Logistics

• All participants are muted during the webinar

• Questions – including technical issues you may be experiencing – should be submitted through the question pane

• Questions will be answered as time permits; additional questions and answers will be posted on the website

• Please complete the post-webinar evaluation you will receive via email
Introducing our Moderator

Dr. Laurie Kirstein, MD, FACS
Attending Breast Surgeon
Memorial Sloan Kettering Cancer Center
Associate Professor
Cornell University Medical College
New Jersey
Introducing Our Panelist

Lauren Janczewski, MD, MS
ACS Cancer Program Scholar

Bruce G. Haffty, MD
Associate Vice Chancellor Cancer Programs
Rutgers Biomedical and Health Sciences
Professor and Chair, Department of Radiation Oncology
Rutgers Robert Wood Johnson and New Jersey Medical Schools
Rutgers Cancer Institute of New Jersey

Sharon Gentry, MSN, RN, HON-ONN-CG, AOCN, CBCN
Program Director Academy of Oncology Nurse & Patient Navigators
Editor in Chief Journal of Oncology Navigation & Survivorship®
Editor in Chief CONQUER: the journey informed™

Elizabeth Wick, MD
Professor of Surgery
Division of Oncology
Vice Chair of Quality and Safety
Co-Chair, Department of Surgery research Committee
Agenda for today

• Welcome
• Data Review
• Approaching QI, Thoughts on Problem Solving
• Breast Cancer Fractionation
• Importance of Nurse Navigation
• Q and A
Participating Programs

329 total programs

93.2% have been able to **identify the most common barriers** for why patients miss scheduled radiation treatments.

93.2% have been able to **prioritize which barriers will have the most impact** on reducing missed appointments at your organization/program.
Participating Programs

- **77.2% of programs** reported patients with 3 or more missed treatments

- Median percent of patients who missed 3 or more radiotherapy treatments = 7.2% [IQR 1.7%-13.3%]
**Missed Radiotherapy Treatments by Disease Site**

Total number of patients who missed 3 or more treatments = 689 (7.7%)

<table>
<thead>
<tr>
<th>Disease Site</th>
<th>Programs (N, %)</th>
<th>Patients (N, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>48 (14.6%)</td>
<td>75 (4.7%)</td>
</tr>
<tr>
<td>Upper GI</td>
<td>73 (22.2%)</td>
<td>32 (11.1%)</td>
</tr>
<tr>
<td>GYN</td>
<td>82 (24.9%)</td>
<td>51 (12.7%)</td>
</tr>
<tr>
<td>H&amp;N</td>
<td>145 (44.1%)</td>
<td>158 (10.7%)</td>
</tr>
<tr>
<td>Prostate</td>
<td>147 (44.7%)</td>
<td>114 (4.5%)</td>
</tr>
<tr>
<td>Lung</td>
<td>142 (43.2%)</td>
<td>150 (12.1%)</td>
</tr>
<tr>
<td>Rectum</td>
<td>78 (23.7%)</td>
<td>31 (9.6%)</td>
</tr>
<tr>
<td>Other</td>
<td>104 (31.6%)</td>
<td>78 (7.1%)</td>
</tr>
</tbody>
</table>
Reasons for Missed Radiotherapy

<table>
<thead>
<tr>
<th>Reason</th>
<th>Baseline</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>24.9</td>
<td>40.7</td>
</tr>
<tr>
<td>Illness</td>
<td>53.3</td>
<td>24.4</td>
</tr>
<tr>
<td>Conflicting Appointments</td>
<td>18.5</td>
<td>8.1</td>
</tr>
<tr>
<td>No more treatment</td>
<td>15.9</td>
<td>3.7</td>
</tr>
</tbody>
</table>
Barriers Chosen to be Addressed

- **70.6%** of programs already have a plan to address these barriers!
- **61.1%** of programs have already identified programmatic and/or community referrals
Approaching QI, Thoughts on Problem Solving

Elizabeth Wick, MD, FACS UCSF
Surgical Site Infection Prevention

OUTCOMES

JHU Colorectal SSI Rate 2009, 30%
Comprehensive Unit Based Safety Program

1. Improve patient safety awareness and systems thinking at the unit level

2. Empower staff to identify and resolve patient safety issues

3. Integrate safety practices into daily work of all staff members

4. Create a patient safety partnership between executives and frontline caregivers

5. Provide tools to help CUSP teams investigate and learn from defects and improve teamwork and safety culture
Identifying defects

How will the next patient be harmed or have an SSI?

What can we do to prevent the next patient from harm or SSI?
2011

Gentamicin

- Increased amount of gentamicin available in the room
- Added dose calculator in anesthesia record
- Educated surgery, anesthesia and nursing in grand rounds

Despite >95% compliance on SCIP

Wick et al. JACS 2011
TEAM for Problem Solving

• Who touches every patient?
• What resources are there ad hoc?
  • Social workers, case management, community health workers, PMD, oncologists
  • Techs, registration, navigators
• Don’t forget patients and families!
Learning from Defects

<table>
<thead>
<tr>
<th>Contributing Factors</th>
<th>Importance to Current Event, 1 (Low) to 5 (High)</th>
<th>Importance to Future Events, 1 (Low) to 5 (High)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do we send reminders? Did we reach the patient with the reminder? Is the reminder a text or call? Do we talk about next appointment at prior appointment? Is there a TEAM behind supporting the patient? Once it happens once, do we change how we approach the patient?

1. Patients are missing radiation because of lack of ride?
   Brainstorm!!!
Why are patients not getting what they need?

• Staff Safety Assessment: AHRQ
  • https://www.ahrq.gov/hai/cusp/toolkit/staff-safety-assessment.html
• Learning from Defects: AHRQ
Conclusions

- QI is hard
- Listen to the frontline
- Simple solutions are sometimes the best
- MEASURE – what you think is happening probably isn’t
  - Even the smallest things!
  - Can measure with small audit tools, don’t have to the EHR reports
- Lean on the community of others trying to do similar things
- We re-invent the wheel too often!
Barriers to Radiation Treatment
Potential Solutions in Breast Cancer Fractionation

Bruce G. Haffty, MD
Professor and Chair
Department of Radiation Oncology
Rutgers, The State University of New Jersey
Cancer Institute of New Jersey, Robert Wood Johnson Medical School and New Jersey Medical School
Barriers to Radiation

- Multiple Studies in Numerous Disease Sites Demonstrate that Interruptions/compliance with the course of Radiation Can Impact outcomes
- Preliminary Studies From this ongoing Barriers Project Confirms that missing 3 or more radiation treatments remains a significant issue in patients undergoing radiation therapy
- Recognizing the possibility of compliance issues with radiation and intervening with appropriate solutions is an important goal
Potential Barriers

• Economic Issues
  – Work Schedule conflicting with RT Schedule
  – Cost of transportation

• Social Issues
  – Child-Care
  – Family Care-Patient is primary caretaker for family member
  – Dependence of family/friends for transportation
  – History of compliance with health care-prior compliance with chemotherapy or surgical schedule

• Travel Distance Issues
  – Daily trips to radiation are inconvenient and costly due to distance

• General Issues
  – Any hesitation or subtle messages from patient that they are not pleased with the idea of coming to radiation daily can signal a barrier to compliance with radiation
Potential Solutions to Barriers

• Socio-Economic Issues
  – Engage Social Workers Immediately for potential solutions

• Travel Distance Issues
  – Consider Solutions including referral to facilities that are closer or providing travel solutions
  – Consider alternate radiation schedules

• General Issues
  – Whatever the reason for hesitation on the part of the patient for potentially not being compliant with daily radiation, consider either social worker intervention, more in-depth discussions regarding the importance of compliance with the radiation schedule, or if appropriate consider alternative radiation schedules

• While this presentation will focus on alternate schedules in breast cancer, shorter course of radiation in multiple disease sites have been or are in the process of being studied
Potential Solutions in Breast Cancer-Alternate Fractionation/Radiation Schedules

- While 5-6 weeks of daily radiation has been the standard for years, this course of treatment has been a significant issue for many patients.
- In fact, many patients in the past have elected mastectomy over breast conservation, simply to avoid the issue of coming for daily radiation treatments over 5-6 weeks.
- However, currently there are alternative options for appropriately selected patients that can help to avoid interruptions in the radiation schedule.
- For any patient, particularly those where one anticipates potential interruptions in treatment, alternate radiation schedules should be considered.
Example of how alternative schedules can impact outcomes in breast cancer

• The following slide is courtesy of Charles Shelton, MD a radiation oncologist in rural NC
• They performed a retrospective review of breast cancer patients treated in a previous era where 5-6 weeks was the predominant schedule, to more recently when 3-4 week courses of radiation were employed
Highlights

• Use of accelerated RT was adopted quickly in rural areas with ~80% of eligible patients being treated with this regimen following lumpectomy (~15 tx) compared to historic 30 tx
• Overall BCT rates also increased as a result of increased access to less treatments (baseline 48% BCT rates, 79% post implementation) and are now in line with national rates
• Missed appointments due to patient barriers (defined as a single missed tx) were half as many using accelerated regimens (16% vs 33%) improving timeliness and compliance.
<table>
<thead>
<tr>
<th>Trial</th>
<th>Years Conducted</th>
<th>Patients (Number)</th>
<th>Whole Breast Fractionation (Gy/Fractions)</th>
<th>Boost Timing</th>
<th>Boost used</th>
<th>Boost Fractionation (Gy/Fractions)</th>
<th>RNI used</th>
<th>10-Year IBTR* (%)</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMH/GOC</td>
<td>1986-1998</td>
<td>1,410</td>
<td>50/25 42.9/13 39/13</td>
<td>Sequential only 74%</td>
<td>14/7</td>
<td>21%</td>
<td>12%</td>
<td>10% 15%</td>
<td>(36)</td>
</tr>
<tr>
<td>OCOG</td>
<td>1993-1996</td>
<td>1,234</td>
<td>50/25 42.5/16</td>
<td>Sequential only 61%</td>
<td>10/5</td>
<td>14%</td>
<td>7% 6%</td>
<td>7% 6% 8%</td>
<td>(37)</td>
</tr>
<tr>
<td>START A</td>
<td>1998-2002</td>
<td>2,236</td>
<td>50/25 41.6/13 39/13</td>
<td>Sequential only 61%</td>
<td>10/5</td>
<td>14%</td>
<td>7% 6%</td>
<td>7% 6% 8%</td>
<td>(9)</td>
</tr>
<tr>
<td>START B</td>
<td>1999-2001</td>
<td>2,215</td>
<td>50/25 40/15</td>
<td>Sequential only 43%</td>
<td>10/5</td>
<td>7% 5% 4%</td>
<td>None</td>
<td>7% 6% 8%</td>
<td>(9)</td>
</tr>
<tr>
<td>DBCG HYPO</td>
<td>2009-2014</td>
<td>1,854</td>
<td>50/25 40/15</td>
<td>Sequential only 23%</td>
<td>10/5</td>
<td>None</td>
<td>3% 3% (9 year)</td>
<td>(19)</td>
<td></td>
</tr>
<tr>
<td>IMPORT HIGH</td>
<td>2009-2015</td>
<td>2617</td>
<td>40/15 36-40/15 36-40/15</td>
<td>Sequential 100%</td>
<td>16/8 13/15</td>
<td>Allowed 1.9% 2.0% 3.2% (5-year)</td>
<td>None</td>
<td>2% 2% 3%</td>
<td>(24)</td>
</tr>
<tr>
<td>CAMS</td>
<td>2010-2015</td>
<td>734</td>
<td>50/25 43.5/15</td>
<td>Sequential only 100%</td>
<td>10/5 vs. 8.7/3</td>
<td>4% 3% 2% 1% (5-year)</td>
<td>None</td>
<td>1% 1% 1% (3-year)</td>
<td>(38)</td>
</tr>
<tr>
<td>MDACC</td>
<td>2011-2014</td>
<td>287</td>
<td>50/25 42.5/16</td>
<td>Sequential only 99%</td>
<td>10/5 or 14/7 vs. 10/4 or 12.5/5</td>
<td>None 1% 1% (3-year)</td>
<td>None</td>
<td>1% 1% 1% (3-year)</td>
<td>(18)</td>
</tr>
<tr>
<td>NRG RTOG 1005</td>
<td>2011-2014</td>
<td>2,354</td>
<td>50/25 or 42.7/16 40/15</td>
<td>Sequential vs. Concurrent 100%</td>
<td>12/6 or 14/7 vs. 8/15 concurrent</td>
<td>None 2% 3% (7-year)</td>
<td>None</td>
<td>2% 3% (7-year)</td>
<td>(23)</td>
</tr>
<tr>
<td>UK FAST</td>
<td>2004-2007</td>
<td>915</td>
<td>50/25 30/5 28.5/5</td>
<td>N/A N/A N/A</td>
<td>10/5 or 16/8</td>
<td>None 1% 1% 1% (5 year)</td>
<td>None</td>
<td>1% 1% 1% (5 year)</td>
<td>(30)</td>
</tr>
<tr>
<td>UK FAST-Forward</td>
<td>2011-2014</td>
<td>4,096</td>
<td>40/15 27/5 26/5</td>
<td>Sequential only 25%</td>
<td>10/5 or 16/8</td>
<td>None 2% 2% 1% (5 year)</td>
<td>None</td>
<td>2% 2% 1% (5 year)</td>
<td>(31)</td>
</tr>
</tbody>
</table>
## Selected Fractionation Schedules

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
<th>Week 6</th>
<th>Week 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional</td>
<td></td>
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<tr>
<td>OCGG</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>RMH/GOC and START A</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>START B and DBCG HYPO</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>FAST</td>
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</tr>
<tr>
<td>MDACC</td>
<td></td>
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<tr>
<td>CAMS</td>
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<tr>
<td>HypoSIB</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>NRG 1005 / Import High</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>F-Forward</td>
<td></td>
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</tr>
</tbody>
</table>

*Whole Breast [ ]*  *Boost [ ]*  *Boost optional [ ]*
Whole Breast Fractionation Options (Without RNI)

• Given the acceptable local control rates and acceptable toxicity profile, any of these fractionation schemes appear to be reasonable options

• Most common in the US currently are the Canadian Fractionation Scheme, the START B Scheme or the Simultaneous Integrated Boost of NRG 1005

• Fast Forward has gained traction in the UK and in the US mainly in older women. Conservative folks caution regarding the relatively short-term follow-up
  • Follow-up from FAST Forward is only 5 years
  • Across all clinical assessments for normal tissue compared to standard fractionation (40 Gy/15 Fx) the odds ratio was 1.55 (p <.001) for 27 Gy in 5 fractions and 1.12 (p=.12) for 26 Gy in 5 fractions.
Hypofractionation in RNI

- Although conventional fractionation remains the acceptable standard for treating the regional lymphatics hypofractionation of the regional lymphatics has been successfully done throughout the years.

- British Columbia Pre-menopausal PMRT Randomized Trial
  - 37.5 Gy in 16 Fractions of 2.34 Gy

- START A and START B-RNI Administered to 14% of Patients
  - 42.9 Gy in 3.3 Gy Fractions x13 over 5 weeks START A
  - 41.6 Gy in 3.2 Gy Fractions x 13 over 5 weeks START A
  - 40 Gy in 2.6 Gy Fractions x 15 over 3 weeks START B
Rutgers Hypo-fractionation Trial

- Prospective Phase II Trial (NCT01417286)
- 69 Patients enrolled between December 2011 and December 2014 at Rutgers CINJ and Huntsman University of Utah
- Stage II A to IIIc disease post-mastectomy with or without reconstruction (41 or 69% of patients had reconstruction)
- Treated PMRT 4995 Gy/3 Weeks (3.33 Gy/11 Fx/ to chest wall and nodes + 3.33Gy/4 Fx Boost)
- Primary Endpoint-total greater than Grade 2 Toxicity Rate below 9%
- Secondary Endpoint-Recurrence Rate between 3.7 and 14.5%
- Reconstruction Complications Attributed to Radiation -24%
Alliance Phase III Randomized Trial (A221505)
Matt Poppe PI  Atif Khan Bruce Haffty Co PI
RT-CHARM

Conventional PMRT:
50Gy/2Gy Chest wall and/or Reconstructed Breast with 50Gy/2Gy to regional nodes** over 5-6 weeks.

Hypofractionated PMRT:
42.56Gy/2.66Gy to Chest wall and/or Reconstructed Breast with 42.56Gy/2.66Gy to regional nodes** over 3-4 weeks.

Reached Accrual Goal-Now Closed

Method

A randomized phase III non-inferior trial comparing HFRT and CFRT (Noninferiority margin: 5% difference in 5-yr LRR rate)

Target sample = 820 (June 2008 - June 2016)

Stage III breast cancer patients after mastectomy

<table>
<thead>
<tr>
<th>Group</th>
<th>Treatment</th>
<th>Dose</th>
<th>Fraction</th>
<th>Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFRT</td>
<td>2Gy*25f, 5wks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HFRT</td>
<td>2.9Gy*15f, 3wks</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

R: 1:1
Randomized Trial-Hypofractionation vs. Standard Fractionation Post-Mastectomy: Wang et al. Lancet Oncology 2019

- LRR Primary Endpoint Median FU 52 Months
- No Difference in LRR (8.4% vs. 6.0%) , DM (21.3% vs. 24.3%), DFS (75.1% vs. 74.6%) or OS (84.9% vs. 87.1%) at 5 Years
- No Difference in lymphedema, shoulder disorder, pneumonitis between arms
- Fewer G3 skin reactions in hypofractionation
- No Brachial Plexopathy
- Notably patients did not have reconstruction
FABREC Trial Comparing Hypofractionation (16 treatments) to Standard Fractionation (25 Treatments) Post Mastectomy with Reconstruction: Preliminary results reported at ASTRO 2023

- Primary outcome and toxicity profile of Hypofractionation comparable to Standard Fractionation
- Improvement in specific QOL domains with HF, especially among younger patients
- Fewer treatment breaks with HF
- Less financial toxicity with HF
- Results support the use of HF PMRT for patients with implant-based reconstruction
The results from this European Society for Radiotherapy and Oncology Advisory Committee in Radiation Oncology Practice consensus state that moderately hypofractionated radiotherapy can be offered to any patient for whole breast, chest wall (with or without reconstruction), and nodal volumes.

Results of RT-CHARM from Alliance and FABREC (Similar randomized comparison as RT-CHARM) will hopefully also demonstrate the safety and efficacy of moderate hypofractionation to the reconstructed chest wall and regional lymphatics.

Notably FAST FORWARD (26 Gy in Five Daily Fractions) did include a subset of patients with regional nodal radiation who were randomized-Results Not Yet Reported
PARTIAL BREAST RADIATION

• Partial Breast Radiation has emerged as an acceptable option for selected patients with early-stage node negative breast cancer and DCIS

• Multiple fractionation schemes have emerged, based on randomized trials that demonstrate acceptable local control rates and acceptable toxicity compared to whole breast radiation

• The use of partial breast radiation has significantly increased over the past few years as patients have embraced the convenience and radiation oncologists have become more comfortable with this approach based on the outcomes reported in randomized trials.
# Key External Beam APBI Trials

<table>
<thead>
<tr>
<th>Trial</th>
<th>Patient #</th>
<th>Dose Fractionation</th>
<th>FU</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSABP-39</td>
<td>4216</td>
<td>50 Gy in 25 vs 38.5 Gy 10 Fractions BID</td>
<td>10 Yrs</td>
<td>1% difference in IBTR/No difference in adverse events</td>
</tr>
<tr>
<td>RAPID-OCOG</td>
<td>2135</td>
<td>50 Gy/25 or 42.5 16 vs. 38.5 Gy 10 Fractions BID</td>
<td>8.6 Yrs</td>
<td>PBI non-inferior local control Toxicity/cosmesis poorer with PBI</td>
</tr>
<tr>
<td>IMPORT-LO</td>
<td>2018</td>
<td>40 Gy/15 vs. 40 Gy in 15 PBI</td>
<td>6 yrs</td>
<td>PBI non-inferior with improved toxicity/cosmesis</td>
</tr>
<tr>
<td>Florence</td>
<td>520</td>
<td>50 Gy in 25 vs. 30 Gy (IMRT) in 5 Fractions QOD</td>
<td>10 Years</td>
<td>PBI non-inferior with improved toxicity/cosmesis</td>
</tr>
<tr>
<td>IRMA</td>
<td>3309</td>
<td>50/25 or 4256/16 or 40/15 vs. 38.5 Gy in 10 fractions BID</td>
<td>5.6 yrs</td>
<td>Increased toxicity and inferior cosmesis with PBI</td>
</tr>
</tbody>
</table>
External Beam APBI

- Based on the inferior cosmesis/toxicity associated with the 38.5 Gy in 10 Fractions BID I and many others are not routinely employing this fractionation scheme any longer
- There are a number of acceptable schemes from the randomized trials as well as Phase II studies
- Given the convenience, and favorable long-term outcomes from the FLORENCE trial, I favor this approach for patients considering partial breast radiation
  - Patients are treated with 30 Gy in 5 Fractions with IMRT Every Other Day
  - Recent Data from the Florence Group Suggests that 30 Gy in 5 Fractions can be done daily with acceptable outcomes
Radiation vs. Hormonal Therapy: EUROPA Trial

- Exclusive endocrine therapy or partial breast irradiation for women aged ≥70 years with luminal A-like early stage breast cancer (NCT04134598 - EUROPA): Randomized controlled trial comparing health related quality of life by patient reported outcome measures
- Plan for > 900 patients in this randomized study
  - Patients will receive either Exclusive Endocrine Therapy
  - Or exclusive Partial Breast Rt over 1-3 weeks

- MY PREDICTION: Radiation Arm will Win!
Partial Breast Radiation-Brachytherapy

- Partial breast radiation can also be accomplished through interstitial implants or balloon based catheter techniques over 2-5 days
  - Interstitial brachytherapy has been compared to whole breast in a randomized trial with favorable outcomes (Strnad et al. Lancet, 2016)
  - Mammosite Registry trial included 1449 patients treated with single catheter balloon based brachytherapy delivered over 5 days demonstrating favorable outcomes and good cosmesis (Shah, Vicini et al. 2013)
  - Triumph single arm study included 200 patients treated with single catheter balloon based brachytherapy delivered over 2 days with favorable outcomes and good cosmesis. (Yashar, Khan, Haffty, Kuske, 2023).
• Europeans accumulating large body of maturing data from randomized trials with **intraoperative single fraction treatment**.

  – TARGIT –Intraoperative using single orthovoltage source in the operating room at lumpectomy

  – ELIOT-Intraoperative electrons delivered in the operating room at lumpectomy
Intraoperative Radiation

• Both the Targit Trial and the Eliot Trial are randomized trials comparing whole breast radiation over 4-6 weeks following lumpectomy to intra-operative treatment with a single fraction of radiation delivered in the OR at the time of lumpectomy.
• Both trials have mature data with long term followup and demonstrate acceptable outcomes in selected patients.
• Local recurrence rates are slightly higher in the intraoperative arm than whole breast RT but are acceptable.
Conclusions

• Multiple factors should be considered in evaluation of patients undergoing radiation that may signal potential lack of compliance with the radiation treatment schedule
  – Work Schedule Conflicts
  – Childcare or Family Care Issues
  – Distance
  – Socio-economic Issues
  – History of non-compliance with medical care

• For patients with breast cancer where compliance with the schedule may be an issue alternate fractionation schedules, if appropriate may be considered:
  – For patients requiring post-mastectomy or regional nodal radiation consider 3–4-week schedules as opposed to 5–6-week schedules
  – For selected patients who meet criteria consider 1–2-week courses of partial breast radiation external beam or brachytherapy or 1-week whole breast RT
Thank You!

Bruce G. Haffty, MD
Involving navigators throughout the care continuum as patients move through treatment

Sharon Gentry, MSN, RN, HON-ONN-CG, AOCN, CBCN
Academy of Oncology Nurse & Patient Navigators Program Director
Editor-In-Chief for Journal of Oncology Navigation & Survivorship® (JONS) and CONQUER: the patient voice™ publications
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Navigation metrics show value

✓ Clinical Outcomes

✓ Patient Experience

✓ Return on Investment (ROI)
Navigation is a Solution for Health Equity

FIGURE 2. Domains of the Cancer Care Continuum with Examples of Activities in Each Domain

Prevention and Risk Reduction
- Tobacco control
- Diet
- Physical activity
- Sun and environment exposures
- Alcohol use
- Chemo-prevention
- Immunization

Screening
- Age- and gender-specific screening
- Genetic testing

Diagnosis
- Biopsy
- Pathology reporting
- Histological assessment
- Staging
- Biomarker assessment
- Molecular profiling

Treatment
- Systemic therapy
- Surgery
- Radiation

Survivorship
- Surveillance for recurrences
- Screening for related cancers
- Hereditary cancer predisposition/ genetics

End-of-Life Care
- Implementation of advance care planning
- Hospice care
- Bereavement care

Acute Care
- Care planning
- Palliative care
- Psychosocial support
- Prevention and management of long-term and late effects
- Family caregiver support

Chronic Care

End-of-Life Care

The blue arrow identifies components of high-quality cancer care that should span the cancer care continuum from diagnosis through end-of-life care. The green arrow identifies 3 overlapping phases of cancer care, which are a way of conceptualizing the period of the cancer care continuum that is the focus of this report.

Making the case for nurse navigators

Method – Gap analysis on why patients were leaving the healthcare system

The retention of 212 patients resulted in an increased diagnostic imaging procedures alone and $125,000 in total net revenues. Incorporating all the services the 212 patients would generate in non-cancer services, as well as the breast cancer services, the potential total net revenues would be $350,000.

Using a nurse navigation pathway in the timely care of oncology patients

A medical oncologist could see an additional patient each day due to the time reduction associated with the navigation visit. $485,312 total cost savings and revenue (4 med oncs; new patient consult was reduced by 24 minutes = medical oncologist could see an additional patient each day due)
And time between oncology referral to the start of treatment was reduced by 7 days; 75% patients have advance directives completed

Navigators reduce no-shows

Method - Each patient is contacted at least once a month, with the most at-risk patients being contacted as often as three times a week.

In 3 months, the reduction in no-shows in those receiving radiation therapy equaled a navigator’s annual salary. The overall return on investment was $5 for every $1 spent

Also, readmissions were cut by one-third, with a similar reduction in emergency visits
Navigator’s Unique View & Perspective
Looking Ahead: What to Expect
Upcoming Data Collection

Data was Released Oct 15-
Due Oct 30

Patients seen August 15- Oct 15
More in depth questions about barriers
• Transportation
• Conflicting appointments
• Does not wish to continue treatment
• Patient Sick

Final Data Collection
December 15-30th

If you need to change your primary contact: email cancerqi@facs.org
Beginning in 2024

Expectations in 2024

• Identify at least one barrier
• Develop a problem statement and goal
• Implement an intervention from the toolkit
• Report Data (via REDCap)
• Meet with small group cohort based on barrier
Reminders
ACS Cancer Conference 2024
February 22-24, 2024 | Austin, TX

Q and A

Reach out to cancerqi@facs.org