ONCOLOGY ISSUES

A Primary Care Provider Helps a Cancer Program Soar to New Heights

ACCC
Association of Community Cancer Centers

2022 ACCC INNOVATOR AWARD
ASSOCIATION OF COMMUNITY CANCER CENTERS

The **12TH ANNUAL ACCC INNOVATOR AWARDS**
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contents

For patients with comorbidities who are in active treatment for cancer and who report having no primary care, having an embedded primary care provider where they receive their cancer therapy is a patient-centered model that brings across-the-board benefits. Learn how this pilot intervention—a cross-departmental collaboration—is viewed as a win-win-win by patients, the oncology service line, and the Department of Family Medicine at ChristianaCare.

The OCM is Ending, What's Next?

BY SIBEL BLAU, MD

The Affordable Care Act was signed into law in March 2010, mandating that the Centers for Medicare & Medicaid Services (CMS) create its Center for Medicare and Medicaid Innovation (the Innovation Center). The Innovation Center's mission: develop new payment and delivery system models. As a result, the agency developed the Oncology Care Model (OCM), a six-year, episode-based payment model, running from July 1, 2016 to June 30, 2022 (extended by one year due to the COVID-19 pandemic).

Participating practices received a $160 per beneficiary/per month Monthly Enhanced Oncology Services (MEOS) payment, with the potential to earn a performance-based payment to drive improvements in cancer care and lower costs. After four reporting episodes, the program saw a small but statistically significant decrease in Medicare spending; however, when all payments (MEOS and performance-based payment) were calculated, Medicare showed a net loss. CMS is currently reviewing comment letters submitted in response to an informal request of information regarding potential successor programs to the OCM, including the Oncology Care First Model.

The Quality Cancer Care Alliance Network (QCCA) is a clinically integrated network of independent oncology practices throughout the United States. Because value-based care is a central focus for the organization, several QCCA practices are also OCM participants. QCCA helps with the infrastructure needed for value-based care, including data analytics, care pathways, and best practices. QCCA practices have been committed to the OCM and most have been high performers.

As independent oncology practices, QCCA affiliates do not share in the substantial financial benefits provided to large hospital systems and academic centers through philanthropy or programs like the 340B Drug Discount Program. Nevertheless, QCCA sites leveraged their OCM MEOS payments to create systems and practices that provide higher quality care at a lower cost.

The OCM required true practice transformation, meaning physicians and ancillary clinic personnel—already stretched to the limits of their capabilities—needed to fundamentally retool workflows and develop new processes. For QCCA sites, the practice of value-based care became integral to the practice of medicine. Cost of care considerations became an essential component of cancer care, alongside discussions on how to improve quality and provide better patient care. As a result, QCCA's nimble practices executed this innovative model by helping one another succeed.

QCCA's bi-annual summit took place in early October 2021. The panel session on what to expect if the OCM is not replaced by another alternative payment model drove much of the conversation at our first in-person meeting since the onset of the COVID-19 pandemic. Panel participants shared data that showed that their practices contributed to millions of dollars in savings to Medicare by transforming care and meeting OCM requirements.

The OCM successfully promoted value-based care. OCM participants learned to be mindful about using less costly drugs (when appropriate) and focusing on holistic and patient-centered quality of care. However, in the absence of a successor to the OCM, the future looks bleak. Most oncology practices will not be able to sustain new programs built to meet OCM requirements. Many OCM participants worry about having to go back to relying on more costly drugs to sustain these new programs and services, or having to cut new program or services entirely. OCM practices are concerned that—in the absence of a successor model—going "all in" with the OCM may actually jeopardize their long-term viability.

QCCA summit participants all hope that CMS develops another program to incentivize oncology to continue to provide patient-centered, value-based care. We believe this country needs a better model to provide cancer care, yet a true value-based care model is one where patients benefit from scientific, medical, and technological advances in responsible ways. We believe in this vision and are prepared to do the work. But to continue to provide quality cancer care, we must be able to afford to keep our doors open. OI

Reversing the Great Resignation

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

As I sat down to write my last column, I decided to use these 700 words as a "call to action" to cancer program and practice leaders to bring flexibility and innovation into—or out of—their workplace. If we learned anything in the past two years, it's that what we thought we knew may not be true. We were stretched and pushed to do everything differently. From where we work, to how we see patients and how we connect, sometimes it's hard to remember the before. Do these changes impair connection and compromise quality care? We all learned that the answer is "no."

I facilitate a support group for individuals with advanced illness. With the transition from in-person to virtual meetings, patients were able to participate while on hospice—literally, in bed—while others joined while receiving treatment in infusion chairs. It allowed connection at a time when people felt lonely and provided the gift of meaningful discussions about fears and goodbyes within a community that has only known each other through Zoom.

Like a patient with cancer facing life after diagnosis, we do not know yet what our "new normal" is. The future is uncertain and in constant flux. For example, who could have predicted the turn from thousands of people losing their jobs at the start of the COVID-19 pandemic to thousands of people choosing not to work, just as it looks like we are finally turning the tide with successful vaccines and improved treatments?

The "great resignation" was coined to describe the record number of people leaving their jobs, and leaders across all industries—including healthcare—are having to re-evaluate how to retain staff. These same leaders are struggling to answer the question: "Why don't workers want to return to the office?"

I believe that the leaders who successfully answer that question will be those who adopt innovative and flexible staffing models, workflows, and processes.

Our focus should be on retention interviews—not exit interviews. What do the members of your cancer care team need to stay in their current jobs or positions? Consider asking your providers and staff, "What could be better in your work setting?" Are there opportunities for continuing education, alternative work schedules, well-being activities, or career growth? Though each of these concepts come with an associated cost, they may incentivize your most precious resource—your staff—to stay, while making your organization more attractive to those who have resigned and who are searching for meaningful work at a place that prioritizes their well-being and fosters a healthy work-life balance.

Let us pause here for a moment and consider the word *well-being*—a term that appears in every post, article, and news story about the great resignation. How *do* you improve well-being in the workplace?

For the Cancer Centers of Colorado at SCL Health St. Mary's Medical Center, improving well-being required the improvement of their culture one idea at a time through a Daily Improvement Program. Starting on page 36, learn how this cancer center leadership team searched for inspiration and found it within their own program. Their incredibly hardworking and experienced staff regularly brought concerns and ideas for change to leadership; it was on leadership to find a structured way to capture these ideas and channel them into staff engagement and positive change. You will be inspired by how the Daily Improvement Program changed the culture of this cancer center for the better. In the first three years of the program, 60 individuals and 13 teams submitted 180 ideas. Of these, more than 100 came to fruition. It is this type of innovation that offers us the best opportunity to reverse the great resignation.

Asking for ideas, being open to feedback, embracing flexibility, and accepting that our world has changed allow leaders to pivot and re-invest in those who stayed the course, while limiting the need to rehire and retrain.

At their very core, a great leader is someone who builds other leaders. Leaders do not have all the answers, but they create a space for others to shine and promote wellness within their teams. ◻️

Virtual Assessment of Physical Function in Adults with Cancer: Practical Tips

WEBINAR

Two experts provide practical strategies to gather critical information quickly and effectively about your patients' functional health—by phone or video. Learn proven methods to perform these assessments on adults with cancer—even when they are not in your physical office. Watch online at accc-cancer.org/telemedicine-for-physical-health.

MRD Implementation Roadmap

TOOL

This innovative learning tool helps multidisciplinary cancer care teams obtain the knowledge they need to implement, expand, and sustain (MDR) testing for adult patients with acute lymphoblastic leukemia. Explore this online tool at accc-cancer.org/ALL-Roadmap.

A Toxic Mixture: Burnout in Oncology Pharmacy

BLOG

A recent study published in *HOPA News* found that 61.8 percent of hematology/oncology pharmacists experienced high levels of burnout based on their emotional exhaustion and depersonalization scores on the Maslach Burnout Inventory. Read more, including practical tools and resources, at accc-cancer.org/oncology-pharmacy-burnout.

Precision Medicine Disparities

VIDEO

Two authors of an ACCC/LUNGevity Foundation study discuss clinician needs related to biomarker testing in non-small cell lung cancer, including increased guideline familiarity and practical applications of guideline-concordant testing, as well as how improving patient-clinician discussions and education and how access to appropriate clinical trials can help eliminate disparities. Watch today at accc-cancer.org/precision-medicine-disparities.

Using Telemedicine to Assess Psychosocial Health

WEBINAR

A panel of supportive care specialists share practical tips on the use of psychosocial screening tools and how to effectively integrate them into practice. Available online at accc-cancer.org/telemedicine-for-psychosocial-health.

fast

Can Watching Horror Flicks Help Build Resilience?

Researchers at Penn State seem to think so. According to research published in *Personality and Individual Differences*, the more movies about zombie uprisings, alien invasions, and apocalyptic pandemics people had watched pre-COVID-19, the better they dealt with the current pandemic. Their hypothesis: these types of movies can serve as mental rehearsal for actual events.

Source. Scrivner C, et al. Pandemic practice: Horror fans and morbidly curious individuals are more psychologically resilient during the COVID-19 pandemic. *Pers Individ Dif.* 2021 Jan 1;168. doi: 10.1016/j.paid.2020.110397.

Americans Face Medication Access Challenges That Delay Care

- When patients cannot afford their prescriptions, **29%** admit to abandoning their medications while **52%** seek affordability options through their physician, a labor-intensive process which creates additional work for the provider and can delay time to therapy.

- **55%** of patients reported delays in time to therapy due to a prescribed medication requiring prior authorization.

- **82%** of patients say they spent at least one hour or more making multiple phone calls to track down needed information to begin specialty therapies. As a result of this time-consuming administrative work, nearly 1 in 10 patients reported waiting 8 weeks or more to receive their first dose of therapy.

Source. CoverMyMeds. The 2020 Medication Access Report. covermymeds.com/main/medication-access-report.

facts

Sticker Shock!

Launch prices of drugs in the U.S. were found to be **186%** to **215%** higher than in Europe (England, Germany, and Switzerland). After launch, prices decreased in **86%** to **90%** of drugs in Europe, compared to decreases in only **19%** of drugs in the U.S.

Source. K. Vokinger et al. Launch prices and price developments of cancer drugs in the United States and Europe. Abstract 2006. ASCO 2020.

Are We at Risk of a Physician Turnover Epidemic?

- Nearly **70%** of physicians surveyed say they are actively disengaged from their employers.

- **54%** of physicians surveyed said COVID-19 has changed their employment plans.

- Of those **54%**, half (**50%**) are considering leaving for a new healthcare employer, **21%** said they may hang up their white coat for early retirement, and **15%** are thinking about leaving the practice of medicine entirely.

Source. Jackson Physician Search. jacksonphysiciansearch.com/physician-retention-and-engagement-survey-results.

30% of hospitals and health systems using revenue cycle automation require 2 or more vendors to manage the process; another 30% have built internal automation teams.

Source. Alpha Health national survey fielded between May 19, 2020 and June 22, 2020 among 587 chief financial officers and revenue cycle leaders at health systems across the United States. alphahealth.com.

Study Finds Patients Need More Education on Medicare Options

A record-breaking **26.9** million Medicare Advantage enrollees are projected in 2021, but that represents less than half (**42%**) of all Medicare beneficiaries. Millions more Americans may miss out due to a lack of knowledge and awareness around the full menu of Medicare, from Medicare Supplement Insurance (Medigap) and Part D to Medicare Advantage. The study found that:

- **86%** of original Medicare respondents believe Medicare alone provides an out-of-pocket maximum (it does not).

- **65%** of original Medicare beneficiaries do not know that Medicare Advantage plans provide Part A and Part B coverage.

- Only **18%** of original Medicare beneficiaries are "very familiar" with Medicare Advantage plans.

- **31%** of original Medicare beneficiaries are unsure if Medicare Advantage and Medigap are the same thing.

Source. GoHealth. gohealth.com/a-new-gohealth-study-reports-older-americans-are-familiar-with-original-medicare-but-lack-awareness-understanding-of-the-alternative-option.

issues

The Build Back Better Act

BY BLAKE MCCREERY-CULLIFER

The huge piece of legislation known as the Build Back Better Act lays the groundwork for many of the healthcare promises Democrats ran on in 2019. If enacted, patients with cancer across the country will benefit from increased access and new fiscal protections, including universal paid family leave. That being said, specific pieces of the Build Back Better Act may have negative consequences for oncology programs and practices nationwide.

A recent Congressional Budget Office score increased the likelihood of passage; the score suggested that the act would only add $367 billion (about $1,100 per person in the United States) to the budget deficit over the next decade.

However, given the lack of support for the current version of the bill in the Senate, it is unlikely that the Act will advance without significant alterations. It is our hope that the problematic pieces of this legislation are addressed in future negotiations. Below are some of the high-level changes the bill would make to the U.S. healthcare landscape in its current form.

ACA Marketplace

During the COVID-19 pandemic, Marketplace premiums received additional subsidies and enrollment time frames expanded. Patient advocates applauded these moves. People who lost their jobs because of the pandemic also became eligible for zero-dollar premiums. Since the expansion of subsidies, the Marketplace has seen millions of new beneficiaries enroll in health plans. Though these measures are only temporary and are set to expire in 2022, Section 137301 of the Build Back Better Act would extend premium subsidies and eliminate any income requirements that made the most impoverished ineligible for premium reductions. Additionally, this section extends the break for those on unemployment insurance through 2025.

Medicaid

At this time, 12 states have chosen not to expand Medicaid. In these states, a coverage gap exists for individuals whose income falls under 138 percent of the federal poverty level. The Build Back Better Act would close this gap under section 137304 by fully subsidizing Marketplace health plans starting in 2022 through 2025. Additionally, these beneficiaries would be eligible for cost-sharing subsidies that would reduce their out-of-pocket costs to 1 percent of overall covered health expenses on average.

Medicare

Currently, most Medicare beneficiaries do not receive coverage for hearing services. Except for specific clinical circumstances found in some Medicare Advantage plans, hearing aid costs can be incredibly high. Section 30901 of the Build Back Better Act seeks to address this issue by creating a pay structure for hearing aids that resembles the current pay structure for most prosthetics. Medicare beneficiaries would be able to obtain hearing aids with a 20 percent coinsurance, every five years, starting in 2023.

Under the current Medicare Part D drug benefit program structure, multiple pay phases exist, such as a deductible, initial coverage phase, coverage gap phase, and catastrophic phase. In other words, beneficiaries maintain some responsibility of drug costs indefinitely. One provision in the Build Back Better Act sets a $2,000 cap on patient out-of-pocket patient costs for Part D drugs.

The most controversial piece of the Build Back Better Act is found in sections 139001, 139002, and 139003. Many refer to these sections jointly as H.R.3 or the Elijah E. Cummings Lower Drug Costs Now Act. These sections seek to lower prescription drug costs. The controversy—and concerns—hinges on how lower drug costs would be achieved. These sections seek to amend the non-interference clause that has barred the secretary of Health and Human Services from negotiating drug prices—even when increases in cost exceed inflation. This amendment would compel the secretary to negotiate specific categories of drugs on a defined timeline and mandate a rebate on drugs that were sold at costs that exceeded inflation. It is worth noting one exception: drugs that have biosimilar competitors would be exempt from these negotiations, at least initially.

Concerning cancer care providers, it is critical to know how these provisions would impact overall reimbursement. These changes represent a potentially egregious cut in physician reimbursement. An analysis by Avalere found that "medical oncology, hematology/oncology, and rheumatology practices would experience reductions of 42.9 percent, 41.3 percent, and 48.5 percent, respectively."[1] Furthermore, Avalere estimated that radiation oncology would see a 39.7 percent reduction in reimbursement.[2]

Blake McCreery-Cullifer is a contractor for Cancer Care Delivery and Health Policy at the Association of Community Cancer Centers, Rockville, Md.

References

1. Sullivan M, Tripp A, Mckinney K, et al. Part B drug negotiation under BBBA would reduce payments to providers. Published November 18, 2021. Accessed November 28, 2021. avalere.com/insights/part-b-drug-negotiation-under-bbba-would-reduce-payments-to-providers.
2. Cox C, Rudowitx, R, Cubanski J, et al. Potential costs and impact of health provisions in the Build Back Better Act. Published November 23, 2021. Accessed January 5, 2022. health-costs/issue-brief/potential-costs-and-impact-of-health-provisions-in-the-build-back-better-act.
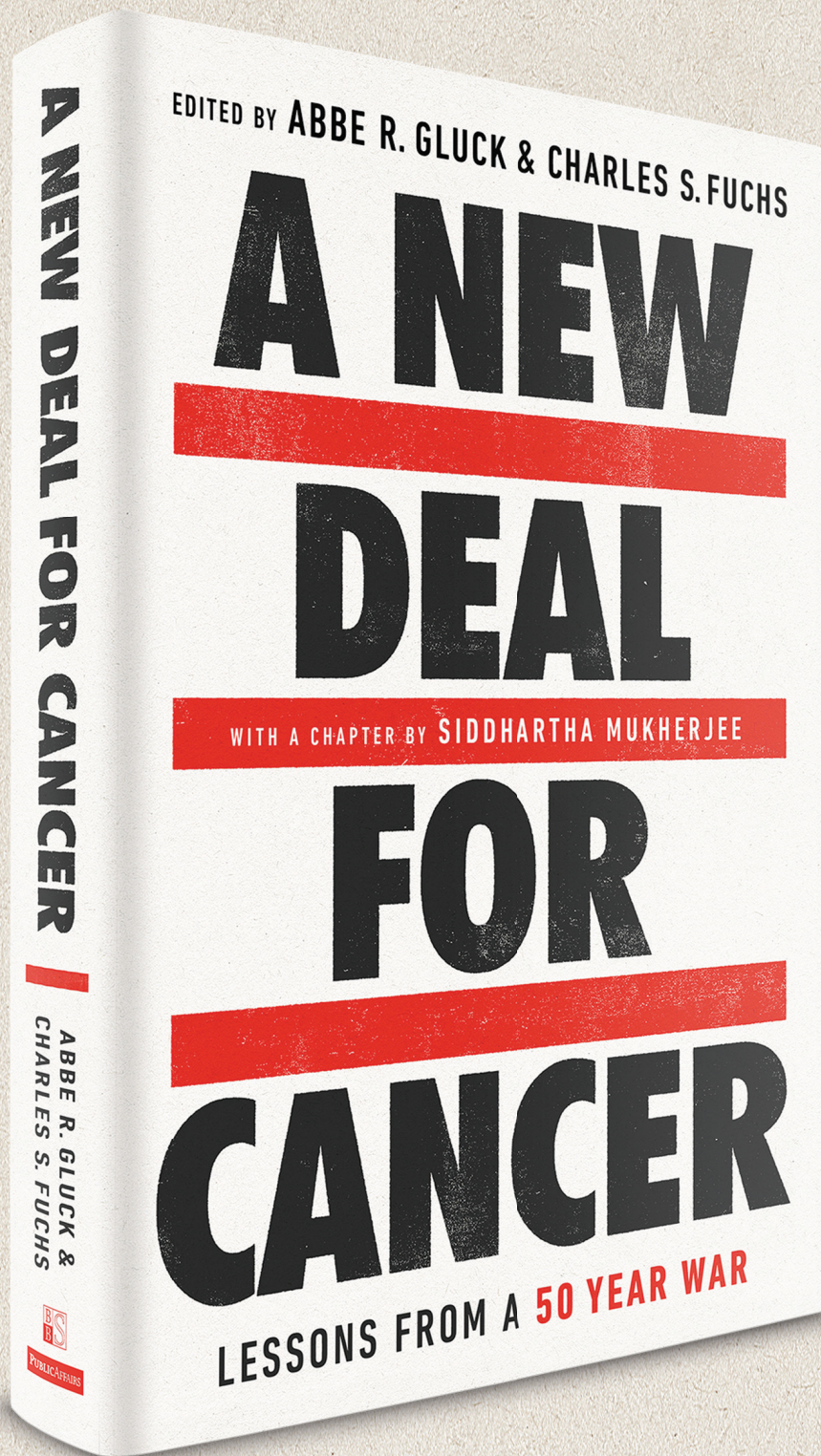
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compliance

2022 Oncology Coding Update

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

The Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) have finalized the coding updates for calendar year (CY) 2022. Overall, there are no significant coding changes impacting oncology, but it is important to be prepared and ensure that coding practices and chargemasters are updated to reflect any necessary code changes. This column outlines coding changes specific to the *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), Current Procedural Terminology (CPT®), and Health-care Common Procedure Coding System (HCPCS) for services that may be provided by or related to oncology specialties.

Revised Guidelines for ICD-10-CM Diagnosis Coding

Many of the guidelines updated for 2022 focus on the need to code the diagnosis to the highest level of specificity. Language was added in several sections of the ICD-10-CM Official Guidelines to press this point. New in 2022, the guidelines state the following:

- *Highest level of specificity*: Code to the highest level of specificity when supported by the medical record documentation.
- *When laterality is not documented* by the patient's provider, code assignment for the affected side may be based on medical record documentation from other clinicians. If there is conflicting medical record documentation regarding the affected side, the patient's attending provider should be queried for clarification. Codes for "unspecified" side should rarely be used, such as when the documentation in the record is insufficient to determine the affected side and it is not possible to obtain clarification.

There may be instances in which signs and symptoms need to be coded based on the reason for the encounter. When there is no specificity supported in the medical record, coders and practitioners will need to discuss documentation. *A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.* The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The diagnosis code is not the only piece of information provided under the ICD-10-CM system. There are factors influencing health status that provide more information about the patient. These factors can be used in registries to provide additional context to the patients seen for healthcare services. For example, "History of" codes, which begin with the letter "Z," contain personal and family history. When practitioners document statements in the medical record related to the "History of," they should be coded. Language was updated to reinforce the sequence of codes listed on the claim form. The reason for the encounter—for example, screening or counseling—should be sequenced first and the appropriate personal and/or family history code(s) should be assigned as an additional diagnosis(es).

Revised ICD-10-CM Codes

New for 2022, codes to denote malignancy to bilateral ovaries are available; previously the codes were only specific to the right or left side:

- **C56.3:** Malignant neoplasm of bilateral ovaries
- **C79.63:** Secondary malignant neoplasm of bilateral ovaries.

There are also new codes related to anaplastic large cell lymphoma for breast cancer. Added codes and guidance include the following:

- **C84.79A**: Anaplastic large cell lymphoma, ALK-negative, breast

For breast implant associated with anaplastic large cell lymphoma (BIA-ALCL), use an additional code to identify: breast implant status (**Z98.82**) and personal history of breast implant removal (**Z98.86**). Do not assign a complication code from chapter 19.

Evaluation and Management Revised Codes

- **99211:** Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified healthcare professional. Note: the last sentence referring to minimal presenting problems was removed from code 99211.

New Evaluation and Management Codes

Code **+99437:** Chronic care management services with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient
- Chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored.

Each additional 30 minutes by a physician or other qualified healthcare professional per calendar month should be listed separately in addition to the code for the primary procedure.

Code **99424**: Principal care management services, for a single high-risk disease, with the following required elements:

- One complex chronic condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- The condition requires development, monitoring, or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities and ongoing communication and care coordination between relevant practitioners furnishing care.

The first 30 minutes personally provided by a physician or other qualified healthcare professional per calendar month.

Code **+99425**: Principal care management services, for a single high-risk disease, with the following required elements:

- One complex chronic condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- The condition requires development, monitoring, or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities and ongoing communication and care coordination between relevant practitioners furnishing care.

Each additional 30 minutes provided personally by a physician or other qualified healthcare professional per calendar month should be listed separately in addition to code for primary procedure.

Code **99426**: Principal care management services, for a single high-risk disease, with the following required elements:

- One complex chronic condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- The condition requires development, monitoring, or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities and ongoing communication and care coordination between relevant practitioners furnishing care.

The first 30 minutes of clinical staff time directed by physician or other qualified healthcare professional per calendar month.

Code **99427**: Principal care management services, for a single high-risk disease, with the following required elements:

- One complex chronic condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- The condition requires development, monitoring, or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities and ongoing communication and care coordination between relevant practitioners furnishing care.

Each additional 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional per calendar month should be listed separately in addition to code for primary procedure.

New Codes for Remote Therapeutic Monitoring

- **98975**: Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial setup and

patient education on use of equipment
- **98976:** Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supplied with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
- **98977**: Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supplied with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
- **98980:** Remote therapeutic monitoring treatment management services and physician or other qualified healthcare professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
- **+98981:** Remote therapeutic monitoring treatment management services and physician or other qualified healthcare professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes. List separately in addition to code for primary procedure
- **99072:** Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a public health emergency, as defined by law, due to respiratory-transmitted infectious disease.

Category III Codes
Two codes were created for mechanical scalp cooling systems, not the manual placement of cold or ice packs, which are used to reduce the potential side effect of chemotherapy-induced hair loss from certain cytotoxic drugs. These codes were created by the AMA CPT® Editorial Panel for utilization July 1, 2021, but are part of the official release of codes in the 2022 CPT® manual.

The initial code is to be billed once per course of chemotherapy and the other is an add-on code for the placement, monitoring, and removal of the cap at the time of chemotherapy treatment.

- **0662T:** Scalp cooling, mechanical; initial measurement and calibration of cap
- **+0663T:** Scalp cooling, mechanical; placement of device, monitoring, and removal of device (list separately in addition to code for primary procedure).

HCPCS Added Modifiers

- **FQ:** The service was furnished using audio-only communication technology.
- **FR:** The supervising practitioner was present through two-way audio/video communication technology.
- **FS:** Split (or shared) evaluation and management (E/M) visit.
- **FT:** Unrelated E/M visit during a postoperative period or on the same day as a procedure or another E/M visit. Report when an E/M visit is furnished within the global period but is unrelated or when one or more additional E/M visits furnished on the same day are unrelated.

HCPCS Codes Added for Radiation Oncology Model

- **M1072:** Radiation therapy for anal cancer under the Radiation Oncology (RO) Model, 90-day episode, professional component
- **M1073:** Radiation therapy for anal cancer under the RO Model, 90-day episode, technical component
- **M1074:** Radiation therapy for bladder cancer under the RO Model, 90-day episode, professional component
- **M1075:** Radiation therapy for bladder cancer under the RO Model, 90-day episode, technical component

- **M1076:** Radiation therapy for bone metastases under the RO Model, 90-day episode, professional component
- **M1077:** Radiation therapy for bone metastases under the RO Model, 90-day episode, technical component
- **M1078:** Radiation therapy for brain metastases under the RO Model, 90-day episode, professional component
- **M1079:** Radiation therapy for brain metastases under the RO Model, 90-day episode, technical component
- **M1080:** Radiation therapy for breast cancer under the RO Model, 90-day episode, professional component
- **M1081:** Radiation therapy for breast cancer under the RO Model, 90-day episode, technical component
- **M1082:** Radiation therapy for cervical cancer under the RO Model, 90-day episode, professional component
- **M1083:** Radiation therapy for cervical cancer under the RO Model, 90-day episode, technical component
- **M1084:** Radiation therapy for central nervous system (CNS) tumors under the RO Model, 90-day episode, professional component
- **M1085:** Radiation therapy for CNS tumors under the RO Model, 90-day episode, technical component
- **M1086:** Radiation therapy for colorectal cancer under the RO Model, 90-day episode, professional component
- **M1087:** Radiation therapy for colorectal cancer under the RO Model, 90-day episode, technical component
- **M1088:** Radiation therapy for head and neck cancer under the RO Model, 90-day episode, professional component

- **M1089:** Radiation therapy for head and neck cancer under the RO Model, 90-day episode, technical component
- **M1094:** Radiation therapy for lung cancer under the RO Model, 90-day episode, professional component
- **M1095:** Radiation therapy for lung cancer under the RO Model, 90-day episode, technical component
- **M1096:** Radiation therapy for lymphoma under the RO Model, 90-day episode, professional component
- **M1097:** Radiation therapy for lymphoma under the RO Model, 90-day episode, technical component
- **M1098:** Radiation therapy for pancreatic cancer under the RO Model, 90-day episode, professional component
- **M1099:** Radiation therapy for pancreatic cancer under the RO Model, 90-day episode, technical component
- **M1100:** Radiation therapy for prostate cancer under the RO Model, 90-day episode, professional component
- **M1101:** Radiation therapy for prostate cancer under the RO Model, 90-day episode, technical component
- **M1102:** Radiation therapy for upper gastrointestinal (GI) cancer under the RO Model, 90-day episode, professional component
- **M1103:** Radiation therapy for upper GI cancer under the RO Model, 90-day episode, technical component
- **M1104:** Radiation therapy for uterine cancer under the RO Model, 90-day episode, professional component
- **M1105:** Radiation therapy for uterine cancer under the RO Model, 90-day episode, technical component. **OI**

2022 Hospital Regulatory Update

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

On Nov. 2, 2021, CMS issued a final rule for the Hospital Outpatient Prospective Payment System (HOPPS) for CY 2022. The HOPPS Final Rule can be accessed online at: federalregister.gov/public-inspection/2021-24011/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment. This rule applies to facility settings (i.e., outpatient hospitals and ambulatory surgical centers). As has been the case over the last few years, CMS did not finalize any dramatic reimbursement changes.

HOPPS Payment Rates

CMS finalized use of CY 2019 claims data for rate-setting rather than CY 2020 claims data out of concern for the significant decrease in utilization of services due to the COVID-19 public health emergency and pandemic. Based on these data, CMS finalized a 2 percent increase to the outpatient department fee schedule. This percentage is based on the proposed market update from the Inpatient Prospective Payment System of 2.7 percent and a −0.7 percent productivity adjustment. The agency used a conversion factor of $84.177 for hospitals that meet the reporting criteria and applied the 2 percent reduction to those hospitals that do not meet reporting requirements. CMS estimates total HOPPS payments to providers to be approximately $82.078 billion—an increase of approximately $5.913 billion compared to CY 2021 HOPPS payments.

CMS will continue applying a wage index of 1 for frontier state hospitals, a policy that has been in place since CY 2011. This policy ensures that lower population states are not penalized for reimbursement due to the low number of people per square mile when compared to other states.

For CY 2022, CMS will continue additional payments to cancer hospitals utilizing a payment-to-cost ratio factor (PCR). Beginning in CY 2018, the 21st Century Cures Act required the weighted average PCR be reduced by 1 percent. CMS finalized the target PCR of 0.90, an increase from the proposed value, to determine the CY 2022 cancer hospital payment adjustment to be paid at cost report settlement, which includes the 1 percent reduction.

Standardizing Ambulatory Payment Classifications Payment Weights

Ambulatory payment classifications (APCs) group services are considered clinically comparable to each other with respect to the resources utilized and associated costs. CMS will continue using HCPCS code **G0463**, a hospital outpatient clinic visit for the assessment and management of a patient, in APC **5012** (level 2 examinations and related services) as the standardized code for the relative payment weights. A relative payment weight of 1 was assigned to APC **5012** (code **G0463**). For CY 2022, CMS will continue to pay code **G0463** at a payment rate of 40 percent of the HOPPS rate for any outpatient, off-campus hospital setting that is excepted or non-excepted.

Ambulatory Payment Classification Updates CY 2022

All services (codes) associated with an APC are paid the exact same amount. If the resources and costs of services change enough that the code with the highest cost of resources within an APC is more than two times that of the code with the lowest cost, CMS must adjust the placement of these codes. This would be considered a two times rule violation and to correct it, codes would need to be moved to APCs that better match their resource cost(s) or CMS would need to create a new APC for the identified services. Over the past few years, CMS has provided an exception to the identified two times rule violation based on the belief that many will work themselves out in the next claims data period with more accurate reporting. CMS identified 23 APCs with two times rule violations that the agency will exempt.

Brachytherapy Sources

CMS did not propose any significant changes to how reimbursement for brachytherapy sources is calculated. The agency did propose and finalize using costs derived from CY 2019 claims data to set the CY 2022 payment rates and basing the payment rates for brachytherapy sources on the geometric mean unit costs for each source. Brachytherapy sources, unless otherwise noted, are assigned the status indicator "U." Codes with status indicator "U" are not packaged into C-APCs; the sources are paid separately in addition to the brachytherapy insertion code in the hospital setting.

CMS will continue to pay for the stranded and non-stranded, not otherwise specified, HCPCS codes **C2698** and **C2699** at a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively, on a per source basis (as opposed to, for example, a per mCi). The agency invites recommendations for new

codes to describe new brachytherapy sources by email to outpatientpps@cms.hhs.gov or by mail to the Division of Outpatient Care, Mail Stop C4-01-26, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

CMS also proposed and finalized the creation of low-volume APCs for designated clinical, brachytherapy, and new technology services. These would be APCs with fewer than 100 single claims in the year used for rate setting for clinical and brachytherapy APCs. As stated previously, brachytherapy APCs **C2698** (Brachytherapy source, stranded, not otherwise specified, per source) and **C2699** (Brachytherapy source, non-stranded, not otherwise specified, per source) would not be included in this payment process. These non-specific APCs already have an established method for determining pricing. Instead, CMS will designate five brachytherapy APCs as low volume. Payment rates will use claims data from 2016-2019, a four-year span. The five brachytherapy APCs are:

- **C2632:** Iodine I-125 sodium iodide
- **C2635**: Brachytherapy, non-stranded, HA, P-103
- **C2636**:Brachytherapy linear, non-stranded, P-103
- **C2645**: Brachytherapy, non-stranded, Gold-198
- **C2647**: Brachytherapy, non-stranded, non-HDRIr-192.

Device-Intensive Procedures

CMS sought comments on the proposal to establish the CY 2022 device offset percentage using CY 2019 claims data when there are no data from CY 2020 for device-intensive procedures. Device-intensive status is assigned to procedures when the device cost exceeds a threshold of 40 percent related to the APC. After reviewing comments, the agency finalized using CY 2019 claims data for 11 procedures, 3 of which may impact interventional radiology departments and should be noted for specific billing guidelines.

- **C9757:** Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone-anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; one interspace, lumbar.
- **C9765:** Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed.
- **C9767:** Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel(s), when performed.

CMS will continue to recognize HCPCS **C1889** (Implantable/insertable device, not otherwise classified) for billing the device as part of a device-intensive procedure when there is no specific Level II HCPCS Category C code to represent it.

Payments of Drugs, Biologicals, and Radiopharmaceuticals

Each year, CMS assesses the drug packaging threshold. For CY 2022, CMS will continue to package drugs and biologicals estimated at a per day administration cost less than or equal to $130, as they did in CYs 2020 and 2021. CMS will continue to separate payment for items with an estimated per day cost greater than $130, except for diagnostic radiopharmaceuticals, contrast agents, anesthesia drugs, drugs, biologicals, radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure, and drugs and biologicals that function as supplies or devices when used in a surgical procedure.

CMS will continue the policy of making packaging determinations on a drug-specific basis rather than by HCPCS code for codes that describe the same drug or biological in different dosages. For all other drugs and biologicals that have HCPCS codes describing different dosages, the agency aggregated claims data and pricing information at ASP+6 percent for all HCPCS codes that describe each distinct drug or biological. This calculation provided the mean units per day in terms of the HCPCS code with the lowest dosage descriptor. For other drugs and biologicals that have HCPCS codes describing different dosages, CMS multiplied the weighted average ASP+6 percent per unit, across all dosage levels of a specific drug or biological, by the estimated units per day for all HCPCS codes that describe each drug or biological to determine the estimated per day cost of each drug or biological at less than or equal to the CY 2022 drug packaging threshold of $130.

For CY 2022, CMS will continue the current payment policy that has been in effect since CY 2013. This payment policy reimburses separately payable drugs and biologicals at ASP+6 percent. These separately payable drugs and biologicals are listed in Addenda A and B of the final rule. The agency will also continue to pay for separately payable, non-pass-through drugs acquired with a 340B discount at ASP−22.5 percent; see the section on the 340B Drug Program for more details (page 19).

For drugs or biologicals without sufficient data on sales price during the initial sales period, CMS will base payments on the wholesale acquisition cost (WAC). Certain payments must be made with a 6 percent add-on; however, the same add-on amount when utilizing WAC-based pricing is not required. CMS will continue using a 3 percent add-on instead of a 6 percent add-on for WAC-based drugs. For drugs and biologicals acquired under the 340B Program, the 340B Program rate (WAC−22.5 percent) would apply.

CMS previously finalized the payment policy for biosimilar biological products to be based on the payment allowance of the product. CMS will continue the policy that was finalized to make all biosimilar biological products eligible for pass-through payment, not just a reference product's first biosimilar biological product. The agency will continue to pay non-pass-through biosimilars acquired under the 340B Program at ASP−22.5 percent of the biosimilar's ASP, instead of the reference product's ASP.

CMS will expire pass-through status for several drugs and biologicals between March 31, 2021, and Dec. 31, 2021. These drugs and

biologicals will have received HOPPS pass-through payment for at least 2 years (no more than 3 years).

Medicare finalized several drugs and biologicals to continue pass-through payment status for CY 2022. CMS will continue to pay for pass-through drugs and biologicals at the ASP+6 percent and update pass-through payment rates on a quarterly basis through its website.

Due to the use of CY 2019 claims data for rate setting, CMS is extending for up to four quarters an equitable adjustment for 27 drugs and biologicals and one device that will expire pass-through status at various quarters in CY 2022 and extend pricing through the end of CY 2022.

340B Drug Discount Program

CMS will continue to pay for drugs purchased under the 340B Drug Program in CY 2022 at ASP–22.5 percent. In addition, the agency will continue to exempt rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals from the 340B payment adjustment. These hospitals are still required to report modifier TB for 340B-acquired drugs on claims forms, and exempt entities will be paid at ASP+6 percent. CMS will continue to pay for drugs not purchased under the 340B program at ASP+6 percent. Drugs and biosimilar biologicals acquired under the 340B program and furnished in on-campus hospital departments, exempted off-campus provider-based departments, and non-excepted off-campus provider-based departments paid under the Medicare Physician Fee Schedule will be paid at ASP–22.5 percent. Biosimilar biological products will be paid at –22.5 percent of the biosimilar's ASP, not the reference drug's ASP.

Payment for Therapeutic Radiopharmaceuticals

CMS grants pass-through status to new drugs, biologicals, and radiopharmaceuticals as a means of establishing a transitional payment until enough data are acquired to determine whether the new agent is to be paid separately or packaged into an APC. For CY 2022, CMS will continue providing payment for diagnostic and therapeutic radiopharmaceuticals granted pass-through payment status at ASP+6 percent; however, if no ASP data are available, CMS will continue to provide pass-through payment at WAC+3 percent. If those data are not available, payment will be 95 percent of the average wholesale price (AWP). CMS will also continue to update pass-through payment rates on a quarterly basis on its website during CY 2022. ◻I

Editor's Note: On December 10, 2021, President Biden signed into law the Protecting Medicare and American Farmers from Sequester Cuts Act. This is the Congressional action we have been waiting on related to the 2022 Medicare Physician Fee Schedule (MPFS) payment rates. For services paid under the MPFS, the conversion factor will be increased by 3 percent from what was finalized. Originally a 3.75 percent decrease from the 2021 value was used when calculating the new value for 2022.

Additionally, the 2 percent sequestration adjustment to every service paid by CMS will still be suspended through March 31, 2022. Beginning on April 1 through June 30, 2022, a 1 percent adjustment will be applied to all payments. Projecting out to fiscal year (FY) 2030, CMS will also adjust the sequestration in place at that time due to the current suspensions. The first six months of FY 2030 the sequestration adjustment will be 2.25 percent and the final six months will be a 3 percent adjustment to each service. The PAYGO 4 percent adjustment, which was to be applied beginning January 1, 2022, is suspended until January 1, 2023, and will be applied if needed; this will be an additional decrease to any other sequestration per service as paid by CMS.

The clinical labor rates were not addressed in the new law, grassroots work continues by many societies to address the changes and the potential continued negative impacts the final values could represent over the next 4 years of the phase-in.

Physician and Freestanding Facilities Update

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

On Nov. 2, 2021, CMS issued a final rule for the Medicare Physician Fee Schedule (MPFS) for CY 2022. The MPFS Final Rule can be accessed online at: federalregister.gov/public-inspection/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part. This rule applies to all physicians and office-based cancer programs and practices. Even if a physician is employed by—or works in—a hospital, their payment rules are governed by the MPFS.

MPFS Payment Rates

For CY 2022, CMS does not have the authority to reverse and apply the 3.75 percent increase outlined as part of the Consolidated Appropriations Act of 2021, which adjusted the finalized conversion factor (CF) for 2021. Due to this, for CY 2022, CMS had to use the finalized 2021 CF –3.75 percent, resulting in a base start for CY 2022 of $33.6319, rather than $34.8931. The agency had originally proposed a budget neutrality adjustment of –0.14 percent, but after adjustments in the MPFS final rule, this percentage was reduced to –0.10 percent, resulting in a finalized CY 2022 CF of $33.5983. Table 1, below, outlines these elements that impact the conversion factor.

The CF reduction results in decreases for many specialties and their estimated impacts; however, CMS also applied additional decreases to many of the practice expense (PE) values, which create a deeper cut to specialties, such as interventional radiology, radiation oncology, vascular surgery, and cardiology. The negative impacts are specifically related to the PE values for equipment and clinical labor and reflect changes that take place within the pool of total RVUs. The changes for CY 2022 per CMS "*result from finalized policies within BN* [budget neutrality] *(such as the revaluation of E/M* [evaluation and management] *codes in CY 2021 or the clinical labor pricing update in CY 2022) but does not include any changes in spending which result from finalized policies outside of BN.*"

Estimated impacts for select specialties are as follows:

- Radiation oncology will see a –1 percent reduction (proposed to be –5 percent reduction).
- Hematology/Oncology will see a –1 percent (proposed to be –2 percent reduction).

Table 2, right, outlines the combined impact per specialty, including interventional pain management, interventional radiology, radiology, radiation oncology, and hematology/oncology, regarding RVU changes for CY 2022.

Clinical Labor

Clinical labor rates were last updated in CY 2002, and CMS proposed to update the values for CY 2022 using CY 2019 survey data from the Bureau of Labor and Statistics (BLS) and other supplementary data when BLS

Table 1. Calculation of the CY 2022 MPFS Conversion Factor

CY 2021 conversion factor	$34.8931
Conversion factor without CY 2021 Consolidated Appropriations Act provision	$33.6319
Statutory update factor	0.00 percent (1.0000)
CY 2022 RVU budget neutrality adjustment	–0.10 percent (0.9990)
CY 2022 conversion factor	$33.5983

RVU = relative value unit

Table 2. 2022 MPFS Estimated Impact on Total Allowed Charges by Specialty

SPECIALTY	ALLOWED CHARGES (MILLIONS)	IMPACT OF WORK RVU CHANGES	IMPACT OF PE RVU CHANGES	IMPACT OF MP RVU CHANGES	COMBINED IMPACT
Radiation oncology and radiation therapy centers	$1,605	0%	−1%	0%	−1%
Hematology/oncology	$1,679	0%	−1%	0%	−1%
Interventional pain management	$865	0%	2%	0%	1%
Interventional radiology	$465	0%	−5%	0%	−5%
Radiology	$4,257	0%	−1%	0%	−1%

PE = practice expense; RVU = relative value unit

data are not available. Note: an increase in labor values is indicated for all labor types reviewed by CMS; however, many of the finalized values decreased from what was proposed due to a decrease in the value of fringe benefits factor, proposed at 1.366 and finalized at 1.296. Because values are maintained in a budget-neutral manner, an increase for one specialty or one code (or code set) is possible only because it was taken or adjusted from another specialty or code (or code set). For some specialties, like family practice, labor has a higher than average share of the direct costs, whereas in other specialties, like radiation oncology, labor has a lower than average share of the direct costs. Accordingly, specialties with the higher share of labor costs are proposed to receive increased payments for their services, whereas specialties that have lower direct costs associated to clinical labor will see decreases in payment for their services. After considerable pushback, CMS finalized the adoption of a 4-year phase-in. When split over 4 years, the clinical labor adjustment still negatively impacts interventional radiology services, but each year has a smaller adjustment than if total cuts were applied at one time.

CMS also moved forward with several revisions to the clinical labor pricing values for a variety of clinical labor types. For

example, stakeholder feedback disagreed with the CMS crosswalk for medical dosimetrist to 19-1040 (medical scientists) at an hourly rate of $46.95. It was suggested to instead use BLS category 29-2098 (medical dosimetrists, medical records specialists, and health technologists and technicians, all other). CMS did not agree with this suggestion, because the median wage is $20.50, and data from SalaryExpert (salaryexpert. com) supports an hourly rate of $48.31. The inclusion of medical dosimetrist in the title is misleading because it is an aggregate of several types of miscellaneous technicians, and if the suggested rate were used, the hourly rate would be less than the 2002 value.

Commenters also disagreed with use of the 75th percentile for medical physicists, because this maintains the current values and suggests that the physicist category would be the most appropriate to use. Again, CMS did not agree with this suggestion, because the median hourly wage is $59.06 for physicists in the BLS category compared SalaryExpert's medical physicist median hourly wage of $66.90. Data from the American Association of Physicists in Medicine (AAPM) 2020 Professional Survey provide a rate of $2.25/minute. CMS believes that these data are more representative with adjustment and therefore proposed a fringe

benefits multiplier value of $2.14/minute for medical physicists. Table 3, page 16, highlights the finalized clinical labor pricing values that impact oncology. Table 4, page 16, illustrates the impact these clinical labor pricing changes will have by select specialties.

Addressing Changes to E/M Services

CMS indicated that when the AMA adopted the new guidelines for outpatient and office setting E/M visits, CMS also adopted the changes. In the months since implementation, CMS indicated that there was a need for clarification or adjustment to previous guidelines to align all guidance more fully with the updates. To do this, CMS specifically addressed a few areas:

- Split (or shared) visits
- New and established patients and initial and subsequent visits
- Payment for the services of teaching physicians.

Split (or Shared) Visits

Per CMS, the guidelines do not address:

- Who to bill under when the visit is performed by different practitioners.
- Whether a substantive portion must be performed by the billing practitioner.
- Whether practitioners must be in the same group.

Table 3. Finalized 2022 Clinical Labor Pricing Updates Impacting Oncology

LABOR CODE	LABOR DESCRIPTION	SOURCE	CURRENT RATE PER MINUTE	UPDATED RATE PER MINUTE	Y1 PHASE-IN RATE PER MINUTE	TOTAL % CHANGE
L050C	Radiation therapist	BLS 29-1124	0.50	0.89	0.60	78%
L050D	Second radiation therapist for IMRT	BLS 29-1124	0.50	0.89	0.60	78%
L063A	Medical dosimetrist	BLS 19-1040	0.63	0.91	0.70	44%
L107A	Medical dosimetrist/ medical physicist	L063A, L152A	1.08	1.52	1.19	41%
L152A	Medical physicist	AAPM Data*	1.52	2.14	1.68	41%
L056A	RN/OCN*	BLS 29-2033	0.79	0.81	0.80	3%
L050B	Diagnostic medical sonographer	BLS 29-2032	0.50	0.77	0.57	54%
L051B	RN/diagnostic medical sonographer	L051A, BLS 29-2032	0.51	0.77	0.58	51%

*Updated in response to comments. OCN = oncology certified nurse; RN = registered nurse.

Table 4. Anticipated Clinical Labor Pricing Effect on Specialty Impacts

SPECIALTY	ALLOWED CHARGES (MILLIONS)	FULLY UPDATED	Y1 PHASE-IN TRANS
Hematology/oncology	$1742	−2%	−1%
Radiation oncology and radiation therapy centers	$1666	−3%	−1%
Interventional pain management	$897	−1%	0%
Radiology	$4417	−1%	0%
Vascular surgery	$1149	−5%	−1%
Interventional radiology	$482	−6%	−2%
Diagnostic testing facility	$689	−7%	−2%

Note: CMS isolated the anticipated impacts that labor value changes would have on the various specialties and the payment for their services. The agency emphasized that the values in this table from the MPFS Final Rule are not the projected impacts by specialty of all policies finalized for CY 2022; the values only represent the anticipated effect of the isolated clinical labor pricing update. Therefore, the allowed changes for each specialty may not match the allowed charges listed in the "Regulatory Impacts Analysis" section of the rule.

- The setting where the split (or shared) visits may be furnished to be billed.

Within the 2021 CPT® E/M guidelines, the AMA states that "*a split or shared visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physicians and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for split or shared visits (that is, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).*"

CMS proposed and finalized defining a split (or shared) visit as an E/M visit performed (split or shared) by both a physician and non-physician practitioner (NPP) who are in the same group in accordance with applicable laws and regulations for new and established patient visits. The visit is provided in a facility setting in which payment for services furnished incident to is prohibited. In the non-facility setting, when the physician and NPP each perform components of the visit, the visit can be billed under the physician if incident-to

criteria are met. The services are provided in accordance with applicable laws and regulations, specifically either the physician or NPP could bill the payer directly for the visit in the facility setting, rather than bill as a split (or shared) visit. CMS also proposed and finalized allowing for split (or shared) visits to be billed for both new and established E/M patient visits. CMS clarified that only the physician or NPP who performs the substantive portion of the split (or shared) visit bills for the visit. CMS is defining "substantive portion" to mean more than half of the total time spent by the physician or NPP performing the visit.

CMS did make an adjustment to its proposal. CY 2022 will be a transitional year, except for critical care visits, and the substantive portion will be defined by one of three key components (history, exam, and medical decision making [MDM]) or more than half of the total time spent by the physician and NPP performing the split (or shared) visit and require a yet defined modifier when billed on a claim. Table 5, below, outlines the differences between CY 2022 and CY 2023 in the MPFS Final Rule as they relate to the definition of "substantive portion" of a visit.

Due to the need to determine the amount of time spent by each entity, CMS recommended documenting the time spent in the note, even if the MDM method is selected to

code the visit. In addition, the entity who performs the substantive portion of the visit is the one to sign and date the note, but documentation should include the names and credentials of both entities.

CMS finalized that the time between the physician and NPP be totaled and the one with more than half of the time will bill the visit based on the total time documented. The agency also finalized that the substantive portion could include time with or without direct patient contact. One of the practitioners performing the visit must have face-to-face (in-person) contact with the patient, but it does not have to be the practitioner who performs the substantive portion and bills for the visit.

CMS proposed and finalized that prolonged services could be billed in addition to a visit when the time-based method is used for billing. This would only apply for other outpatient and inpatient/observation/hospital/nursing facilities; use of prolonged services would *not* apply to emergency department and critical care visits.

CMS outlined a list of services that count toward the total time for determining the substantive portion. Activities include:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately captured history
- Performing a medically appropriate examination and/or evaluation

Table 5. Final Definition of Substantive Portion for E/M Visit Code Families

E/M VISIT CODE FAMILY	2022 DEFINITION OF SUBSTANTIVE PORTION	2023 DEFINITION OF SUBSTANTIVE PORTION
Other outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/observation/hospital/nursing facility	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical care	More than half of total time	More than half of total time

*Office visits will not be billable as split (or shared) services. MDM = medical decision making.

- Counseling and educating the patient/ family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other healthcare professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported)
- Communicating results to the patient/ family/caregiver
- Providing care coordination (not separately reported).

The agency also identified services and items that do not count toward time spent in the visit:
- Performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient.

If the physician and NPP are not in the same group, each would be expected to bill independently based on the full E/M criteria for the work provided. If neither clinician meets the criteria to bill a visit, modifier 52 for reduced services cannot be applied to the E/M visit codes. In this scenario, the visit is not billable for either entity.

Payment for the Services of Teaching Physicians

Stakeholders requested guidance on how time spent by the resident should be counted when selecting the appropriate E/M office visit level. Section 1842(b) of the Act specifies that "*in the case of physicians' services furnished to a patient in a hospital with a teaching program, the secretary shall not provide payment for such services unless the physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which payment is sought.*"

CMS proposed and finalized that when total time is used to determine the appropriate E/M office visit level, only the time that the teaching physician was present can be

included. Because Medicare already makes payment for the program's share of the resident's involvement, CMS does not feel it would be appropriate to count the resident's time toward the total time and only that of the teaching physician would count.

Telehealth Services

CMS received several requests from stakeholders to permanently add several services to the Medicare telehealth services list effective for CY 2022. None of the requests received by the imposed deadline met the category 1 or category 2 criteria to be added permanently.

In response to the COVID-19 public health emergency (PHE), CMS created a category 3 for temporarily added services to the telehealth list. To be permanently added to the list, the services would need to meet category 1 or category 2 criteria; otherwise, services would only be on the list under category 3 for a temporary basis.

CMS proposed and finalized maintaining a category 3 for telehealth services through CY 2023 to allow for the collection of data regarding utilization to better determine whether the temporary designated codes actually meet the criteria to be permanently added. There are a series of codes that CMS only added to the list of telehealth services for the duration of the PHE, and these have not been extended to temporary category 3 status. These services will be removed from telehealth when the PHE ends. As of right now, the PHE is scheduled to end Jan. 16, 2022. CMS solicited comments as to whether any of the services added for the duration of the PHE should be added to the Medicare telehealth list on a category 3 basis to allow for the collection of data to consider permanent addition to the list.

CMS did extend its plan to maintain many of the waivers and extensions related to telehealth for mental health conditions once the PHE ends. Services for diagnoses not related to mental health conditions will begin to end in accordance with their initial application. Temporary services that were added as category 3 codes will remain available on the list until the end of CY 2023 per CMS.

Communication-Based Technology

CMS will remove the audio-only visit codes (CPT **99441-99443**) from the list of approved telehealth services for all services except those related to mental health services. At the initiation of the PHE, CMS noted there was a significant increase in telehealth services, but these telehealth services dropped off for all specialties except for mental health services.

CMS proposed and finalized permanently adopting coding and payment for HCPCS code **G2252**, one of the communication-based services recognized by CMS as billable by physicians or qualified healthcare professionals for a brief check-in lasting 11 to 20 minutes. Originally, this service was created to be used on an interim basis. After stakeholder feedback identified the need for a communication service longer than 10 minutes, CMS finalized code **G2252** as permanent with an assigned payment.

Physician Supervision of Therapeutic Services

CMS sought feedback on the flexibilities extended during the PHE related to physician supervision. The agency also sought comments on whether additional time is needed beyond the conclusion of the PHE before returning to the standard application of direct supervision. Outside the PHE, direct supervision in the office setting is the requirement. This "*requires the immediate availability of the supervising physician or other practitioner, but the professional need not be present in the same room during the service, and we have interpreted this as 'immediate availability.'*" Through PHE waivers and extensions, CMS continued the requirement of direct supervision but allowed this to be performed through real-time audio and/or video capabilities. CMS sought comments as to whether direct supervision in the office setting should be permanently allowed by real-time audio and/ or video capabilities for only a subset of services and whether a service-level modifier should be created to identify when the requirements for direct supervision were met using real-time audio and/or video capability if extended. After receipt of comments, CMS

indicated that it was reviewing the input from commenters and will consider addressing the issues raised by the comments in future rules as appropriate.

Medicare Part B Drug Payment for Drugs Approved as Part of the Food, Drug, and Cosmetic Act

Medicare Part B covers drugs on a limited benefit for specific drugs and biologicals. These drugs and biologicals are in one of three categories and typically paid at an ASP+6 percent:

- Drugs and biologicals furnished incident to a physician's service(s)
- Drugs and biologicals administered via a covered item of durable medical equipment (DME)
- Other drugs and biologicals specified by statute.

Payments for separately payable Part B drugs and biologicals are defined using a methodology established within section 1847A of the Act, which involves assigning payable drug products to either a multiple or single source drug code for the purpose of payment. Drugs (which do not include biologicals or biosimilar biological products defined in section 1847A of the Act) fit into one of two mutually exclusive categories: multiple source drugs and single source drugs.

When assigning payment to newly marketed drugs, CMS looks at whether an existing multiple source drug code descriptor describes the new drug product and whether the active ingredient(s), drug name, and portions of the prescribing information coincide with existing products already assigned and paid under a multiple source drug code. The agency interprets this to mean that if there is an existing HCPCS code that includes two or more drug products that are rated to be therapeutically equivalent and meet the remaining conditions of multiple source drug code, the billing and payment is for a multiple source drug code.

If the product is assigned to an existing multiple source drug code, payment is based on the volume-weighted average ASP of all products assigned to the code, rather than based solely on its own ASP. As a result, a multiple source drug code may include generic and branded drug products within an individual HCPCS code. A new single payment is determined based solely on its own ASP. When assigning a classification of services, CMS believes in maintaining consistency of payment by paying similar amounts for similar services.

CMS has identified a number of section 505(b)(2) drug products that are described by an existing multiple source drug code; however, these drugs are priced significantly higher than their related products. CMS is concerned about potential abuse of the system when drug products are assigned unique separate HCPCS codes despite being described by a multiple source drug code. CMS believes that assigning these drug products described to existing multiple source HCPCS codes is a method to curb drug prices. CMS proposed assigning certain drug products to existing multiple source drug codes if the products, as part of the Food, Drug, and Cosmetic Act, are described by an existing multiple source drug code and consistent with the interpretation of the definition of the multiple source drug code. In response to stakeholder feedback requesting more information on the details for how this would be applied, CMS delayed implementation of its proposals to allow the agency to further review and consider the issues presented.

As part of the proposed rule, CMS published a framework to build on the current CMS policy for assigning drug products to billing and payment codes. The agency is not proposing to adopt the framework at this time but rather seeks comments on the framework for future policy making. The framework includes a comparison of a drugs:

1. Active ingredient(s)
2. Dosage form (if part of the drug product name)
3. Salt form
4. Other ingredients in the drug product formulation.

If the drug product matches, the drug would continue onto a verification step that would compare the pharmacokinetic and clinical studies referenced on the FDA's approval labeling with the other drug products assigned to an existing multiple source code. At this point, determination would be made regarding the assignment of the drug to the existing multiple source code.

CMS received several comments and feedback on its proposed framework. The agency indicated that it is taking the comments and suggestions under advisement for consideration in future rulemaking.

Services Provided by Physician Assistants

Currently, physician assistants (PAs) cannot bill independently for their services. In addition, all payments are made to the PA's employer, not directly to the PA. CMS proposed and finalized allowing PAs to bill for services directly to Medicare and the reimbursement for those services to be paid directly to the PA, which is similar to nurse practitioners (NPs) and clinical nurse specialists (CNSs) currently effective Jan. 1, 2022. PAs would be allowed to reassign their rights to payments for their services and may choose to incorporate as a group solely including practitioners in their specialty billing in the same manner as NPs and CNSs.

Removal of National Coverage Determination Positron Emission Tomography Scans

CMS proposed and finalized to remove national coverage determination (NCD) 220.6, positron emission tomography (PET) scans, to allow the Medicare administrative contractor (MAC) to make decisions of coverage per their beneficiaries. Stakeholder feedback suggests that the NCD is outdated, because it was originally created in 2000 to provide broad national non-coverage for non-oncologic indications of PET. This, in turn, created the need for every non-oncologic indication to have an individual NCD to receive coverage. CMS believes that by leaving this to the MACs to decide, the MACs can equip the necessary immediate means to provide coverage for non-oncologic indications or not provide coverage. **OI**

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tools

Approved Drugs

- On Nov. 12, the U.S. Food and Drug Administration (FDA) approved **Besremi® (ropeginterferon alfa-2b-njft)** (PharmaEssentia Corporation, us.pharmaessentia.com) for the treatment of adults with polycythemia vera.

- On Nov. 29, the FDA approved **Cytalux™ (pafolacianine)** (On Target Laboratories, Inc., ontargetlabs.com) as an imaging drug intended to assist surgeons in identifying ovarian cancer lesions.

- On Nov. 30, the FDA approved **Darzalex Faspro® (daratumumab and hyaluronidase-fihj)** (Janssen, janssen.com) **in combination with Kyprolis® (carfilzomib)** (Amgen, amgen.com) **and dexamethasone** for the treatment of adult patients with relapsed or refractory multiple myeloma who have received one to three prior lines of therapy.

- On Nov. 23, the FDA approved **Fyarro™ (sirolimus protein-bound particles for injectable suspension) (albumin-bound)** (Aadi Bioscience, Inc., aadibio.com) for intravenous use for the treatment of adult patients with locally advanced unresectable or metastatic malignant perivascular epithelioid cell tumor.

- On Oct. 13, the FDA approved **Keytruda® (pembrolizumab)** (Merck, merck.com) **in combination with chemotherapy, with or without bevacizumab**, for patients with persistent, recurrent, or metastatic cervical cancer whose tumors express programmed death ligand 1 (PD-L1), as determined by an FDA-approved test. On Nov. 18, the FDA also approved Keytruda for the adjuvant treatment of patients with renal cell carcinoma at intermediate-high or high risk of recurrence following nephrectomy or following nephrectomy and resection of metastatic lesions.

- On Oct. 29, the FDA approved **Scemblix® (asciminib)** (Novartis, novartis.com) for the treatment of chronic myeloid leukemia (CML) in two distinct indications: the FDA granted Scemblix 1) accelerated approval for adult patients with Philadelphia chromosome-positive CML in chronic phase (Ph+ CML-CP) previously treated with two or more tyrosine kinase inhibitors, based on major molecular response rate at 24 weeks, and 2) full approval for adult patients with Ph+ CML-CP with the T315I mutation.

- On Oct. 15, the FDA approved **Tecentriq® (atezolizumab)** (Genentech, Inc., gene.com) for adjuvant treatment following resection and platinum-based chemotherapy in patients with stage II to IIIA non-small cell lung cancer whose tumors have PD-L1 expression on greater than or equal to 1 percent of tumor cells, as determined by an FDA-approved test.

- On Oct. 12, the FDA approved **Verzenio® (abemaciclib)** (Eli Lilly and Company, lilly.com) **with endocrine therapy (tamoxifen or an aromatase inhibitor)** for the adjuvant treatment of adult patients with hormone receptor-positive, human epidermal growth factor receptor 2-negative, node-positive early breast cancer at high risk of recurrence and a Ki-67 score greater than or equal to 20 percent, as determined by an FDA-approved test.

Drugs in the News

- Isofol Medical AB (isofolmedical.com) announced that the FDA granted fast track designation to **arfolitixorin** for the treatment of patients with metastatic colorectal cancer.

- Bluebird bio, Inc. (bluebirdbio.com) announced that the FDA accepted the biologics license application (BLA) and granted priority review for **betibeglogene autotemcel (beti-cel)**—a gene therapy for adult, adolescent, and pediatric patients with β-thalassemia across all genotypes who require regular red blood cell transfusions.

- CRISPR Therapeutics (crisprtx.com) announced that the FDA granted regenerative medicine advanced therapy designation to **CTX110™** for the treatment of relapsed or refractory CD19+ B-cell malignancies.

- Epizyme, Inc. (epizyme.com) announced that the FDA granted fast track designation to **EZM0414** as an investigational agent for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma.

- Novartis (novartis.com) announced that the FDA accepted the supplemental BLA

and granted priority review for **Kymriah® (tisagenlecleucel)** in adult patients with relapsed or refractory follicular lymphoma after two prior lines of treatment.

- AstraZeneca (astrazeneca.com) announced that the FDA accepted and granted priority review to the supplemental new drug application (NDA) for **Lynparza® (olaparib)** for the adjuvant treatment of patients with BRCA-mutated human epidermal growth factor receptor 2-negative high-risk early breast cancer who have already been treated with chemotherapy either before or after surgery.

- Alkermes plc (alkermes.com) announced the FDA granted fast track designation to **nemvaleukin alfa (nemvaleukin) in combination with pembrolizumab** for the treatment of platinum-resistant ovarian cancer.

- CTI BioPharma Corp. (ctibiopharma.com) announced that the FDA extended the review period for its NDA for **pacritinib** for the treatment of adult patients with intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis with a baseline platelet count of $<50 \times 10^9$/L.

- Incyte (incyte.com) announced that the FDA accepted its NDA for **parsaclisib** for the treatment of patients with relapsed or refractory follicular lymphoma, marginal zone lymphoma, and mantle cell lymphoma.

- Coherus BioSciences, Inc. (coherus.com) and Shanghai Junshi Biosciences Co., Ltd. (junshipharma.com/en/Index.html) announced that the FDA accepted and granted priority review to the BLA for **toripalimab in combination with gemcitabine and cisplatin** as the first-line treatment for patients with advanced recurrent or metastatic nasopharyngeal carcinoma and toripalimab monotherapy for the second-line or above treatment of recurrent or metastatic nasopharyngeal carcinoma after platinum-containing chemotherapy. Both companies also announced that the FDA granted orphan drug designation for toripalimab for the treatment of esophageal cancer.

- Ultimovacs ASA (ultimovacs.com) announced that the FDA granted fast track designation to its **universal cancer vaccine (UV1) in combination with checkpoint inhibitors** for the treatment of unresectable or metastatic melanoma—as add-on therapy to either pembrolizumab or ipilimumab.

- Y-mAbs Therapeutics, Inc. (ymabs.com) announced that the FDA granted rare pediatric disease designation to **177lu-omburtamab-DTPA** for the treatment of medulloblastoma.

Devices and Assays in the News

- Agilent Technologies Inc. (agilent.com) announced that the FDA approved **Ki-67 IHC MIB-1 pharmDx (Dako Omnis)** as an aid in identifying patients with early breast cancer.

- Delphinus Medical Technologies (delphinusmt.com) announced that the FDA gave pre-market approval to **SoftVue 3D Whole Breast Ultrasound Tomography System** to be used in addition to digital mammograms for screening patients with breast cancer with dense breast tissue.

- Datar Cancer Genetics Inc. (datarpgx.com) announced that the FDA granted breakthrough device designation to its **TriNetra™** blood test to detect early-stage breast cancer.

- Roche (roche.com) announced FDA approval of the **VENTANA PD-L1 (SP263) Assay** in non-small cell lung cancer as a companion diagnostic test for Tecentriq.

- Zetagen Therapeutics (zetagen.com) announced that it has received breakthrough device designation from the FDA for **ZetaMet™**, a synthetic, small-molecule, and inductive biologic technology that is being developed to target and resolve metastatic bone lesions while inhibiting future tumor growth and regenerating bone. **OI**

spotlight

San Juan Cancer Center, Montrose, Colo.

Located in Montrose, Colo., and 20 miles from the Black Canyon of Gunnison National Park, San Juan Cancer Center offers community-based oncology and hematology services to a population of 80,000 to 100,000 people. It is the only local provider of radiation oncology, and the closest medical oncology clinic is about 25 miles away.

San Juan Cancer Center is a freestanding facility that was built in 2006, and it is a department of Montrose Regional Health. Located three blocks from Montrose Regional Health Hospital, the cancer center sits within a residential neighborhood and has a dedicated parking lot. Patients can be dropped off at the front doors, or they can park at no extra cost and walk a short distance to the cancer center.

A Suite of Services

San Juan's clinical and non-clinical staff are all employees of Montrose Regional Health, with the exception of its radiation oncologists, who are employed by the Cancer Centers of Colorado at SCL Health St. Mary's Medical Center. All radiation oncology services are offered as a joint venture between Montrose Regional Health, SCL Health in Grand Junction, Colo., and its practicing radiation oncologists. San Juan's radiation oncology department is located on the first floor of the cancer center and is staffed by a full-time radiation oncologist, a part-time radiation oncologist (who travels from Grand Junction twice a week), three radiation therapists, one dosimetrist, two nurses, three registration/billing staff, and a physicist. With the addition of a physicist,

San Juan Cancer Center will begin offering SBRT and other procedures in early 2022. Using one Varian TrueBeam®, the cancer center provides IMRT and IGRT to patients.

San Juan's medical oncology department is located on the second floor of the cancer center. San Juan leadership are proud to have on staff three full-time medical oncologists who have 15 to 20 years of experience each. Each oncologist has one clinic nurse, who manages physician orders, prescriptions, and provides symptom management over the phone. The clinic nurses are slowly transitioning to nurse navigator roles, and each will focus on a specialization in medical oncology (e.g., thoracic, breast, etc.). Next to the medical oncology clinic is the infusion suite and dedicated infusion pharmacy. The infusion suite has nine chairs, including two private rooms that are available to patients, and is staffed by four infusion nurses.

The infusion-dedicated pharmacy—just 10 feet from the infusion suite—gives infusion nurses direct access to the pharmacists who dispense patients' medications. The pharmacists in turn have convenient access to patients during their treatment to help address any adverse events or answer questions. Staffed by one full-time pharmacist, one half-time pharmacist, and one pharmacy tech, the pharmacy orders all medications, mixes chemotherapies, and ensures that treatment regimens are ready for patients before they arrive.

If a patient requires surgical oncology services, San Juan's providers refer them to the general surgeon's office near the hospital. Patients who require more complex

surgeries are referred to Grand Junction (about 60 miles away) or other large medical systems in Denver, Colo. (about 270 miles away), across the heart of the Rocky Mountains.

San Juan staff and Montrose Regional Health are seeking to further their dedication to quality cancer care for patients in the community by pursuing Commission on Cancer accreditation and offering clinical trial opportunities through a partnership with an academic medical center. Both initiatives are under discussion with a desire to begin processes in 2022.

Supportive Care

Because San Juan provides care to a rural population, patients often face long-distance drives to get to their appointments. Harsh Colorado winter weather can further hinder transportation. Knowing this factor can sometimes be a barrier to obtaining care, the cancer center's social worker works closely with local resources and foundations to help patients bridge the gap that insurance cannot. These efforts may include working to book a hotel at a discounted rate or securing financial assistance to cover gas expenses.

San Juan's social worker also assists with insurance prior authorizations, financial advocacy services, and referrals and can help patients with their psychosocial needs. In addition, a dietitian visits the cancer center once a week to offer patients nutrition recommendations, weight gain support, gastrostomy tube assistance, and treatment-related side effect management strategies. These supportive care services are

free to patients, who can self-refer. Montrose Regional Health Hospital also offers a comprehensive rehabilitation program to which oncology patients can be referred by their care team.

A Focus on Lung Health

According to Dean Putt, cancer service line director at Montrose Regional Health, smoking rates in the community are high (about 22 percent). To address the high smoking rates among their patients and to promote cancer screenings, Montrose Regional Health hired a pulmonologist and established a dedicated lung program to find and diagnose lung cancers early. The program is made up of a navigational bronchoscopy unit within the hospital's surgery department and the pulmonologist's lung nodule clinic. Through this clinic, all patients' computed tomography (CT) scans are screened for incidental findings. Using third-party software that is integrated into the hospital's electronic health record, the pulmonologist can see the radiologist's notes and the software will filter out any scans or notes unrelated to a nodule finding. This software will be fully integrated in early 2022.

If patients are found to have a significantly large nodule, nurse navigators will contact patients and schedule them at the weekly nodule clinic. For nodules that appear smaller in size, patients may be referred to the diagnostic imaging and pulmonology clinical team for follow-up lung cancer screening. Low-dose CT screening is also available to a high-risk group as defined by the U.S. Preventive Services Task Force. "Most patients who are worried that they have lung cancer tend to avoid the screenings," says Putt. "If you just look at all patients who have incidental findings, 8 to 14 percent of them are later diagnosed to be lung cancer (generally at a more treatable early stage), compared to 1 to 2 percent of those going through low-dose CT screening. So, the incidental findings are much more important to track."

Although patients in the nodule clinic are not directed to San Juan Cancer Center until they have a positive biopsy for malignancy, a San Juan medical oncology clinic nurse works closely with the nodule clinic staff to ensure that patients are followed up with appropriately. The clinic nurse communicates regularly with the nodule clinic nurse navigator, so patients are seamlessly directed from the lung program to the cancer center when necessary.

To further Montrose's lung health efforts, two nurses and a respiratory therapist at Montrose Regional Health received training to become tobacco treatment specialists through the state of Colorado. These staff are working on a hospital-wide tobacco cessation program that will be available to patients who use tobacco and who are admitted, and the cancer center will address those patients who have already been diagnosed with lung cancer, are still smoking, or are receiving treatment. Staff hope to help patients and community members quit smoking through dedicated, long-term support, rather than referring patients to an external resource for help.

San Juan Cancer Center staff—some of whom have been with Montrose Regional Health for more than a decade—are proud to be seasoned employees of the health system. "I've been with five other cancer centers, and this is the best staff as far as the caring that they give to the patients and the ability to work with others on the team," says Putt. "It's remarkable. A small cancer center, like this, has been able to attract quality staff, which in turn gives patients that peace of mind that they're getting really good care." OI

Patients with Cancer, Comorbidities, and No Primary Care Provider

BY DEBRA DELANEY, MSN, FNP-BC; CHRISTOPHER KOPROWSKI, MD, MBA;
CYDNEY TEAL, MD; AND NICHOLAS PETRELLI, MD
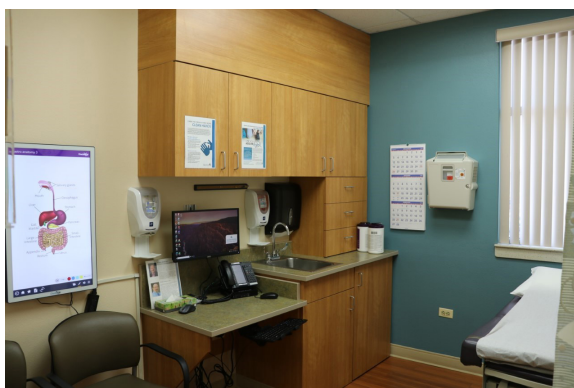
Embedding a PCP in oncology helps one program soar to new heights

Not too long ago, the Helen F. Graham Cancer Center and Research Institute of ChristianaCare shared the success of its Supportive Care of Oncology Patients (SCOOP) program at the 2018 ASCO Quality Care Symposium and with *Oncology Issues*.[1,2] The SCOOP program implemented a clinical care pathway based on the working hypothesis that, for select patients with advanced disease, integration of supportive care management along with nurse navigator access to electronic aids for care coordination could result in both cost savings and an enhanced patient experience. A cross-disciplinary team, including leaders from Organizational Excellence, Medical Oncology, Radiation Oncology, Inpatient Oncology Nursing, Supportive and Palliative Care, IT, and Psychosocial Oncology, designed the SCOOP pathway. Patients with potentially curable thoracic, colorectal, or head and neck cancers diagnosed in the cancer center's multidisciplinary clinics were eligible to participate in the SCOOP pathway, which was implemented in November 2016.

During the program's first year, 59 patients enrolled in the clinical pathway. Of these, 32 percent had emergency department visits, compared with 54 percent of patients in the control group (non-SCOOP patients). Hospital admissions were 25 percent for the SCOOP cohort vs. 34 percent for the control group; 20 percent of SCOOP patients experienced readmission vs. 32 percent of non-SCOOP patients. Over a three-year period (2016-2019), the

> A PCP embedded in the cancer center could provide patients in active treatment who lacked a PCP with the care needed to manage their comorbidities and maintain ongoing communication with the multidisciplinary oncology team.

SCOOP program enrolled 143 patients and realized a total cost savings of $220,850.

"As the program matured, it became obvious that by doing this multi-factorial set of interventions, we were actually able to diminish ED [emergency department] visits and [hospital] admissions substantially," said Christopher Koprowski, MD, MBA, associate cancer community of practice leader at the Helen F. Graham Cancer Center and Research Institute. "We were able to administer [enhanced] care to patients without increasing costs and give them a better experience."

Debra Delaney, MSN, FNP-BC

Addressing the Lack of a Primary Care Provider

Building on the success of the SCOOP pathway, cancer service line leadership zeroed in on another challenge ripe for interdisciplinary, cross-department collaboration: care coordination for patients with cancer, comorbidities, and no primary care provider (PCP).

The problem is described by Sarfati and colleagues in the article, "The Impact of Comorbidity on Cancer and Its Treatment."

> *The presence of comorbidity poses substantial challenges for traditional models of care. Because of the complexity of health needs that must be addressed, a greater diversity of expertise is required for optimal management. Delivery of care to patient [sic] with multiple problems requires significant care coordination within the cancer setting as well as within the broader health care context, including community care.[3]*

The challenge becomes even more complex when patients in active treatment for cancer have no established primary care provider with whom the oncology care team can coordinate the management of pre-existing comorbid conditions.

Despite advances in information technology, electronic health records, multiple virtual platforms for collaboration, and the development of quality metrics and measures, in the fragmented U.S. healthcare system, achieving seamless care coordination can appear to be a Sisyphean task. Beyond care coordination and communication among and between oncology specialists from different disciplines, there is communicating and connecting across settings of care—inpatient, outpatient, and freestanding programs—and more. Ideally, patients with cancer and existing comorbidities connect the cancer care team to their primary care provider so that these physicians can communicate regarding management of the patient's comorbidities and be prepared to take over the patient's care once the treatment for cancer has ended. But what happens to care coordination when patients in active treatment for cancer have no PCP? Or when patients whose high blood pressure, hyperlipidemia, chronic obstructive pulmonary disease, or diabetes need to be managed while they are receiving anti-cancer therapy?

For patients with comorbidities who are in active treatment for cancer and who report having no primary care, having an embedded PCP where they receive their cancer therapy is a patient-centered model that brings across-the-board benefits.

In 2019, results from a brief general survey revealed that about 15 percent of gynecologic oncology patients coming to the cancer center lacked a PCP. In follow-up conversations with the cancer program's medical and surgical oncologists, service line leadership found that these providers believe that the percentage of those without PCPs among their patient populations was probably even higher.

The Helen F. Graham Cancer Center currently cares for more than 70 percent of all patients with cancer in Delaware, and cancer is a disease most often seen in the elderly, a patient population more likely to have one or more of the most common co-occurring conditions—hyperlipidemia, hypertension, and/or diabetes.

Nicholas Petrelli, MD, medical director of the Helen F. Graham Cancer Center and Research Institution, had a solution in mind. Why not embed a PCP on-site at the cancer center? Just as the cancer center's Oncology Express Unit streamlines access to emergent care for patients with cancer, a PCP embedded in the cancer center could provide patients in active treatment who lacked a PCP with the care needed to manage their comorbidities and maintain ongoing communication with the multidisciplinary oncology team. Even if a patient had a PCP, this position within the cancer center would enhance provider-to-provider communication during the patient's treatment for cancer.

In late spring 2019, Dr. Petrelli discussed the concept with Lisa Maxwell, MD, MHCDS, chief clinical transformation officer at ChristianaCare. Dr. Maxwell was enthusiastic about the concept and even recognized future potential for a primary care/oncology fellowship, if the initiative was successful. Dr. Petrelli and Dr. Cydney Teal, service line leader of Primary Care and Community Medicine and chair of the Department of Family and Community Medicine at ChristianaCare, met to discuss the primary care in oncology concept. In the meantime, Dr. Koprowski proposed that the initiative's pilot could be launched using a seasoned primary care advanced practice provider (APP) in a half-time capacity, rather than a full-time PCP position. Overall, the clinical leadership group met more than a dozen times to flesh out the program and develop the position description for the APP who would initiate the pilot. Dr. Teal helped recruit a highly experienced primary care APP for the position and suggested that, when appropriate, virtual primary care could be an option as well.

Serendipitously, Debra Delaney, MSN, FNP, had recently spoken with Dr. Teal about her interest in returning to primary care practice. Ms. Delaney became an APP in 2009, joining the trauma service at ChristianaCare. "Similar to the oncology patients we were encountering, a lot of trauma patients did not seem to have a primary care provider," she said, "which is how I got started in primary care." She moved from the trauma service to a ChristianaCare primary care practice and then to a ChristianaCare Urgent Care. Here, too, she saw patients without PCPs who relied on urgent care centers for many of their health issues. "So primary care has been a part of every position that I've held as an advanced practitioner," she said.

Ms. Delaney was confident in her skills as an advanced primary care and trauma practitioner but understood that this new position in the cancer center would offer her exceptional learning opportunities.

In late January 2021, she inaugurated the new primary care position in the cancer center. The full time equivalent position is split 50-50 between the cancer center and ChristianaCare's Virtual Primary Care Department. In this role, she reports to Cindy Waddington, MSN, RN, AOCN, NE-BC, clinical director of the Helen F. Graham Cancer Center; Weston Riesselman, MHA, program manager, Center for Virtual Health Operations; and Cydney Teal, MD (her collaborative physician). The primary care APP is on-site at the cancer center, Monday through Wednesdays and Fridays from 8:00 AM to 12 PM. On Thursdays, the primary care APP is scheduled at the cancer center from 11:00 AM to 3:00 PM.

How Patients Access the PCP

When oncology physicians have a patient with comorbidities in treatment who has no PCP, they refer the patient to Debra Delaney. In the six months since the pilot's start, she has had more than 70 patient referrals. The number of patients in the practice fluctuates as cancer treatment is completed or, in some cases, as end of life occurs. To date the most common comorbidities seen have been hypertension, hyperlipidemia, and diabetes. Ms. Delaney works with these individuals to keep their comorbidities under control while they are in active treatment for cancer.

Communication is at the heart of this new role, Delaney notes. Because she is embedded in the cancer center, she has quick access to oncology providers should questions arise. As all of the providers are on the same electronic health record, she can also connect rapidly with specialists if she needs to discuss a specific issue, such as blood sugar control in a patient with diabetes. To further her integration with the cancer care team, when possible, she attends the cancer center's disease-specific multidisciplinary conferences. This not only expands her knowledge of oncology but also provides another opportunity for her to connect with physicians who may have a patient who could benefit from a referral to her.

As she pilots this new role, Ms. Delaney is finding that she is another care touchpoint for patients. She can listen to their concerns and challenges as they go through treatment and help connect them to any support or resources needed to keep them

Delaney visits with a patient.

Primary care provider leadership at the Helen F. Graham Cancer Center and Research Institute.

engaged with the care process. Patients have expressed their appreciation for this added support and attention to their co-existing health concerns as they move through cancer treatment.

When patients complete active treatment, if they would like to continue to receive primary care at ChristianaCare, Delaney connects them with a PCP. She also has resources in the community to which she can refer patients.

For patients with comorbidities who are in active treatment for cancer and who report having no primary care, having an embedded PCP where they receive their cancer therapy is a patient-centered model that brings across-the-board benefits. Although the pilot intervention is in its early phase, this cross-departmental collaboration is viewed as a win-win-win by patients, the oncology service line, and the Department of Family Medicine at ChristianaCare. Stay tuned for updates. ◨

Debra Delaney, MSN, FNP-BC, is the primary care nurse practitioner; Christopher Koprowski, MD, MBA, is the associate cancer community of practice leader; and Nicholas J. Petrelli, MD, is the medical director at the Helen F. Graham Cancer Center and Research Institute, ChristianaCare Health System, Newark, Del.; Cydney Teal, MD, is the service line leader of Primary Care Community Medicine and chair of the Department of Family and Community Medicine at ChristianaCare in Newark, Del.

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Strategies to Address Comorbidity Among Patients with Cancer[3]

- Improving the **evidence base** from which to make cancer treatment decisions for those with comorbidity
- Improving the **measurement** of comorbidity among patients with cancer
- Improving **integration** and **coordination** of care
- Preventing the occurrence of **new comorbidities** and limiting **exacerbations** of existing conditions
- Developing **better tools** for clinicians
- Facilitating **skill development** for clinicians
- Building **research** collaborations

Patient Case Study

K.W. is female in her mid-30s with a history of squamous cell carcinoma of the cervix. The cancer was diagnosed in 2018, and the patient was treated with a course of chemotherapy and vaginal brachytherapy in 2019. Unfortunately, the cervical cancer recurred, and in 2019 the patient underwent a radical hysterectomy. In 2020, due to persistent disease spread, she had anterior pelvic exenteration surgery and a percutaneous nephrostomy tube placed. To be closer to family, the patient moved to Delaware in 2021. She established care at the Helen F. Graham Cancer Center and with the cancer center's embedded primary care practice.

Having access to primary care at the cancer center saved the patient the time and energy of trying to find a PCP who was within her network and accepting new patients. During the initial examination, the embedded primary care APP created a plan of care based on the patient's concerns and medical diagnoses.

K.W. was already scheduled for chemotherapy through the Oncology Department. The embedded APP was able to quickly obtain an appointment with urology for management of a nephrostomy tube (the patient required a tubing change when she arrived in Delaware).

With the primary care APP, the patient was able to talk about her emotional state and began a medication treatment plan for her anxiety and depression along with a referral to a behavior health provider while at the cancer center. The primary care APP advised the patient to reach out with any questions and helped the patient navigate healthcare in Delaware. Over the course of her treatment, the patient connected with the primary care APP multiple times with questions about her healthcare journey. The primary care APP was helpful in providing contact information for the local school district when the patient had difficulty enrolling her son in school. The primary care APP reaches out to K.W. monthly to check in. The patient is currently stable.

As a small practice, the primary care APP embedded within the cancer center can provide quality time to individual patients. This whole-patient model can make a world of difference to patients who are dealing with multiple appointments while feeling absolutely worn out from ongoing cancer treatment.

A Psychological First Aid Program in the COVID-19 Era

BY AMANDA PATTON, MA

Three years ago, Avera Cancer Institute in Sioux Falls, S.D., shared with *Oncology Issues* its experience implementing community-based psychological first aid training for staff. The 2018 article described training in community-based psychological first aid as "a promising intervention that promotes adaptive functioning by instilling individuals with the knowledge and skills necessary to support oneself and others when stressful events occur." The authors explained that community-based psychological first aid is "a type of 'grassroots' psychological care provided within a community's natural support system, from one community member to the next, to mitigate stress ranging from daily hassles to extreme stressors." The basic idea is to help "prepare people for stressful events by teaching them about stress and giving them strategies to care for themselves and others in stressful times." (Read the article in its entirety at: accc-cancer.org/Psychological-First-Aid-for-Oncology-Professionals.)

Although community-based psychological first aid training is most often provided to prepare for front-line community-wide emergencies, such as natural disasters, after the two-year COVID-19 global pandemic and the resulting high levels of burnout in the healthcare workforce, Avera Cancer Institute recognized the potential for this training to help foster a culture of resilience and mutual support.

Based on feedback from participant evaluations, the training now focuses on the key pieces that Avera Cancer Institute wants all team members to know as they onboard to the oncology program.

Then

Avera Cancer Institute's community-based psychological first aid started with a week-long "train the trainers" workshop in April 2017. Nine staff members and one provider completed the intensive training program conducted by Gerard A. Jacobs, PhD, past director of the Disaster Mental Health Institute at the University of South Dakota in Vermillion. During this week, the future trainers adapted the course content to the Avera Cancer Institute's culture. For example, the modules on grief and self-care were expanded, and a chaplain trainer was added to lead a new prayer module that would begin training sessions because Avera Health is a faith-based health ministry.

Christina Early, MSW, CSW, Avera Cancer Institute

In August 2017, the psychological first aid training program launched at the cancer institute. The one-day program was primarily lecture based but included interactive components, such as experiential learning with active role-playing.

To evaluate the program, Avera Cancer Institute implemented three surveys: pre-training, post-training, and one-month post-training follow-up. Initial survey results suggested that employees found the psychological first aid training to be "highly beneficial." The authors shared that 97 percent (*n* = 63) reported feeling more knowledgeable about community-based psychological first aid (more knowledgeable about traumatic stress and grief) and better able to use the training to identify and cope with stress and get others additional help when needed. Participants (91 percent) found the training to be personally useful; 97 percent felt it would be useful for others in oncology.

Now
Fast forward to 2022. Is Avera Cancer Institute's community-based psychological first aid training program still in place? If so, does it look the same? Has the training been helpful during the COVID-19 public health emergency? Christina Early, MSW, CSW, manager of the Navigation Center & Support Staff at Avera Cancer Institute, Prairie Center in Sioux Falls, shared an update with *Oncology Issues*. She confirmed that the training is ongoing but, not surprisingly, there have been some significant changes over the past four years.

Now the program is focused on reaching new employees, she said, and it is a mandatory component of new employee orientation, which typically runs on a quarterly basis. (Note: the training is not mandatory for physicians or advanced practice providers; however, these clinicians are free to sign up for the course.) New employee orientation is one day long (nine hours). The first half of new employee orientation is dedicated to the psychological first aid training with the aim of educating new employees on recognizing symptoms of stress, managing these symptoms, and supporting their colleagues.

"We really focus solely on care for the caregiver, knowing that if you are taking care of yourself as a healthcare provider that trickles down to how you are caring for patients," said Early. "If you're not feeling energized, fulfilled, and rested, then it's hard to provide really good care to patients."

She explained that the initial training developed by Dr. Jacobs was intended more specifically for front-line responders to disasters, such as natural disasters affecting the community (e.g., tornados, severe storms, flooding, etc.). In revising the program, there was consideration of "how do we take pieces of psychological first aid and the overall skills that he [Dr. Jacobs] is presenting and make them more applicable to the chronic type of psychological distress and stress of working in oncology day after day?" Though the initial impetus for the training grew out of the model developed by Dr. Jacobs, over time, "we continued to mold the training to the needs of staff." An important focus of change was making it clear that "we're doing this training because we care about them [staff]," Early said. "To continue calling it community-based psychological first aid is probably not the best title because we're no longer following Dr. Jacob's program as it was originally written."

Tailoring Psychological First Aid for Oncology
Based on feedback from participant evaluations, the training now focuses on the key pieces that Avera Cancer Institute wants all team members to know as they onboard to the oncology program, explains Early. This includes "how they can manage stress, how they can support their co-workers, and how does stress manifest differently in different individuals? The program also looks at adjusting to change because healthcare is constantly changing."

Today, the training is shorter: three-and-a-half hours (half day) compared to the initial nine-hour (full-day) format. To accomplish this, some of the information with less relevance to the cancer program has been omitted. Table 1, at right, is an example of the current course agenda. "The content itself hasn't substantially changed," said Early. Modifications to the curriculum were also made based on experiences of the facilitators who had conducted the training for several years.

The training covers information that attendees may integrate into their personal lives, as well as on the job. "A lot of examples we speak to are work related but might also pertain to relationships that they have outside of work and how they use these skills to navigate those [relationships]," explained Early. Although the training is scheduled as part of new employee orientation, cancer institute leadership will attend sessions and current staff are also

Table 1. Course Agenda: Psychological First Aid	
8:15 am	**Prayer and Introductions** Brenda Ling, MSW, CSW-PIP, OSW-C Virginia Strubbe, MSW, CSW
8:30 am	**Stress** Brenda Ling, MSW, CSW-PIP, OSW-C Virginia Strubbe, MSW, CSW
9:00 am	**Helping Oneself** Jordan Jenkins, MSW, CSW, OSW-C Lacey Ballew, MSW, CSW-PIP, OSW-C
10:00 am	**Break**
10:10 am	**Change** Christina Early, MSW, CSW, OSW-C Stacey Graber, CRT-BD-R
10:25 am	**Helping Others** Christina Early, MSW, CSW, OSW-C Stacey Graber, CRT-BD-R
11:30 am	**Adjourn for lunch**

welcome to attend. "Sessions are open to anyone to attend. We don't close it off. It's just that our target audience is new employees," she said.

Another change is that facilitation responsibilities are now handled by the clinical social work team at Avera Cancer Institute. Early manages a cohort of six facilitators. "There are different facilitators for each session. We have the facilitators work in pairs of two, which I think also helps with the engagement."

One piece of the training curriculum is the opportunity for facilitators to share their own experiences. "I'm one of the facilitators, but I am also an oncology social worker and leader in the cancer institute. So, I can share my experiences as a gynecologic oncology social worker," said Early. "But I may also share about personal and leadership experiences. Again, going back to the idea that the training is for the workplace, but it's also relevant in our personal lives. So we talk about recognizing our stress reactions and how to take care of ourselves both within the walls of the cancer institute and our homes."

The COVID-19 pandemic has not significantly disrupted this training program, which is conducted in person. However, the facilitators found themselves talking more about coping with the change to their lives due to COVID-19 and how to provide support to those around them. For example, what are ways to show support, care, and compassion without physical touch?

> The training makes clear that staff have options, including the clinical social workers within the cancer institute, as well as an employee assistance program that is free for staff and their family members and completely confidential.

"Being in the Midwest, we have a lot of people who hug or shake hands; physical touch is such a big part of showing support, particularly in this setting in healthcare." This is just one example of the ways people working in healthcare are asked to adapt and adjust. "Obviously COVID-19 brought change," said Early. "[In the training] just discussing how everyone adjusts differently to the situation and that there is really no timeline [in the midst of a pandemic] and how there is a lot of grief that goes with that."

In the final session of the half-day training, the focus is on active listening and problem-solving skills, as well as recognizing when it is appropriate to refer someone for help. "If you're supporting a colleague and it's become bigger than you, to where you're having traumatic stress because of what your colleague is going through, what are your resources?" Early said. The training makes clear that staff have options, including the clinical social workers within the cancer institute, as well as an employee assistance program that is free for staff and their family members and completely confidential.

"That's one of the reasons we are doing this training. We want everyone to be aware of their resources, but also have baseline skills to support themselves and their colleagues regardless of what their role is within our program. They definitely leave the training with tangible resources." ◻

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.

Our Cancer Program At-a-Glance

The Avera Cancer Institute is the outpatient community cancer center of McKennan Hospital & University Health Center in Sioux Falls, S.D. Each year, the cancer center treats approximately 2,100 new patients with cancer. Most patients are white (96 percent), female (54 percent), rural (i.e., 64 percent drive 50+ miles for treatment), and Medicare recipients (52 percent). The Avera Cancer Institute has a large geographic reach across the Northern Plains and into Minnesota and Iowa. These services are provided via a combination of in-person and telehealth care.

ACCC Provider Resources for the COVID-19 Era

In March 2021, newly elected ACCC President Krista Nelson, MSW, LCSW, OSW-C, FAOSW, announced "Real-World Lessons from COVID-19: Driving Oncology Care Forward" as her 2021-2022 President's Theme. To illustrate these lessons, for the next 12 months, ACCC focused in on three key issues: 1) health equity and social justice, 2) the escalating need for high reach, high impact psychosocial and supportive care services, and 3) professional well-being and resilience. Below are just a few of the tools and resources developed in these key areas.

Health Equity

- *Oncology Issues:* The "Center for Indigenous Cancer Research at Roswell Park Comprehensive Cancer Center." As part of its mission to reduce the impact of cancer on Indigenous communities regionally, nationally, and internationally, this Center participated in research to identify disparities, shared research findings with affected communities, and engaged community members on how best to close the gaps.
- *Oncology Issues*: "A Spotlight on the Sutter Health Institute for Advancing Health Equity."
- On-demand webcast: *Practical Solutions to Better Engage Cancer Professionals with Communities of Color*. An expert panel reviews currently available data on cancer care disparities, discusses the needs of disadvantaged populations, and shares practical solutions and methods for implementing bias training.
- On-demand webcast: *Integrating the Community Voice to Advance Cancer Research*. Optimal care delivery changes from place to place—what works best for one location and patient population may not be ideal for another. The same applies to cancer research. Understanding the needs of your patient population is critical to trial design and implementation. Tips to proactively involve your community in cancer research activities.
- CANCER BUZZ MINI-PODCAST, Ep 52: *End-of-Life Health Disparities*. Learn cultural and logistical barriers to end-of-life health equity and how to address palliative care earlier in the care continuum and reduce health disparities.
- CANCER BUZZ MINI-PODCAST, Ep 51: *Cultural Humility & Sensitivity*. A conversation about how the legacy of racism in American healthcare continues to affect today's research, including strategies to effectively communicate with underrepresented and marginalized populations.
- CANCER BUZZ MINI-PODCAST, Ep 49: *Building Trust with Marginalized Groups*. Discover what steps to take to build trust with patients from marginalized and underrepresented groups and ensure a more equitable and accessible healthcare environment.

These and more health equity resources are available at online: accc-cancer.org/health-equity.

Oncology Team Resiliency and Self-Care

- ACCC Mindfulness Mediation Series. Through meditation, we cultivate an awareness of the present moment and train the mind to better understand how and why we think and feel the way we do. This online meditation series can help you manage stress levels and improve your social, emotional, physical, and mental health.
- *Oncology Issues*: "What Does Leading with Mindfulness and Compassion Look Like?" Learn why compassion is critical in all levels of healthcare—from the clinic to the boardroom—as well as compassion's role in improving resiliency and building a more equitable and diverse workforce.
- *Oncology Issues*: "Caring for the Caregiver." A holistic self-care and resiliency program for oncology professionals helped decrease oncology staff burnout rates. Key components include patient remembrance ceremonies, staff support groups, educational opportunities, and social events.
- CANCER BUZZ MINI-PODCAST, Episode 67: *Coping with Pandemic Grief*. Oncology social worker and ACCC President Krista Nelson, MSW, LCSW, OSW-C, FAOSW, talks about the overwhelming grief of the pandemic and its toll on cancer care professionals.
- CANCER BUZZ MINI-PODCAST, Ep 68: *Supportive Care in Radiation Oncology*. Early in the pandemic, members of the Stanford Health Care Radiation Oncology Department created an internal podcast for their department to creatively address the need for connections among on-site and remote staff, acknowledge the emotional and psychological toll of caring for patients during this challenging time, and support the well-being and mental health of oncology staff.

These and more oncology team resiliency and self-care resources are available at: accc-cancer.org/oncology-team-well-being.

Telehealth

- *Oncology Issues*: "Rapid Practice Change During COVID-19 Leads to Enduring Innovations and Expansion of Integrative Oncology Services."
- *Oncology Issues*: "Cancer Care in the Comfort of Your Car." Learn how Moffitt Cancer Center's curbside clinic gives patients another option for accessing care.
- *Oncology Issues*: "Telehealth After the Public Health Emergency."
- CANCER BUZZ PODCAST, Episode 53: *Telehealth & Genetics During COVID-19*. Learn how genetic healthcare services have adapted to virtual care delivery, and what challenges face its widespread use after the COVID-19 pandemic is over.

These and more telehealth resources are available online at: accc-cancer.org/telehealth.

Chronic Lymphocytic Leukemia

Given that chronic lymphocytic leukemia (CLL) can spread very slowly, asymptomatic patients diagnosed with CLL are often monitored over time (also called "watchful waiting"). The long duration of the pandemic has led many patients to continually postpone regular office appointments, potentially contributing to unmonitored disease. And given that CLL mostly affects older people, these patients may be even less likely to keep office appointments during a pandemic. Learn tips and strategies to better meet the needs of your patients with CLL:

- CANCER BUZZ PODCAST, Episode 66: *CLL, COVID-19, and Why Patient Registries Matter*. Hear how patients with blood cancer are joining the The Leukemia & Lymphoma Society (LLS) National Patient Registry to increase scientific knowledge about COVID-19 vaccination and booster shot efficacy.
- CANCER BUZZ PODCAST, Episode 61: *CLL Patient Education in Transitional Times*. As the COVID-19 pandemic recedes and restrictions loosens, learn how patient education has become even more critical during this transition.
- CANCER BUZZ PODCAST, Episode 57: *COVID-19 Challenges: Managing Patients with CLL*. A physician assistant shares the challenges related to COVID-19, vaccines, and how his program is adapting to keep diagnosed patients with CLL safe.
- On-demand webcast: *Learning from COVID-19: Coping Strategies for CLL Providers & Patients*.
- On-demand webcast: *CLL Treatment Considerations: COVID-19 and Beyond*. Treatment timing, changes to traditional regimens, and how to prepare for the future.
- On-demand webcast: *The COVID-19 Vaccine for Patients with CLL and Other Cancers*.

These and more CLL resources are available online at: accc-cancer.org/post-covid-cll.

Improving the Culture of Your Cancer Center, One Idea at a Time

BY KEVIN DRYANSKI, MBA; AUTUMN CLARK, RN, BSN, OCN; ERICA KINSEY, PHD, MBA; GREG RYDER, MPS, CSSBB; AND ALICE IRELAND, BS, CSSBB

The Cancer Centers of Colorado at SCL Health St. Mary's Medical Center is the largest cancer center between Denver, Colo., and Salt Lake City, Utah. The cancer center delivers comprehensive care to the people of western Colorado and eastern Utah. It employs seven physicians, three advanced practice providers, and a staff of more than 80 people. St. Mary's Medical Center is the only level II trauma center between Denver and Salt Lake City. Together, the medical center and cancer center serve a catchment area greater than 150-miles. The cancer center has been accredited by the Commission on Cancer since 1992 and by the American Society for Radiation Oncology's Accreditation Program for Excellence® since 2018. It provides a full complement of oncology services, including medical oncology and hematology via a 25-chair infusion center, radiation oncology and radiation therapy services via two linear accelerators, an American College of Radiology-accredited breast care center, gynecologic oncology, and survivorship and palliative care services. Despite the current accolades, several years ago, the Cancer Centers of Colorado at SCL Health St. Mary's Medical Center experienced years of physician and staff turnover. To combat the low morale produced from this turnover, we needed to build a culture of continuous improvement.

How do you improve the culture of your cancer center? For the Cancer Centers of Colorado at SCL Health St. Mary's Medical Center, it was accomplished one idea at a time through our new Daily Improvement Program.

The culture at St. Mary's needed a transformation, a reinvigoration of life. Cancer center leadership found themselves putting out fires every day. Staff did not have a clear direction about the center's operations from one day to another because our operational system was mainly tailored to fit each physician's needs—not the needs of the cancer center as a whole. This system led to fragmented processes and unreliable workflows. As staff's work moved between the physicians, operational expectations changed dramatically. It was tough to meet the needs of patients, and it was even more challenging to meet the needs of our physicians. Our incredible staff were resilient and did the best they could with regards to evolving expectations, but it was taking a toll. On top of that, our cancer center recently lost three medical oncologists and a member of the leadership team. The cancer center needed a way to redefine itself and to ensure that day-to-day operations were consistent, reliable, and safe for patients and staff.

Getting Started

The constant adversity fractured the cohesiveness of our staff, and the stress wore down our leadership team. We needed a way to bring the staff together and engage with them to solve a myriad of issues that were creating friction throughout all ranks. One thing in our favor: our incredibly hardworking and experienced oncology team regularly brought concerns and ideas for change to our leadership team. We quickly realized that we needed to

find a structured way to capture these ideas and channel them into staff engagement and positive change.

As cancer center leadership searched for inspiration, we found it within our own organization. Other hospital departments had recently implemented associate-driven ideas board programs aimed at engaging front-line staff in continuous improvement initiatives. This program was still in its infancy and had yet to be adapted to the clinic setting. Our cancer center leadership team felt the time was right to make a change and implemented a new model for continuous improvement. We did not re-create the wheel but re-created the cancer center one idea at a time. In short, our cancer center wanted to use an ideas board to accelerate our rate of improvement and, more important, build a sense of community and ownership among staff. We needed to build an organizational and operational structure that would support this change and encourage its adoption and growth. The answer: our Daily Improvement Program.

The Huddle Approach

Some daily operational huddles were already occurring, but they existed in silos. To rebuild the culture and create a stronger community among our staff, those silos needed to be broken down. It felt simple at the time, but holding structured daily huddles with our staff had an immediate positive impact on the cancer center's day-to-day operations and the staff's sense of community. Staff looked forward to attending each morning's huddle where they could touch base with colleagues they did not see often. Leadership established a well-defined structure to the daily report out of operational and safety concerns (Figure 1, right). Additionally, they ensured that there was also unstructured time to give kudos and recognize others for going above and beyond as well as time to laugh and joke with one another, leading to new friendships and bringing existing ones closer together.

"The daily huddle keeps me up to date on the goings-on in the whole clinic and gives me insight as to how busy other areas are, helping guide my work and allowing for compassion, empathy, and grace since I know what the other areas are up against," shared JoJo Cowan, RN, oncology nurse navigator at Cancer Centers of Colorado at SCL Health St. Mary's Medical Center.

One major piece of the huddle was leadership—not from the formal cancer center leadership team but from our front-line staff themselves. Each day, different areas of the cancer center are asked to lead the huddle discussion, allowing them to take on leadership roles and facilitate conversations with their colleagues. These informal leadership opportunities helped break down communication silos and encouraged staff to communicate consistently, giving them opportunities to improve their ability to communicate with each other effectively. We want to build and foster leadership abilities in all of our staff, not just our leadership team. Giving staff structured time to lead daily huddles was the first step to building this capacity within our entire team. It was the first step in building continuous improvement leaders in every staff member of the cancer center.

The daily huddles built the foundation for the core tenets of our ideas board: open communication, front-line leadership, and continuous improvement.

Improving Patient and Provider Satisfaction

Our cancer center has always held itself to a high standard of quality care and patient satisfaction, as evidenced by its almost 30 years of Commission on Cancer accreditation. It has also seen its fair share of evolutionary changes with staff and provider groups throughout the years. We have always been able to weather the storms of adversity because of the incredible resiliency of our staff. However, in 2017, our cancer center experienced more leadership turnover. The administrative director was replaced by the hospital's director of process improvement, who took inventory of the current operating model, quality and operational metrics, and patient and staff satisfaction metrics. He found that the cancer service line's quality remained high and that patients received excellent clinical care. But we were missing high levels of satisfaction and engagement among our patients and staff.

Our cancer center had spent the past few years focusing on improving the quality of its patient care; however, it was apparent that we needed to adjust our focus to encompass the non-clinical aspects of patient care as well. Simply put: we wanted to achieve excellence in *all* areas of patient care.

Our patient satisfaction levels were at an all-time low, and our staff satisfaction scores left quite a bit to be desired. Press Ganey patient satisfaction top box scores were 47 percent and there were opportunities to improve in nearly every domain. Press Ganey staff engagement scores were nearing the bottom of the scale (tier 2). Something had to be done to dramatically make improvements in both areas.

Developing the Ideas Board

With the help of our Process Improvement Department, cancer center leadership began to develop the next step of the Daily Improvement Program—the ideas board. We set the framework for how this program would work. Much like the PDSA (Plan, Do, Study, Act) model, we spent a lot of time and paid attention to details when planning the ideas board. Building the framework right the first time was vital to the initial success of the Daily Improvement Program. Our guiding principles were:

- Ideas should be action-oriented and solution-driven. Each idea must identify a problem and a meaningful way to solve that problem.

Figure 1. Daily Huddle Template

Staffing and Volume | Safety and Operations

Medical Oncology

Staffing: Provider MA **Volume:**
Pod 2: _____
Pod 3: _____
Pod 4: _____
Pod 5: _____
Pod 6: _____
Navigators: _____
New Patient Cord: _____
Genetics: _____
Research: _____
Inpatient: Physician: _____
APP: _____
On Call: _____
Weekend: _____

Other Clinics

Staffing: **Volume:**
Palliative Care: Provider: _____ 0
MA: _____
Craig - telehealth: Provider: _____ 0
RN: _____
Moab: Provider: _____ 0
RN: _____
Rifle: Provider: _____ 0
RN: _____
GYN Oncology: Provider: _____ 0
MA: _____

Infusion

Staffing: **Volume:**
Clinic Doc: _____
MAs: Infusion: _____
Lab: _____
RNs: Charge: _____ #1: _____
Infusion RNs: _____
Lab: _____
Late Nurse: _____
Weekend: _____
Pharmacy: _____ Total: _____
IP: _____

Radiation Oncology

Staffing: **Volume:**
RNs: _____ Total: _____
Dual Therapy: _____
Special Procedures: _____
Physicians: _____
On Call: _____

Support Services

Staffing:
Social Work: _____
Dietician: _____
Chaplain: _____
Financial Advocate: _____

Relevant safety events since last huddle:

What are we preoccupied with today?

Operational concerns for the day:

Upcoming/current process changes:

Announcements:

Kudos:

Open Positions:

Leadership rounding today:

Remote:

Off:

- Focus should be on the process, not people. We set out to improve the system and its processes, knowing that our staff are great people who need more support and a way to improve their work lives.
- Focus should also be on processes that staff are directly involved in or that they own. We wanted to be able to act quickly to solve problems, implementing new ideas in a matter of days or weeks, not months or years.
- All entry fields on the submission form must be completed, including the submitter's name. We wanted staff to take ownership of the identified problem(s) and solution(s); we did not want the ideas board to become a dumping ground for problems for others to solve.
- The person submitting the problem/solution should lead or be part of the identified improvement process. This principle put subject matter experts and individuals who know the issues at the forefront of solving the problem. It also created skills among staff to lead continuous improvement initiatives, which may not have previously existed.
- All ideas are welcome, both big *and* small. We wanted to focus on minor problems that our leadership team did not always see that often caused a significant amount of waste and re-work within our current operating model.
- Managers should review ideas daily. Our leadership team's role was to first review ideas for feasibility and then support staff as they navigate the improvement process, removing barriers and ensuring that staff had the tools they needed to solve a problem.
- Staff should be encouraged to participate. In fact, submissions of new idea(s) for improvement were built into our annual staff goals.
- Successes should be celebrated. Each person who submitted an idea was thanked by their direct leader, and staff were initially incentivized by a points system. Staff could use their earned points to purchase a wide range of items if they implemented the identified improvement idea.

At the same time, cancer center leadership developed the process for the ideas board. We wanted something visual, a place where staff could gather and see what ideas their colleagues had submitted in hopes of encouraging others to participate. There was thought given to the idea of making the ideas board electronic. Our organization was making the transition to the Google Workspace at the time, so this could have been done. However, it would not have been possible to create a water-cooler effect if all submissions were made electronically. Instead, we decided to create a physical ideas board with paper submission slips made available in the huddle meeting room. This created a gathering place and a mini think-tank for staff to share ideas and collaborate.

The submission form is simple. It has a section for demographic information: name of the person submitting the idea, the submission date for tracking purposes, and the department(s) affected by the problem. It also includes a section to tie back to our four major organizational goals: associate/patient safety, associate/patient satisfaction, clinical excellence, and throughput. We want staff to think about the bigger picture and how their improvements

would impact the cancer center and overall healthcare organization. The "meat" of the submission form is where staff clearly define the problem they wanted to solve. Staff are encouraged to write freely about the issue at hand and share a problem statement from their perspective. Next is space for their solution and/or idea. This is where staff share how they would like to solve the problem, describing their idea in detail, often painting a picture of their ideal future state. The form also asks staff to describe what they think the expected benefit from implementation of their idea should be. It could be anything related to the organization's goals; however, the focus was more so on clearly defining how much improvement or savings would occur. Finally, the back of the submission form has space for staff to document updates on their process using the PDSA model of improvement.

Our ideas board has a tracking system. It was built like a kanban board with sections for:

- Submitted ideas (Ideas)
- Ideas that are approved (To-Do)
- Ideas that are in progress (Doing)
- Ideas that are completed (Done)
- Ideas that need to be pushed back due to additional resource(s) or time requirements (Parking Lot).

The ideas board also measures the volume (number) of submissions. Staff can see how many total ideas are submitted and how many ideas are completed. This allows us to track our internal goal of reaching 50 percent completed ideas by the end of each calendar year.

Ownership and Accountability

Our ideas board is a way of empowering front-line staff to improve the work they do every day by introducing them to the PDSA model of continuous improvement. Our leadership found that the ideas board not only improved staff satisfaction but it also aligned with the throughput, cost savings, efficiency, and safety efforts of the organization.

Ownership and accountability from staff were simple, well-defined, and easy to understand: staff submitted the ideas, owned the ideas, and led implementation efforts. Ownership and accountability for our cancer center leadership team were equally simple: we were the owners of the ideas board itself and supported our staff with idea submission and implementation. Our number one standard is to allow and support the experimentation of implementation for every idea possible. We review the ideas board daily with an initial focus on feasibility. For example, a submitted idea for "margarita Mondays" was not feasible, but the idea for an infused water and coffee bar for patients was considered entirely feasible.

"The leadership team allowed us to categorize ideas quickly and determine priority and feasibility of ideas. We were then able to support the associate [staff member] with whatever was needed to complete the idea," said Crystal Tucker, RN, OCN, infusion registered nurse (RN) supervisor at Cancer Centers of Colorado at SCL Health St. Mary's Medical Center.

When cancer center leaders determine that an idea is feasible, they move it to "To-Do." If it is determined that an idea needs more time or resources, the team moves it to the "Parking Lot." Most ideas that end up in the parking lot are due to the immediate feasibility of the idea. In other words, the idea is determined to be feasible but it is not doable at that moment. For example, the submitted idea that we needed 10 more RNs was just not feasible, but an idea proposing to reorganize the patient check-out process was feasible and needed further review with the Patient Access Department. Feasibility is leadership's initial concern. Even if we have doubts about a solution, we are dedicated to trying as many new solutions as possible. At the very least, we will learn something new that will allow us to improve in other ways. Sometimes a solution that is determined to not be the right fit for an issue ends up being a perfect fit for a different problem—sometimes for a problem we did not realize we had. When a feasible idea is submitted by staff in a leader's area of responsibility, we follow up directly with the staff member, thank them for submitting the idea, ask any clarifying questions about the problem and solution, and walk them through the next steps in the improvement process.

Our leadership serves as guides for staff, ensuring that they understand the ramification(s) of a change and how best to navigate the improvement process, while also removing barriers to ensure successful implementation. As ideas move through this process, leadership is responsible for moving the submission forms to the appropriate section on the ideas board. When ideas are completed, both the submitter and the successful implementation are celebrated at the next daily huddle. This is a way to recognize the staff member(s) who put in the work to improve an area of the cancer center and to remind others to submit their ideas.

Implementing the Ideas Board

The initial kick-off of the ideas board was met with great anticipation. An all-staff meeting was held where the board was introduced, and everyone received a brief overview of continuous improvement tools and tactics. Cancer center leadership and the Process Improvement Department trained staff in lean thinking and gave tools (e.g., root cause analysis, error-proofing, the PDSA model for improvement, and change management) for support. The team laid out the program's ground rules and principles in detail.

The rollout of the ideas board, in conjunction with the structured daily huddle, went off exceptionally well. Attendance at the daily huddle was tremendous. The small room in which huddles are held typically overflows with staff members who want to provide input on operational concerns and safety preoccupations. We received 50 submissions to the ideas board for improvement within the first six months of implementation, and nearly all submissions have been completed, surpassing our initial goal of a 50 percent completion rate.

The ideas board placed additional work on the plates of our leadership team—there was no doubt about that. It took more work to review the ideas board daily and to guide staff through their improvement project while managing one's own daily work activities and projects. As ideas kept rolling in, adding to the management tasks of the leadership team, there was light at the
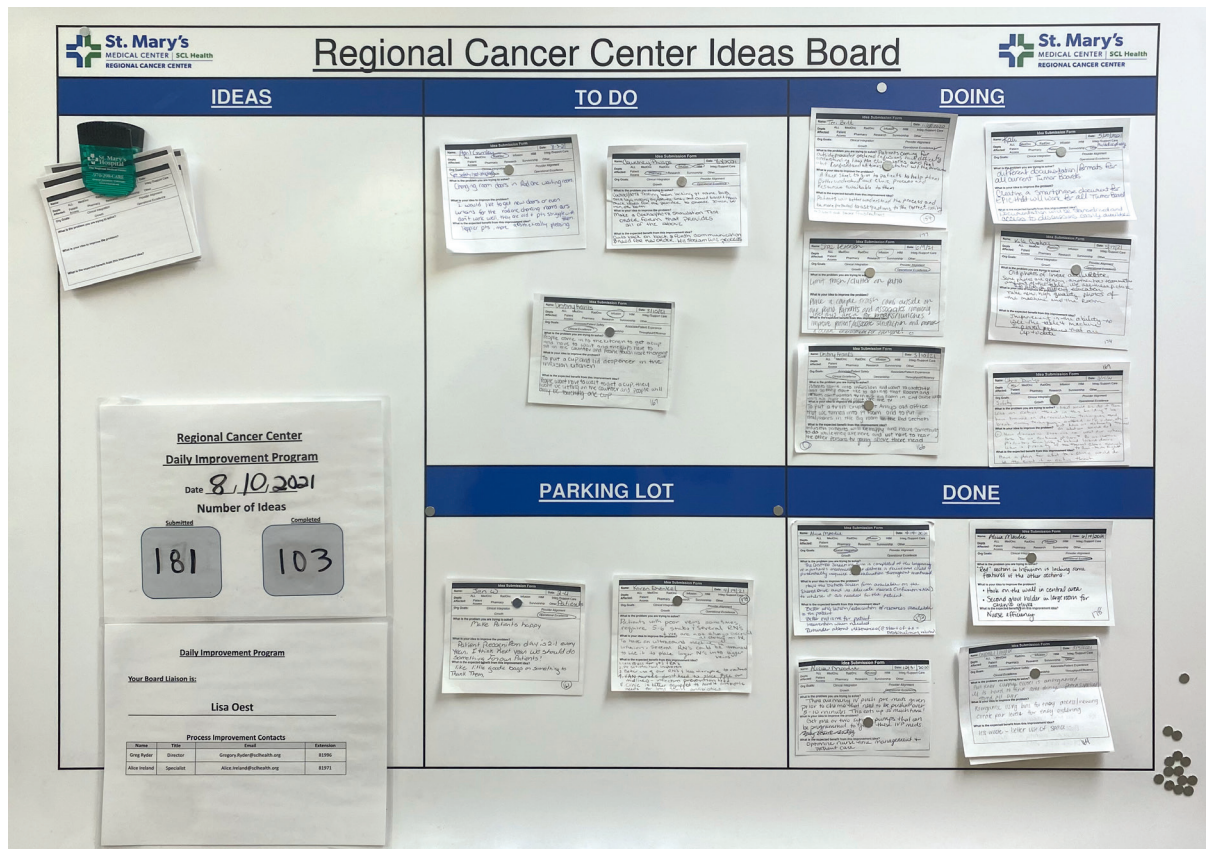
Ideas Board in the huddle meeting room.

end of the tunnel. It did not take long for our leadership to see the benefits of the ideas board. The buzz around the ideas board itself was enough to lift the morale of the staff. Staff could see that leadership wanted and needed their input and engagement for improving the cancer center.

"The ideas board allowed our team to bring really valuable ideas to the table and have ownership of changes by helping implement them. Seeing ideas completed so quickly encouraged other associates [staff] to add ideas to the board," shared Tucker.

Staff were excited to have a more prominent and influential voice in our continuous improvement efforts. The leadership team reinforced this way of thinking. When staff come to us to discuss or complain about a problem, our standard response is, "Put it on the ideas board." This mantra is an easy way to get staff engaged in fixing the problem rather than venting about their frustration.

"The ideas board gives us ownership of change, which creates a sense of personal investment," said Alicia Moodie, infusion RN at Cancer Centers of Colorado at SCL Health St. Mary's Medical Center.

The ideas board puts words into action and allows leadership to gauge how true an identified problem really is. Instead of putting out several fires every day, cancer center leadership can identify fires before they start. The entire culture of the cancer center shifted in a positive direction.

It is difficult, if not nearly impossible, to change an institution's culture overnight. Our story is no different. Though buy-in to the daily huddles and ideas board was swift for most staff members, these types of transformations take time to prove that it is more than concept or design. Our leadership team needed to prove to staff that the ideas board was not just a "flavor of the month." Leadership follow-through was the most crucial factor in proving this to staff.

The phrase, "Put it on the ideas board" became commonplace. Staff know that if their ideas are on the board, their issue will be addressed. If something needs to get done, the fastest way to do so is to submit it to the ideas board. Leadership began leaving submission forms all over the cancer center to make it easy for staff to document their ideas in real time. The concept of tying annual performance goals to the ideas board further incentivized staff to submit ideas for improvement. Though ideas are continuously highlighted throughout the cancer center via the daily huddle, during the COVID-19 pandemic, leadership began a monthly newsletter in lieu of monthly staff meetings.

Measuring Success

It is leadership's responsibility to track all ideas electronically. Even though the staff-facing portion of the ideas board is manually done via pieces of paper, leadership needed a way to track submissions and improvements over time. Therefore, each idea is entered into a tracking spreadsheet. Leadership tracks ideas over time and keeps metrics to measure the ideas board's outcomes as a whole. Primary metrics include the volume of ideas submitted, the volume of ideas completed, and the lead time from submission to completion. Our initial goals were to complete at least 50 percent of all submitted ideas and to complete (implement) each idea in under one month's time. The cancer center's administrative assistant plays a vital role in this process. She is responsible for the tracking and electronic documentation of ideas, allowing our leadership to follow through with the submitter and move ideas through the improvement process.

"Being involved in this program has allowed me to see the bigger picture of process improvement and how it has changed the culture within the cancer center," said Lisa Oest, administrative assistant at Cancer Centers of Colorado at SCL Health St. Mary's Medical Center.

To ensure the ideas board's long-term success, the leadership team put structures in place beyond the daily review of the board. We also hold weekly check-in meetings at the ideas board to discuss the status of ideas as a team. This allows us to share thoughts, concerns, and resources. Further, the cancer center leadership team and the Process Improvement Department scheduled monthly check-in meetings to discuss what is working well or what needs to be improved. This also gave cancer center leadership a direct line to continuous improvement experts within the organization to help them solve more complex problems.

Leadership uses "blitzes" to increase idea submissions. "Blitzes" are short sprints of submission time periods centered around one specific problem. For example, one area where the cancer center lagged behind was in our patient satisfaction scores. For far too long, these scores were well below our standards and did not show signs of improvement no matter what we tried. A call to action was sent out, and staff were incentivized to submit ideas that would dramatically improve the patient experience. The scope shifted from small ideas to big ones that would have a considerable impact on creating positive, memorable experiences for patients. The patient experience "blitz" produced more than 60 ideas in one month. The top three ideas were selected, and a team supported each submitter to ensure the idea's successful implementation. The remaining submissions were placed on the ideas board for staff to continue forward as if it were a typical submission. Ultimately, this particular "blitz" was a major success for idea generation, staff engagement, and improvements in patient satisfaction. Before implementing the Daily Improvement Program, the overall top box score for patient satisfaction was 47 percent.

Figure 2. Submissions by Process Step, March 2018 to July 2021
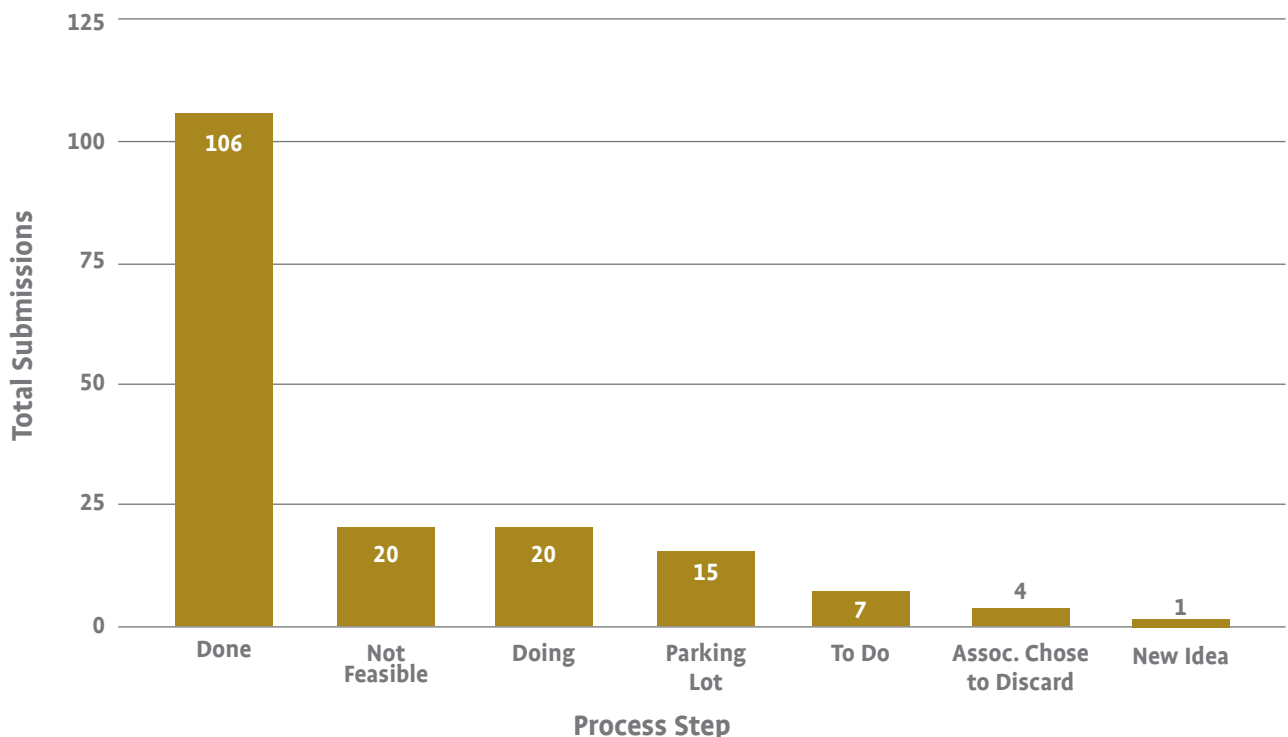
After implementation, the overall mean score improved to 88 percent.

Another area we needed to improve was staff engagement. Before implementation of the Daily Improvement Program, our staff engagement scores were unsatisfactory. Press Ganey engagement results showed an engagement factor of 4.17, and staff responses to the question "I am involved in decisions that affect my work" came in at a score of 3.69. We were not proud of either scores. Nearly all of the departments in the cancer center were in tier 2, so though the situation could have been worse, they needed to be better. Within two years, our staff engagement results show the Daily Improvement Program's proof of concept was as effective as hoped. The post-implementation engagement factor was 4.25, the question "I am involved in decisions that affect my work" score was 4.05, and all departments in the cancer center were in tier 1. There were uniformly higher results in all domains of the staff engagement survey:

- Organization domain increased from 3.93 to 4.14
- Manager domain increased from 4.10 to 4.21
- Employee domain increased from 4.17 to 4.28
- The leader index increased from 85 to 88
- The resiliency index incrased from 4.22 to 4.35.

Table 1. Select Submissions Implemented from the Ideas Board

Hand-Written Thank You Letters to All New Patients of the Cancer Center

We developed a standard thank you letter script for all cancer center and non-oncology infusion center patients. We brought together a group of staff who all had excellent penmanship. They receive a weekly list of all new patients and hand-write a thank you card for those patients. The cards are shared with a patient's specialty, so all related staff can sign the card. The response from patients about this implementation was overwhelmingly positive. It brightened up their day and showed them that we were willing to go out of our way to make them feel like they were a part of our family.

Submitted by Dave C., MA

Follow-Up Phone Calls to New Infusion Patients

The infusion charge nurse makes personal phone calls to every new infusion patient who came in the previous business day. The purpose of these calls is to check in on patients and to see how they are feeling after their first infusion treatment. The call allows for an additional touchpoint from a highly trained nurse back to the patient. We can gather meaningful input from the patient about their experience and address any clinical questions they may have. This improvement added work to the charge nurses' daily task list, but it has also addressed some minor concerns patients have before those concerns can grow more significantly.

Submitted by Crystal T., RN, OCN

Changing Scrub Color to Create a More Uplifting Environment

Historically, the scrub color for radiation therapists was black. This color always felt out of place for our radiation oncology staff. We changed the color to a bright blue to create a more uplifting environment for staff and patients especially. Patients loved the color change, and now these scrubs bring some brightness to their day.

Submitted by Breanne G., RT(R)(T)

Enlarging Drug Name on Chemo Bags

Reading the text on a chemotherapy bag from more than a couple feet away is very challenging, especially for staff with less than perfect eyesight. The idea was submitted to enlarge the drug name text, which would allow for easier safety checks. This change was not as easy as it sounds. Several IT tickets needed to be placed to work through this issue. Ultimately, the font was enlarged and the safety check process became much easier for infusion center staff.

Submitted by Katie M., RN

Purchase Ergonomically Correct Treatment Station Chairs

Radiation therapists spend most of their day at the treatment station, which has a counter-height desk. The chairs we had for this space were old and starting to cause undue stress on the backs and arms of staff. At the direction of staff, we purchased ergonomically correct chairs that allow for easy adjustments to meet the needs of all staff. The therapists especially loved being able to try out and ultimately decide which chair they would purchase.

Submitted by Melissa M., RT(T)

Across the board, the culture of the cancer center showed vast improvement over the three years the Daily Improvement Program was in place. Due to these changes, there were positive impacts on staff turnover rates. Prior to implementation, our turnover rate was typically above 15 percent; our turnover rates dropped to well below 10 percent throughout the cancer center post-implementation.

The positive impact the Daily Improvement Program had on the culture of the cancer center is in some ways immeasurable. For the many staff who experienced the cultural transformation firsthand, the impact reverberates throughout the entire building. Through the first three years of the program, 60 individuals and 13 teams submitted 180 ideas. Of these, more than 100 ideas (106) were completed (see Figure 2, page 42). Table 1, page 43, lists select submissions from the ideas board that were completed. Figures 3-5, pages 44-45, offer more detailed information about the submissions to our ideas board.

There is a direct correlation between the work to improve the culture of our cancer center and the incredible improvements shown in our patient and provider satisfaction numbers. However, there is no better proof than that of direct patient feedback. Recently, when rounding with a patient, the oncology director asked a patient what stood out to him about the cancer center from when he started treatment to today. The patient stated, "When I first came all those months ago, I wanted to go home and let cancer take me away. Now when I come in, I have an overwhelming feeling of hope, and it is all because of the staff and doctors that are here. They give me hope." There is no greater calling for a cancer center than to give its patients an overwhelming feeling of hope. All it took to get there was a significant culture change, one idea at a time. ◙

Kevin Dryanski, MBA, is director of the Oncology Service Line; Autumn Clark, RN, BSN, OCN, is clinical nurse manager; Erica Kinsey, PhD, MBA, is chief medical physicist and manager of radiation oncology; Greg Ryder, MPS, CSSBB, is director of Process Improvement; and Alice Ireland, BS, CSSBB, is process improvement specialist; at Cancer Centers of Colorado at SCL Health St. Mary's Medical Center, Grand Junction, Colo.

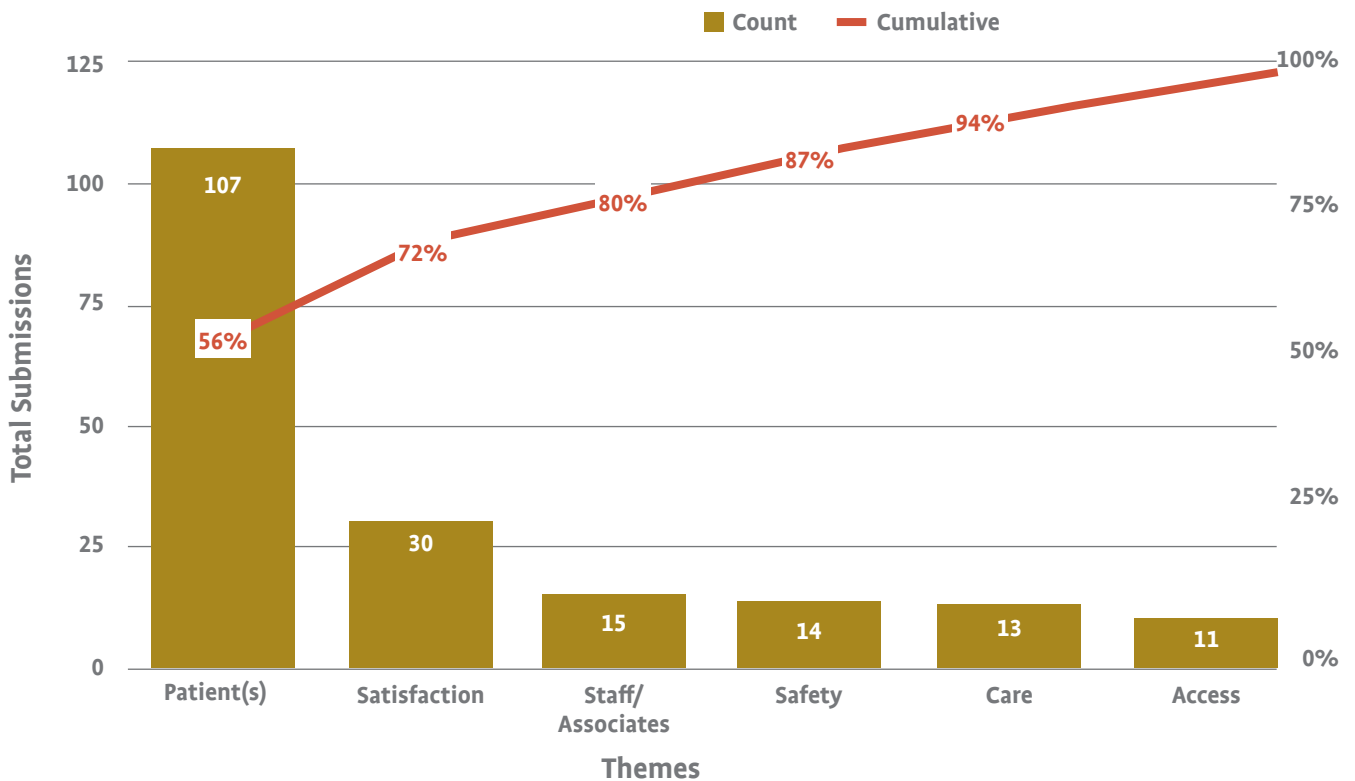Figure 3. Expected Benefit Themes, March 2018 to July 2021

Figure 4. Submissions by Area, March 2018 to July 2021

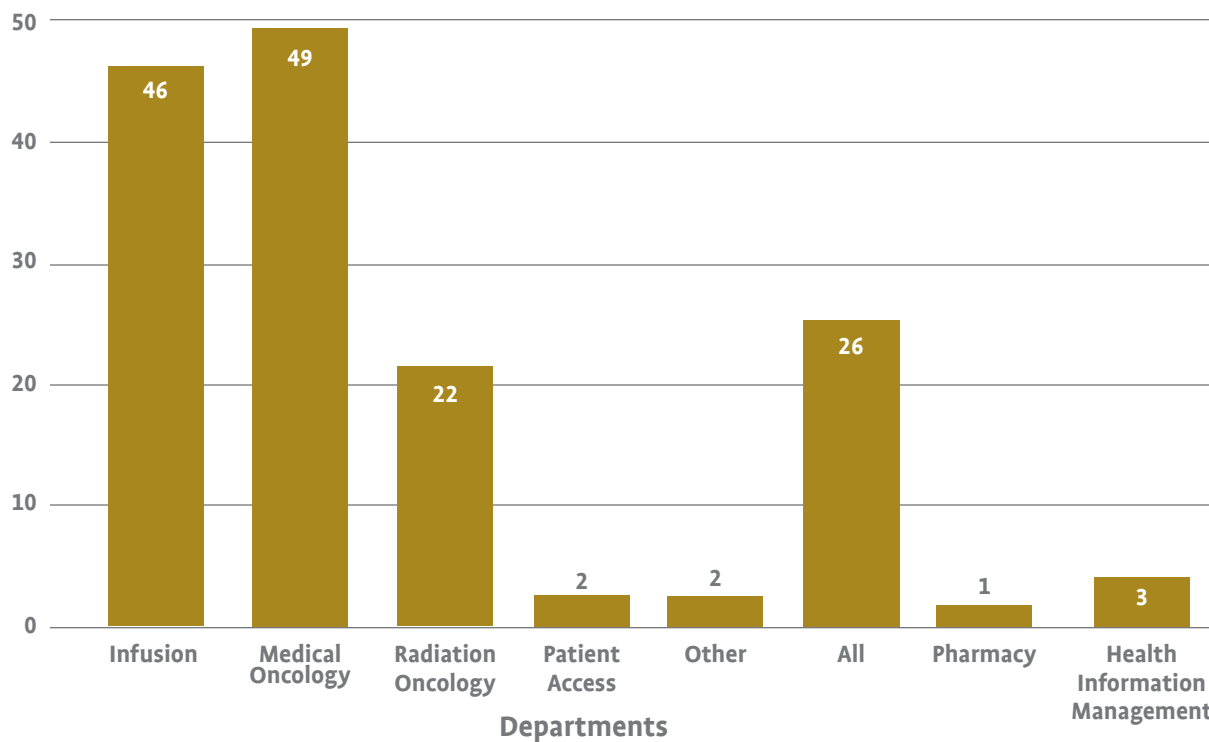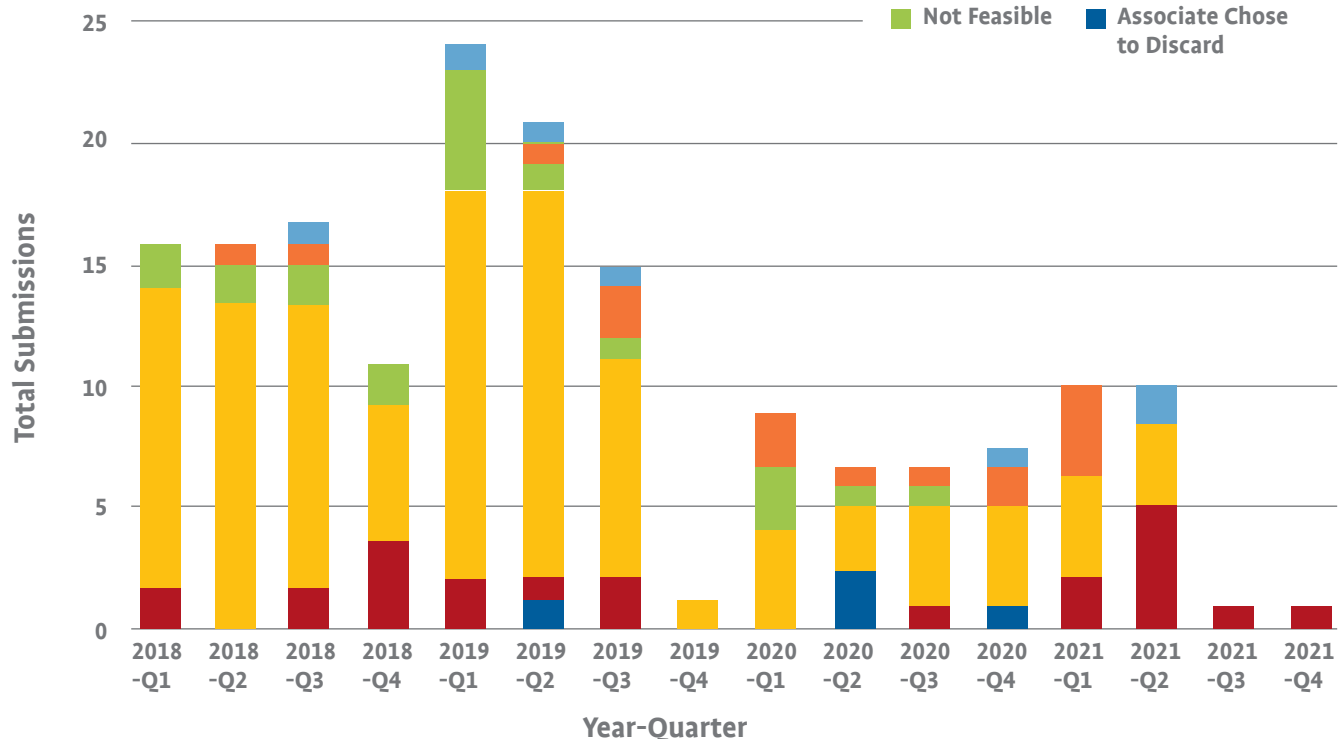*n*=151 (29 submissions did not identify a department)

Figure 5. Submissions by Process Step, March 2018 to July 2021

Welcome to ACORI

ACORI

ACCC COMMUNITY ONCOLOGY RESEARCH INSTITUTE

BY BARBARA GABRIEL

ACCC Brings Clinical Research to Local Communities

"Every patient in every community deserves to be offered clinical trials." Though this sentiment from Randall A. Oyer, MD, immediate past president of the Association of Community Cancer Centers (ACCC), seems self-evident, it is far from reality.

Although 85 percent of patients with cancer are diagnosed and treated in community settings, only 3 percent of those patients are enrolled in clinical trials.[1] Inadequate time, infrastructure, resources, incentives, and reimbursement all contribute to this sparse participation rate. Indeed, respondents to a 2019 ACCC member survey, Trending Now in Cancer Care, identified a lack of staff resources and training, poor program infrastructure, and poor patient understanding of clinical trials as the top three barriers to offering trials in community cancer centers.

To address this, in 2021, ACCC established the ACCC Community Oncology Research Institute (ACORI) to build on the organization's mission to use oncology partnerships to promote cancer research in local communities. ACORI evolved from ACCC's year-long examination of equity in and access to clinical trials in local communities. This initiative was led by Dr. Oyer, who assembled a multidisciplinary task force comprised of 16 high-level oncology leaders across the country.[2]

> "Communities belong in cancer research, and cancer research belongs in the community."
>
> — Randall A. Oyer, MD

Through ACORI, ACCC is working to establish clinical trials as a standard of care for all patients, regardless of where they are treated. "ACCC is diffusing research into communities by connecting community programs with academic and industry sponsors to get the right trials into communities in an expedited fashion," explains Dr. Oyer, the medical director of the Oncology Program at Penn Medicine Lancaster General Health. "Communities belong in cancer research, and cancer research belongs in the community."

Under ACORI, ACCC helps community oncology programs access the tools, knowledge sharing, effective practices, and peer

mentorships that can increase their ability to offer clinical trials. At the same time, ACCC serves as a primary resource for academic and industry sponsors to foster relationships with community cancer centers. ACORI's task force vets research and trial opportunities and disseminates them to interested community oncology research programs.

The Trial That Could

When Dr. Oyer began his tenure as ACCC president in 2020, he formed a President's Task Force to articulate and put into action his priorities for the organization. After Dr. Oyer adopted the expansion of clinical trials in community cancer centers as his 2020-2021 ACCC President's Theme, the task force set as one of its objectives the selection and vetting of clinical trials to be presented to task force members for consideration at their own institutions.

While researching and vetting active trials for their applicability to community cancer centers, Leigh Boehmer, PharmD, chief medical officer at ACCC, came upon a study that he believed would be a good candidate. The trial, Duloextine to Prevent Oxaliplatin-Induced Peripheral Neuropathy in Patients with Stage II-III Colorectal Cancer, involves the use of an anti-depressant to possibly prevent nerve pain in patients undergoing treatment with oxaliplatin. "The trial examines the feasibility of using an anti-depressant off-label to prevent a known painful side effect of select chemo agents," explains Dr. Boehmer. "It is being studied in patients with colon cancer to proactively prevent neuropathy and to characterize the degree of duloxetine-related side effects experienced at two different dosages."

When Dr. Boehmer suggested this trial for consideration at a task force meeting, Lawrence Wagman, MD, a surgical oncologist and regional medical director for the City of Hope's Inland Empire Program at the eastern side of the greater Los Angeles area, was intrigued. Dr. Wagman recognized the power of the trial for City of Hope's community campuses. "Our doctors and staff had all already identified neuropathy as a problem that affects many patients," says Dr. Wagman. "The doctors and staff who looked at it thought this was a meaningful trial for which we have many eligible patients."

Dr. Wagman took the trial to Camille Adeimy, MD, MMM, a medical oncologist and hematologist who joined City of Hope two years ago. The City of Hope main campus research department had selected and recruited Dr. Adeimy to champion, establish, and maintain quality and robust clinical trials at City of Hope's Upland site, which serves as an outpatient department of the health system's National Medical Center in Duarte, Calif.

"I brought the trial to Dr. Adeimy and suggested we present it at a regular conference he established to talk about potential new trials," recalls Dr. Wagman. "We did a presentation, and everyone said it was perfect for our community. We were sure our patients would be interested in it, and they are. Dr Adeimy brought the trial to reviewers at the main City of Hope campus and got permission to open it at his community site."

Hub-and-Spoke Model

As the lead clinical researcher at Upland campus—the largest and busiest of City of Hope's community sites—Dr. Adeimy is growing a research program in local communities served by the institution. "We have three surgeons, five medical oncologists (of which I am one), and two radiation oncologists," says Dr. Adeimy. "We are aiming to bring to our community the same level of care as that provided on the main campus of City of Hope."

Dr. Wagman says the main campus research department at City of Hope recently reorganized its (community-based) network research activities into a hub-and-spoke model, in which a selected community site is in the center (hub) and geographically surrounding community sites are the spokes. Larger community

Dr. Randall Oyer
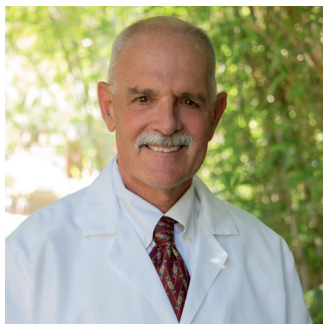
Dr. Lawrence Wagman

Dr. Camille Adeimy

practices—such as the one in Upland—may be the hub for smaller community sites. "There is the general attitude that community cancer programs are not the leaders in research," says Dr. Wagman. "To challenge that requires that the main campus be comfortable with the hub and spoke sites and recognize what they have to offer. ACCC has created a platform to start doing that."

Dr. Adeimy says that all trials at City of Hope must first be approved by the main campus, where they are reviewed and approved by the appropriate disease team (prostate, lung, breast, etc.). Dr. Adeimy was the first physician outside of City of Hope's main campus to bring a trial for approval. "Usually it's the other way around," says Dr. Adeimy. "The main campus vets trials and then offers them to us."

To make the hub-and-spoke model successful, Dr. Adeimy says there was a decision made early on to engage all of the specialties in research together to ensure researchers would not work in silos. "Researchers have been given leave to work independently and to talk at faculty meetings about clinical trials and their processes, so everyone can weigh in," says Dr. Adeimy. He explains that Dr. Wagman is engaging surgical, radiation, and medical oncology together in the selection of clinical trials. "These departments each provide different entrances into our cancer program," says Dr. Adeimy. "Combining our research efforts gives us the opportunity to better engage community sites in trials."

Once Dr. Adeimy obtained approval from City of Hope to conduct the duloxetine trial, he brought the study to City of Hope's community clinical network, which added multiple sites to the trial. The trial has enjoyed so much success at these community sites that the health system's main campus is also offering the trial—something Dr. Wagman says he's never seen done. "This is the first time this has happened at City of Hope," he adds. "It's almost a new paradigm."

Advantages of Local Sites

What community sites lack in resources, says Dr. Adeimy, they make up in being close to their patient population. Whereas the main campus concentrates on specific, later-stage cancers, community oncologists mostly serve patients newly diagnosed with cancer, and they know what their populations need most. "In community sites, our resources are very limited," says Dr. Adeimy.

"Communication is key. Community providers better recognize what they can and cannot do."

Dr. Adeimy says patients at his clinic deal with barriers to care that are unique to their location. "Our patients come from a variety of backgrounds," explains Dr. Adeimy. "Some have poor socio-economic backgrounds or poor health coverage. It's challenging to be able to offer them the same level of care and clinical trials as City of Hope's main campus provides."

Before coming to City of Hope, Dr. Adeimy worked in rural Kansas. Rural practices, Dr. Adeimy says, must concentrate on the needs of their patients rather than the needs of trial sponsors. "In Kansas, we made an effort to first recognize what a community needs and then build a clinical trial around that," says Dr. Adeimy. "Otherwise, a community won't be open to it. The resources needed for a trial must already be in place."

Dr. Adeimy says he gains support from local providers to back a trial before patients are enrolled. "Recruitment is at the level of the provider," he explains. "We aim to educate all of the providers at a practice about potential trials, so they are more motivated to recruit their patients." At Dr. Adeimy's location, clinical research staff screen each newly diagnosed patient to identify any appropriate clinical trials that may benefit them.

Dr. Adeimy's advice to other community cancer centers interested in offering trials to their patients is to concentrate on multidisciplinary research rather than conducting separate trials for different subspecialties. "Avoid the silos that these trials can erect," says Dr. Adeimy. "It leads to breakdowns in communication and missed opportunities. Adopting a multidisciplinary approach to trials allows us to capture more patients and improve quality of care as matter of principle." OI

Barbara Gabriel is the senior writer/editor at the Association of Community Cancer Centers, Rockville, Md.

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Integrating Spiritual Care in the Outpatient Oncology Setting

BY ALISON SNOW, PHD, LCSW-R; LORI SCHWARTZ, LCSW-R; EMILY SZAFARA, LMSW;
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In Brief

Spiritual care is recognized as an essential component of caring for patients with serious illnesses, like cancer. Chaplains are a unique part of the healthcare team, addressing patients' concerns around sacred and existential questions. This article highlights findings from a 38-item needs assessment survey of 82 patients in an outpatient New York City cancer center who shared their level of spirituality and/or religiosity, interest in spiritual care, and key demographic and clinical data. This survey also assessed patients' interest in meeting with a chaplain, and for those who elected to meet with a chaplain, feedback was obtained on the provided services. Study results suggest that most patients were open to receiving a visit from a chaplain in the outpatient setting. Based on this demonstrated interest, the cancer center implemented a referral protocol for this service.

A cancer diagnosis and its treatment frequently engender a personal and spiritual struggle as patients and those around them grapple with existential issues related to life and meaning.[1-5] For patients who receive a diagnosis of a life-threatening illness, such as cancer, spiritual beliefs can offer guidance and a sense of support and belonging.[6] A chaplain is a trained spiritual care expert who holds an essential position within the multidisciplinary cancer care team.[7] Spirituality is increasingly recognized as a critical component of a multidimensional understanding of one's psychological well-being and as a means of supporting the holistic needs of patients.[1-5] The National Cancer Institute (NCI) defines spirituality as "an individual's sense of peace, purpose, and connection to others, and beliefs about the meaning of life. Spirituality may be found and expressed through an organized religion or in other ways."[8,9] The National Cancer Institute defines religion as "a set of beliefs and practices that center on questions about the meaning of life and may involve the worship of a supreme being."[8,9] Spiritual care providers support the religious and spiritual needs of patients and their caregivers.

National organizations, like the Association of Community Cancer Centers, have identified these services as a key component to comprehensive cancer care.[10] As such, spiritual care is incorporated into national care quality guidelines, including those of the National Consensus Project for Quality Palliative Care and The Joint Commission.[11]

Religion, Spirituality, and Cancer

Numerous studies have examined the relationship between religion and spirituality and their impact on coping with illness, specifically cancer. Alcorn and colleagues conducted a qualitative study of patients with advanced cancer in the United States and found that 78 percent of patients identified religion and/or spirituality as an important factor of their cancer experience.[12] These studies suggest that the majority of patients with cancer view religion and spirituality as personally significant.[13,14] Moreover, there is growing recognition of religious and spiritual importance in association with improved quality of life among oncology patients.[15-17]

> There is a need for spiritual providers to extend their services beyond the walls of the inpatient setting and integrate their expertise into the outpatient, multidisciplinary care team to better meet the needs of patients across all care settings.

Though there is evidence that spiritual well-being can positively contribute to health-related quality of life,[18,19] Balboni and colleagues reported that 72 percent of patients in the United States with advanced cancer felt that their spiritual needs were met minimally or not at all by their care team and were not incorporated into their care planning.[14] Patients and caregivers whose spiritual needs are not addressed may experience higher levels of distress and feelings of hopelessness.[20] On the other hand, addressing the spiritual needs of patients and caregivers can help mitigate anxiety, as well as help them to create meaning in relation to their circumstances.[21] Furthermore, spiritual struggles are associated with poor physical outcomes and higher rates of morbidity.[22] A healthcare team's support of patients' religious and spiritual needs has also correlated with improved patient satisfaction with their care.[23] Patients who reported that their spiritual needs were not being met gave lower ratings of the quality of their care and reported lower levels of satisfaction with their care.[24]

Though the importance of addressing spiritual needs in the inpatient setting has been demonstrated, with the shift in oncology care to outpatient clinics, the literature supporting the provision of spiritual care in the outpatient setting is building.[25-30] There is a need for spiritual providers to extend their services beyond the walls of the inpatient setting and integrate their expertise into the outpatient, multidisciplinary care team to better meet the needs of patients across all care settings.

This study, consisting of a needs assessment and referral protocol, examines and addresses patients' level of interest in receiving spiritual care in the ambulatory cancer care setting and describes the implementation of a system to improve access to spiritual care.

Study Methods

In 2018 Mount Sinai Beth Israel Cancer Center, New York City, N.Y., developed a one-time survey to give to patients who received outpatient oncology services during a one-year period. Approved by the internal review board of Mount Sinai Beth Israel, the survey tool included questions on key demographics, clinical data, self-identified levels of personal spirituality and/or religiosity, and participants' desire to receive spiritual care support in the outpatient setting. Eligible participants were 18 years of age or older, able to read and write in English, and patients of Mount Sinai

Beth Israel Cancer Center. Patients were approached for the survey by a trained volunteer in the waiting rooms of medical and radiation oncology and the chemotherapy suite.

Measurement

The 38-item self-report questionnaire was developed based on clinical judgment and a literature review by oncology social workers and the chaplains assigned to this clinical setting. Following the approach of Schultz et al., patients were asked to provide demographic and clinical information (20 questions).[31] Demographic information explored patient gender, race, ethnicity, marital status, religion, educational level, and age. Patients were also asked about their attendance at religious services and their perception of the level of support they were currently receiving from friends, family, and their community. Clinical questions addressed patients' cancer diagnosis, treatment type, time since primary diagnosis, cancer recurrence, whether the cancer had metastasized, and how worried the patient was about their illness. One clinical question addressed overall satisfaction with care provided by the cancer program. Additionally, patients were asked about their spiritual identity and to describe their level of spirituality and/or religiosity on a four-item scale (*not spiritual/religious* to *very spiritual/religious*). Patients were asked the following questions about their attitudes toward spiritual care:

1. How important is it for the cancer program to incorporate spiritual care into its services?
2. How open do you think you would be to a visit from a spiritual care provider?
3. Do you think you have a good understanding of what a spiritual care provider does?

Participants were also given the Religious (*n* = 5) and Spiritual (*n* = 13) subscales of the Spiritual Needs Assessment for Patients (SNAP).[32] The Religious subscale consists of five items, with the sum of the scores ranging from 5 to 20, with higher overall scores indicating greater religious needs.[32] The Spiritual subscale consists of 13 items, with the sum scores ranging from 13 to 51, and higher scores indicate greater spiritual needs.

Lastly, patients who had already received a visit(s) from a chaplain were asked six additional questions. The first two questions explored whether the patient met with a chaplain (yes/no) and, if so, how many times they met. Four questions from the Patient Satisfaction Instrument for Pastoral Care-Chaplaincy Supportive Ministry of Chaplains subscale were used.[33] This is a six-item Likert scale in which patients are asked to identify within a range from *strongly disagree* to *strongly agree* regarding statements about their experience with a chaplaincy visit. The decision was made to not include two items from this subscale because they were not relevant to the current chaplaincy services being offered in the outpatient setting.

Patient Characteristics

A total of 83 participants completed the survey. Table 1, right, presents a descriptive analysis of the categorical study variables. Data reflect that the participant sample was half female and half

Table 1. Descriptive Analysis of Demographic Study Variables (n = 82)	
Gender	
Male	41 (50)
Female	41 (50)
Education level	
Some high school	6 (7)
High school	15 (18)
Some college	19 (23)
College	21 (26)
Master's	11 (13)
Post-baccalaureate	2 (2)
Other/unknown	8 (10)
Ethnicity	
Hispanic	20 (24)
Non-Hispanic	62 (77)
Race	
White	48 (59)
African American	24 (29)
Asian	8 (10)
Other	2 (2)
Marital Status	
Single	28 (34)
Married	38 (46)
Divorced	12 (14)
Widowed	4 (5)
Recurrence	
Yes	22 (27)
No	52 (63)
Don't know	8 (10)
Metastases	
Yes	23 (28)
No	39 (48)
Don't know	20 (24)
Type of treatment	
Receiving chemotherapy	37 (45)
Receiving radiation therapy	17 (21)
Receiving chemo and radiation	17 (21)
Completed chemo and/or radiation in past six months	3 (4)
Other	8 (10)
Visits with chaplain	
Yes	28 (34)
No	54 (67)

male (*n* = 41; 50 percent). Participants had an average age of 58, and most participants had at least some college (*n* = 53; 64.6 percent) or a college degree or higher (*n* = 34; 41.4 percent). Most patients were of non-Hispanic ethnicity (*n* = 62; 76.6 percent). More than half of participants identified as White (*n* = 48; 58.5 percent), over a quarter identified as African American (*n* = 24; 29.3 percent), nearly 10 percent identified as Asian (*n* = 8; 9.8 percent), and two participants identified as "other." Close to half of participants were married (*n* = 38; 46.3 percent), about one-third were single (*n* = 28; 34.1 percent), 12 were divorced (14.6 percent), and 4 were widowed (4.9 percent). Roughly one-third of patients reported cancer recurrence (*n* = 22; 26.8 percent). Nearly half of patients did not have metastatic cancer (*n* = 39; 47.6 percent) and were receiving chemotherapy (*n* = 37; 45.1 percent). About one-third of the study sample reported receiving a visit from a chaplain (*n* = 28; 34.1 percent).

Data indicate that participants were split regarding their level of worry about their illness (Table 2, page 54). Eighteen participants (21 percent) reported that their illness was "not that worrisome," and nearly a quarter of respondents answered "quite worrisome" (*n* = 20; 23 percent). Most patients responded that their illness was "somewhat worrisome, but maybe manageable" (*n* = 28; 32 percent), and 21 patients (24 percent) answered "somewhat worrisome." Most participants reported that they attend religious services at least once per year (31 percent), and others responded that they attended religious services daily (5 percent), weekly (32 percent), once per month (11 percent), or never (21 percent).

In terms of the two questions on religiousness and spirituality, 38 percent (*n* = 33) identified as "very spiritual," while 28 percent (*n* = 24) identified as "not religious." Though 24 participants identified as not religious, only 8 (9 percent) identified as "not spiritual." Both "somewhat religious" and "somewhat spiritual" responses made up 20 percent and 25 percent of respondents, respectively. For both questions, nearly 25 percent of participants responded that they were "spiritual" and "religious."

For the SNAP Spiritual subscale, the mean score for the 13-item Spiritual Needs scale was 34, and scores ranged from 13 to 51. The mean SNAP Religious subscale score was 12, and scores ranged from 5 to 20.

Of the 82 participants, 65 percent (*n* = 53) responded that they would be "maybe interested" or "definitely interested" in having a visit from a chaplain. Nine participants (11 percent) said they felt indifferent about a visit from a chaplain, and 20 participants (24 percent) responded either "not at all" or "not really open" to a visit from a chaplain. These findings are summarized in Table 2, page 54.

Additionally, of those who received a visit from a chaplain prior to the survey (*n* = 28), 26 participants (93 percent) reported that they were satisfied with their care. In contrast, of the participants who did not previously receive a visit from a chaplain (*n* = 54), only 45 (83 percent) reported being satisfied with their care. A chi-square analysis of the questions regarding a visit from a chaplain and patients' satisfaction with their care is shown in Table 3, page 55; this relationship did not show significance.

Table 2. Spiritual Identification Responses

Spiritual Identification Responses	n (%)
How would you describe your level of spirituality?	
Not spiritual	8 (9)
Somewhat spiritual	22 (25)
Spiritual	19 (22)
Very spiritual	33 (38)
Declined to answer	6 (7)
How would you describe your level of religiousness?	
Not religious	24 (28)
Somewhat religious	18 (21)
Religious	22 (25)
Very religious	14 (16)
Declined to answer	11 (13)
How often do you attend religious services when healthy?	
Daily	4 (5)
Weekly	28 (32)
Once a month	10 (11)
Once a year	27 (31)
Never	18 (21)
Declined to answer	2 (2)
How worrisome do you think your illness is?	
Not that worrisome	18 (21)
Somewhat worrisome	21 (24)
Somewhat worrisome but maybe manageable	28 (32)
Quite worrisome	20 (23)
Declined to answer	1 (1)
How open are you to have a visit from the chaplain?	
Not at all	5 (6)
Not really open	12 (14)
Indifferent	8 (9)
Maybe interested	26 (29)
Definitely interested	25 (29)
Declined to answer	13 (15)
Do you think you have a good understanding of what a spiritual care provider is or does?	
Not at all	10 (11)
Not really	13 (15)
Unsure	14 (16)
I think so	31 (36)
Definitely	21 (24)

Finally, most patients (*n* = 51, 58 percent) responded that they were "maybe interested" in having a visit from the chaplain. Most respondents also believed that they understood a spiritual care provider's role, as 36 percent (*n* = 31) answered "I think so" and 24 percent (*n* = 21) answered "definitely" to this question.

Discussion of Survey Findings

Although there was no statistically significant relationship between chaplain visits and patient satisfaction with their overall care, survey data suggest this effect because the proportion of study participants satisfied with their overall care is approximately three times higher among those who reported having a visit from a chaplain (Table 3, right). This finding is supported by a large study sample by Clark et al., which found that patient satisfaction was significantly associated with meeting their spiritual needs.[34] As public and private payers are increasingly linking patient satisfaction with their care to reimbursement, many cancer programs and practices are looking to improve patient reported satisfaction scores.

Most respondents (58 percent) were open to a visit from a chaplain and believed that they understood the role of the chaplain (60 percent). This is an important indicator that chaplains are being accepted into outpatient cancer care delivery.

The sample size for the needs assessment was small and limited to one treatment center location. Additionally, patients who declined to fill out the survey were not asked for their reasons why, nor did we track the number of total refusals. The respondents were disproportionately Christian; future research should explore whether chaplain interventions are welcomed by non-Christian patients.

Based on patient interest (as demonstrated through the survey) and an increased availability of chaplains in the outpatient setting, three ambulatory cancer centers (Mount Sinai Beth Israel Union Square and Chelsea Cancer Centers and Mount Sinai West Cancer Center in New York City) implemented practice changes, including a mechanism for chaplains to identify patients who have spiritual concerns.

Developing an e-Referral Protocol

Building on the established referral system already in place for social workers, the three Mount Sinai outpatient cancer programs above added questions to the electronic distress screening survey that is used to address patients' spiritual care needs. This e-distress screening tool CancerSupportSource® is given to patients at their medical oncology visits (at a patient's second visit and then once every three months). The screening tool has 18 questions that address cancer-related distress in addition to two customized self-referral questions. Patients answer the questions using a Likert scale (1 = *not at all concerned* to 5 = *very seriously concerned*). Distress screening is conducted via an iPad while medical assistants prepare patients for their visit with their oncologists. Patients have the option to decline the screening. Upon completing the distress screening, results are transferred automatically to the

Table 3. Chi-Square Analysis of Having a Visit from the Chaplain (Yes/No) and Care Satisfaction (Yes/No)

	Had a Visit from the Chaplain			
	Yes n (%)	No n (%)	X^2 (df)	p
Care satisfaction			1.86 (1)	0.17
Yes (scores = 4-5)	26 (36.6)	45 (63.4)		
No (scores = 1-3)	1 (12.5)	7 (87.5)		

patient's electronic health record and emailed to the cancer center's social workers.

Because there was no formal referral protocol in place for chaplains, one was developed using the survey item "finding meaning and purpose in life." Using a Likert scale, patients who respond "seriously" or "very seriously" to this question are now automatically referred to a chaplain. Additionally, there is also an option for patients to self-refer to chaplains. The self-referral is worded as: "You have the option to speak with a chaplain, and someone may reach out to you based on the concerns you shared. Would you like to speak to a chaplain?" The addition of the self-referral question allows patients to actively seek support, which empowers patients throughout the course of their treatment. Chaplains assigned to a specific outpatient clinic call patients who trigger an automatic referral or who self-refer. This distress screening measure also supports cross-discipline interaction and collaboration in support of patients.

Chaplains are tasked with providing support services to patients on an as-needed and ongoing basis. The e-referral protocol allows chaplains to streamline their workflow and identify and triage patients most at risk for spiritual distress. The automatic referrals, triggered by a positive answer to the meaning and purpose question, are consistently higher than patient self-referrals. From January 2019 to December 2020, three chaplains at the three ambulatory cancer centers received 413 automatic referrals and 174 self-referrals. Through distress screening, chaplains better identify patients who have spiritual concerns and who may be more likely to accept spiritual interventions.[29] Similarly, Sprik et al. found that using distress screening for "struggle to find meaning" among several other religious and spiritual concerns helped chaplains identify patients who had spiritual concerns and who would be receptive to chaplain interventions.[30]

Given the importance of spiritual well-being as a component of one's overall quality of life, particularly among patients with cancer, services that enhance spiritual well-being are essential. In addition, research shows that effective chaplain services improve patient-reported outcomes and programmatic effectiveness overall. An automatic referral process to chaplaincy for spiritual and religious needs should be considered an integral part of the assessment process. Future research should consider spiritual and religious care interventions and their impact on patients' experiences and satisfaction. Adding chaplains to the outpatient cancer care team provides patients an additional resource for support to maximize well-being and quality of life. ◙

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PATIENT PERCEPTIONS OF BIOMARKER TESTING

A mixed-methods approach to understand the patient experience related to biomarker testing for NSCLC

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In Brief

As precision medicine becomes more common in the management of lung cancer, little is understood about the patient experience with biomarker testing, particularly patients of underserved populations. This study used survey and focus group methodology to determine patient perspectives on the educational needs within this community.

A patient-directed survey was developed by a patient advocacy group collaboration and distributed in April-June 2020. The survey criteria included a diagnosis of non-small cell lung cancer (NSCLC), age of 21 years or older, and United States residency. Two main groups were surveyed and analyzed: a patient group sourced through a general panel of patients and the email database of the Patient Advocate Foundation (a non-profit organization supporting low-income patients), and a group connected to the LUNGevity Foundation, a lung cancer patient advocacy organization. While patients connected to advocacy groups have better awareness and perceptions of biomarker testing, the entire process may need adjustment to improve the patient experience.

Advances in precision medicine using biomarker testing to determine therapy targeted specifically for an individual patient promise to optimize cancer treatment. However, the medical community has concerns around key issues related to increasing use of precision medicine, including potential privacy issues, discrimination (by employers, payers, or other groups), personal safety, limited personal benefit, and patient confusion.[1,2] Additionally, previous research efforts have shown gaps in communication about precision medicine education particularly related to breakdowns in the patient-provider interaction.[3,4] With 20 drugs approved for the treatment of lung cancer with 9 unique biomarkers, such testing has become more common. Therefore, patients are likely to have many questions about the process, including:

- How do I learn more about biomarker testing?
- How is biomarker testing different from other tests and biopsies?
- Who will help me understand the results?
- How are these tests used for treatment planning?

Little research outside of the context of genetic counseling has explored perceptions of communication toward use of precision medicine in patients with cancer. Fewer studies have considered the perspectives of patients themselves. Despite lung cancer treatment being highly biomarker-driven, patients with lung cancer typically do not receive genetic counseling because a clear inheritable component has not been demonstrated. To highlight areas of need for continued education and information for both patients and their treating clinicians, this study explores the patient perceptions of communication and experience with biomarker testing, specifically to better understand barriers faced in accessing comprehensive testing in diverse patient groups. Alongside the accompanying article focusing on clinician perceptions and use of biomarkers, which will be published in Volume 37, Number 2, *Oncology Issues*, this study attempts to identify the patient perspective related to biomarker testing, with a goal of recommending specific interventions that can be conducted in conjunction with other clinician-directed initiatives to optimize nonbiased guideline-concordant cancer care.

Survey Development

In 2020, LUNGevity developed a comprehensive survey with questions focused on understanding the treatment journey of individuals with advanced-stage NSCLC. The Patient Advocate Foundation also contributed to survey development. Specific questions related to understanding the biomarker testing experience were developed with input from patients with lung cancer and tested with other patients. The survey was semistructured, with most questions having multiple choice answers or Likert-type questions. Survey data findings were used to create an in-depth focus group guide specifically on understanding barriers to testing and receiving feedback about specific types of interventions to bridge the testing gap. The study protocol was approved by Advarra IRB on April 13, 2020, and the instruments (Appendix A and Appendix B) are available online at accc-cancer.org/eliminating-disparities.

Study Sample and Data Collection

Patient survey recruitment was conducted through three sources: 1) LUNGevity Foundation social media; 2) the Patient Advocate Foundations' email database; and 3) an online national panel of patients. For Patient Advocacy Foundation email recipients and Edge national panel respondents, invitations to complete the survey were distributed by email from April to June 2020 to a random sample of patients with lung cancer. The survey was open to anyone living with a diagnosis of locally advanced or metastatic NSCLC, and 21 years of age or older. Sampling was restricted to the United States.

Survey Analysis

Descriptive statistics were conducted on key items of the patient survey, using Chi-square (X^2) analysis for categorical variables and T-tests for continuous variables to examine differences between the LUNGevity and general patient sample. Analysis between these cohorts was conducted to understand whether a more educated and engaged patient population with a higher socio-economic status encountered the same issues as the general population of patients with NSCLC. Statistical analysis was conducted using SPSS 27 (IBM: Armonk, NY). Values were considered significant when $P<.05$.

Post-Survey Focus Groups

Following the survey data analysis, a guide for patient focus groups was created to help provide context to ongoing questions about use of biomarker testing. Six patient focus groups representing diverse ages and geographic locations were conducted recruiting from LUNGevity outreach platforms and from a panel sample through Edge Research and had the same eligibility criteria as the survey. Focus groups were conducted using Zoom and recorded. Data were transcribed verbatim and thematic analysis was conducted to identify emergent themes. All focus group transcriptions were coded, and themes were coalesced until saturation was reached.

Sample Demographics

Demographics of the LUNGevity and general patient sample are provided in Table 1 on the ACCC website at accc-cancer.org/eliminating-disparities. A total of 248 total patients were included for analysis. The two samples were similar in age and race, but differed in gender ratio, type of NSCLC, insurance status, income, and treatment status. The LUNGevity sample cohort was predominantly female patients with adenocarcinoma with higher socioeconomic status, and the general population reflected patients from more diverse ethnic and racial backgrounds, lower income levels, and low-to-no insurance coverage.

Characteristics of Biomarker Testing

When first learning about biomarker testing, 66 percent of the LUNGevity patient group report having their doctor raise the topic, compared to 40 percent of patients in the general population ($P<.01$). In terms of patient-reported testing rates, 85 percent of the LUNGevity cohort report having biomarker testing conducted compared to just 52 percent of the general sample. Of the patients who indicated that they have had biomarker testing conducted, 78 percent of the LUNGevity cohort and 54 percent of the general patient sample ($P<.01$) only had to see one doctor before receiving biomarker testing (Table 2, at accc-cancer.org/eliminating-disparities). The LUNGevity sample is more likely than the general population group to have multiple mutations tested at a single time (55 percent vs. 31 percent $P<.01$) rather than testing for only the most common mutations (23 percent vs. 41 percent), a guideline-concordant means of testing. Despite being more likely to have multiple mutations tested at once, which typically delays receipt of results for the more thorough comprehensive testing, 46 percent of LUNGevity patients report receiving their results within 14 days of testing compared to 34 percent for the general population ($P=.12$).

In the focus groups with LUNGevity patients, awareness of the term "biomarker testing" has permeated, compared to varying degrees of awareness and understanding of the term among patients in the general population. Focus groups with general patients revealed a lack of knowledge of what the term means, and for those who may have heard the term, there was some confusion of biomarker testing with genetic testing for inherited mutations. Some patients had a good awareness of the link between biomarker testing and precision medicine, but this was more common for patients in the LUNGevity cohort compared to the general population.

"I heard of it. Don't know too much about it, just heard of it as far as the name. [It was] not discussed with me."
Black Patient

"[It is] custom medicine. They take your tissue or blood, trying to look for these mutations to get your specific cancer under wraps. It's really precision medicine. Customized to your specific cancer and can avoid chemo."
Younger, Urban Patient

Further, focus group patients indicated that they did not always know when biomarker testing was conducted as it blends in with other appointments and tests. The most knowledgeable patients were those who had recurrence and were tested or re-tested and the least knowledgeable patients were those whose first-line treatment worked and have not had a recurrence.

"[I heard about it] during the first biopsy, my report had EKG, etc., and know from reading that they can treat you with targeted therapies. I didn't know that they were doing it."
Patient from Rural Area/Small Town

Comprehension of Biomarker Testing Results

Most patients report being informed of the results of their testing: 93 percent of the LUNGevity group and 76 percent of the general patient sample (P < .01) (Table 3, at accc-cancer.org/eliminating-disparities). A similar percentage indicated that having access to a copy of the testing results is important to them. However, roughly half of patients reported not having their results shared with them; less than a quarter of patients in both groups received a printed copy.

In the LUNGevity group, 84 percent report that their doctor explained the results of their biomarker testing to them. Just over half (55 percent) of the general patient population indicated that their doctor explained the results to them (P< .01); 21 percent reported that another healthcare professional explained the results of the testing. LUNGevity patients are more likely than the general patient sample to report that their oncologist referenced their biomarker testing results (91 percent vs. 55 percent, P < .01). Patients in both groups did not indicate that many other healthcare professionals referenced their results during an appointment.

Even though more patients in the LUNGevity panel indicated that their doctor explained the results of testing and their oncologist referenced testing in their appointments, only 65 percent indicated that they understood the terms included in the testing results, not much higher than the 56 percent of the general patient population (P = .24). Despite this, biomarker testing

provides benefits to patients. Nearly all patients reported that biomarker testing gave them confidence that the care team was doing everything possible to treat their specific lung cancer type and they (patients) understood how this information would be used to make decisions about their treatment. Most patients also believed that they made better decisions about their own care based on the results of the biomarker testing.

Focus group participants confirmed the survey data. They indicated that the oncologists were the main conduit to both learning about biomarker testings, as well as to understanding the results of that testing. However, trust and connection with the oncologist varied. Younger and older urban patients in the focus groups had the best connection with the oncologist, while rural, low-income, and patients of color reported not getting as much time with the oncologist as they would like.

"The doctors see 10 patients a day. Each of us have different kinds of cancers…The person most likely to talk to you about biomarker testing is the person you spend the most time with and that's in your treatment center. I spend 30 minutes with doctors. I spend 6 hours with the nurses in the immunotherapy treatment."
Low Income Patient

"The pulmonologist never mentioned biomarkers. I have to think if anyone knew, it was my oncologist who changed my chemo cocktail. I also had a radiation oncologist, but he didn't do bloodwork, strictly scans. I assume my oncologist knew what my biomarker was. I would be interested to go back and ask him about that."
Low Income Patient

Concluding Thoughts

The survey reveals a significant divide in access to testing and incidence of biomarker testing being discussed with healthcare providers between LUNGevity-connected patients and those in the general patient population. Patients associated with an advocacy group appear much more likely to learn about and pursue biomarker testing without having to see multiple providers to access the technology, while patients with low socio-economic status are less likely to report having received biomarker testing. Generally, focus group participants reported a huge variation in how they were treated (in terms of communications and empowerment with decisions) by their healthcare team. Lower-income and patients of color were more likely to describe unsatisfactory experiences.

The data presented here show just over half of patients with NSCLC undergo some form of biomarker testing. While the majority who are tested are informed of their results and get

some explanation, 27 percent of those in the general patient population do not know their results. A primary concern for patients is that while the majority believe it is important to have access to their testing results, fewer actually receive a copy.

Oncologists are the primary source of testing information and discussion of results, suggesting a significant opportunity to educate and encourage other members of the cancer care team on biomarker testing and how to communicate about it. For patients, it makes sense for the oncologist to be the "source of truth" for diagnosis and treatment plans, but the relationship, time spent, and trust level is mixed and some patients, especially those of color, say the oncologist is not always on top of their care. There may be a role here for education on interpreting and explaining biomarker testing for other advanced healthcare providers, such as oncology nurse practitioners, physician assistants, and pharmacists. As mentioned in a focus group, patients may have limited time with the oncologists but could spend hours with other oncology staff members.

The study has limitations. The online distribution of the survey may have excluded patients with limited internet access. Furthermore, patient survey opinions were reported with descriptive statistics only, which limits the generalization to the complete population of patients with NSCLC.

In summary, this study shows potential missed opportunities for patient education as patients believe that biomarker testing benefits them even though all their questions are generally not answered prior to testing. There may be a disconnect between oncologists and patients on how test results should be communicated and perhaps the ideal biomarker-testing journey should be more patient-centric (Figure 1, following page). Patients prefer to hear about their biomarker testing from their oncologist. Patients are less interested in the specifics of the biomarkers but want to know what it means for their treatment approach and potential side effects of that treatment. Patients want a tangible take-away, written in clear language and supported with visuals that explains key points of discussion with their doctor. Such a tool would be useful for the provider as well to ensure consistent, comprehensive communication with each patient. Additional links and reference information for patients to continue to read on their own time would be appreciated. Lastly, time to process the information and follow-up visits to discuss any additional questions are important to feel secure with their understanding of testing results.

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FIGURE 1. The Desired Biomarker Testing Experience, from the Patient Perspective*

1 CONNECTION WITH HEALTHCARE TEAM

3 TIME TO PROCESS AND FORMULATE QUESTIONS

2 APPROPRIATE INFORMATION PROVIDED

1. Connection with healthcare team: Patients want to hear from the oncologist directly or someone from the oncology team, such as the oncology nurse practitioner. Patients are also open to hearing from a biomarker specialist. From these discussions, patients want to know more about treatment and side effects and are less concerned with the "alphabet" of biomarkers.

2. Appropriate information provided: Following a discussion with the oncologist, patients want information when there is an action to take, such as written information with visuals (but not images of cancer tissue).

3. Time to process and formulate questions: Patients want at least a day to review the materials and think about the questions they have for the oncology team prior to meeting again. Biomarker testing results need to be easily accessed for patient review.

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Leveraging Telehealth Solutions to Provide Supportive Services to Patients with Metastatic Breast Cancer

A focus on symptom management, psychological health, and genetic counseling

Some patients with metastatic breast cancer face numerous challenges and disparities in accessing quality cancer care, particularly underserved patient populations that are less likely to receive optimal care due to low income, ethnicity, uninsured or publicly insured status, and/or geographic disadvantages. While local and national organizations attempt to address these challenges, there remains a need to reduce disparities and increase access to care to improve disease outcomes.

In 2019, the Association of Community Cancer Centers (ACCC) held a Multidisciplinary Metastatic Breast Cancer Summit focused on addressing disparities in care for these patients, wherein telehealth delivery was identified as a key action item to improve access to supportive services. Patients with metastatic breast cancer facing disparities in care can benefit from telehealth services by receiving much of their care at home through virtual appointments, via patient portals, and through online education. In light of social distancing throughout the COVID-19 pandemic, more cancer programs are offering telehealth services than ever before. Benefits of cancer care delivery through telehealth solutions include:

- Increased access to services, particularly for previously hard-to-reach geographic areas
- Decreased cancellation rates
- Flexibility for patients, especially those feeling unwell, or when there is urgency to the request, or when an in-person appointment is not immediately available
- Decreased "waiting room" time, which can improve patient satisfaction and reduce time away from work, home, or other responsibilities
- Frequent contact with patients, opening the door to additional supportive care
- Availability for interpretation for deaf patients or patients more comfortable with other languages.

In 2021, ACCC held a series of focus groups to learn how cancer programs are effectively implementing telehealth to manage symptoms and treatment side effects, deliver psychosocial screening and support services, and provide genetic counseling and testing. Practical tips from these focus groups include:

- **Orient patients, caregivers, and care partners to the technology.** Whether in-person or virtually, make step-by-step instructions available through an online patient portal or mobile app. Patients may be hesitant or lack devices that allow optimal access to telehealth. Bringing caregivers into telehealth discussions can help ensure an efficient process.
- **Staff a volunteer telehealth team.** Provide outpatient hours to answer patient calls specific to the telehealth platforms and/or technology.
- **Embed video link(s).** Incorporating video links into the patient portal or through a mobile app can streamline the experience for less technology-savvy patients.
- **Have a backup plan.** Provide several options for video appointments (e.g., Zoom, Doximity, etc.) or use a telephone to help decrease the risk of technological glitches or incompatibility issues.
- **Provide reliable contact information.** In case of a disconnected video and/or phone call, provide patients with multiple means of reconnecting to providers to simplify the virtual process and ease tech-related anxiety.
- **Be aware of licensure issues.** Laws vary across states. If patients plan to connect from a location outside of their primary residence where a provider is unlicensed, a state waiver may be needed. Check with the local professional licensing board for details.
- **Assess the effectiveness of a hybrid model.** An initial in-person evaluation can establish baseline data, followed by as-needed virtual appointments. For instance, patients may attend a telehealth appointment prior to an infusion appointment to identify symptoms or toxicities, which can

alert clinicians to the need for an in-person evaluation when the patient is in the infusion room.

Symptom and Side Effect Management via Telehealth

Metastatic breast cancer can involve nearly any organ and a multitude of treatment options makes disease management challenging. Patients with metastatic breast cancer are commonly in treatment for extended stretches of time, with an added burden of medication side effects, despite intermittent periods of stable disease. The cancer care team must respond quickly to disease progression so that the patient is able to start a new treatment plan. Working with patients to manage symptoms and side effects, caregivers and care partners can offer useful feedback and a different perspective, while providing support to ensure treatment success, such as scheduling and attendance of follow-up appointments or prescription pick-ups.

Unfortunately, patients frequently feel uncomfortable initiating the reporting of symptoms or side effects or claim better treatment tolerance than they are experiencing out of fear of treatment being discontinued. A valuable method for monitoring care for patients not regularly in clinic is the use of patient-reported outcomes (PRO) measurement scales, to provide clinicians with a starting point for a deeper discussion and a more accurate picture of the impact of symptoms or side effects on the patient. Many PRO measurement tools, however, were initially designed for in-person assessment and have yet to be tested heavily in the telehealth setting. As telehealth use expands, this opportunity presents an area of research that will help improve symptom and side effect management.

Monitoring tools include:
• **Patient-Reported Outcomes Version of the Common Terminology Criteria for Adverse Events (PRO-CTCAE).** Used to evaluate frequency, severity, interferences, and presence and/or absence of a wide range of treatment toxicities in clinical trials
• **Patient-Reported Outcomes Measurement Information System (PROMIS).** A set of measures for monitoring physical, mental, and social health outcomes, this free tool can be delivered through several major electronic health record (EHR) platforms, REDCap, or through a tablet application
• **Functional Assessment of Chronic Illness Therapy – Fatigue (FACIT-F).** Developed to assess quality of life issues related to fatigue for patients with cancer
• **Edmonton Symptom Assessment Scale (ESAS).** A free tool with a 0-10 rating scale for nine symptoms, both physical and emotional, which can be incorporated into EHR platforms.

Tips for Effective Symptom and Side Effect Management via Telehealth

Disease management in patients with metastatic breast cancer is challenging. While tracking PROs is a simple, yet effective, method to monitor patients and create systems to triage at regular intervals, cancer care teams must be prepared to respond rapidly to disease progression through alternative treatment options in managing symptoms (e.g., pain, nausea) and side effects (e.g., skin toxicities, diarrhea), while providing supportive care for treatment success. Telehealth services provide the cancer care team the opportunity to effectively evaluate and manage chemotherapy-induced neuropathy or aromatase inhibitor-related pain, for instance, by posing key questions and providing treatment options through virtual appointments, as appropriate. Similarly, telehealth appointments allow providers to evaluate the cause of skin irritation and/or toxicities brought on by radiation or targeted therapies used to treat metastatic breast cancer. Likewise, determining the underlying cause for disease-related nausea and/or diarrhea can, at least initially, be evaluated by telehealth so that patients can stay close to home while feeling unwell. If an in-person appointment is needed after the initial virtual appointment, a follow-up visit or a scheduled home health nurse visit can be arranged.

Genetic Counseling via Telehealth

Genetic counseling for patients diagnosed with cancer is standard of care at academic medical centers, but patients cared for at community-based programs may not have access to these resources. Telehealth delivery via telephone counseling and video conferencing has become more widely accepted for genetic counseling, and is most often offered through two prevailing models:

1. Patients visit a clinic to use clinic equipment to speak with the off-site genetic counselor.
2. Patients attend a virtual appointment with the genetic counselor by phone or video from home.

Table 1, next page, outlines benefits and drawbacks to both models.

Tips for Offering Genetic Counseling via Telehealth

To increase the success of genetic counseling service utilization, ACCC focus group participants recommended the following strategies:
1. **Clear communication of value.** Referring providers must clearly explain the value of genetic testing and what patients can expect to help ensure successful telehealth appointments

TABLE 1. Advantages and Disadvantages to Two Models for Offering Genetic Counseling via Telehealth

MODEL	ADVANTAGES	DISADVANTAGES
Telehealth Services Offered	• Patients without adequate technology at home can access services • On-site staff can assist patients with technology • Health system can recoup certain costs through facility fee(s) • Easy sample specimen collection	• Schedule restricted to clinic hours • Patients living far away may face geographic barriers
Telehealth Services Offered from Patient's Home	• Flexible scheduling, often with evening and weekday appointment options • Family members attend • Fewer cancellations	• Requires staff at the clincic to manage logistics • Easier to overlook sending in sample specimen(s) for testing

2. **Timing of testing.** Once a diagnosis is made, testing as early as possible is encouraged. Logistical barriers—such as treatment side effects or previous appointments—may make patients less likely to follow through with the start of new treatment options.

3. **Clear communication of purpose.** Patient consent and comfort level is critical; results of a genetic test will guide treatment decisions. Emphasizing the value of testing is necessary, since available options exist for patients with metastases who carry a gene mutation.

4. **Patient education.** Providing patient education materials about genetic test results for the patient and their family is advised, and tips on how to share information can help ease decision-making.

Improving sample collection and submission for patients with metastatic breast cancer is a key aspect of telehealth success.

Assigning a designated on-site staff member to help with logistics—specifically when working with third party genetic testing companies—will ensure a smooth process. Ideally, sample collection will occur before patients begin chemotherapy, since treatment may result in dry mouth and make saliva samples more difficult to obtain. Using home saliva kits or engaging a mobile phlebotomist to visit the patient's home for a blood draw can simplify the process. At times, mobile phlebotomists may be unable to draw blood from a port, or patients with a port may not want blood drawn from their arm. In such cases, patients must wait for their next scheduled chemotherapy appointment to have blood drawn, which delays testing.

Many patients may need a reminder or need help coordinating genetic testing, especially if they fail to initially follow-through with the specimen collection process. This outreach can be used as an additional touchpoint to provide patient education and answer additional questions.

Psychosocial Screening via Telehealth

While many cancer programs screen patients for psychosocial distress during in-person appointments, transitioning this process to a virtual environment requires new considerations with regards to which screening tool(s) to use, and how or when to deliver screening tools to patients.

Many patients report wanting to know sooner about the availability and benefits of psychosocial programs. If psychosocial services are not provided in-house, becoming familiar with local or national telehealth support services (e.g., Cancer Support Community, Cancer*Care*, etc.) can help to get patients needed support. The ACCC focus group suggested that individual psychotherapy, group therapy, and mindfulness coaching has been effective for most patients in a telehealth setting, while participation in active crisis management or real-time support for the clinical team might be better delivered in-person.

Tips for Doing Psychosocial Assessment via Telehealth

It can take longer to build rapport with new patients via telehealth, whether in virtual individual or group settings. Being patient and using verbal statements—instead of relying on non-verbal cues to show interest—can demonstrate active involvement and listening by staff, while openly acknowledging that building trust in a virtual setting may take longer. Video conferencing can allow for assessment of non-verbal cues, though certain signals that would traditionally be more evident in-person may be missed. Having a second facilitator on hand to address technological challenges arising during the group, without derailing the meeting, will further provide a sense of ease and comfort, helping to decrease patient anxiety and stress.

Whether in a virtual group or individual treatment session, engaging the patient to fill out informed consent and confidentiality agreements can drive home the point of a process that enforces patient privacy.

A Look Ahead

Cancer programs have made significant improvements and adjusted well to recent expansion of telehealth delivery of supportive care services for patients with metastatic breast cancer. The transition to incorporate telehealth services has resulted in increased service use, decreased logistical and geographic barriers to supportive care, and helped to decrease disparities. Despite these successes, cancer programs must continue to think creatively to ensure that lack of appropriate devices, restricted internet access, and low technology literacy do not interfere with patient access to telehealth services, while allowing for patient readiness and willingness to use telehealth services. The next logical step in incorporating telehealth delivery into cancer care programs is to refine current approaches and adapt to diverse patient needs to ensure that telehealth delivery benefits as many patients as possible.

Acknowledgments

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A publication from the ACCC education program, "Multidisciplinary Metastatic Breast Cancer Care." **Learn more at accc-cancer.org/MBC-care or scan this QR code.**

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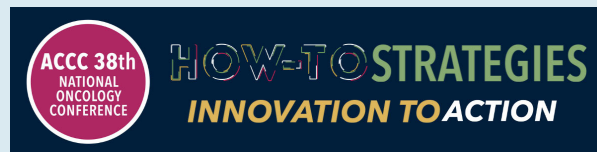
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Telehealth in Action

As part of its Adoption & Expansion of Telehealth Solutions education project, ACCC documented successes in the rapid adoption of telehealth to maintain patient care during COVID-19. To obtain multiple perspectives on team-based telehealth delivery, ACCC conducted focus groups with the multidisciplinary cancer care teams at Cone Health, Emory Healthcare, and Texas Oncology. In addition to these three case studies, ACCC conducted interviews with members of the multidisciplinary cancer team, including:

- A financial advocate who shared how one cancer program used their online portal as an important tool to let patients know about available financial resources.
- An information technology professional who talked about how IT staff worked collaboratively with clinicians to optimize patient care and create consensus.
- A palliative care nurse who provided insight into how to connect to patients in their home environment.
- An oncologist who adapted technology to match in-person workflows and promote better team-based care.
- A pharmacist who shared how flexibility, communication, evaluation, and triage are critical to implementing a successful rural telehealth program.
- A social worker who created workflows that worked well for in-person and virtual visits.

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A Pandemic's Silver Lining: Building a Collaborative Integrative Therapy Program

BY BRENDA BIGGERSTAFF, MSW

Patients and staff at St. Mary-Corwin Hospital, Dorcy Cancer Center in Pueblo, Colo., identified two great impacts of the COVID-19 pandemic: 1) feelings of isolation and 2) identification of silos that existed between Centura Health Cancer Network sites in our offerings of integrative therapies. Prior to the pandemic, a few Centura sites had their own in-person Integrative Therapy programs, which varied in shape and size. Furthermore, six of the total nine sites did not have any integrative therapy offerings. To meet patients' needs during the height of the pandemic, Centura's social workers and a nurse navigator took it upon themselves to create a collaborative and more efficient hybrid-style Integrative Therapy Program for all of its oncology sites.

What is Integrative Therapy?

Integrative therapy is used in conjunction with conventional care—not in replacement of—to aid patients' physical side effects due to their disease or treatment that cannot be alleviated in totality with conventional treatment. Integrative therapies provide relief from psychological distress, depression, and/or anxiety, and they can increase one's spiritual strength, hope, and desire or ability to cope with emotions. Integrative therapies can include auricular detox, yoga, tai chi, education sessions, and so much more. Often the terms "complementary therapy" and "alternative medicines" can be used interchangeably with "integrative therapy."

Globally, over the past few decades, there has been close to a 25 percent increase of cancer survivors who utilize integrative and/or complementary therapies.[1] Anywhere from 40 percent to 83 percent of cancer survivors use integrative therapies after a diagnosis, and up 90 percent of those who use integrative therapies report some benefits, whether it be improved coping with stress or side effects.[1]

Going Virtual

The COVID-19 pandemic gave our health system the opportunity for staff to learn more about each other and to ask ourselves how we could continue to support our patients. Patients needed our integrative therapy offerings more than ever before. Many people found themselves feeling socially isolated and disconnected because of the pandemic. We wanted to make sure that despite current events we could continue to provide a space for our patients, survivors, and caregivers to share their emotions and experiences. Many may have feelings of sadness, anger, and depression (all of these emotions accompany a cancer diagnosis), and those feelings were intensified by the pandemic.

Transitioning Centura's various site-specific Integrative Therapy programs to a virtual format ensured we could continue to support the psychosocial health of our patients, survivors, and caregivers. The social workers and nurse navigators who led the program at three Centura sites, including myself, met via Zoom to decide what classes to offer to our entire network and at what time. This collaboration led us to create a monthly calendar of our offerings, so no two subjects overlapped. We combined the programs at the cancer centers to touch more people. Now we offer an array of groups and classes (e.g., exercise, self-care, COVID-19, etc.) that are put on by different Centura sites and that are offered to the entire network via Zoom. These opportunities are for patients, survivors, caregivers, and community members. People do not have to be affiliated with Centura to engage in these opportunities. Additionally, those clinic sites that did not originally have an integrative therapy program can now access our centralized virtual program, to which they can make referrals.

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Funding and support provided by Lilly Oncology.

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In starting this transition, I and two others came together and asked who wanted to offer what programs. For example, Parker Cancer Center wanted to host a tai chi class that is offered Tuesday mornings, Dorcy Cancer Center offers yoga every Tuesday evening, and Penrose Cancer Center offers an easy chair yoga every Wednesday. We worked hard to break down existing silos and to not duplicate any efforts. This way all classes and groups are better spread out over the week.

Once we got the schedule in place, the next step was to determine how to offer these opportunities virtually in the easiest manner for our participants. We knew we wanted to make sure that there was consistency in the Zoom link used, so participants did not have to juggle multiple links for multiple classes. Therefore, we decided to have all our classes use one Zoom link and one login. The exercise classes we offer do require a waiver consent form to participate, so we determined how to complete this step electronically as well.

Finally, we decided that one person should develop the flyer, which includes a visual monthly calendar and course descriptions. I took this task on, so I send the updated calendar to the social workers, nurse navigators, and the marketing team in the Centura network every month. They then share the flyer with their patients, survivors, and caregivers. Though some of our programs are recorded, most are not, like the exercise classes. But if a class is on an educational topic and a patient is not able to make it, we record the class and share it with them if they reach out to us prior to the class. Additionally, we send out slide decks to all participants. Because of this new virtual model, we can provide more options to participants. We offer chair yoga, tai chi, support groups, a biweekly survivorship "sit, stand, and stabilize" class, as well as classes on self-care strategies, journaling, guided meditation, nutrition, wellness, and more.

Coming together during the pandemic was easy. Our social workers and nurse navigator had this great idea that we all agreed needed to happen. Gaining buy-in from our leadership team was an easier task than expected. We all spoke to our directors at our cancer centers. They bought in right away because they saw the value in the program and did not want to see this

necessary support removed from patients during the pandemic.

Continuing to Adapt

If it were not for COVID-19, we may have never thought about changing the way we offer our Integrative Therapy Program at Centura Health Cancer Network. The pandemic gave us an opportunity to think outside of the box and to continue this thinking as we move into a post-COVID-19 era. As pandemic-related restrictions loosen in our communities and across the nation over time, we will have an opportunity to do some activities in person, while keeping other offerings virtual. We do not want to remove anything we currently offer because we still want to be able to reach our communities in the way that they need.

When our fully virtual program went live in January 2021, we sent out a survey after the first month because we wanted to make sure that participants were receiving our intentions as we wanted them to be. When asked what made participants choose to attend a certain class or classes:

- 69 percent said to improve their quality of life
- 34 percent said because of current life stressors
- 28 percent said for social connection
- 18 percent said because of the topic
- 19 percent said for pain
- 13 percent said for anxiety
- 9 percent said for another reason.

Note: Percentages may equal more than 100 because respondents could select multiple answers.

What's great is that 92 percent of the respondents indicated that after attending a class(es), their symptom or concern improved. Eighty-five percent indicated that the quality of the class(es) was excellent. When asked whether attendees prefer virtual or in-person classes, 39 percent of respondents said they prefer virtual, whereas only 5 percent said in-person and 45 percent said they prefer a combination of the two.

For me these data were eye-opening. Prior to COVID-19, we never thought about offering a virtual integrative therapy program. What we are seeing now is that 45 percent of participants prefer virtual and

in-person offerings, and 39 percent prefer virtual only. These results could be for a variety of reasons: virtual classes cut back on participants' travel time (many of whom drive over 30 miles for treatment), it is easy to hop on and access them from the privacy of one's home, and if participants are busy, they can access these classes from anywhere (work or home). This hybrid format now removes travel as a barrier to attending our Integrative Therapy Program.

The final question in the survey asked respondents whether they were a current oncology patient, caregiver, or cancer survivor. Fifty-three percent of respondents identified as a survivor, 34 percent identified as a patient, and 13 percent identified as a caregiver. What these statistics mean is that the Integrative Therapy Program is making a difference in the communities we serve. Data show us that our patients, survivors, and community members are receiving relief from symptoms by attending the program. We are providing evidence that the program is reducing pain, anxiety, and life stressors while also improving social connection and quality of life, which is wonderful. Furthermore, these data suggest that transition to a hybrid model (with virtual and in-person options) allows us to better meet the needs of all of our patients, survivors, and caregivers.

Brenda Biggerstaff, MSW, is an oncology social worker and program manager at St. Mary-Corwin Hospital, Dorcy Cancer Center in Pueblo, Colo.

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