District Court dismissed the suit, *Simkins v. Moses H. Cone Memorial Hospital*, as being out of the purview of state and federal government. In November 1963, the case went to U.S. Court of Appeals, Fourth Circuit, which ruled three to two that "separate but equal" racial segregation in publicly funded hospitals violates equal protection under the U.S. Constitution.[5] This decision marked the first time that federal courts applied the Equal Protection Clause of the Fourteenth Amendment to prohibit racial discrimination by a private entity. After the U.S. Supreme Court refused to hear an appeal, the decision gave birth to a movement to desegregate hospitals built with federal funds throughout the South.

We Are Right Here with You

In 2017 Cone Health—a comprehensive healthcare network located in Greensboro—launched its vision for a "bold new future"—a future where the tradition of health and well-being is woven into the fabric of its communities. Cone Health also shared a brand promise with its customers to be "right here with" them through every encounter they have with the health system.

To fulfill this promise, we had to face reality—despite various awards for patient outcomes and high-quality care, Cone Health had not achieved health equity.

To identify and then address disparities, we shifted our attention from the 90 percent of patients who reported improvement of outcomes to the 10 percent of patients who did not see improvement in outcomes. Our new norm: an intentional focus on eliminating healthcare disparities throughout the organization. Cone Health CEO Terry Akin champions our diversity, equity, and inclusion efforts. This sets a tone throughout the organization that we always want to achieve more, continuously improve, and ensure that no patient is left behind. Additionally, COO Mary Jo Cagle, MD, leads our continuum of care work, which includes health equity, so that in every patient interaction we connect healthcare to well-being.

Social Determinants of Health and Navigation

In our deep dive into the disparate outcomes experienced by our patients, several factors continued to surface. Generally, these patients were part of a racial minority group, had a low-socio-economic background (or were living in poverty), and had a high school education or less. These social determinants of health were more accurate indicators of a patient's ability to experience wellness than the quality of care they received at Cone Health.

As value-based healthcare transitions to the outpatient setting, these disparate outcomes are fueled by patients who now bear the burden of navigating the complex outpatient healthcare system. Patients with cancer face additional challenges with this disease—and its short- and long-term side effects—and its complex treatment regimens.

The staff of Cone Health Cancer Center at Wesley Long are no strangers to helping patients navigate their social determinants of health. Cone Health social workers, care navigators, and nursing staff are trained and equipped to identify and/or refer patients to a fragmented infrastructure of potential solutions—fragmented because there is not one solution that fits every patient. Rather, team members often must navigate four, five, and six different solutions to meet our patients' needs. Patients experiencing food insecurity may be referred to a local food bank, given a gift card for groceries, or connected with a local nonprofit that provides meals. Patients experiencing transportation issues may receive a bus pass or a taxi voucher or, depending on the circumstances and number of treatment visits, a gas card to alleviate the financial burden of traveling to every appointment. These examples illustrate the reality that our staff spends more time identifying and navigating potential solutions than we do closing gaps to care. And, of course, these staff efforts come with costs that the healthcare system must assume. It is a price that Cone Health is willing to pay to help increase access and improve outcomes for its patients. Unfortunately, these services and the expenses they incur do not have a clearly defined value proposition and are therefore not reimbursed by payers—despite the obvious patient benefits.

Barriers to Radiation Oncology Treatment

Due to the challenges associated with an extended daily treatment regimen and the navigation of available resources, a certain level of treatment noncompliance was expected and ultimately accepted. Labeling patients as "non-compliant" or "difficult" is a norm that many of us are unwilling to admit exists in our organizations. Patients are blamed for their inability to continue a prescribed treatment plan more often than any of us in healthcare want to admit. The truth is, this inability to comply is not only a frustration for providers, because it means last-minute cancellations and appointment no-shows, but also for patients, because delays and interruptions in radiation treatment can negatively impact an individual's ability to control the disease.

Our region has a limited number of radiotherapy facilities. In some communities, all patients are served by a single radiotherapy site. Cone Health operates one of the busiest radiation treatment facilities in North Carolina, which typically treats more than 120 patients a day with four linear accelerators. We bring in patients from a five-county service area and treat an economically and racially diverse population. Though we are certified by the American College of Radiology as a top-performing radiation oncology department, none of our current American College of Radiology quality-of-care metrics address treatment compliance or disparities of care. Tragically, what this means is that health disparities will continue to flourish despite our best efforts, simply because we lack an understanding of the complexities to this problem.

Patient Case Study Part 1: Pre-Transportation Hub Implementation

Ms. Emma is an 84-year-old Black woman with a significant family history of breast cancer. Despite the widespread nature of the disease throughout her family, Ms. Emma thought that if she were going to get it, it would have happened by now. Then she received the news: stage 3 breast cancer and treatment needed immediately.

Her treatment regimen called for a lumpectomy, followed by a daily regimen of radiation therapy, and later several rounds of chemotherapy. Ms. Emma tried to process the simple logistics of getting to and from her appointments each day. She left the cancer center discouraged, not just because she may not complete treatment but because she may not even be able to start treatment.

Ms. Emma is fortunate to own her own motor vehicle. Although she might not be able to accurately predict the costs associated with traveling to the cancer center every day, she thought she could make it work. However, Ms. Emma is disabled in one foot. She cannot operate a vehicle properly and knew that driving back and forth to so many appointments would not be a viable option.

Ms. Emma has eight children—a large, supportive family. Although none of them reside in North Carolina, she lives with her 20-year-old granddaughter. The granddaughter commutes an hour each way for work Monday through Friday, and Ms.

Ms. Emma and Allison Moore, transportation coordinator, at Westley Long Cancer Center.

Emma knew that she could not ask her granddaughter to take time off from work to drive her to her medical appointments.

Finally, Ms. Emma thought about taking the bus to her appointments. The nearest bus stop to her home is more than two miles away and, because her of disability, walking would be difficult. Worse, the bus ride from her home to the cancer center is more than 1.5 hours each way. Given the treatment side effects she could experience, the bus did not seem to be a feasible option either. Ms. Emma eventually decided that she had lived a good life and to accept her prognosis and forgo treatment.

A healthcare system that is set up to drive value for the entire healthcare system falls short of delivering whole-person care. When value-based care tips to the value side, all too often patients like Ms. Emma fall through the cracks. No gas card or bus pass could provide relief for her situation.

Understanding the Transportation Problem

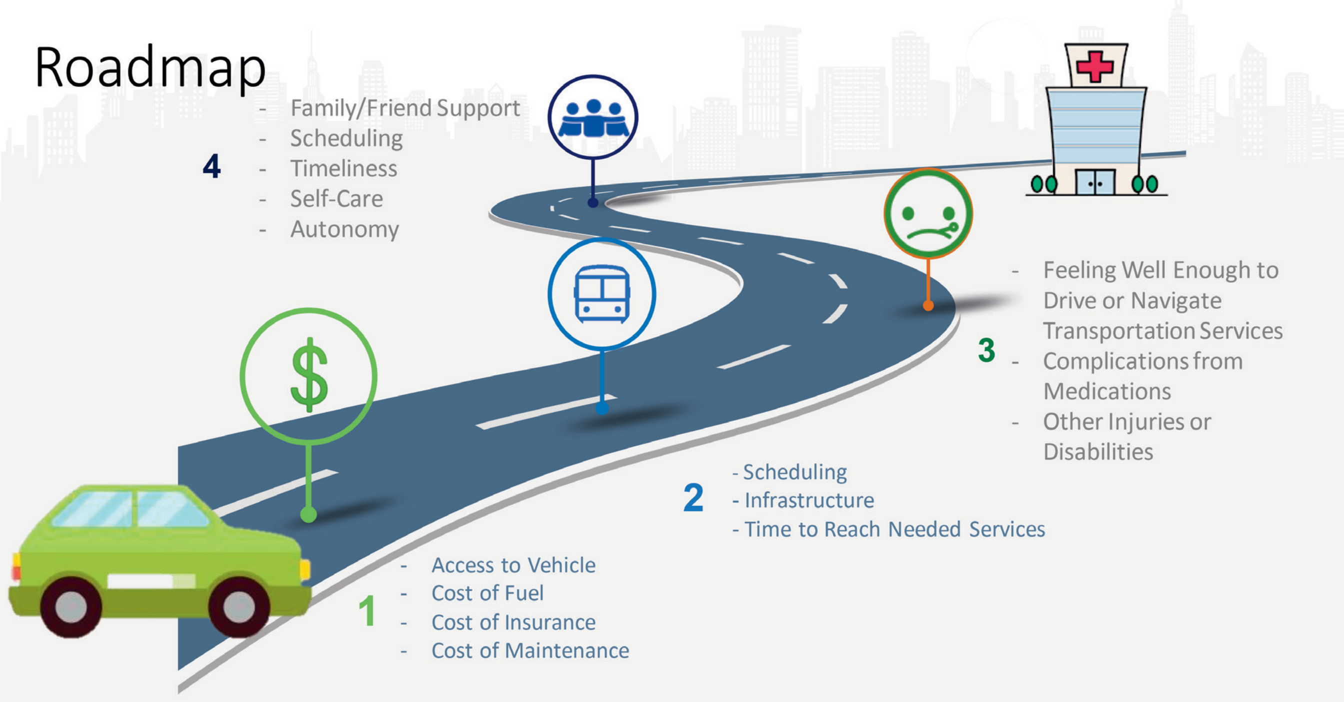
Patients with cancer who face transportation barriers often find themselves at a crossroads: They must either continue to piece together various forms of assistance to try to complete a treatment regimen and protocol or throw in the towel altogether. In the past, my team addressed patient compliance issues with a standard mixture of support (gas cards, bus vouchers, etc.) and encouragement. We referred patients to our program's social workers and/or care managers and hoped that they could assist the patient in need. Today we understand that these efforts are not enough and that we must do better.

Instead of reacting to patients' needs after they fall out of compliance with their specified treatment, we pledged to proactively offer and find transportation assistance that meets *all* patient needs. Creating a system like this required us to once again do a deep dive to understand the scope of the problem we were trying to solve. We found that transportation barriers can be bucketed into four major areas (Figure 2, right):

- ***Cost of Ownership.*** The first roadblock to consider is the financial barrier to transportation. Do patients own or have access to a motor vehicle? Can they afford to put fuel in that vehicle? Is the vehicle insured and in good working order? Finally, is the patient able to obtain a license to operate a vehicle?
- ***Transportation Infrastructure.*** Greensboro is a large metropolitan city with a well-run public bus service. Unfortunately, Greensboro also has a large rural area that is not served by the city bus system. Many bus stops are in areas without sidewalks or shelters and most of these unsheltered stops are in lower socio-economic communities where the likelihood of needing bus service is greater. On one street in particular, individuals must cross four lanes of busy traffic without a crosswalk to get to the nearest bus stop. Additionally, navigation from one side of the city to the other can take about 90 minutes, which is a luxury that many patients do not have. As noted earlier, we serve individuals from a five-county area. Our closest surrounding counties do not have a robust public transportation infrastructure within their own county, let alone across county lines.
- ***Wellness.*** Simply offering patients gas cards and bus passes can negate the importance of this category. Instead, we need to treat the whole patient by asking questions like: Do patients feel well enough to drive or to navigate the bus system? Do patients have a disability that would prevent them from doing so? Are patients taking medications that alter their mental and physical abilities?
- ***Support.*** Finally, when all else fails, we look to patients' support systems. Maybe a friend or family member can help this individual access life-saving treatment. And so, we ask, "Is there anyone that can bring you to your appointment?" All the while not knowing the burden that "finding someone" can place on the patient—a burden that sometimes is more detrimental than the cancer itself.

After understanding the complexities of these transportation barriers, we set out to map a solution. We also wanted to ensure that patients would not have to voice concerns or miss a treatment before they received assistance.

Figure 2. Cone Health Identified Transportation Barriers



A Data-Driven Solution

Knowing the needs that would have to be met, the final piece of the puzzle was to understand which patients were being affected the most by transportation barriers, resulting in missed or rescheduled appointments. Working with our enterprise analytics team, we gathered information on these patients. What we found should have come as no surprise, yet we were still shocked.

Earlier, I noted the segregated nature of our community. Individuals who live in the southeast portion of Greensboro experience poorer outcomes than in any other area of the city. The ZIP codes for that area are 27405 and 27406. Our data showed that individuals seeking care at our cancer center who reside in either 27405 or 27406 have a 12 percent and 15 percent no-show rate, respectively, compared to the average of 2.9 percent across all ZIP codes serviced by our cancer program (Figure 3, page 36). Other demographic data were available on patients who missed appointments. So, next, we mapped out our no-shows by race, ethnicity, payer, ZIP code, time of day, and appointment type.

Piloting Our Transportation Hub

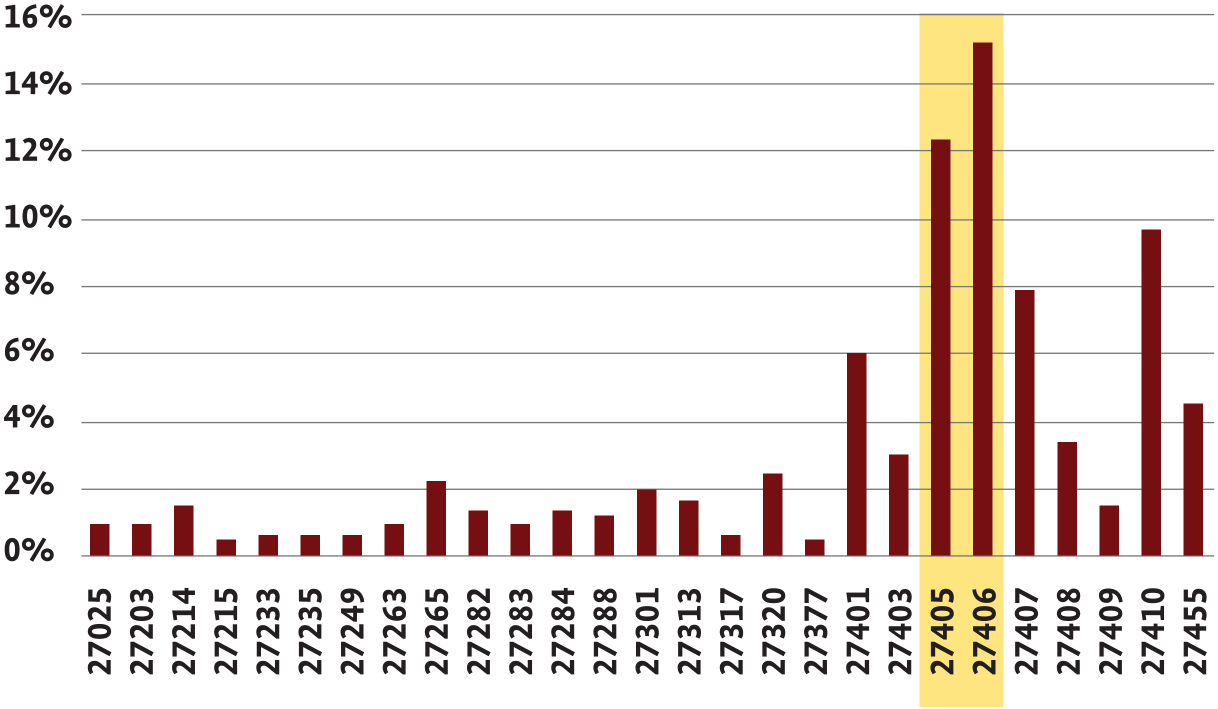
Leveraging the information we collected on transportation barriers and the patients most affected by these barriers, we implemented our Transportation Hub pilot program. To be proactive instead of reactive, we developed and implemented a screening tool to initiate transportation discussions with patients *before* "non-compliance" with treatment became an issue. The screening tool includes the following three questions:

1. In the last month, have you ever had to go without healthcare because you didn't have a way to get there?
2. In the last 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
3. Would you like to receive assistance with this need?

The pilot program used an online transportation platform that coordinated rides across rideshare services, like Uber and Lyft, non-emergency medical transportation providers, and wheelchair accessible vehicles. Rides can be requested immediately, by appointment time, or by pick-up time. Rides are offered proactively and free of charge to:

- All patients coming from a 27405 or 27406 ZIP code.
- Patients who express transportation needs.
- Patients who screen positively on our social determinants of health transportation screening.

Figure 3. Radiation Oncology Patient No-Show Rate by ZIP Code



Breaking Down Barriers

The greatest implementation barrier to our Transportation Hub centered around risk and compliance. Given the complexities of rideshare and transportation services, we needed to ensure our patients' safety and lower the risk for the cancer program. Specifically, the compliance and risk team outlined the following risks the cancer program faced:

- Personal injury liability if a patient is hurt during the ride.
- Vicarious liability for the selected ridesharing service provider.
- Failure to adequately protect the patient.
- Regulatory violations of Stark laws and anti-kickback statutes.
- Reputational damage.
- Health Insurance Portability and Accountability Act violations and/or data breach of personal health information.
- Patient assault.

Our solutions included implementing Health Insurance Portability and Accountability Act and liability release waivers and developing and disseminating a patient education tool with rider safety tips that effectively communicates potential risks to patients (Figure 4, right).

Federal Stark laws and anti-kickback statutes pose potential problems for cancer programs that offer free services to patients. Under these laws, healthcare systems are not allowed to use these to "induce" patients to receive services at a given facility. Offering free transportation can be seen as such an inducement and, thus, violate these federal laws. Thankfully, our compliance team identified a safe harbor to the anti-kickback statute. Specifically, "This final regulation maintains the proposed 25-mile distance for patients in an urban area but expands the definition of 'local' to 50 miles for patients in a rural area, as defined in this rule." Cone Health drafted a policy to include the safe harbor language and ensured that any transportation assistance provided to patients was within a 25-mile radius in an urban area and a 50-mile radius in a rural area.

Transportation Hub Pilot Results

During a four-month period (June to September 2019), 47 patients were enrolled in the pilot Transportation Hub and received a total of 419 rides. Their combined historic average no-show rate was 7 percent. The anticipated revenue loss per radiation treatment was set at $250. We used these data to calculate an opportunity cost. Specifically, our opportunity cost was calculated as the product of the no-show rate, the revenue per treatment, and the number of treatments prescribed by the physician. We recorded all transportation costs and subtracted these costs from the opportunity cost to calculate our return on investment.

Following the four-month pilot, we measured our results to ensure the sustainability of the Transportation Hub. Our data

(continued on page 38)

Figure 4. Transportation Patient Education Tool

5 TIPS
FOR RIDER SAFETY

- Verify the make, model and color of the car. ☐
- Check the license plate to make sure it matches. ☐
- Ask the driver their name to make sure it matches and make sure they know who they are picking up. Never give them your name first. ☐
- Never hand out cash. ☐
- Share your location with family and friends. ☐

CONE HEALTH®

(continued from page 36)

were more promising than we could have hoped. Not only did offering transportation free of charge make financial sense for our cancer program, but it also improved the wellness and satisfaction of our patients with cancer. The Transportation Hub had truly moved the needle and connected healthcare, health equity, and patient well-being.

Reducing Disparities and No-Shows

The most important outcome for this pilot program was for Cone Health to live out its brand promise: to be "right there with" patients, delivering whole person care inside a value-based care framework. We wanted to ensure patient access to medical appointments and treatment—on time and without interruption. We achieved that objective.

In the four-month pilot program, overall no-show appointments for the cancer center decreased by 48 percent, from 6.1 percent to 3.2 percent. No-show incidence by ZIP code decreased for the specific, disparate ZIP codes. ZIP codes 27405 and 27406 had a 12 percent and 15 percent no-show rate, respectively, before Transportation Hub implementation. After hub implementation, no-shows dropped to 1.2 percent and 1.3 percent, respectively (Figure 5, right).

> Given that 92 percent of individuals said they would *not* have been able to attend their appointment if not for the pilot program, patient feedback suggests that we are reaching our intended audience.

Increasing Revenue

Given the historic no-show rates for the patients involved in the pilot program, our cancer center was projected to lose $69,557 in revenue during that four-month period. Transportation costs for the pilot program totaled $6,166, with an average ride cost of $14.72. Therefore, we calculated our return on investment on the four-month pilot program to be $63,391.

Improving Patient Satisfaction

After each ride, patients were given a survey to rate their experience (above average, average, neutral, and below average) and asked whether they would have been able to attend their appointment that day had the ride not been provided (yes, no, unsure).

Survey data allowed us to gauge whether we were enrolling patients whose true need was, in fact, transportation. Given that 92 percent of individuals said they would *not* have been able to attend their appointment if not for the pilot program, patient feedback suggests that we are reaching our intended audience (see Figure 6, right). Additionally, the survey allowed for open responses (qualitative data), so patients could share notes about their experience. One patient wrote, "Could not have been better. Driver was excellent. When I got in the car, I was feeling that I was on my last leg; by the time I was home, I felt totally rejuvenated. Wonderful experience."

Patient Case Study Part 2: Post-Transportation Hub Implementation

In Part 1 of our case study, Ms. Emma had decided to forgo treatment due to her inability to make her daily radiation appointments. Thankfully, we reached Ms. Emma just in time. She received daily transportation to and from each of her radiation appointments. We were then fortunate enough to be alongside her as she rang the bell after completing treatment.

Like Ms. Emma, patients who need transportation assistance to make their medical appointments can get it. Because transportation assistance is now engrained in our staff as a part of patients' medical treatment protocol, patient access and treatment compliance and completion have improved. Some patients may only need one ride—when a loved one is busy or unable to assist—and others need rides for all appointments. Our goal is to now meet every transportation need and "be right there" with the individuals in our community. To date, our Transportation Hub has been in operation for more than a year and we have completed a total of 5,425 rides with an average ride cost of $14. Patients participating in the transportation program experience a less than 1 percent no-show rate; overall, no-show rates at the cancer program are holding steady at about 3 percent.

Patient satisfaction continues to be in the 90th percentile, with many citing our Transportation Hub as the reason for being able to beat their cancer.

Given the financial return on investment and ability to improve outcomes for patients, Cone Health has adopted the Transportation Hub system-wide, offering transportation assistance for patients for all types of medical encounters and appointments. OI

Rachel Marquez, BS, MPH, is a healthcare administrator at Cone Health Cancer Care in Greensboro, N.C.

References

1. Nelson RK, Winling L, Marciano R, et al. Mapping inequality. Available online at: dsl.richmond.edu/panorama/redlining/#loc=5/39.1/-94.58&text=downloads. Last accessed January 28, 2021.

2. North Carolina State Center for Health Statistics. North Carolina provisional vital statistics. Available online at: schs.dph.ncdhhs.gov/data/vital.cfm. Last accessed January 28, 2021.

3. McLaughlin N. In 1960, 4 young men sat at the Woolworth lunch counter in Downtown Greensboro. They wanted to make a "better world for all of us to live in." *Greensboro News and Record*. January 27, 2019. Available online at: greensboro.com/news/local_news/in-1960-4-young-men-sat-at-the-woolworth-lunch-counter-in-downtown-greensboro-they/article_12c03848-fb56-5b7b-a487-b60cf7af13b0.html. Last accessed January 26, 2021.

4. Thomas KK. *Simkins v. Cone*. Available online at: ncpedia.org/simkins-v-cone. Published 2006. Last accessed January 26, 2021.

5. Greensboro doctor honored as pioneer on landmark case anniversary. *Times-News*. September 13, 2016. Available online at: thetimesnews.com/news/20160913/greensboro-doctor-honored-as-pioneer-on-landmark-case-anniversary. Last accessed January 26, 2021.

Figure 5. Patient No-Show Rates Post-Transportation Hub Implementation

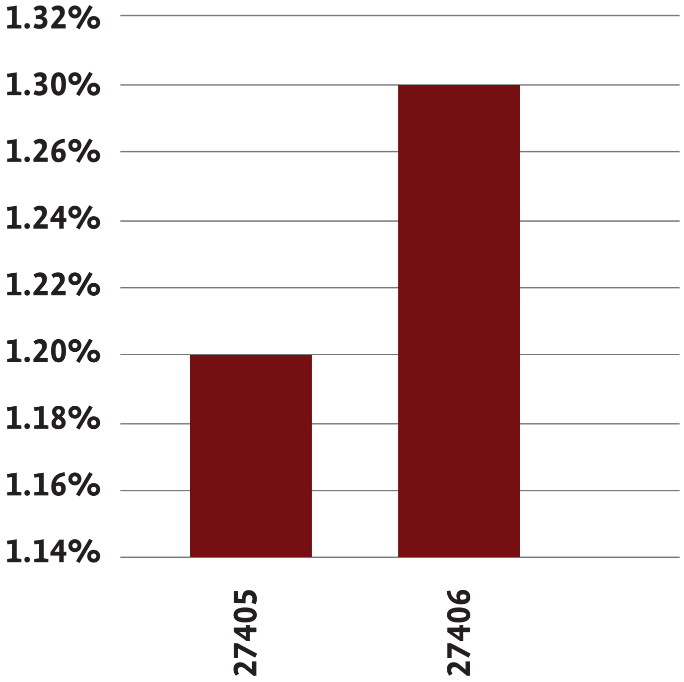


Figure 6. Patient Feedback on Transportation Hub

Question 1. How would you rate your transporation experience today?

Response	June	July	August	September	Total	%
Below Average	0	1	1	0	2	1%
Neutral	0	0	1	1	3	2%
Average	0	4	11	9	24	15%
Above Average	3	29	39	65	136	82%
	3	34	52	76	165	100%

Question 2. Would you have been able to attend your appointment today if this Cone Health program did not exist?

Response	June	July	August	September	Total	%
Yes	0	1	0	5	6	5%
Unsure	0	0	2	1	3	3%
No	2	23	32	47	104	92%
	2	24	34	53	113	100%

Trending Now in Cancer Care

HEALTH EQUITY

STAFFING & OPERATIONAL INTEGRITY

SERVICE LINE DELIVERY & REVENUE OPTIMIZATION

TELEHEALTH & SUPPORTIVE TECHNOLOGY

CLINICAL RESEARCH

BY ALEXANDRA HOWSON, PHD

Findings from the 2020 ACCC Focus Groups

The common thread uniting members of the Association of Community Cancer Centers (ACCC) is the opportunity to amplify voices in ways that support one another. Coronavirus disease 2019 (COVID-19) presented cancer programs and practices with extraordinary professional and personal challenges, disruptions, and opportunities for pause and reflection.

Rather than fielding its annual *Trending Now in Cancer Care* survey while cancer programs were experiencing unprecedented challenges due to the extended public health emergency, ACCC chose to facilitate conversations with its members to capture the lived experiences of the most pertinent issues impacting oncology practice and care delivery. ACCC convened three focus groups in November-December 2020 representing the President's Theme Task Force, the Financial Advocacy Network Committee, and the Education Committee to discuss the following topics:

- Staffing and operational integrity.
- Service line delivery and revenue optimization.
- Telehealth and supportive technology.
- Clinical research.
- Health equity.

When we asked discussion participants how their cancer programs were impacted by COVID-19, "burnout," "exhaustion," "fatigue," and "stress" were the words most frequently used across all three focus groups. Participants revealed strains that tested institutional, professional, and personal resilience and transformed the dynamics of clinical and personal communication.

> Clinicians not only had fewer opportunities for hands-on clinical examination, but the absence of a second set of eyes and ears and the loss of vital details about symptoms that family members provide when they accompany patients on clinic visits made patient examination much more challenging.

But focus group participants also shared silver linings. They told us how their cancer programs and practices developed new operational approaches and workflows to minimize disruptions to staff and patients and ensure continuity of care. They shared how cancer programs and practices implemented telehealth virtually overnight to support care delivery—often without the benefit of robust infrastructure. And they underscored the remarkable resilience of cancer program staff. Figure 1 (page 42) paints a picture of the lived experience of these focus group participants.

Figure 1. The Lived Experience of COVID-19

Cancer program staff have been *tested.*

- The COVID-19 pandemic strained the resources of cancer programs. Patient volume and revenue dropped dramatically in the first COVID-19 wave. Workloads increased and provider and staff roles and responsibilities expanded.
- Mandatory physical distancing contributed to social and emotional isolation for many staff and patients. Providing support for staff became a full-time occupation for many leaders and managers.
- Information flow and exchange was severely disrupted in 2020. Cancer programs and practices spent more on resources to support COVID-related safety protocols and telehealth.

COVID-19 *transformed* the dynamics of clinical and operational practices.

- The shift from being in the clinic to remote work was seismic. Financial navigators, oncology social workers, genetic counselors, administrators, and other staff worked remotely more than physicians and nurses, who often had to be in clinics and infusion centers. This shift reshaped communication between clinicians, staff, and their patients and colleagues.
- Cancer programs and practices identified new operational approaches to address disruptions.
- Telehealth became more prominent in 2020, often despite lack of infrastructure and multiple implementation barriers. Members are hopeful that relaxed regulations introduced in 2020 will remain and emphasized the potential for telehealth to improve health equity by removing transportation barriers, particularly for those in rural and underserved communities.
- Flexibilities established in clinical research have long-term potential to reshape the design and conduct of clinical trials and potentially address health inequities.

Cancer program staff have shown remarkable *resilience.*

- Cancer care teams acutely felt the loss of in-person social connection and the disruption of everyday professional and personal life.
- COVID-19 reinforced the importance of face-to-face communication for clinical practice and financial navigation. Oncology staff found new ways to communicate and connect—with each other and with their patients.
- To bolster this resiliency, cancer programs and practices repurposed conference rooms and other areas as designated staff spaces; got innovative with staff recognition and perks, like hosting milkshake and ice cream bars; developed robust buddy systems; sent daily supportive messaging and shared positive stories and accomplishments; and reinforced a “speak up” culture, especially when issues and challenges arose.

Staffing and Operational Integrity

Cancer program staffing was adversely impacted at different points in the pandemic. In the first wave, staffing cuts and furloughs were widespread and many clinical staff members were redeployed to support COVID-19 operations or cover the shortfall for other services. An ACCC Education Committee member observed, "The ambulatory clinics closed down in March and April. Those nurses moved to the inpatient units, and the staffing just kind of moved around."

Over the summer, cancer programs continued to experience staffing shortages even as inpatient volumes rebounded and new COVID-19-related clinical and administrative roles were created to screen patients prior to clinic visits. During the second surge in late 2020, staffing shortages remained a significant problem as elective surgeries increased in volume and clinics reopened. By the fall, many staff had also contracted COVID-19 or were still furloughed.

Staff workloads increased, roles were reshaped, and many cancer program staff absorbed new responsibilities as colleagues were furloughed or redeployed.

Impact on Clinical Staff

Virtual visits increased expectations about the volume of patients that clinicians can see in a day, and oncology team members had to absorb some tasks usually performed by colleagues. For instance, clinicians felt they spent more time ensuring that remote office staff contacted patients following office visits to schedule scans or blood draws.

As one President's Theme Task Force member shared, "We're not having the direct interaction within the office. In terms of workload, it means that after we see the patient, we must make other contacts to make sure things are carried out, like scheduling and scans. We want all those things done during the office visit, but that can't happen if staff aren't there. It means that we [clinicians] have to make sure the office contacts the patient and that the patient also knows they have to communicate with the office. It's added to the workload—not having the whole team physically present."

As processes for communicating with colleagues and patients shifted toward virtual channels early in 2020, clinicians keenly felt the loss of one-on-one interaction with patients and families. Clinicians not only had fewer opportunities for hands-on clinical examination, but the absence of a second set of eyes and ears and the loss of vital details about symptoms that family members provide when they accompany patients on clinic visits made patient examination much more challenging.

As one President's Theme Task Force member shared, "You might have a husband and wife in the exam room when you ask about diarrhea. The patient knows they're getting their scan results that day, and they don't want to reveal all of the symptoms that might stop their therapy. So when you say, 'Do you have any diarrhea?' The patient says, 'No.' But their partner says, 'You were in the bathroom five times last night!' So that other part of the assessment that comes from the honesty of their partner is missing when there's nobody in the room."

Impact on Financial Navigators and Supportive Care Staff

The workload for financial navigators and supportive care staff increased considerably, both to meet an expanding volume of patient needs and to accommodate resource gaps. New COVID-19-specific programs and resources emerged for which many patients were eligible and about which financial navigators and supportive care staff had to rapidly educate themselves.

Pre-pandemic, financial navigators linked patients directly to supportive care resources, like social work, during an in-office visit. In 2020, these professionals spent more time trying to identify resources and following up with contacts themselves after talking with patients by phone. In response to these challenges, ACCC developed a COVID-19 Financial Advocacy Resource Hub (accc-cancer.org/FAN-COVID19) and shared tips for financial navigators via a town hall.

At the same time, many financial navigators and supportive care staff were redeployed or worked from home and it was challenging for colleagues to communicate directly with each other. Navigators and supportive care staff who worked from home had to rely on on-site staff for signatures, email, and other resources and felt that this added a layer of extra burden on their colleagues.

Financial navigators and supportive care staff were largely unable to have face-to-face conversations with patients on-site and had to rely on phone calls or virtual platforms to communicate with patients. However, technology and connectivity issues added to the challenge of having candid conversations with patients about their financial and other supportive care needs because many patients experienced technology and connectivity barriers. Patients were, in fact, harder to reach by phone—they were often unfamiliar with the cell phone numbers of navigators and cancer program staff and ignored calls. These access issues created additional workload for financial navigators and supportive care staff who had to schedule follow-up calls to reach patients, sometimes multiple times.

Even when financial navigators and supportive care staff could reach patients by phone, they found it harder to build a relationship and trust with patients, which is especially key for initial financial assistance assessment. In response to communication deficits, financial navigators and supportive care staff developed new processes. They created information packets on benefits and resources for patients to collect when they attended the hospital or clinic, combined with a follow-up phone call. To improve patient access, some staff connected their cell phones to a hospital-wide app, which identified callers as the oncology clinic versus a personal cell phone user. This approach increased patient response to calls from financial navigation and supportive care staff.

Though the volume of patient financial needs increased in 2020, access to financial and other supportive care resources decreased. Many patients with cancer experienced economic hardships in 2020. Accordingly, financial navigators noticed an uptick in patients asking about care costs prior to even scheduling a clinical consult.

Patients' financial situations are now more complex or precarious than pre-COVID-19. For example, unemployed patients are having to make decisions between COBRA or purchasing health insurance on state exchanges. Cancer program staff are also reporting seeing more patients struggling with food insecurity. Underserved and non-English-speaking populations had less access to COVID-related information, which was often only available in English.

> Institutional strategies to address the impact of low patient volume and reduced procedures on revenue also had direct financial consequences for cancer program staff. Many programs, or the health systems of which they are part, established revenue-protecting strategies.

Elevated Personal Stress

Across the board, personal stress levels increased dramatically in all members of the cancer care team—clinical and non-clinical. By the end of 2020, staff exhaustion had reached a zenith. The terms most frequently used by focus group participants to describe the toll of COVID-19 were "burnout," "exhaustion," "fatigue," and "stress." In addition to increased workloads, cancer program staff had their own personal health concerns to contend with, as well as home responsibilities, such as school-age children participating in virtual learning.

Institutional support for remote work varied and was mostly used for service line leadership and supportive care staff. These staff experienced considerable uncertainty around work schedules and acutely felt the push-pull nature of moving on- and off-site at different points over the year in response to infection rates. This uncertainty demanded significant personal flexibility and a forward-thinking mindset to ensure that cancer program staff were prepared to meet patient needs.

One Financial Advocacy Network Advisory Committee member said this about the ongoing uncertainty, "Am I going to work? Am I not? Do I have everything I need at home? Do I have enough stamps and envelopes so that at least I can mail resources?"

Institutional strategies to address the impact of low patient volume and reduced procedures on revenue also had direct financial consequences for cancer program staff. Many programs, or the health systems of which they are part, established revenue-protecting strategies that included:

- Placing holds on 2021 merit raises, 403(b) contributions, or IRA matches.
- Staff furloughs.
- Workforce reductions of five to ten percent (as reported by focus group participants).
- Flexing staff to patient volume, productivity levels, or remote work.
- Reducing or eliminating personal time off.

New Ways to Inform and Support Staff

Service line leaders often stepped in to respond to inconsistent COVID-19-related information, especially at the beginning of the pandemic. The absence of widely shared science in a rapidly evolving situation created an information vacuum all too often filled by mixed messages and misinformation. To combat mounting staff anxiety, service line leaders initiated their own communication processes to keep staff informed and up to date; for example, virtual COVID-19 huddles and team-specific Facebook pages.

As the pandemic evolved, service line leaders also developed a heightened awareness of the potential for staff burnout. They sought ways to provide emotional support to mitigate the loss of social contact that resulted from remote work or redeployment policies and the frustration around reduced remuneration (see Figure 1, page 42). But providing support for staff also took a toll on leadership morale and energy and became increasingly challenging in the context of dwindling public recognition of health professionals and loss of pay and/or vacation time.

Safety-Related Operational Changes

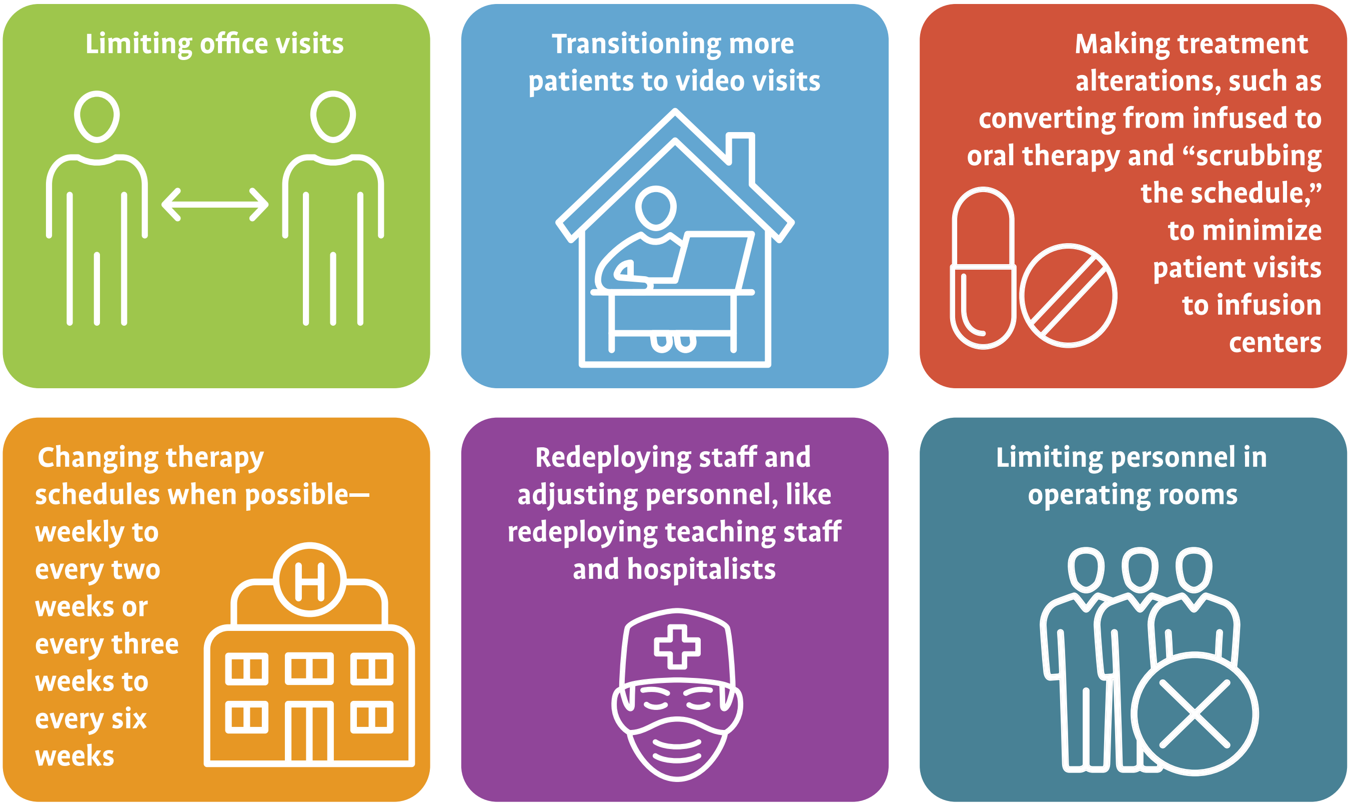
Cancer programs and practices devised operational changes to expedite cancer treatment and minimize risk of exposure to coronavirus for patients and staff, many of which continue (see Figure 2, right). These changes included transitioning more patients to video visits or changing therapy schedules when possible (e.g., from weekly to every two weeks or from every three weeks to every six weeks). As one member of the President's Theme Task Force reflected, these changes amounted to an "endless list of disruptions."

Patients and their families were affected by safety protocols set in place to reduce the risk for COVID-19 exposure. Inpatients were restricted from having visitors and many were scared and alone and lacked personal advocates or support systems. In turn, family members experienced increased anxiety because they were unable to be with their loved ones in hospital and worried that they might not be contacted in a timely manner if their loved one's condition changed.

Pharmacy Operational Changes

Some operational changes were extensive, especially in the oncology pharmacy setting. For instance, new protocols were necessary to ensure cleanroom compliance with certain compounding mandates (e.g., USP 797 and 800) in a context of diminishing supplies (e.g., gowns, masks) and budgetary constraints. Some oncology pharmacy service lines also created new safety protocols for staff working on-site to address emergent needs (e.g., drug shipments) and established formal expectations about home office setup for offsite employees (e.g., having a shredder, a secure location, adequate Internet speed) to ensure compliance with the Health Insurance Portability and Accountability Act and to protect sensitive data.

Figure 2. COVID-19 Safety-Related Operational Changes Made by Cancer Programs



COVID-19-Related Operational Changes

COVID-19 testing is required for oncology patients prior to beginning chemotherapy. Cancer programs and practices are using text messaging, automated screening and tracking, or phone calls from physician assistants or registered nurses to identify whether patients have been exposed to coronavirus or have COVID-19 symptoms prior to treatment or clinic appointments. Oncology patients who test positive for COVID-19 are treated in separate units or isolated in the infusion center—placing additional demand on already strained space, time, and staffing resources. An additional challenge is that many cancer or treatment-related symptoms (e.g., fever, diarrhea, shortness of breath, cough) overlap with COVID-19 symptoms. Some cancer programs and practices have instituted secondary screening by the infusion provider and testing for patients with new or worsening symptoms. This additional layer of testing further delays initiation of cancer treatment.

Service Line Delivery and Revenue Optimization

Patient volume and revenue fluctuated according to pandemic surges. In March and April, many cancer programs and practices experienced reductions in patient volume and revenue. Elective surgeries were delayed because intensive care unit beds were required for COVID-19 patients and additional space was also required for transfusions. Cancer screening volume decreased because either screening sites closed down or primary care providers stopped offering screening to their patients. At the same time, patients avoided regular physical exams, which reduced the potential for incidental findings. Some health systems suspended outpatient scheduled appointments and entire service lines. Oncology inpatient volume also dipped for some cancer programs, as one member of the Education Committee noted: “I had an average daily census of five to six patients from about the end of March until the first of August. And I could not meet productivity, of course, because I didn’t have any patients.”

These reductions in overall patient volume and procedures adversely impacted health system revenue and contributed to significant financial losses for cancer programs and practices.[1] One focus group participant noted a $128 million loss for their cancer program in the first COVID-19 surge when elective surgeries were stopped. The staffing required for COVID-19 screening has also increased the overall costs of providing care. Screening is a highly paid activity with no associated revenue, the cost for personal protective equipment remains high, and the steps involved in operationalizing safety protocols require time and reduce efficiency.

Cancer Service Lines Shored Up Health System Revenue

Cancer programs and practices shored up health system revenues diminished by reduction in other service lines, as one Education Committee member described, “As far as oncology care went, chemo infusions, radiation treatments, there was really no drop in volume in March, April, or May. In some ways we were holding up the health system a little bit financially.” Another Education Committee member shared, “We have our own specialty pharmacy. We also have home infusion services. And revenue has gone up about 40 percent in both of those areas.”

Although government assistance (e.g., Paycheck Protection Programs) helped defray revenue losses, some cancer programs and practices adjusted their approaches to managing accounts receivable. Financial navigators became even more vital to the process of maintaining the integrity of revenue cycles through effective communication with patients about the availability of financial assistance resources.

As one Financial Advocacy Network Advisory Committee member said, “I noticed our revenue business office zeroing in more on the money…looking for payment…coming back and asking us [about payments] where before they would be more lenient to adjustments. I feel like the revenue department itself is more conscious of asking, ‘Are we getting every dollar from the insurance?’”

Telehealth and Supportive Technology

Though telehealth use in oncology surged in 2020, some cancer programs and practices were better prepared to accelerate than others. Sites with access to existing telehealth infrastructure or a “strategic roadmap” for telehealth experienced more rapid implementation and moved “from 0 to 60” in a short timeframe. As one member of the President’s Theme Task Force said, “We had a telemedicine platform, and we had a handful of people who knew how to use it. We were able to pivot in a minute. We went from doing zero percent telemedicine visits to 46 percent in less than a month.”

Cancer programs and practices that were able to accelerate their use of telehealth during the first COVID-19 surge were supported by some or all these infrastructural components:

- Telehealth platforms embedded in workflows.
- Visit types integrated in electronic health records.
- Organizational commitment to telehealth.
- Dedicated telehealth staff and/or clinical information liaisons.
- Information technology support.
- Prior education and training for providers and non-clinical staff.
- Robust patient accounts and scheduling teams able to integrate virtual and real-time visits and support patients with technical questions.
- Patient education, training, and real-time troubleshooting on technology requirements and use.

Yet telehealth expansion was not linear but fluctuated with COVID-19 surges. The first surge saw rapid expansion. In the summer, however, there was less urgency to keep patients and personnel out of clinics and hospitals, and telehealth use receded. By July or August, many cancer programs and practices had established protocols and processes for mitigating infection and acquired personal protective equipment that was largely absent at the beginning of the pandemic, so people felt more comfortable being physically in clinic space. The second surge in the fall ramped up telehealth again for many programs, with telehealth accounting for about 40 to 50 percent of patient visits.

Barriers to Telehealth Implementation

Initially, lack of coding for reimbursement was a major impediment to oncology telehealth expansion. Congress acted quickly to ensure compensation for most virtual visits, and the Centers for Medicare & Medicaid Services changed regulations concerning reimbursement and other requirements.[2] These flexibilities eased the adoption of telehealth. Nonetheless, rapid telehealth expansion demanded a concentrated learning curve from staff to design protocols “on the fly,” often in circumstances of decreasing staff numbers and little guidance about telehealth platforms.

“You felt like you were just thrown in the deep end and you had to learn to swim. I don’t think many of us had something readily available at our fingertips to identify the best way to optimize telemedicine,” shared one Education Committee member.

Cancer programs and practices had to contend with multiple other implementation barriers, such as the lack of information technology (IT) staff to provide technical support on how to use “off-the-shelf” telehealth platforms (e.g., Doximity, WebEx). Clinician comfort with telehealth varied, too, as one President’s Theme Task Force member noted: “Sometimes it’s the faculty members who have been around for a long time who have more of a problem utilizing the telehealth equipment.” Access to telehealth equipment among cancer program staff was also patchy, as another President’s Theme Task Force member shared: “I don’t have a camera in my office. I had to go and purchase one. I can use my laptop, but then the laptop doesn’t connect with the electronic health record. There's still ongoing issues that need to be addressed."

Other providers had reservations about using telehealth. They preferred real-time, face-to-face interactions and physical contact with patients and were surprised to find that telehealth brought them closer to patients. Some providers came to view masks as a barrier to social and emotional connection and found that virtual communication allowed them to see a patient's face, which felt more connected and intimate. "I liked the video visits because we could interact with patients without wearing a mask. Wearing a mask puts distance between us and the patient and diminishes the connection. I have patients who have never seen my face because they were new patients to me during COVID-19," shared one Education Committee member.

Clinical Research

COVID-19 significantly impacted cancer research. Although there was a dip in approvals for clinical trials in the March-April time frame that rebounded somewhat in the summer,[3] many clinical trial programs suspended studies and shifted research staff to work from home in 2020. Ongoing clinical research was affected in multiple ways. Deviation filings were common due to delays in blood tests, imaging, treatment, or the need to use telehealth versus in-person visits. Patient transportation and challenges in taking time away from work also remained significant barriers for clinical trial enrollment.

Many research programs adapted to these disruptions in response to recommendations from national regulatory authorities. The following flexibilities that emerged in 2020 offer potential as standard of care in future clinical trials:

- Decentralizing care based on U.S. Food and Drug Administration guidance.
- Clarifying protocol-required essential tests.
- Amending studies to lengthen testing intervals.
- Using telehealth for clinical assessment and patient-reported symptom collection.
- Leveraging biometric devices to support patient evaluation (e.g., sleep, movement) and mapping them to Eastern Oncology Cooperative Group Performance Status.
- Shipping oral anti-cancer drugs directly to select patients from specialty pharmacies and allowing pharmacy professionals to practice medication therapy management via telehealth.

Other emergent flexibilities have potential to reduce patient burden in clinical trial participation and increase trial retention rates, such as remote consent and trial eligibility screening and using telehealth to reduce time and travel burden for patients and the frequency of in-person visits. Involving patients upfront and early in clinical trial design could also enhance health equity and reduce disparities in participation. A wider conversation is already occurring within the oncology community about "future-proofing" cancer clinical research and clinical trials in general.[4,5]

Health Equity

The pandemic exacerbated existing access disparities along socioeconomic, racial, ethnic, age, gender, and geographic fault lines.[6]

Telehealth Use

Access to telehealth has been especially challenging for patients in rural or impoverished areas, as well as for people of color, who are more likely than urban or White patients to lack cell phone minutes, cell phone service, connectivity, and/or privacy. Hispanic, non-Hispanic Black, and Asian people and people over 65 years are also less likely to use email or engage in telehealth activities.[7] Patients on Medicare struggled more with technology access than younger patients. These patients tended to want to be on-site for clinical exams and were therefore more at risk from potential COVID-19 exposure. In contrast, younger patients were more likely to use telehealth, be impacted financially through unemployment or economic changes, and more in need of financial assistance.

Cancer Outcomes

COVID-19 will likely exacerbate racial, ethnic, and socioeconomic disparities in cancer outcomes, although the overall impact on new cancer diagnoses has yet to be calculated for 2020. One focus group participant noted a 50 percent reduction in new breast cancer diagnoses for their cancer program in the second quarter and a 20 percent reduction for new breast cancers in 2020 overall. This pattern of a short-term dip in incidence followed by an uptick in advanced stage disease and increased mortality will likely be widespread.[8]

Transportation

Transportation support provided by the American Cancer Society and other organizations virtually disappeared due to COVID-19 restrictions. Rural communities, states with no Medicaid expansion, and underserved populations suffered especially from transportation barriers to care. Many cancer programs and practices devised alternative strategies to meet the shortfall such as gas cards or liaising with family members to provide transportation for patients. On page 30 of this issue, learn how a virtual rideshare hub developed by an ACCC member program is improving patient access and eliminating disparities.

Strategies to Support Underserved Populations

The pandemic has shown that moving forward, cancer programs and practices must be more conscious of the role that social determinants of health play in patient access to oncology care. Strategies to pre-emptively address health inequities in access to oncology care and alleviate patient burden include:

- Creative clinic and treatment scheduling for employed patients and family members.
- Transportation support for treatment and clinical trial participation; for example, gas and public transportation vouchers and rideshare partnerships.

- Counseling and social work to address financial need, as well as additional support to address food insecurity, childcare needs, and other home support.
- Wider adoption of telehealth services.
- Partnering with community organizations to connect with and reach at-risk patient populations.
- Use of lay navigators from communities who represent the racial, ethnic, cultural, and linguistic patient populations they serve. This will support appropriate messaging and gain stakeholder buy-in for population health navigation programs.

One focus group participant suggested that comprehensive cancer centers that are renewing their National Cancer Institute designation should include engagement and community outreach in their renewal application as a foundation to address disparities and access to care.

Although cancer incidence and mortality overall are declining in the United States, certain underserved patient populations continue to be disproportionately impacted by certain cancers. The oncology community, including organizations like ACCC and the American Society of Clinical Oncology, have pledged to identify opportunities and develop programs to ensure equitable access and quality cancer care for *all* patients—regardless of race, ethnicity, age, gender identity, socio-economic status, sexual orientation, and/or geographic region.

In this edition of *Oncology Issues*, 2021-2022 ACCC President Krista Nelson, MSW, LCSW, OSW-C, FAOSW, announced her President's Theme: "Real-World Lessons from COVID-19: Driving Oncology Care Forward." One of the key lessons learned is that health equity and social justice are critical drivers of quality cancer care delivery. In this issue, ACCC shines a spotlight on two pioneering cancer programs, the Center for Indigenous Cancer Research at Roswell Park Comprehensive Cancer Center (pages 18-24) and Cone Health Cancer Care (pages 30-39), and breast cancer advocate Reverend Tammie Denyse (pages 14-17) and the work they are doing to improve health equity and empower patients with cancer. OI

Alexandra Howson, PhD, is an experienced medical writer, researcher, and educator with a strong background in principles of adult learning combined with clinical practice as a registered nurse. Based in Seattle, Dr. Howson trained in Scotland as a registered general nurse and has a doctorate in sociology.

References

1. Gordan LN, Weidner S. Impact of COVID-19 pandemic on specialty community practices: an oncology perspective. *Am J Manag Care.* 2020;26(10):SP333.

2. Royce TJ, Sanoff HK, Rewari A. Telemedicine for cancer care in the time of COVID-19. *JAMA Oncol.* 2020;6(11):1698-9169.

3. Unger JM, Blanke CD, LeBlanc M, et al. Association of the coronavirus disease 2019 (COVID-19) outbreak with enrollment in cancer clinical trials. *JAMA Netw Open.* 2020;3(6):e2010651.

4. Doherty GJ, Goksu M, de Paula BHR. Rethinking cancer clinical trials for COVID-19 and beyond. *Nat Cancer.* 2020;1:568-572.

5. Clinical Trials Transformation Initiative. Join Transforming Trials 2030. Available online at: ctti-clinicaltrials.org/take-action/join-transforming-trials-2030. Last accessed March 5, 2021.

6. Lopez L III, Hart LH III, Katz MH. Racial and ethnic health disparities related to COVID-19. *JAMA.* 2021;325(8):719-720.

7. Balogun OD, Bea VJ, Phillips E. Disparities in cancer outcomes due to COVID-19—a tale of 2 cities. *JAMA Oncol.* 2020;6(10):1531-1532.

8. Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer statistics, 2021. *CA Cancer J Clin.* 2021;71(1):7-33.

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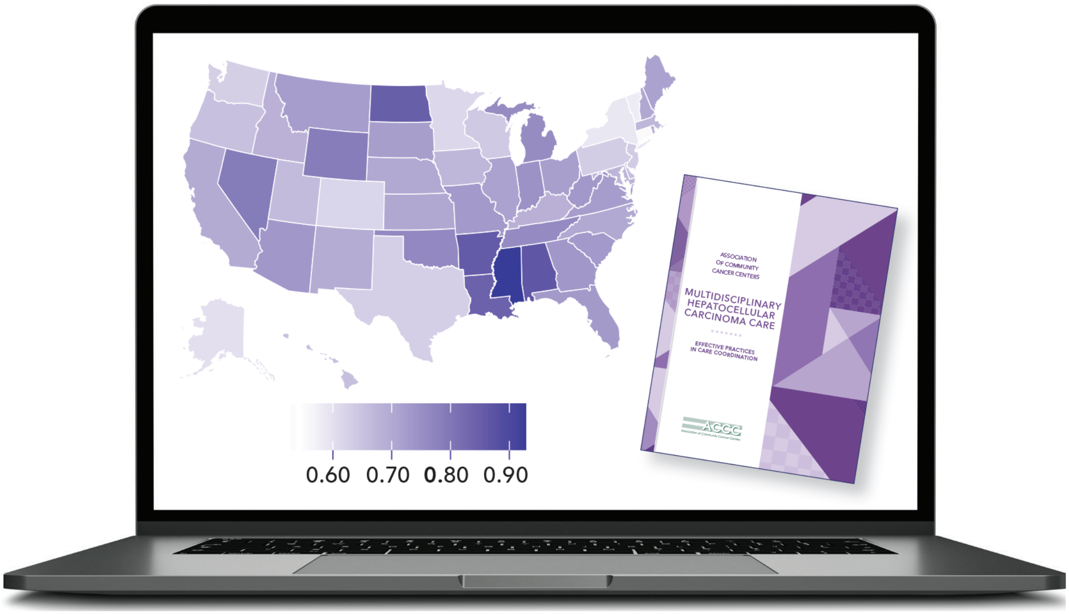

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A Nurse Navigator Led Community-Based Cardio-Oncology Clinic

BY RACHAEL ZIRKELBACH, BA; KERRY SKURKA, RN, BSN;
AND VIJAY U. RAO, MD, PHD, FACC, FASE, FHFSA

2020 ACCC INNOVATOR AWARD
ASSOCIATION OF COMMUNITY CANCER CENTERS

In the summer of 2016, Dr. Vijay Rao of Franciscan Physician Network Indiana Heart Physicians was alarmed when he realized that three patients he was treating for congestive heart failure had a history of treatment for breast cancer. Could any of the oncologic treatment regimens be responsible for these patients' cardiac conditions? Having worked at Genentech, the biotechnology company responsible for the development of the breakthrough breast cancer treatment trastuzumab, Dr. Rao recognized that the combination of anthracycline chemotherapy and trastuzumab was likely the culprit. Around the same time, the American Society of Echocardiography released a consensus statement recommending routine monitoring for chemotherapy-related cardiotoxicity with serial echocardiograms. Dr. Rao reached out to Dr. Eric Stephen Rubenstein, a medical oncologist at Franciscan Physician Network Oncology and Hematology Specialists, striking up a conversation about this topic that led to their joint attendance at the Global Cardio-Oncology Society meeting later that year. Dr. Rao and Dr. Rubenstein left that meeting with the realization that they could do much more to protect patients with cancer from potential cardiac toxicity of chemotherapy. The two returned to Franciscan Health Indianapolis with the goal of preventing the cancer survivor of today from becoming the heart failure patient of tomorrow.

> But how could hospital administration be convinced to hire a new navigator when there was no budget for the position? The answer was simple: Following oncologic guidelines for monitoring patients for cardiovascular toxicity via echocardiography increased the number of echocardiograms performed at the hospital.

In the Beginning

Over the next few months, in conversations with Franciscan Health Indianapolis leadership about developing and implementing a cardio-oncology program, key stakeholders from the hospital and its two affiliated practices identified the following strengths:

- An interdisciplinary program with two passionate physician champions—one in cardiology and one in oncology.
- Improved alignment of oncologists and cardiologists as part of Franciscan's multi-specialty physician network.
- Administrators with experience in leading cardiology, imaging, and oncology service lines.
- Experienced nurse navigators in breast, colorectal, and lung tumor sites who could help shape a new nurse navigator role, if needed.
- A healthcare system transitioning from fee-for-service to value-based healthcare, identifying quality changes to make along the way to ensure success in the transition.
- A robust cancer survivorship program with emphasis on long-term wellness and outcomes.

Stakeholders identified several hurdles and/or barriers to a cardio-oncology program, including:

- The biggest challenge: no budget for developing and implementing a new program.

- Lack of general education among oncologists and nursing staff regarding cardio-oncology.
- The need to establish a direct line and workflow to cardiology for timely consults and imaging so oncology treatment would not be delayed.
- Concerns from oncology providers that chemotherapy would stop or be slowed due to cardiac evaluation.
- Patient scheduling challenges given that oncology and cardiology providers were not physically housed in the same building.

While examining these strengths and challenges, it became obvious to stakeholders that someone—an experienced clinician—was needed to act as a "bridge" to connect the two disciplines, oncology and cardiology, as well as establish screening algorithms to allow monitoring of patients through their treatment journey. From this revelation, the position for a cardio-oncology nurse navigator was born. But how could hospital administration be convinced to hire a new navigator when there was no budget for the position?

In the end the answer was simple: Following oncologic guidelines for monitoring patients for cardiovascular toxicity via echocardiography increased the number of echocardiograms performed at the hospital. Identifying this revenue stream was a great start for making a cardio-oncology nurse navigator business case. In addition, downstream revenue generated from new visits and additional testing, such as electrocardiograms, cardiac magnetic resonance imaging, and Holter monitors, added to the business case. Despite the potential for additional revenue, the new position was a leap of faith for the hospital because stakeholders did not know whether the volumes predicted would come to fruition because there were no other cardio-oncology programs to model ours after. In the end, the belief that a significant improvement could be made in patient care largely drove the decision to hire.

Here is where Kerry Skurka, RN, BSN, a registered oncology infusion nurse, enters the story. Professionally, Skurka was a practicing nurse and leader in cardiology, critical care, and emergency medicine for the last 40 years at several different Indiana hospitals. Her own personal battle with cancer occurred in 2008 when she was diagnosed with non-Hodgkin's lymphoma. Despite her successful battle, she encountered cancer again in 2013, this time with her husband, who was diagnosed and treated for head and neck cancer and later passed away from non-Hodgkin's lymphoma. This personal history drove her to a career change involving the bedside care of oncology patients, and in 2014 she joined Franciscan Physician Network Oncology and Hematology Specialists as an infusion nurse. While once again assessing patients at the bedside, Skurka quickly identified cardiac issues, such as hypertension and atrial fibrillation, and began calling clinician attention to these issues. Her experience in both cardiology and oncology made Skurka the perfect fit for the cardio-oncology nurse navigator position, where she hit the ground running.

Where Do We Start?

Early on, Dr. Rao and Skurka met often and set forth with two overarching goals: (1) to improve clinical outcomes and survivorship by minimizing cardiovascular effects of cancer treatment and (2) to shift the paradigm to early recognition and treatment of cardiotoxicities through cardiovascular risk stratification and prevention, thus creating a "proactive cardio-oncology" mindset.

In a practice with nearly 2,000 new patients with cancer per year, where does one start? The first step to meeting these goals was to assess the current oncology practice. Overall, the questions addressed fit into the following four categories.

Clinical

- What is the current cardio-oncology knowledge base among oncology and cardiology providers?
- What is the established practice in oncology as it relates to cardiac side effect care?
- What is the practice for cardiac surveillance, if any, and for what treatment regimens?
- Which subset of oncology patients will be seen by cardio-oncology first?
- What resources are available to aid the program in addressing cardio-toxic effects without delaying cancer treatment?

Administrative

- What infrastructure changes are needed to create a direct line to cardiology so that oncology patients are seen in a timely manner?
- Will Epic (the electronic health record) support an easy referral process and the scheduling of timely patient appointments, as well as prompt medical record documentation for the oncologist to assist with treatment management?
- How will continued follow-ups be facilitated and what will the process be to ensure patients return to their own cardiologist if a patient had one prior to cardio-oncology care?
- What guidelines and resources are available to lay the foundation of a cardio-oncology plan?

Actionable

- How will providers and staff get the training they need to identify signs and symptoms?
- In what format will follow-up information be shared with medical oncologists and their staff?
- Who will address the operational issues within the cardiology and oncology practices?

Outcomes

- Is a regularly scheduled meeting necessary to oversee program development and present updated data with key stakeholders in attendance? Will process improvement be addressed at the same time?
- How will clinical outcomes be shared with the medical oncologists and their staff?

To begin to answer these questions, it became apparent that foundational education was necessary, including clinical guidelines and research studies. Dr. Rao shared this information with key stakeholders in oncology and cardiology by presenting at Franciscan's bi-annual oncology symposium, speaking at oncology Grand Rounds, and creating internal case-based conferences.

Next, the team settled on 2D echocardiography with intravenous contrast to screen for left ventricular dysfunction in patients receiving anthracyclines and/or trastuzumab. Echocardiography was selected because it was readily available and easy to perform, lacked radiation exposure, and provided information about valves and pericardial effusions, which were not assessed with historical multi-gated acquisition scans. Decrements in global longitudinal strains on echocardiography were shown to predict future drops in heart function, leading Dr. Rao to educate Franciscan echocardiography technicians on how to perform measurement and his cardiology colleagues on how to interpret the studies.

New Processes and Workflows

The next step included developing processes and workflows within the Franciscan Health Indianapolis system that would ensure quality care of the cardio-oncology patient (see Figure 1, page 54). The workflow included the following steps.

Through chart mining, Skurka identifies oncology patients with a treatment plan that includes a cardio-toxic drug. Initially, Skurka focused on patients who were prescribed trastuzumab and anthracyclines because these two agents are known to have high rates of cardiotoxicity, particularly if combined in treatment regimens.

Next, these patients undergo an echocardiogram to measure their baseline heart function (ejection fraction). Skurka monitors patient charts to ensure that the echocardiogram is completed. Additionally, she reviews their history, calculates a cardiac risk score, and determines whether a cardio-oncology consult is warranted.

At this point in the process, it is extremely important and beneficial to have a direct line to cardiology, because the cardiology practice schedules patients several weeks out. At the start of the cardio-oncology program, there were not enough appointment times on Dr. Rao's schedule alone to accommodate oncology patients. The need for additional cardiologists with cardio-oncology expertise became apparent, so Dr. Rao approached Drs. Atul Chugh and Ryan Daly, two of his partners with extensive experience in cardiovascular imaging, to join the cardio-oncology team. With efforts coordinated by Dr. Rao, both cardiologists became more comfortable seeing cardio-oncology patients within a year. The addition of two more cardio-oncologists and Skurka acting as the direct line between the two practices means that oncology patients are now seen by cardio-oncologists within days instead of weeks, ensuring minimal delays in oncology treatment.

The cardio-oncologists work closely with Skurka and their colleagues in oncology to ensure that each patient moves forward with oncology treatment, including prescription of cardio-protective medications and initiating a cardiac surveillance plan. The cardio-oncology nurse navigator follows the patient, tracking surveillance testing and health status while addressing any issues from testing or symptoms in a timely manner.

The last step in the process was to find any pre-existing tools to identify patients with cardiac risk. Mayo Clinic's Cardio-Risk Assessment Tool (Figure 2, page 56) became the team's assessment tool of choice.

> Today pharmacists and nurse navigators play an integral role in the cardio-oncology clinic, from educating patients about drug-drug interactions to helping patients with the emotional stress associated with hearing about cardiovascular complications while receiving chemotherapy.

The Cardio-Oncology Nurse Navigator Role

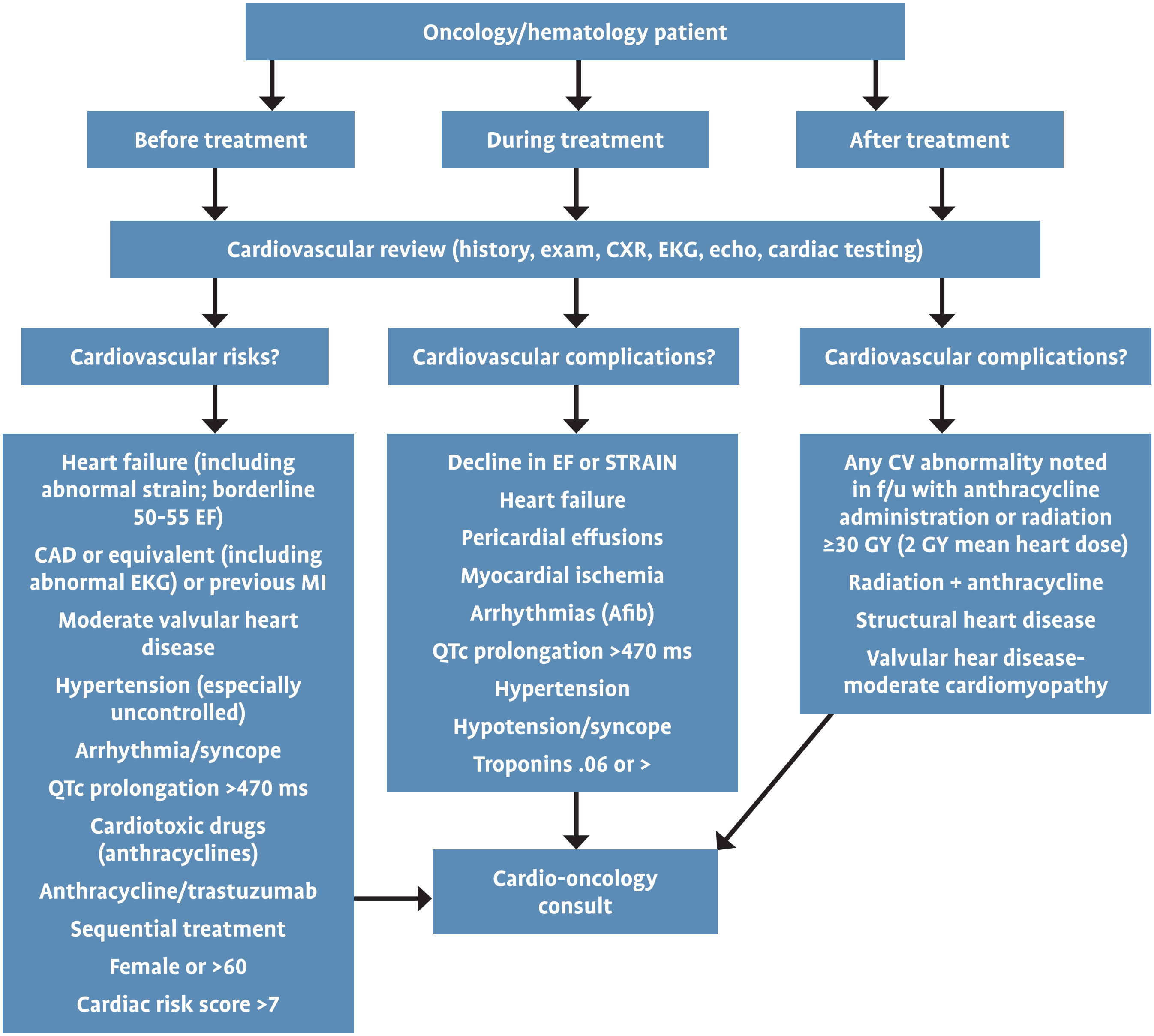
Once the team set goals and identified the steps needed to make the program impactful for patients, they had to decipher which workflows would work for navigation. Outside of mining patient charts, how was Skurka going to identify patients? What processes were already in place to ensure timely surveillance? What was the oncologist responsible for and what was the cardio-oncologist responsible for? The team identified the current workflows and assessed the gaps, some of which included:

- Inconsistent and ill-defined workflow processes.
- Lack of ownership over the completion of tests, as well as follow-up for abnormal results.
- Knowledge gaps surrounding several topics. In oncology this meant understanding and following new recommended guidelines related to evidence-based cardiovascular surveillance testing and interventions. It meant understanding old versus new standards of cardiac diagnostic testing. For example, Definity, an image enhancer used in echocardiography, has a very short half-life and is not a contrast agent therefore does not affect kidney function. Other gaps in knowledge were around use of biomarkers, such as troponin; comfort levels with abnormal results; and drawing and timing of draws for oncology staff. For cardiology, clinicians had to have knowledge of oncology medical regimens, timelines of patient flow for all care providers, and chemotherapy.

Like Dr. Rao, Skurka's job quickly morphed into one of education. To do so, she spent countless hours in Franciscan Physician

(continued on page 55)

Figure 1. Franciscan Health Cardio-oncology Workflow



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*ASCO, NCCN, Mayo Proceeding 2014 CRS-Cardiac risk assessment. Source: Adapted from Herrmann et al.[2] AFIB = atrial fibrillation; CAD = coronary artery disease; CV = cardiovascular; CXR = chest x-ray; EF = ejection fraction; EKG = electrocardiogram; Echo = echocardiogram; F/U = follow up; GY = gray; MI = myocardial infarction; MS = milliseconds; QTc = QT corrected.

Top Row, Left to Right: Angela Brittsan, MD, PhD; Casey Browning, NP-C; Atul Chugh, MD, FACC, RPVI; Ryan Daly, MD, FACC, FASE, FSCMR, FSCCT
Bottom Row, Left to Right: Holly Page, RN, BSN, CCRN; Meghana Raghavendra, MD; Vijay Rao, MD, PhD, FACC, FASE, FHFSA; Kerry Skurka, RN, BSN

(continued from page 53)

Network Oncology and Hematology Specialists' infusion suite, training the nursing staff on the signs and symptoms related to cardiac disease. Her focus was continuous rounding that included checking in, listening to concerns, and sharing patient follow-up information with the nursing staff and medical oncologists. This format allowed Skurka to share up-to-date patient information daily.

Skurka spoke often with medical oncologists about patients who were under the cardio-oncologists' care to foster collaboration and to strengthen interdisciplinary relationships. Today Skurka admits that this was one of her biggest personal and professional challenges because she had to convince each set of physicians—cardiology and oncology—that she could be the eyes and ears who understood both sides of patient care. To successfully fulfill this role, both the cardio-oncologist and the medical oncologist had to see and accept the cardio-oncology nurse navigator as an extension of them. Confident with her strong clinical and foundational knowledge in both disciplines, Skurka was able to support the respective patient management strategies in her assessments and decision-making skills.

Education and training are ongoing. For example, during routine follow-up on discharge rounds, Dr. Rao found that coronary vasospasms were being incorrectly charted as unknown etiology. This revelation led to a patient care initiative, including education in the emergency department, critical care unit, cardiac catheterization lab, and oncology units. Education included the fact that coronary vasospasm can occur with 5-F-based chemotherapy and emphasized the critical need to shut off the infusion pump when patients present with chest pain.

Growing the Program

Bolstered by success stories supporting its positive impact, the cardio-oncology program quickly grew. A part-time medical assistant (MA) was added in 2017; this position took over the scheduling portion of patient care, so the cardio-nurse navigator could focus on identifying more patients who would benefit from a cardio-oncology consultation. The MA became a second direct line from oncology to cardiology with access to scheduling echocardiograms and appointments with the cardio-oncologists. That same year, time was blocked out on the cardio-oncologists' schedule, allowing for two to three dedicated appointments per week that the MA could use for oncology patients.

In 2018, a second nurse navigator, Holly Page, RN, was hired to follow patients who were receiving oral chemotherapy only.

Figure 2. Mayo Clinic Cardio-Oncology Risk Assessment Tool

Medication-related risk	**Score**
High (risk score of 4)	
Anthracyclines, cyclophosphamide (>150 mg/kg, >1.5 g2/daily), ifosfamide, clofarabine, trastuzumab	
Intermediate (risk score of 2)	
Docetaxel, pertuzumab, sunitinib, sorafenib	
Low (risk score of 1)	
bevacizumab, dasatinib, imatinib, lapatinib	
Rare (risk score of 0)	
Etoposide, rituximab, thalidomide	
Medication Score	

Patient-related risk factors (1 point per risk)	**Score**
CAD or equivalent (include PAD)	
Hypertension	
Diabetes mellitus	
Prior or current use of anthracycline	
Prior or current chest radiation	
Smoking	
Atrial fibrillation	
Hyperlipidemia	
BMI >30	
OSA	
Female; Age <15 or >60	
Patient Risk Score	

Recommended Surveillance Testing
Baseline 2D transthoracic echocardiogram with strain/definity and troponin/brain natriuretic peptide for all who require monitoring
Anthracyclines: baseline; at cumulative dose of 240-300 mg/m2; at cumulative dose of 400-450 mg/m2; then prior to each additional 50 mg/m2; completion, then again at 6 months to 1 year
Trastuzumab/pertuzumab: baseline; Q3 months, completion and then every 6 months for 2 years (neoadjuvant with both drugs echo surveillance is recommended at 6 weeks)

Medication + patient risk = total cardiac risk score
Cardiac monitoring: Baseline echo/troponin/Cardiac risk score
Cardiac Risk Score (CRS)
>8: Very high
7-8: High
5-6: Intermediate

Note: The patient-related risk factors (bold, second column) were added based on new cardio oncology guideline recommendations. BMI = body mass index; CAD = coronary artery disease; OSA = obstructive sleep apnea; PAD = peripheral artery disease; TTE= transthoracic ecocardiogram

During planning for this full-time position expansion, much discussion took place as to what type of experience was required for the new position. The team decided it was best that the new nurse navigator have cardiology experience because oncology could be more easily learned, especially with the help of the many oncology nursing experts. The MA position went from part time to full time to keep up with the additional oral chemotherapy patients managed by the second nurse navigator. Given the programmatic growth, the need for a dedicated cardio-oncology clinic became evident by June 2018. This clinic was scheduled to occur as a half day every other week. Today pharmacists and nurse navigators play an integral role in the cardio-oncology clinic, from educating patients about drug-drug interactions to helping patients with the emotional stress associated with hearing about cardiovascular complications while receiving chemotherapy. Patient satisfaction surveys are regularly conducted for all patients seen in this clinic and have routinely included positive feedback, such as:

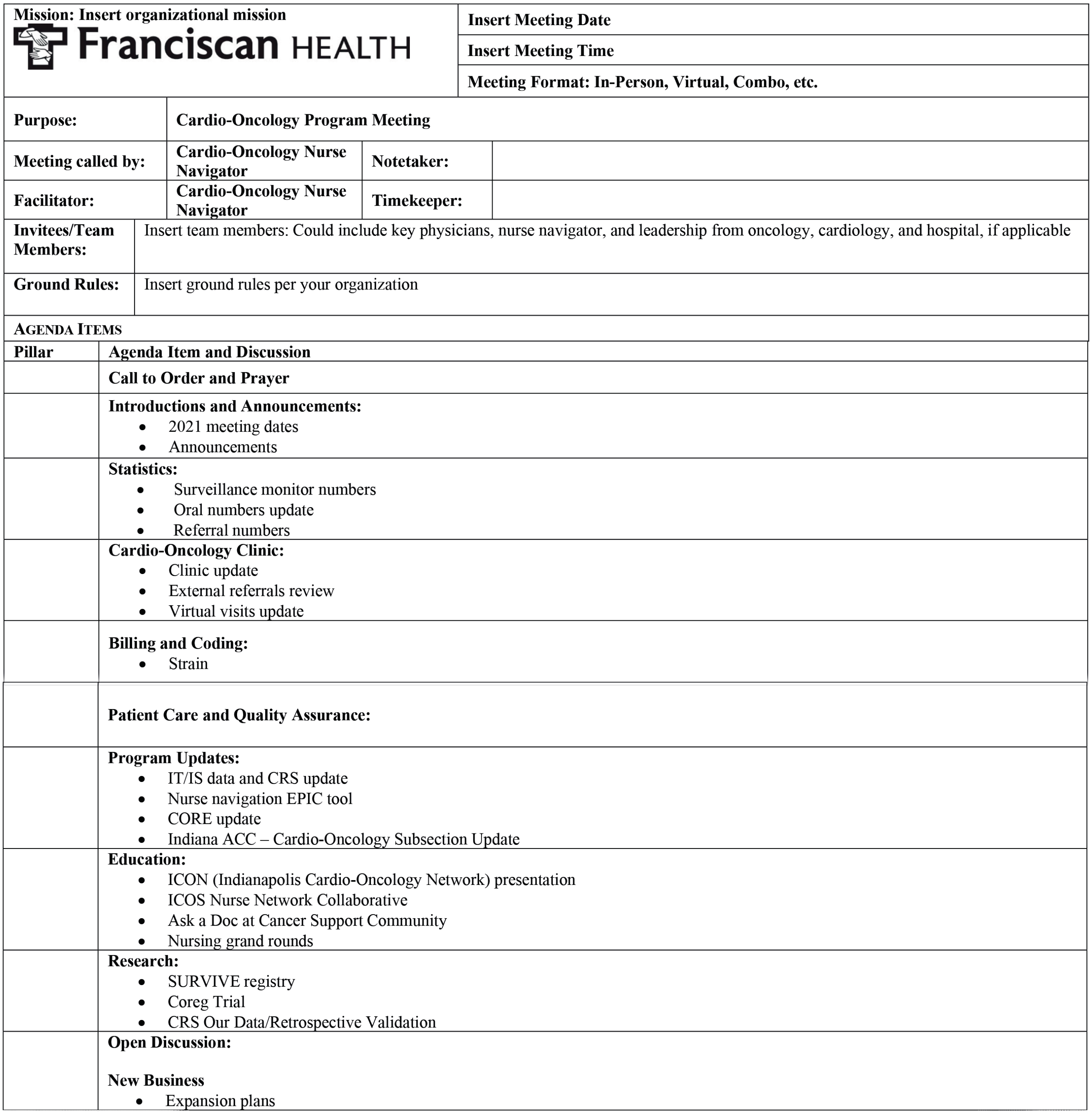
> "The entire staff is well-trained, compassionate, and put me at ease!"
>
> "The team makes you feel important and well-informed."
>
> "I had a great time at my appointment, so thankful the radiation oncologist recommended I come here."

Along the way, the team developed and implemented nurse navigator-led quarterly cardio-oncology board meetings, which included key stakeholders in clinical leadership and administration. At these board meetings, key metrics are reviewed and issues in clinical care are discussed and addressed by the group who can make the necessary changes. These meetings allow clinical leadership and administration to see the cardio-oncology program's impact in real time and have been an asset to further program development. Figure 3, right, is a template agenda for these quarterly cardio-oncology board meetings.

A strong component of Franciscan Health Indianapolis's cancer program is the multidisciplinary tumor boards offered for breast, lung, colorectal, gynecologic oncology, and melanoma. These tumor boards are well attended by not just medical and radiation oncology but also research, pathology, surgery, and radiology.

(continued on page 58)

Figure 3. Cardio-Oncology Quarterly Board Meeting: Sample Agenda



Mission: Insert organizational mission Franciscan HEALTH	**Insert Meeting Date**
	Insert Meeting Time
	Meeting Format: In-Person, Virtual, Combo, etc.

Purpose:	**Cardio-Oncology Program Meeting**		
Meeting called by:	**Cardio-Oncology Nurse Navigator**	**Notetaker:**	
Facilitator:	**Cardio-Oncology Nurse Navigator**	**Timekeeper:**	
Invitees/Team Members:	Insert team members: Could include key physicians, nurse navigator, and leadership from oncology, cardiology, and hospital, if applicable		
Ground Rules:	Insert ground rules per your organization		

AGENDA ITEMS

Pillar	**Agenda Item and Discussion**
	Call to Order and Prayer
	Introductions and Announcements: • 2021 meeting dates • Announcements
	Statistics: • Surveillance monitor numbers • Oral numbers update • Referral numbers
	Cardio-Oncology Clinic: • Clinic update • External referrals review • Virtual visits update
	Billing and Coding: • Strain
	Patient Care and Quality Assurance:
	Program Updates: • IT/IS data and CRS update • Nurse navigation EPIC tool • CORE update • Indiana ACC – Cardio-Oncology Subsection Update
	Education: • ICON (Indianapolis Cardio-Oncology Network) presentation • ICOS Nurse Network Collaborative • Ask a Doc at Cancer Support Community • Nursing grand rounds
	Research: • SURVIVE registry • Coreg Trial • CRS Our Data/Retrospective Validation
	Open Discussion: **New Business** • Expansion plans

(continued from page 56)

When the cardio-oncology program first started, Skurka attended these tumor boards to get face-to-face time with the physicians, to learn the styles and methodologies of the medical oncologists, and to share more information about cardio-oncology. Eventually cardio-oncology tumor boards were added to Franciscan Health Indianapolis Cancer Center's robust lineup, fostering important dialogue that showed the value of cardiology participation in oncology care. Dr. Rao also wanted to improve awareness of and access to this specialized knowledge and reached out to fellow cardio-oncology program directors in Indianapolis and started the Indianapolis Cardio-Oncology Network. Indianapolis Cardio-Oncology Network is a quarterly multidisciplinary case conference that involves fellows, pharmacists, nurses, cardiologists, oncologists, and bone marrow transplant clinicians. Cases are videotaped with a plan to distribute to a larger audience via social platforms.

The team at Franciscan Health Indianapolis has a track record of quality patient care, coupled with innovation in healthcare. Given the success with its cardio-oncology program in Indianapolis, Franciscan Alliance, is looking to develop similar programs across the 12-hospital system. Skurka and Dr. Rao are currently working with the team at Franciscan Health Lafayette in Lafayette, Ind., to develop their program and have recently given Grand Rounds to engage with the oncology and cardiology teams there. Not only has the cardio-oncology team educated hospitals within Franciscan Alliance, but Dr. Rao and Skurka have also shared best practices with Franciscan-affiliated community hospitals across south-central Indiana.

Today, the cardio-oncology team includes four cardio-oncologists: Vijay Rao, MD, PhD, FACC, FASE, FHFSA (program medical director); Atul Chugh, MD, FACC, RPVI; Angela Brittsan, MD, PhD; and Ryan Daly, MD, FACC, FASE, FSCMR, FSCCT; one cardio-oncology nurse practitioner, Casey Browning, NP-C; one medical oncologist lead, Meghana Raghavendra, MD; two full-time cardio-oncology nurse navigators, Kerry Skurka, RN, BSN, and Holly Page, RN; and one full-time medical assistant, Amelia McElyea, CMA, CPA. In addition to these team members, the following specialties are also involved in the care of cardio-oncology patients:

- Radiology
- Pharmacy
- Cardiovascular testing
- Lab services
- Infusion center nurses and staff at Franciscan Physician Network Oncology and Hematology Specialists
- Intake staff at Franciscan Physician Network Oncology and Hematology Specialists and Franciscan Physician Network Indiana Heart Physicians
- Oncology social workers
- Oncology and cardiology leadership via the cardio-oncology board
- Oncology and cardiology research
- Oncology Supportive Care Clinic
- Information technology department.

Future Plans

As many have experienced, 2020 disrupted healthcare in a way that none of us predicted. One bright spot in that disruption was the installation of telemedicine at Franciscan Health Indianapolis. Telemedicine allowed oncology patients to see cardio-oncologists throughout the early days of the pandemic while minimizing their risks given their often immuno-compromised status. Approximately 50 percent of cardio-oncology visits were virtual in third quarter 2020, as total overall visits increased 40 percent from 12 to 20 patients per week. This technology change is something that Dr. Rao explores in his 2020 co-authored manuscript in *Frontiers in Cardiovascular Medicine*, which focuses on precision medicine and the digital transformation of cardio-oncology in the post-pandemic world.[1] Additional opportunities being explored include virtual cardio-oncology exercise rehabilitation and real-time, three-way consultations between the patient, oncologist, and cardiologist at the time of initial consultation. Though the cardio-oncology program has experienced intense growth over the last four years, we have not yet been able to expand into our radiation oncology or bone marrow transplant departments. Future plans include hiring a third full-time nurse navigator to address these populations.

Thanks to efforts of clinician champions, a supportive administration, and the tireless work of our cardio-oncology nurse navigators, cardio-oncology patient care has seen a swift transformation at Franciscan Health Indianapolis over the last four years. Day in and day out, our care providers advocate for the best cardiac and oncologic care for their patients—changing more than 1,000 patient lives and counting. As our program grows, we hope to set an example of a gold standard for care for community-based programs across the nation while ensuring that today's cancer survivor does not become the heart failure patient of tomorrow. OI

Rachael Zirkelbach, BA, is a business development manager at Franciscan Health Indianapolis; Kerry Skurka, RN, BSN, is a cardio-oncology nurse navigator at Franciscan Health Indianapolis Cancer Center; and Vijay U. Rao, MD, PhD, FACC, FASE, FHFSA, is a cardiologist at Franciscan Physician Network Indiana Heart Physicians and medical director, Cardio-Oncology Program at Franciscan Health Indianapolis, Indianapolis, Ind.

Reference

1. Brown SA, Rhee JW, Guha A, Rao VU. Innovation in precision cardio-oncology during the coronavirus pandemic and into a post-pandemic world. *Front Cardiovasc Med*. 2020;7:145.

2. Herrmann J, Lerman A, Sandhu NP, Villarraga HR, Mulvagh SL, Kohli M. Evaluation and management of patients with heart disease and cancer: cardio-oncology. *Mayo Clin Proc*. 2014;89(9):1287-1306.

3. Teske AJ, Linschoten M, Kamphuis JAM, et al. Cardio-oncology: an overview on outpatient management and future developments. *Neth Heart J*. 2018;26(11):521-532.

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Leveraging Technology to Reduce Hospital and Emergency Room Admissions and Identify Patient Comorbidities

BY LARRY E. BILBREY; STEPHEN M. SCHLEICHER, MD, MBA;
L. JOHNETTA BLAKELY, MD, MS, MMHC; LEAH R. OWENS, MSN, RN;
SUSAN A. FRAILLEY, MBA, LSSGB; GARRETT R. YOUNG;
AND NATALIE R. DICKSON, MD, MMHC, FACP

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Years before value-based care agreements and alternative payment methodologies became a reality, community oncology practices had a major blind spot when it came to hospital and emergency department (ED) admissions.[1] As practices joined the Centers for Medicare & Medicaid's Center for Medicare and Medicaid Innovation Oncology Care Model (OCM) pilot, the need for these data became glaringly apparent. Community oncology practices that participate in the OCM are responsible for all Medicare Part A and B costs and most of Medicare Part D costs for patients attributed to the OCM program—regardless of the cause or connection to their cancer diagnosis.[2] OCM reconciliation data, along with other commercial payer value-based care data, quickly uncovered the disparate gap with hospital- and ED-related costs attributed to patients with cancer (Table 1, page 62).[3] These OCM reconciliation data also showed very high costs associated with comorbidities, specifically when patients with comorbidities presented to the hospital or ED.

Tennessee Oncology's Medical Home Pilot

Tennessee Oncology is a physician-owned community oncology practice based in Nashville, Tenn., with more than 30 locations across middle and east Tennessee and northern Georgia. The practice has just under 100 physicians and more than 60 advanced practice providers. Most providers represent medical oncology, with others representing gynecologic oncology, radiation oncology, palliative care, psychology, and genetic counseling.

> Though drug costs are an increasingly important topic as it pertains to value-based care, this article will focus on our approach to reduce hospital-related and comorbidity costs.[5]

In 2015 Tennessee Oncology understood that alternative payment methodologies were on the horizon and launched a medical home pilot. The primary focuses of our medical home pilot were clinical pathways, palliative care, telephone triage, and care coordination. Because the medical home was a new program, Tennessee Oncology created many new processes and procedures, addressed several new staffing needs, and introduced new technologies. This new technology allowed for ongoing data collection, which accelerated quality improvement efforts and led to improvement in key performance indicators, primarily related to telephone triage (Figure 1, page 63).[4] It was, however, difficult to show a return on investment for technology costs and human resource expenses.

Table 1. Medicare Expenditures per Beneficiary per Month by Type of Service (Risk-Adjusted Four-Quarter Average for April 2019 to March 2020, Excluding Medicare Part B and Part D Drug Costs)

Cost Category	Cost per Patient ($)	Percentage of Costs
Inpatient admissions to short-term acute care hospitals and critical access hospitals, all causes	866.00	13.2
Excluding admissions for chemotherapy, bone marrow transplant, and cancer surgery	753.00	11.5
Unplanned readmissions within 30 days of discharge	206.00	3.1
Resulting from ED visit and/or observation stay	555.00	8.4
Resulting from ED visit only	451.00	6.9
Resulting from observation stay only	19.00	0.3
Resulting from ED visit that led to an observation stay	85.00	1.3
Resulting from neither ED visit nor observation stay	316.00	4.8
Observation stays not leading to admissions	28.00	0.4
Resulting from ED visit	16.00	0.2
Not resulting from ED visit	12.00	0.2
ED visits not leading to admission or observation stay	25.00	0.4
Radiation oncology in all ambulatory settings	181.00	2.8
Physician services, excluding (1) lab/testing/imaging, (2) radiation oncology, and (3) Part B drugs	589.00	9.0
Oncology providers	86.00	1.3
Other providers	503.00	7.6
Ancillary services in all ambulatory setting	400.00	6.1
Laboratory and testing: Total	179.00	2.7
Laboratory and testing: Advanced	144.00	2.2
Laboratory and testing: Other	36.00	0.5
Imaging: Total	221.00	3.4
Imaging: Advanced	108.00	1.6
Imaging: Other	113.00	1.7
Other outpatient facility services	259.00	3.9
Home healthcare	91.00	1.4
Skilled nursing facility	91.00	1.4
Long-term care hospital	5.00	0.1
Inpatient rehabilitation facility	53.00	0.8
Hospice: All	76.00	1.2
Hospice: Facility only	11.00	0.2
Hospice: At home only	60.00	0.9
Hospice: In both settings	5.00	0.1
Durable medical equipment, excluding Part B drugs	33.00	0.5
Total expenditures (cost per patient)	6,576.00	
Hospital related expenditures	3,332.00	50.7

ED = emergency department. *Source:* OCM Practice Feedback Report for the period Jan. 1-Mar. 31, 2020. Data exclusive to Tennessee Oncology and provided by the Centers for Medicare & Medicaid's Center for Medicare and Medicaid Innovation. Prepared by RTI International, 3040 Cornwallis Road, Research Triangle Park, NC 27709; Actuarial Research Corporation (ARC), 6928 Little River Turnpike, Annandale, VA 22003; and Telligen, 1776 West Lakes Parkway, West Des Moines, IA 50266; September 2020.

Tennessee Oncology's OCM Participation

Launched in June 2016, the OCM offered the opportunity to expand our medical home program to meet OCM requirements and to obtain payer-level data that might answer many of our questions on our return on investment and operational success. Tennessee Oncology applied for and was accepted as an original OCM pilot participant. As an OCM participant, Tennessee Oncology receives monthly care management payments that allow us to expand our care coordination and palliative care teams to serve our large Medicare patient population, which is approximately 35 percent of our total patient-payer mix.

In 2021 Tennessee Oncology opted-in for two-sided risk in the OCM pilot. This additional risk requires that we sharpen our focus on resource management and further cost reductions. Though Tennessee Oncology has been successful overall in our value-based care contracts, including overall cost savings in all payment periods for the OCM pilot thus far, the data, unfortunately, are received six months to one year after the payment period. This delay in data delivery makes it difficult to use these data for real-time operational changes. However, we are using these data to identify opportunities for long-term improvement and operational movement. Using data analytics, we realized that we had three major gaps from a patient-cost perspective as it relates to value-based care:

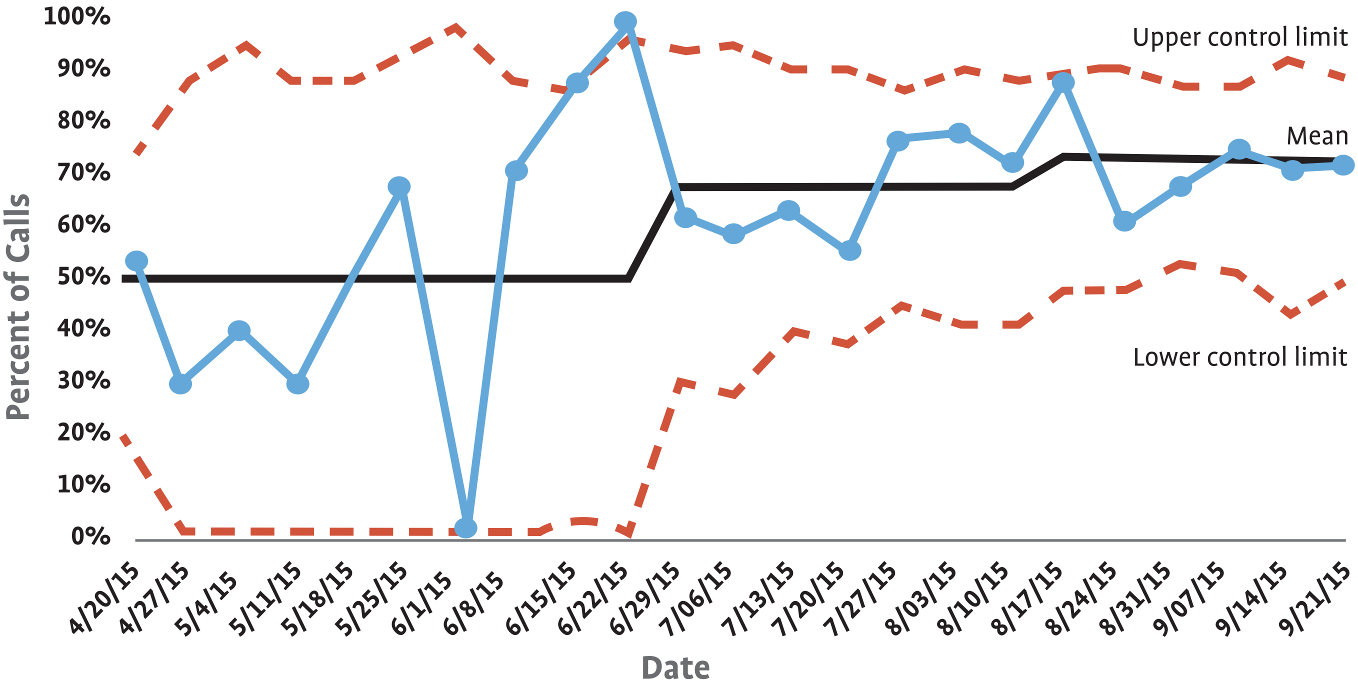
- Drug costs
- Hospital-related costs
- Costs associated with patients with comorbidities.

Though drug costs are an increasingly important topic as it pertains to value-based care, this article will focus on our approach to reduce hospital-related and comorbidity costs.[5]

Hospital and Emergency Room Utilization

It is well documented, even beyond our OCM experience, that patients with cancer generally have some type of hospital-related costs during their disease treatment.[6] Outside of drug costs, ED and hospital visits are the most expensive contributors to a patient with cancer's cost of care. Though it has always been our goal at Tennessee Oncology to minimize unnecessary hospitalizations, we were not well resourced to make that a primary focus prior to our medical home, because the bulk of our resources were focused on day-to-day clinic operations. Participation in value-based care programs magnified the need to be able to track or be notified when one of our patients presented to the ED or hospital.[6] Often, many of the reasons why patients go to the ED are non-emergent issues that can generally be resolved in an outpatient setting like our clinics or infusion suites.

Figure 1. Symptom Management Calls Receiving Clinical Intervention Within Two Hours (April-September 2015)



Source: Data exclusive to Tennessee Oncology; Data provided by Tennessee Oncology and published in *J Oncol Pract*.[7]

Additional costs associated with untimely or unneeded ED visits or hospital admission(s) are the workup elements. Tennessee Oncology's physicians and advanced practice providers are trained and guided to do the most thorough workup recommended by accredited entities, such as the National Comprehensive Cancer Network guidelines or evidence-based pathways applications. These workups almost always include extensive labs and imaging. ED physicians or internists have little to no visibility into the patient's medical history outside of the hospital. Recent workups not performed in the hospital are generally not available to the hospital providers. As standard practice, ED physicians follow their workup procedures, which often lead to unnecessary or repeated labs or scans that often had been recently completed elsewhere.

> Tennessee Oncology formed a Care Transformation Team with the focus of addressing admissions in real time, as well as follow-up care for discharges.

An additional gap surrounded discharge from the ED or hospital. Almost across the board, there is no process for a hospital to notify our practice when our patients are being discharged from the hospital or ED.

As we faced these challenges and worked toward keeping patients out of the ED and hospital, we quickly realized that there were no viable or feasible avenues that gave us a real-time alert when patients presented to the ED or hospital or even any acceptable reflective information of why patients presented to the ED or hospital. Around this time, we entered into a value-based contract with a single payer in which the payer provided us daily with a hospital file; however, the information was 48 to 72 hours old. Though this was the best window into ED visits and hospitalizations of any of our patient populations, the delay of two to three days, coupled with the payer representing less than 5 percent of our overall payer mix, was not significant enough for us to gauge our success or needs for our entire patient population.

Reducing ED Visits and Hospital Admissions

Tennessee Oncology implemented many solutions to lower ED and hospital utilization, including:

- 24-hour on-call physicians.
- "Call Us First," a patient education initiative about the importance of reaching out to the clinic before going to the ED or hospital.
- A custom telephone triage system.
- Registered nurse care coordinators to proactively engage high-risk patients.
- An online patient engagement tool, also available as a mobile app, which included a patient portal, the ability to direct message care providers, and a symptom diary in which the patient could log any issues they were having, which would immediately be transmitted to care coordinators or telephone triage nurses.

Our many attempts over the years to work directly with various hospital systems to obtain real-time notifications of our patients' hospital activity failed due to multiple reasons. However, in 2020, Tennessee Oncology partnered with a third-party vendor to potentially provide these real-time hospital alerts. The state of Tennessee had contracted with this company for a project in which the state needed transparency and real-time data on their state Medicaid patient population. Any participating state-reimbursed hospital was required to comply with this program; this included more than 85 percent of the hospitals in the state, which numbered over 100 hospitals. The vendor was forward-thinking and, when contracting for the Medicaid data feed, it negotiated with hospital systems to get all patient data, presumably with the intent to contract with healthcare organizations, like ours, who would be able to turn these data into actionable analytics for performance and quality improvements. Along with the data purchase came access to the vendor's portal with real-time alerts on any patient activity as it pertains to ED visits or hospital admissions, hospital transfers, or hospital or emergency room discharges.

Understanding the impact of these real-time alerts and data, Tennessee Oncology formed a Care Transformation Team with the focus of addressing admissions in real time, as well as follow-up care for discharges. The practice instituted a pilot project using our current care coordinators who managed our value-based care patient populations. We provided the vendor with our full patients with cancer roster (more than 40,000 patients). For the pilot, we identified a small subset of patients based on our current value-based care contracts (approximately 4,500 patients) and focused on four physicians who were already involved with the Care Transformation Team from a physician-leadership perspective. This pilot served several purposes, of which resource determination, improved processes, and data and analytics were a few of the top priorities. The long-term goal: to expand coverage to include all physicians and all patients.

The pilot was set to begin in the first quarter of 2020; however, COVID-19 delayed our contracting and implementation timelines. The contract was signed in the early part of the second quarter of 2020, and the data feed and portal went live in early July of 2020.

Very specific processes were put in place for the pilot. If one of our identified patients triggers an event (ED or hospital admission or discharge) in the vendor's system, an alert is generated (configurable by us) and emailed to our care coordinators. The responsible care coordinator logs in to the nurse portal to address the alert and identify the patient. During this identification process, the care coordinator identifies and logs:

- The admitting and/or triage diagnosis.
- Whether the diagnosis is related to the patient's cancer.
- The admitting and/or treating provider.

At this point, the care coordinator establishes communication with the ED or hospital. This communication allows the sharing of information to avoid duplication of unnecessary testing and workup, such as scans or labs. The care coordinator provides the ED with the last office note(s), recent lab results, recent scans (if applicable), or any other patient records that would be valuable to the ED provider, with the goal of completing the patient's workup, reducing the overall time needed in the ED, and keeping resource costs to a minimum, while also increasing the patient's satisfaction by expediting their discharge.

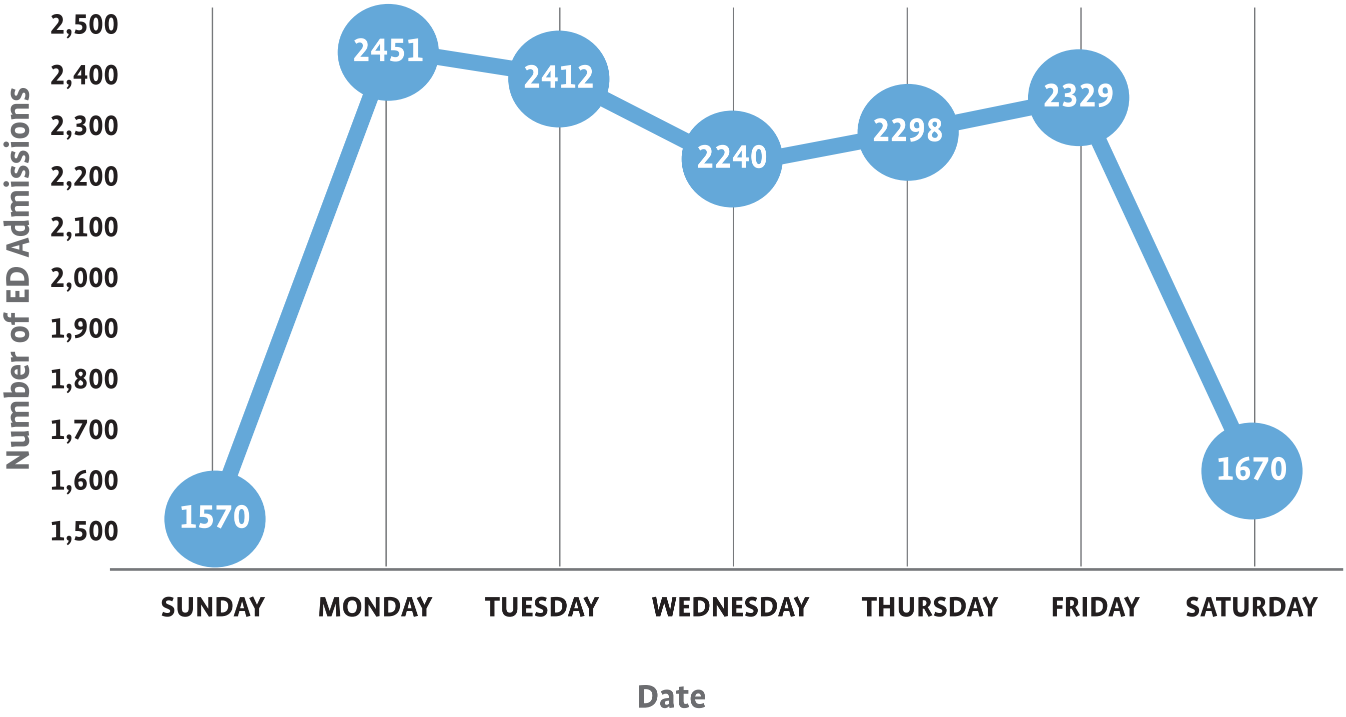
Once the patient is identified, contact with the ED/hospital is made, and medical records are shared, the care coordinator then determines, based on the admitting diagnosis, the level of involvement needed by a Tennessee Oncology provider. If the admitting diagnosis is related to the patient's cancer, the care coordinator will reach out to the attending Tennessee Oncology provider via urgent communication channels, as established in our policies, to obtain the Tennessee Oncology provider's input on next steps for the patient's care. The provider may then communicate instructions to the care coordinator to relay to the ED or hospital provider, or the Tennessee Oncology provider may reach out directly to the ED or hospital provider to discuss care options. If the presenting diagnosis is not related to the patient's cancer, the care coordinator notifies the Tennessee Oncology attending provider via non-urgent communication channels to keep the provider informed and improve care coordination.

We quickly identified a gap in this process because patients who go to the ED are often triggered in the alert system without an admitting diagnosis. Because of this gap, the communication step is often moved before the identification step to procure the admitting diagnosis. This involves a manual process where the care coordinator calls the emergency room directly and obtains the admitting diagnosis from ED staff.

A process for hospital discharge was also implemented. Care coordinators receive alerts for ED or hospital discharges. Upon receiving these alerts, a care coordinator reaches out to the patient to arrange follow-up care and support and determine whether an in-clinic or telemedicine appointment is needed within 24 to 48 hours after discharge, with the goal of reducing hospital readmissions.

While this pilot was being implemented, we analyzed the first round of data. These data were provided by the vendor to our data analysts directly via a daily data feed. This feed provided a comprehensive record of patient demographic information, provider information, related Tennessee Oncology provider information, admitting diagnosis, dates and times, and insurance information, among others.

Figure 2. ED Admission Trendline by Day of the Week (July 9-Oct. 25, 2020)



Note: Data exclusive to Tennessee Oncology; data provided by Tennessee Oncology October 2020; not previously published. ED = emergency department.

Analysis of these data showed several conclusive takeaways. First, there is a very distinct pattern associated with hospital and ED admissions (Figure 2, page 65). This pattern shows a prominent peak at the beginning of each work week with a drop-off through the middle of the week and a small peak at the end of the work week, ending with a massive drop on the weekend. This pattern was eye-opening when first discovered. Our assumption had always been that the bulk of our attributed ED and hospital admissions were on the weekends, when the office was closed. This analysis showed the exact opposite. Further analysis was done to show the correlation of the time of admission. Again, this result was the opposite of assumptions. Our assumption was that if admissions were during the work week, then they were happening in the evening and night times, when the clinic was closed. However, the analysis showed the opposite; the admissions were happening mostly between 8:00 am and 4:00 pm, when the clinics were open (Figure 3, below).

Additional analysis is ongoing to compare the incidence of triage calls to the incidence of patient admissions to see whether patients are calling our offices first or are going to the ED or hospital without calling.

Though we are still in the early phases of determining the best process and analyzing the data, we are hopeful to see in our next round of OCM reporting, as well as in our other value-based care key performance indicators, that we are making an impact on reducing hospital and ED utilization and thus reducing the overall healthcare costs of our patients. Additionally, as satisfaction survey data are available, we are confident that patient satisfaction scores will increase as ED and hospital utilization decrease.

Improving Comorbidity Management

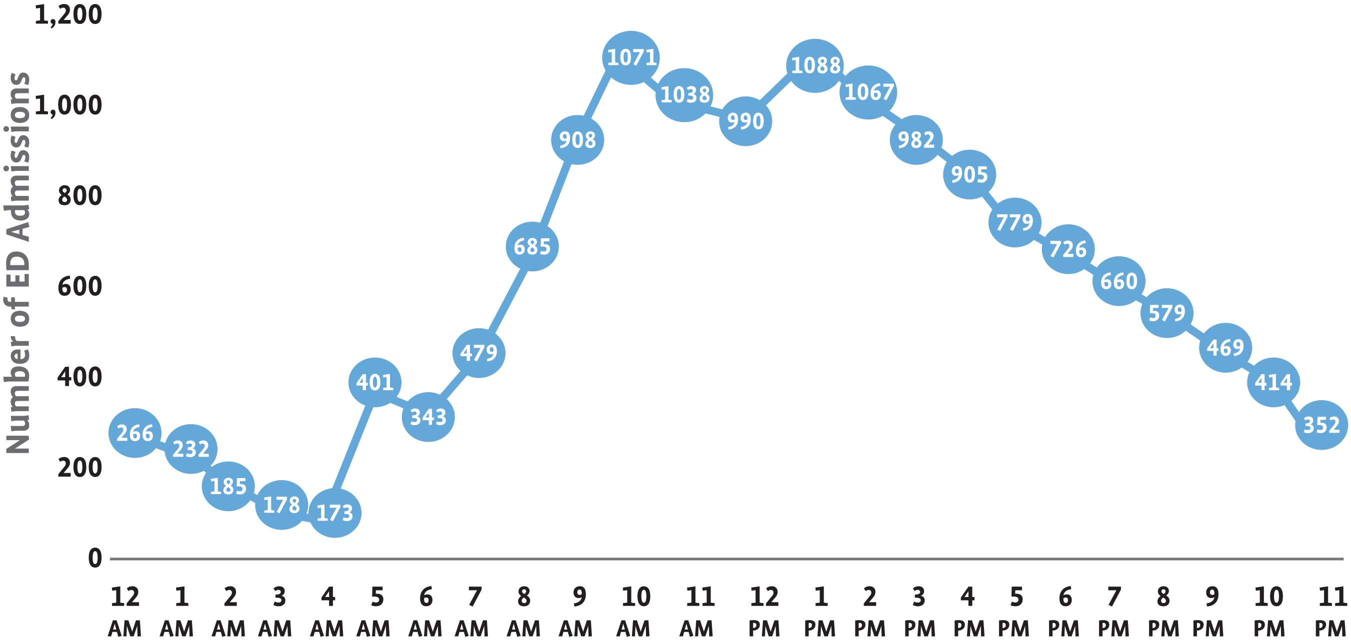
In addition to hospital and ED utilization, another specific area of focus for Tennessee Oncology is the costs associated with patient comorbidities. Analyzing our OCM data, we identified the top four comorbidities from a cost perspective:

1. Chronic obstructive pulmonary disease
2. Congestive heart failure
3. Diabetes mellitus
4. Pain.

For several reasons, these comorbidities, along with several others, proved challenging from an oncology care management standpoint. Sometimes providers are not always aware that patients have a comorbidity and, thus, it is not documented in the electronic health record (EHR)—potentially because patients are not always forthcoming when providing their medical history and/or providers do not routinely test for these conditions. Also, due to our providers' limited knowledge of these conditions, medical management of these conditions is typically referred to or left up to the patient's primary care provider or a designated specialist, if patients have one. Many primary care providers and/or specialists are overwhelmed by patient volume and are unable to see patients in a timely fashion. This situation has been particularly true during the COVID-19 pandemic.

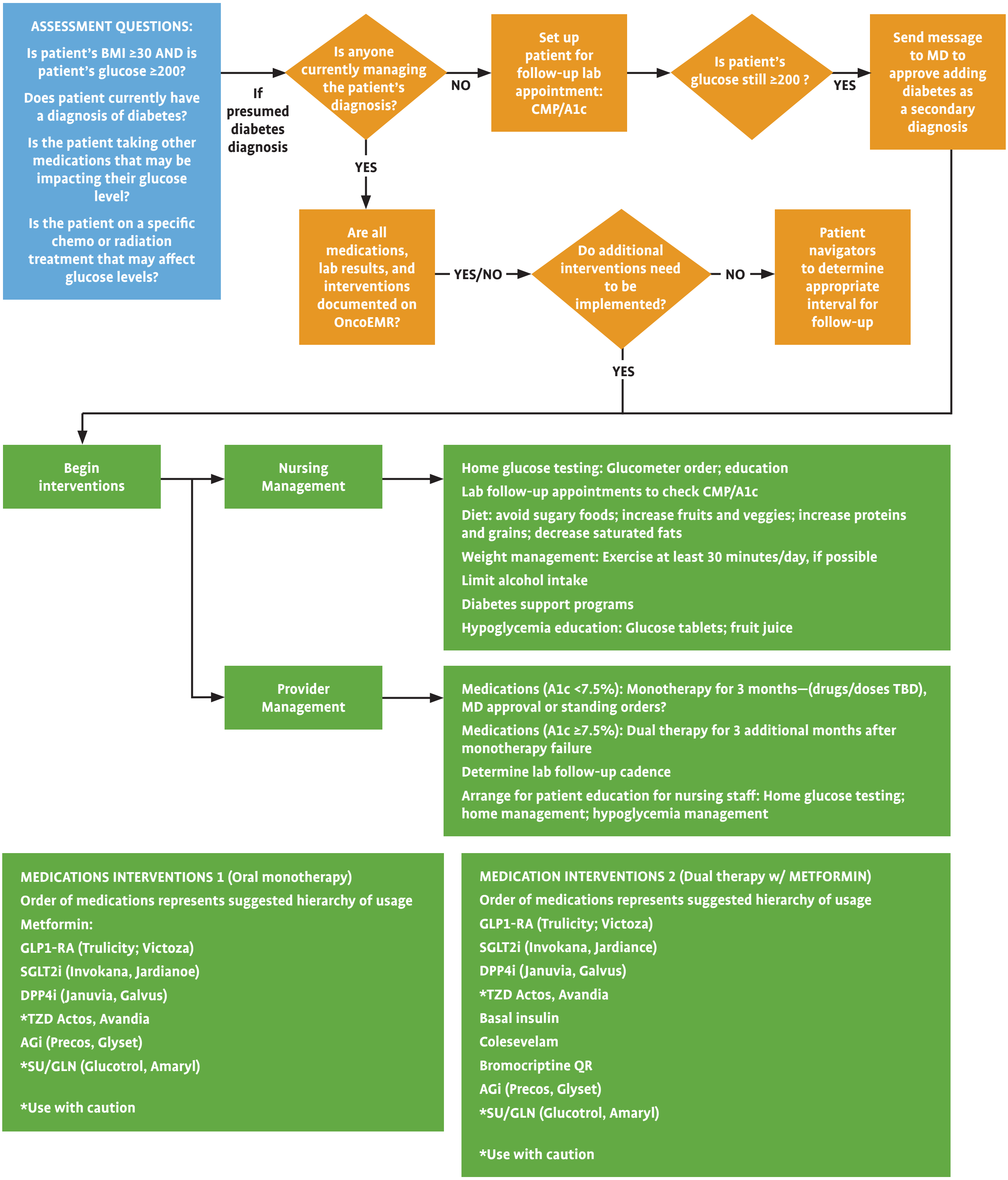
(continued on page 68)

Figure 3. ED Admissions Trendline by Time of Day (July 9-Oct. 25, 2020)



Note: Data exclusive to Tennessee Oncology; data provided by Tennessee Oncology October 2020; not previously published. ED = emergency department.

Figure 4. Diabetes as a Secondary Diagnosis to Cancer: Comorbidity Management Workflow



ASSESSMENT QUESTIONS:

Is patient's BMI ≥30 AND is patient's glucose ≥200?

Does patient currently have a diagnosis of diabetes?

Is the patient taking other medications that may be impacting their glucose level?

Is the patient on a specific chemo or radiation treatment that may affect glucose levels?

Nursing Management

- Home glucose testing: Glucometer order; education
- Lab follow-up appointments to check CMP/A1c
- Diet: avoid sugary foods; increase fruits and veggies; increase proteins and grains; decrease saturated fats
- Weight management: Exercise at least 30 minutes/day, if possible
- Limit alcohol intake
- Diabetes support programs
- Hypoglycemia education: Glucose tablets; fruit juice

Provider Management

- Medications (A1c <7.5%): Monotherapy for 3 months—(drugs/doses TBD), MD approval or standing orders?
- Medications (A1c ≥7.5%): Dual therapy for 3 additional months after monotherapy failure
- Determine lab follow-up cadence
- Arrange for patient education for nursing staff: Home glucose testing; home management; hypoglycemia management

MEDICATIONS INTERVENTIONS 1 (Oral monotherapy)

Order of medications represents suggested hierarchy of usage

Metformin:
GLP1-RA (Trulicity; Victoza)
SGLT2i (Invokana, Jardianoe)
DPP4i (Januvia, Galvus)
*TZD Actos, Avandia
AGi (Precos, Glyset)
*SU/GLN (Glucotrol, Amaryl)

*Use with caution

MEDICATION INTERVENTIONS 2 (Dual therapy w/ METFORMIN)

Order of medications represents suggested hierarchy of usage

GLP1-RA (Trulicity; Victoza)
SGLT2i (Invokana, Jardiance)
DPP4i (Januvia, Galvus)
*TZD Actos, Avandia
Basal insulin
Colesevelam
Bromocriptine QR
AGi (Precos, Glyset)
*SU/GLN (Glucotrol, Amaryl)

*Use with caution

Note: This decision workflow is the exclusive work and property of Tennessee Oncology (January 2020). Not previously published. CMP = comprehensive metabolic panel; TBD = to be determined.

(continued from page 66)

To reduce the time associated with the care management of our patients' comorbidities, as well as the cost of layering additional providers, our practice decided to take on routine management of these comorbidities. To do this, we are building decision algorithms for these four primary comorbidities, which will include clinical support staff pathways as well as provider pathways (see Figure 4, page 67). We are building our own pathways because we have found a surprising lack of resources on patient comorbidity management.

Additionally, we are improving our documentation of these comorbidities in our EHR in several ways. We are identifying secondary conditions that may be related to these comorbidities and documenting these in the EHR. For example, is a patient's blood sugar often high? If so, could we run an additional diagnostic, like an A1c to determine whether the patient has diabetes mellitus?

We are also abstracting physician notes to determine whether other conditions are mentioned in the notes but not documented in the EHR. We are data mining the patient's other provider information to determine whether they see a specialist that might be related to a comorbid condition, like an endocrinologist for diabetes mellitus. We are also pulling data on other lab values, medications, or other discrete fields that may give us insight into other conditions the patient may not have documented. For example, is the patient on a high-dose, frequent prescription for an opioid? If so, the patient may have a chronic pain diagnosis.

In addition to identification of the comorbid illnesses and the algorithms being developed for treatment of the comorbid illnesses, we are implementing a new workflow for patient treatment. If a patient presents to triage or submits a symptom-related questionnaire that identifies a symptom related to a comorbid illness and the patient has been identified in our system as having one of those four comorbid illnesses, the care coordinator or triage nurse will use the staff-level algorithm to care for the patient. If physician intervention is required, the provider will then follow the physician level of the care algorithm. These algorithms include home care for the nurses to relay, as well as prescription guidance for the providers. The algorithms also include appropriate follow-up management for the specific condition.

We will collect data throughout this pilot to compare our primary patient data with their documented comorbid diagnosis data. We will correlate those data with our historic OCM ED/hospitalization data, as well as our new real-time ED/hospital data, to determine whether our management has improved short-term outcomes for patients. We will also collect secondary data to identify improvement in other measurables, like blood sugar/A1c or reduction in pain medication dosage or frequency.

A Look Forward

It appears that healthcare is finally understanding the importance of data, particularly as they relate to patient outcomes. Access to the level of hospital data that we are now contracted to receive will allow Tennessee Oncology an unprecedented vision into ED and hospitalization patterns and allow us to address those findings—proactively and reactively. As we continue to analyze these data and develop models like risk stratification or disease-specific patterns, the goal is to proactively engage those patients with the necessary care management to reduce, or eliminate entirely, hospital or ED utilization.

By focusing on specific comorbidities that lead to increased ED and hospital visits and increased resource utilization, we hope to reduce healthcare costs. As Tennessee Oncology ventures into two-sided risk in the OCM pilot, the ability to wrap our arms around and control ED and hospital utilization as much as possible will be key to our value-based care success. More important, however, the primary key performance indicator that we will focus on to determine whether our efforts are successful is patient satisfaction. If we can decrease our costs, even slightly, but see a significant increase in patient satisfaction, because we are more attentive, more educated on patients' overall wellness, and more determined to keep them at home, then we will mark these efforts down as a win. OI

Larry E. Bilbrey is care data systems manager at Tennessee Oncology, Nashville, Tenn; Stephen M. Schleicher, MD, MBA, is medical director of Value Based Care at Tennessee Oncology, Nashville, Tenn and OneOncology, Nashville, Tenn; L. Johnetta Blakely, MD, MS, MMHC is executive director of Health Economics and Outcomes Research at Tennessee Oncology, Nashville, Tenn; Leah R. Owens, MSN, RN, is executive director of Care Transformation at Tennessee Oncology, Nashville, Tenn; Susan A. Frailley, MBA, LSSGB, is chief administrative officer at Tennessee Oncology, Nashville, Tenn; Garrett R. Young is director of Clinical and Strategic Analytics at OneOncology, Nashville, Tenn; and Natalie R. Dickson, MD, MMHC, FACP, is president and chief medical officer at Tennessee Oncology, Nashville, Tenn.

References

1. Aviki EM, Schleicher SM, Mullangi S, et al. Alternative payment and care-delivery models in oncology: a systematic review. *Cancer.* 2018;124(16):3293-3306.

2. Centers for Medicare & Medicaid Services. *Oncology Care Model.* Available online at: innovation.cms.gov/innovation-models/oncology-care. Last accessed February 10, 2021.

3. Aviki EM, Schleicher SM, Mullangi S. The Oncology Care Model and other value-based payment models in cancer care. *JAMA Oncol.* 2019;5(3):298-299.

4. Dickson NR, Bilbrey LE, Lesikar PE, et al. Use of a case management system to reduce the response time for symptom management calls in a high-volume practice. *J Oncol Pract.* 2016;12(10):851-854.

5. Lyss AJ, Supalla SN, Schleicher SM. The Oncology Care Model-why it works and why it could work better: accounting for novel therapies in value-based payment. *JAMA Oncol.* 2020;6(8):1161-1162.

6. Brooks GA, Li L, Uno H, et al. Acute hospital care is the chief driver of regional spending variation in Medicare patients with advanced cancer. *Health Aff.* 2014;33(10):1793-1800.

7. Dickson, NR, Bilbrey LE, Lesikar PE, et al. Use of a case management system to reduce response time for symptom management calls in a high-volume practice. *J. Oncol. Pract.* 2016;12(10):851-854.

6 STEPS
to IMPROVE CARE COORDINATION
for Lung Cancer Patients on Medicaid

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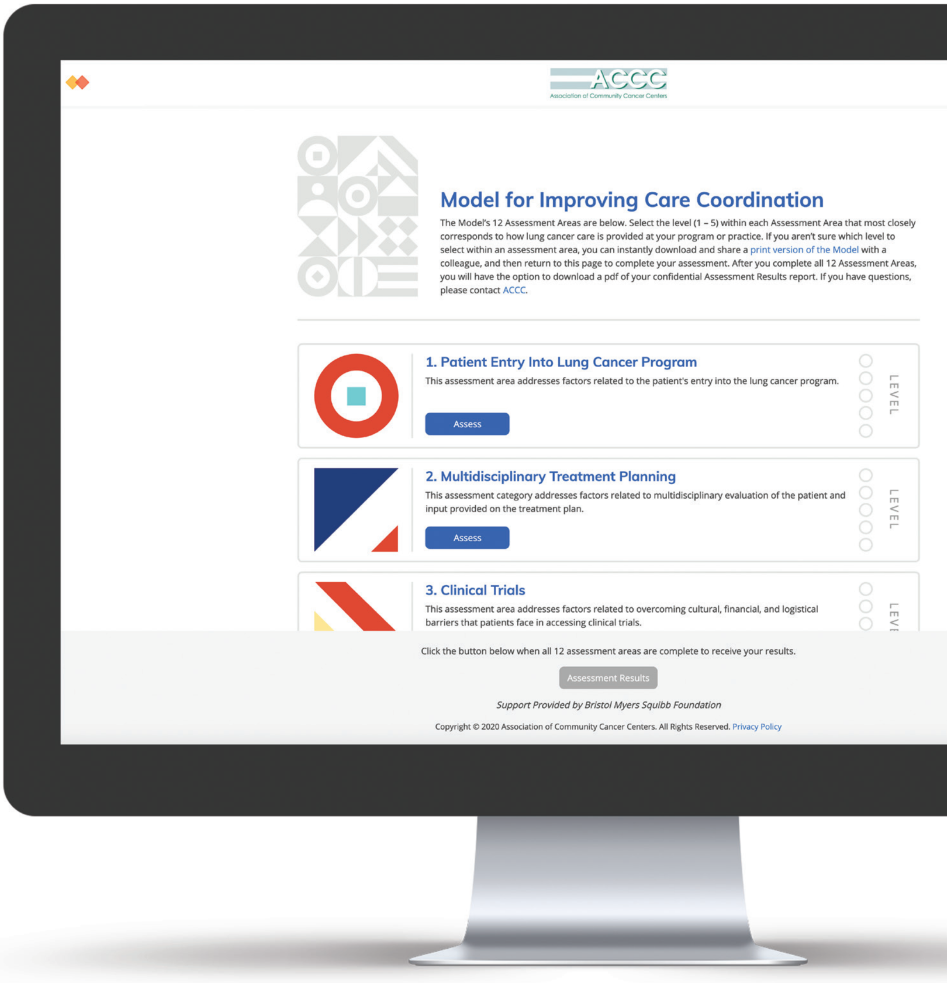

Model for Improving Care Coordination

The Model's 12 Assessment Areas are below. Select the level (1 – 5) within each Assessment Area that most closely corresponds to how lung cancer care is provided at your program or practice. If you aren't sure which level to select within an assessment area, you can instantly download and share a print version of the Model with a colleague, and then return to this page to complete your assessment. After you complete all 12 Assessment Areas, you will have the option to download a pdf of your confidential Assessment Results report. If you have questions, please contact ACCC.

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Q.
A.

BY BARBARA A. GABRIEL, MA

Reflections on a Career:

A Conversation with ASCO's Dr. Richard Schilsky

Richard L. Schilsky, MD, FACP, FSCT, FASCO, the former chief medical officer and executive vice president of the American Society of Clinical Oncology (ASCO), retired this year after a distinguished career in cancer care and research that has spanned more than 40 years. An expert in gastrointestinal cancers and new drug development, Dr. Schilsky's career bridged oncology's early wave of progressive treatments to today's era of precision medicine. Dr. Schilsky came to ASCO as chief medical officer in 2013, after spending nearly 30 years at the University of Chicago Medicine, where he served as the chief of hematology/oncology in the Department of Medicine and the deputy director of the University of Chicago Comprehensive Cancer Center. For 15 years, Dr. Schilsky also led the Cancer and Leukemia Group B, a National Cancer Institute-funded cancer research cooperative group. *Oncology Issues* sat down with Dr. Schilsky to look back on his career and look forward to future research breakthroughs in this era of COVID-19 and beyond.

OI. What are you most proud of when you look back at your career?

Dr. Schilsky. That's a tough question for someone with a 40+ year career. I am most proud of creating opportunities for other people to flourish in clinical research. I spent nearly 30 years on the faculty of the University of Chicago, where I taught scores of oncology fellows, many of whom have emerged as leaders in their fields. I take pride in their accomplishments and the contributions I have made to their successes.

> The biggest immediate impact of COVID-19 on clinical care has been the shift to telemedicine services...and many people feel that telemedicine is here to stay.

Throughout my career, I've been able to create mechanisms that have enabled other people to collaboratively pursue research opportunities. I spent another decade at the University of Chicago as the associate dean for clinical research. During that time, I was able to develop programs and infrastructure that provided the support faculty needed to carry out their work.

I also spent 15 years leading the Cancer and Leukemia Group B—a national cooperative group that is now part of The Alliance for Clinical Trials in Oncology—which brought together

> Like all great crises, the pandemic has created many changes and opportunities. How we carry forward the changes that we find to be positive will make a difference in cancer care and outcomes.

investigators from hundreds of institutions across the country. I was able to identify and bring together top researchers to work with one another in committees and programs that allowed them to bring their ideas to fruition. From that effort, we completed many clinical trials that have fundamentally changed cancer care by bringing new drugs to market and developing new treatment paradigms.

OI. Has the experience of the pandemic opened your eyes to any aspects of cancer care that you think need more attention?

Dr. Schilsky. ASCO looked into this quite a bit with our recently published report, *Road to Recovery* (see box, right).[1] In this report, we make recommendations about the future of cancer care and research beyond the pandemic. Through the work that went into developing this report, we made a number of recommendations about how some of the changes that were necessary in the wake of the pandemic could be carried forward to make cancer care more efficient and accessible. In clinical medicine and research, a lot of the things we've done by tradition do not have to be done that way. We've been forced to make changes as a result of the pandemic, many of which can be retained going forward.

For example, we can design clinical trials that are simpler and easier on patients. We recognize trials can be conducted in combination with a patient's routine care, so many patients do not need to travel to a research site to participate. This can make clinical trials more available to more people.

The biggest immediate impact of COVID-19 on clinical care has been the shift to telemedicine services. This brought some vulnerable patient populations into contact with the healthcare system out of necessity. Many people feel that telemedicine is here to stay. If that's true, we need to determine where its limitations exist. You can't fully examine someone through a video call—you can miss subtle things that way. Doctors can detect important clues as to how a patient is doing by glancing at that patient's posture, demeanor, and expression.

But there are some real advantages to telemedicine. It has the ability to bring more family members into a patient's treatment. There are lots of other people who may be interested in how a patient is doing, but it has not been practical to bring all those people physically together. It's also easier to bring in translators for non-English speakers, since family members who speak English can be on the call to translate.

Many patients with cancer receive long-term care for follow up on treatments they have finished. For many of them, it is not necessary to be seen in person, so telemedicine might work well. The pandemic has been very disruptive, and we still have much to learn about how that disruption will impact patient treatment and outcomes.

OI. What is the status of the cancer registry that ASCO launched last summer?

Dr. Schilsky. More than 2,500 patients have been enrolled in the ASCO Survey on COVID-19 in Oncology Registry[2] thus far, and ACCC has been a fantastic partner in recruiting practices to participate. The information is already allowing us to follow the care of patients with cancer whose treatment has been disrupted or otherwise affected by the pandemic. If a patient's treatment regimen has been postponed, will that affect outcomes? If treatments are modified in response to limitations brought on by the pandemic, are there long-term implications? Like all great crises, the pandemic has created many changes and opportunities. How we carry forward the changes that we find to be positive will make a difference in cancer care.

Providers are continuing to enroll their patients into the database, and we intend to keep it open indefinitely. Our immediate goal was to identify the patients who were having their care disrupted by COVID-19. We are able to track those patients longitudinally, and we will follow patients as they are vaccinated and track their long-term symptoms.

Thus far, we've been able to make some preliminary observations about these patients as a group. The majority of the patients in the registry—72 percent—are overweight or obese. There is an over-representation in these patients of B-cell malignancies—such as multiple myeloma, non-Hodgkin's lymphoma, and chronic lymphocytic leukemia—which are not as common as other cancers but represent a high proportion of patients with COVID-19 and a cancer diagnosis. These patients are very susceptible to COVID infection, and they have the highest mortality rates. In looking at the symptoms of COVID-19 these patients present with, we've found that nine percent report a loss of taste or smell.

We are currently collecting these observations and compiling a formal manuscript for publication. I strongly encourage ACCC members who are not yet participating in this registry to enroll their patients today at: redcap.asco.org/surveys/?s=K4RA99XHPF. There are no costs associated with it for participating providers. Registering patients is a simple process.

Thanks to support from Conquer Cancer® and the ASCO Foundation, ASCO is now providing payments (both for start-up and for each patient entered) to help cover expenses involved in participating.

OI. In July 2020, ASCO and ACCC announced another joint initiative designed to identify and implement novel strategies and practical solutions to increase the clinical trial participation of racial and ethnic minority populations who continue to be under-represented in cancer research. What is it about this specific effort that you believe can address this ongoing problem?

Dr. Schilsky. We have really committed leadership to this project with ASCO's president, Dr. Lori Pierce, and ACCC's immediate past president, Dr. Randall Oyer. Both ASCO and ACCC are fully behind this, and we have staff working hard to make this project successful. We have appointed a steering committee composed of leaders who have successfully tackled this problem before.

We have an opportunity through this partnership with ACCC to make a difference. We understand that it is crucial for all patients with cancer to have access to clinical rials. To the extent to which we do not have adequate representation of all people in clinical research, we are limited in how much we can apply the results of our trials to the people who need treatment. This is going to be a long haul—you don't solve a problem like this quickly. But I think that the experts we have assembled with these particular leaders, supported by the dedicated staff of ASCO and ACCC, have as good a chance as anyone to take on this challenge and make meaningful improvements in enrollment of minority populations.

OI. Adequately monitoring and caring for patients who have finished their cancer treatment is getting more difficult as new therapies continue to lengthen patients' lives. Why is providing survivorship care proving to be so difficult?

Dr. Schilsky. There is a significant lack of information exchange between oncologists and primary care physicians (PCPs) when a patient is transferred to a primary care provider after completing cancer treatment. Many patients with cancer want to retain ties with their oncologists; it is important to their emotional and physical well-being to do so. Oncologists want that as well. The problem is that there are too many patients and too few physicians. Oncologists have limited time available, and they need to devote their time and effort to their patients in active treatment. So there needs to be an effective handoff of these patients to their PCPs, and several survivorship care plans[3] have been created for that purpose.

Primary care doctors know that patients who have completed cancer therapy regimens are at risk and in danger of relapse; that they may develop long-term side effects. Monitoring for these things is a lot to put on the shoulders of PCPs with high patient loads.

So ASCO invited leaders representing primary care physicians to talk through these issues. The message we heard was, "Just tell us what to do, and we'll do it." Survivorship care plans have not been as successful as we had hoped; they have incorporated too much detail and not enough direction. We want to improve current care plans so we can get to the point at which we clearly communicate to PCPs what they can do for patients and then enable them to do it. This is what happens when there is good information exchange, but our fragmented healthcare system does not always allow for that. OI

Barbara Gabriel, MA, is associate editor, Oncology Issues.

References

1. Pennell NA, Dillmon M, Levit LA, et al. American Society of Clinical Oncology road to recovery report: learning from the COVID-19 experience to improve clinical research and cancer care. *J Clin Oncol*. 39(2):155-169.

2. American Society of Clinical Oncology. ASCO Survey on COVID-19 in *Oncology Registry*. Available online at: asco.org/asco-coronavirus-information/coronavirus-registry. Last accessed February 24, 2021.

3. American Society of Clinical Oncology. Survivorship care planning tools. Available online at: asco.org/practice-policy/cancer-care-initiatives/prevention-survivorship/survivorship-compendium. Last accessed February 24, 2021.

Road to Recovery Report

In January 2021, ASCO published its report, *Road to Recovery: Learning from the COVID-19 Experience to Improve Clinical Research and Cancer Care*, with the aim of learning from the experiences of the pandemic to make patient care and research more accessible and equitable. The report presents ASCO's evaluation of the adaptations in care delivery, research operations, and regulatory oversight made in response to the coronavirus pandemic and presents recommendations for moving forward as the pandemic recedes. ASCO organized its recommendations for clinical research around five goals to ensure that lessons learned from the COVID-19 experience are used to craft a more equitable, accessible, and efficient clinical research system that protects patient safety, ensures scientific integrity, and maintains data quality. The specific goals are to:

- Ensure that clinical research is accessible, affordable, and equitable.
- Design more pragmatic and efficient clinical trials.
- Minimize administrative and regulatory burdens on research sites.
- Recruit, retain, and support a well-trained clinical research workforce.
- Promote appropriate oversight and review of clinical trial conduct and results.

ASCO Registry

Last year, Dr. Schilsky led the creation of the ASCO Survey on COVID-19 and Oncology Registry (ASCO Registry), which aims to help the cancer care community learn more about the patterns of symptoms and the severity of COVID-19 among patients with cancer. The ASCO Registry is designed to collect both baseline and follow-up data on how the virus impacts cancer care and oncology patient outcomes during the COVID-19 pandemic. The registry data are updated weekly to help inform treatment approaches for patients with cancer who have a confirmed COVID-19 infection.

Community Oncology Can Close the Gap in Cancer Research

BY AMANDA PATTON, MA

The research program at Lahey Health Cancer Institute

Resources, information, and tools developed as part of the Association of Community Cancer Center's 2020-2021 President's Theme, "Community Oncology Can Close the Gap in Cancer Research," have highlighted practical steps for increasing community engagement (both provider and patient) in cancer clinical trials.

One of the ways in which community oncology is helping to close gaps in cancer research is through participation in the National Cancer Institute Community Oncology Research Program (NCORP) clinical trials. These National Cancer Institute (NCI)-supported multi-site clinical trials—most often phase III studies—are available in the areas of cancer control, prevention, and care delivery.

The NCORP network makes clinical trials available through a hub-and-spoke structure. Seven NCORP research bases serve as hubs for clinical trial development and research coordination for NCORP studies. Radiating out from these hubs are the nearly 50 NCORP community sites (32 community sites and 14 minority/underserved community sites), around which cluster "mini-networks" of local community cancer programs and oncology practices that affiliate to participate in NCORP trials. The mini-networks branching from NCORP community sites range from small (15 affiliated cancer programs and/or practices) to large (100 or more affiliates and sub-affiliates at one site).

Of the seven NCORP research bases, five are associated with the oncology cooperative groups (Alliance for Clinical Trials in Oncology, COG, ECOG-ACRIN, NRG Oncology, SWOG) and two are located at cancer centers (Wake Forest Baptist Comprehensive Cancer Center and University of Rochester Wilmot Cancer Center). The latter two research bases focus exclusively on NCORP studies related to improving symptom management, survivorship, and quality of life and do not lead cancer treatment trials.

Other community hospitals not affiliated with an NCORP network have successfully launched cancer clinical trial programs through a partnership with allied academic centers. One example is the community network within the Lahey Health Cancer Institute.

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The Lahey Health Cancer Institute Experience

Lahey Hospital & Medical Center has a long history of participation in clinical research. The Lahey Health Cancer Institute, a part of the Beth Israel Lahey Health System, continues to expand access to clinical trials and, in particular, the NCI National Clinical Trials Network into the community by partnering with affiliated community hospitals. In 2018 and 2019 Lahey Hospital & Medical Center received the National Cancer Institute's National Clinical Trials Network (NCTN) High Performing Site Initiative award, which recognized trial sites that enrolled large numbers of patients onto NCTN trials while maintaining excellence in trial data quality.

For insight on what it takes for an academic center and an affiliated community cancer program to partner successfully to increase clinical trial access in the community, *Oncology Issues* reached out to Lahey Health Cancer Institute. Sharing perspectives are Paul J. Hesketh, MD, FASCO; Corrine Zarwan, MD; and Julia Roache. Dr. Hesketh is director of the Lahey Health Cancer Institute, director of the Sophia Gordon Cancer Center, and director of Thoracic Oncology at Lahey Hospital & Medical Center and a professor of medicine at Tufts University School of Medicine. He serves as a member of the Executive Leadership Group of the SWOG Lung Committee and chairs a subcommittee focused on community provider engagement. Corrine Zarwan, MD, is interim chair, Division of Hematology Oncology, and associate director and clinical research director of Lahey Health Cancer Institute. Julia Roache has 17 years of experience with Lahey. She is senior research associate and team lead, Hematology and Oncology, Lahey Hospital & Medical Center.

"If we are really going to increase the proportion of patients with cancer that get onto clinical trials, we need to figure out a way to successfully reach out to the sites of care where they are receiving treatment, which for the majority is in the community," said Dr. Hesketh. "This is something that we feel very passionate about at Lahey. It is something that SWOG has been very committed to as well." Dr. Hesketh recommends that community sites answer these four questions in advance of considering opening a clinical research program:

1. *What are our community's cancer research needs?* Does your program see a sufficient volume of patients in disease sites for which NCTN or NCORP trials are available?
2. *Do we have a physician champion(s) and physician buy-in?* Do the providers in your community view the capacity to offer clinical trials locally as an important initiative? Are they interested in participating in research? "It's not going to work in any setting if you don't have provider buy-in," Dr. Hesketh said.
3. *Do we have administration support?* How will your site manage trial activation, patient recruitment, and trial execution? At a minimum, the remote site needs to have administration support to staff a local, on-site clinical research associate position—either full- or part-time. There must be some infrastructure commitment from the community site, which is then supported by the central infrastructure at the main site. Dr. Hesketh attributes Lahey Health Cancer Institute's success in helping affiliates launch or expand their research programs to this two-way commitment. "At Lahey we have the resources in terms of nurses and senior clinical research coordinators to provide support to our affiliated community research sites," he said.
4. *What studies should be activated?* Community sites must make a realistic assessment of studies that will be the "right fit" for their cancer program. "You have to decide how complex a study you can do," said Dr. Hesketh. "For some sites, even some of the cooperative group trials may be too complex. And you have to decide whether the trial matches your patient population. There are certain diseases that you may see disproportionately more commonly than others, and those should be the ones you concentrate on in terms of activating the studies."


Dr. Paul J. Hesketh


Dr. Corrine Zarwan


Julia Roache

NCI NCTN group trials are "ideally designed" to be conducted in the community, said Dr. Hesketh. "Lahey is member of two NCTN groups: SWOG and NRG. I think the NCTN studies have been set up, in a way, to maximize community-based participation by, if possible, limiting some of the complex issues that can at times make the pharmaceutical trials so challenging to do."

Lahey Health Cancer Institute Director of Research Dr. Corrine Zarwan agrees that "must-haves" for affiliated programs to succeed are institutional commitment and willingness to provide resource(s) toward the program.

As an example, Dr. Zarwan describes how Lahey and Winchester Hospital, an affiliated community facility in Winchester, Mass., worked collaboratively to launch Winchester's first cancer clinical trials program. Winchester's cancer program had engaged physicians eager to offer clinical trials to their patients close to home and administration provided support for a clinical research coordinator (CRC) position. What the site did not have was experience in starting a clinical trials program. "Once Winchester Hospital had secured administration support for that resource [the CRC position], they came to us to help build the program." Beverly Hospital, another affiliated site, had an existing clinical trials program staffed by a part-time research nurse, and Lahey was also able to extend administrative and regulatory support for this site. "I do find that is the key," Zarwan said. "A model for a smaller community hospital is to pair with a larger academic center. What works and has worked for us at our successful sites is having a dedicated resource on the ground locally, and having that staff trained at the academic center and working very collaboratively with the academic center."

The community-site CRC position may not require a full-time equivalent; for smaller community cancer programs this staff member may have the bandwidth to manage additional duties. Without this local on-site staff, however, logistical and coordination challenges are likely. For example, the academic site "would have to send someone to [the remote site] repeatedly to handle research specimens," Dr. Zarwan said. "You really need a person who is physically there, primarily working out of that site, to handle the day-to-day patient management issues, and then we can help with the regulatory piece."

Measuring Success

In collaborating with community sites to expand clinical trial access, Lahey Health Cancer Institute's main measure of success is patient accrual. "We want to make sure that all of our sites are actively accruing patients," said Dr. Zarwan. This shows that the right trials are open, that providers are engaged, and that effective screening processes are in place to identify eligible patients. As director of research, Dr. Zarwan monitors accrual for all open trial disease sites on at least a quarterly basis. "If any of the community sites have not enrolled during that time period, we investigate further as to what the reasons might be. Do we not have enough trials open? What barriers might there be?"

Attention to physician engagement is another factor critical to the success of affiliate-site research programs. Lahey Health Cancer Institute uses two main tools to keep providers connected: a monthly e-newsletter and consistently incorporating relevant studies into the agendas for regularly scheduled meetings. Dr. Zarwan personally maintains the email list for the research e-newsletter. When highlighted studies involve disciplines outside of oncology, she ensures that those specialists receive the pertinent e-newsletter. "If it's a urology study, for example, I'll make sure to add additional urologists onto that newsletter," she said, "but they wouldn't receive it every month." The research e-newsletter goes to the Lahey Health Cancer Institute research sites but also to additional Beth Israel Lahey Health sites. Each issue highlights a specific trial, lists up-and-coming studies, and includes links to all Lahey Health Cancer Institute open trials along with the email address of the clinical research associate who is responsible for the study.

Community physicians are kept informed about clinical trials at various Lahey and system-wide meetings. At Lahey Health Cancer Institute, system-wide disease site-specific multidisciplinary model of care meetings are held each quarter. "As part of the meeting agenda, we try to include a focus on research, highlight specific trials, and provide a list of available trials," said Dr. Zarwan. "For example, in the breast team quarterly meeting, I will usually present on breast cancer trials, often with a focus on the studies that are more pertinent for the broader group in terms of the community centers … the studies that I think will be easier for them [community sites] to accrue to or interesting studies that I encourage them [community sites] to refer to us if it is a particularly exciting trial."

Supporting Research Staff

Lahey Health Cancer Institute's model—a local clinical research coordinator on the ground at the community site with ongoing support from the larger research program—is one that has proven effective and replicable. The level of support provided to the remote clinical research coordinators is an important component. "Every other week, I meet with our research team and this includes the research associates from the other hospitals," said Dr. Zarwan. "They attend our local research meeting, and we get updates on their program. They learn a lot from continuing to meet with their colleagues locally and are able to bring issues forward, and I get to hear if there are any provider-related issues so that I can follow up and support them."

For instance, research associates may sometimes struggle to get an email response from busy providers and are hesitant to "nag." "We have a policy that if they haven't gotten a response after two attempts, they can include me on the correspondence," said Dr. Zarwan. "That usually gets it done. I don't have a problem tapping the person on the shoulder virtually or in person and saying can you please take care of this now. It's a way for research staff to have somebody to hear their concerns on a regular basis."

Two-Way Communication

Affiliate sites that have worked with Lahey Health Cancer Institute to initiate or expand clinical trials in their communities also benefit from ongoing education and resources through Lahey's oncology cooperative groups, SWOG and NRG. Providers at the affiliate sites are encouraged to attend cooperative group meetings, where newly opening trials are discussed. "We do have engaged physicians at these sites that have requested that we consider opening trials and we've done that," said Dr. Zarwan.

Achieving Excellence in Data Collection

Julia Roache is senior clinical research associate and team lead in the clinical trials research program at Lahey Health Cancer Institute. She heads a team of five clinical research coordinators who manage patients through the clinical trial cycle—from the point at which the patient consents through the end of the trial (or to the point at which the patient comes off treatment). "We make sure the consent forms are correct, that they've [patients] gotten all the tests that are required per the protocol, and that we have the information to ensure everything is done correctly

Lahey Hospital and Medical Center

Beverly Hospital

Winchester Hospital

for the trial," said Roache. "We ensure that every test is ordered and that the patient is booked for the appropriate appointments, and we coordinate with our research nurses as well."

In addition to Roache and five CRCs, the Lahey Health Cancer Institute's dedicated research staff includes two regulatory coordinators, one of whom also serves as an administrative assistant. Two research nurses are assigned to see on-trial patients but are not dedicated full-time to cancer clinical trials.

The CRCs are typically assigned to specific disease sites. So, for example, one CRC will manage only on-study patients with breast and gynecological cancers. This approach enables the CRC to become knowledgeable about the active trials for their assigned disease sites and to become acquainted with the specialist clinicians who care for these patient populations. This policy also streamlines communication between physicians and the research coordinators.

The CRCs coordinate the patient screening for and enrollment into the clinical trial. At Lahey Health Cancer Institute, identifying patients who may be eligible for trial participation is a cooperative effort. As time permits, each week the CRCs scan the physicians' schedules for any new patients or any incoming patients who fit trial eligibility criteria but, still, "a lot of the time, it's the physicians finding these patients for us," said Roache.

Research is further embedded into routine practice at Lahey Health Cancer Institute during regularly scheduled tumor boards. In advance of the disease site conference, the CRCs provide lists of currently available disease-specific protocols so that the conference participants have information at hand. The CRCs also attend the tumor board conferences for their assigned disease sites.

High-Quality Data Collection

As mentioned previously, in 2018 and 2019 Lahey Hospital & Medical Center received NCI's NCTN High Performing Site Initiative award, which recognized trial sites that enrolled large numbers of patients into NCTN trials while maintaining excellence in trial data quality. Close collaboration and communication between the research nurses and the CRCs are the key to this achievement.

Roache explained: "We have a 'start-up' phase when we're opening a new trial. During that phase, our research nurses will work with the clinical research coordinators to go through all the data that needs to be collected for the entire length of the study. Our research nurses will then go through in advance and create a template for each visit of the study. For each visit, the nurses have a set of forms to capture the required data and collect the data points that the study needs. When the nurses see the patient at the study visit, they will capture all the information that the study is asking. I think that's a huge part of being able to enter the data correctly and get all the information that the study requires—the research nurses asking the appropriate study required questions." With the requisite data collected in the progress notes, the CRCs can easily capture it. "The research nurses make our job easy."

Pre-COVID-19, the CRCs and regulatory staff were co-located at Lahey Hospital & Medical Center. This proximity helped facilitate team communication, Roache said. However, the COVID-19 public health emergency required some work site changes as staff switched to remote work on specific weekdays.

On-Boarding and Training CRCs

When new clinical research coordinators join the team, they go through a well-developed on-boarding program. Experienced CRCs at Lahey Health Cancer Institute manage, on average, between 15 and 20 studies. During the on-boarding process, a new CRC may be assigned just a few trials to start. "Or we'll have the new staff shadow an experienced coordinator who may have taken on an extra trial while we were waiting for the new employee," explained Roache. "When the new staff arrives, we'll have them shadow that CRC for a few days or a few weeks. It just depends on how complicated the study is. We all really work as a team and if anybody has questions, it's a great, very open team environment."

This on-boarding process is extended to community sites partnering with Lahey Health Cancer Institute for clinical research, Roache said. For example, the team at Lahey supported the recruitment and training for the newly created CRC position at Winchester Hospital. "Because we knew what they were looking for, we were able to help them hire the coordinator," said Roache. Once this new staff was hired, "she actually spent some time working at our site to see the research patients and see how the data gets entered. She spent several weeks with us. It was a great training experience, and she actually helped us with some of the data collection." Going forward, the team at Lahey would handle the clinical trial administrative and regulatory tasks for the Winchester Hospital cancer clinical trials program. A further significant benefit for Winchester's fledgling research program was the ability to use Lahey's institutional review board.

"This is a huge advantage for smaller hospitals," said Roache. Winchester Hospital's cancer program now had the opportunity to open any of the trials that Lahey opens through the NCTN oncology cooperative groups SWOG and NRG, and providers at the affiliate hospital can also become members of these cooperative groups.

Each of the cooperative groups offers training programs for clinical research coordinators and clinical trial nurses. Additional training opportunities are available for physicians and allied research staff. "When new coordinators on-board, I have them complete those trainings as well. Our research administration department also provides training on the conduct of clinical trials that everyone involved in research is required to complete, including the study investigators." CRCs at Lahey are also required to complete a Collaborative Institutional Training Initiative (CITI) human protections course. Education is an ongoing process, Roache said.

Cancer programs looking to grow or strengthen their research programs often want to know the attributes needed for a successful CRC. "It takes a very type-A person to do this job," said Roache. "There are many little details and things you need to keep track of. You really have to be organized. It means finding that right person that's going to read every line of that protocol to make sure they didn't miss something."

Infusion center at the Sophia Gordon Cancer Center

In addition to skilled CRCs, the team at Lahey Health Cancer Institute offers these takeaways for success in partnering to offer clinical trials in the community setting. Clinicians at the community sites need to:

- Have a clear understanding of the clinical trial process. Be responsive to the study staff when they have queries.
- Be willing to follow the schedule of assessments and dose modifications within the protocols.
- Make an effort to be very familiar with the studies open at their sites.
- Have access to updates when there are amendments to the protocols.

Finally, a physician leader should oversee this process and be available to step in when procedures are not followed or staff do not respond to the research team. OI

Amanda Patton, MA, is a freelance healthcare writer. She worked as a senior writer and editor for the Association of Community Cancer Centers for more than 15 years.

Beth Israel Lahey Health At-a-Glance

In 2012 Lahey Clinic Medical Center in Burlington, Mass., merged with Northeast Health System to form Lahey Health. Seven years later, in 2019, Beth Israel Deaconess Medical Center, its affiliated community hospitals, three additional previously independent hospitals, and Lahey Health merged to form Beth Israel Lahey Health, the state's second largest health system. Within the Beth Israel Lahey Health network are three academic teaching hospitals that have affiliations with Harvard Medical School and Tufts University School of Medicine, eight community hospitals, specialty hospitals for orthopedics and behavioral health, and ambulatory and urgent care centers. The health system serves 1.3 million patients in eastern Massachusetts.

An Optimal Care Coordination Model for Medicaid Patients with Lung Cancer:

Results from Beta Model Testing

BY MATTHEW P. SMELTZER, PHD, MSTAT; LEIGH M. BOEHMER, PHARMD, BCOP;
AMANDA KRAMAR; THOMAS M. ASFELDT, MBA, RN, BAN; NICHOLAS R. FARIS, MDIV;
CHRISTINE F. AMOROSI, RN, MHSA, MSN, AGNP; MEREDITH A. RAY, PHD, MPH;
VIKKI G. NOLAN, DSC, MPH; RANDALL A. OYER, MD; CHRISTOPHER S. LATHAN, MD, MS, MPH;
AND RAYMOND U. OSAROGIAGBON, MBBS, FACP

Lung cancer continues to be the leading cause of cancer mortality in the United States, with an estimated 142,670 deaths in 2019.[1] Gaps in the quality of care remain in many areas, contributing to the suboptimal outcomes.[2-6] A key component of high-quality cancer care delivery systems is an adequately staffed and well-coordinated multidisciplinary team to support the delivery of evidence-based, patient-centered care that is accessible and affordable to all.[7]

In 2016, the Association of Community Cancer Centers (ACCC) initiated a three-year multiphase project to develop an Optimal Care Coordination Model (OCCM) for Medicaid patients with lung cancer that would help assess and strengthen care delivery systems by facilitating and expanding access to multidisciplinary coordinated care. The rationale for and development of the OCCM (i.e., Phase I) are described in a companion publication.[8] The target population was Medicaid patients diagnosed with lung cancer. These patients often have less favorable outcomes than non-Medicaid patients, such as significantly lower median overall survival, which may be attributable to the prevailing social determinants of health, including socio-economic disparities between these groups.[5,9-11]

OCCM design was adapted from the multidisciplinary care assessment tool of the National Cancer Institute Community Cancer Centers Program.[12] The OCCM beta framework comprised 13 independent care delivery areas and spanned elements from patient access to care to supportive care and survivorship. This framework allows cancer programs to identify locally relevant barriers to access and use of care, with a focus on Medicaid patients, and therefore enables optimal care coordination. The primary aim of beta testing was to understand how cancer programs utilize the OCCM to improve their lung cancer care delivery systems, especially for Medicaid patients. In addition, it was important to ensure that the Model could offer practical and easy-to-use guidance to cancer programs interested in advancing multidisciplinary coordinated care for Medicaid patients with lung cancer.

Testing Sites

Phase II of the initiative included a request for applications, open to most ACCC Cancer Program Members in the United States, and the subsequent selection of testing sites between

March 2017 and June 2017. Selection criteria allowed for adequate representation of cancer programs (rural/urban, private practice/hospital-based, and across U.S. geographic regions). ACCC Cancer Program Members in eight U.S. states (Alabama, Georgia, Kentucky, Mississippi, North Carolina, Tennessee, South Carolina, and West Virginia) were excluded from participation under the terms of the grant to avoid overlap with a separate initiative funded by the same foundation.

As part of the application process and the first step in using the beta OCCM, testing sites conducted initial program self-assessments to identify baseline and anticipated target levels of OCCM assessment areas using ranking levels from 1 (fragmented care) to 5 (optimal care coordination with a patient-centered focus). Use of quantitative metrics, where available, was encouraged to support these baseline assessments. Sites received feedback on the assessments, developed quality improvement (QI) projects for their Medicaid patient populations using at least 1 of the 13 OCCM assessment areas (Figure 1, right), and identified their ranking goals for the 12-month performance period (e.g., moving from Level 2 to Level 4 for a specific assessment area).

Support during the project period included two on-site meetings with clinical consultants (fall 2017 and summer/fall 2018) and biweekly calls between the ACCC QI team and testing site staff. The ACCC QI team comprised lung cancer and health services researchers, including one medical oncologist, two epidemiologists, one biostatistician, one hospital administrator, one QI/qualitative researcher, two program coordinators, and two graduate assistants with public health training. This team had oversight from the project's Advisory Committee and Technical Expert Panel, comprising experts in medical oncology, disparities research, and community outreach (Table 1, page 84).

OCCM Beta Testing

Phase III involved beta OCCM testing through the implementation of QI projects from October 2017 to September 2018. A mixed-methods approach was used to understand how testing sites applied the beta OCCM, using at least 1 of the 13 OCCM assessment areas. Quantitative data on patient demographics, baseline disease and care pathway characteristics, and established, measurable quality benchmarks specific to each OCCM assessment area (e.g., "adult current smoking prevalence" as part of tobacco cessation) were collected. We established a centralized Data Coordinating Center at the University of Memphis School of Public Health, managing data from each testing site using Research Electronic Data Capture (REDCap®).[13,14] REDCap is a secure, web-based software platform designed to support data capture for research studies. Data were analyzed at the Data Coordinating Center using SAS® version 9.4 (Cary, N.C.).[15]

Qualitative information on successes, challenges, key transferable lessons, and sustainability plans for the OCCM was collected via site-specific quarterly progress reports to complement quantitative findings. These reports were reviewed manually to extract emerging themes using inductive reasoning. Each testing site submitted a signed attestation confirming that their institutional review board determined that the OCCM project was designated as exempt.

Statistical Analysis

Data were collected for four payer groups, namely, Medicaid, Medicare, commercial, and other (i.e., military insurance, none, or self-pay). Patients who were "dual-eligible" for Medicaid and Medicare were evaluated as a separate group in some analyses. Summary statistics were computed, with continuous data reported as mean ± standard deviation or median (first quartile, third quartile) and categorical data reported as frequency (percentage). Associations between categorical variables were compared using chi-square or Fisher's exact tests (expected cell counts less than five). Continuous outcomes were compared across payer groups using analysis of variance, t-test, the Wilcoxon-Mann-Whitney test, or the Kruskal-Wallis test. Statistical significance was assessed at an alpha level of 0.05, with no adjustments for multiple comparisons.[16]

Results

In July 2017, seven community-based cancer programs in six states across the United States were selected as testing sites. A total of 926 patients were enrolled; 27.8 percent ($n = 257$) had Medicaid insurance or dual eligibility and 72.2 percent ($n = 669$) had non-Medicaid insurance. Sites conducted self-assessments of at least 1 of the 13 OCCM assessment areas, supported by evidence-based, measurable quality metrics, to identify the current level of care coordination and a corresponding target level (achievable or aspirational) to facilitate improvements over the implementation period. Each assessment area was mapped to established quality measures, and some testing sites worked with the ACCC QI team to develop internal measures.

The preparedness of the sites had implications for the subsequent implementation of QI projects. Our qualitative needs assessment identified operational challenges, including:

- Decentralized research leadership structures
- Changes in leadership and supporting roles
- Lack of or limited patient navigation services to assess barriers and needs
- Timing of patient recruitment for a targeted intervention in relation to the cancer care continuum
- Inadequate and transient staff resources to implement project work
- Lack of formalized plans for transitioning project tasks to new staff
- Limited availability of existing data sources or the need for further data collection efforts as part of OCCM quality metrics reporting.

Across the seven testing sites, 8 of 13 OCCM assessment areas were selected for QI projects (Figure 1, below).

(continued on page 90)

> Site participation in beta testing appeared beneficial to both cancer programs and the patient populations they serve. Key successes were enhanced collaboration and improved lung cancer programming, such as patient navigation services, that may address low rates of psychosocial distress screening.

Figure 1. OCCM Assessment Areas Selected by Testing Sites for QI Projects

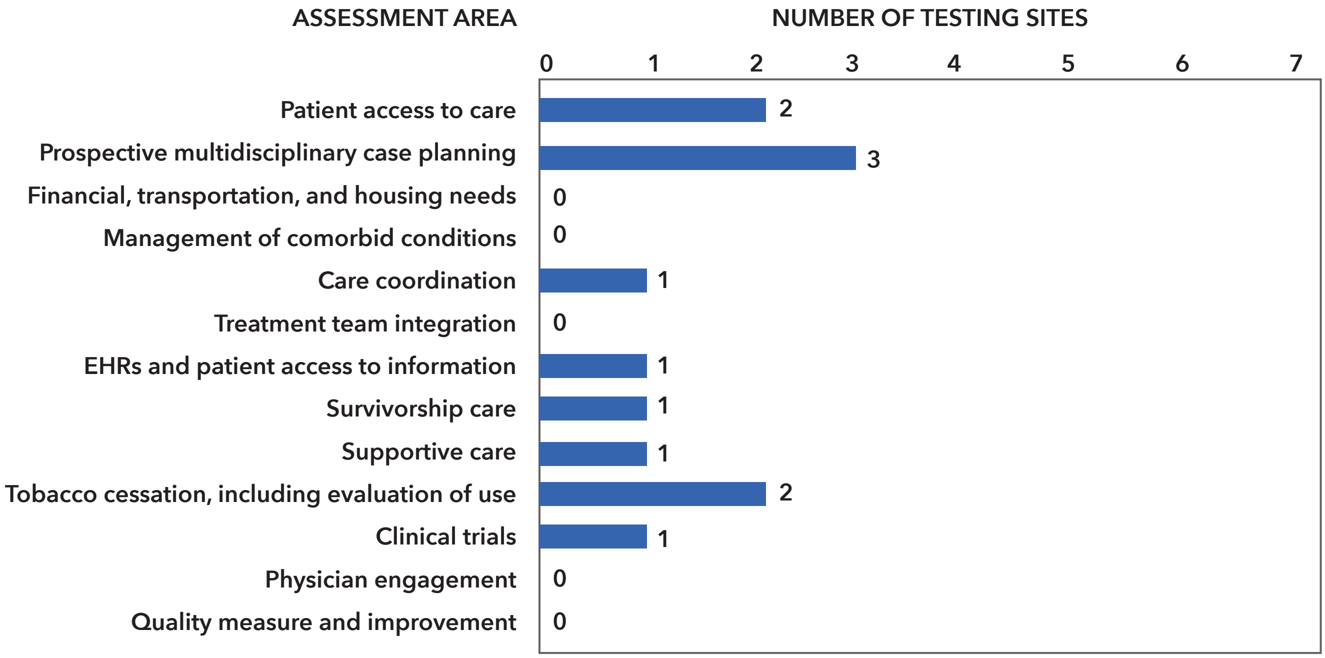


Table 1. OCCM Advisory Committee and Technical Expert Panel

OCCM Advisory Committee Co-Chairs
Christopher S. Lathan, MD, MS, MPH, faculty director for cancer care equity, Dana-Farber Cancer Institute; medical director, Dana-Farber at St. Elizabeth's Medical Center; assistant professor of medicine, Harvard Medical School, Boston, Mass.
Randall A. Oyer, MD, medical director, Oncology Program, Penn Medicine Lancaster General Health, Lancaster, Pa.
OCCM Advisory Committee Members
Thomas M. Asfeldt, MBA, RN, BAN, (former) director, Outpatient Cancer Services and Radiation Oncology, Sanford USD Medical Center, Sioux Falls, S.D., and Sanford Health Cancer Center, Worthington, Minn.
John V. Cox, DO, MBA, FACP, FASCO, professor of internal medicine, medical oncologist, UT Southwestern Medical Center, Dallas, Tex.
Becky DeKay, MBA, (former) executive director, Oncology Service Line, University Health Shreveport, Feist-Weiller Cancer Center, LSU Health Shreveport, Shreveport, La.
Andrea Ferris, president and chairman of the board, LUNGevity, Bethesda, Md.
Lovell Jones, PhD, professor and associate dean for research, Prairie View A&M University College of Nursing, Corpus Christi, Tex.
Matthew J. Loscalzo, LCSW, Liliane Elkins Professor in Supportive Care Programs; executive director, Department of Supportive Care Medicine, City of Hope National Medical Center, Duarte, Calif.
James Mulshine, MD, professor, internal medicine, Rush Medical College; vice president for research, Rush University Medical Center, Chicago, Ill.
Kathleen Nolan, MPH, regional vice president, Health Management Associates, Washington, D.C.
Shawn M. Regis, PhD, patient navigator, associate research scientist, Lahey Hospital & Medical Center, Burlington, Mass.
Maureen Rigney, LICSW, director of support initiatives, GO2 Foundation for Lung Cancer, Washington, D.C.
Cardinale B. Smith, MD, PhD, associate professor of medicine, Division of Hematology and Medical Oncology, Bookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, New York, N.Y.
Mark S. Soberman, MD, MBA, FACS, senior safety officer, Ethicon, Inc.
Technical Expert Panel Chair
Thomas M. Asfeldt, MBA, RN, BAN, (former) director, Outpatient Cancer Services and Radiation Oncology, Sanford USD Medical Center, Sioux Falls, S.D. and Sanford Health Cancer Center, Worthington, Minn.
Technical Expert Panel Members
Karyl Blaseg, MSN, RN, OCN, practice manager, University of Arizona Cancer Center/Dignity Health, Phoenix, Ariz.
Richard Deming, MD, medical director, MercyOne Cancer Center, Des Moines, Iowa
Nancy Johnson, MSM, executive director/administrator, Nancy N. and J.C. Lewis Cancer & Research Pavilion at St. Joseph's/Candler, Savannah, Ga.
Lead Clinical Research Consultant
Raymond Uyiosa Osarogiagbon, MD, FACP, director, Thoracic Oncology Research Group; director, Multidisciplinary Thoracic Oncology Program, Baptist Cancer Center, Memphis; research professor, University of Memphis School of Public Health, Memphis, Tenn.

Table 2. Patient Demographics and Baseline Clinical Characteristics for All Testing Sites Combined by Medicaid/Dual-Eligible Versus Non-Medicaid Payer Status (*n* = 926)

Characteristic *n* (%)	Medicaid/Dual-Eligible *n* = 257	Non-Medicaid[a] *n* = 669	*p* Value
Sex			
Female	124 (48.2%)	345 (51.6%)	
Male	133 (51.8%)	324 (48.4%)	0.3655[b]
Age group			
< 90 years	256 (99.6%)	656 (98.1%)	
≥ 90 years	1 (0.4%)	13 (1.9%)	0.1289[c]
Race			
White	176 (68.8%)	593 (88.8%)	
Black or African American	21 (8.2%)	19 (2.8%)	
Other[d]/not reported	59 (23.0%)	56 (8.4%)	
Missing = 2			<0.0001[b]
Ethnicity			
Hispanic/Latino	9 (3.5%)	12 (1.8%)	
Not Hispanic/not Latino	209 (81.3%)	608 (90.9%)	
Not reported	39 (15.2%)	49 (7.3%)	0.0003[b]
Employment status			
Currently employed	37 (14.4%)	144 (21.5%)	
Retired	67 (26.1%)	347 (51.9%)	
Unemployed	87 (33.9%)	57 (8.5%)	
Unknown	66 (25.7%)	121 (18.1%)	<0.0001[b]
Median (range) age at diagnosis (in years)	61 (39 to 88 years)	70 (39 to 89 years)	<0.0001[e]
Median (range) duration of Medicaid enrollment (in years)	2 (0, 144)	1 (1, 10)	0.2866[e]
Smoking status			
Active	122 (47.5%)	191 (28.6%)	
Former	113 (44.0%)	400 (59.8%)	
Never	19 (7.4%)	53 (7.9%)	
Not reported	3 (1.2%)	25 (3.7%)	<0.0001[b]
Type of smoking: cigarettes			
Yes	208 (80.9%)	472 (70.5%)	
No	49 (19.1%)	197 (29.5%)	0.0014[b]
Type of smoking: cigars			
Yes	6 (2.3%)	6 (0.9%)	
No	251 (97.7%)	663 (99.1%)	0.1038[c]
Type of smoking: pipes			
Yes	1 (0.4%)	3 (0.5%)	
No	256 (99.6%)	666 (99.5%)	1.0000[c]
Type of smoking: hookah			
Yes	0 (0)	0 (0)	
No	257 (100)	669 (100)	N/A
Median (range) duration of smoking (in years)	40 (2 to 67 years)	40 (3 to 69 years)	0.8927[e]
Median (range) pack-years	44 (4 to 220 packs)	40 (1 to 240 packs)	0.5577[e]

(table continued on page 86)

Table 2 (continued). Patient Demographics and Baseline Clinical Characteristics for All Testing Sites Combined by Medicaid/Dual-Eligible Versus Non-Medicaid Payer Status (*n* = 926)

Characteristic *n* **(%)**	**Medicaid/Dual-Eligible** *n* **= 257**	**Non-Medicaid[a]** *n* **= 669**	*p* **Value**
Use of smokeless tobacco			
Yes	5 (2.2%)	8 (1.3%)	
No	225 (97.8%)	604 (98.7%)	
Missing = 84			0.3577[c]
Median (range) number of comorbidities	2 (0 to 6 comorbidities)	2 (0 to 5 comorbidities)	0.0115[e]
Patients with any prior cancer(s)			
Yes	224 (87.2%)	528 (78.9%)	
No	33 (12.8%)	141 (21.1%)	0.0041[b]
Patient has caregiver support			
Yes	119 (58.6%)	396 (67.5%)	
No	84 (41.2%)	191 (32.5%)	
Missing = 136			0.0226[b]
T category[f]			
T0	10 (3.9%)	17 (2.5%)	
T1	73 (28.4%)	200 (29.9%)	
T2	55 (21.4%)	122 (18.2%)	
T3	18 (7.0%)	47 (7.0%)	
T4	46 (17.9%)	110 (16.4%)	
Insufficient/not reported	55 (21.4%)	173 (25.9%)	0.5485[b]
N category[g]			
N0	84 (32.7%)	252 (37.7%)	
N1	26 (10.1%)	53 (7.9%)	
N2	48 (18.7%)	111 (16.6%)	
N3	33 (12.8%)	63 (9.4%)	
Insufficient/not reported	66 (25.7%)	190 (28.4%)	0.2501[b]
M category[h]			
M0	124 (48.3%)	316 (47.2%)	
M1	72 (28.0%)	145 (21.7%)	
Insufficient/not reported	61 (23.7%)	208 (31.1%)	0.0354[b]
Aggregate staging			
Stage 0	1 (0.4%)	2 (0.3%)	
Stage I-IIA	61 (23.7%)	158 (23.6%)	
Stage IIB	18 (7.0%)	41 (6.1%)	
Stage IIIA	25 (9.7%)	68 (10.2%)	
Stage IIIB-IIIC	18 (7.0%)	34 (5.1%)	
Stage IV	72 (28.0%)	145 (21.7%)	
Insufficient/not reported	62 (24.1%)	221 (33.0%)	0.1456[b]

Column percentages may not add up to 100.0 percent due to rounding. N/A, not applicable.

[a] Commercial insurance, Medicare only, military insurance, none, or self-pay.

[b] p Value based on chi-square test.

[c] p Value based on Fisher's exact test.

[d] Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Other, and Unknown.

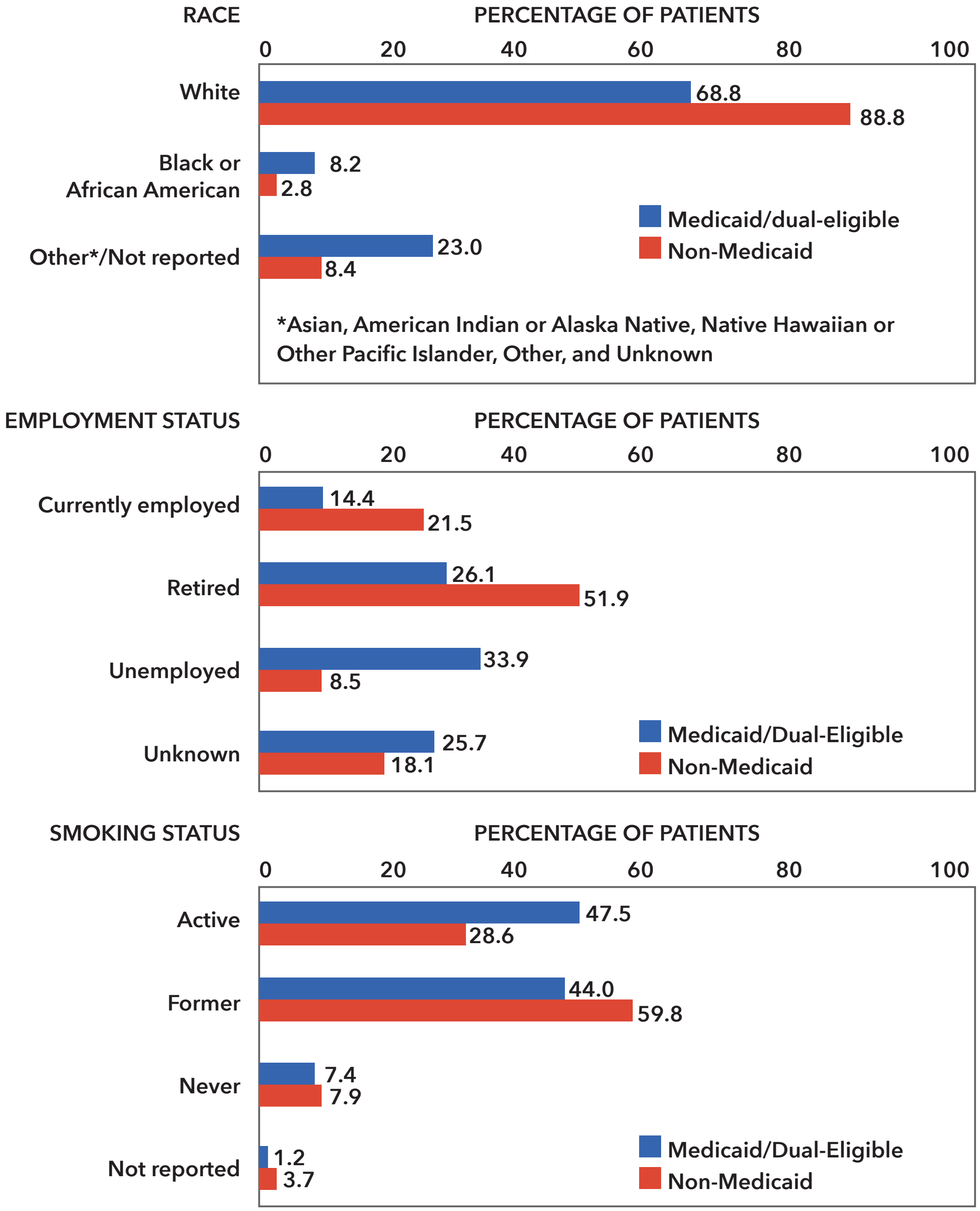
[e] p Value based on median one-way analysis.

[f] T category, primary tumor.

[g] N category, regional lymph nodes.

[h] M category, distant metastasis.

Figure 2. Distribution of Select Patient Demographics Between Medicaid/Dual-Eligible and Non-Medicaid Patients Across All Testing Sites Combined



Note: Non-Medicaid includes commercial insurance, Medicare only, military insurance, none, or self-pay.

Table 3. Patient Demographics and Baseline Clinical Characteristics Across All Testing Sites Combined by Payer Type (*n* = 926)

Characteristic ***n* (%)**	**Commercial** ***n* = 219**	**Medicaid only** ***n* = 139**	**Medicare only** ***n* = 443**	**Other[a]** ***n*= 7**	**Dual-Eligible** ***n*= 118**	***p* Value**
Sex						
Female	107 (48.9%)	64 (46.0%)	236 (53.3%)	2 (28.6%)	60 (50.9%)	
Male	112 (51.1%)	75 (54.0%)	207 (46.7%)	5 (71.4%)	58 (49.1%)	0.4449[b]
Age group						
< 90 years	219 (100%)	139 (100%)	430 (97.1%)	7 (100%)	117 (99.1%)	
≥ 90 years	0 (0)	0 (0)	13 (2.9%)	0 (0)	1 (0.9%)	0.0057[c]
Race						
White	190 (86.7%)	84 (60.9%)	397 (89.8%)	6 (85.7%)	92 (78.0%)	
Black or African American	5 (2.3%)	13 (9.4%)	13 (2.9%)	1 (14.3%)	8 (6.8%)	
Other[d]/Not reported	24 (11.0%)	41 (29.7%)	32 (7.2%)	0 (0)	18 (15.2%)	
Missing = 2						<0.0001[b]
Ethnicity						
Hispanic/Latino	6 (2.7%)	6 (4.3%)	6 (1.4%)	0 (0)	3 (2.5%)	
Not Hispanic/not Latino	194 (88.6%)	101 (72.7%)	407 (91.9%)	7 (100%)	108 (91.5%)	
Not reported	19 (8.7%)	32 (23.0%)	30 (6.8%)	0 (0)	7 (5.9%)	<0.0001[b]
Employment status						
Currently employed	84 (38.4%)	30 (21.6%)	59 (13.3%)	1 (14.3%)	7 (5.9%)	
Retired	70 (32.0%)	21 (15.1%)	273 (61.6%)	4 (57.1%)	46 (39.0%)	
Unemployed	23 (10.5%)	56 (40.3%)	33 (7.5%)	1 (14.3%)	31 (26.3%)	
Unknown	42 (19.2%)	32 (23.0%)	78 (17.6%)	1 (14.3%)	34 (28.8%)	<0.0001[e]
Median (range) age at diagnosis (in years)	63 (39 to 86 years)	58 (39 to 74 years)	73 (43 to 89 years)	70 (50 to 83 years)	67 (47 to 88 years)	<0.0001[e]
Median (range) duration of Medicaid enrollment (in years)	1 (1, 10)	2 (0, 144)	N/A	N/A	2 (0, 144)	0.5642
Smoking status						
Active	80 (36.5%)	68 (48.9%)	109 (24.6%)	2 (28.6%)	54 (45.8%)	
Former	100 (45.7%)	61 (43.9%)	296 (66.8%)	4 (57.1%)	52 (44.1%)	
Never	24 (11.0%)	9 (6.5%)	29 (6.6%)	0 (0)	10 (8.5%)	
Not reported	15 (6.9%)	1 (0.7%)	9 (2.0%)	1 (14.3%)	2 (1.7%)	<0.0001[b]
Type of smoking: cigarettes						
Yes	155 (70.8%)	116 (83.5%)	314 (70.9%)	3 (42.9%)	92 (78.0%)	
No	64 (29.2%)	23 (16.5%)	129 (29.1%)	4 (57.1%)	26 (22.0%)	0.0134[b]
Type of smoking: cigars						
Yes	2 (0.9%)	3 (2.2%)	4 (0.9%)	0 (0)	3 (2.5%)	
No	217 (99.1%)	136 (97.8%)	439 (99.1%)	7 (100%)	115 (97.5%)	0.3036[c]
Type of smoking: pipes						
Yes	1 (0.5%)	0 (0)	2 (0.5%)	0 (0)	1 (0.9%)	
No	218 (99.5%)	139 (100%)	441 (99.6%)	7 (100%)	117 (99.1%)	0.7923[c]
Type of smoking: hookah						
Yes	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	
No	219 (100%)	139 (100%)	443 (100%)	7 (100%)	118 (100%)	N/A
Median (range) duration of smoking (in years)	40 (3 to 65 years)	40 (3 to 67 years)	40 (4 to 69 years)	37 (30 to 45 years)	45.5 (2 to 65 years)	0.0168[e]

Table 3 (continued). Patient Demographics and Baseline Clinical Characteristics Across All Testing Sites Combined by Payer Type (*N* = 926)

Characteristic *n* (%)	**Commercial** *n* = 219	**Medicaid only** *n* = 139	**Medicare only** *n* = 443	**Other[a]** *n*= 7	**Dual-Eligible** *n*= 118	*p* **Value**
Median (range) pack-years	40 (1 to 180 packs)	40 (10 to 120 packs)	44 (1 to 240 packs)	35 (18 to 68 packs)	50 (4 to 220 packs)	0.0572[e]
Use of smokeless tobacco						
Yes	3 (1.5%)	1 (0.8%)	5 (1.2%)	0 (0)	4 (3.9%)	
No	193 (98.5%)	126 (99.2%)	407 (98.8%)	4 (100%)	99 (96.1%)	
Missing = 84						0.2329[c]
Median (range) number of comorbidities	1 (0 to 5 comorbidities)	2 (0 to 5 comorbidities)	2 (0 to 5 comorbidities)	0 (0 to 2 comorbidities)	2 (0 to 6 comorbidities)	<0.0001[e]
Patients with any prior cancer(s)						
Yes	39 (17.8%)	16 (11.5%)	102 (23.0%)	0 (0)	17 (14.4%)	
No	180 (82.2%)	123 (88.5%)	341 (77.0%)	7 (100%)	101 (85.6%)	0.0090[b]
Patient has caregiver support						
Yes	134 (70.5%)	58 (51.8%)	257 (65.9%)	5 (71.4%)	61 (67.0%)	
No	56 (29.5%)	54 (48.2%)	133 (34.1%)	2 (28.6%)	30 (33.0%)	
Missing = 136						0.0095[b]
T category[f]						
T0	1 (0.5%)	8 (5.7%)	16 (3.6%)	0 (0)	2 (1.7%)	
T1	61 (27.9%)	33 (23.7%)	138 (31.2%)	1 (14.3%)	40 (33.9%)	
T2	41 (18.7%)	28 (20.1%)	80 (18.1%)	1 (14.3%)	27 (22.9%)	
T3	11 (5.0%)	12 (8.6%)	36 (8.1%)	0 (0)	6 (5.1%)	
T4	37 (16.9%)	24 (17.3%)	71 (16.0%)	2 (28.6%)	22 (18.6%)	
Insufficient/Not reported	68 (31.1%)	34 (24.5%)	102 (23.0%)	3 (42.9%)	21 (17.8%)	0.0693[b]
N category[g]						
N0	72 (32.9%)	36 (25.9%)	178 (40.2%)	2 (28.6%)	48 (40.7%)	
N1	17 (7.8%)	12 (8.6%)	36 (8.1%)	0 (0)	14 (11.9%)	
N2	35 (16.0%)	30 (21.6%)	74 (16.7%)	2 (28.6%)	18 (15.3%)	
N3	23 (10.5%)	20 (14.4%)	40 (9.0%)	0 (0)	13 (11.0%)	
Insufficient/Not reported	72 (32.9%)	41 (29.5%)	115 (26.0%)	3 (42.9%)	25 (21.2%)	0.0996[b]
M category[h]						
M0	91 (41.6%)	56 (40.3%)	222 (50.1%)	3 (42.9%)	68 (57.6%)	
M1	47 (21.5%)	49 (35.3%)	97 (21.9%)	1 (14.3%)	23 (19.5%)	
Insufficient/Not reported	81 (37.0%)	34 (24.5%)	124 (28.0%)	3 (42.9%)	27 (22.9%)	0.0006[b]
Aggregate staging						
Stage 0	0 (0)	1 (0.7%)	2 (0.5%)	0 (0)	0 (0)	
Stage I-IIA	46 (21.0%)	22 (15.8%)	110 (24.8%)	2 (28.6%)	39 (33.1%)	
Stage IIB	11 (5.0%)	8 (5.8%)	30 (6.8%)	0 (0)	10 (8.5%)	
Stage IIIA	19 (8.7%)	14 (10.1%)	49(11.1%)	0 (0)	11 (9.3%)	
Stage IIIB-IIIC	14 (6.4%)	10 (7.2%)	19 (4.3%)	1 (14.3%)	8 (6.8%)	
Stage IV	47 (21.5%)	49 (35.3%)	97 (21.9%)	1 (14.3%)	23 (19.5%)	
Insufficient/Not reported	82 (37.4%)	35 (25.2%)	136 (30.7%)	3 (14.3%)	27 (22.9%)	0.0175[b]

Column percentages may not add up to 100.0 percent due to rounding. N/A, not applicable.

[a] Includes military insurance, none, or self-pay. This payer category was excluded from significance testing.

[b] *p* Value based on chi-square test.

[c] *p* Value based on Fisher's exact test.

[d] Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Other, and Unknown.

[e] *p* Value based on median 1-way analysis.

[f] T category, primary tumor.

[g] N category, regional lymph nodes.

[h] M category, distant metastasis.

Figure 3. Beta Testing Successes, Challenges, Transferable Lessons, and Sustainability Plans

Successes	Site-Specific Challenges	Transferable Lessons	Sustainability Plans
Enhanced collaboration within programs Improved lung cancer programming, such as patient navigation services, to address low rates of psychosocial distress screening	Inadequate staffing throughout testing Lack of centralized data collection and coordination, especially for quality monitoring	Adopt data-driven approach to formulating QI project goals Leverage appropriate technologies to meet care coordination needs Understand special needs of patient groups and calibrate services to meet these needs	Use of existing OCCM framework Increased staffing, particularly for lung cancer navigation Expanded community outreach

(Continued from page 83)

Prospective multidisciplinary case planning (three testing sites), patient access to care (two testing sites), and tobacco cessation (two testing sites) were most frequently selected. Financial, transportation, and housing needs (limited scope); management of comorbid conditions; treatment team integration; physician engagement; and quality measurement and improvement were not selected by any sites.

Aggregate summaries of patient demographics and baseline clinical characteristics across all testing sites by Medicaid/dual-eligible and non-Medicaid payer status are presented in Table 2, page 85. Statistically significant differences ($p < 0.0001$) were observed by race, employment status, and smoking status (Figure 2, page 87). A statistically significant difference ($p < 0.0001$) was also observed in the median age at diagnosis between Medicaid/dual-eligible patients (61 years; range, 39 to 88 years) and non-Medicaid patients (70 years; range, 39 to 89 years). Aggregate summaries across all testing sites by five payer groups are presented in Table 3, page 88. Subsequent sections describe how the Model was used for QI projects, with a summary on each assessment area.

Prospective Multidisciplinary Case Planning: Three Testing Sites

This assessment area addresses factors related to multidisciplinary evaluation of the patient and inputs provided on the treatment plan, including contributing providers, process for treatment recommendations, and developing and disseminating a collaborative treatment plan.[17] The three sites utilized three different models for multidisciplinary case discussion, including traditional biweekly (in-person) tumor board, a virtual tumor board (dislocating time and space), and a multidisciplinary team huddle (time variable, in-person interactions facilitated and tracked by a lung cancer nurse navigator). For Medicaid/dual-eligible patients, presentation of eligible patients at prospective virtual tumor board or multidisciplinary team huddle were both at 100 percent (19/19 and 29/29, respectively) for the study period, and 23 percent (5/22) of eligible patients were discussed in the traditional in-person tumor board ($p < 0.0001$). Median time to presentation for newly diagnosed patients was 18 days (range, 13 to 23 days) for in-person tumor board, 14 days (range, 7 to 20 days) for virtual tumor board, and 9 days (range, 7 to 13 days) for multidisciplinary team huddle ($p = 0.14$).

Patient Access to Care: Two Testing Sites

This assessment area addresses factors related to the patient's entry into the lung cancer program, including referral sources and process, and the strength of the relationship between the program and referral source for the purpose of providing patient-centered and timely access to appropriate care.[17] Quality metrics on timeliness of care were evaluated. At one testing site:

- Median time from initial detection to positive diagnosis was 13 days (range, 5 to 46 days) for Medicaid/dual-eligible patients versus 15 days (range, 11 days to 26.5 days) for commercially insured patients ($p = 0.96$).
- Median time from the detection of a suspicious lesion to positive diagnosis was 16 days (range, 6 to 26 days) for Medicaid/dual-eligible patients versus 16 days (range, 10 to 24 days) for Medicare patients and 18.5 days (range, 8.5 to 44.5 days) for commercially insured patients ($p = 0.68$).
- Median time from diagnosis to initial treatment was 27 days (range, 18 to 41 days) for Medicaid/dual-eligible patients versus 27 days (range, 10.5 days to 38.5 days) for Medicare patients and 26.5 days (range, 10.5 to 43.5 days) for commercially insured patients ($p = 0.83$).

Tobacco Cessation, Including Evaluation of Use: Two Testing Sites

This assessment area addresses factors related to evaluation of tobacco use and provision of tobacco cessation interventions, such as counseling and medications.[17] Quality metrics related to tobacco use and cessation programs were evaluated. At one testing site that offered tobacco cessation services with referrals to national or state assistance programs, more than half of the active smokers among Medicaid/dual-eligible patients (55.6 percent, 10/18) expressed readiness to quit the use of tobacco products compared with 43.2 percent (16/37) of active smokers among all patients. At another site that offered the Freedom from Smoking® program,[18] more than half of the active smokers among Medicaid/dual-eligible patients (54.5 percent, 6/11) expressed readiness to quit compared with 21.3 percent (10/47) of active smokers among all patients. Among the Medicaid/dual-eligible patients, 66.7 percent (2/3) of patients who enrolled and completed the program quit smoking compared with 50.0 percent (3/6) of overall patients.

Care Coordination: One Testing Site

This assessment area addresses factors related to identifying patient needs, barriers to care coordination, and strategies to minimize gaps in service.[17] Among Medicaid-only patients who were offered navigation services, 92.5 percent (62/67) agreed to work with these services compared with 90.9 percent (80/88) of dual-eligible patients and 75.0 percent (3/4) of non-Medicaid patients who were offered these services.

Electronic Health Records and Patient Access to Information: One Testing Site

This assessment area addresses electronic health records (EHRs), which provide a platform for documentation of clinical care, including patient adherence to treatment plans, compliance with national standards and guidelines, billing support, and a mechanism for patients to access information regarding care delivery.[17] All patients (124/124, 100 percent), including Medicaid/dual-eligible patients (14/14, 100 percent), had EHRs for care coordination. Though the median time to initial treatment was 33 days (range, 3 to 36 days) for Medicaid/dual-eligible patients versus 15 days (range, 0 to 25 days) for commercially insured patients, this difference of 18 days was not statistically significant ($p = 0.23$).

Supportive Care: One Testing Site

This assessment area addresses factors related to the evaluation of physical, emotional, mental, and spiritual symptoms; program infrastructure and resources; and established processes to manage these symptoms throughout the continuum of care.[17] Among Medicaid patients with lung cancer, 33.9 percent (21/62) who were offered and agreed to work with patient navigation services were administered a psychosocial distress screening via a tool compared with 66.7 percent (2/3) of non-Medicaid patients.

Survivorship Care: One Testing Site

This assessment area addresses factors related to ongoing surveillance for recurrence of the original cancer, prevention and early detection of new health problems, management of toxicities associated with treatment, and overall wellness.[17] Among Medicaid/dual-eligible patients, all patients who were considered eligible received a survivorship care plan and treatment summary (7/7, 100 percent) compared with 97.1 percent (34/35) of overall patients. Most eligible patients—that is, Medicaid/dual-eligible (85.7 percent, 6/7) and overall (94.1 percent, 32/34)—received survivorship care plans within 90 days of their last active treatment visit.

Clinical Trials: One Testing Site

This assessment area addresses factors related to overcoming cultural, financial, and logistical barriers, such as lack of access to culturally competent research staff, inadequate assessment of patient eligibility, and insufficient support

Nationwide dissemination of the final Model, including a web-based benchmarking tool, can enable expanded use by cancer programs to advance multidisciplinary coordinated care delivery and optimal outcomes for Medicaid patients.

during the informed consent process.[17] Overall, more than half (58.1 percent, 72/124) of patients were provided education on clinical trials. This was lower for Medicaid/dual-eligible patients (35.7 percent, 5/14) compared with commercially insured patients (63.6 percent, 21/33).

Key Successes and Further Discussion

Across the seven testing sites, key successes included:

- Enhanced collaboration within cancer programs
- Improved lung cancer programming (e.g., instituting formal patient navigation services or forming a lung health leadership team)
- Organic changes to the cancer programs owing to engagement over the 12-month implementation period.

Key transferable lessons included the adoption of a data-driven approach to formulating QI project goals, leveraging of appropriate technology to meet care coordination needs, and understanding the needs of patients and calibrating lung cancer-dedicated navigation to meet these needs (see Figure 3, page 90).

OCCM beta testing highlighted the different approaches adopted by the seven testing sites to improve care coordination for patients with lung cancer using the Model. The selection process provided an opportunity to understand how cancer programs successfully utilized the OCCM for topics, such as multidisciplinary case planning and timeliness of care delivery, and identified specific areas to target for improvement. The OCCM provided an avenue for building consensus around quality benchmarks and the capacity to measure them.

Site participation in beta testing appeared beneficial to both cancer programs and the patient populations they serve. Key successes were enhanced collaboration and improved lung cancer programming, such as patient navigation services, that may address low rates of psychosocial distress screening. The overarching principles that guided the development of the OCCM—that is, a patient-centered focus and the reliance on data and evidence as an integral part of all assessment areas—emerged as key transferable lessons. During the initial site visits, many testing sites reiterated that patients are treated the same, regardless of insurance status; however, over the course of OCCM beta testing, the sites realized that Medicaid patients required special considerations to achieve clinical outcomes similar to those of non-Medicaid patients.

Some examples of institutional support received by testing sites during project implementation included opportunities for staff training and leadership commitment from other hospital departments to assist with improvements in lung cancer care delivery. Challenges in OCCM implementation were informed by the unique characteristics and context of each testing site; specific examples included inadequate staffing throughout testing and the lack of centralized data collection and coordination, especially for quality monitoring. Use of the existing OCCM framework; increased staffing, particularly for lung cancer navigation; and expanded community outreach were identified in the sustainability plans of the testing sites. The results indicate that the OCCM can serve as a valuable framework for cancer programs to evaluate current levels of care coordination and to identify areas of improvement toward achieving optimal care coordination. This has also been documented in evaluations of the multidisciplinary care assessment tool,[19] which was central to the design of the OCCM.

Though Medicaid patients were the target population, the observed distribution by payer status was evidence that many non-Medicaid patients at each testing site were able to participate in and benefit from QI projects for lung cancer care delivery. This includes beneficiaries eligible for both Medicare and Medicaid programs who often incur higher costs compared with non-dual-eligible beneficiaries owing to more complex care needs.[20, 21] This suggests future service- and policy-related implications for care delivery.

Strengths of the beta testing phase included adaptability of the OCCM tool to meet program and patient needs and real-world evidence on how a diverse group of community-based cancer programs utilized the framework to evaluate their lung cancer care delivery systems for Medicaid patients, identified areas for improvement, and implemented QI projects. Limitations included the restricted generalizability owing to the unique characteristics and context of each testing site and the limited overlap in OCCM assessment area selection to understand how different testing sites addressed a common care delivery area. Further, site-specific quality measures may not have mapped perfectly with the OCCM quality measures.

Subsequently, the results of the OCCM beta testing were used to refine the framework and develop a final version of the Model. This included evidence that cancer programs can use the Model to objectively assess their care delivery capabilities for Medicaid patients diagnosed with lung cancer. Programs can also identify areas for improved care coordination and reduce the effects of disparities between Medicaid and non-Medicaid patients by facilitating and expanding access to appropriate care. Nationwide dissemination of the final Model, including a web-based benchmarking tool, can enable expanded use by cancer programs to advance multidisciplinary coordinated care delivery and optimal outcomes for Medicaid patients. These details will be described in a separate publication.[22]

In conclusion, beta testing enabled seven U.S. cancer programs to assess their lung cancer care delivery capabilities for Medicaid patients, identify areas for improved care coordination, and implement these improvements, through varied approaches, in support of multidisciplinary coordinated care delivery. Consequently, it was apparent that prioritizing the unique care and treatment needs of Medicaid patients with lung cancer is an important step toward achieving health outcomes comparable to those of non-Medicaid patients.

Matthew P. Smeltzer, PhD, MStat, is assistant professor in the Division of Epidemiology, Biostatistics, and Environmental Health, School of Public Health, The University of Memphis, Memphis, Tenn. Leigh M. Boehmer, PharmD, BCOP is chief medical officer and Amanda Kramar is chief learning officer, Association of Community Cancer Centers, Rockville, Md. Thomas M. Asfeldt, MBA, RN, BAN, was formerly the director, Outpatient Cancer Services and Radiation Oncology, Sanford USD Medical Center, Sioux Falls, S.D., and Sanford Health Cancer Center, Worthington, Minn. Nicholas R. Faris, MDiv, is with the Multidisciplinary Thoracic Oncology Program, Baptist Cancer Center, Memphis, Tenn. Christine F. Amorosi, RN, MHSA, MSN, AGNP, is president/founder at Health Quality Solutions, Arlington, Va. Meredith A. Ray, PhD, MPH, is assistant professor and Vikki G. Nolan, DSc, MPH, is associate professor in the Division of Epidemiology, Biostatistics, and Environmental Health, School of Public Health, The University of Memphis, Memphis, Tenn. Randall A. Oyer, MD, is medical director, Ann B. Barshinger Cancer Institute, Penn Medicine Lancaster General Health, Lancaster, Pa. Christopher S. Lathan, MD, MS, MPH, is medical director, Dana-Farber Cancer Institute at St. Elizabeth's Medical Center, Boston, Mass., and assistant professor of Medicine Harvard Medical School, Boston, Mass. Raymond U. Osarogiagbon, MBBS, FACP, is director, Multidisciplinary Thoracic Oncology Program, Baptist Cancer Center, Memphis, Tenn.

References

1. Siegel RL, Miller KD, Jemal A. Cancer statistics. *CA Cancer J Clin*. 2019:69(1):7-34.

2. Bradley CJ, Dahman B, Given CW. Treatment and survival differences in older Medicare patients with lung cancer as compared with those who are dually eligible for Medicare and Medicaid. *J Clin Oncol*. 2008;26(31):5067-5073.

3. Maguire FB, Morris CR, Parikh-Patel A, et al. Disparities in systemic treatment use in advanced-stage non-small cell lung cancer by source of health insurance. *Cancer Epidemiol Biomarkers Prev.* 2019;28(6):1059-1066.

4. Pezzi TA, Schwartz DL, Pisters KMW, et al. Association of Medicaid insurance with survival among patients with small cell lung cancer. *JAMA Netw Open*. 2020;3(4):e203277.

5. Slatore CG, Au DH, Gould MK, and the American Thoracic Society Disparities in Healthcare Group. An official American Thoracic Society systematic review: insurance status and disparities in lung cancer practices and outcomes. *Am J Respir Crit Care Med*. 2010;182(9):1195-1205.

6. Walker GV, Grant SR, Guadagnolo BA, et al. Disparities in stage at diagnosis, treatment, and survival in nonelderly adult patients with cancer according to insurance status. *J Clin Oncol.* 2014;32(28):3118-3125.

7. Institute of Medicine. *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis*. Washington, DC: National Academies Press; 2013.

8. Oyer RA, Lathan CS, Asfeldt TM, et al. An optimal care coordination model for medicaid patients with lung cancer: rationale, development, and design. *Oncol Issues*. 2021;36(2):30-35.

9. Niu X, Roche LM, Pawlish KS, et al. Cancer survival disparities by health insurance status. *Cancer Med.* 2013;2(3):403-411.

10. Shi R, Diaz R, Shi Z, et al. The effect of payer status on survival of patients with stage I/II non-small cell lung cancer: NCDB 1998-2011. *Anticancer Res*. 2016;36(1):319-326.

11. Singh GK, Williams SD, Siahpush M, et al. Socioeconomic, rural-urban, and racial inequalities in U.S. cancer mortality: part I—all cancers and lung cancer and part II—colorectal, prostate, breast, and cervical cancers. *J Cancer Epidemiol.* 2011:107497.

12. Swanson PL, Strusowski P, Asfeldt T, et al. Expanding multidisciplinary care in community cancer centers. In Marino MJ, ed. *The NCCCP: Enhancing Access, Improving the Quality of Care, and Expanding Research in the Community Setting*. Rockville, MD: Association of Community Cancer Centers; 2012:40-44.

13. Harris PA, Taylor R, Thielke R, et al. Research electronic data capture (REDCap)—a metadata-driven methodology and workflow process for providing translational research informatics support. *J Biomed Inform*. 2009;42(2):377-381.

14. Harris PA, Taylor R, Minor BL, et al. The REDCap consortium: building an international community of software platform partners. *J Biomed Inform*. 2019;95:103208.

15. SAS [computer software]. Version 9.4. Cary, NC: SAS; 2013.

16. Rothman KJ. No adjustments are needed for multiple comparisons. Epidemiology. 1990;1(1):43-46.

17. Association of Community Cancer Centers. Improving care coordination: a model for lung cancer patients on Medicaid, 2020. Available online at: accc-cancer.org/docs/projects/carecoordination/accc-lun-cancer-ful-report-final.pdf. Last accessed February 18, 2021.

18. American Lung Association. Freedom from smoking. Available online at: freedomfromsmoking.org. Last accessed February 18, 2021.

19. Friedman EL, Chawla N, Morris PT, et al. Assessing the development of multidisciplinary care: experience of the National Cancer Institute Community Cancer Centers Program. *J Oncol Pract*. 2015;11(1):e36-e43.

20. Coughlin TA, Waidmann TA, Phadera L. Among dual eligibles, identifying the highest-cost individuals could help in crafting more targeted and effective responses. *Health Aff (Millwood)*. 2012;31(5):1083-1091.

21. Kane RL, Wysocki A, Parashuram S, et al. Effect of long-term care use on Medicare and Medicaid expenditures for dual eligible and non-dual eligible elderly beneficiaries. *Medicare Medicaid Res Rev*. 2013;3(3):mmrr.003.03.a05.

22. Oyer RA, Lathan CS, Smeltzer, MP, et al. An optimal care coordination model for Medicaid patients with lung cancer: finalization of the model and implications for clinical practice in the U.S. *Oncol Issues*. In press.

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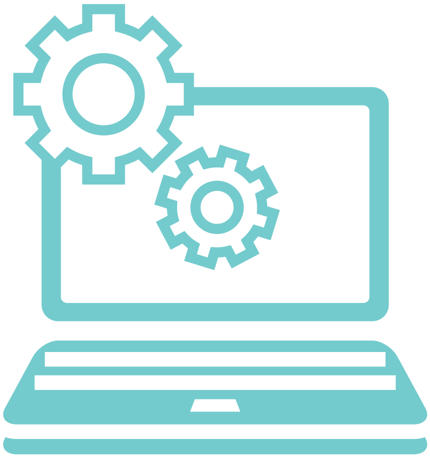

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Website: cedars-sinai.org/programs/cancer.html

ACCC Unveils New Program to Recognize Engaged Members

At the March 5 ACCC House of Delegate Meeting, Laeton J. Pang, MD, MPH, FACR, FACRO, Membership Committee Chair, announced a new program—the Fellow of the Association of Community Cancer Centers distinction. This designation was created to recognize the Association's most active and engaged volunteers. Based on five different levels of engagement, points are earned through participation in qualifying activities, which are tracked using badges in the ACCC member database, including:

- One point for ***Engaged Members***; for example, those attending an ACCC meeting.
- Two points for ***Participating: Engaged Champions***; for example, delegate representatives and those who answer a survey, participate in a focus group, or graduate the Financial Advocacy Boot Camp.
- Three points for ***Creating: Subject Matter Experts and Content Contributors***; for example, faculty members, those who present at an ACCC meeting, those who write an article for *Oncology Issues* or contribute to a blog or podcast.
- Four points for ***Serving: Thought Leaders***; for example, task force and advisory committee members.
- Five points for ***Governing: Strategic Leaders***; for example, members of the board of trustees, chairs of committees and task forces, liaisons.

The inaugural Fellow of the Association of Community Cancer Centers class will be the past presidents of ACCC—a group that truly exemplifies the level of commitment and dedication recognized by this distinction. Questions about the program? Email bspruill@accc-cancer.org.

ICYMI: ACCC 2020 Impact Report

Also at the March 5 ACCC House of Delegate Meeting, ACCC Executive Director Christian G. Downs, JD, MHA, introduced the ACCC 2020 Impact Report—a digital chronicle that shows how ACCC members came together as a community to make a difference in 2020. Featuring live links and videos, the report provides an engaging and interactive snapshot of our collaborative work. This report is your roadmap to maximize and show return on investment on your ACCC Cancer Program Membership. Share the link today with your team members and colleagues. accc-cancer.org/2020-impact-report.

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AMCCBS *Virtual* is Now On-Demand!

It's a wrap! The ACCC 47th Annual Meeting and Cancer Center Business Summit (AMCCBS *Virtual*) was held March 1-5, 2021. More than 1,000 cancer care professionals and industry supporters registered for this virtual meeting, with nearly 650 unique participants logging on live the week of the event. At the request of members to keep virtual sessions shorter and spread over more days, the extended five-day format offered sessions centered around "Issues of the Day," including:

1. Policy and COVID-19's Impact on Cancer Care Delivery
2. Telehealth and Virtual Visits
3. Cancer Service Line Efficiency and Revenue Optimization
4. Managing for Success
5. Research and Clinical Trials and Business Consolidation (separate topics).

Response to this change was overwhelmingly positive: 95 percent of survey respondents liked this new format. From meeting evaluations received thus far, 71 percent of attendees ranked the meeting as exceptional or above average.

Healthcare Policy Update

AMCCBS *Virtual* opened with an overview of the rapidly changing national political climate and what it may mean for healthcare policy in the months and years ahead. Kavita Patel, MD, MS, FACP, a fellow at the Center for Health Policy at the Brookings Institution, began by recognizing the immensity of the impact that COVID-19 has had on healthcare delivery across the country. "No one could have predicted at the end of 2019 that a new disease would kill more than 500,000 Americans within a year and bring the world to its knees," said Dr. Patel. "COVID-19 is the start, middle, and end of what will define healthcare practice and policy in 2021 and beyond."

Dr. Patel addressed the actions that the Biden administration can take to advance its healthcare policy agenda. Some of the changes that the Biden administration wants can be enacted by executive order, which is an increasingly popular tool to advance legislation from the executive branch. Though President Biden can take some crucial steps to stem the effects of the pandemic without congressional support—such as invoking the Defense Production Act to accelerate the production of medical supplies or working with governors to enact mask mandates—there are many things he cannot do alone.

Among the actions that Dr. Patel said the federal government must do to stem the damage of COVID-19 are creating a unified approach to testing and enhancing the federal collection of healthcare data. Dr. Patel also noted that Biden's stated commitment to increase funding for the National Institutes of Health and the National Science Foundation—as well as his plan to provide $300 billion in innovation funding to industries, including health, medicine, and biotechnology—will help the United States be better prepared when the next pandemic strikes.

Another issue touched on by Dr. Patel is drug pricing, which she noted captured considerable attention during the Trump administration. The state of the "Most Favored Nation Model" status and other efforts to reign in drug costs remains in flux, and Dr. Patel said she does not think they will be fully settled until they land in court. "Anything that will change the trajectory of drug pricing in oncology will be met with a lawsuit," she said. "We will need legislative action in this area."

In reference to the Centers for Medicare & Medicaid Services' Oncology Care Model program, Dr. Patel said that, to date, the program's data show little impact on cost of care, even though it has helped improve care coordination. Calling it "extremely complex," Dr. Patel predicted that the Oncology Care Model program will soon end. "The program will not make the cut to be so compelling that it becomes permanent," she said.

COVID-19 Panel

A six-person panel consisting of physicians and nurses from cancer programs and practices across the country shared personal experiences at the intersection of cancer care and the ongoing pandemic. A point everyone quickly agreed on was the lasting impact of the rapid transition to telemedicine in the early months of the pandemic. Although several people said the provision of telehealth has slowed some because many programs are now open to in-person visits again, they agree that there is no going back to pre-pandemic levels. "Telehealth is here to stay," said Luis Isola, MD, director of cancer clinical programs at Mount Sinai Health System & Tisch Cancer Institute. "It has become part of the fabric of the care we provide."

David Dougherty, MD, MBA, medical director of the Dana Farber Cancer Institute Network, noted that aspects of telehealth have "given patients a higher degree of self-efficacy, allowing them to better manage their own care." Other panel members noted that telehealth has given them a new appreciation of the essential role that family members play in their loved ones' care, because many patients did not previously have the technological access or know-how to participate in telehealth on their own.

But on the flip side of telehealth's positive impact of being able to provide quality at-home care is the fact that many patients simply do not have the means to access telehealth services. Sibel Blau, MD, medical director at Northwest Medical Specialties and president and CEO of the Quality Cancer Care Alliance, said that her practice hired technology coordinators to visit nursing homes and give patients access to the technology they needed to receive remote care. "We need to give access to care to all patients, regardless of how remote they are," said Dr. Blau. Other panelists said they had patients whose socio-economic status made telehealth impossible. "It's essential to keep in mind social determinants of health," said Adam Riker, MD, FACS, chair of oncology at Anne Arundel Medical Center DeCesaris Cancer Institute. "We could not do telehealth with many of our patients because they do not have access to tools like Zoom or MyChart®."

The emotional and physical burden of patient care during the pandemic has had a huge impact on nursing staff, the panelists agreed. "Nurses are extremely stressed," said Mary Miller, MSN, RN-BC, OCN, nurse manager at Franciscan Health Cancer Center Indianapolis. As a result, she said, many have left their positions for less stressful work. "We have lost 14 of our nurses in the ICU [intensive care unit] alone who are now traveling nurses," Miller said. She added that she has found that frequent and open communication with nursing staff helps, to some extent, manage their fear of the unknown. "We hold regular video chats with staff to keep them updated on what we are doing and why we are doing it," said Miller. "It helps if they understand the reasoning behind our decisions."

Jody Pelusi, PhD, FNP, AOCNP, an oncology nurse practitioner at Honor Health Research Institute, said that it's important to remember that the stress factors affecting staff can extend far beyond those found in the workplace. "Nurses cannot come to work because they have children at home, and schools are closed," said Dr. Pelusi. "Some of them even have food insecurity issues. We need to take care of staff, so they can take care of patients."

All panelists agreed that the effects of the plunging cancer screening rates brought on by the pandemic will be felt far into the future. To bring people back in for their regular screenings, Dr. Riker said that the Anne Arundel Medical Center DeCesaris Cancer Institute has recorded a series of two-minute videos that teach patients the importance of maintaining their screenings and explain to them the actions the cancer center is taking to keep them safe. Fighting patients' fears to come in for screenings is crucial, said Dr. Isola: "The lack of screening for cancer due to the pandemic is going to become evident over the next few years."

While assessing the changed landscape of a healthcare system still in the throes of a global pandemic, Dougherty said it's important to consider how COVID-19 has been and can be a source of disruptive innovation—for good. "COVID-19 has not ignited new problems," said Dr. Dougherty. "It has exacerbated the issues already there. We need to think about how we can apply the innovations wrought of necessity into long-term solutions."

Dr. Isola agreed: "What we have learned from this crisis is that we can be problem solvers."

Telehealth and Revenue Optimization

Telehealth and revenue optimization and their intersection with COVID-19 were hot topics at sessions throughout the week. Speakers discussed the appropriate use of telehealth in cancer care, debated the continuation of such care as the pandemic recedes, and addressed persistent gaps in oncology services in diverse populations.

In the wake of many cancer programs across the United States being compelled to develop some version of telehealth due to COVID-19, session panelists shared their insight into the adequacy of the different platforms through which patient care is delivered remotely. "There is no one-size-fits-all solution," said Kelley Simpson, MBA, director and practice leader at The Chartis Group. She explained that virtual care should be defined differently depending on where along the cancer care continuum it occurs. For example, the design and goals of telehealth differ depending on whether providers are conducting cancer screenings, discussing treatment options, or providing survivorship and follow-up care.

"The definition of telehealth itself is in dispute," said Feyi Olopade Ayodele, MBA, CEO of Cancer IQ, Inc. She emphasized that by understanding telehealth as simply providing the same in-office services virtually, providers do not take into account the unique capabilities of telehealth and thus sell it short. "Telehealth is not just a new way of conducting typical office visits," said Ayodele. "It can be transformative in the way it provides patient care."

One recurring topic running throughout AMCCBS *Virtual* was the uneven distribution of telehealth services in relation to geography, age, race, and socio-economic status. "We need to understand what the gaps in telehealth are, rather than assume we know them," said Frank Micciche, vice president of public policy and communications at the National Committee for Quality Assurance. "For example, there is an assumption that older people do not like telehealth, but some providers find that older adults accept it more than others, since they've recently needed to learn new technologies to stay in touch with their grandchildren."

"Since the ultimate goal of telehealth is to increase access to care," said Johanna Garzon, MHA, HBAT, cancer center director at Central Care Cancer Center, "it is a big topic of conversation in rural regions." Through Garzon's experience designing and implementing a telehealth program across the ten rural sites her cancer center services in Kansas and Missouri, she has found significant disparities in access to the technology that fuels remote care.

Twenty percent of the patients Central Care Cancer Center serves have a landline phone or non-smart cell phone, precluding them from participating in video-based telehealth visits. Even more surprising to Garzon was her discovery that some patients—and some providers—are unaware of the existence of telehealth. "Eliminating these barriers is key to implementing and effectively using telehealth in rural settings," said Garzon, adding that relatives and care teams can play important roles in providing access to geographically isolated patients.

Garzon has identified poor access to technology as the biggest barrier to the long-term provision of telehealth. "We don't have the same technology that our patients have, and vice versa," she explained. "This poses reimbursement challenges with coverage rules that preclude telephone-only visits."

But whether audio-only communication is appropriate for patient visits is up for debate. Michael Kolodziej, MD, vice president and chief innovation officer at ADVI Health, said that he believes audio-only visits are inferior to video interactions. "If you just do a telephone call, you are unable to visually evaluate the patient," said Dr. Kolodziej. "When you see patients in the office, watching them walk into the room can tell you so much about how they are doing and what treatment may be most appropriate. You don't want to lose that entirely."

Shelley Fuld Nasso, MPP, CEO of the National Coalition for Cancer Survivorship, agreed that though audio-only is inferior to video for patient visits, it's better than nothing. Even if patients have the necessary technology, Nasso said, that doesn't mean they know how to use it: "If you spend half of the visit struggling to talk to a patient who is having problems using the technology, it's better to just have a quality phone call."

In the end, though, telehealth is only as workable as it is reimbursable. Before the dawn of COVID-19, obtaining adequate reimbursement for providing care remotely was a rare feat. Providers fear that, as the pandemic recedes, so too, will coverage for telehealth. "We need an impartial assessment of when and where telehealth is comparable to in-person care," said Micciche. "It's not easy; it will require us to create processes that everyone can agree to."

Ayodele added that, like telehealth itself, reimbursement for telehealth should not take a one-size-fits-all approach. Having a regulatory body or process to impartially identify when telehealth services are superior to or comparable with in-person care will go a long way toward developing appropriate reimbursement guidelines. "If advocacy for telehealth comes from both patients and providers attesting to its value, and showing data proving its value, that is huge," Micciche said. "Show that your costs did not spiral out of control, show that deferred care is more costly. Document it, get patients to advocate for it, and show that to the decision makers."

Sessions from AMCCBS *Virtual* are now available on demand! Register today at https://courses.accc-cancer.org/AMCCBS2021. For the best registration experience, please use Chrome, Edge, or Safari web browsers. Internet Explorer users may experience difficulties accessing this content. OI

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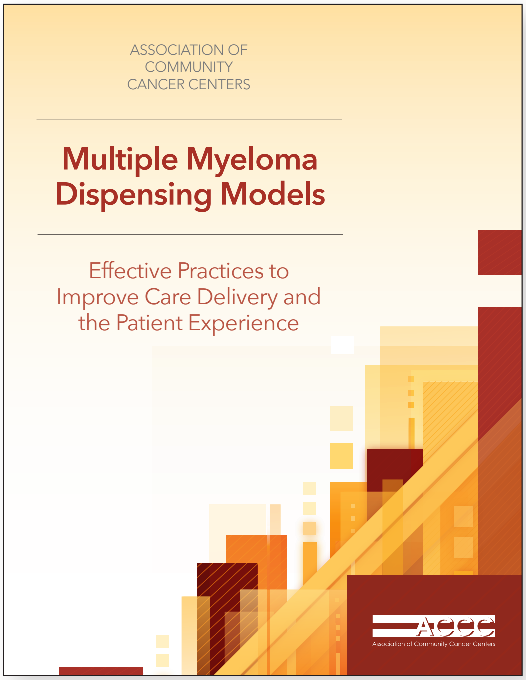

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Developing Effective Cancer Program Leadership

BY BARBARA SCHMIDTMAN, PHD, MAOL, CNMT

Effective leadership comes in many shapes and sizes, especially within the ever changing and fast-paced environment of oncology. Unfortunately, according to a 2015 national survey completed by Harris Poll and Interact, 91 percent of U.S. employees (out of 1,000 respondents) say their leader lacks the ability to communicate.[1] The same survey found that:[2]

- 63 percent of employees are not recognized for their achievements.
- 52 percent feel their leader does not have the time for them.
- 51 percent of leaders refused to talk to their subordinates.

As the senior director of cancer services at Spectrum Health Lakeland in St. Joseph, Mich., I led a breakout session at the 37th [Virtual] ACCC National Oncology Conference in September 2020, where I shared tips for effective and positive leadership in oncology. The first step to becoming an effective leader is to understand the type of leader you are—even if you hold an informal leadership position.

Styles of Leadership

There are many different leadership styles that have been studied, but the four that I predominately study and see in practice are 1) transformational, 2) transactional, 3) servant, and 4) dysfunctional.

The two most effective and positive leadership styles are transformational and servant leaders. A transformational leader is someone who wants to engage, be innovative, and motivate their team members in an inspirational way. This leadership style allows your team members to be the best they can be. A servant leader is someone who serves their team first. These leaders place their team members' needs above their own. Transformational and servant leaders usually have a high moral and ethical character and support each one of their team members, and both promote a positive work environment.

On the other hand, transactional leaders are not engaged with their team, and they usually adhere to a reward-punishment system. These leaders may not directly say to their staff, "If you do as I say, then you will be rewarded. Or if you don't do what I say, you may be punished" but usually run their teams in such a way where this system is implicitly understood. Lastly, a dysfunctional leader is more aggressive. These leaders create uncomfortable work environments for their team members and do not foster positive engagement and communication with their team.

As leaders in oncology, we should want to foster a positive work environment of growth and development for our team members, especially because our teams are working directly with patients. Whichever leadership style you are will ultimately impact your employee satisfaction and your patients' experiences. Therefore, leaders should also develop a space for communication and mentorship between them and their team members.

Mentorship is a mechanism of "providing guidance, motivation, emotional support, or role modeling to another to help explore personal growth, goals, and identify resources for success."[3] Each aspect of this definition should speak to leaders because this is what we need to do to relate and help our team members grow. By developing a mentor-mentee relationship with each team member, leaders will exhibit the transformational and servant leadership styles, while providing space for employees to connect with their leaders and share in open dialogue. Read more about mentoring in "Mentoring Those New to Oncology," *Oncology Issues*, Volume 36, Number 2.[4]

The Field of Oncology

Working in oncology comes with numerous complexities that leaders in cancer programs and practices, whether you are managerial, service line, or an executive, must juggle daily. I would also argue that oncology is one of the most complicated areas of care delivery in our healthcare system. So, being a leader in this space requires a lot from us. Because we have many different positions and sub-specialized positions within our staff (e.g., medical oncology, radiation oncology, various supportive care teams, etc.), we lead a wide range of specialties. This may also require us to foster a positive work environment across several locations, depending on how your cancer program or practice is set up. In my case, Spectrum Health Lakeland provides oncology services at six locations in southwestern Michigan, and as the senior director of cancer services, I must oversee teams at each location.

In addition to multiple specialties and disciplines, oncology leaders oversee many areas of service like:

- Quality
- Performance reviews
- Coordination of care
- Morbidity and mortality
- Patient experience
- Accreditations
- Financial performance
- COVID-19.

All of these factors contribute to oncology leaders' daily workdays, which can quickly become overwhelming. Being a positive, effective leader allows us to manage the complexities of oncology more easily and more enjoyably as we build employee satisfaction, patient satisfaction, quality, and outcomes. So, how do we manage positive and innovative leadership, as well as effective strategy and approach within our service line?

Tips for Effective Leadership in Oncology

In our current COVID-19 environment, it is incredibly difficult to connect with our teams virtually. Much of our communication is done through body language and non-verbal cues, so change management behind computer screens is difficult. Because all of my team members are on-site, I make sure that we all engage in dialogue safely by social distancing and using masks. One interesting topic that is starting to emerge is the vast amount of literature coming out about post-traumatic stress disorder and employee morale in healthcare, as well as burnout associated with the COVID-19 challenges we are experiencing. As we navigate through our next how-to strategies, I think it is important to lead with grace and to truly be understanding of every team member's individual feelings and perspectives, what they are going through in their personal lives, and how we as leadership can be supportive.

To improve communication, I conduct **one-on-one meetings with my direct leadership reports**. These meetings are focused on the quantitative metrics of our cancer program, as well as my relationship with those who are managing the frontline staff. These meetings allow my team leaders and I to solve or work through barriers or roadblocks together.

I also host **bi-monthly meetings with my direct non-leadership reports** (i.e., tumor registrars, nurse navigators, etc.). I do this because it is important for these team members to feel connected to me and know that their leader has the time in their schedule to address their barriers and/or concerns.

Lastly and most recently, I implemented a **twice-per-year meeting with every member of my team** (about 70 staff members total). I commit to having this one-on-one communication twice a year with every single member of my team to ensure that everyone has face time with me. Many times these interactions are brief, about 5 to 10 minutes; however, I find these meetings to be incredibly enjoyable because they allow time for us to connect and chat about what they have going on in their lives and what ideas they have for improving patient care and the overall patient and team member experience.

I have also found **rounding** to be a very effective leadership practice. There are times where I will get up very early in the morning and address all of my office work, so at 7:00 AM I can hit the ground running. In rounding, I make every attempt to greet and speak to every member of my staff on-site that day. This practice is important because it gives me the time to connect with my teams and provide mentorship in the moment if needed. One important tidbit for rounding is to not do so with the intent to pick on errors. (Rounding with the goal of

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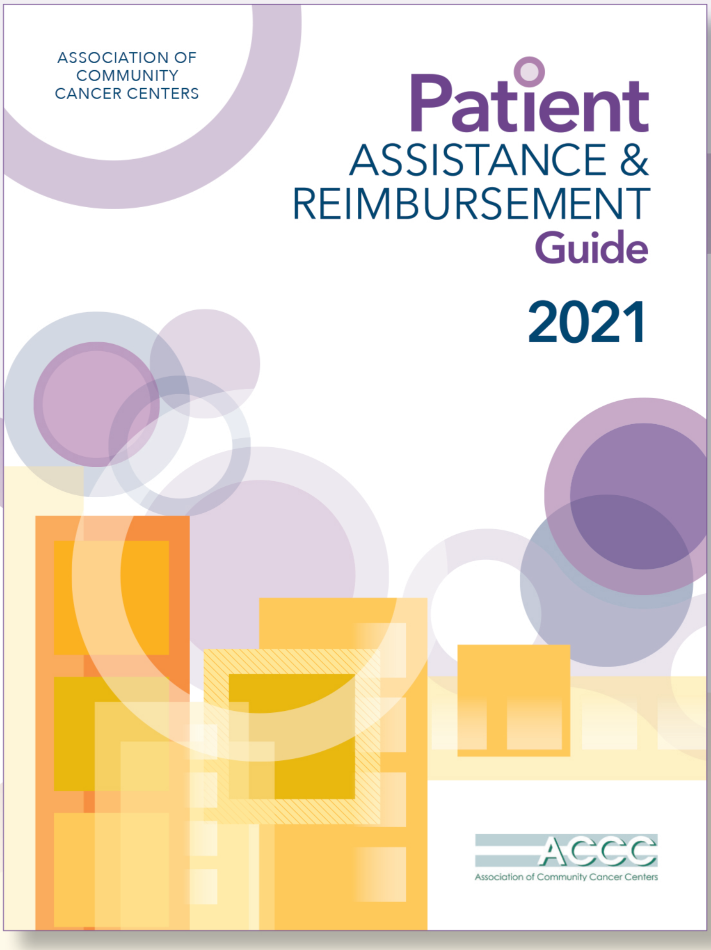
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identifying errors is an example of a transactional leadership style.) When leaders round, they should do so with the intent to build relationships with their team members. Also, executive leaders will join in rounds, which is very enjoyable for the staff, as well as myself. This practice allows my teams to connect and receive support from executive leadership—not just front-line leadership.

As a cancer program leader, I abide by an **open-door policy**. I believe that when team members have a need, it is important to be available, even if by phone when traveling between locations. (This would be an example of the servant leadership style.) I also suggest to other leaders that you not be constrained by the walls of your office. Sometimes I may work within the radiation oncology department for the day and then visit another location to work from the next day. Because my program has different locations, I use this opportunity to be actively engaged in the moment. I have since found that my team enjoys that I do this and is receptive to me being readily available in this way.

Lastly, it is important to **include your oncologists and physicians as part of leadership**, even if they do not hold a formal title. Physician behaviors have just as much, if not more, of a profound impact on staff as a cancer program leader would have. If a physician in your program or practice demonstrates dysfunctional or transactional leadership styles, they are going to have a negative effect on your team. **Coach physicians to be active, positive contributors to your team**. I host monthly meetings with the physicians on our team so that when there is something that needs to be coached or discussed more formally, I am available. In addition, it is important to make sure oncologists and physicians feel that they can connect with leadership on the same level as any other staff member.

Effective leaders in any industry exude courage, professionalism, and positivity and are generally defined as "upbeat." They lead by example. For new leaders or even seasoned leaders looking for resources, I suggest reading the book *Grit: The Power of Passion and Perseverance* by Angela Duckworth.[5]

As a leader in oncology, it is truly a blessing to lead the teams that fight the good fight with our patients. And remember, to continue to be able to provide high-quality care to our patients, leaders must make sure that their teams truly feel supported, listened to, and valued.

Barbara Schmidtman, PhD, MAOL, CNMT, is the senior director of cancer services at Spectrum Health Lakeland in St. Joseph, Mich.

References

1. Solomon L. The top complaints from employees about their leaders. Available online at: inc.com/marcel-schwantes/survey-91-percent-of-1000-employees-say-their-boss.html. Published June 24, 2015. Last accessed March 18, 2021.
2. Schwantes M. Survey: 91 percent of 1000 employees say their bosses lack this 1 critical skill. This recent Interact/Harris Poll tells the whole story about the current state of managers. Available online at: hbr.org/2015/06/the-top-complaints-from-employees-about-their-leaders. Published August 10, 2017. Last accessed March 18, 2021.
3. University of Washington. What is the role of a mentor? Available online at: washington.edu/doit/what-role-mentor. Published April 29, 2019. Last accessed March 18.2021.
4. Michalik K. Mentoring those new to oncology. *Oncol Issues*. 2021;36(2):82-84.
5. Duckworth A. *Grit: The Power of Passion and Perseverance*. Scribner/Simon & Schuster, New York; NY. 2016.

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