

IN THIS ISSUE

- 1 Addressing Racial and Socioeconomic Inequities in Gynecologic Cancer Care: Challenges and Opportunities for Improvement
- 7 Bridging Gaps in Gynecologic Cancer Care: An Interview With Stakeholders From Texas Oncology

Addressing Racial and Socioeconomic Inequities in Gynecologic Cancer Care: Challenges and Opportunities for Improvement

Gynecologic cancers involve the uncontrolled growth and spread of abnormal cells that originate in female reproductive organs including the cervix, ovaries, uterus, fallopian tubes, vagina, and vulva (Table).^{1,2} Over 108,000 women in the United States will be diagnosed with a gynecologic cancer in 2024. Each type of gynecologic cancer presents unique signs, symptoms, and risk factors. Genetic factors can substantially increase the risk of developing certain gynecologic cancers; for example, mutations in the *BRCA1* and *BRCA2* genes are associated with an increased likelihood of developing ovarian and breast cancers.^{3,4}

Symptoms of cervical, uterine, ovarian, and vaginal cancers can include abnormal vaginal bleeding or discharge; of ovarian cancer may include bloating, feeling full quickly, and abdominal or back pain; of ovarian and uterine cancers may include pelvic pain; of ovarian and vaginal cancers may include urinary changes; and of vulvar cancer may include itching, burning, pain, or skin changes like rashes or sores.⁵ Treatment for gynecologic cancers include surgery, chemotherapy, and radiation.⁶ First-line treatment options vary depending on the specific type of cancer and its stage at diagnosis.

Uterine cancer, which includes endometrial cancer and uterine sarcomas, is the most common gynecologic cancer and the ninth most common cancer diagnosed in the US, with an estimated 67,880 new diagnoses expected in 2024.⁷ Mortality from ovarian cancer was historically higher than that from uterine cancer in the early 1990s, but it has been decreasing; on the other hand, the incidence and mortality rates of uterine cancer have been rising with mortality rates increasing 1.7% each year since 2013.^{7,8} Mortality associated with uterine cancer among Black women is particularly high; mortality rates for this population are now twice as high as those for White women

Table. Types of Gynecologic Cancers^{1,2}

Cervical	Starts in the cervix, the lower part of the uterus that connects to the vagina; often caused by persistent infection with certain types of HPV
Fallopian tube	Starts in the fallopian tubes, which connect the ovaries to the uterus
Ovarian	Originates in the ovaries, the reproductive glands that produce eggs; includes several subtypes, with the most common being epithelial ovarian cancer
Uterine ^a	Originates in the lining of the uterus; the most common gynecologic cancer (the most common type, endometrial cancer)
Vaginal	Begins in the vagina, the muscular tube that connects the outer genitals to the uterus; rare; most often occurs in older women
Vulvar	Starts in the vulva, the external part of the female genitalia

HPV, human papillomavirus.

^aUterine cancer includes both uterine carcinomas and endometrial cancer.

(9.5/100,000 vs 4.7/100,000 women) even though the incidence rates for the malignancy are similar.⁷

Uterine cancer is most frequently diagnosed among women aged 55 to 64 years, with the median age at diagnosis being 64 years. The prognosis for endometrial cancer varies depending on the stage at diagnosis. Five-year relative survival rates for regional and distant uterine cancer are approximately 70% and 19%, respectively. The 5-year relative survival rate for early-stage or localized uterine cancer is about 95%.⁷

(CONTINUED ON PAGE 7)

(CONTINUED FROM PAGE 1)

Early diagnosis and treatment are critical for improving outcomes of patients with gynecologic cancers. However, the absence of screening tests remains a challenge—diagnosis primarily is based upon symptom onset, and often correlates with more advanced disease severity.^{9,10} Considerable gaps in care, particularly among members of racial and ethnic minority groups, contribute to disparities in diagnosis, treatment, and survival.

CURRENT GAPS IN CARE

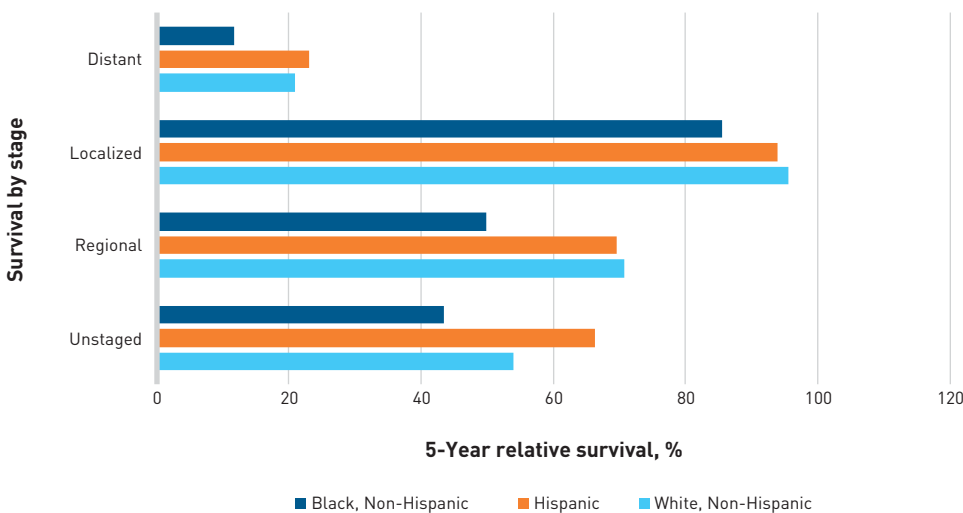
The 5-year relative survival rates for Black women with regional and distant uterine cancer are 49.8% and 11.7%, respectively, compared with 70.7% and 20.9% for White women (Figure).¹¹ Further, compared with White women, patients from other racial and ethnic groups have a lower proportion of early-stage cervical cancer diagnoses. For example, the results of a study of 23,942 women aged 21 to 64 years who were diagnosed with early-stage cervical cancer showed that 48.7% were American Indian or Alaska Native, 49.9% were Asian or Pacific Islander, 41.7% were Black, and 51.6% were Hispanic or Latina as compared with 53.3% who were White.¹² Women

with private or Medicare insurance were more likely to be diagnosed at an early stage than were those who had Medicaid coverage or who were uninsured (57.8% vs 41.1%, respectively). After adjusting for various factors, Black women had higher odds of receiving advanced-stage cervical cancer diagnoses than did White women (odds ratio, 1.18; 95% CI, 1.08-1.29). Health insurance mitigated more than half of the racial disparities in advanced-stage diagnoses across all minority groups.¹² Limited health care accessibility and affordability contributes to delays in diagnosis, which is a key concern related to the observed disparities in gynecologic malignancies.¹³

Disparities in Patient Care

Racial, ethnic, and economic disparities across the incidence, treatment, and mortality among patients with uterine cancer are well documented.¹⁴ Black patients are less likely than are White patients to receive appropriate diagnostic workups after experiencing postmenopausal bleeding, and this delay may contribute to delayed diagnoses.¹⁵ Additionally, minority and low-income women often are less likely to undergo regular screenings for cervical, breast, colorectal, and lung malignancies, among

Figure. 5-Year Relative Survival for Uterine Cancer by Stage and Race for All Ages^{11,a}



NOS, not otherwise specified; NPCR, National Program of Cancer Registries.

^aEstimates based on cases of corpus uteri and corpus NOS cancer reported by selected cancer registries from 2014 to 2020 and follow-up of patients through December 31, 2020. Selected registries include 43 NPCR registries (Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming) that met the data quality criteria for survival analysis covering approximately 92% of the US population. Illinois, Kansas, New Jersey, and New York opted not to present state-specific American Indian and Alaska Native, Non-Hispanic data. The national rates and counts include data for these registries. Cases reported by Surveillance, Epidemiology, and End Results-only registries are currently not included in survival estimates. Data are suppressed if fewer than 16 cases were reported in a specific category, such as cancer type, race and/or ethnicity, age, and state.

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others, because of various aspects of social determinants of health.¹⁶ Further, individuals with low incomes, limited health literacy, long travel distances to access care, no or insufficient insurance, lack of transportation, or unpaid medical leave are less likely to seek out recommended cancer screenings. Black women also are less likely than are White women to receive guideline-concordant care, even when receiving treatment at an academic medical center.¹⁷ Among many factors, differences in adherence to evidence-based treatment guidelines between Black and White women with endometrial cancer have been associated with variations in survival rates.

The underrepresentation of women belonging to racial and ethnic minority groups in clinical trials also poses a considerable challenge to the delivery of equitable and effective health care. Clinical trials play a crucial role in the study of disease pathophysiology and treatment modalities. The representation of patients belonging to racial and ethnic minority groups in these trials is essential for studying genetic variances and socioeconomic factors to better understand their impact on patient outcomes and potentially identify more suitable treatment options. However, women belonging to minority groups are significantly underrepresented in clinical trials, particularly in the United States. For instance, in clinical trials leading to FDA approval of new drugs in 2018, only 4% of participants were Black even though Black individuals make up 13.4% of the US population. This disparity is also evident in gynecologic oncology, which further impacts disparities in patient care. However, the results of clinical trials that randomly assigned women with ovarian cancer to treatment groups irrespective of race demonstrated that disparities in outcomes between Black and White women disappeared, suggesting that unequal access to care is a significant driver of differences in cancer trajectory.¹⁸

ECONOMIC CONSEQUENCES OF DISPARITIES IN GYNECOLOGIC CANCER CARE

Financial toxicity refers to the financial strain and burden that patients experience due to the costs associated with their cancer treatment. For patients with gynecologic cancers, financial toxicity can be considerable. Often, patients with gynecologic cancers face high medical expenses related to insurance, health services, and travel to care. This financial burden can be exacerbated by indirect costs related to lost income, cost of transportation, and caregiving needs. More than half of patients with gynecologic cancer experience financial distress when they begin a new treatment, and this is linked to material hardship.¹⁹

Patients with gynecologic cancers face increased odds of financial toxicity if they are younger than 65 years, belong to Black or Hispanic ethnic groups, have lower income or education levels, or are uninsured or unemployed. Financial assistance programs exist, but they often are limited, especially for Medicare patients. Although the Inflation Reduction Act of 2022 was intended to alleviate some of these financial burdens by capping annual out-of-pocket costs at \$2000 and introducing measures to control drug prices, patients still experience challenges.¹⁹

THE IMPORTANCE OF PATIENT AND PROVIDER EDUCATION

Patient education is crucial in the early detection and treatment of gynecologic cancers. Knowing the symptoms of cervical, ovarian, uterine, vaginal, and vulvar cancers can lead to early detection and timely, appropriate medical care.²⁰ The CDC's Division of Cancer Prevention and Control provides targeted research, programs, and partnerships that focus on cancer prevention and treatment, particularly for underserved populations.²¹ The CDC's *Inside Knowledge* campaign plays a vital role in this effort by raising awareness and providing critical information about gynecologic cancers.²⁰ *Inside Knowledge* supports the Gynecologic Cancer Education and Awareness Act of 2005, also known as Johanna's Law. Key initiatives include raising awareness about cancer risks among populations having a high incidence of malignancy, improving access to cancer screening for medically underserved and low-income individuals, and studying the cost of and barriers to preventive care and treatment.²¹

The Gynecologic Cancer Education and Awareness Act of 2005 aimed to increase awareness and knowledge of gynecologic cancers among health care providers and patients. It includes activities such as maintaining a supply of written educational materials for women and making public service announcements. These announcements are designed to encourage discussion about cancer risks among women and their health care providers and to highlight early warning signs and risk factors based on the latest medical information.²²

In addressing disparities in gynecologic cancer care, and particularly for endometrial cancer, targeted interventions are essential to improve outcomes among underserved populations. Reducing gaps in early diagnosis, increasing access to evidence-based treatments, and providing financial support can lessen the disproportionate burden on members of racial and ethnic minority groups and women who are experiencing economic disadvantages. •

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Bridging Gaps in Gynecologic Cancer Care: An Interview With Stakeholders From Texas Oncology

Texas Oncology is an independent oncology practice with more than 550 physicians and 300 sites of service across Texas and southeastern Oklahoma; these include 50 comprehensive cancer centers.¹ Editors from *AJMC* spoke with Texas Oncology physicians **Joseph de la Garza, MD, FACOG**, a gynecologic oncologist located in San Antonio, and **Kathryn E. Hudson, MD**, a medical oncologist and Director of Survivorship, located in Austin, on the practice's program and processes for addressing disparities and advancing access to treatment for appropriate patients with endometrial cancer.

AJMC: Please describe the gynecological cancer program at Texas Oncology. How do patients with endometrial cancer come to the practice center to be treated?

de la Garza: At Texas Oncology, our gynecologic cancer program operates on a referral-based model. We work closely with hospitals, where patients may enter our care through consultations—often after arriving at the emergency department (ED) as unassigned cases. In addition, we cultivate relationships with community providers (eg, primary care providers [PCPs] and community oncologists) to ensure they are aware of our specialized gynecologic oncology services and successful patient outcomes. Our goal is to be the first resource that providers consider for their patients with gynecologic cancer, including those with endometrial cancer. This reputation-based referral system is key to connecting patients to our center for specialized care.

Hudson: We also support through partnerships with nonprofit organizations. In Austin, for instance, we provide financial support to breast cancer screening initiatives such as the Big Pink Bus,² a mobile mammography unit that travels to underserved communities. Additionally, the Texas Oncology Foundation³ conducts health screenings in various regions, and our team collaborates with the National Ovarian Cancer Coalition⁴ and with local organizations such as the Breast Cancer Resource Center⁵ to enhance outreach.

AJMC: What does the patient journey look like for patients with endometrial cancer?

de la Garza: For patients with endometrial cancer who are treated at Texas Oncology, the journey begins with timely recognition and referral. Patients are typically sent to us after receiving a diagnosis or when symptoms—such as abnormal ultrasounds or postmenopausal bleeding—raise sufficient suspicion. Once referred, we prioritize rapid clinic access and evaluation, aiming to move the majority of patients quickly to surgery. In cases in which pre-surgical treatment with chemotherapy or radiation therapy would be beneficial, we tailor the treatment plan accordingly.

Our coordinated approach includes focused efforts to reduce time-to-appointment, an important metric linked with treatment success and care accessibility. To expedite care, we partner with advanced practice providers (APPs) who are available 5 days a week, whereas surgeons and oncologists have more limited clinic days. New patient referrals often are seen by an APP within 1 to 3 days, allowing preliminary workups—including imaging and biopsy review—to be initiated promptly, expediting treatment decisions and surgical scheduling. This streamlined approach ensures timely, comprehensive care from initial referral through posttreatment surveillance.

AJMC: Please describe the demographics of patients with endometrial cancer at your practice and the gaps in care seen with the patients in your program.

de la Garza: At Texas Oncology, we care for a diverse patient population with endometrial cancer across various demographics and financial backgrounds. As a private practice, we have many patients with insurance who are referred to us after diagnosis by gynecologists or PCPs. Additionally, we work with hospitals to treat uninsured or underinsured patients who enter through the ED, enabling us to serve a full spectrum of financial backgrounds.

Our San Antonio location sees a high volume of Hispanic and Black patients, reflecting the region's demographics. The team also receives many referrals from areas such as Corpus Christi and Laredo. One of the most common characteristics across all groups is obesity, which can substantially impact gynecologic cancer care and outcomes. Gaps remain in managing obesity effectively, often due to limited insurance coverage and the high cost of surgical and/or pharmacological treatments and support. Addressing these barriers is critical to improving outcomes in this patient population.

One of the most common characteristics across all groups is obesity, which can substantially impact gynecologic cancer care and outcomes. Gaps remain in managing obesity effectively, often due to limited insurance coverage and the high cost of surgical and/or pharmacological treatments and support. Addressing these barriers is critical to improving outcomes in this patient population.

—Joseph de la Garza, MD, FACOG

AJMC: What strategies are used by your organization to address barriers to care, especially for underserved populations?

Hudson: As an example, our program minimizes transportation barriers by bringing care closer to patients. We have over 300 sites across Texas, so most patients live within an hour of a clinic. For those in remote areas, we leverage telemedicine, enabling specialists from larger hubs to consult with patients and providers in smaller hub areas that are rural.

The cost of oncology care still poses a major hurdle for many patients, especially among those who are uninsured and underinsured. Our team will work to find financial solutions for these patients—often with the help of social workers who assist with financial support programs. The demand for social workers remains high, and many practices lack the resources and support. We also advocate for broader legislative efforts to address gaps in health care funding and insurance coverage.

AJMC: Who are the key stakeholders involved in the patient's care team?

de la Garza: At Texas Oncology, a dedicated care team ensures timely, effective treatment across each stage of the patient journey. New patient coordinators play a vital role by receiving and reviewing referrals, contacting patients, and coordinating initial visits. APPs facilitate *first-touch appointments* within 1 to 3 days to expedite the initial workup and to manage surveillance visits, chemotherapy, and even genetic testing, which is now offered to all women with endometrial cancer. The broader treatment team also includes other providers, such as nurses and radiation oncologists.

AJMC: How did your organization develop an institutional care pathway for optimizing care decisions for patients with endometrial cancer?

Hudson: Texas Oncology developed its institutional care pathway for endometrial cancer based on National Comprehensive Cancer Network guidelines, with additional focus on being cost effective and minimizing toxicity. The pathway integrates directly with our electronic health record (EHR), allowing providers to access detailed information on treatment options, including clinical data supporting each regimen. Providers can request off-pathway treatments if they are warranted by new research; these requests go to a committee for approval, ensuring flexibility without compromising quality.

To support financial transparency, each patient meets with a financial counselor before starting treatment. If necessary, financial assistance can be explored with a social worker. Pathway costs are not adjusted individually by insurance type, but preferred regimens are generally aligned with Medicare.

Patients without coverage are typically referred to safety-net programs that are usually affiliated with other hospitals or federally funded clinics. Aspects of social determinants of health (SDOH) also influence care decisions—for example, if indicated, consideration of oral regimens (vs intravenous [IV]) for patients experiencing transportation challenges or consideration of options that require fewer visits for those with limited access to care. This comprehensive approach enables providers to deliver optimized, patient-centered care across all stages of treatment.

AJMC: What innovative and personalized disease management approaches are you currently exploring for patients with endometrial cancer?

de la Garza: A key innovation in our approach is the extensive use of robotic surgery, which has transformed treatment options for patients with endometrial cancer, especially those with obesity or comorbidities in whom surgery is considered high risk. With the robotic platform, we can perform minimally invasive surgeries that offer faster recovery, reduced hospital stays, and fewer complications in cases in which patients have been advised that surgery is not possible due to high body mass index, elevated hemoglobin A_{1c}, or prior surgical history. Our success with robotic surgery has been a momentous advancement, ensuring that more women—regardless of location or complexity of care—can access effective, personalized treatment.

AJMC: How does Texas Oncology partner with community oncologists to advocate for and facilitate access to cutting-edge treatments for patients with endometrial cancer?

de la Garza: Community oncologists play a vital role in advocating for and facilitating access to advanced treatments for patients with endometrial cancer, especially by partnering with our program. With the rapid emergence of new guidelines for immunotherapies, for example, these partnerships are crucial. Community oncologists provide care close to patients' homes in more remote areas, but they may not have the latest gynecologic oncology-specific insights due to their broad focus across cancer types. Through collaboration, we can

share current recommendations garnered from recent conferences, journal clubs, and other avenues to ensure that patients receive the most current, high-quality care within their communities.

AJMC: How does Texas Oncology ensure that all providers are up to date on the latest advancements in treatment for endometrial cancer?

Hudson: Texas Oncology is part of The US Oncology Network, which offers regular educational webinars to keep providers informed about the latest advancements in endometrial cancer treatment. In addition, the clinical pathways incorporated into our EHR system (iKnowMed),⁶ are reviewed and updated every 6 months by a dedicated committee to ensure that they reflect the latest evidence-based regimens. This integrated system helps keep oncologists informed of the most current treatment options across all US Oncology practices.

AJMC: How do you educate patients about endometrial cancer care options to promote optimal treatment outcomes?

Hudson: Patient education is prioritized through the Texas Oncology Foundation. A key initiative is the annual *Survive and Thrive Symposium*,⁷ to which all of our patients with cancer from across all the state of Texas are invited for educational workshops. These sessions cover vital topics, including cancer treatment, long-term adverse effects, financial toxicity, and overall wellness.

Additionally, the Foundation hosts a virtual survivorship boot camp that offers support and educational resources and features expert-led discussions on various subjects. Many of our centers also conduct educational sessions led by social workers and dietitians. These sessions focus on nutrition, caregiving, and other important areas. In my role focused on survivorship, I strive to enhance our supportive care offerings. We have developed a nutrition program accessible to all patients that includes virtual consultations with bilingual dietitians. Monthly webinars provide further education. Additionally, before starting treatment, each patient receives an hour-long educational session with an APP to ensure that they understand their specific treatment plan.

Not all sites have social workers, but a social work director is available to assist practices with urgent needs and connect patients with resources. A mental health crisis professional is available to support those experiencing immediate mental health challenges. Palliative care providers are also available. We aim to support our patients holistically throughout their cancer journey.

AJMC: Please expand on how Texas Oncology addresses gaps in care to minimize the health care disparities among patients with endometrial cancer.

de la Garza: Our approach emphasizes education and outreach, informing both patients and referring providers that we are willing to conduct evaluations, including procedures like pelvic examinations, dilation and curettage, or biopsies, without requiring a prior diagnosis. By making our services known and accessible, we aim to alleviate the burden on patients who may lack the understanding or resources to navigate their symptoms. For example, we encourage

patients experiencing symptoms such as postmenopausal bleeding to consult with us directly.

In our efforts to expand access to gynecologic oncology care, Texas Oncology has prioritized providing services to underserved and remote areas. Texas Oncology works closely with hospitals and referral networks to offer surgical and oncology services to both funded and unfunded patients across these regions.

Hudson: We also are advancing our personalized approach to endometrial cancer management by integrating SDOH screening into our EHR. Currently, each visit includes a paper-based screening using a distress thermometer and questions about SDOH. High scores on the distress thermometer automatically trigger a social worker referral, ensuring timely support for patients experiencing substantial stressors. This process will be moving to an electronic format soon, which will streamline SDOH data collection and make it accessible in the EHR for more comprehensive, individualized care.

In addition, to minimize disparities in cancer care, we also are focusing on enhancing access to clinical trials, which are critical for delivering innovative treatments. Texas Oncology offers clinical trials through Sarah Cannon Research Institute, one of the world's leading oncology research organizations conducting community-based clinical trials.⁸ Unlike traditional academic centers, which often require patients to travel for trial participation, we open trials at multiple community sites throughout the state. This approach has been shown to reduce travel burdens and increase access for underrepresented populations.

Recently, we collaborated on a study to increase participation of underrepresented groups in clinical trials. By opening sites at locations convenient to these patients, we achieved the highest representation of Black and Hispanic patients in the trial. Through innovative strategies like this, we are committed to bringing clinical trials to all patients.

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—Kathryn E. Hudson, MD

AJMC: How do you collaborate with patients to navigate and manage their preferences and expectations for treatment?

de la Garza: Effective collaboration with patients begins with building trust. From the first visit to the last, it's essential to communicate honestly in a language they understand and to ensure that they feel

comfortable and confident. Once trust is established, patients are more likely to fully commit to their treatment plans.

Additionally, it's crucial to meet patients halfway by adapting to their needs. For instance, if a medical oncologist can provide treatment closer to home, or if an APP can offer chemotherapy on a day when I am in surgery, these options can enhance the patient experience. Ultimately, the foundation of a successful partnership lies in developing a strong partnership based on trust, adaptability, and a shared commitment to the patient's well-being.

Hudson: Patient preferences substantially influence oncology treatment decisions. During discussions about treatment options, I assess patients' priorities. For example, some patients undergoing chemotherapy may prefer oral medications (if possible) for convenience, whereas others may choose IV treatment based on efficacy or personal comfort.

As oncologists, it is essential to engage patients in these conversations and to consider their preferences alongside clinical data, financial implications, and potential adverse events. This collaborative approach not only respects patient autonomy but also ensures that treatment plans align with patients' priorities and lifestyle.

AJMC: How does Texas Oncology use patient-reported outcomes to improve care, and how do you make these tools accessible to all patients?

Hudson: At Texas Oncology, we utilize the Navigating Cancer platform,⁹ a patient-reported outcomes (PRO) tool in which all patients undergoing active treatment are enrolled. This platform allows patients to enter their symptoms and receive tailored educational materials regarding their specific cancer and treatment regimen. Our dedicated committee reviews these materials (developed by the platform) to ensure that they are appropriate and beneficial before distribution.

We have found that PRO programs can enhance quality of life for patients with cancer. Since initiating the PRO program in 2020, we have enrolled thousands of patients, aiming to effectively manage symptoms, reduce hospitalizations, and potentially extend survival. Our PRO program enables patients to receive real-time responses to their reported symptoms. Patients complete weekly questionnaires, and if any symptoms reach a certain severity, triage nurses promptly address their concerns, often within hours. This approach has been successful in reducing ED visits and hospital admissions,¹⁰ demonstrating the program's value. One of the reasons it has been successful is that we have really invested in our nurses, hiring more triage nurses to address the patients' responses and investing in provider education.

To accommodate patients who may not have smartphones or those living in rural areas with limited internet access, we plan to implement alternative communication methods such as telephone calls and in-office assessments. We also aim to develop an audio program that allows patients to report symptoms via recorded messages on landlines. These enhancements will ensure that all

patients can participate in our PRO program regardless of their technological access.

AJMC: What advice would you give to another organization looking to ensure that all patients with endometrial cancer have access to the most innovative and appropriate treatments?

de la Garza: To implement a successful program, organizations should focus on leveraging their strengths and establishing a robust business model. A high-volume, efficient practice that provides value-based care not only improves service quality but also opens opportunities to support underfunded patients.

Understanding patient needs also is essential. For example, a single physician will not be able provide the needed care for a large, underserved population. Instead, integrating with successful, resource-rich systems can enhance care coordination and support for patients lacking coverage. The key is to create a hybrid model that allows high-functioning clinics to incorporate unfunded patients.

Our success in ensuring access to innovative treatments stems from a strong foundation: a dedicated team of hardworking providers and a sustainable clinic model. By building a high-functioning, patient-centered program, we're able to serve diverse patient groups, expand access, and deliver the best care to all patients.

AJMC: What are some low-cost initiatives that centers could implement to address the disparities in care among their patient populations?

Hudson: To address disparities in care, community outreach is essential. Many communities harbor distrust toward health care providers and systems, so it's vital for oncology professionals to engage directly with patients in their local settings. For example, offering screenings at community centers not only demonstrates available resources but also helps to build trust and rapport.

Additionally, fostering strong relationships with PCPs and facilities that serve underserved populations can improve care access. By collaborating with these providers, oncology centers can create a more integrated approach to health care that effectively addresses the needs of these communities. •

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