





FROM 2010 TO 2019, the Association of Cancer Care Centers (ACCC) fielded an annual “Trending Now in Cancer Care Delivery” survey to its membership to gain insights into challenges faced and—most importantly—solutions to address those challenges. Members shared that during and after the COVID-19 pandemic, they did not have the time and/or resources to take this annual survey. This led ACCC to identify alternative ways to collect these data. In 2020, ACCC conducted a series of focus groups to produce the [2020 Trending Now in Cancer](#) report. In 2023, ACCC hosted a series of interactive sessions at its Annual Meeting & Cancer Center Business Summit (AMCCBS). Insights and solutions from these discussions were used to develop the 2023 Trending Now In Cancer Care [Part 1](#) and [Part 2](#) reports. Discussions from the ACCC 50th AMCCBS held from February 28 to March 1, 2024, were used to develop 2024 Trending Now In Cancer Care: Part 1.

COLLABORATIVE CARE MODELS

Cancer has emerged as the top driver of employer health care costs,¹ fueling the need for new models of cancer care delivery. More, there is an emerging shortage of oncologists, and many clinicians are challenged by the pace of innovation in cancer treatment.^{2,3} Collaborative care models help clinicians keep up to date with advances in precision medicine such as next-generation genome sequencing, adoptive immunotherapy, gene therapy, and more.

Facilitators

- Amy Corrao, MSN, NP-C, scientific director, US Medical Affairs–Cellular Therapy at Bristol Myers Squibb
- Kelly Filchner, PhD, RN, OCN, CCRC, director of the Fox Chase Cancer Center Partners & Fox Chase Cancer Center Care Connect at the Fox Chase Cancer Center; and assistant professor of Nursing at the, University of Scranton
- Keri Halsema, MSN, RN, a nurse practitioner at the Blood Disorders Center of the University of Colorado Anschutz Medical Campus
- Karina Lee, associate director of US Health & Wellbeing Benefits at Gilead Sciences, Inc
- Harlan Levine, MD, president of Health Innovation and Policy, at City of Hope and chairman of the board of AccessHope
- Amy D. Smith, FNP-BC, director, Meredith & Jeannie Ray Cancer Center at Ivinson Memorial Hospital.

Model 1. Community and Academic Partnerships to Deliver CAR T-Cell Therapy

This collaborative care model benefits both providers and patients. For small—often rural—cancer programs with a limited number of clinicians who treat all types of cancer, this model connects local providers to experts. Often, complicated treatment regimens like CAR-T cell therapy are only available

at larger academic programs, so this type of partnership allows community providers to offer such treatment to patients who would otherwise not receive it.

This type of partnership is also in the best interest of patients who want community and academic providers to collaborate to develop the treatment plan, to communicate throughout treatment, and to work together to align treatment needs, outcomes, and clinical, financial, and caregiving support.

Patients expect transitions between community and academic providers to be seamless and to avoid duplicate testing and procedures whenever possible. In brief, the pros of this collaborative care model include:

- The ability to provide and improve patient access to complex therapies
- The expectation that patients will receive the best possible care and experience the best outcomes
- The opportunity to build relationships between community and academic providers, including opportunities for peer-to-peer education and training
- Optimized use of the electronic health record (EHR) to communicate across care settings
- The opportunity for patients and families to return home and receive care and follow-up in their community, reducing travel and financial burdens.

This collaborative care model is not without its challenges, including:

- A sense of loss of control that affects both community and academic providers
- The time commitment and financial resources needed to conduct required assessments and to understand whether this type of care model is feasible for providers and staff and safe for patients
- The time commitment and financial resources required to stand-up the model, develop processes and resources, and educate and train clinicians and other staff members.

To succeed, this collaborative care model requires that community and academic programs understand their respective roles and responsibilities.

The community program needs to quickly identify patients who will benefit from complex treatment regimens, like CAR T-cell therapy; have a referral process in place; understand what services they can provide to patients when patients return to the community; and know when to reach out to the academic program with questions and/or information on complications.

The main role of the academic program is to deliver complex treatment to the patient. For CAR T-cell treatment, this complicated process includes:

- Performing apheresis of immune effector cells (ie, removal of blood plasma from the body by withdrawing blood, separating it into plasma and cells, and reintroducing the cells)
- Administering bridging chemotherapy (which may sometimes be delivered in the community setting)
- Coordinating insurance coverage
- Performing lymphodepleting chemotherapy and CAR T-cell infusion

“Develop a process for how community cancer programs will communicate with their academic partner. Know the point person at the academic site. Is there a direct line to that individual? Know what steps to take when patients start to present with late complications. What questions should the community site be asking patients? What information does the academic site need to know to help the community site manage these patients remotely?”

ADVICE FROM ACADEMIC SITE

“Sharing a common EHR is key. We use templated notes within the EHR that are easily accessible both at the academic center and at the community program, which communicate to providers key topics that need to be addressed at each clinic visit and what the care plan is going forward.”

ADVICE FROM COMMUNITY SITE

- Following patients over the first 30 days posttreatment
- Developing and maintaining the progress note template, including timing of the next disease assessment, infection prophylaxis given, and complications of CAR T-cell therapy.

Direct communication, the cornerstone of this collaborative care delivery model, ensures that academic providers, community providers, and patients and caregivers are all on the same page.

Resource: CAR-T Academy

Developed specifically for health care professionals, these 12 modules review key concepts along the CAR T-cell patient journey. These include patient considerations, bridging therapy and lymphodepleting chemotherapy, outpatient management, and long-term follow-up of patients receiving CAR T-cell therapy. Learn more at car-t-academy.com.

Model 2. Fox Chase Cancer Center Care Connect: A Collaborative Care Model Between Oncology and Primary Care

Fox Chase Cancer Center Care Connect is an engagement strategy between oncology and primary care to improve coordination of patient care. The model was developed to meet 2 key needs. First, it is intended to safely transition patients with cancer back to their primary care provider (PCP) after treatment. Second, it was designed to connect patients who did not yet have a PCP with a provider in their community. Fox Chase Cancer Center received a 2016 ACCC Innovator Award for this [collaborative care model](#).

Key to the success of this program is the value proposition it has for oncology and primary care. For Care Connect members (primary care), the value proposition includes:

- Effective access and communication with Fox Chase Cancer Center
- The opportunity to improve Quality Physician Measure (QPM) scoring
- A brand identity for the primary care practices
- Staff and clinician education to improve core competencies
- Shared collaboration to support a growing cancer survivor population.

“There’s lots of recent research out there about comfort levels and shared care models between primary care and oncology and how the 2 disciplines are managing survivorship. And some of what we’ve learned is that primary care providers want to be involved in the survivorship journey, but they don’t necessarily feel comfortable doing it. So what can oncology do to make primary care providers feel more comfortable?”

For Fox Chase Cancer Center, the value proposition includes:

- An effective transition of survivorship care planning back into the community
- The opportunity to provide screening, risk, and diagnostic services when appropriate
- The ability to dispel the idea that Fox Chase Cancer Center is only a place for cancer treatment
- The ability to connect patients with cancer to an organized group of PCPs.

Fox Chase Cancer Center Care Connect is built around 4 program pillars:

1. **Education** of primary care providers
2. **Support** that includes patient-related education and resources and access to a Resource Education Center
3. **Collaboration** opportunities between oncology and primary care in care coordination and survivorship
4. **Access** to resources and education through the Epic EHR (Epic Systems) or Care Link (Epic Systems). Through the Care Link web-based program, Fox Chase Cancer Center can give PCPs permission to access the EHRs of shared patients. Participating PCPs also have access to Fox Chance Cancer Center navigators.

At the initial intake, Fox Chase navigators ask patients if they have a primary care provider. Patient who do not have a PCP will receive a direct referral from the navigation team at Care Connect. This allows Care Connect to reach out directly to patients and help them schedule an appointment with a PCP in their community.

Fox Chase Cancer Center Care Connect was piloted first with PCPs in the health care system and then rolled out to other providers in the community. Looking at data on referral patterns and the zip codes of patients coming into the cancer center, Fox Chase staff traveled to those communities, talked to PCPs about available services and resources, and invited them to join the Care Connect program. Today, 44 family medicine and/or internal medicine practices and 2 gynecologic practices—representing 108 physicians (not including APPs)—are participating in the Care Connect program. PCP resources include:

- **Care Connect e-blast** to communicate important information like changes in screening recommendations and/or coverage.
- **Care Connect Education On the Go**, which are brief continuing education and informational videos to keep primary care physicians and nurses up to date on cancer-related topics. These resources include a 5-minute synopsis on screening mammography and a 5-minute video on next steps for a patient with a lung nodule.

Educational programming is developed by a clinical advisory team comprised of oncologists and PCPs. Future directions include development of virtual education having *buttons* for PCPs to *push* to retrieve next steps or more formal algorithms; these can help PCPs to identify actions needed for patients who require referral to an oncology specialist. The clinical advisory team is examining resources that educate PCPs about actions that can improve the process for patients. Fox Chase Cancer Center Care Connect is also looking to expand its geographic footprint based on satellite locations and its referral patterns.

“[This model] resonated with me. At our cancer center, we see many patients who either don’t have a primary care provider or their primary care provider just isn’t comfortable seeing them. So, we have...patients [with prostate cancer who] are 10 years out, and the cancer center is still monitoring their PSA. How do we move those [patients] back into primary care?”

AMCCBS ATTENDEE

Model 3. AccessHope: A Virtual Model Connecting Employers, Treating Physicians, and Experts

Science and medicine continue to advance, yet improvements in cancer outcomes are not being realized equally across cancer types, populations, and/or geographic regions. Data from a retrospective analysis of patients with cancer who lived in California revealed that less than 50% received “National Comprehensive Cancer Network (NCCN) guideline concordant care.”⁴ Despite consensus that participation in a clinical trial represents the best possible care only about 5% of adult cancer patients in the United States are enrolled in a clinical trial—this despite 70% of adult cancer patients expressing a willingness to participate in clinical trials.⁵ Data for patients with cancer who live in a rural area are equally sobering. Rural areas have higher cancer death rates;⁶ further, 66% of rural counties lack an oncologist even though nearly 1 in 5 Americans reside in a rural area.²

In the United States, cancer treatment accounts for 12% of the total medical costs incurred by employers with an estimated \$125 billion spent on direct medical costs alone.⁷ In addition to costs, cancer affects workforce productivity. In 2022, there were approximately 18.1 million cancer survivors in the United States—and this number is growing; further, 67% of these survivors were of working age (ie, 65 years or younger).⁸ Treatment costs, loss of productivity, and a desire to support the workforce have made cancer care a top priority for US employers. The US workforce stretches across the country, and accessible and equitable cancer care is of paramount importance to these employers.

“[In the United States], we don’t recognize how much of health care innovation is driven by the employer. It’s the employer that cares about the quality, the cost, and the patient experience...[and] the disease management field is really driven by employers. They’re the ones asking for collaboration between academic and community programs.”

Collaborations between community and academic institutions like the one discussed above are key to addressing care disparities, yet many leaders believe that we need solutions that reach a broader

“AccessHope looks to elevate the role of the community clinician; that role is so important. But there’s so much information coming at them. How can AccessHope make it easier for community providers to practice medicine and...do so without [them] having to work every night [outside of clinic hours]?”

oncology network. One solution is AccessHope, an approach that aligns academic programs, community programs, and employers. In addition to closing care gaps and reducing disparities, this program is designed to make it easier for clinicians to practice medicine.

How does the program work? AccessHope offers expert case reviews that align with evidence-based recommendations, including treatment recommendations about genetic testing, specialized diagnostic interventions, emerging and cell-based medications, and clinical trials. A key differentiator of the AccessHope program is its ability to proactively identify complex cancer cases and offer help for their management. The AccessHope program takes data from claims, preauthorizations, precertifications, and other sources; these data are processed through algorithms that identify complex cases likely to have the biggest therapeutic gaps and, potentially, the biggest care disparities. These complex cancer cases are shunted to subspecialists at National Cancer Institute-designated cancer centers for review and development of a written report. That report is then provided to the treating oncologist; subspecialists also are available to talk to treating oncologists. In layman’s terms, the program is like a private tumor board for complex cancer patients. “The idea behind AccessHope is to keep treatment local but to close knowledge gaps,” shared Harlan Levine, MD, chairman of the board for AccessHope.

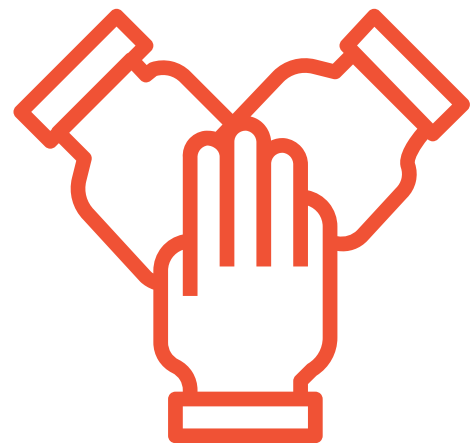
In a case-use model, 1 employer shared why it chose to partner with AccessHope. “Because our employees are the assets and the people who make our vision and mission possible, we dedicate the same thought process and resources to ensure that their well-being and their families are looked after,” shared Karina Lee, associate director of US Health and Wellbeing Benefits at Gilead Sciences, Inc. “We are competing to attract and retain the top talents, and so [we are] constantly looking at the [employee] benefits we offer.”

At 12% of its health care spend, cancer was 1 of the top 3 drivers of health care costs for this employer. In 2023, the company had \$13

“If there’s 1 key takeaway for today’s session, it’s this: for those of you who are already looking into a collaborative care model, continue to do so. Encourage your patients to explore other solutions that may be out there. There are employers offering to take care of their employees’ holistic journey and not just the time spent at their doctor’s office. And for those who may be still skeptical, I challenge you to lean into it and explore [available collaborative care models.]”

million in cancer claims. In the first 90 days after implementing the AccessHope program, the company had 9 different complex cancer cases reviewed for 9 different treating oncologists. Employees who used this service ranged in age from the mid-20s to 70 years old. Four different tumor types were reviewed. In 11% of the cases, AccessHope experts agreed with treatment recommendations with no changes. In 78% of the cases, AccessHope experts agreed with the treatment regimen but recommended enhancements. For the remaining 11%, AccessHope experts suggested revisions to the treatment recommendation. Outcomes from these 9 cases were as follows:

- 89% included recommendations that would have improved cancer management and outcomes
- 67% identified or recommended a relevant clinical trial
- 56% suggested a change in the patient’s current treatment or supportive care
- 33% suggested a change in the patient’s subsequent treatment
- 22% recommended germline testing, tumor testing, biopsy, colonoscopy, and/or imaging studies
- 11% suggested a change in the patient’s cancer diagnosis or staging
- 11% validated the treating provider’s current plan of care without any changes.





COMMUNITY ENGAGEMENT IN CANCER EDUCATION AND PREVENTION

To truly move the needle on improving equity in cancer care delivery, we need to engage with our communities, acknowledge the expertise they bring to the table, and work together to build sustainable partnerships.

Below are 2 models for accomplishing these goals.

Facilitators

- J. Renea Austin-Duffin, FACCC, vice president, Cancer Support and Outreach, Mary Bird Perkins Cancer Center, Baton Rouge, Louisiana
- Gladys Pico-Gleason, BSN, RN, supervisor, Community Health Programs, Healthier Communities, More Life Mas Vida, Corewell Health, Grand Rapids, Michigan
- Amber Leach, marketing director, MMR Group, Inc, Baton Rouge, Louisiana
- Katherine Williams, supervisor, Oncology Community Programs, Corewell Health, Grand Rapids, Michigan.

A Model for Partnering with Employers in Your Community

For more than 20 years, Mary Bird Perkins and its mobile medical units have traversed Louisiana and southwest Mississippi, bringing free and convenient cancer screenings to residents who would otherwise be hard-pressed to have access to these services, especially in some of the region's most rural areas where health care resources are scarce.⁹ But what about employed people who don't necessarily have convenient access to screening and preventative services?

"If you think about what it's like to get a mammogram—you usually have to take half a day off from work, drive to the brick-and-mortar facility, wait in the clinic, have your procedure done, and then drive back to work," said Renea Duffin "[At Mary Bird Perkins], we began to think about how we could offer our services as an employee benefit to improve the health and well-being of employees within an organization."

Then the fates aligned. In 2015, the former CEO of Mary Bird Perkins met with the CEO of the Albemarle Foundation, a Fortune 500 company that was then located in Baton Rouge, to discuss a philanthropic gift to the cancer program's foundation. The Albemarle Foundation CEO asked, "Mary Bird Perkins does this great work in the community. Why not do it for workplaces?" From that visit, the cancer center used the generous gift from the Albemarle Foundation

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to start *Prevention On the Go*, a workplace program that had an immediate and tremendous impact on the employer community. Many employers offer wellness benefits to employees, but very few offer cancer screenings as part of those benefits. Today, this innovative workplace program eliminates barriers and brings early detection services—primarily skin, oral cavity, and breast screenings—to employees curbside at their workplace.

The workplace program also offers an important educational benefit, including a microsite co-branded to the employer and Mary Bird Perkins that is customized to meet the needs of employers and employees. To do so, Mary Bird Perkins staff meet with key stakeholders within the organization to gather employee demographics. For example, if the organization has a number of employees who smoke or use tobacco, the microsite would include information about tobacco risk including resources for quitting tobacco; or, if the employer has a large number of employees who are sedentary for

“What was very surprising to us—because 99.9% of the individuals screened had health insurance—was that 54% reported they had never been screened before. This [percentage] is actually higher than what we see in the community. And that was very shocking for us.”

most of the day, the microsite would include information about the importance of exercise as a risk reduction strategy for certain types of cancers. This microsite is populated for 12 months with information about different cancers, prevention activities, and risk reduction behaviors that employees can adopt. In advance of the screening event, Mary Bird Perkins staff come to the workplace for an education session that includes a pre- and a post-survey to test and measure the effectiveness of the education provided.

Employers are charged for Mary Bird Perkins’ staff time and the resources needed to deliver this customized workplace education. But prices are reasonable, and employers can choose from a tiered menu of services.

Since 2016 and through the end of 2023, the cancer center has visited more than 70 work sites from car wash locations to chemical plants, privately-owned businesses, and companies like the MMR Group, Inc, the largest open-shop electrical and instrumentation contractor in the United States. Mary Bird Perkins has also offered this service on its own campus and to its own employees. The *Prevention On the Go* workplace program has hosted more than 213 events, screening more than 7000 individuals. “What was very surprising to us—because 99.9% of the individuals screened had health insurance—was that 54% reported they had never been screened before,” shared Duffin. “This [percentage] is actually higher than what we see in the community. And that was very shocking for us.”

Looking at these data, approximately 8% of those screened through the *Prevention On the Go* workplace program had an abnormal finding. Of these, 96 cancers were diagnosed and many of those malignancies may have gone undiagnosed without this screening. In addition, more than 150 precancerous lesions have been removed from screened individuals. Again, many of these lesions could have progressed to cancer if the screening had not been offered and performed.

The Employer’s Perspective

Amber Leach, marketing director of the MMR Group spoke about the benefits this program has afforded the company and its employees. “It’s a partnership—more than just a sponsorship between corporate and Mary Bird Perkins. It’s a partnership and a testament to what can be accomplished when different groups come together for 1 common goal,” said Leach. “Our journey as a corporate sponsor began in 2018, when several of our employees received devastating cancer diagnoses. We’re a very close company, and we consider ourselves family. [These diagnoses] affected all of us as well as the employees and their families. The company wanted to do something in terms of [providing] early detection and bringing cancer awareness to our employees and our community.”

Like the other companies participating in the *Prevention On the Go* workplace program, the MMR Group saw immediate results. In the program’s first year, 135 employees were screened for skin and oral cancers, and abnormal findings were noted in 9 employees. Mary Bird Perkins navigated these individuals through the health care system and expedited the necessary testing. In all, 3 of the 9 employees received a diagnosis of cancer. Now 5 years into the program, more than 630 MMR Group employees have been screened for skin, breast, and oral cancers. Mary Bird Perkins and the MMR Group have grown and deepened their partnership, adding services and outreach to showcase this partnership in the community. This included an invitation extended to a local radio show for a skin cancer screening event. “The radio station hosted a live remote at a table next to the mobile units, and an MMR Group employee spoke about her cancer journey,” shared Leach. “All participants received a cooling towel, water bottle, lip

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balm, sunscreen, sunburn detection information, and educational stickers—useful items that complimented the event’s sun skin care theme—all branded to the MMR Group.”

Leach said that not only is the *Prevention On the Go* workplace program a true value to employees, but it serves as a recruitment tool in the company’s benefits package. The MMR Group recognizes that in addition to saving lives, the workplace program reduces health care expenses for the company and its employees; this type of education and screening detects cancers earlier, often resulting in shorter and less costly treatments.

Amber concluded her presentation with a moving story about MMR Group employee Holly Hollis Stars, who was just 34 years old when she was diagnosed with stage IV triple-negative breast cancer. In a video shown to conference participants, Hollis shared this message: “The health and wellness screenings that MMR provides are so important to me. I wish that I had been in that room a couple of years ago receiving that type of information and the education. I think it’s important for women to be educated on early warning signs to look for when it comes to breast cancer. And the fact that you can get a screening right here at your work is unique. It’s an amazing opportunity that everyone should take advantage of.”

Holly’s journey with cancer tragically ended in 2022, but her spirit lives on. To honor her memory, her friends and family established the [Holly Hollis Stars Endowment Fund](#). This everlasting gift created a permanent endowment within Mary Bird Perkins Cancer Foundation to support cancer prevention and education efforts throughout Louisiana and Southwest Mississippi in perpetuity.

Corewell Health’s Model for Community Engagement

At Corewell Health, Katherine Williams, supervisor, Oncology Community Programs, leads a team of community health workers, social workers, and supportive care service providers to design strategies and build programs that address access barriers, promote cancer prevention and screening, foster health and wellness activities, and support people and families impacted by cancer.

“COVID-19 definitely had an impact on access to cancer prevention and screening programs. I was 3 weeks into my role when the pandemic hit. And I quickly became the cancellation specialist,” said Williams. “It was a whirlwind of pausing and even stopping some of the engagement opportunities we had set up for our communities. And it’s taken some time to get back to a full-steam approach to working outside of our 4 walls.”

During the COVID-19 pandemic, this team put together a plan to advance population health, decrease the prevalence and burden of cancer, and make prevention and screening more accessible and equitable. Team members knew the importance of connecting with their community to promote an understanding and awareness of why certain behavioral changes are important to cancer prevention and then maintaining a consistent presence within that community to provide easy and seamless maintenance of behavioral changes.

The team used human-centered design to develop and implement activities and outreach initiatives. “In my former life as a teacher, I talked to my students about human-centered design being the scientific method but with empathy applied at the beginning,” Williams explained. This approach requires team members to first listen to the

person(s) experiencing the challenge or problem, understand where they are coming from, and then work collaboratively to develop and implement solutions. Using human-centered design helped the team identify several stakeholder partners, including:

- [Healthier Communities More Life Más Vida](#)
- The [Grand Rapids African American Health Institute](#)
- The [Grand Rapids Pride Center](#)
- The [Inter-Tribal Council of Michigan, Inc](#)
- Various community churches and congregations, like [Renaissance Church of God in Christ](#) and [Grace for the Nations Church](#).

“Human-centered design helps us identify where we can share the workload and where we [Corewell Health] need to bring resources out into the community and lean into where trust already exists,” explained Williams. “We are then moving in alignment with our partners to inform and empower our partners to provide screening and prevention to help treat and diagnose certain cancers and provide monitoring and surveillance of any diagnosed cancers.”

With community partnerships established, the team has been able to identify key geographic regions and focus on screening gaps. This has created a ripple-like effect to continue that outreach to other communities with similar barriers. And community health workers are key to breaking down access barriers. “We advocated for developing a community health worker role within our cancer care program,” stated Williams. “We have amazing community health workers in other parts of our health system, but we had never brought in a community health worker who would be embedded in the [oncology] team.”

Enter Gladys Pico-Gleason, a community health nurse who has been working closely with Grand Rapids’ Latino and Black commu-



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Figure 1. Corewell Health’s Community Engagement Framework



nities for the past 13 years. “Community health nurses have always focused on health equity. For us, it was like everybody was catching up to what we had been saying for a long time,” shared Pico-Gleason. “But it’s great to be able to use that focus now to our advantage—to build sustainable partnerships and to get dedicated resources.”

Currently, Pico-Gleason is the supervisor of Healthier Communities More Life Más Vida at Corewell Health. More Life Más Vida is a chronic disease prevention program where nurse case managers and community health workers work in tandem to focus on prevention for cancer, diabetes, and cardiovascular disease in underserved communities in Kent County, Michigan.

“Our community health workers are part of the communities we serve. They are key to finding ideal locations for screening events; whether it’s churches they attend or a grassroots organization in their neighborhood, they help us make those connections,” Pico-Gleason explained. “Community health workers also help recruit participants. These participants are part of their extended families, members of their schools, neighbors, and so they’re able to get people to come to cancer screenings.” Community health workers also close the loop

on all patient encounters by answering questions, coordinating follow up appointments, navigating any identified social determinants of health needs, and providing additional resources as required.

Half of More Life Mas Vida’s community health workers are bilingual; they are fluent in English and Spanish. They do door-to-door engagement to educate members of underserved communities about cancer prevention and provide resources concerning nutrition and physical activity. Pico-Gleason added, “We [Corewell Health staff] sponsor fitness instructors in the community; they are often people of color...many [of whom] own their business.”

These community health workers also act as internal advocates within their own health care system. “Those of us who are working in the community need to continue advocating within our health systems to help ensure services are truly accessible for all,” Pico-Gleason advised.

For example, it was Williams and Pico-Gleason’s team that pointed out that Corewell Health could do better on the patient education front. “We did a lot of advocacy around this issue. [We were] always making requests and having our cost centers pay for translation of

“Patient education materials need to be culturally specific. The questions we ask for anxiety and depression don’t resonate the same in all cultures. I know some of my patients are depressed, but the way they answered the [screening] questions, it doesn’t look like it... So, you can’t just have a one-size-fits-all approach to patient education and engagement.”



materials handed out at our community events. Often, we would have to wait quite a while and sometimes even pay for the translation ourselves,” shared Pico-Gleason. Corewell Health is intentionally developing new processes that will in the future ensure that all patient-facing education and materials will be available in the top 5 language spoken in the community as part of its health equity efforts.

Corewell Health also conducts health literacy screening and offers a health literacy course. Both are culturally relevant, which is why the health care system places such importance on ensuring that its community health workers and care teams are made up of people who are part of the communities served. “Patient education materials need to be culturally specific. For example, the questions we ask for anxiety and depression don’t resonate the same in all cultures,” explained Pico-Gleason. “I know that some of my patients are depressed, but by the way that they answered the [screening] questions, it doesn’t look like it. I also think in different cultures, the thresholds for depression, anxiety, and trauma are higher. So, you can’t just have a one-size-fits-all approach to patient education and engagement.”

In addition to its long-standing partnership with the Betty Ford Breast Care Services Mobile Mammography Unit to travel to underserved communities and make services accessible to at-risk patient populations, Corewell Health also partners with the Michigan Department of Health and Human Services Breast and Cervical Cancer Control Navigation Program (BC3NP) on community outreach. Corewell Health added colorectal FIT (fecal immunochemical test) kits to screening events in 2023, cervical cancer screening in 2024, and is now adding community health workers at rural cancer clinics. The organization also wants to improve access to skin cancer screening.

As many (but not all) participants at these screening events are uninsured or underinsured, Corewell Health uses state resources and grants to help pay for screenings and any necessary follow up for diagnostic testing. Taking time off from work is not always an option. Transportation to go to a clinic and get a mammogram or colonoscopy requires coordination; not everyone has accessible transportation. “While I don’t know if this is the right term, it is a very accurate one,” Williams shared. “[Corewell Health] has developed a 1-stop-shop approach, so people don’t have to go to 3 different locations or schedule 3 different appointments for services. And this approach has yielded a lot of success for our community.”

Today, the cancer program is expanding the responsibilities of its community health workers, embedding them with social work teams and clinical teams. These skilled professionals now have a seat at the table and a chance to discuss the structure of supportive care and wraparound services to better meet the needs of those who live, and are treated, in their community.



ONCOLOGY WORKFORCE CHALLENGES

COVID-19 took a significant toll on all health care workers, and many continue to contend with mental health challenges.¹⁰ The global pandemic exacerbated the health care workforce burnout crisis, leading to acute shortages of public health care workers. Staffing shortages, heavy workloads, and burnout continue to be the most reported challenges by many organizations and professional societies, including ACCC.¹¹⁻¹⁴ In 2024, American Society of Clinical Oncology (ASCO) leadership reinforced that workforce shortages continue to be 1 of the greatest challenges in the post-COVID era.

Facilitators

- Kevin Dryanski, MBA, director of the Oncology Service Line, Cancer Centers of Colorado at SCL Health St. Mary's Medical Center
- Kathleen Reed, MS RN, director, External Scientific Partnerships, AstraZeneca Global Medical Affairs, Oncology Business Unit
- Kimberly Smith, MPA, FACHE, vice president, Mount Sinai Health System & Tisch Cancer Institute
- Susanne Tameris, MHA, senior director of Cancer Services, Luminis Health Anne Arundel Medical Center.

A Technology Solution to Reduce Burnout and Improve Physician Resiliency

In health care, documentation is critical to patient care, quality measures, and revenue. “The regulatory burdens are getting heavier, and we [oncology] need accurate documentation and all the related data elements for MIPS [Merit-Based Incentive Payment System], MACRA [Medicare Access and CHIP Reauthorization Act of 2015], and other payer requirements,” said Kimberly Smith, of the Mount Sinai Health System. “Without adequate documentation, we cannot obtain [treatment] authorizations. If we are subjected to audits and the documentation is incorrect or incomplete, the revenue is reversed and we could be subject to penalty. So, for [a] multitude of reasons, we must focus on the accuracy and completion of documentation.”

At the same time, documentation is 1 of the biggest dissatisfiers for clinicians. In 2017, Mount Sinai surveyed more than 7500 physicians and 1 of the primary survey questions concerned burnout. Not surprisingly, documentation was identified as the top driver of burnout, specifically how much time it takes away from face-to-face interaction with patients and how it negatively impacts work-life balance, shared Smith.

“From the administrator perspective, we had to think about our role and how we can be change agents to improve processes and

“Without adequate documentation, we cannot obtain [treatment] authorizations. If we are subjected to audits and the documentation is incorrect or incomplete, the revenue is reversed and we could be subject to penalty.”

reduce that burden,” said Smith. “Documentation doesn't go away, but we needed to explore how we could make it easier.”

Mount Sinai's radiation oncology service line found the solution in its electronic health record (EHR), MOSAIQ, and its sophisticated voice-enabled documentation and automation platform [MOSIAQ Voice](#).¹⁵ “The intuitive technology of MOSIAQ Voice uses highly personalized, voice-activated templates to streamline and automate the entire patient documentation process.” (Note, while Mount Sinai Health System is on the Epic Systems EHR, the radiation oncology service line chose MOSIAQ for quality, efficiency, and safety reasons.)

For Mount Sinai, the technology solution automated many tasks and significantly reduced administrative time for both physicians and staff. “With [MOSIAQ] Voice, our physicians can easily navigate

“All of the quality checklists that clinicians are required to complete will auto populate [upon] signing the note. Clinicians no longer have to remember to go back into the EHR after they’ve completed notes to finish tasks or enter charges.”

through adding a note, entering data, removing data, inserting an image, completing charges, and a host of other activities all by using their voice,” shared Smith.

MOSAIQ Voice also offers flexible favorites and reverse entry EHR functionality. For example, consider this appraisal from a breast radiation oncologist who offers the same education on adverse effects and symptoms to all patients. “It takes time to write 2 or 3 paragraphs. [MOSAIQ] Voice allows the physician to create a ‘favorite’ such as ‘side effects, breast.’ Then, when the physician speaks those 3 words, those 2 or 3 paragraphs automatically populate the patient note.”

Reverse entry EHR is another powerful solution. “From an administrative perspective, it’s 1 of our favorite functions,” admitted Smith. She offered an example of this functionality: imagine a physician examining a patient note that had been initiated by a first- or second-year resident who may not be well versed in diagnosing or staging a tumor. “When the physician opens the note, those data elements are missing; the physician does not have a complete, accurate note. Not only would that note not pass an audit, but our billing staff are [reviewing] that same note and trying to authorize treatment. If data are missing, they must call or email the physician to complete this information,” explained Smith. “Or, if they’re savvy enough, which our billing staff often are, they’re combing through the EHR to find this information—an incredible time waste.”

MOSAIQ Voice allowed Mount Sinai to customize a pop-up; now, when physicians complete their note by signing out, they will be prompted to enter any missing data elements. “Those data then automatically reverse back into the EHR as structured data,” said Smith. “And now we can report on it [data], and our staff can do their jobs more quickly and efficiently.”

MOSAIQ Voice automates many other tasks, including ordering imaging and scans, making referrals, and more. “All of the quality checklists that clinicians are required to complete will auto populate [upon] signing the note,” Smith added. “Clinicians no longer have to remember to go back into the EHR after they’ve completed notes to finish tasks or enter charges. All these activities are automated.”

When Mount Sinai implemented this technology solution in 2020, providers reported that use of this software was saving about 30% of their time every week. And the technology was easy to use. Within 1 to 2 hours of being trained, providers were already reaping the benefits.

Today Mount Sinai providers are using this technology across the health system to help standardize templates and processes—and it’s not just clinicians, but administrative and billing staff as well. Smith shared a story of a billing manager who worked with a technology trainer to create custom processes to support additional revenue opportunities. As Smith clarified, “In radiation oncology, some treatments can bring in additional revenue when specific codes like special treatment procedures are added. But if a code is added, additional documentation is required. The note is not enough. Now, based on certain parameters within the note, [MOSAIQ] Voice knows to add the necessary documentation to the note when the physician is signing out.”

Administrative staff reported that use of MOSAIQ Voice saved about 10% of time in their day. “We didn’t reduce staff, but it allowed our staff to focus on activities like complex authorizations and getting patients on to treatment in a timelier manner.”

Because this solution was meant to reduce physician burnout, Mount Sinai did not mandate use of the technology. Smith shared an anecdote about 1 physician who was slow to embrace the new technology. “Our busiest physician just would not use [MOSAIQ] Voice. Finally, after much encouragement, he decided to try the software. On January 17—with the help of a village—he was trained on the technology.” Soon after, Smith received a report that showed this physician had nearly 500 documents completed in the first 4 weeks, and Smith expects the 2024 numbers to go up significantly.

While MOSAIQ Voice software is proprietary and cannot be used with other EHRs, Smith urged attendees to research available AI options. “I’ve heard that Epic may offer an AI documentation solution for its providers, and I would say jump in with both feet. Get your IT people to the table because this technology was truly a game changer for our physicians, our staff, and our radiation service line as a whole.”

Improving Provider Satisfaction and Work Culture Through Implementation of a Process Improvement Program

For many years, Cancer Centers of Colorado at SCL Health St. Mary’s Medical Center was the only major referral center west of the Rockies and for a big swath of eastern Utah. That changed in 2015 when a local hospital opened a cancer program and ended up recruiting several St. Mary providers and about half of their staff. Essentially, St. Mary’s experienced a 50% turnover of staff and providers. And the situation worsened.

“In 2017, I moved over from the process improvement team and into the cancer center service line director role. There was an opportunity to create a more effective operational structure and improve the work culture,” shared Kevin Dryanski, of SCL Health St. Mary’s Medical Center. “So, in early 2018, we made the decision to essentially wipe the slate clean. We lost 3 of the 4 medical oncologists and ended up operating medical oncology with locum [tenens].”

Dissatisfied providers, dissatisfied staff, ineffective operations all led to dissatisfied patients. Improvements were needed stat. Luckily, process improvement was in Dryanski’s DNA. “We needed a daily improvement program to understand what [staff] were doing, what work was coming down the pipe, and engage staff and providers in operations,” said Dryanski. “So much of what we were doing at the time was driven by managers and myself as the director. Every problem came right to our front door. And we ended up just putting out fires because we didn’t have capacity or capability within frontline staff.”

The first steps in this daily improvement program: building out and supporting the leadership team and giving others the autonomy and authority to identify and solve issues before they become big problems. This required process improvement, PDSA (plan-do-study-act), and Lean Six Sigma training for supervisors, managers, and team leads. This training focused heavily on change management. “We wanted our leaders to understand change management so that they could effectively help frontline staff navigate the changes that were coming,” said Dryanski. “We needed to identify early adopters of change, as well as the blocking stakeholders and how to communicate effectively with both.”

According to Dryanski, the term blocking stakeholder does not necessarily mean that individuals are against change, but that they need to understand where the change is coming from.

As part of this effort, St. Mary’s leaders were trained in mistake-proofing, a Lean technique for identifying root causes of errors and then implementing processes to prevent mistakes from occurring and, when errors do occur, to mitigate harm to individuals and organizations.

The next step in the multilayered process improvement initiative was the rollout of an ideas board. While not a new concept, Dryanski thought an effective ideas board managed by a team of frontline change agents would allow senior leadership to spend time on larger initiatives and be more involved in strategic operations and strategic growth. “An ideas board is not a suggestion box; it is a place for staff to meaningfully engage in improvement initiatives.”

Ground rules for the ideas board were simple:

- Ideas should be action-oriented and solution-driven.
- The focus is on process—not people.
- All fields on the submission form must be filled out, including name.

Table 1. Examples of Completed Ideas

| Department/Role | Idea | Benefit |
|--|--|--|
| Outpatient Oncology/RN | Follow-up calls to new non-oncology infusion patients | <ul style="list-style-type: none"> • Increase clinical outcomes • Increase patient satisfaction • Earlier identification of adverse reactions |
| Outpatient Oncology/RN | Larger font for patient name, bold date of birth on chemo bags | <ul style="list-style-type: none"> • Increase patient safety • Safety checks are easier (time savings) • Increase staff satisfaction |
| Outpatient Oncology/Medical Assistant | Cross-train medical assistant to scheduling | <ul style="list-style-type: none"> • Reduce scheduling turnaround time • Increase patient satisfaction • Increase staff satisfaction |
| Outpatient Oncology/APP | Purchase pocket talkers for palliative care clinic | <ul style="list-style-type: none"> • Increase patient safety • Increase patient satisfaction • Increase staff satisfaction |
| Radiation Oncology/Radiation Therapist | Change scrub colors | <ul style="list-style-type: none"> • Increase patient satisfaction • Increase staff satisfaction |
| Radiation Oncology/Radiation Therapist | Purchase ergonomically correct chairs | <ul style="list-style-type: none"> • Increase staff satisfaction • Fewer avoidable musculoskeletal staff injuries |

“St. Mary’s attributes the lack of provider turnover to the cultural transformation that it went through. It had a domino effect on everything we do... We’ve embraced a continuous improvement culture, and we try to live that every day.”

- Those who submit an idea or solution will be part of the improvement process.
- All ideas are welcome—big and small.
- Leadership will review all ideas at least weekly.

The ideas board put into practice the change management skills taught. Leaders who see an idea is submitted in their area or department are responsible for finding the individual who submitted the idea, thanking them, and then asking follow-up questions about the issue and the proposed solution. “Once we have that conversation and we know we’re going to move the idea forward, it is physically moved into the *to do* area of the ideas board,” explained Dryanski. At the end of these interactions, it is expected that the leader and the individual who submitted the idea will have identified action items. Then it is the individual’s responsibility to start moving forward with support from the leader.

The ideas board has both a physical and virtual presence. The ideas board itself is centrally located in the cancer center and “has a watercooler effect. Staff walk by daily and often stop to see what ideas have been submitted.” Once an idea is implemented, it is moved over to the done section of the board and both the individual who submitted the idea and the success are celebrated. Ideas with merit but that may require longer planning and/or delayed implementation due to resource and/or time constraints are moved to the parking lot section of the board.

The ideas board is also posted to an online portal where it can be viewed, and ideas submitted electronically. This online portal is also searchable by keyword and locations. “We’ve integrated it as part of our Leader Standard Work so that when an idea is submitted physically, it is carried over to the virtual board.”

Staff responded with many ideas—both big and small. Dryanski shared this idea from the palliative care team. After noticing an increase in the number of patients with hearing difficulties, 1 staff member posted the idea of purchasing pocket talkers; within 1 week

a number of these out-of-the-box hearing assistance devices that help amplify sounds were being used in the clinic (Table 1).

When ideas slow down, leadership rolls out special challenges. For example, to help increase patient satisfaction scores, they may encourage and/or incentivize staff to submit as many patient satisfaction ideas as possible for the next 60 days. “Use of the ideas board does ebb and flow,” admits Dryanski. “But there are always things you can do reinvigorate staff and inject new life into the process.”

An additional component of the process improvement plan that rolled out in tandem with the ideas board was a cadence of huddles: a daily operational huddle, a weekly leadership huddle, and a monthly continuous improvement team huddle. These huddles “really helped bring folks closer together and have meaningful, structured conversations every single day.” These huddles were also a way to keep safety at the forefront. “We asked every single day about any safety concerns.”

Like the ideas board, St. Mary’s leadership looked to frontline staff to take ownership of the daily operational huddles. Instead of leadership facilitating and leading these conversations, frontline staff from across the disciplines were asked to lead. “Mondays a nurse navigator would lead the huddle. Tuesdays was an infusion nurse. Wednesday was led by 1 of the oncology pharmacists. Thursday was led by a radiation therapist. And Friday was a member of our research team,” outlined Dryanski. “We intentionally put frontline staff in positions where they could grow—both professionally but also personally—and build capabilities and capacities.”

At these daily operational huddles, the staff reviews clinic staffing and patient volume for the day; they also share safety concerns and an escalation process for these concerns, discuss current and/or upcoming process changes, and provide kudos and celebrate wins.

The weekly leadership huddle focuses on key performance indicators, the communications plan, new ideas submitted to the ideas board, updates on ideas in progress, barriers to progress, and successes to be celebrated. It is also an opportunity to strategize and prioritize where to spend time and resources.

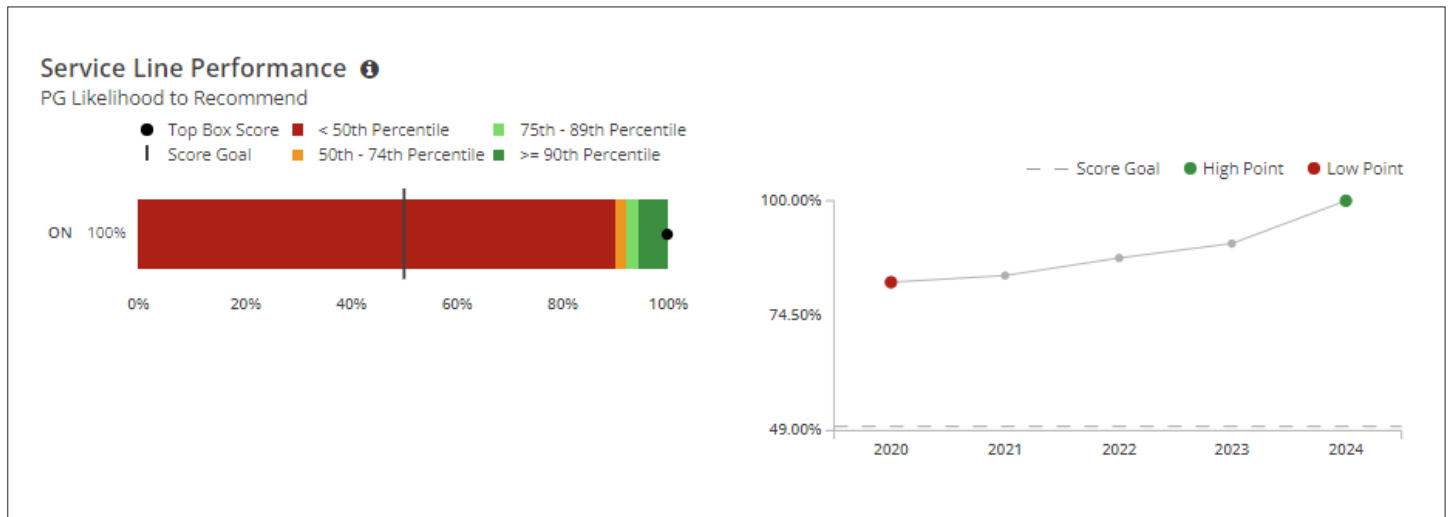
Conversations at the monthly continuous improvement team huddle include: a review of the ideas board; shared learnings from other care site boards; barrier removal; and leadership mentoring.

With the process improvement initiative in place, the next step was to measure the success of all these efforts. On a scale of 0-5, staff satisfaction increased from 4.07 in 2022 to 4.20 in 2023; in 2023, provider satisfaction was 4.33. From 2022 to 2023, staff turnover was reduced from 18.2% to 10.8%, respectively. Provider turnover was reduced from a high of 50% in 2018 to 0% in 2023. As provider and staff satisfaction increased, so to did patient satisfaction (Figure 2).

“St. Mary’s attributes the lack of provider turnover to the cultural transformation that it went through. It had a domino effect on everything we do,” said Dryanski. “We want to continue to evolve. We’ve embraced a continuous improvement culture, and we try to live that every day. We are finding ways to obtain more feedback and more input. This month, we’ll have our first patient and family advisory council where we can start soliciting even more feedback from patients and their families.”

St. Mary’s is also engaging with community physicians, including a steering council that’s made up mostly of primary care physicians

Figure 2. Patient Satisfaction



(PCPs), to provide feedback about how the cancer program’s operations impact them and how it can be improved. For example, one PCP shared feedback that the cancer program could improve how they communicate about upcoming tumor boards so that PCPs know when patients are scheduled and can attend if they are able. “We’re going to put that on the ideas board and put a team together to operationalize it.”

Improving Recruitment, Onboarding, and Retention

As with most health care organizations across the country, Luminis Health Anne Arundel Medical Center, is challenged by staff turnover, open positions, and what seems like a nearly constant stream of onboarding and offboarding. One approach Luminis Health is taking to fill these vacancies is to host specialty and virtual hiring events. Luminis Health works with HR business partners to identify hard-to-fill positions across the health care system and then plans an event for a large number of potential applicants. So, for example, if the health care system is having difficulty recruiting medical assistants (MAs), HR would put a call out that Luminis Health is hosting a job fair where MAs can come in, meet with health care leaders from different disciplines and programs, and participate in round-robin interviews—including first-line interviews with future team members—for open positions. Luminis Health works with HR to hire candidates same-day at these events or to identify promising applicants to bring in for shadowing opportunities. The great benefit to these events is that they attract a large pool of candidates to 1 location at 1 time, so staff are not spending weeks in an interview process that must be scheduled around everyone’s existing work commitments.

Luminis Health has also worked with third-party vendors to fill vacant positions and created internal hiring groups that focus on certain positions. In these models, the health care system provides the company

“I’ll be honest. [This hiring model] was a little bit of an adventure. But these are some of the things that you must start doing. You have to get outside your comfort zone and try new solutions if you’re going to bring on staff.”

or internal hiring group with a set of expectations that they look for in a successful candidate, and the third-party vendor or internal hiring group does all the interviewing and hiring. Some hiring managers had reservations about this hiring model: “What do you mean someone else is going to hire people to come and work in my program or office? That’s not going to work. I need to meet them first.”

Susanne Tameris of Luminis Health clarified how these concerns were addressed. “We brought these employees in with the expectation that there would be a 90-day evaluation period. [Luminis Health] also shared its expectation that leaders and managers across the different service lines and departments would need to work alongside these new employees to make it work.” In other words, leaders and managers need to give these candidates the support, resources, and

“What happens when the 2 nurses who staff an offsite satellite clinic cannot come to work on the same day? This resource hub model allows us to pull and send resources to that location... that model has worked very well for us.”

tools to make the onboarding experience a success. “I’ll be honest. [This hiring model] was a little bit of an adventure. But these are some of the things that you must start doing. You have to get outside your comfort zone and try new solutions if you’re going to bring on staff.”

Luminis Health has found it particularly challenging to fill its oncology nurse vacancies. Like other health care systems during and after the COVID-19 pandemic, Luminis Health has used agencies and traveling nurses to fill those roles, but neither are sustainable options. Then several experienced oncology nurses retired. “We had to fill those nursing positions, and we ended up hiring 4 brand new nurses with no oncology experience. We filled our positions, our staffing model looked good, [so] we should be able to staff our infusion center, right?” asked Tameris. “But with 4 new nurses who can’t give chemo yet because of the competency period Luminis Health has in place, we were in a bind.”

Luminis Health found a solution by leveraging a position in the health care system called contingent part time, which requires team members to work a minimum of 36 hours a quarter. So, when faced with a shortage of experienced oncology nurses, within a 2-month period the cancer program was able to onboard 5 experienced contingency part time staff to work while the new hires were trained. “We filled some of these contingency part time positions with nurses who do shift work 2 to 3 days on the hospital’s inpatient units. These experienced nurses give chemo to the hospital inpatient; they can also give chemo in an outpatient infusion center,” said Tameris. “And what that allowed us to do is [have time to] train these new nurses and get them up to speed.”

And the cancer program continues to use these contingency part time team members to fill in when staff are out on PTO or maternity leave or when someone goes on family medical leave.

At the onset of the COVID-19 pandemic, Luminis Health challenged all areas of the health system to identify team members who do not need to be in the office or clinic every day. “In oncology, we automatically thought that remote work was off the board.

[We thought,] ‘Everyone’s got to be here for oncology,’” admitted Tameris. But if there was 1 benefit to COVID-19, it was realizing that some members of the multidisciplinary cancer care team can perform their work remotely. “We looked at our cancer registry team; we looked at our dosimetrists. These are staff who are already located in areas outside of the clinic and who could do their work from home.” For Luminis Health, remote work became another tool in its arsenal to retain qualified staff. Some dosimetrists, cancer registrars, and other staff preferred to work from home because of the flexible hours and time saved from long commutes.

When possible, Luminis Health is extending these flexible hours to clinic staff. “Because our infusion centers run 10 hours a day, we offer some 10-hour shifts for oncology nurses. This flexibility means that while nurses are working a 40-hour week, it’s a 4-day work week.”

Luminis Health has also created staffing pools using a resource hub model, especially for infusion services. In this model, a team of oncology nurses, pharmacists, pharmacist technicians, and patient care technicians staffs the main infusion center. When hired, these team members know that while they work in the main infusion center, there is an expectation that they will rotate out to work in satellite infusion centers. “What happens when the 2 nurses who staff an offsite satellite clinic cannot come to work on the same day? This resource hub model allows us to pull and send resources to that location,” said Tameris. “Training and services are standardized so that cancer care team members can work at any Luminis Health site. That model has worked very well for us.”

The resource hub model works especially well in surgical oncology where physicians are typically only in the office 1 to 2 days a week. “It was hard to find staff who only want to work 1 or 2 days a week. Now, when the surgical oncologists are not in the clinic, their medical assistants work the other days in a medical oncology office,” shared Tameris. “They’re all trained on the same competencies and the same workflows; we try to keep tasks standardized so that staff can easily shift and move to different office and clinic locations.”

Once a candidate is hired, onboarding is critical to retention. Luminis Health has put in place a robust onboarding program. Each new staff member receives 1 week of training on computer systems, workflows, standard operating procedures, processes, and so forth. An onboarding team visits all new hires 1 month into their positions. “They actually come into the offices and clinics and sit with new employees to see how things are going, ask if new employees have any questions, and go through workflow and work processes in person,” explained Tameris. “From that 4-week visit, the onboarding team sends reports back to hiring managers detailing what these new hires are able to do and what they’re not able to do—where they could use some more help—and how we [the onboarding team and the hiring managers] can get them that help.”

Based on the success of its nursing preceptorship program, Luminis Health has instituted a preceptorship program for all its positions. Today, every new hire is formally assigned a preceptor, who is more than just a buddy—this is the individual new employees can call with questions, someone who has the time and resources to address any issues the new hire may be facing.

Always looking to improve its onboarding and retention, Luminis Health recently worked with an instructional design graduate student

(Continued on page 43)

Figure 3. Luminis Health Oncology Nurse Navigator Onboarding

Luminis Health Hospital Orientation Requirements

| DAY 1 | | |
|--|-------------------|------------------|
| Onboarding Opportunity | Date(s) Completed | Initials |
| Luminis Health Orientation <ul style="list-style-type: none"> • Meet a Luminis Health Chief Officer • General orientation from HR • Self-paced orientation e-learning • If needed – general EPIC training | | |

Luminis Health Oncology Nurse Navigator Onboarding

| WEEKS 1 – 4 | | |
|---|-------------------|------------------|
| Onboarding Opportunity | Date(s) Completed | Initials |
| Navigator-specific EPIC training with preceptor | _____ | _____ |
| Shadow current navigators to get a feel for the general workflow and understand processes | _____ | _____ |
| Meet with mentor (once a week in month 1) | _____ | _____ |
| Meet key plays in your area of specialty: <ul style="list-style-type: none"> • All nurse navigators • Surgeons • Radiation Oncology • Medical Oncology • Senior leadership of cancer services | | |
| Observe a tumor board in specialty | _____ | _____ |
| Have a professional headshot taken | _____ | _____ |
| Meet with manager for 30-day check-in | _____ | _____ |

(continued on next page)

Figure 3. Luminis Health Oncology Nurse Navigator Onboarding

(continued from previous page)

| MONTHS 1-3 | | |
|--|--|--|
| Onboarding Opportunity | Date(s) Completed | Initials |
| Meet with manager for 60-day check-in | _____ | _____ |
| Meet with manager for 90-day check-in | _____ | _____ |
| Meet with mentor (ongoing throughout year 1) | _____ | _____ |
| Attend review session to learn about strategic initiatives of cancer service line | _____ | _____ |
| <p>Shadow key partners and processes in your area including:</p> <ul style="list-style-type: none"> • Oncology Social Work • Financial Social Work • Dietitian • Genetics • PT/Rehab • Applicable support groups or training classes (ie, Gear Up) • New cancer consults with surgeon • Annual follow-up appointments • Pre-op appointments • Post-op appointments • Survivorship visits • Subspecialty shadowing visit (ie, urology, ENT, plastics, gastro, neuro, etc.) • Cancer prevention • Integrative medicine | <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">_____</p> | <p style="text-align: center;">_____</p> |

(Continued from page 40)

from Purdue University to develop an onboarding program specifically for nurse navigators (Figure 3). For Luminis Health, this role has been especially challenging to fill; in fact, the health care system had about one-third of its nurse navigators leave during a 6-month period.

The first part of the process was to define and set expectations about the role of this cancer care team member. “We actually took the nurse navigator job description and aligned it with the Oncology Nursing Society’s [Oncology Navigation Standards of Professional Practice](#).¹⁶ We went through each competency and aligned it with the standards. If it [the competency] did not align with 1 of those standards, we questioned whether it was something [that individuals in] this position should be doing,” explained Tameris. “We then took all of those competencies and created a notebook that included an official onboarding and ongoing support schedule.”

Also included in this comprehensive onboarding notebook:

- Job aids, such as a tip sheet on how to log in and document a note in the EHR (Epic)
- New patient planning guides, by diagnosis and disease sites
- Care pathways, by diagnosis and disease sites, that explain how the nurse navigator will follow patients through the health care system
- An entire section on continuing education and resources
- Information about the nurse navigator mentorship program that outlines the 12-month process, including a schedule of the meetings, what is going to be discussed, and activities the mentor and mentee will participate in
- Information about the nurse navigator fellowship program (Figure 3). In this program, nurse navigators rotate through different teams (eg, pathology and radiation oncology) participate in different activities (eg, tumor boards and shadow programs) to fully understand the continuum of care points for patients.

At the conclusion of Tameris’ presentation, an attendee had this to say, “You shared so many great ideas like partnering with inpatient nurses to expose them to the outpatient setting. [Inpatient nurses] work 12-hour shifts, so the ambulatory setting is not only a new experience but may be a great relief in being able to work a shorter shift, which could boost morale.”

Another participant added, “One strategy I use at my cancer program is to partner with nursing schools. A lot of our new nursing students have never been exposed to infusion in the ambulatory setting. And it’s great exposure for them to come and spend some of their clinical time in the outpatient infusion setting. Some might have seen chemo infusion as part of their inpatient rotation; others may see it as part of their community service rotation. We’ve hired new grads after we’ve had them rotate in [our infusion centers] as students so that we could observe firsthand their competency levels.”





COMPREHENSIVE CANCER CARE

The literature shows us that the area in which people live, the color of their skin, their income level, their education level, and other social determinants of health impact their health outcomes. For patients with cancer, these social determinants of health impact affect when—of even if—individuals are diagnosed, where they receive treatment, and how they receive and respond to that treatment. To truly provide comprehensive cancer care, we need to change the standard of care to address barriers and ensure equitable access to the full array of supportive care services. The [ACCC Institute for Comprehensive Cancer Care Services](#) has resources to support these efforts.

Facilitators:

- Krista Nelson, LCSW, OSW-C, FAOSW, FAPOS, FACCC, manager of Oncology Social Work Supportive Care at Providence Cancer Institute in Portland, Oregon
- Jennifer Bires, MSW, LCSW, OSW-C, FACC, executive director of Life With Cancer and Patient Experience at Inova Schar Cancer Institute in northern Virginia
- Jessie Dorne, MHS, PA-C, gynecology oncology physician assistant at Baystate Medical Center, Baystate Regional Cancer Program in Springfield, Massachusetts
- Jay Harness, MD, chief medical officer at Maple Tree Cancer Alliance
- Lisa Marquette Porat, MSW, LCSW, OSW-C, FAOSW, US lead in patient advocacy at BeiGene USA in Bargersville, Indiana
- Mandi L. Pratt-Chapman, PhD, MA, Hon-OPN-CG, associate center director at the George Washington University Cancer Center in Washington, DC
- Nicole Tapay, JD, director of Cancer Care Delivery and Health Policy ACCC in Rockville, MD.

Patient Navigation: A Critical Component of Comprehensive Cancer Care

Patient navigators play a key role in the experience of patients with cancer, and that role varies depending on who is providing the service. These providers include:

- Nurse navigators
- Social workers
- Patient or non-clinical navigators
- Financial navigators
- Community health workers
- Clinical trial navigators.

Given the wide scope of navigation and the different disciplines who can perform these services, it is helpful to think about navigation less as a discipline and more as multidisciplinary standard of care that

encompasses how patients are moved through the health care system as they maintain a high quality of life. When patients feel isolated and lost, patient navigators bridge the gap and connect patients and families with important resources.

When defining and quantifying wellness, access to and quality of health care only account for about 20% of wellness.¹⁷ Health behaviors such as tobacco and alcohol use, diet, exercise, and sexual activity contribute to 30% of wellness; on the other hand, 50% of wellness can be traced back to where an individual lives (zip code) and specifically their physical environment and socioeconomic factors (Figure 4). In the absence of supportive care resources like navigation, providers may only impact 20% of a patient's well-being. Meanwhile, provision of navigation services helps reduce disparities across the care continuum, treatment costs, and emergency department visits and hospitalizations while it improves access to care, care coordination, symptom management, and patient outcomes.

Despite the slow uptake in implementing navigation in health care organizations across the country, navigation is not a new concept. Shortly after the publication of the 1989 “ACS (American Cancer Society) Reports on Cancer and the Poor,”¹⁸ which defined barriers to care, navigation emerged as a strategy to improve patient outcomes by eliminating those barriers. In 1990, the first patient navigation program was initiated by Harold Freeman, MD, in Harlem, New York. Other navigation milestones include:

- 2005: The ACS launched its patient navigator program.¹⁹
- 2009: The Association of Cancer Care Centers (ACCC, then the Association of Community Cancer Centers) published its *Cancer Care Patient Navigation: A Practical Guide for Community Cancer Centers*.²⁰
- 2009: The Academy of Oncology Nurse and & Patient Navigators (AONN+) was founded.²¹
- 2010: The Oncology Nursing Society (ONS), Association of Oncology Social Workers (AOSW), and the National Association of Social Workers published a joint position statement on patient navigation.²²

“These [navigation] standards have been so invaluable in defining our roles as nurses and as social workers...Putting those core competencies together has also helped immensely with developing job descriptions and performance appraisals [for the field].”

- 2013: ONS published *Oncology Nurse Navigator Core Competencies*.²³
- 2015: Consensus-based core competencies for patient navigators were published in collaboration with representatives from ONS, AONN+, ACCC, and navigators from community-based organizations.²⁴ These competencies served as a foundation for the Professional Oncology Navigation Task Force and ACS projects that followed.

In 2017, the Biden Cancer Moonshot Initiative formed its patient navigation working group to identify barriers and implement solutions to facilitate widespread adoption of patient navigation. The working group found that the biggest challenges facing the profession centered around a lack of foundational definitions and standardization and reimbursement. The initiative was disbanded shortly afterward, but the working group then formed a Professional Oncology Navigation Task Force—made up of staff from such organizations as the ACS, AONN+, and AOSW—to work toward creating some of those standards.

This task force developed definitions for entry level, intermediate, and advanced navigators (Figure 5),²⁵ qualifications, and responsibilities associated with the role to help providers start and/or grow their navigation programs. The task force also developed other resources like navigation billing codes, trainings, and standards and core competencies (Table 2)²⁶ to ensure the quality of patient navigation services. Many in the field believe that these standards of practice and definitions have helped with role delineation between providers in the many disciplines that provide navigation; these include nurse navigators, social workers, financial navigators, and nonclinical navigators.

When the Biden Cancer Moonshot Initiative formed again in 2022, patient navigation was a priority for many key stakeholders who met with the representatives from the Centers for Medicare & Medicaid Services (CMS) to request that the agency recognize patient navigation as a reimbursable service. These efforts paid off in 2024, when CMS
(continued on page 47)

Figure 4. Social Determinants of Health

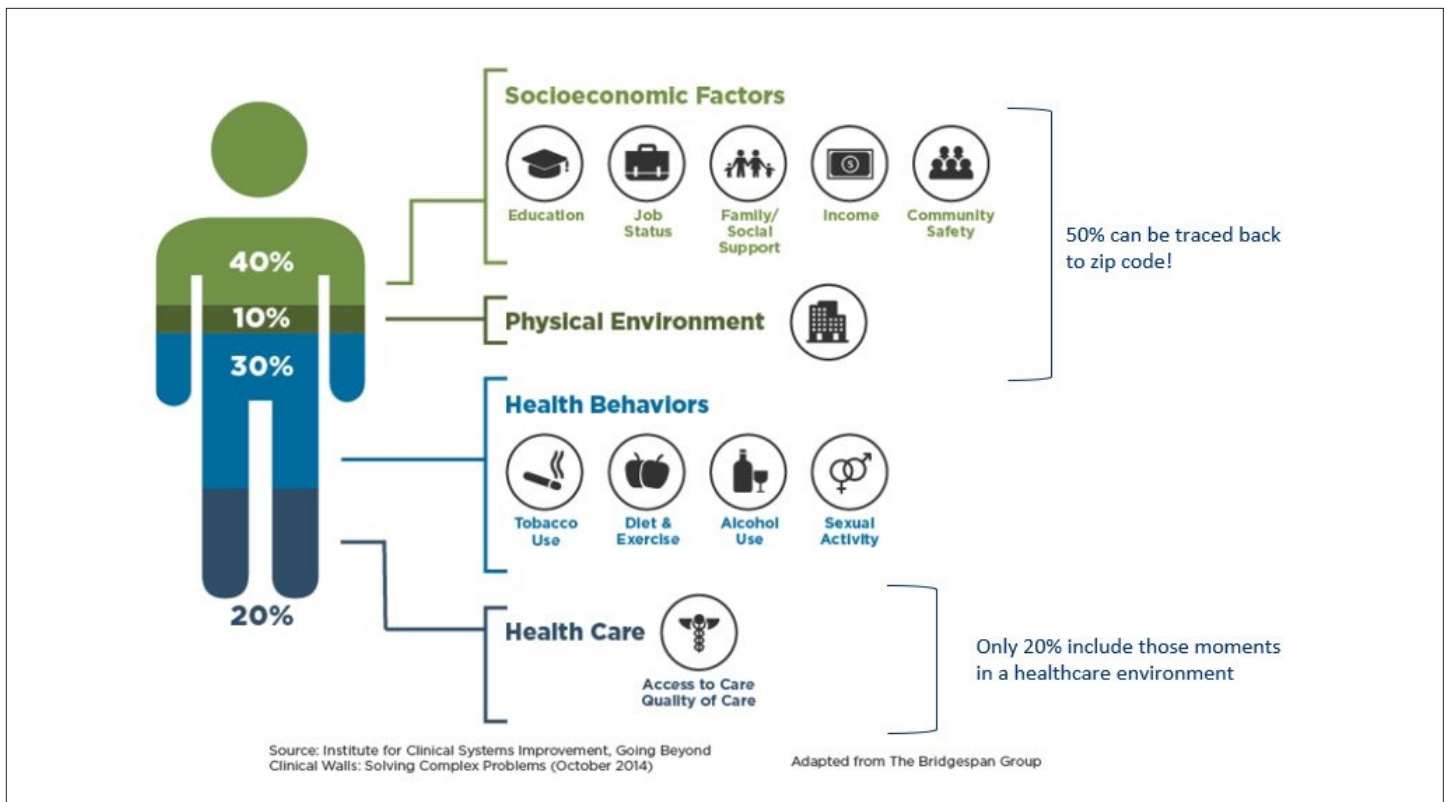


Figure 5. National Navigation Roundtable Task Definitions for Entry Level, Intermediate, and Advanced Navigators²⁶

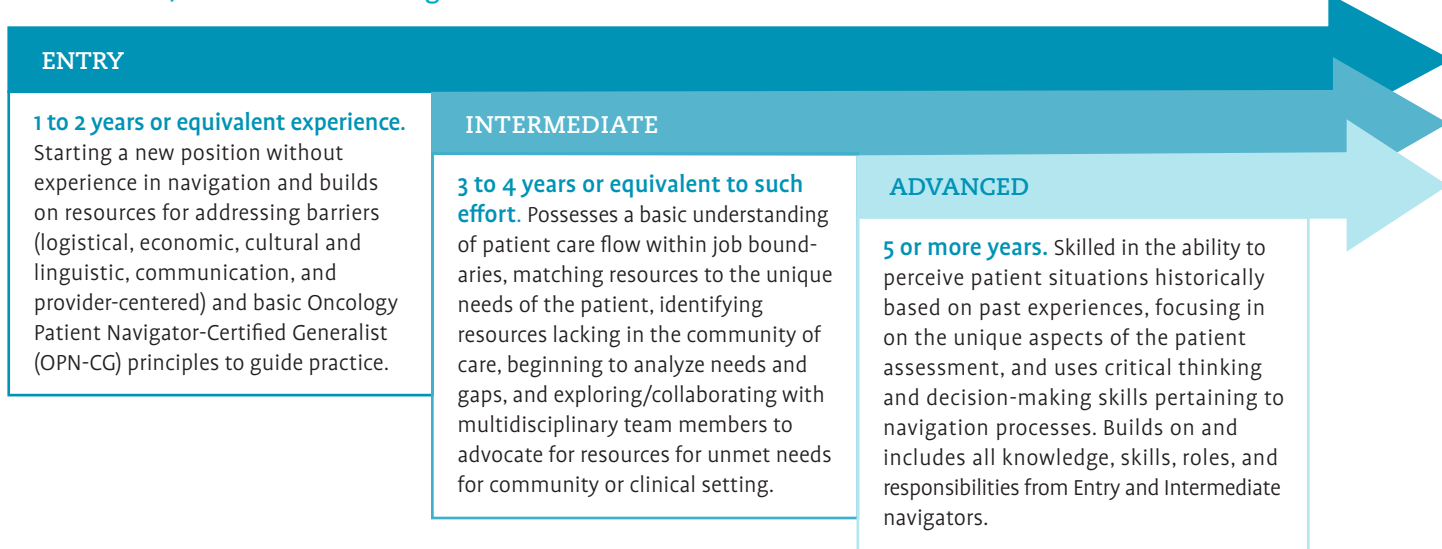


Table 2. National Navigation Roundtable Task Group Domains for Training and Certification Competencies²⁶

| |
|---|
| <p>I. Competency domain: ethical, cultural, legal, and professional issues</p> <p>Performance of competency: Demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to respecting confidentiality, organizational rules and regulations, ethical principles, and diversity in sex, age, culture, race, ethnicity, religion, abilities, sexual orientation, and geography.</p> |
| <p>II. Competency domain: client and care team interaction</p> <p>Performance of competency: Apply insight and understanding concerning human emotional responses to create and maintain positive interpersonal interactions leading to trust and collaboration between the patient/client/family and the health care team. Patient safety and satisfaction are a priority.</p> |
| <p>III. Competency domain: health knowledge</p> <p>Performance of competency: Demonstrate knowledge of health, the cancer continuum, psychosocial and spiritual belief systems, and types of patient attitudes and behaviors specific to the patient navigator (clinical/licensed or nonmedical licensure) role.</p> |
| <p>IV. Competency domain: patient care coordination</p> <p>Performance of competency: Participate in the development of an evidence-based or promising/best practice patient-centered plan of care, which is inclusive of a client's personal assessment and health provider/system and community resources. The patient navigator acts as a liaison among all team members to advocate for patients to optimize health and wellness with the overall focus of improving access to services for all patients. The patient navigator conducts patient assessments (needs, goals, self-management, behaviors, and strategies for improvement) integrating a client's personal and cultural values.</p> |
| <p>V. Competency domain: practice-based learning</p> <p>Performance of competency: Optimize navigator practice through continual professional development and the assimilation of scientific evidence, based on individual patient navigator gaps in knowledge, skills, attitudes, and abilities, to continuously improve patient care.</p> |
| <p>VI. Competency domain: systems-based practice</p> <p>Performance of competency: Advocate for quality patient care by acknowledging and monitoring needed (desirable) improvements in systems of care for patients along the cancer care continuum from prevention through end of life. This includes enhancing community relationships and developing skills and knowledge to monitor and evaluate patient care and the effectiveness of the program.</p> |
| <p>VII. Competency domain: communication/interpersonal skills</p> <p>Performance of competency: Promote effective communication and interactions with patients in shared decision making based on their needs, goals, strengths, barriers, solutions, and resources. Resolution of conflict among patients, family members, community partners, and members of the oncology care team is demonstrated in professional and culturally acceptable behaviors.</p> |

“The new CMS rule shows that Harold Freeman’s workaround to the problems he faced as he tried to cut cancer out of Harlem in the 1960s is of utmost relevance today. This is the proof of principle that when you help the poorest of the poor, you address systemic problems—including those that afflict the rich.”

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created new codes to reimburse for support services to assist patients with health-related social barriers that interfere with treatment adherence for cancer and other serious illnesses. Beginning on January 1, 2024, CMS pays for the below navigation services billed under the supervision of a qualifying practitioner. These include:²⁷

- Principal illness navigation services to help patients complete a treatment plan for a serious condition expected to last at least 3 months
- Principal illness navigation-peer support that aligns with rigorous training, primarily for behavioral health support
- Social determinants of health (SDOH) assessment
- Community health integration service coordination responsive to SDOH assessment.

To date, [Oncology Patient Navigator Training: The Fundamentals](#) is the only free training that meets CMS requirements for payment for navigators of people with all types of cancer.

Today, oncology programs and practices across the country are working to implement these billing codes. In addition to the ability of navigators to now bill for the critical services they provide to patients, data are key to growing navigation services. Showing how patients benefit from navigation services (including higher patient satisfaction scores and improved patient outcomes), cost savings from addressing barriers to care like transportation (which contributes to missed appointments), and early identification and treatment of adverse events, (which can help reduce ED visits and hospitalizations) are especially compelling to administration and leadership. Most importantly, these data highlight the importance of the patient navigator to the cancer care team and justify the growth of navigation services and the hiring of additional navigators.

Sexual Health Concerns in Oncology Patients

About 90% of patients report that sexual health is 1 of their top unmet needs during their cancer care. Across different types of cancer, patients report significant sexual health concerns following treatment:²⁸

- Over 50% of women treated for breast cancer, some 65% to 90% of women treated for gynecological cancers, and more than 60%

of women treated for colorectal cancer report long-term impact on sexual function

- About 81% of men with prostate cancer have sexual issues following treatment
- Some 86% of all patients with rectal cancer and 39% of those with colon cancer report sexual dysfunction
- Nearly 50% of patients experience impaired sexual function after stem-cell transplant
- Approximately 30% of childhood cancer survivors experience sexual dysfunction.

Cancer treatment impacts sexual function both physically and psychosocially. Procedures like surgery, chemotherapy, radiation therapy, and stem-cell transplant have the potential to cause a loss of sex hormones, weight loss or gain, decrease in genital sensation, fatigue, pain with sex, and many other side effects. Emotionally, patients often report negative body image, low libido, or a lack of self-confidence with their partner due to a change in their appearance caused by anticancer treatment. In addition, many patients have neuropathy (nerve damage from their treatment) that can negatively impact their sexual function.

Further, cancer treatment is typically accompanied by major changes in the dynamic of personal relationships. A couple no longer is made up of 2 partners; these individuals become patient and caretaker who may find intimacy difficult after treatment. Infertility is another component of sexual health that providers often fail to address with patients. The 2 cancers associated with the highest divorce rates are cervical cancer and breast cancer, which most commonly affect women in their 30s. Lacking the ability to be in an intimate relationship with their partner combined with infertility are common drivers of divorce.

“Why are 90% of patients saying this [sexual health] is an unmet need? Well, a lot of it has to do with us as providers. We don’t have time to address it; we don’t have the training. It’s this hot potato topic. Your medical oncologist says, ‘Ask your surgeon,’ and your surgeon says, ‘Find a urologist,’ or, ‘Find a gynecologist,’ and no one wants to own this. [As providers], we might have our own discomfort with the topic, our own biases, and our own cultural differences. We might also think our patients have no desire to be intimate,” shared Jessie Dorne a gynecology oncology physician assistant at Baystate Medical Center “But I will tell you that our patients, even at end of life and with stage 4 cancer, desire intimacy with their partners, so it’s not something that we should assume and ignore.”

Patients with cancer do not have their sexual health needs met by providers, because no 1 group wants to own the issue. Providers cannot rely upon patients to bring up these concerns, because patients face their own barriers to communication that include:

- Embarrassment and/or fear that their concerns will be dismissed or judged
- Cultural and religious beliefs
- A feeling of being overwhelmed with medical information
- Belief that their concern is only valid if brought up initially by the clinical team
- Expectation of improvement over time
- Perception of futility.

“LGBTQI—
I’m assuming everyone
in the room knows all of those
letters, but I will say them once
just in case: lesbian, gay,
bisexual, transgender, queer,
and intersex individuals.”

“What do we need
in terms of good care for
queer people? First, we need
to know who they are; we need
to collect sexual orientation and
gender identity data. We need
to be willing to ask, just like
we need to be willing to
ask about sexual health.”

To end this cycle of discomfort and lapse in communication, providers must ask patients about sexual function at regular intervals. Doing so creates a pattern that provides patients with a safe space to bring up these concerns. If patients raise a concern, providers should perform a prompt medical assessment and offer first-line therapies and referrals for multidisciplinary care.

Conferences and resources are available to educate care teams about sexual health issues commonly faced by patients with cancer. These include programs developed by the [Scientific Network on Female Sexual Health and Cancer](#), the [International Society for the Study of Women’s Sexual Health](#), and the [International Society for Sexual Medicine](#). Many offer free online trainings and modules to add to clinicians’ understanding.

Screening tools like the National Comprehensive Cancer Network’s (NCCN’s) Brief Sexual Symptom Checklist for Women (Figure 6),²⁹ the Sexual Health Inventory for Men (Figure 7),³⁰ and the NCCN Distress Thermometer and Problem List³¹ are also helpful in facilitating conversations with patients, as they give providers clear points to address. Providers also must legitimize and normalize sexual concerns early in the discussion. A provider simply saying, “Many women who have gone through similar cancer treatment notice changes in sexual function,” can go a long way in making patients feel safe and comfortable enough to open up about personal issues.

Simple nonpharmacologic treatments such as moisturizers, lubricants, and vibrators are often enough to fix patients’ problems. Most of the time, patients’ concerns are simple and easily fixed with the right information and validation from a provider. It is also helpful for providers to know gynecologists, urologists, and pelvic floor physical therapists in the area to whom they can refer patients if necessary.

There are definite benefits to in-person examinations and appointments for sexual health issues, yet many patient problems can be just as easily addressed over the phone. Even pelvic floor physical therapy is offered via telehealth in some states.

Sexual health support groups also can be highly beneficial. An educated and understanding provider is important, but a lot of good can come from patients connecting deeply about shared experiences that they have never spoken about before.

Because sexual dysfunction is underdiagnosed and undertreated in oncology patients, screening should be done early and often in survivorship. Many sexual health side effects may not occur until midway through treatment or after, so it’s important to bring up the topic frequently. Identifying a referral chain of multidisciplinary specialists enables providers to guide patients to the care they deserve and make sure their needs are met.

Learn more and read how University of Pittsburgh Medical Center Hillman Cancer Center in York, Pennsylvania, developed and implemented its sexual health clinic in “Addressing the Unmet Need of Sexual Health in Oncology Patients” by Dreibelbis.³²

Meeting the Unique Needs of LGBTQ+ Patients With Cancer

To provide quality evidenced-based care for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more (LGBTQ+) individuals, clinicians and care teams must be willing—and
(continued on page 51)

“I advocate for
organizations to ask about sexual
orientation and gender identity. I do not
advocate for organizations to force people
to answer those questions, because that is a
personal choice. And—depending on where
you live—that [choice] could be incredibly
affirming and give you excellent care,
or it could be very scary and lead to
care that is not so great.”

Figure 6. Brief Sexual Symptom Checklist for Women²⁹

| |
|---|
| <p>1. Are you satisfied with your sexual function?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If, no, please continue.</p> |
| <p>2. How long have you been dissatisfied with your sexual function?</p> <p>_____</p> |
| <p>3a. The problem(s) with your sexual function is (are): (mark 1 or more)</p> <p><input type="checkbox"/> 1. Problem with little or no interest in sex</p> <p><input type="checkbox"/> 2. Problem with decreased genital sensation (feeling)</p> <p><input type="checkbox"/> 3. Problem with decreased vaginal lubrication (dryness)</p> <p><input type="checkbox"/> 4. Problem reaching orgasm</p> <p><input type="checkbox"/> 5. Problem with pain during sex</p> <p><input type="checkbox"/> 6. Other:</p> |
| <p>3b. Which problem is most bothersome? (circle)</p> <p>1 2 3 4 5 6</p> |
| <p>4. Would you like to talk about it with your doctor?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |

Figure 7. The Sexual Health Inventory for Men (SHIM) Questionnaire³⁰

For each question, note your answer by circling the number that approximates your belief. Add your numbers together and refer to the table below to see what your score may mean.

Over the past 6 months...

How do you rate your confidence that you could get and keep an erection?

| | |
|-------------|--------------|
| 1. Very low | 4. High |
| 2. Low | 5. Very high |
| 3. Moderate | |

When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

| | |
|---|--|
| 0. No sexual activity | 3. Sometimes (about half the time) |
| 1. Almost never or never | 4. Most times (much more than half the time) |
| 2. A few times (much less than half the time) | 5. Almost always or always |

During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

| | |
|---|--|
| 0. Did not attempt intercourse | 3. Sometimes (about half the time) |
| 1. Almost never or never | 4. Most times (much more than half the time) |
| 2. A few times (much less than half the time) | 5. Almost always or always |

During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

| | |
|--------------------------------|-----------------------|
| 0. Did not attempt intercourse | 3. Difficult |
| 1. Extremely difficult | 4. Slightly difficult |
| 2. Very difficult | 5. Not difficult |

When you attempted sexual intercourse, how often was it satisfactory for you?

| | |
|---|--|
| 0. Did not attempt intercourse | 3. Sometimes (about half the time) |
| 1. Almost never or never | 4. Most times (much more than half the time) |
| 2. A few times (much less than half the time) | 5. Almost always or always |

Total: _____

Based on this SHIM score, you may have...

- 1 to 7** Severe erectile dysfunction (ED)
- 8 to 11** Moderate ED
- 12 to 16** Mild to moderate ED
- 17 to 21** Mild ED
- 22 to 25** No signs of ED

“The scientific data available on the value and importance of exercise for patients with cancer [are] extensive and impressive. It is essential that providers familiarize themselves with this literature as well as [with] national guidelines and standards for exercise oncology programs.”

(continued from page 48)

able—to collect and then act on sexual orientation and gender identity data, cultural and clinical training, and affirming care contexts. One of the biggest challenges to achieving this standard of care is failure to even ask about sexual orientation and gender identity. Some providers may collect these data, but they may have few standardized measures to do so in a systematic fashion. Other key barriers to asking and acting on sexual orientation and gender identity data include:

- A lack of understanding of relevance to care and research
- Institutional inertia
- A lack of system interoperability for documentation of these data
- Gendered inclusion/exclusion criteria
- A lack of clinician and staff training.

Another challenge to collecting these data is providers not knowing *how* to ask about sexual orientation and gender identity. Identifiers like *sex assigned at birth*, *organ inventory*, *hormone status*, or *intersex status* often are left out of the medical record. If these data are not collected, they cannot be used to inform better clinical guidelines and better clinical care; providers are then forced to make assumptions about patients instead of relying on information.

To mitigate these challenges, patients want the following solutions:

- Intake forms that include questions about sexual orientation and gender identity
- Visual displays of LGBTQ+ acceptance and representation (ie, posted nondiscrimination policies, inclusive educational materials)
- A safe environment to disclose their sexual orientation and gender identity to their oncologist
- Providers who are friendly, supportive, and culturally and clinically LGBTQ+ competent.

Generally, when people feel safe disclosing their sexual orientation and gender identity to their oncologist, it's easier to get quality care, including guidance on sexual health.

To meet the unique needs of LGBTQ+ patients with cancer, providers are encouraged to:

- Demonstrate that they have a safe environment
- Reflect the patient's words
- Be patient to allow for responses
- Display open body language
- Follow the patient's lead in terms of eye contact
- Check their own assumptions
- Be respectful, nonjudgmental, professional, supportive, and genuine
- Be a champion for change
- Provide training for clinical competence and cultural humility
- Remember that providers are there for the patient—the interaction is not bidirectional.

Above all, providers need to be comfortable in making mistakes and commit to continual learning so that they can create a safe, inclusive environment for every patient. To help providers on this learning journey, we refer readers to Pratt-Chapman's 2019 article, "[Cancer Care Considerations for Sexual and Gender Minority Patients](#)," for key terminology that may be useful in discussions with LGBTQ+ patients, as well as an example of a LGBTQ+ inclusive intake form.³³ For the latest examples of how to ask about sexual orientation and gender identity, see the 2024 Pratt-Chapman et al article, "Strategies for Advancing Sexual Orientation and Gender Identity Data Collection in Cancer Research."³⁴ ASCO offers additional resources for improving the care of LGBTQ+ patients.³⁵

Exercise Oncology

Exercise oncology is an adjunctive therapeutic approach to cancer patients emerging from results of over 2600 prospective and, often,

“I am now a client of Maple Tree Cancer Alliance, and I wanted to comment on a few things...My goal is to keep people out of the hospital...[and have] better outcomes and better survivorship. And exercise oncology does all of that. You mentioned the virtual component. That's been key for us because we cover a huge geographic area—a small program with a 14-county area...I think the biggest challenge is making this service as important in the eyes of our providers and our patients as anything else we do with them.”

“Mental health is still considered a taboo topic for many, so it’s important to elevate the patient’s voice and put them first at all times to continually improve the care they receive,” shared Lisa Marquette Porat of BeiGene USA. “In the spirit of patient-first care, BeiGene launched *Let’s Talk About It*, a cancer mental health platform and discussion, in 2023.”

randomized clinical trials conducted over the last 20 years. Exercise oncology clinical trials have produced moderate to strong evidence of the positive impact of exercise on patients’ fatigue, anxiety, depression, quality of life, physical function, sleep, bone health, and breast cancer-related lymphedema. Exercise oncology programs are evidence-based programs of supervised, individualized exercise training that is performed on site or virtually.

There is evidence that the impact of exercise oncology is considerable. A 2023 report from the [Maple Tree Cancer Alliance](#) that included over 11,000 patients noted the following physical and psychological benefits:³⁶

- 58.7% increase in quality of life
- 15.2% increase in cardiovascular endurance
- 18.2% increase in muscular endurance
- 31.9% increase in flexibility
- 75.9% increase in feeling more positive
- 58.7% increase in feelings of support.

The same report included the following financial impact of exercise oncology:³⁶

- 6% decrease in inpatient hospital stays
- 19% decrease in length of hospital stays
- 27% decrease in ED visits
- 33% decrease in total patient encounters
- 47% decrease in readmissions.

“Once patients get into exercise oncology programs, their compliance rate of continuing with the program is around 92%,” shared Dr. Harness of Maple Tree Alliance. “And many experience supportive bonding with both their trainers and fellow group members.”

Exercise oncology is supported by nationally recognized guidelines. For example, the NCCN guidelines for survivorship include the

following recommendations for physical activity as a preventive health measure for cancer survivors:³⁷

- Avoid inactivity and return to normal activities as soon as possible after diagnosis and treatment.
- Start slowly and gradually increase physical activity over time.
- Aim for 150 to 300 minutes of moderate activity or 75 to 150 minutes of vigorous activity each week.
- Exercise several times a week for at least 10 minutes at a time.
- Include resistance training at least twice a week.
- Include stretching at least twice a week.

“We want to know, can [patients with cancer] move? What are their limitations? And we want that information documented in their medical records,” said Dr. Harness. “That’s in the new NCCN guidelines under the medical oncology section, exercise therapy recommendations. We need to get people into programs and get them moving.”

Maple Tree Cancer Alliance is working in tandem with ACS to launch virtual exercise oncology programs and give patients access to a variety of videos, as outcomes of recently published studies have shown that virtual programs work as effectively as in-person ones.

“The scientific data available on the value and importance of exercise for patients with cancer [are] extensive and impressive,” ended Dr. Harness. “It is essential that providers familiarize themselves with this literature as well as [with] national guidelines and standards for exercise oncology programs so they can be properly implemented.”

Maple Tree Cancer Alliance is also working behind the scenes with public and private payers to obtain reimbursement for exercise oncology.

Cancer & Mental Health: Bridging the Gap Between Industry and Community

In addition to *Let’s Talk About It*, BeiGene also partnered with ACCC, AOSW, and the American Psychosocial Oncology Society (APOS) to garner research and put together a think tank with the goal of creating helpful resources and sparking discussions about mental health in oncology. On March 8, 2023, this partnership resulted in the forum, “A Call to Action: Delivery of Psychosocial Care in Oncology Summit,” in which providers spoke about psychosocial care and the impact of mental health on oncology. A main theme of the forum was the great demand for psychosocial care in the post-COVID-19 health care landscape; this care is needed for patients with cancer, their families and caregivers, and medical professionals who need supportive care for burnout and emotional distress.³⁸

One of the most important takeaways from this summit was identifying a lack of psychosocial providers and staffing shortages as the most critical barrier to care. “Many institutions do not have nurse navigators, social workers, or staff who know where to refer patients for psychosocial care,” shared Marquette Porat. “There’s also a general lack of understanding of the scope and expectations of providers of psychosocial care. These professionals typically aren’t trained in mental health specialties, leaving them unaware and unequipped to provide the care patients need.”

Another key insight from the summit was that a lack of reimbursement and coverage for in-person and telehealth care compounds existing access issues. Without virtual appointments as an option, location is a major barrier to care for patients with cancer.

To combat these barriers, it is important to actively promote collaborative care models³⁹ through sharing findings and partnering across disciplines. Developing standards to create a culture of care is also key. Providers and their organizations must prioritize the mental health of their staff to provide quality care for patients. Combating burnout, feeling supported by leaders, and calling out toxicities in the workplace are all essential for putting providers' mental health first. A culture of care also goes hand in hand with the availability of education, tools, and resources for community partners across all settings.

The following calls to action were identified in the Delivery of Psychosocial Care in Oncology Summit:³⁸

- Elevate the discussion of mental health internally and understand the toxicities in the workplace (aside from just burnout)
- Normalize conversations about mental health, services given to health care providers, and safety in having these conversations
- Teach self-advocacy skills
- Develop leadership ladders for social workers and psychologists
- Collaborate with community and industry partners to bridge gaps.

Health care providers must work together not only within institutions but between institutions. Working in silos benefits no one. Instead, collaborative care across disciplines provides better care for patients with cancer.

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