

# ASSOCIATION OF CANCER EXECUTIVES UPDATE

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## HAVE SOME NEWS TO SHARE?

Please send to Brian Mandrier at [brian@mandriergroup.com](mailto:brian@mandriergroup.com)



## Upcoming Events

### IOLC VIENNA 2023

Early-bird registration is now open! Lowest registration rates available till June 1<sup>st</sup>. Please visit the [IOLC website](#) for more information.

### ACE NASHVILLE 2024

Save the Date for the 30th ACE Annual Meeting to be held at the Grand Hyatt Nashville from February 4-6, 2024!



## Announcements & Reminders

### ACCEPTING NOMINATIONS!

Accepting nominations for the 6th Annual Marsha Fountain Award for Excellence in Oncology Administration. The award is reserved for nominees currently working in the oncology administration field. [Learn more here.](#)

### LOOKING FOR A NEW OPPORTUNITY?

Be sure to visit the [ACE Job Board](#).



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# ACE 2023 Recap: 3 Reasons to be Optimistic About Cancer Care

BY JOHN HANSEL

Health systems face no shortage of challenges right now, from financial to patient access to labor. But the Association of Cancer Executives 29th Annual Meeting showed there's a lot to be optimistic about in cancer care and prevention. Here are my three takeaways from #ACE2023:

## 1. A POPULATION HEALTH APPROACH TO CANCER PREVENTION IS DRIVING HIGHER VALUE CARE.

We heard from health system leaders like [Mike Koroscik, Vice President of Oncology at Allina Health Cancer Institute](#), who are partnering with payers to make cancer risk management part of their overall population health strategy. Health systems like Allina are working alongside payers to put quality metrics in place for cancer screening, align incentives around preventive care and invest in data analytics to better understand the risk profiles of their populations. Driven in part by the shift from volume to value, this strategy can help lower the cost of care, improve patient outcomes, and lay the foundation for long-term, sustainable preventive care programs.

## 2. CANCER CENTERS RECOGNIZE THE URGENT NEED FOR MORE EQUITABLE CANCER TREATMENT, PREVENTION AND EARLY DETECTION.

This was a theme that came through loud and clear: It's time for more equitable cancer care. [City of Hope Vice President and Chief Pharmacy Officer Wafa Samara](#) spoke to the disparities in access to cancer medications and the importance of connecting underserved patient populations to clinical innovation. [American Cancer Society CEO Karen Knudsen](#) also highlighted the long standing racial disparities in cancer screening. For example, [ACS data](#) shows Black people in the U.S. are most likely to be diagnosed with late stage cancers that have recommended screenings. This tells us that one-size-fits-all screening guidelines are allowing patients to fall through the cracks.

## 3. HEALTH SYSTEMS ARE TURNING TO CREATIVE LABOR SOLUTIONS AMID THE CURRENT STAFFING CRISIS.

[Meagan O'Neill of ECG Management Consultants](#) highlighted the significant challenge oncology providers are facing in

the wake of the Great Resignation. Many health systems are thinking outside-of-the-box to navigate patient care backlogs and ongoing labor shortages in this environment. For example, David Randall, Chief Strategy Officer of [UAB Medicine](#), shared how the Alabama health system is doubling down on specialized cancer navigation resources and digital tools to fill in the gaps. A major focus at UAB is to engage patients between appointments whenever possible, so that providers can get the most out of patient care time.

Recognizing these challenges, at CancerIQ we are committed to helping health systems connect every patient to the care they need to stay ahead of cancer. We are working to make comprehensive cancer risk assessments, which include genetic, hereditary, lifestyle and screening adherence risk factors, the norm. And we believe cross-sector collaboration and digital innovation can help ensure greater access to cancer prevention pathways for all patients. I'm excited to hear how many of these partnerships are already changing cancer care for the better.

John Hansel is SVP at [CancerIQ](#). Connect with him directly at [bd@canceriq.com](mailto:bd@canceriq.com) or learn more at [canceriq.com/oncology](https://canceriq.com/oncology).

# The Future of Cancer

BY RYAN LANGDALE, DIRECTOR AT CHARTIS AND SOPHIE CLAMON, ENGAGEMENT MANAGER AT CHARTIS

The healthcare industry is in a period of profound change. Policymakers, financial markets, and technology are working unpredictably and often at cross purpose. The cancer sector is subject to amplified disruption—driven, much like the disease, by unchecked and uncontrolled growth in disease prevalence, medical cost, and care model complexity.

For the 18 million Americans with cancer, it is a time of both optimism and concern. Artificial intelligence (AI) is identifying previously missed tumors. New drugs emerge monthly. Scientists are using the “C-word”—cure— as the potential of immunotherapy becomes fully understood. But there are serious challenges. Obesity and vaccine hesitancy threaten to undo decades of progress in prevention. New business models are fragmenting an already-fractured care model. And society’s health equity failures portend a devastating outcome in which many could lack access to next-generation cancer medicine.

Over the next 5 years, we expect these forces to begin remaking the cancer care ecosystem. Its participants—providers, payers, purchasers, and private capital—will array in ways previously unimaginable, shifting how cancer care is consumed, delivered, and financed. In this paper, we explore a few predictions on the nearterm

future of oncology—and what it will take for community and academic cancer centers to thrive in the ecosystem that is emerging.

## 1) PREVENTION AND TREATMENT ADVANCES WILL REDEFINE THE CANCER “CONSUMER”

Several interrelated forces are dramatically increasing demand for cancer care. The first is demographic—the Baby Boomer generation is aging into a high-risk window for cancer. New diagnoses are expected to grow to 2.5 million by the end of the decade, despite advancements in primary prevention. At the same time, people are living longer. Cancer mortality rates have fallen 30% over 20 years, and cancer survivors will number 22 million by 2030, generating immense demand for long-term surveillance.<sup>1</sup> These trends are augmented by a maturing understanding of hereditary and lifestyle-based cancer risk. As a result, providers are increasingly able to stratify the highest-risk population (or “pre-vivors”) and, in some cases, intervene to prevent or detect cancer at its earliest manifestation.

Taken together, these cohorts (pre-vivors, active cancer patients, and survivors) number in the tens of millions—representing a step change in the traditional population cared for by cancer

programs. Each segment represents a unique consumer, with distinct wants and needs that will need to be addressed by the cancer center of the future.

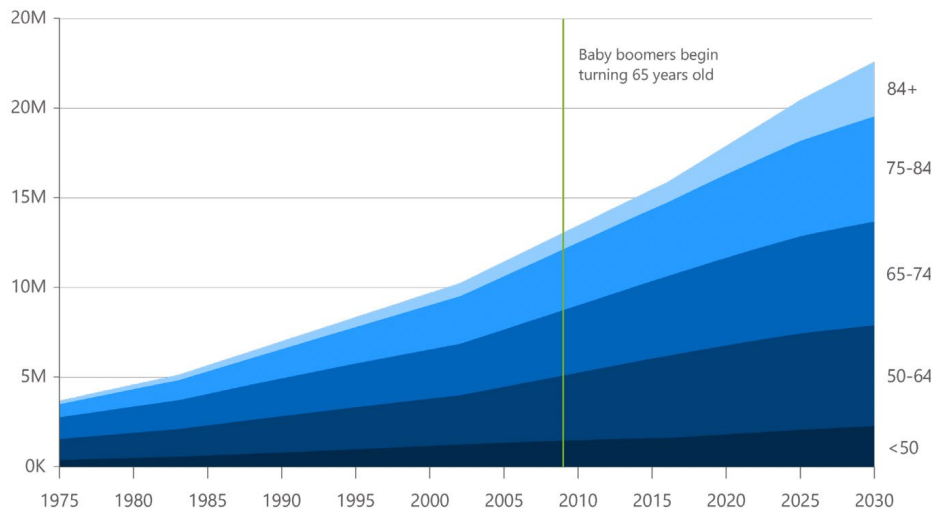
### FUTURE FORCE IN ONCOLOGY

- 1 Prevention and treatment advances will redefine the cancer “consumer”**
- 2 Rapid innovation will remake the requirements of contemporary care**
- 3 Unsustainable costs will prompt intervention across the value chain**
- 4 Traditional provider identities will blur, creating new ecosystems of care**
- 5 New entrants will accelerate disruption and innovation in the care continuum**

### WHAT CANCER CENTERS NEED TO DO

- Excel in the spaces before and after cancer, addressing the needs of millions of cancer “pre-vivors” and survivors.
- Build care models that reflect the complexity of the disease, capable of adapting to high-velocity clinical innovation.
- Diversify the business model and create value-based competence, preparing for challenges to today’s onco-economics.
- Redefine target patient segments and the role of partnerships in a marketplace of fungible community and academic roles.
- Assemble the expertise and capabilities required to modernize the experience of cancer care.

Figure 1: Cancer Survivors (1975-2030)<sup>2</sup>



Source: Adapted from Bluethmann SM, Mariotto AB, Rowland JH. "Anticipating the 'Silver Tsunami': Prevalence Trajectories and Comorbidity Burden Among Older Cancer Survivors in the United States." *Cancer Epidemiol Biomarkers Prev.* 2016 Jul;25(7):1029-36. doi: 10.1158/1055-9965.EPI-16-0133. PMID: 27371756; PMCID: PMC4933329.

## Cancer Centers Must Excel in the Spaces Before and After Cancer

While the core business of cancer treatment will continue to dominate in the near term, cancer centers should begin asking the existential question of what it means to instead be in the business of cancer prevention and chronic disease management. The requirements of that shift are immense. They include investment in upstream areas like community outreach, hereditary genetics, high-risk patient management, and screening assets. On the other end of the continuum, cancer centers will be required to reimagine the survivorship experience and the ways in which they interact with 22 million people in need of surveillance, medical management, and support in returning to health and normalcy.

As providers grow into these spaces—before and after cancer—they will encounter new consumer behavior, mirroring that of other chronic disease segments. For a growing subset of patients, quality will be assumed. Purchasing decisions will prioritize the importance of timeliness, ease of use, and agency as patients confront what could be a decades-long care experience. In certain cancer centers that serve narrow segments (generally AMC/ NCI), or lack meaningful alignment with primary care, the next few years will prove

especially critical. These organizations will need to broaden the aperture of their clinical focus and align the resources and partners needed to co-manage the growing population of cancer pre-vivors and survivors. Other cancer centers with strong primary care alignment and population health capability will be well positioned for growth as they leverage these assets in the emerging cancer care ecosystem.

## 2) RAPID INNOVATION WILL REMAKE THE REQUIREMENTS OF CONTEMPORARY CARE

We are in the early days of precision oncology's "Cambrian moment"—as our molecular and biologic understanding of cancer transform the ways we detect, classify, and eliminate tumors. At the nucleus of this change are new technologies capable of personalizing cancer care—including tools like blood-based early detection (e.g., GRAIL), AI-assisted radiology and pathology, predictive treatment modeling (e.g., "digital twins"), targeted therapeutics, radiopharmaceuticals, engineered T-cells, and cancer vaccines. These innovations, and many others, are elevating oncology's standard of care writ large and producing isolated but astonishing results, like 100% response rates to anti-PD-1 antibodies in "mismatch-repair deficient" rectal cancer

and decade-long leukemia remissions in CAR-T therapy.<sup>3,4</sup>

As these trends unfold, the world has changed for cancer centers. The disease has multiplied (as organ-based taxonomies give way to molecular subtypes). Adoption cycles have accelerated (evidenced by >120 programs with immune cellular therapy programs). Research has become more targeted (with >55% of clinical trials using biomarkers for eligibility). And information has increased exponentially (with an abundance of patient data and real-world evidence ready to be fed to emerging AI and machine learning platforms). Adapting to this new world will, of course, require modernization of cancer center resources and capabilities—but it will also demand new organizing frameworks to assemble physicians and researchers around complex diseases, and mechanisms to ensure leading practices are not confined to well-resourced settings.

## Cancer Centers Must Build Care Models that Reflect the Complexity of the Disease

As the arc of cancer medicine moves toward personalization, so too must the care model. In larger population centers, that means we will witness the passing of the "generalist" model—organized around discrete modalities and tumor-agnostic programs and expertise. Like their academic peers, community centers must undergo a transformation toward tumor-specific service lines, brought to life through multidisciplinary interactions among physicians with highly specific expertise.

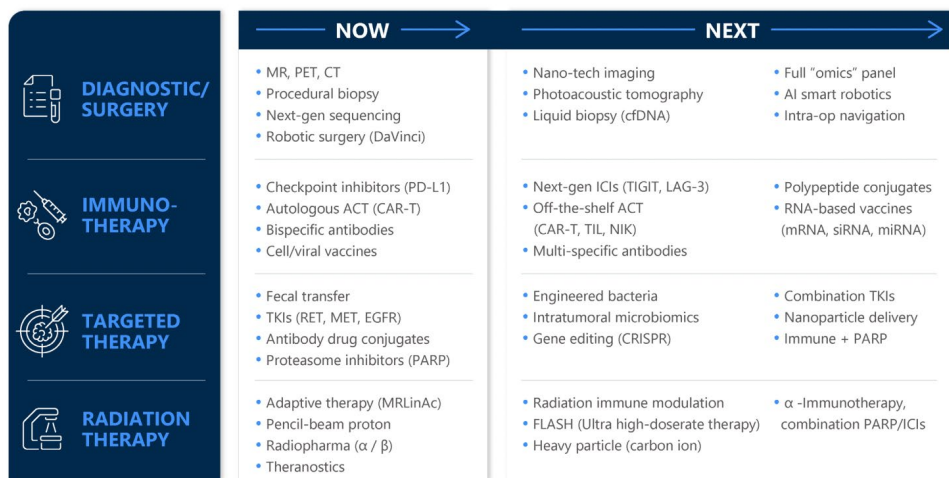
Evolution will be forced by a savvy consumer, seeking providers that specialize in "their cancer," and by the practical limitations of remaining a generalist as the body of cancer knowledge continues to expand. In small communities and rural settings, the importance of interconnectivity with sub-specialized hubs will be critical as generalists collaborate with colleagues through virtual second opinions, remote tumor conferences, and decision support systems that disseminate contemporary guidelines for disease-specific care. In larger environments, practical planning

dilemmas will need to be overcome—like the volume/scale thresholds required to sustain subspecialists, care team efficiency in multidisciplinary settings, the impact of sub-specialization on productivity-based compensation models, and continuous reexamination of the capabilities needed in each tumor program to remain on the vanguard of clinical care and research.

### 3) UNSUSTAINABLE COSTS WILL PROMPT INTERVENTION ACROSS THE VALUE CHAIN

The cost of cancer care is tremendous. Spend among payers totaled \$211 billion in 2022, or 7% of total healthcare expense, and is expected to grow to more than \$300 billion by 2030. For the individual patient, cost in the first year of cancer therapy often exceeds median U.S. household income.<sup>6</sup> The key drivers of this cost include market prices for cancer drugs (which are 7 times the cost they were 20 years ago); mark-up on those prices (frequently exceeding 200% in hospital-based settings); and

Figure 2: Precision Oncology Roadmap<sup>5</sup>



broader disutility and unwarranted care that accumulate across a frequently unmanaged and fractured cancer care episode.<sup>7</sup>

Multiple stakeholders are challenging the unsustainable trajectory of cancer cost. The Centers for Medicare and

Medicaid Services is pursuing drug pricing reform through direct negotiation with manufacturers (enabled through the Inflation Reduction Act of 2022), 340B payment changes, and voluntary risk-sharing arrangements on total cost of care (e.g., the Enhanced Oncology Model launching in 2023). Commercial

## WELCOME

Welcome to our new members & renewal members since January 1, 2023. We are thrilled to have you be a part of the ACE!

**Charles Nash, M.D.** Medical Director of Oncology Services and Medical Director of Research, Northeast Georgia Medical Center

**Micheal Silver,** Senior Director, Cancer Center Operations, Fox Chase Cancer Center

**Brenda Brown, RN, MSN, OCN,** NEA-BC, Administrative Director, MD Anderson Cancer Center

**Brittany Cook, MBA,** Sys VP Adult and Pediatric Cancer Svc Ln Support Services, Norton Cancer Institute

**Leanne Mendoza,** Business Process Optimization Manager, John Muir Health

**Kristin Mensonides, MHA, MLS, FACHE,** Executive Director, Integrated Service Lines, UC Davis Health

**Susie O'Neill, MSN, RN, OCN,** Executive Director of Oncology, Southern Illinois Healthcare

**Regina Hinkle, MBA,** Director, Cancer Support Services, St. Luke's University Health Network

**Fran Spine,** Administrative Director, Premier Oncology Hematology Management Society

**Jaime Reiter, RN,** Vice President/Assoc Chief Nursing Officer Clinical Network, City of Hope

**Sara Caiazza, MHA, BSN, RN,** CENP, Vice President Patient Care Services Associate Chief Nursing Officer, City of Hope

**Angela Quick, MS,** Director of Cancer Services, HSHS Sacred Heart Hospital/Prevea Health

**Cynthia Gaddy, RN, MBA, BSN, FACHE,** CENP, Executive Director of Oncology, Titus Regional Medical Center

**Greg Green,** Director, Business Development, Memorial Sloan Kettering Cancer Center

**Suzanne Hennis,** Director of Oncology Operations for MedStar Southern Maryland Hospital Center and MedStar Saint Mary's Hospital, MedStar Georgetown Cancer Institute

**Susan Ganz,** Vice President of Enterprise Support Operations and Planning, City of Hope National Medical Center

**Bridget LeGrazie, RN, MSN, APN, c.,** AGN-BC, AVP Oncology Service Line, Virtua Health

**Michael McDowell,** Client Executive, Value-Based RCM

**Laura Godel, PMP, LSBB, CSM,** VP Oncology Services, Sarah Cannon Cancer Institute at Centennial Medical Center

payers are seeking to control spend through infusion site-of-service mandates, specialty pharmacy requirements like white bagging (which nearly doubled between 2019 and 2022), narrow networks, and owned “payvider” capacity (e.g., Optum Cancer Centers).<sup>8</sup> Large employers are also taking an active role, directly contracting in high-spend areas like cancer and seeking out fixed-price agreements for certain early stage cancers like those being facilitated through Carrum Health at Memorial Sloan Kettering Cancer Center (MSKCC), City of Hope, and the University of Chicago.

### Cancer Centers Must Diversify the Business Model and Build Value-Based Competencies

Cancer programs face the classic dilemma of disrupt or be disrupted as site-of-care pressures mount on ancillaries like imaging, infusion, and radiotherapy. The threat is most imminent in infusion, directed by private equity (e.g., Vivo Infusion), home-based platforms (e.g., CVS Coram), payer-owned infusion (e.g., United Optum), and oncology physician practice management models (PPMs) (e.g., One Oncology). In the near term, cancer centers will need a multi-pronged strategy that protects the medically necessary (and financially critical) hospitalbased setting, while simultaneously building or partnering in infrastructure that can retain infusion directed to ambulatory and home-based settings.

In addition to site-of-care diversification, building competencies to succeed under valuebased contracting will be important, including things like patient reported outcomes, clinical pathways, end-to-end care coordination, financial counseling, symptom management, and early palliative intervention. These tools require investment unlikely to be offset by additional reimbursement but critical to shaping a value proposition for risk-bearing entities. Investment will be especially critical in high-resource settings (e.g., freestanding cancer hospitals) as purchasers begin placing the burden of proof on them to demonstrate whether there is a quality or long-term cost advantage associated with being treated in their ecosystems.

### 4) TRADITIONAL PROVIDER IDENTITIES WILL BLUR, CREATING NEW ECOSYSTEMS OF CARE

Consolidation in healthcare has been prolific over the past decade. Nearly 70% of hospitals have joined health systems, and more than 1,000 oncology practices have been acquired.<sup>9,10</sup> A byproduct of this consolidation is community cancer programs that have an equal or greater scale than NCI-designated centers (e.g., Atrium Health, Providence, Intermountain Health, Inova Health System, and Northwell Health). Many of these organizations have invested heavily in tertiary/quaternary services and early phase clinical trials, altering the

balance between traditional academic and community roles, and challenging long-held market beliefs about the appropriate destination for complex care and research. At the same time, NCI centers have begun expanding regionally into community hospital backyards with owned and partnered assets. Places like MSKCC report delivering 60% to 70% of infusion and radiotherapy volume at regional sites, rather than on the main campus in Manhattan.<sup>11</sup> This decentralization of the NCI center is both a signal of the new competitive environment (i.e., the need to compete in the community) and an acknowledgment of the premium patients place on close-to-home access for cancer care.

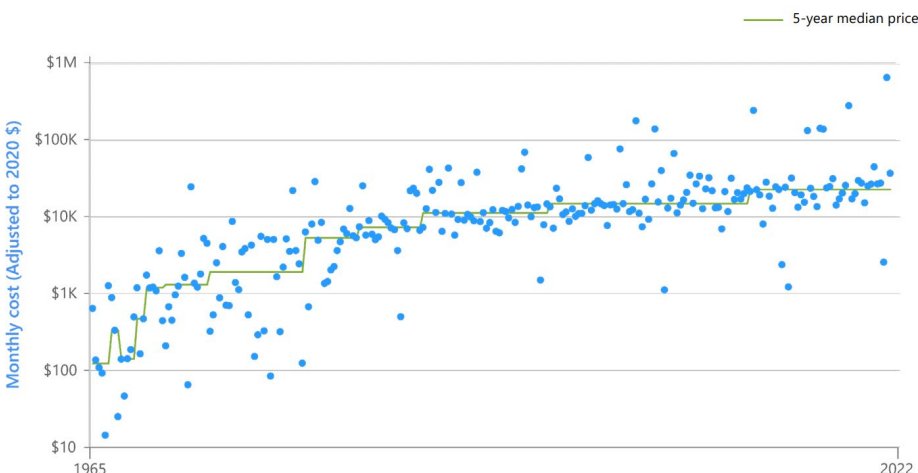
The dual effect of community scale and academic expansion is an erosion of the constructs by which NCI centers and community hospitals have traditionally collaborated. That model—fashioned around co-branding, aligned quality standards, and fast-track referral—no longer serves the needs of sophisticated community sites or academic centers in need of a diversified customer base. In coming years, we expect a rewrite of the strategic playbook for NCI centers to include new forms of community partnership, predicated on higherfidelity clinical integration and strategic/financial alignment.

### Cancer Centers Must Redefine Target Patient Segments and Reimagine the Role of Partnerships

The emergence of consolidated and scaled community competitors will require NCI centers to revisit the fundamentals of their delivery models. That includes rationalizing their target patient segments—classically skewed toward high-complexity cancers—and competing more intentionally in earlier-stage, higher-incidence tumors. This urgency is evident in campaigns from places like Dana-Farber that emphasize “when it comes to cancer, it matters where you start.” This reenforces the prerogative to be in the business of diagnostics, front-line therapy, and common cancer subtypes.

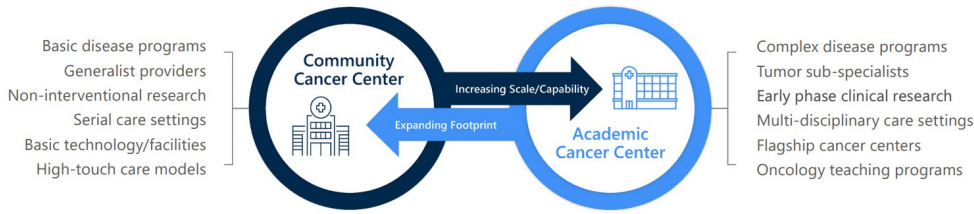
A key requirement of serving these segments will be decentralization of the cancer center, pushing closer to where patients live. That decentralization may

Figure 3: Monthly and Median Cancer Drug Cost 1965-2022



Source: Chartis review of therapeutics & monthly & median costs of cancer drugs at the time of FDA approval from Drug Pricing Lab <https://www.drugpricinglab.org/issue/launch-price-tracker/>

Figure 4: Convergence of Cancer Roles



resemble the constellation of owned satellites around places like the Siteman Cancer Center in St. Louis or Johns Hopkins in Baltimore; the co-managed and virtually merged cancer service lines between UCSF Health and John Muir Health, and between Stanford Medicine and Sutter Health; or the national footprints assembled by MD Anderson Cancer Center’s recently narrowed Partner network, Dana-Farber’s southward expansion with Christ Hospital in Cincinnati, or City of Hope’s acquisition and integration of Cancer Treatment Centers of America. These examples all represent variations on the same theme—modern network strategies for an increasingly decentralized and role-fungible cancer industry.

### 5) NEW ENTRANTS WILL ACCELERATE DISRUPTION AND INNOVATION IN THE CARE CONTINUUM

For decades, the cancer care model has been constructed around physical hospital assets and a sequentially discrete value chain. These dynamics are being challenged as nontraditional entrants, often backed by private capital, bring to market innovative care models and point solutions that alleviate common friction in the cancer continuum. These players include modernized practice models and physical care environments (e.g., Solis Mammography, Oncology Care Partners) as well as digitally native solutions that span the cancer continuum (e.g., Thyme Care’s virtual care coordinators and Reimagine Care’s digital platform for cancer care at home, Figure 5). Collectively, these new entrants are setting the pace for care model innovation and, in some cases, disintermediating traditional cancer center consumer relationships and business lines.

The response from incumbent cancer providers to industry disruption has been mixed and market dependent. Many are relying on reputation and referring channel relationships to box out would-be competitors and taking a wait-and-see approach to site-of-care diversification or a full embrace of the digital cancer care experience. Others are disrupting the status quo by “sharing the ground” with nontraditional providers—including literal examples like One Oncology and US Oncology’s co-habitation with MSKCC in Brooklyn and University of Colorado (UC) in Longmont, respectively—or adopting a fail-fast mentality to site-of-care innovation—like Intermountain Health and Sprinter Health’s mobile lab draw pilot and UC and Reimagine Care’s digitally enabled home-based care model for complex bone marrow transplants.

### Cancer Centers Must Modernize the Care Experience

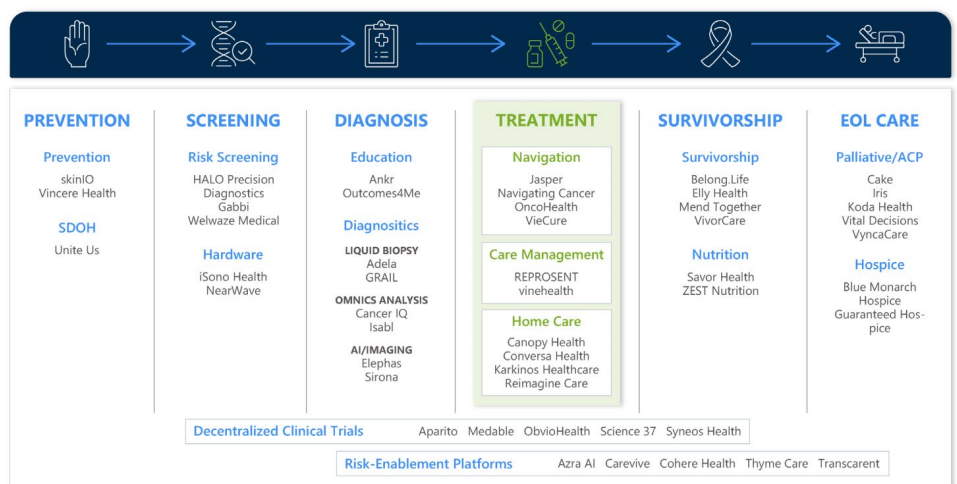
While disruption will manifest in different timeframes across different markets, relying on structural market advantages to protect share in outdated cancer care

models will not be a winning strategy over the long term. Cancer centers need to look inward and candidly assess their patient experiences, understanding where they meet, exceed, or fall short of those offered by new entrants in the space. The results of this introspection may lead some toward partnership with erstwhile competitors in areas like diagnostics, chemotherapy at home, etc. Others may choose to transform from within—building or buying the tools capable of modernizing their care models, including end-to-end navigation, remote monitoring and symptom management, and virtual-first supportive care. In this swirl of innovation and unorthodox collaborations, it will be critical for cancer centers to discern which solutions add real value and reduce complexity—by listening to the consumer. They also will need to assemble the expertise to determine where innovation intersects with patient needs and ensure that multivendor, multipartner ecosystems are not reductive to the goal of a frictionless and seamless patient journey.

### BUILDING A FUTURE FOR ALL

As the future trends in this report manifest—growing demand, rapid innovation, and unsustainable cost—there is material risk that existing inequities in cancer care will be made worse. At baseline, the disparities are sobering: cancer mortality rates are 13% higher for Black versus white patients; uninsured women are 33% less likely to have routine breast screening; and Black

Figure 5: Cancer’s Digital Health/Enablement Ecosystem<sup>12</sup>



Source: Inventory of digital enablement partially sourced from Flare Capital

and Hispanic patients are 3.4 times less represented in clinical trials.<sup>13,14</sup>

The challenge of the decade for cancer centers will be to ensure equitable access to preventative, and potentially curative, cancer medicine. These aims are a major focus of the Biden Administration's renewed Cancer Moonshot—specifically in reducing cancer screening disparities. It is also the focus of the U.S. Food and Drug Administration's Project Equity, which requires clinical trials data submitted for new drug approvals to mirror the demographic diversity of the intended patients.<sup>15</sup>

But the real work of cancer health equity will not be at the federal level—it will be in local communities. We expect that work to look like Cone Health's online transportation assistance program, the Levine Cancer Institute's Financial Toxicity Tumor Board, St. Elizabeth Healthcare's lung cancer screening and rural outreach, and the University of Chicago's OCECHE program to promote Black participation in clinical trials, to name a few.

## SUCCEEDING IN THE ECOSYSTEM THAT EMERGES

The future of cancer care will be a story of rapid clinical innovation, managing the cost of that innovation, and a reshuffling of roles in the oncology industry. The implications for today's providers are clear:

- Expand services that accommodate the needs of millions of cancer pre-vivors, patients, and survivors.
- Remake care models that accommodate the pace and complexity of clinical innovation.
- Diversify the business model and build value-based competencies.

- Redefine strategy in a marketplace of fungible provider, payer, and private capital roles.
- Modernize the patient experience, ensuring care model innovation is guided by the voice of the consumer.
- Ensure the promises of tomorrow's cancer ecosystem are accessible to everyone, in equal measure.

Succeeding in these aims will require balance as cancer centers seek to reposition themselves for tomorrow's relevancy while maintaining today's viability. Navigating this duality will require cancer leaders to create time and space for planning. It will require an openness to exploring new solutions, often through new forms of collaboration. And it will demand dexterity, as the cancer industry—like its namesake—continues to evolve in complexity, develop resistance to traditional solutions, and command our most innovative thinking to build toward a brighter future for cancer care.

Read the [original article here](#).

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## HAVE SOME NEWS TO SHARE?

Please send to Brian Mandrier at [brian@mandriergroup.com](mailto:brian@mandriergroup.com) or tag us on social!





# Benefits of an Early Mobility Program for Hospitalized Patients With Cancer

BY JULIA H. ARONSON, MD;<sup>1</sup> OLIVIA S. ALLEN, MS;<sup>2</sup> ASEM BERKALIEVA, MS;<sup>3,4</sup> MADHU MAZUMDAR, PHD;<sup>5,6</sup> KSENIA GORBENKO, PHD;<sup>3,6</sup> MELISSA GUNNING, PT, MBA;<sup>7</sup> MARK LIU, MHA;<sup>4</sup> CAROL KISSWANY, MHA, MS;<sup>4</sup> AARTI BHARDWAJ, MD;<sup>8</sup> AND CARDINALE B. SMITH, MD, PHD<sup>4,8</sup>

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## ABSTRACT

### Purpose

Patients with cancer are often hospitalized with complications from cancer and cancer treatment. Many experience a decline in physical functioning, including loss of mobility, which likely contributes to increased length of stay (LOS) and increased readmissions. We aimed to determine whether a mobility program would improve quality of care and decrease health care utilization.

### Methods

We implemented a mobility aide program on an oncology unit in a large academic medical center for all patients without bedrest orders between October 1, 2018, and February 28, 2021. The program consisted of nursing evaluation using the Activity Measure for Post-Acute Care (AMPAC), an ordinal scale ranging from bed rest to ambulating  $\geq 250$  feet, to quantify mobility. Plan of care was determined in a multidisciplinary manner with physical therapy (PT), nursing, and a mobility aide, who is a medical assistant with enhanced rehabilitation training. Patients were then mobilized two times per day 7 days a week. Using descriptive statistics and mixed effects logistic regression, we evaluated the programs impact on LOS, readmissions, and changes in mobility during this time period compared with the 6-month interval before implementation.

### Results

A total of 1,496 hospitalized patients were identified. The odds of hospital readmission within 30 days of discharge was significantly less for those who received the intervention (OR, 0.53; 95% CI, 0.37 to 0.78;  $P = .001$ ). The odds ratio (OR) of having a final AMPAC score at or above the median was significantly higher for those who received the intervention (OR, 1.60; 95% CI, 1.04 to 2.45;  $P < .05$ ). There was no significant difference in LOS.

### Conclusion

Use of this mobility program resulted in a significant decrease in readmissions and maintained or improved patients' mobility. This demonstrates that non-PT professionals can effectively mobilize hospitalized patients with cancer, thereby decreasing the burden on PT and nursing resources. Future work will evaluate the sustainability of the program and evaluate association with health care costs.

## BACKGROUND

Hospitalized patients are at risk for functional decline because of bed rest and limited mobility.<sup>1</sup> As many patients fail to return to their prehospitalization levels of mobility, increasing patients' mobility during their hospital stay represents a key opportunity to prevent functional decline in both the short term and long term.<sup>2</sup> Furthermore, mobility loss can significantly alter patients' well-being, independence, and quality of life. In fact, a study showed that more than 33% of adults age 70 years and older were discharged from the hospital with a major disability they did not have before admission.<sup>3</sup>

Research indicates that patients derive numerous benefits from mobility interventions during their hospital stays. For instance, in the hospitalized general medicine patient population, a multidisciplinary mobility promotion intervention was associated with improved mobility during and after patients' hospital stays.<sup>4</sup> In an early active mobility pilot study in the medical intensive care unit (MICU), patients experienced statistically significant decreases in hospital-acquired pressure ulcer rate, hospital readmission rates, and length of stay (LOS).<sup>5</sup> In addition to improved patient outcomes, studies suggest that mobility interventions may decrease hospital costs and improve efficiency.<sup>6</sup> With these findings, it remains

clear that promoting early mobility may enhance patient outcomes.

However, there is minimal research implementing and evaluating early mobility interventions for hospitalized patients with cancer. Patients with cancer are often hospitalized with complications from both cancer and cancer treatment. During extended hospital stays, they are at a higher risk for declines in functional status, which likely contributes to increases in LOS and readmissions.<sup>7</sup> With the limited availability of physical therapists and increased demands on bedside nurses presenting an additional challenge, innovative solutions are needed to improve mobility and help prevent functional decline in the population of patients with cancer. In this study, we evaluated the effects of an early mobility program facilitated by medical assistants on health care utilization and level of mobility at discharge for hospitalized patients with cancer.

## CONTEXT

### Key Objective

To determine whether a mobility program would improve quality of care and decrease health care utilization.

### Knowledge Generated

Use of this mobility program resulted in a significant decrease in readmissions and maintained or improved patients' mobility.

### Relevance

This study demonstrated that non-physical therapy (PT) professionals can effectively mobilize hospitalized patients with cancer, thereby decreasing the burden on PT and nursing resources. Future work will evaluate the sustainability of the program and its association with health care costs.

## METHODS

In this prospective pre-post study, all adult patients with a cancer diagnosis admitted to the inpatient oncology units at the Mount Sinai Hospital in New York City were identified and considered eligible for the mobility aide program. Data were collected between October 1, 2018, and February 28, 2021, using a single electronic medical record (EMR; EPIC). Each patient on the unit had an Activity Measure for Post-Acute Care (AMPAC) assessment at the time of admission, at least once daily during their hospitalization, and at discharge completed by the nurse assigned to them for that shift. The previously validated AMPAC consists of six brief questions that measure functional limitations in mobility by quantifying the level of assistance a patient requires to perform daily mobility activities.<sup>8</sup> Each question is evaluated on a 4-point ordinal score, resulting in summative scores as high as 24, indicating no assistance required to mobilize, and as low as 6, indicating complete dependence on another person to mobilize. The AMPAC questionnaire is shown in Table 1. We used a mobility aide to perform the intervention. The mobility aide is a medical assistant who received a 2-week enhanced rehabilitation training from physical therapists as part of the Department of Physical Medicine and Rehabilitation onboarding program to safely and effectively mobilize patients. Training included safe patient handling techniques, body mechanics training to reduce risk of injury, and an overview of equipment and assistive devices (ie, mechanical lifts, walkers) that may be used to facilitate transfers out of bed and

ambulation. Mobility aides also received training on basic clinical thresholds for safe activity, including vital signs and laboratory values. Daily huddles consisting of mobility aides, physical therapists, and frontline nurses were conducted to review each patient and determine which patients were most appropriate for mobility aide intervention on the basis of AMPAC scoring. Patients with AMPAC scores <24 qualified for the intervention. Eligible patients were mobilized a minimum of two times per day, 7 days per week. The mobilization itself was tailored to each patient and their specific mobility level, ranging from exercises in bed to ambulation, on the basis of their specific mobility limitations as identified in the AMPAC questionnaire. Each patient session with a mobility aide lasted anywhere from 15 to 30 minutes depending on the level of patient ability.

Sociodemographic data including race, ethnicity, sex, marital status, BMI, and insurance type were collected using a report generated from the EMR. Similarly, we collected information on admitting diagnoses that were grouped into the following four categories: hematological malignancy, solid tumor malignancy, active treatment and treatment side effects, and noncancer-related diagnoses. In terms of mobility data, we collected information on the first and last AMPAC score and documentation from the mobility aide about each patient's movement, including the number of attempts to perform certain actions. Additionally, we collected information on LOS, 30-day readmission status, systemic treatment administration (ie,

chemotherapy, immunotherapy) during hospitalization (yes/no), comorbidities, fall risk, and disposition. Comorbidities were reported as an Agency for Healthcare Research and Quality (AHRQ)-weighted Elixhauser Comorbidity Index (weights range from 27 to 112 with higher scores indicating higher mortality risk).<sup>9,10</sup> Fall risk was determined by the Morse Fall Scale, a validated metric that assesses a patient's risk for falling and completed by nursing on patient admission.<sup>11</sup> Although the metric varies by hospital system, the universal theme of the assessment tool identifies patients with higher scores as those with a greater fall risk compared with patients with lower scores having a lesser fall risk. Disposition, defined as a patient's anticipated living arrangements and medical-related needs on discharge from the hospital, was classified as home, rehabilitation facility, long-term care facility, institutional transfer, hospice care whether at home or a facility, and death.

We excluded patients who met any of the following criteria: patients who were admitted between March 23, 2020, and May 26, 2020, during which time the inpatient oncology units were temporarily converted into COVID-19 treatment units, and all patients with an order for bed rest at any time during hospitalization who were therefore unable to participate in the mobility intervention.

### Assessments

Our primary end points included the change in AMPAC score from the time of admission to discharge, LOS (number of days from admission to discharge), and 30-day readmission (any unplanned readmission within 30 days of the index

**TABLE 1.** AMPAC Questionnaire With Scoring

AMPAC Questionnaire	Unable	A Lot	A Little	None
How much difficulty does the patient currently have?				
Turning over in bed (including adjusting bedclothes, sheets, and blankets)?	1	2	3	4
Sitting down on and standing up from a chair with arms (eg, wheelchair, bedside commode, etc)?	1	2	3	4
Moving from lying on back to sitting on the side of the bed?	1	2	3	4
How much help from another person does the patient currently need?				
Moving to and from a bed to a chair (including a wheelchair)?	1	2	3	4
To walk in hospital room?	1	2	3	4
Climbing three to five steps with a railing?	1	2	3	4

Abbreviation: AMPAC, Activity Measure for Post-Acute Care.

admission) among the preintervention group (October 2018-March 2019) and the intervention group (April 2019-February 2021). An assessment of disposition on discharge after initial admission was included, in addition to the number of days to hospital readmission.

### Statistical Analysis

Baseline characteristics of patients who did and did not receive the mobility intervention were assessed using descriptive statistics. We calculated the standardized mean difference (SMD), which compares the difference in means/prevalence between treatment groups (baseline v intervention) in units of standard deviation.<sup>12</sup> Mixed effects logistic regression was applied to the data to assess the association between the final AMPAC score and the mobility aide's intervention. A median cutpoint was used to dichotomize the final AMPAC score into two groups: at or above the median versus below. This was done to prevent

model violations, which arose when using a continuous outcome under various distribution parameters. Nested random effects were incorporated to account for multiple mobility aide visits per inpatient hospital visit, as well as multiple inpatient visits per patient. LOS and 30-day readmission were also assessed using mixed effects logistic regression. LOS was similarly dichotomized using the median cutpoint, and random effects were incorporated for multiple visits per patient. The choice of logistic regression was driven by both the question at hand and data distributions. We controlled for age, sex, race, ethnicity, BMI, primary payer, admission diagnosis, AHRQ-weighted Elixhauser score, systemic treatment administration, and Morse fall risk. Statistical reporting was prepared according to the SAMPL guidelines.<sup>13</sup> All analyses were performed using R version 4.0.3.<sup>14</sup> The Icahn School of Medicine at Mount Sinai's Institutional Review Board reviewed and approved this study.

## RESULTS

A total of 1,496 hospitalized patients were identified, including 212 (14.2%) during the baseline period and 1,284 (85.8%) during the intervention. There were no significant SMD differences between the intervention and baseline groups (Table 2). Approximately half of all patients were age 65 years and older (SMD 5 0.08), greater than half identified as a minoritized group (Black and/or Hispanic; SMD 5 0.23), Medicaid was the primary payer (SMD 5 0.09), > 70% of patients had a high mortality risk on the Elixhauser Comorbidity Index (SMD50.31), and there was no difference in fall risk (SMD 5 0.10). There was no significant difference in the proportion of patients receiving systemic treatment during hospitalization (SMD 5 0.24). Nearly 90% of patients were discharged home (SMD 5 0.13).

The adjusted associations between the intervention and outcomes are shown in Table 3. The odds ratio (OR) of having

**TABLE 2.** Characteristics of Patients in the Baseline and Intervention Period

Characteristic	Baseline (October 2018-March 2019)	Intervention (April 2019-February 2021)	SMD
No. of patients hospitalized (N)	212	1,284	
Inpatient stays per patient (%)			0.08 <sup>c</sup>
Patients with 1 stay	175 (82)	1,094 (85)	
Patients with 2 stays	29 (14)	144 (11)	
Patients with 3+ stays	8 (4)	46 (4)	
Female (No. %)	118 (56)	633 (49)	0.13
Age, <sup>a</sup> years, No. (%)			0.22
Younger than 65	106 (50)	598 (47)	
65-74	67 (32)	366 (29)	
75-84	33 (16)	227 (18)	
85 and older	6 (3)	93 (7)	
Race, No. (%)			0.23
White	60 (28)	391 (31)	
Black	64 (30)	337 (26)	
Asian	19 (9)	90 (7)	
Others	69 (33)	441 (34)	
Not reported	0 (0)	25 (2)	
Ethnicity, No. (%)			0.19
Hispanic	63 (30)	365 (28)	
Not Hispanic	142 (67)	821 (64)	
Not reported	7 (3)	98 (8)	
BMI			0.07
<18.5	14 (7)	84 (7)	
18.5-24.9	91 (43)	525 (41)	
25-29.9	63 (30)	371 (29)	
≥30	44 (21)	304 (24)	
Primary payer, No. (%)			0.09
Commercial/managed care	65 (31)	351 (27)	
Medicaid	94 (44)	583 (45)	
Medicare	50 (24)	337 (26)	
Others/unreported	3 (1)	13 (1)	
Elixhauser Comorbidity Index, No. (%)			0.31
<0	2 (1)	91 (7)	
0	22 (10)	169 (13)	
1-4	7 (3)	73 (6)	
5+	181 (86)	951 (74)	
Morse fall risk, No. (%)	137 (65)	887 (69)	0.10
Admitting diagnosis, No. (%)			0.45
Hematological	81 (38)	366 (29)	
Treatment/side effects	33 (16)	111 (9)	
Solid tumors	72 (34)	449 (35)	
Noncancer-related	26 (12)	358 (28)	

(continued in next column)

**TABLE 2.** Characteristics of Patients in the Baseline and Intervention Period (continued)

Characteristic	Baseline (October 2018-March 2019)	Intervention (April 2019-February 2021)	SMD
Systemic treatment, No. (%)	50 (24)	184 (14)	0.24
Disposition, <sup>b</sup> No. (%)			0.13
Home	191 (90)	1,011 (87)	
Rehabilitation	6 (3)	54 (5)	
Institution transfer	5 (2)	39 (3)	
Hospice	3 (1)	26 (2)	
Miscellaneous	7 (3)	39 (3)	

Abbreviation: SMD, standardized mean difference.

<sup>a</sup>Age is calculated as of 2021.

<sup>b</sup>One hundred fifteen patients had an unknown disposition at their last visit. These data were excluded from the frequency calculation.

<sup>c</sup>SMD values < 0.10 are considered minor differences.<sup>15</sup>

a final AMPAC score at or above the median for the patients who participated in the mobility aide intervention was significantly higher than those who did not receive the intervention (OR, 1.60; 95% CI, 1.04 to 2.45; P < .05). The odds of hospital readmission within 30 days of discharge was significantly less for those who received the intervention (OR, 0.53; 95% CI, 0.37 to 0.78; P5.001). The average LOS for patients in the intervention group was 6 days with a range of 4-11 days, compared with the baseline group which was 6 days with a range of 4-10 days. The odds of having an inpatient hospital visit with a LOS at or above the median (6 days) for those with the intervention compared with those without the intervention was 0.78 (95% CI, 0.57 to 1.05; P 5 .11), although this value was not significant.

## DISCUSSION

In this study involving hospitalized patients with a cancer diagnosis, we demonstrated that a mobility aide intervention was associated with a significant maintenance or increase in functional ability at the time of hospital discharge and a significant reduction in hospital readmissions. This study is the first to our knowledge to focus distinctively on hospitalized patients with cancer and demonstrates an improvement in mobility and utilization.

Hospitalized patients with cancer tend to experience a significant decline in physical movement throughout their hospital course, which, in turn, leads to a slower recovery and decline in functional capacity.<sup>16</sup> This decline in functional capacity has been shown to correlate with the length of time a patient is admitted to the hospital and the frequency of which a patient is admitted.<sup>17</sup> One week of physical inactivity for hospitalized patients translates to approximately a 12% loss of muscle strength and approximately a 50% loss after 3-5 weeks.<sup>18</sup> With this dramatic loss, return to preadmission level of functioning is challenging and, therefore, contributes to the amount of time patients stay in the hospital. Given this drastic decline in functional capacity for hospitalized patients, physical

**TABLE 3.** Logistic Regression Analysis for Final AMPAC Score, LOS, and Readmissions

Logistic Regression Analysis	Odds Ratio	95% CI	P
Final AMPAC score <sup>a,b</sup>	1.60	1.04 to 2.45	<.05
30-day readmission <sup>c,d</sup>	0.53	0.37 to 0.78	.001
LOS <sup>c,e</sup>	0.78	0.57 to 1.05	.11

Abbreviations: AHRQ, Agency for Healthcare Research and Quality; AMPAC, Activity Measure for Post-Acute Care; LOS, length of stay; OR, odds ratio.

<sup>a</sup>Controlled for first AMPAC score, age, sex, race, ethnicity; BMI, primary payer, cancer diagnosis, AHRQ-weighted Elixhauser score, receipt of systemic treatment, Morse fall risk, LOS, and 30-day readmission.

<sup>b</sup>Total sample size = 2,055 visits from mobility aide. Total of 1,094 visits with final AMPAC score  $\geq$  median and 961 visits with final AMPAC score < median.

<sup>c</sup>Controlled for age, sex, race, ethnicity, BMI, primary payer, cancer diagnosis, AHRQ-weighted Elixhauser score, receipt of systemic treatment, and Morse fall risk. Total sample size = 1,806 visits.

<sup>d</sup>Total of 261 stays with 30-day readmission and 1,545 stays without.

<sup>e</sup>Total of 1,010 stays with LOS  $\geq$  median and 796 stays with LOS < median.

rehabilitation has become a mainstay component of hospitalizations.

Several randomized controlled trials with postoperative, critically ill, and older patients have established that early physical rehabilitation improves functional capacity, pain control, and overall quality of life.<sup>19,20</sup> One study demonstrated that of 42 critically ill patients with a cancer diagnosis and admitted to the intensive care unit, there was a significant increase in functional status of patients who participated in early mobilization activities (average score of 7 of 7 indicating full independence) compared with those who participated in baseline physical therapy (PT) activities (average score of 4 of 7 indicating moderate assistance required).<sup>20</sup> Given that hospitalized patients with a cancer diagnosis often require prolonged hospital stays with an average duration of approximately 9 days, their level of functional capacity on hospital discharge is generally significantly reduced compared with time of admission.<sup>21</sup> In our study, we found the hospital LOS of patients with a cancer diagnosis to be comparable with other studies, roughly 1 week. Patients with cancer diagnoses are usually medically complex because of factors such as intensive treatments, disease progression, and immunosuppression and other side effects and therefore may require specialized needs that may impede timely discharge. Furthermore, many of these patients remain in the hospital until specific hospital equipment has been delivered to their homes, transportation

can be appropriately arranged, home nursing care coordination for devices and drains has been established, or until medications have been properly titrated and approval is granted by insurance companies for medication prior authorizations. Physical mobility remains one of many factors that require significant coordination on discharge from the hospital. The combination of several factors affecting patients' timeline for discharge in addition to mobility may explain why LOS was not significantly different between the control and intervention groups.

Additionally, our study demonstrates improvements in functional ability and time to hospital readmission, which are similar to results seen in the hospitalized general medicine patient population and MICU patients who participated in specialized mobility interventions.<sup>4,5</sup> These data are important for patients with cancer diagnoses who may be undergoing active treatment with therapeutic agents where preservation of quality of life and home environment can have a large impact on treatment tolerability. Similarly, preventing hospital readmissions is particularly important for hospital systems that use readmissions as a metric of success and may have penalties associated with greater numbers of them. Improvements in functional ability using the mobility aide resource may also present a benefit from a cost perspective as there would likely be a decreased need for specialized PT resources and more time for nurses to focus on care delivery.

Additional work is needed to evaluate the true financial impact on hospital system costs, however, and will be included in future work.

Our study has some limitations. First, our baseline period was shorter than the intervention period. We only started collecting AMPAC data on hospitalized patients 6 months before the intervention and thus are unable to evaluate before this period. Second, this was conducted in a single, urban, academic institution and thus the findings may not be generalizable to all populations. Third, this study has a prepost design, and there may have been other changes to the care delivery system during the time our study took place that we were unable to control for. Finally, we did not assess the rate of falls; however, we did include fall risk. Further research is needed to accurately assess correlation of increased mobilization with falls and fall risk.

Promoting mobility is critically important for hospitalized patients with cancer to avoid the many clinical consequences associated with decreased mobilization. This intervention demonstrated that identifying hospitalized patients with cancer using a validated assessment during routine clinical activities and involving mobility aides in their care is associated with improvements in health care utilization, mobility, and functional status. Use of mobility scores at admission can help achieve early engagement of mobility aides and determine the most appropriate use of mobility resources,

enabling physical therapists to care for patients who are most likely to benefit from enhanced services. Future work is needed to identify the types of patients with cancer who are most likely to benefit from early mobility interventions and the association with health care costs that may be affected by such a program.

Access the [original article here](#).

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#### EQUAL CONTRIBUTION

J.H.A. and O.S.A are cofirst authors.

#### AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Disclosures provided by the authors are available with this article at DOI <https://doi.org/10.1200/OP.22.00761>.

#### AUTHOR CONTRIBUTIONS

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**Administrative support:** Madhu Mazumdar, Mark Liu, Cardinale B. Smith

**Provision of study materials or patients:** Cardinale B. Smith

**Collection and assembly of data:** Julia H. Aronson, Carol Kisswany, Cardinale B. Smith

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**Manuscript writing:** All authors

**Final approval of manuscript:** All authors

**Accountable for all aspects of the work:** All authors

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## DAY 1 12 NOVEMBER 2023

Registration Desk & Welcoming Reception will be at the Almanac Palais Hotel

**10:00 - 12:00**

Vienna History Walking Tour (separate registration required)

**13:00 - 14:30**

Registration Desk Open

**15:00 - 17:00**

Tour of the Wiener Privatlinik

**18:00 - 19:00**

Welcoming Reception

**19:00**

Evening On Your Own

## DAY 2 13 NOVEMBER 2023

All sessions, lunch and the evening reception will be located at the Almanac Palais Hotel

**9:00 - 9:30**

Arrivals & Registration

**9:00 - 9:05**

Welcoming Remarks

**IOLC 2023 Co-Chairs:**

David M. Gosky, MA, MBA, Executive Director - Administration, The Ohio State University Comprehensive Cancer Center

Didier Verhoeven, MD, PhD, Head Department Medical Oncology - AZ KLINA, Belgium  
Chair Breast Clinic Voorkempen Guest Professor University Antwerp

**9:05 - 9:45**

**Keynote Speaker Address:** Organization of Oncology /  
Research in East Europe: How to Tackle Disparities

**Speaker:**

Univ. Professor Dr. Dr.h.c. Christoph Zielinski, Medical Director, Wiener Privatlinik and Central European Cancer Center, Wien, Austria, President, Central European Cooperative Oncology Group (CECOG)

### Paradigm Shift Block

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**9:45 - 10:30**

The Role of Artificial Intelligence in the Modern Oncology

**Speakers:**

Luca Tagliaferri, MD, PhD, Head of Interventional Radiotherapy Unit - Responsabile UOS di Radioterapia Interventistica, Gemelli ART (Advanced Radiation Therapy) - Interventional Oncology Center (IOC), Fondazione Policlinico Universitario «Agostino Gemelli» IRCCS

Ron DiGiaino, MBA, FACHE, Chairman of the Board, Revenue Cycle Coding Strategies

Marc Gelinias, MHA, CMPE, FACHE, Vice President, The Oncology Group

John J. Montville, MBA, FACHE, FACMPE, COA, Executive Director, Oncology Service Line, Mercy Health/Lourdes Hospital

**10:30 - 11:00**

Networking Break

**11:00 - 11:45**

Minding the “Bedside” Genomic Gap: Challenges in Real-World Cancer Care Precision Medicine

**Speakers:**

Melissa Childress, MBA, Chief Operating Officer, University Hospitals Seidman Cancer Center

Shannon Allen, Design and Transformation Consultant, IBM Simpler

Rebecca Klisovic, MD, Assistant Chief Medical Information Officer, University Hospitals Seidman Cancer Center

Christina Wu, MD, Professor in the Department of Internal Medicine, Division of Hematology/Oncology, Mayo Clinic

**11:45 - 12:30**

Cancer Screening for Breast, Lung, Colon, and Prostate Cancers: Examining Select European Countries for the use of Appropriate Cancer Screening Guidelines

**Speakers:**

Warren Smedley, DSc, MSHA, MSHQS, Vice President, The Kinetix Group

Didier Verhoeven, MD, PhD, Head Department Medical Oncology - AZ KLINA, Belgium  
Chair Breast Clinic Voorkempem Guest Professor University Antwerp

**12:30 - 14:00**

Varian Gold Sponsor Listening Lunch - Paradigm Shifts: How Ten Breakthroughs in one year will impact the Future of Humans within the Cancer Continuum

**Speakers:**

Amy Hay, Vice President, Strategic Initiatives at Varian Multi-Disciplinary Oncology, a Siemens Company | International Expansion & Business Development

Mosie Hackett, Strategic Initiatives Analyst, Oncology, Varian Multi-Disciplinary Oncology, a Siemens Company

## Access to Care in an Evolving Landscape Block

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**14:00 - 14:30**

Cancer Care in CSE Europe

**Speaker:**

Tanja Čufer, MD, PhD, Medical Oncologist, Professor of Oncology at the Medical Faculty, University of Ljubljana, Slovenia

**14:30 - 15:00**

Shortcomings of Diagnostics in Molecular Pathology in Central Europe

**Speaker:**

Prof. Aleš Ryška, MD, Ph.D. Head, Fingerland Department of Pathology Charles University, Medical Faculty Hradec Králové, Czech Republic

**15:00 - 15:30**

Networking Break

**15:30 - 16:15**

How to Plan for and Manage Refugee Care

**Speakers:** TBD

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the agenda!



## DAY 3 14 NOVEMBER 2023

All sessions, lunch and the evening reception will be located at the Almanac Palais Hotel

**16:15 - 18:00**  
Self-Exploration of Vienna

**18:00 - 19:00**  
Networking Reception

**8:30 - 9:00**  
Registration

### Clinical Evolution Block

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**9:00 - 9:30**  
Promoting Transparency and Equitable Value in Cancer Care via a Global Standardised Quality and Value Assessment Model

**Speaker:**

Matt Hickey CEO, The Health Value Alliance

**9:30 - 10:15**  
Back to Basics: Focusing your Clinical Operations to Achieve Breakthrough Improvement in System Quality and Financial Performance

**Speaker:**

Anthony Paravati, MD, MBA, Clinical Director, SRS/SBRT Services, Department of Radiation Oncology, Kettering Health Network

**10:15 - 11:00**  
Aging in Cancer - Preparing for the Silver Tsunami Around the World

**Speakers:**

Andrew Chapman, DO, FACP, Director of the Sidney Kimmel Cancer Center – Jefferson Health (SKCC), EVP, Oncology Services

Matthew Huesser, MBA, DBA, Vice President of Cancer Research Administration

**11:00 - 11:30**  
Networking Break

**11:30 - 12:00**  
Cancer Support Services Improving Patient Outcomes

**Speakers:**

Mark Liu, Senior Director of Oncology Strategy, Transformation & Analytics, Mount Sinai

**12:00 - 12:30**  
Integrated Oncology Tumor Boards

**Speakers:**

Dominick Mesdjian, MHA, Administrative Fellow, Northwestern Medicine

Razvan Andrei Popescu MD, MRCP(UK), Co-Chair Tumor Center Aarau, Head of Medical Oncology, Tumor Center Aarau and Hirslanden Clinic Aarau

Alex Zafirovski MBA, RT(T) ARRT, Chief Administrative Officer, Robert H. Lurie Comprehensive Cancer Center of Northwestern University

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**12:30 - 14:00**  
Networking Lunch (on your own)

## Oncology Leadership Block

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**14:00 - 14:30**

Addressing Well-Being, Burnout, and Resiliency in the Cancer Care Delivery Team

Speakers:

Susana Banerjee, MD, MBBS MA Ph.D. FRCP, Consultant Medical Oncologist and Research Lead for the Gynaecology Unit at the Royal Marsden

David Cohn, MD, Interim Chief Executive Officer, Chief Medical Officer, and Physician at The James Cancer Hospital and Solove Research Institute at Ohio State University

Valerie P Grignol, MD, Specialist, Gastrointestinal Stromal Tumors at The James Cancer Hospital and Solove Research Institute at Ohio State University

**14:30 - 15:15**

How to Create Effective Leadership Teams Discussion Session

Moderators:

Mosie Hackett, Strategic Initiatives Analyst, Oncology, Varian Multi-Disciplinary Oncology, a Siemens Company

Ted Yank, Senior Director of Research Operations, The Ohio State University Comprehensive Cancer Center/James

Panelists:

Razvan Andrei Popescu MD, MRCP(UK), Co-Chair Tumor Center Aarau, Head of Medical Oncology, Tumor Center Aarau and Hirslanden Clinic Aarau

Anthony Paravati, MD, MBA, Clinical Director, SRS/SBRT Services, Department of Radiation Oncology, Kettering Health Network

Univ. Professor Dr. Dr.h.c. Christoph Zielinski, Medical Director, Wiener Privatklinik and Central European Cancer Center, Wien, Austria, President, Central European Cooperative Oncology Group (CECOG)

Didier Verhoeven, MD, Ph.D., Head Department Medical Oncology - AZ KLINA, Belgium Chair Breast Clinic Voorkepen Guest Professor University Antwerp

David Cohn, MD, Interim Chief Executive Officer, Chief Medical Officer, and Physician at The James Cancer Hospital and Solove Research Institute at Ohio State University

**15:15**

Adjourn

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*Agenda subject to change. Visit the [IOLC website](#) for the latest updates.*