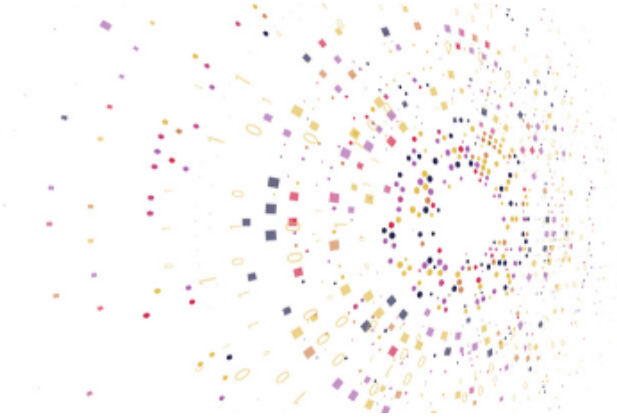

ACCC Research Review
HELPING COMMUNITY ONCOLOGY TO CLOSE THE GAP IN CANCER RESEARCH
MARCH 2021

Overcoming Consent Challenges: A Message from the President's Theme Task Force

By Lawrence D. Wagman, MD, FACS

An overview or commentary on the challenges to the mechanics of accrual to cancer clinical research trials is best started by providing a measure of trial availability. In 2019 Unger et al.[1] published a systematic review and meta-analysis of the scope of structural, clinical, physician, and patient barriers to clinical trial participation. Reviewing the literature on U.S. trials from 1999 – 2017, Unger and colleagues looked at the potential for cancer patients to be accrued to clinical trials. Based on staging and cancer type at the time of diagnosis, they found 55.6% of patients had no available trial match. Of remaining participants for the synchronously available studies, 21.5% did not meet eligibility criteria. This left only 22.9% (less than one-quarter) of diagnosed cancer patients who could be approached for clinical trial participation.

I've chosen to start with this bleak finding, to emphasize the importance of high-yield successful accrual! Informed consent is a critical phase of the study accrual process and the focus of this issue of the ACCC *Research Review*.

The informed consent process for clinical trials is designed to be informative, explicit, participant protective, and neutral (i.e., agnostic in terms of participation decision-making). The information covered in the informed consent is designed to explain how the participant was selected to be offered inclusion; who will oversee the study and collect the results; what is being examined/tested; how the study will be performed; the risks, benefits, costs of participation; and to identify the responsible scientific and administrative individuals in the healthcare system. Highlighted in the consenting process is the mandate to avoid any coercion or "baiting" to induce patient participation.

In the dynamic, rapidly advancing field of oncology, the clinical trial enterprise is evolving. The structural paradigm of clinical research is necessarily rigid; at the same time, as the COVID-19 pandemic has shown us, it must also allow for malleability. ASCO's recently released *Road to Recovery* report, highlighted below, sets goals for achieving a "more equitable, accessible, and efficient clinical research system that protects patient safety, ensures scientific integrity, and maintains data quality" as we look to the future. Thoughtful consideration of how best to overcome recognized

challenges in the informed consent process (including, but not limited to the length of informed consent documents, readability/patient comprehension, health literacy, complexity of trial design, etc.) are integral to this work. Articles in this issue of the *Research Review* touch on possible areas for advancement, such as tailored education for staff and physicians on communication/delivery of informed consent information, including real-time sensitivity—informed by cultural awareness—to language use, body language, and the patient's status in the course of their disease.

At the start of the informed consent process, orientation to the clinical trial continuum of phases 1–4 can help the patient place themselves in the continuum. In each phase, consenting requires a description of the different paradigms, risks, and benefits, as well as an explanation of what will be required of study participants. As the informed consent process reaches its conclusion, the healthcare provider presenting the informed consent must validate and comfortably secure the patient's understanding. This will often, if not always, require a closure session.

The length of the consent document itself can present a delivery challenge. For an interesting discussion of this challenge, see the article by Nathe and Krakow, featured in this issue. The authors conducted a systematic review of informed consent challenges in "high-stakes," randomized oncology studies. The article notes that the mean length of informed consent documents increased 10-fold in the last 30 years.[2] When I looked at the consent forms for the current clinical trials offered at our community hub on the City of Hope Cancer Center Research Network, I found the average number of pages was 25.7 (ranging from 21 to 36). Simply turning these pages is time and effort consuming. It is quite likely that during the process of reading the document, attention to key features that will connect a patient to the trial will be lost or diverted.

In reaching toward the goals of improving clinical trial equity, accessibility, and efficiency, there are timely opportunities to examine the informed consent document through the lens of the following attributes: length, readability, complexity, quality, the explanation of "what is in it for the participant" versus future patients, and the potential short and long-term toxicities.

The "readability" of the document encompasses both the reading level and patient comprehension. Clearly, these two features interact and are impacted by the way in which the consent form is created. Many consents contain "cut-and-paste" sections from the original protocol and concomitant submissions to the institutional review boards. The protocols themselves are written by teams of experts, with graduate-level experience, for presentation to an equally educationally prepared audience. In sharp contrast, studies have determined that the average American reads at an eighth-grade level and consent forms are frequently at an eleventh-grade level.[3] Although the reading level may be adequate, an understanding of the research topic centering the trial may not be germane to the individual. Of course, some consent features are boilerplate components and "non-negotiable." These generally consist of legal terminology, policy-based inclusions, and precise wording that have become required components in the consent form. They yield little understanding of the clinical experiment.

Another vital aspect of the informed consent process is making the connection between the investigator's perspective and the patient's interests. Long, detailed protocols usually have a flow sheet

for the schema with concisely presented eligibility and exclusion criteria. In the research team review, during discussions of protocol acceptability, these flow sheets are often used to assess trial operability. Similarly, providing a two-page summary for the patient that begins with their most often-expressed interests—both self-centered and altruistic—would be immensely helpful to accrual. This summary document should include a simplified focus on the issues of patient concern, describe aspects of patient control (e.g., when a patient can express their input on stopping treatment), provide a gauge for the side effects, explain how logistical barriers such as travel and parking will be accommodated, and provide a specific description of patient costs—either incurred or saved—with trial participation. (Ideally, in keeping with the newer requirements for cost transparency, this would include an estimate of costs or savings unique to trial-based requirements for extra visits, longer visits, travel, etc., to address anxiety associated with financial toxicity.) Investigators should prepare an outline table showing the key features of the trial: number of treatments, chance of toxicity—minimal and severe, effects of trial participation on social inclusion, main chance of improvement, and one or two secondary outcomes.

Conceptually, clinical trials are our opportunity to bring potential scientific developments to rigid testing. The consenting process is the informative moment to ask those who are facing cancer or already engaged in treatment for cancer to participate in the future together.

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Legal Perspective: Clinical Trial Flexibilities Granted During COVID-19

During the COVID-19 Public Health Emergency, the U.S. Food and Drug Administration (FDA) granted some flexibilities for the conduct of clinical trials of medical products to help mitigate the impact of the pandemic on clinical studies and study participants. For perspective on what the landscape may look like post-pandemic, ACCC Research Review spoke with pharmaceutical and biotechnology regulatory law attorney Robert Church. Mr. Church brings extensive expertise to his current role as global lead of the clinical trials working group at Hogan Lovells, LLC. Previously, he was associate chief counsel at the FDA and served in senior positions at Amgen, Inc.

ACCC: The COVID-19 Public Health Emergency has resulted in an increase in flexibility for some aspects of clinical trial conduct. What can you tell us about the status of electronic consent for clinical studies and movement toward de-centralization of trials?

Robert Church: In addition to the U.S. Food and Drug Administration's (FDA's) November 2020 guidance on enhancing diversity of clinical trial populations, two other FDA guidance documents help inform the discussion about electronic consent and, basically, what people are referring to now as de-centralized clinical trials, meaning the ability to at least conduct some patient visits remotely through the use of telehealth or some other technology.

First, in December 2016, the FDA issued a standalone guidance document on use of electronic informed consent. This set the agency's initial public expectations for what parties involved in clinical research should be thinking about in terms of the standards for electronic consent.

Certainly, the FDA and stakeholders throughout industry and academia had been thinking about electronic informed consent for a while before this guidance document came out. With the release of this guidance, the FDA for the first time formally went on the record with specific recommendations about its expectations for the use of electronic informed consent. The guidance goes into detail on the sorts of questions that normally come up in the context of the consent process: How do you make sure the necessary information is being provided to the patient? How do you make sure the patient's questions are being answered? How do you make sure the patient is who they say they are? Then, importantly, what sort of electronic systems' requirements are necessary to assure that the data is accurately captured in terms of what's presented to the patient and that the patient's signature is being transcribed and captured in a way that can be documented for FDA satisfaction.

After that guidance was issued, we saw a number of organizations starting to think in a more focused way about electronic informed consent . . . But at least in my own practice, I did not see a major increase in the use of electronic informed consent until the start of the pandemic. Then, in March of last year, the FDA issued another guidance document that also speaks to this issue, The Conduct of Clinical Trials of Medical Products During the COVID-19 Public Health Emergency. That document set forth the FDA's expectations for clinical trials during the pandemic. Obviously, a number of new challenges have arisen because of the COVID-19 pandemic. Chief among those is how do you get patients into clinics in order to administer the study drug, or conduct routine visits, or for that matter perform the informed consent process? In the guidance, the FDA addressed all of those questions. Putting these three guidance documents together, what I've seen in my own practice, is a massive acceleration within the last year in terms of the adoption of electronic informed consent and some of these other telehealth tools, like remote visits.

The FDA's recent guidance document on enhancing diversity in clinical study populations, I think, fits neatly within this broader trend which is that the agency—suddenly forced by circumstances—is now reckoning daily with the idea that there needs to be more flexibility in terms of remote site visits, electronic informed consent, and more flexibility with protocols so that you can deal with different, more dynamic circumstances. Within this context, you could use some of the tools developed in this environment to enhance diversity in clinical trials.

ACCC: One question that is top of mind for clinicians is what will happen once the Public Health Emergency ends and the COVID-19 virus is under control? Will there be a rollback of flexibilities granted during the pandemic?

Church: We're definitely not going back to the pre-COVID days in terms of the types of flexibilities that the FDA has started permitting in clinical trials. All the things I just mentioned: use of telehealth visits, remote monitoring of clinical studies, electronic informed consent, I am convinced that those are all here to stay. In terms of industry perspective, many pharma and biotech companies are in the process of not only adopting those sorts of new tools but really institutionalizing them. Most of the big pharma companies that I'm working with right now are actively and aggressively engaged with everyone involved in their clinical trials—their CROs, their vendors, their clinical sites—to try to figure out a way to standardize and implement what people are referring to as decentralized trials strategies. I think that's all here to stay, and I think the FDA is actually welcoming of that.

Certainly, the two most important things to the FDA in the context of clinical trials are protecting the safety and welfare of patients enrolled in the studies and, secondly, making sure the quality of the data isn't compromised by anything that occurs in the study using new, untested tools. I think the FDA is still going to focus very heavily on that: protecting patients and the integrity of the data. But having said that, what's become obvious to the FDA and everyone involved in the clinical trial enterprise is that you can accomplish all these things—protect patients, ensure the quality of the data, and build in a certain amount of flexibility into clinical trials.

ACCC: As cancer clinical trials have become increasingly complex, informed consent forms have gotten longer and longer. Have you seen any progress in the area of the length of informed consent documents?

Church: Since the start of my practice in the mid-90s, there's always been this concern that informed consent documents are too long and too complicated. It is a very legitimate concern. At the same time, everyone wants to make sure that the individuals who are enrolling in a study have sufficient information to make an informed decision about whether to join the trial. So, it is a difficult balance. On the one hand, providing all the information that people universally agree is accepted and required to provide the patient; on the other hand, keeping the consents reasonably short.

Electronic informed consent does start opening up all sorts of new possibilities, which are only now beginning to be explored. One of the things I've seen some references to, but not yet seen put into practice, is building in some kind of comprehension measurement along the way in providing an electronic consent. Not that you would necessarily build a test at the end of the consent, but you could potentially have a staged electronic tool that takes the patient through different aspects of the trial, and have comprehension measurement at key points along the way. At this point, I've seen this more as a theoretical concept; I haven't seen anybody try it. Certainly, that is the direction the world is moving in. If you're going to have electronic consent there is no reason to just follow the same basic paper-based format that everybody has used for the last 50 years. We can use some of the technology tools that are available to us.

ACCC: What will remain unchanged in terms of informed consent going forward?

Church: All of these new strategies—whether it's using electronic informed consent, revising the content for delivery to the patient, finding some way to assess comprehension throughout the process—all material that is presented to the patient does need to be reviewed and approved by the IRB. So,

there are traditional components built into the informed consent process that are not going away. The IRB is there to help protect the rights and safety of patients. That is what the FDA wants. So even though there is going to be a major movement toward some of these new online tools, some of the basic elements, like IRB review, will still remain.

ACCC: Has there been any change as far who obtains the informed consent? The in-depth patient education about a study, in many instances, is performed by research staff such as advanced practice providers, research nurses, or clinical research coordinators.

Church: In a classic FDA-regulated clinical trial, the actual regulatory obligation on obtaining consent is on the investigator. But, to your point, that responsibility is often delegated from the investigator to somebody else on the staff, whether it's a sub-investigator, a nurse, or a research coordinator, which is acceptable. Of course, investigators always need to remember that they are the ones ultimately responsible to ensure that consent has been carried out effectively.

If you're doing remote consent (electronic consent), I think it's important to ask to what level is the investigator or the immediate study staff involved in the process? Can they stand by and let the patient do this all online by themselves? Or, does there need to be some ability to ask questions and get answers? The FDA would expect that. It raises an interesting question of how far down can these responsibilities be delegated. I think we're still seeing some of that playing out, but ultimately the investigator needs to satisfy themself that informed consent has been handled appropriately under the FDA's expectations.

ACCC: When it comes to liability and informed consent, what is important for those involved in clinical trials to know?

Church: In terms of what they can do to help protect themselves from potential liability, I would say the following. First, the FDA's number one concern is always protecting the rights and welfare of those individuals who are participating in studies. I would strongly recommend that investigators and research institutions closely read the FDA's guidance document on informed consent. If concerns are ever raised by a patient or a patient's family about the effectiveness of consent that's been given remotely through the use of electronic technologies, I think it would be helpful for the institution to demonstrate that they followed all of the FDA's guidelines very closely. That, I believe, would go a long way to insulating the institution from claims that they somehow acted inappropriately. Also, as I mentioned previously, any content that's developed for delivery to patients electronically, should be reviewed by an IRB. In fact, I would say that the whole electronic consent process and tools should be reviewed and approved by the IRB before it is used for the first time. That goes a long way toward protecting the patients but also demonstrating that the institution acted with appropriate care and thoughtfulness.

Applying COVID-19 Lessons Learned to Improve Cancer Care & Research

In January, the American Society of Clinical Oncology (ASCO) published the *Road to Recovery Report: Learning From the COVID-19 Experience to Improve Clinical Research and Cancer Care*. The

report sets out a roadmap for applying lessons learned during the COVID-19 pandemic for positive change in cancer care delivery and research. Guided by the Steering Group on Cancer Care Delivery and Research in a Post-Pandemic Environment, comprising two multidisciplinary tasks forces— the Cancer Care Delivery Task Force and Research Task Force — the Road to Recovery lays out specific recommendations aimed at building momentum from the adaptations mandated by healthcare ecosystem-shattering experiences of care delivery during the pandemic and, where possible, build on these lessons to address much-needed change.

The roadmap's recommendations for clinical research focus on five goals that aim to support the drive toward a "more equitable, accessible, and efficient clinical research system that protects patient safety, ensures scientific integrity, and maintains data quality." These goals are to:

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

Table 1 of the report provides more detail on each goal along with action steps for achieving these aims.

Many of the flexibilities allowed to support the clinical research enterprise while keeping patients and research team staff during that COVID-19 pandemic appeared in March 2020, with the U.S. Food and Drug Administration release of Emergency Guidance. These flexibilities included:

- Enabling patient participation in research through telehealth visits
- Allowing research-related care to take place at clinical sites in the community rather than at research center, and closer to patients' homes
- Increasing flexibility in protocol requirement
- Permitting remote visits between research site and sponsors and CROs (remote visits/remote monitoring
- Allowing use of electronic signature and documentation.

Although ASCO and others have long advocated for many of these changes, overcoming systemic resistance to change from established procedures and processes is difficult. ASCO's Road to Recovery is a call to continue this forward momentum post-pandemic and to retain those process modifications that have served patients, providers, regulators, and sponsors well to address inefficiencies, access barriers, costliness, and disparities in the cancer clinical trials enterprise.

Complementing the *Road to Recovery* research goals, ASCO also released a new research statement with recommendations for streamlining and standardizing clinical trial site feasibility assessments (FAs). The statement critiques current standards as "costly, inconsistent, inefficient, labor intensive, and of uncertain effectiveness." In brief, ASCO believes that the current FA process impedes timely access to studies and delays advancements in safe and effective novel therapies.

ASCO recommends that all trial sponsors and contract research organizations implement a streamlined, uniform feasibility assessment process. To accomplish this, ASCO proposes that the FA be completed in one of three ways:

1. A short feasibility questionnaire and an in-person pre-study site visit
2. A long feasibility questionnaire only
3. An in-person pre-study site visit or a teleconference only.

Additional recommendations to streamline the FA process include:

- Establishing standard operation procedures at each organization
- Maintaining a standardized site capabilities document at trial sites for sharing with sponsors and CROs
- Designating a single point of contact
- Completing the process remotely as much as possible.

For the feasibility questionnaire, ASCO recommends reducing redundancy and variation across sponsors and CROs, and standardizing the assessment questions where possible, to include:

- Standardize feasibility assessment questions with common nomenclature, questions, and response options
- Keep feasibility assessment questions focused on site capability to conduct the trial and specific protocol feasibility.

These FA recommendations reflect the work of an ASCO task force, which was informed by feedback from stakeholders including trials sites, biotech-pharma sponsors, and CROs.

Food for Thought: The Future of Clinical Trial Design

Informed Consent in High-Stakes, Randomized Oncology Trials

In *The Challenges of Informed Consent in High-Stakes, Randomized Oncology Trials: A Systemic Review*, authors Julia Nathe and Elizabeth F. Krakow explore major barriers to informed consent and discuss "best consent practices" for multi-stage randomized trials. The authors conducted a review of literature (published from 1990 to 2018) that centered around informed consent documents in the following domains: readability, quality, complexity or length of the documents, and the "stakes involved" (i.e., potential for benefit or harm given a patient's level of illness, study participants' outlook, and the "riskiness versus curative potential" of the trial treatment). The evidence, taken together, seems to show that enhancing informed consent documents for readability, simplifying forms through redesign, and/or reducing the length of the documents results in modest improvements in patient understanding. The article includes a table of additional modifications that studies have found to improve patient comprehension while also increasing satisfaction and decreasing anxiety. Among these are:

- Decision aids, e.g., booklets, brochures, and information sheets that support patient decision making.
- Multimedia, e.g., audiovisual aids, computer-based technology (education module)
- Teach-back or repeat-back communication
- Communication-trained physician or patient advocate.

The article, published online in March 2019 in *MDM Policy & Practice*, concludes with pertinent questions about the informed consent process in multistage randomized oncology trials, and the authors request that: *"We encourage researchers to include consent-related aims in the design of their multistage trials so that our field can better fulfill both the legal and ethical requirements of informed consent."*

Reference

1. Nathe JM, Krakow EF. The challenges of informed consent in high-stakes, randomized oncology trials: a systematic review. *MDM Policy Pract*. 2019;28;4(1):2381468319840322.

Clinical Trial Design: Past, Present, and Future in the Context of Big Data and Precision Medicine

In November 2020, the journal *Cancer* published a review article from Allen Li and Raymond C. Bergan that provides not only a concise overview on cancer clinical trial design from the first in human chemotherapy studies in the 1940s but also a brief look at the future of trial design in the era of big data, precision medicine, and machine learning.

With the advent of targeted anticancer drugs and other novel therapies, the authors note that oncology is continuing to see an evolution in clinical trial endpoints. As understanding of the biology of cancers increases, precision medicine is helping drive a shift from the historical approach of trials based on cancer type (i.e., breast cancer, lung cancer) to clinical trials by molecular phenotyping. The article provides a brief review of new trial designs (e.g., adaptive design, main protocol, basket and umbrella trials, platform trials) that have developed as precision medicine continues to advance. Looking to the future, the authors highlight trial design approaches that aim to incorporate real-world data. Examples include the recently announced Registry of Oncology Outcomes Associated with Testing and Treatment (ROOT) trial (NCT04028479). The ROOT trial is one of the first master observational trials (MOT) to be launched, designed to provide a path for collection of "high-quality and comprehensive molecular data from both clinical trials and clinical practice."

The authors conclude that future clinical trial design offers opportunities to "bridge and leverage the strengths" of both institutions with large, dedicated clinical trial infrastructure and community-based facilities close to where patients live and work, offering "convenience and deep relationships." Examples already underway include centralized analysis and remote MTB (molecular tumor boards) with treatment delivered in the community, which bolster collaboration among health care settings.

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1. Li A, Bergan RC. Clinical trial design: past, present, and future in the context of big data and precision medicine. *Cancer*. 2020;126:4838-4846.

Multi-Regional Clinical Trials (MRCT) *Leaning In* Webinar: Study Design, Eligibility, Site Selection & Feasibility

Part of the MRCT webinar series complementing the release of "Achieving Diversity, Inclusion, and Equity in Clinical Research," this recorded webinar features guest speakers Rachael T. Fones, Director,

Government & Public Affairs, IQVIA, and Theresa Devins, DrPH, Associate Director, Global Trial Optimization, Global Clinical Operations at Regeneron.

Topics discussed include opportunities to involve, engage, and incorporate patients, participants, communities, and advocates in study design; the importance of broadening eligibility criteria to support inclusion of diverse populations; and strategies for successful site selection and accurate feasibility assessment.

Reference

1. Bierer BE, et al. Achieving diversity, inclusion, and equity in clinical research guidance document. Version 1.1. Cambridge and Boston, MA: Multi-Regional Clinical Trials Center of Brigham Women's Hospital and Harvard (MRCT Center). Available at http://www.mrctcenter.org/diversity-in-clinical-trials.

A Message from Randall A. Oyer, MD, ACCC President 2020 - 2021

With this issue, ACCC concludes its Research Review newsletter series. Over the past year, the President's Theme Task Force has brought expertise, insight, guidance, and contributions to the newsletter—all in support of my President's Theme: *Community Oncology Can Close the Gap in Cancer Research*.

As the American Society of Clinical Oncology's recent *Road to Recovery* report asserts, we must build on the lessons the COVID-19 pandemic has brought to oncology—specifically practical improvements to processes that can streamline efficiency and access to cancer clinical trials. If you haven't already, please take time to explore the ACCC resources developed over the past months that aim to strengthen community oncology's potential role in the future of cancer clinical studies. These include a webinar series (see below), podcasts, and an ongoing article series in *Oncology Issues* that highlights how community practices and cancer programs are succeeding in improving access to clinical trials in the community.

In closing, I want to thank the members of the President's Theme Task Force and the ACCC membership for your dedication to improving patient care. Although this is the final issue of the Research Review, in the coming months look for more resources, tools, and practical information from ACCC on how community oncology can amplify its role in cancer clinical trials.

- COVID-19 Implications for Cancer Clinical Research and Quality Care: An expert panel of past ACCC Presidents share their perspectives on changes to clinical research during the pandemic.
- Integrating the Community Voice to Advance Cancer Research: Strategies to incorporate your community's needs and perspective into your research program.
- The Role of Tissue Acquisition in Advancing Community Precision Oncology: Key issues in high-integrity tissue acquisition facing community cancer programs.
- How Oncology Advanced Practitioners Can Enhance Community Oncology Research: Key results from a recent nationwide survey on the role of advanced oncology practitioners (AOPs), including NPs, PAs, and pharmacists, in cancer clinical research.
- Closing the Oncology Research Gap—Pharmacy's Role Defined: Learn more about successful models for pharmacist integration into oncology research teams and the unique skills which pharmacists offer the interdisciplinary team.

- In Pursuit of Equity: Diversity in Clinical Research Participation: Discover strategies to improve clinical trial accrual for racial and ethnic minorities, as well as other at-risk groups.

Live Webcast: Practical Solutions to Better Engage Cancer Professionals and Communities of Color

Although cancer incidence and mortality overall are declining in the U.S., certain underserved communities continue to be at risk of developing or dying from particular cancers. More work needs to be done to address the needs of these populations, and critical in that work is engaging marginalized communities in their care, providing bias training to healthcare professionals, and forming impactful, collaborative relationships with patients, caregivers, and local agencies.

On **Thursday, March 18, 3:00 – 3:45 PM EDT**, an expert panel will review currently available data on cancer care disparities, discuss the needs of disadvantaged populations, and share practical solutions and methods for implementing bias training and bidirectionally engaging your cancer program or practice with local community representatives.

Speakers:

- **Sanford E. Jeames, DHA**, Adjunct Professor, *Huston-Tillotson University*
- **Lailea Noel, PhD**, Assistant Professor, Department of Oncology; Assistant Professor, Department of Social Work, *Dell Medical School at the University of Texas at Austin*
- **Nadine J. Barrett, PhD, MA, MS**, Director, Office of Health Equity and Disparities, *Duke Cancer Institute*; Director, Duke Community Connections Core, *Duke CTSA* (Moderator)

Click here to register.

The **ACCC Research Review** newsletter is developed as part of the 2020-21 ACCC President's Theme. Its goal is to help bring research opportunities into community practices/programs to ensure that all Americans may benefit equally from cancer research. For additional resources and to learn how your cancer center can become involved, please visit accc-cancer.org/president-20-21.

The **Association of Community Cancer Centers (ACCC)** is the leading education and advocacy organization for the cancer care community. Founded in 1974, ACCC is a powerful network of 28,000 multidisciplinary practitioners from 2,100 hospitals and practices nationwide. As advances in cancer screening and diagnosis, treatment options, and care delivery models continue to evolve—so has ACCC—adapting its resources to meet the changing needs of the entire oncology care team. For more information, visit accc-cancer.org or call 301.984.9496. Follow us on Facebook, Twitter, LinkedIn, and Instagram; read our blog, ACCCBuzz; and tune in to our podcast, CANCER BUZZ.