Plenary Session—The Patient Journey: Access to Cancer Care

Presented by Diane K. Hammon, MHA; Elizabeth A. Souza, MHA; Anne Chiang, MD, PhD; Lawrence N. Shulman, MD, MACP; and moderated by Timothy Kubal, MD, MBA

ABSTRACT

As difficult as it may be to comprehend, quality affordable healthcare, particularly cancer care, is not accessible to every individual in every region of the United States. Without timely use of the full range of cancer care services, the best health outcomes cannot be achieved. To explore the scope of this contemporary scenario in cancer care and share ongoing efforts to improve access to cancer care for all, a distinguished panel shared their views at the NCCN 2022 Annual Conference. From the varied perspectives of patients, providers, and researchers, the panel featured a discussion of shared-care models at Massachusetts General Hospital and Penn Medicine Cancer Care to enable patients to expand their access to cancer care and receive that care closer to where they live. In addition, the panel explored initiatives to build and expand the network of clinical trials to enable patients to access such trials in their communities.

J Natl Compr Canc Netw 2022;20(5.5):e225011
doi: 10.6004/jnccn.2022.5011

Using a Shared-Care Model to Provide Care Close to Home

As Vice President and Chief Strategy Officer at Moffitt Cancer Center, Diane K. Hammon, MHA, knows cancer on a professional level. But because of her father's cancer diagnoses, she has experienced it on a personal level as well. Even though he did not live near his care team at Moffitt Cancer Center, he was able to maintain convenient access to high-quality care because of an innovative approach to a shared-care model.

"A lot of us are trying to serve communities that may be a several-hour drive from where we work," she said during a roundtable discussion, moderated by Timothy Kubal, MD, MBA, Senior Medical Director, Moffitt Cancer Center, at the NCCN 2022 Annual Conference. "This places a significant burden on patients in those communities who are diagnosed with cancer; these patients want high-quality cancer care, but the distance can be a challenge for them, particularly if they're older."

Ms. Hammon's father had been a patient at Moffitt Cancer Center for years due to a previous malignancy, and needed only in-person appointments sporadically. But after a diagnosis of high-risk myelodysplastic syndrome in late 2019, he required more consistent treatment at Moffitt; however, the 2.5-hour drive from his home made that a challenge.

Given his prognosis, age, and other comorbidities, it was clear he did not have a curative option. "So, his desire for treatment was dignity, respect, honesty, and partnership," Ms. Hammon explained. "He wanted little disruption to my mom, wanted to be close to home, to live an active life, and to see family and friends for as long as possible."

Focusing on these wishes, they devised a treatment plan that would keep him out of the emergency department, urgent care, and hospital, while limiting the number of trips he would have to take to Moffitt. "We achieved all of those goals through the use of monthly, then biweekly, then weekly virtual visits; robust and responsive communication via the patient portal; a shared-care model with a trusted local oncologist; laboratory tests and transfusions at the local hospital; and oral chemotherapy," she said.

According to Ms. Hammon, her father's diagnosis and personal goals led them to a treatment plan that would not be considered typical from a strategic planning perspective. But it did honor his wishes and provide him a high quality of life for his last 9 months.

She hopes that her father's experience will inspire cancer centers to think differently and find innovative ways to reduce the logistical burden of cancer care and improve the overall patient experience. "I'm a firm believer and champion that we as cancer centers can and should do more for delivering high-quality care to patients closer to home, and even in the home," she said. "This certainly challenges our historic economic models, but I believe that collectively, we can provide creative solutions for our patients."

Network Expansion Initiatives and Ensuring Quality Cancer Care

The COVID-19 pandemic was undoubtedly challenging for cancer centers, but according to Elizabeth A. Souza,

MHA, a member of the NCCN Best Practices Committee and Senior Administrative Director of Cancer Center Operations at Massachusetts General Hospital (MGH) Cancer Center, it did create opportunities for enhanced communication and collaboration across cancer networks. This has been evidenced in the collaboration achieved within the MGH Cancer Center Network over the past 2 years, which has positioned them for ongoing expansion and growth, she said.

Building a cancer center network is a multiyear strategic initiative—one that MGH has been working on for more than 25 years, according to Ms. Souza. Cross-site integration and collaboration take time, patience, and willingness from all stakeholders, and ensuring quality cancer care across multiple sites requires a multitude of resources, infrastructure, and engagement. However, because patients are now seeking care closer to home, cancer centers must essentially provide quality cancer care where patients are choosing to receive treatment.

The MGH Cancer Center Network has 14 sites across New England. According to Ms. Souza, its leadership team has been working collaboratively with their many locations for years.

"Much of the work we did prior to COVID enabled further integration when we were faced with a pandemic," she said. "Having an aligned leadership structure with common information systems enables enhanced opportunities to streamline processes across multiple sites, which was essential during COVID operational planning and communications."

Pandemic-driven challenges forced MGH Cancer Center in Boston to rely more heavily on the other sites within their network. "These constraints increased the importance of leveraging the 'Near-Network' locations (including MGH Boston, Newton-Wellesley Hospital, Danvers/Salem Hospital, and Waltham), to ensure patients could receive their cancer treatment uninterrupted and closer to their homes," she said.

According to Ms. Souza, the value of this integrated system was highlighted by its ability to seamlessly facilitate care for patients across the MGH Cancer Center Network. The MGH Cancer Center in Boston saw a decrease in overall cases treated at that location, from 71% in fiscal year 2019 to 68% in fiscal year 2021. "We still have an opportunity to move more care to the Near-Network locations and are continuously working toward a goal of having 50% of cancer care within the MGH Cancer Center Network provided at our community locations," she said.

An integrated cancer care network allows patients to receive care closer to home, but ensuring that all sites have the same level of quality can be a challenge, Ms. Souza added. To ensure the same level of care is provided at its Near-Network sites, MGH focuses on the safety and quality of services delivered before fully integrating staff across sites.

Expanding Access to Clinical Trials in the Community

From the beginning, the vision at Smilow Cancer Hospital included clinical research as a vital aspect of quality care, according to Anne Chiang, MD, PhD, Chief integration Officer, Deputy Chief Medical Officer, and Associate Professor of Medicine, Smilow Cancer Hospital at Yale Cancer Center (YCC) and a member of the NCCN Affiliate Forum, Policy Advisory Group, and Small Cell Lung Cancer Panel. Conducting clinical research in the community is a way of providing cutting-edge technology and opportunities for patients where they live, she said, adding that about 25% of the therapeutic trial accruals at YCC come from within its community.

According to Dr. Chiang, building a clinical trials network requires institutional leadership, commitment, and support; engagement from disease teams and community physicians; and innovative thinking to address issues regarding trial feasibility and access in distant sites.

"We've really tried to expand and leverage clinical research within our community—including the state of Connecticut as well as Rhode Island—to better support our patients," she said. "We've found this is also a great way to support our academic investigators while providing cutting-edge treatments to our patients."

YCC sites saw broad participation in 2021, with a total of 37 physicians accruing at 11 sites. Not surprisingly, she noted, the highest-accruing sites were found to have a larger portfolio of trials, and a clinical research laboratory on site.

According to Dr. Chiang, physician engagement is the key to success. A clinical research working group (or protocol review committee) with physician research champions from each site meets monthly to vote and determine which trials will be added to its disease team portfolios. The committee reviews accruals and open/pending trials and invites the disease teams to present their portfolios for discussion, focusing on feasibility concerns.

Care center physicians can serve as principal investigators on trials and receive "credit" for accruals. "These clinicians are very busy, so the credit does allow for recognition of that extra time they're putting into accruing patients on trial," Dr. Chiang noted.

Robust relationships between disease teams also boost accruals and referrals. Thus, Dr. Chiang noted the importance of disease team integration through meetings, retreats, and opportunities for collaboration. Infrastructure is another critical component of clinical trials support, with a combination of central support and local support interfacing with teams, including 23 research staff across sites. The challenges encountered by the portfolio selection process and the potential solutions devised by the YCC team are shown in Figure 1.

Challenges and Solutions

- Feasibility of trials limits selection (eg, pharmacokinetics, biopsies)
  - Building local research laboratories in community sites
  - Pilot for decentralizing laboratory specimen processing and shipping in distant cancer centers
- Disease team integration
  - Automatic consideration of feasible trials in selected sites
  - Community trial involvement is "free" to the disease team (care center research staff costs are covered)
- Sponsors limit number of sites to activate
  - Education, partnerships with sponsors
- Radiation oncology trial requirements limit participation
  - Pilot specific partnerships with Yale radiologists

Figure 1. Challenges and potential solutions encountered in the portfolio selection process.

Since COVID, other barriers have also arisen, such as clinic relocation, remote work, new/modified workflows, activation delays, staffing shortages, and physician burnout. "There's a lot of opportunity for quality improvement and transformation," she said. "That's the silver lining."

Finally, developing partnerships within the community (eg, Oncologists Welcome New Haven Into Trials [OWN IT], and the Center for Community Engagement and Health Equity [CEHE], has been a vital step for YCC in increasing diversity and inclusion within clinical trials.

Moving Cancer Care to the Home

Penn Medicine's Cancer Care @ Home (CC@H) Program has demonstrated that home infusion of certain anticancer therapies can take the place of inpatient or outpatient administration, according to Lawrence N. Shulman, MD, MACP, Professor of Medicine, Perelman School of Medicine, and Deputy Director for Clinical Services and Director, Center for Global Cancer Medicine, Abramson Cancer Center at the University of Pennsylvania, and a member of the NCCN COVID-19 Vaccine Advisory Committee, the Best Practices Committee, and the Policy Advisory Group. "For appropriate cancer medications and patient populations, treatment can take place at home, with high patient satisfaction levels and time savings," he added. "It can also free up clinic and infusion capacity."

To illustrate the need for home care in oncology, Dr. Shulman discussed a study that focused on opportunity costs for patients with advanced pancreatic cancer.[1] The study found that in the last month of their lives, patients spent about 10% of their time in a healthcare encounter, with a median of 4.6 hours per encounter. Additionally, more than half of that time was spent either commuting or waiting to receive care.

"As Diane [Hammon] articulated much better than I can, this just isn't the way people want to spend the last months of their lives," said Dr. Shulman. "This is really important to keep in mind."

A shared decision-making model was used in the development of the CC@H Program.

Dr. Shulman noted that many touchpoints had to be carefully considered, such as different preauthorization times for home infusions compared with hospitals, scheduling issues (because patients often don't receive all of their treatment at home), issues with compounding, delivery/pickup, and direct care nursing, to name a few. "It was an extensive process, and we had to get into the weeds with each of these aspects," he noted. "I think that was part of the reason why things went relatively well in our program."

According to Dr. Shulman, the CC@H program actually started as a small research project in early 2020 with the goal of optimizing patient care and the clinician experience. However, it "exploded" after the onset of the COVID-19 pandemic. "We all felt this was a successful and rapidly operationalized program, but it also made us realize some of the opportunities that existed for our patients," he explained.

When deciding which treatments could be administered at home, the team carefully weighed certain considerations, including:

- Safety
  - ➤ What can be safely administered at home?
  - ➤ Should the first dose be administered in the hospital infusion unit?

- What treatment can practically be administered at home?
  - ➢ Length and complexity of treatment
  - ➢ Ancillary medications
  - ➢ Stability of medications (some have short stability times and need to be administered quickly, whereas others can be mixed centrally and administered later at home)
- How are "ready-to-treat" criteria evaluated and by whom?
  - ➢ Toxicity assessments
  - ➢ Pretreatment blood work
- Hybrid models
  - ➢ Not all doses are administered at home
  - ➢ Some visits require testing (imaging)
  - ➢ Some visits require clinician discussion and future direction

Additional considerations included nurse staffing levels/training, pretreatment laboratory tests, information technology challenges, and financial issues. "One of the biggest obstacles we encountered was out-of-pocket expenses for patients, particularly for some of our Medicare patients," Dr. Shulman stated. "For some of these therapies, the cost was prohibitive if they got the therapy at home. We'd like to see that change over the coming years, but it's a reality right now."

Dr. Shulman emphasized the need for electronic health record integration. "Traditionally, home-care companies have not been on our hospital electronic health records, and this has been a huge challenge," he said. "All orders—with all safety checks—need to be able to be transitioned to the home-care units, and all order sets and laboratory test orders need to flow to the right place."

Dr. Shulman concluded by stressing the importance of finding "financial equipoise" with payers. "It's unfortunately a reality for all of us, but we need to figure it out. Because if done correctly, I think this could benefit all of us."

Disclosures: Ms. Hammon, Ms. Souza, Dr. Shulman, and Dr. Kubal have disclosed no relevant financial relationships. Dr. Chiang has disclosed receiving grant/research support from AbbVie, Inc., Amgen Inc., AstraZeneca Pharmaceuticals LP, and Bristol-Myers Squibb Company; and consulting fees from AstraZeneca Pharmaceuticals LP, Catalyst Pharmaceuticals, Flatiron Health, Inc., Genentech, Inc., and Regeneron Pharmaceuticals, Inc.

Correspondence: Timothy Kubal, MD, MBA, Moffitt Cancer Center, 12902 Magnolia Drive, Tampa, FL 33612. Email: Timothy.Kubal@moffitt.org

Reference

1. Bange EM, Doucette A, Gabriel PE, et al. Opportunity costs of receiving palliative chemotherapy for metastatic pancreatic ductal adenocarcinoma. JCO Oncol Pract 2020;16:e678–687.