

ASSOCIATION OF COMMUNITY CANCER CENTERS  
AND HARBORSIDE

**A VIRTUAL SUMMIT  
TO DEFINE THE ROLE OF  
ONCOLOGY ADVANCED PRACTITIONERS  
IN EQUITABLE CANCER CARE DELIVERY**

**EXECUTIVE SUMMARY AND REPORT**



Association of Community Cancer Centers



The nexus of knowledge

## EXECUTIVE SUMMARY

The Association of Community Cancer Centers (ACCC) and Harborside co-hosted a virtual Summit on March 30, April 1, and April 6, 2021, bringing together oncology advanced practitioners (APs)—defined as nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), and oncology pharmacists—along with oncology and non-oncology physicians and patient advocates. Participants engaged in focused conversations on equitable cancer care across three domains: care coordination and communication, clinical trials, and acknowledging and mitigating implicit bias. In each session, facilitated discussion helped to define how oncology APs may play a role in the delivery of equitable care.

To accommodate the virtual format (Zoom), the Summit took place in 2.5-hour sessions held over 3 days:

- March 30 focused on equity in the context of care coordination and communication
- April 1 explored equity in cancer clinical trials
- April 6 centered on acknowledgment and mitigation of implicit bias

Summit facilitator Robert Mittman, MPP, MS, designed a discussion framework to elicit maximum engagement and dynamic exchange among participants. Each session followed a four-part format beginning with conversation on the current state of equitable cancer care delivery and intersectionality with the advanced practitioners' roles. Participants were then challenged to share perspectives on what an ideal future state, achievable in a three-year time frame, would look like. Next, participants identified actionable gaps between the current and ideal future state of equitable care delivery. To conclude each session, participants brainstormed action steps to address these gaps. To optimize the conversation on the virtual platform, approximately 30 participants attended each day. Some participants were invited to participate in more than one discussion. (See Appendix A: Summit Faculty & Planning Committee; Appendix B: Agendas; Appendix C: Summit Participants; and Appendix D: ACCC and Harborside Representatives.)

## Why This Conversation Now?

The COVID-19 public health emergency spanning 2020-2021 has focused national attention on the devastating real-world consequences of health inequities in the United States.<sup>1</sup> Over recent months, the nation has witnessed how racism, bias (both explicit and implicit), and lack of equity can result in social injustice, brutality, morbidity, and mortality. Across the US healthcare enterprise, in recognizing that health equity is fundamental to achieving population and societal health, there has been renewed commitment to advancing health equity in the delivery of healthcare, understanding more deeply the intersectionality between inequities and health outcomes, and identifying effective strategies for improving equitable healthcare delivery, with the overarching aim of reducing health disparities.

## Why Oncology Advanced Practitioners?

In the evolving oncology landscape, APs are playing an increasing variety of roles from the chair side to the C-suite. Highly trained professionals employed across the spectrum in oncology, advanced practitioners—as colleagues, educators, trainers, clinicians, program managers, researchers, authors, administrators, quality improvement leaders, and more—are well positioned to help advance equitable cancer care delivery.

Even as the role of APs in oncology is expanding, in two recent research surveys—one of NPs and PAs, the other of NPs, PAs, CNSs, and pharmacists—respondents reported spending the majority of their time in direct patient care, including such responsibilities as counseling, prescribing, patient management, and follow-up.<sup>2,3</sup> These activities provide opportunities for NPs, PAs, and other APs in oncology to impact equity in the Summit's three discussion domains: care coordination and communication, clinical trials, and acknowledging and mitigating implicit bias.

# A CALL TO ACTION

After the Summit, the action steps identified in each of the discussion domains were collated. Via an online polling platform, participants were asked to rank these recommendations according to two criteria: feasibility and impact. Through this consensus-driven process, action steps receiving the highest scores (i.e., the most votes for both feasibility and impact) were identified. This process helped define 10 feasible and impactful opportunities for oncology APs to play a greater role in equitable cancer care delivery.

- **Encourage and engage in active shared decision-making.** Participants identified a need to create resources for APs to learn to foster open dialogue with patients and engage in dynamic shared decision-making that elicits the patient's care preferences.
- **Identify existing data collection metrics and equity screening tools.** A unifying theme across Summit sessions was the need to curate and build on existing resources. Participants supported establishing a working group of APs to conduct a literature review (including grey literature) and research to aggregate existing data collection measures and screening tools. The importance of identifying tools that integrate into EHRs was emphasized. Participants agreed that such resources are vital to accurately measuring health disparities and demonstrating the value of care coordination and to developing an understanding of where and how breakdown in care coordination/communication occurs, relative to disparities for specific patient populations.
- **Deliver a consistent message about clinical trials.** Participants agreed that APs can help level-set clinical trials for patients and all members of interdisciplinary teams by delivering a consistent message that clarifies how clinical trials represent a standard of care, and that every patient with cancer should be considered for clinical trial participation. They recommended advocating for cancer programs/practices to include "discussion of clinical trials" in AP job descriptions.
- **Step into research.** Many oncology APs have an interest in greater participation in research.<sup>3</sup> Summit participants agreed that APs in oncology are often ideally situated for conducting health disparities research. To extend the AP's role in research, participants recommended development of quality improvement (QI) CE/CME education programs so that APs can gain the added skills needed to plan and conduct research.
- **Advocate for inclusive cancer clinical research.** Research-focused APs working at the top of their licensure have proven capacity to engage in all aspects of clinical research, including serving as principal investigators (PIs) and co-PIs. Summit participants strongly agreed that advocacy to enable APs to sign off on clinical trial orders is an important step in support of their evolving role on clinical research teams. Advanced practitioners are often the healthcare professionals most engaged with clinical trial participants. On behalf of their patients, APs can amplify patient-voiced barriers to trial enrollment, challenges faced by patients who are participating in clinical studies, and at the trial's completion, the importance of sharing aggregate trial results with study participants.

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# A CALL TO ACTION

- **Support and engage in research publication. Summit participants concurred that expansion of the AP's role in publication, curated resources, tools, and education is needed.** Areas of opportunity cited by participants include unpublished clinical trial data that APs may utilize to develop and publish original research papers as lead author and co-authors, particularly in the area of novel agent adverse event prevention, mitigation, and management.
- **Ask for training resources for APs related to diversity, equity, and inclusion in clinical trials.** Elevating equitable care delivery will require ongoing learning and commitment, participants acknowledged. Advanced practitioners need access to training resources, such as short videos, podcasts, or webcasts that explore issues related to diversity, equity, and inclusion in cancer clinical trials and that include APs interacting with patients to describe trial enrollment, what participation in a clinical trial entails, and the voices of patients who have participated in clinical trials.
- **Create a checklist to support a top-of-mind focus on equity.** An equity-focused checklist can serve as a low-cost, easily integrated tool—ideally into the EHR—that APs could use to support awareness of implicit bias. Summit participants recognized that implicit (or unconscious) bias exists in all human beings and is a consequence of how the human brain is hardwired. At the same time, awareness of the subtle ways in which implicit bias may affect equitable cancer care delivery through a process of regular self-assessment, intervention, and re-assessment is essential to effect change at the individual level.
- **Call for equity in medical professional curricula.** During Summit discussions, some participants shared their lived experience with biases embedded in professional education and training. Participants agreed that APs have a role in advocating for medical professional graduate programs to examine their curricula and to take action to address explicitly and implicitly biased training, and to require that faculty be trained in implicit bias awareness. An additional call to action is for APs to encourage their professional organizations/societies to join in a collective statement of support for this action to graduate curriculum programs and accrediting/credentialing bodies.
- **Request that your professional societies reserve space at events and in publications for discussion of implicit bias education and equity in cancer care delivery.** Advanced practitioners, together with professional organizations such as American Academy of PAs (AAPA), ACCC, Advanced Practitioner Society for Hematology and Oncology (APSHO), Harborside, and others, can commit to publishing on these issues to help disseminate best practices in moving toward more equitable cancer care delivery.

Summaries of the three Summit discussions follow. Look for three mini-podcasts on the Summit Call to Action on [CANCER BUZZ](#), ACCC's podcast as well as the JADPRO podcast. For more information on "A Virtual Summit to Define the Role of Oncology Advanced Practitioners in Equitable Cancer Care Delivery" contact Elana Plotkin, Assistant Director of Provider Education at ACCC, at [eplotkin@accc-cancer.org](mailto:eplotkin@accc-cancer.org).

## DAY 1: CARE COORDINATION & COMMUNICATION

### March 30, 2021

In a study on "Understanding the Role of Advanced Practice Providers in Oncology in the United States" from Suanna S. Bruinooge and colleagues, 80% of the surveyed oncology advanced practitioners (comprising NPs and PAs), reported spending the bulk of their time on patient care. The top four patient care activities identified by respondents were patient counseling (NPs 94%, PAs, 98%), prescribing (NPs 93%, PAs 97%), treatment management (NPs 89%, PAs 93%), and follow-up visits (NPs 81%, PAs 86%).<sup>2</sup>

Oncology APs are at the hub of care coordination and communication, Summit participants agreed. Typically, these professionals are in continuous interaction with patients, providers, and allied team members. In a pre-Summit survey of Day 1 participants, most strongly (56.3%) or somewhat (31.3%) agreed with this statement: *APs at my institution communicate with the patient more frequently than the treating physician/oncologist.*<sup>4</sup> As one participant commented during the Summit discussion, *"I think we all subjectively know that we're the ones who move the needle on care coordination."*

### Current State

The discussion on the intersection of care coordination, communication, and equity started with participants reviewing how things stand at present. A comment that resonated with many participants is that there is a prevailing lack of awareness. *"Unfortunately, there are still some out there who do not believe that there is a problem,"* said one participant, adding, *"We need to continue putting the data in front of people."*

The following characteristics of the current state of equity were highlighted during the discussion:

- Insufficient (or absence of) training of healthcare professionals to think about the intersection of equity and cancer care delivery.

- Lack of incentives to drive health equity in care delivery in our healthcare system.
- No institutional push toward a cultural shift that prioritizes equity; thus, no processes are in place as scaffolding to support equity, and institutional performance metrics for equity variables are lacking.
- Variation in addressing health equity issues from within healthcare programs and across different health systems.
- Misunderstanding about the impact of communication and care coordination on outcomes.

Despite these deficits, participants described some strategies in place at their institutions that aim to reduce inequities in cancer care delivery.

These included:

**Screening tools.** Several participants described screening tools or processes to identify patients at risk for barriers to care such as transportation, housing insecurity, lack of a caregiver, and financial distress or toxicity. More than one participant noted that the challenge is being prepared to respond when needs are identified: *"We don't always have every answer to meet every patient's needs. We're working on different resources and creating a whole pathway because providers need to have a pathway so they can move forward and address those issues."*

**Health equity training for staff.** A number of participants commented on the availability of health equity training at their programs. While the many interventions cited represent positive action, participants agreed on the need to think beyond "one-offs" and individual interventions, and to instead consider "a more structural systemic approach."

## Future State

When the discussion facilitator challenged participants to describe what care coordination and communication would look like in an ideal future state of equitable cancer care delivery, a patient advocate participant responded:

*“As a patient, I think it would feel like being able to go to receive treatment and know that I was getting the best treatment no matter how good my insurance was, or how much money I made. I think it would feel like going into conversations with my doctors and being able to trust that I was being given all the options, not that someone was making those decisions for me. I think it would feel like being heard and being seen as a patient, being treated as a person, and not just the disease. . . I feel like the conversation defining quality of life would be held during active treatment as well, not just during end-of-life planning.”*

In the conversation that followed, participants shared perspectives on practical steps toward achieving this vision of equitable cancer care delivery. For APs to fully realize opportunities to advance equitable care, participants identified the following five areas of need:

- Dedicated time with each patient after the initial consult to dig into the patient’s needs outside of treatment counseling and to gain an understanding of the whole person—for example, communication and care coordination needs, financial needs, psychosocial needs—and to then connect the patient with available resources.
- Metrics to benchmark and measure improvement and demonstrate impact.
- Multi-pronged approaches that leverage technology advances, such as telemedicine, telemonitoring, and patient-reported outcomes to help APs “meet the patients where they are.”
- Multi-sector commitment to move the needle on equitable care delivery. *“Equitable care is not something that can be fixed by one party or one group of people,”* one participant emphasized. *“How do we take shared ownership of it? I think we have to look at it from that lens as well. How do we engage different industries?”*

- Ongoing assessment. Participants agreed that the ideal future state of care coordination and communication should encompass continuing assessment of the patient’s access to care. (Included under the umbrella of access are resources that support health and unmet needs, particularly as these relate to the social determinants of health.) This process should be dynamic and ongoing; access may be affected by multiple forces, including individual, personal circumstances.

## Getting from Here to There: Action Steps

In the final segment of the Day 1 session, participants were asked to frame action steps for APs to help improve equitable care delivery in the context of care coordination and communication.

Proposed actions included:

- **Ask the patient.** Each healthcare professional who interacts with an individual can identify if there is anything lacking in terms of that patient’s care.
- **Encourage and engage in active shared decision-making.** Participants identified a need to create resources for advanced practitioners to learn to foster open dialogue with patients and engage in dynamic shared decision-making that elicits the patient’s care preferences.
- **Capture social determinants of health in the EHR.** Participants recommended leveraging existing technology to redesign tools already in use to save information on social determinants of health in discrete fields. This step would make it easier to flag specific information and optimize the data usability. Another recommendation from participants: programs need to have a consistent method of collecting and entering such data into the EHR, with training for the team on how to document.

- **Identify existing data collection metrics and equity screening tools.** A unifying theme across Summit sessions was the need to curate and build on existing resources. Participants supported establishing a working group of advanced practitioners to conduct a literature review (including grey literature) and research to aggregate existing data collection measures and screening tools. The importance of identifying tools that integrate into EHRs was emphasized. Such resources, participants agreed, are vital to accurately measuring health disparities and demonstrating the value of care coordination and to developing an understanding of where and how breakdown in care coordination/communication occurs relative to disparities for specific patient populations.
- **Outreach. Outreach. Outreach.** Advanced practitioners can be proactive in forging connections between larger centers and the community center where the patient receives care, and between primary care providers and the cancer care team.
- **Make equitable cancer care a requirement of quality metrics,** including in job descriptions and performance reviews.
- **Convene an inter-professional group** to create a “coding best practices for equitable care” tool/resource.
- **Develop a QI project or process improvement (PI) initiative** similar to the “Outside the Box” model described by Zuber and colleagues.<sup>5</sup> Create easy-to-access continuing education that can be quickly implemented.
- **Establish a Patient Bill of Rights that includes equity and accountability** so that social determinants of health factors do not undermine everything that medical advances have been able to provide others.
- **Improve education on equity, diversity, and inclusion for healthcare professionals** to increase understanding of why this is a priority in care communication and coordination.

## DAY 2: CLINICAL TRIALS

April 1, 2021

Clinical research studies are the bedrock of evidence-based medicine. They inform every component of cancer care: prevention, screening, diagnosis, treatment advances, care delivery, patient-centeredness of care, post-treatment quality of life, palliative treatment, and end-of-life care. Inequities in the United States clinical trial enterprise are widely recognized.<sup>6-8</sup>

Oncology stakeholders across all sectors—government, industry, professional societies, and patient advocacy organizations—are prioritizing actionable steps to develop a more diverse, inclusive, and equitable clinical research enterprise: to increase diversity among researchers, principal investigators, and study staff; to reform study design so that studies reflect those populations most affected by the disease; to re-assess eligibility criteria for increased inclusivity; to improve clinical trial recruitment processes; and more.

ACCC and Harborside shared with Summit participants pre-publication highlights from a recent study by Christa M. Braun-Ingliis, MS, APRN, FNP-BC, AOCNP, and colleagues that describes the current landscape of AP involvement in clinical research.<sup>3</sup> Respondents included NPs, CNSs, PAs, and pharmacists who practice in the oncology setting in the United States. Concordant with the study by Bruinooge et al., more than 80% of those surveyed indicated direct patient care as their primary role. An overwhelming majority (91%) of respondents believed that APs should participate in clinical research, and 75% reported an interest in becoming more involved in the clinical trials process. Responses indicated a wide diversity in the current level of involvement with clinical research. Approximately 70% of respondents said they are involved in identifying, recruiting, and coordinating patients for clinical trials; and 11% report serving as the primary provider for patients on clinical studies at their institutions.

## Current State

The April 1 discussion further characterized the variability in AP roles and responsibilities in cancer clinical research, as well as in education, training, and processes for engaging with patients about trial opportunities. Key reflections of the current state included:

No standardization of AP involvement in organizations' clinical trials programs. Several participants commented that, at their programs, APs are not involved in the "up-front" aspect of clinical trial development (e.g., protocol design, feasibility, staffing considerations). Others remarked that APs at their institutions have no role in recruitment for or conduct of clinical trials.

Participants referenced institutional barriers and disincentives to AP involvement in clinical trials. A medical oncologist participant commented: "APs don't have clinical trials in their job descriptions, at least here [in my institution]," and "APs are not part of the Quality Incentive Program (QIP) for trial enrollment."

Additional present-day barriers were emphasized:

- Lack of standardized information on clinical trials within institutions and across facilities within health systems.
- Insufficient/absence of education on clinical trials for APs.
- Clinical trial offerings do not reflect the patient population of the community in which the facility is located.
- Lack of dedicated AP time to focus on research.
- Overly restrictive trial eligibility requirements that present barriers to diversity and inclusion.

In contrast, several participants shared that the AP's role in clinical research in some disease-specific teams is well established, and that acceptance is also increasing across the oncology program.

*"We have disease-oriented multidisciplinary groups here and, at least on the solid tumor side, the APs are involved early on in the clinical trials."* Other tumor groups at this institution are moving in this direction, a participant said. *"They realized that the APs are the ones in the clinic who are going to see these patients, and that if they [the APs] don't have the time to do it, they're not going to get people accrued to their trials."*

At another program, a participant explained: *"The nurses, study coordinators, and advanced practitioners all sit in on the meeting to determine the feasibility of a study. I think that this is a best practice. We also run it by patients and let patients decide if this is something that they'd participate in."*

A participant from a cancer center that has a community research program through the National Cancer Institute concurred: *"We regularly engage APs in protocol review. They are PIs on different types of trials. [Most often these are] supportive care and cancer care delivery trials. We try to make that a priority."* In the locale where she practices, she further shared, *"We have a small group [of providers], and we are all in the community. Because of our diverse population, we are also able to recruit minorities. But it takes a lot of time, and it takes care coordination."*

Another nurse practitioner added that her program serves a diverse patient population and the program has been successful in increasing diversity in clinical trial enrollment: *"We're still continuing to focus on making that a priority as far as the role of the AP,"* she said. For years, advanced practitioners at this program *"really have pushed to have maximum integration of APs on the disease team and in clinical research. We really pushed to say, 'If we're going to be actively managing these patients—which we do, independently, a majority of the time—we need to be on the trials.' That also means that APs need to be educated and ready to address protocol concerns."*



## Future State

As the discussion shifted to characteristics of an ideal future state where cancer clinical trials have become inclusive, diverse, and equitable, participants described a research enterprise that:

- Designs studies that are based on the population of those who are most affected by the disease, with mechanisms in place within the design of the study to ensure that the research team reaches patient populations affected by lack of equity.
- Delivers a consistent message. One participant shared, "We have our own elevator speech [to ensure that] clinical trial participation is entwined in everything we do."
- Develops strong navigation programs to reach underserved minority patients and engage with diverse communities in ways that are culturally relevant to them.
- Honors patients who have participated in clinical trials by reporting aggregate trial results to them when a study is completed.
- Ensures that, in developing grants for trials, funding is included for true community development and dialogue so that [researchers/investigators] are not only going into the community when they want something from the community.
- Provides access to clinical trials in the setting where the patient is getting their care.
- Involves APs in all aspect of clinical trials. This will require training, participants said, not only training about the conduct of clinical trials, but also bias training so that there is no inadvertent bias in design, recruitment, and conduct of trials.
- Becomes even more intentional about community engagement, for example, by creating consent forms that are accessible and in clear, plain language.
- Develops a budgeting template for a diversity plan and strategy within the clinical trial recruitment and retention plan.

- Advocates that a diversity and inclusion plan is required as part of any NCI-approved trial.
- Proactively incorporates community partners in research so that they then become advocates in the community on behalf of clinical studies. In this way, people in the community hear about clinical trials before they hear the words: You've got cancer.
- Includes community members as the IRB community representative.
- Hosts weekly, bi-weekly, or monthly team meetings that include APs so that they can hear about trial eligibility criteria and studies that are the focus of current enrollment efforts. Then, when APs see patients, they will have the information needed to talk about the study with the patient.
- Protects AP time for clinical trials. *"We all know it takes longer to discuss clinical trials and enrolling in clinical trials [with patients],"* said one participant. *"If you have a quota of how many patients need to be seen, which many institutions do, there's a disincentive for APs. We have to incentivize APs from a scholarship perspective."*
- Closes the loop. If someone is not meeting their goals for diversity in clinical trial enrollment, provide help, participants recommended. For example, have them visit with the appropriate office of diversity for assistance with strategies for recruiting diverse patient populations.

## Getting from Here to There: Action Steps

In this closing segment of the Day 2 discussion, the participants collaborated to brainstorm actions that APs can integrate into their roles to support equitable cancer clinical research. Suggestions ranged from individual to institutional level actions, as well as actions that cross healthcare silos.

- **Ask our patients** if they want to enroll in a clinical study.
- **Deliver a consistent message about clinical trials.** Participants agreed that APs can help level-set clinical trials for patients and all members of interdisciplinary teams by delivering a consistent message that clarifies how clinical trials represent a standard of care, and that every patient with cancer should be considered for clinical trial participation. Advocate for cancer programs/practices to include “discussion of clinical trials” in AP job descriptions.
- **Advocate for an institutional requirement that every patient be asked about clinical trial participation** and call for an institutional imperative that all trials generated at the institution are made accessible to patients in all the institution’s satellite facilities.
- **Urge that the U.S. Office for Human Research Protection develop guidance** on targeted financial support, e.g., to cover transportation and parking costs, for clinical trial participants.
- **Keep trial options top-of-mind** by advocating for clinical trials to be integrated into the EHR (so they appear on the patient problem list) as a reminder to clinicians.
- **Step into research.** Many oncology APs have an interest in greater participation in research.<sup>3</sup> Summit participants agreed that APs in oncology are often ideally situated for conducting health disparities research. To extend the role of APs in research, participants recommended development of QI CE/ CME education programs so that APs can gain the added skills needed to plan and conduct research.

- **Advocate for inclusive cancer clinical research.** Research-focused APs working at the top of their licensure have proven capacity to engage in all aspects of clinical research, including serving as PIs and co-PIs. Summit participants strongly agreed that advocacy to enable APs to sign off on clinical trial orders is an important step in support of their evolving role on clinical research teams. Advanced practitioners are often the healthcare professionals most engaged with clinical trial participants. On behalf of their patients, APs can amplify patient-voiced barriers to trial enrollment, challenges faced by patients who are participating in clinical studies, and at the trial’s completion, the importance of sharing aggregate trial results with study participants.
- **Engage with professional societies representing oncology advanced practitioners** to join in support for the critical role of APs in research and to increase awareness and recognition for advanced practitioner participation in clinical trials and AP leadership in symptom management and treatment of adverse events.
- **Support and engage in research publication.** Summit participants concurred that to expand the role of the AP in publication, curated resources and tools are needed. Areas of opportunity cited by participants include unpublished clinical trial data that APs may utilize to develop and publish original research papers as lead author and co-authors, particularly in the area of novel agent adverse event prevention, mitigation, and management.
- **Ask for training resources for APs related to diversity, equity, and inclusion in clinical trials.** Elevating equitable care delivery will require ongoing commitment, participants acknowledged. Advanced practitioners need access to training resources such as short videos, podcasts, or webcasts that explore issues related to diversity, equity, and inclusion in cancer clinical trials and that include advanced practitioners interacting with patients to describe trial enrollment, what participation in a clinical trial entails, and the voices of patients who have participated in clinical trials.

- **Advocate for increased diversity in AP professions.** Summit participants agreed on the need for greater diversity among advanced practice professionals in oncology.
- **Encourage independent-practice APs to share their interest in and intention to be more involved with clinical trial design.** By bringing this to the attention of their clinical teams, their departments, and colleagues, APs may also support broader inclusion criteria and diversity in cancer clinical trials.
- **Think more broadly about which healthcare providers APs are educating about clinical research in oncology.** For example, APs can establish educational connections with primary care providers and AP colleagues in the primary care setting.
- **Urge that clinical trial participants receive the aggregate results of the trial in which they have participated.** Patient advocate participants in the Summit emphasized that this helps to close the loop for study volunteers and offers some recognition for their vital contribution to the understanding and advancement of cancer care.

## DAY 3: ACKNOWLEDGING & MITIGATING IMPLICIT BIAS

April 6, 2021

*“There is extensive evidence and research that finds unconscious biases can lead to differential treatment of patients by race, gender, weight, age, language, income and insurance status.”*

—The Joint Commission<sup>9</sup>

The closing Summit session challenged participants to define the role of oncology APs in equitable cancer care delivery through acknowledgment and mitigation of implicit bias. In a pre-Summit survey, three-fourths of Summit participants (76%) reported that their organizations provided some type of cultural competency/humility training; however, one-quarter (24%) were either uncertain or said no such training was offered.

Survey responses indicate that most organizations assess their patient population for trends in race (94%), age (71%), and socioeconomic status (71%), while fewer look at the patient population in regard to sexual orientation/gender identity (35%) and health literacy (53%).<sup>4</sup>

In a brief introductory presentation, Soumya J. Niranjani, BPharm, MS, PhD, helped to level-set the discussion: *“Manifestations of bias in cancer care can be through many different ways, whether it is patient-provider interactions, treatment decisions, treatment adherence, and, of course, patient health outcomes. No one appears to be immune to implicit bias, including those who explicitly disavow such beliefs.”*

### Current State

Participants agreed that acknowledging and mitigating implicit bias is a dynamic responsibility that demands ongoing attention and commitment from both the individual and the institution. Whether that commitment, or “will for change,” is prioritized or even exists at the institutional level was questioned by participants. Of note, in response to a pre-Summit survey question, 82% of participants selected “strongly agree” with this statement: “Improving equitable access to cancer care is a priority for me.” However, only 59% responded that they “strongly agree” that “improving equitable access to cancer care is a priority for their institution.”<sup>4</sup>

**Is the will there?** A medical oncologist and oncology leader questioned whether our healthcare delivery system has truly prioritized mitigation of implicit bias: *“I really wonder if the current state is that the will isn’t there, that we really haven’t made a decision to make this [implicit bias] better.”*

**Variability in training; lack of requirements around training.** Several participants raised the issue of whether diversity and inclusion training amounts to more than “lip service” or ticking off a check-box.

**Lack of understanding and awareness of impact.** In the words of one participant, *“I’m not sure people understand what implicit bias is.”*

*"I think we talk a lot about explicit bias, and I'm not entirely sure people understand the differences. We hear comments such as, 'Oh, I treat everyone the same.' I'm not sure that there's an understanding of why this kind of comment can be problematic and what the adverse health outcomes really are as a result of those types of comments. . . . I feel that with education and more assistance there would be an understanding of exactly what implicit bias is, what the adverse health outcomes of it are, and the disparate treatment that we may have."*

**Not incentivized.** Participants emphasized that in our current healthcare system, measures or processes to routinely and consistently assess for or remediate implicit bias in the context of quality improvement or performance improvement do not exist.

**Lack of or inconsistent data collection.** Data drives cancer care delivery and informs clinical decision-making. A participant questioned why the problem of implicit bias is not examined through the lens of research and looked at "with the same vigor" as a cancer treatment: identifying the problems, the solutions, and making that part of the facility's mission.

**Access and health literacy barriers.** Limited access to care and limited health literacy may stand in the way of patients asking questions and amplify patient fears of not getting the answers they need. Participants agreed that there is a need for cultural humility awareness so that the healthcare professionals better interact with patients, and in order to preempt unconscious biases.

Participants once more emphasized that as currently structured, our healthcare delivery system fails to incentivize health equity. A physician advocate participant commented:

*"As a provider I often get dinged because I see very high-risk complex patients, and I choose for them the care they need. But providers are rewarded for volume and bringing in dollars, and not the outcomes they give their patients . . . Nowhere in our healthcare system are there metrics for things like closing healthcare disparities and improving outcomes in the highest risk patients and in those who are medically underserved."*

## Future State

To reach an ideal state in terms of recognition, assessment, and mitigation of implicit bias, participants agreed that a culture change will be required. A participant who is a leader in diversity, inclusion, and community engagement put the challenge in context:

*"Our culture is really such a critical part. It is important to couch implicit bias within the context of institutional systemic racism. I think this has to be a multi-pronged approach. I'd also love to see us focusing in on what does it mean to actually change our culture. That is not just about educating people. . . . I would love to see people, through more bystander training, for example, learn how to not just address the work environment in general, but how to actually intervene when they see a micro-aggression happening in the workplace. And when we have a culture and a space in which people feel safe in being able to actually say as one of my white peers did—"Hey, that's not ok"—because we've shifted our culture so much that the onus doesn't rest on those of us who are in underrepresented groups to address it, but it actually becomes all of us."*

Participants described an ideal future for an equitable cancer care delivery system as:

- Less promoting of bias.
- More accountable. With accrediting bodies instituting requirements that healthcare professionals be prepared, through education and training, to care for patients with consideration for race, ethnicity, sexual and gender identity, disability, faith, and social determinants of health. [A participant noted that this requirement has already been established for the credentialing of PAs.]
- More reflective of the populations in the communities in which healthcare institutions are located, including more professional staff from those communities.
- Responsible for emphasizing implicit bias awareness as much as annual requirements to renew safety competencies (e.g., handwashing).

An empowering and safe place for providers, patients, and staff to confront racism and bias when they see it.

In the words of an advocate participant, the ideal future state would be: *“Cancer care in a world where cancer care is free of judgments based on our non-medical differences, but in which providers and systems are held accountable for their contributions, or lack thereof, to these improvements.”*

## Getting from Here to There: Action Steps

With the discussion momentum building, participants brainstormed how APs can embed acknowledging and mitigating implicit bias into their various cancer care delivery roles.

- **Make a start.** Every oncology AP can complete a self-assessment for implicit bias.
- **Be specific and intentional about our individual commitment to equity.** Whatever the AP’s role, there is an opportunity to advocate for equity as part of our organizational mission, our job descriptions, and our annual reviews.
- **Be ready to feel uncomfortable.** *“For change to happen, we have to be willing to admit that our research is inherently flawed,”* commented a participant. *“[We have to be willing] to break that down and examine what we would do differently the next time we put a research project together.”*
- **Advocate for all patients to receive a functional assessment so that cancer care providers can treat the “whole person.”**
- **Take a stand.** Acknowledging and mitigating implicit bias is a continuous process, participants agreed. APs can play a role in uniting oncology groups around this issue, in acknowledgment that implicit bias occurs and can negatively impact clinical outcomes, and in commitment to closing gaps that result as an unintended consequence of implicit bias.

- **Call for equity in medical professional curricula.** During Summit discussions, some participants shared their lived experience with biases embedded in professional education and training. Participants agreed that APs have a role in advocating for medical professional graduate programs to examine their curricula and take action to address explicitly and implicitly biased training, and to require that faculty be trained in implicit bias awareness. An additional call to action is for APs to encourage their professional organizations/societies to join in a collective statement of support for this action to graduate curriculum programs and accrediting/credentialing bodies.
- **Recommend equity be embedded in the definition of quality care,** e.g., “quality care equals equitable care.”
- **Join with leading oncology organizations to make the case for collaboration on equitable cancer care delivery** and raise the volume on equity as critical for the outcomes of all patients. Advocate collectively that equity be a required accreditation standard.
- **Request that your professional societies reserve space at events and in publications** for discussion of implicit bias education and equity in cancer care delivery. Advanced practitioners, together with professional organizations such as AAPA, ACCC, APSHO, Harborside, and others, can commit to publishing on these issues to help disseminate best practices in moving toward more equitable cancer care delivery.
- **Create a checklist to support a top-of-mind focus on equity.** An equity-focused checklist can serve as a low-cost, easily integrated (ideally into the EHR) tool that APs could use to support awareness of implicit bias. Summit participants recognized that implicit (or unconscious) bias exists in all human beings and is a consequence of how the human brain is hardwired. At the same time, awareness of the subtle ways in which implicit bias may affect equitable cancer care delivery through a process of regular self-assessment, intervention, and re-assessment is essential to effect change at the individual level.

## CONCLUSION

Across the three Summit sessions, common areas of concern and action emerged. Participants agreed that advancing equitable cancer care delivery will require commitment and engagement from the entire healthcare enterprise and a multi-pronged approach. Prioritizing health equity and ensuring that equity is recognized as synonymous with quality care will demand focused action on every level: individual, professional, cancer program, hospital, health system, and across all healthcare sectors (patients, providers, payers, and industry).

Oncology APs are an expanding workforce of highly trained professionals in diverse roles throughout the oncology care delivery system. Advanced practitioners fill positions in all areas of oncology and have opportunities to drive and foster engagement in elevating equity through personal education and action, leadership within professional organizations and their healthcare facilities, research and publications, and advocacy. However, APs' capacity for advancing equitable cancer care delivery will depend on factors outside of their direct control, including:

- Time to engage in this work
- Educational resources
- Recognition and requirements from accrediting bodies related to diversity, equity, and inclusion education and training
- Data, metrics, and tools to benchmark and measure progress
- Commitment from healthcare entities to assessment and evaluation of equitable care delivery as an ongoing process
- Support from professional societies and organizations
- Health system commitment to prioritizing diversity, equity, and inclusion.

Through engaged and thoughtful discussion, Summit participants not only identified paths forward toward improved equity in cancer care delivery, but also set out potential action steps for walking the walk.

## SUPPORTER ACKNOWLEDGMENT

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## APPENDIX B: Agendas

	<b>SUMMIT DAY 1: TUESDAY, MARCH 30</b>	<b>SUMMIT DAY 2: THURSDAY, APRIL 1</b>	<b>SUMMIT DAY 3: TUESDAY, APRIL 6</b>
	<b>Care Coordination &amp; Communication</b>	<b>Clinical Trials</b>	<b>Acknowledging &amp; Mitigating Implicit Bias</b>
	Presenter: Josh Epworth, MSN, ARNP	Presenter: Beth Faiman, PhD, MSN, APRN-BC, AOCN®, FAAN	Presenter: Soumya J. Niranjana, BPharm, MS, PhD
4:00 PM EST	Welcome & Group Introductions	Welcome & Group Introductions	Welcome & Group Introductions
4:30 PM EST	<b>Current State</b>	<b>Current State</b>	<b>Current State</b>
	Equity in Care Coordination & Communication	Equity in Clinical Trial Design, Conduct & Engagement	Acknowledging & Mitigating Implicit Bias in Cancer
5:05 PM EST	<b>Desired Future State</b>	<b>Desired Future State</b>	<b>Desired Future State</b>
	Promoting Health Literacy, Shared Decision-Making, & Care Transitions	Patient Engagement in Clinical Trials & Role of the Advanced Practitioner	Measuring Implicit Bias & the Role of the Advanced Practitioner in Reducing Bias
5:30 PM EST	<b>Action Planning</b>	<b>Action Planning</b>	<b>Action Planning</b>
	Activating Advanced Practitioners to Drive Equity Through Care Coordination	Strategies to Design & Conduct More Equitable Clinical Trials	Programs & Resources to Advance Equitable Access to Care
6:25 PM EST	Wrap-Up	Wrap-Up	Wrap-Up
6:30 PM EST	Adjourn	Adjourn	Adjourn

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