

Conversations on Equity in Cancer Care: Meet the Leaders of NCCN's DEI Directors Forum

INTERVIEWS BY MATTHEW GAVIDIA

CONTINUED FROM COVER

One way to narrow the gap in outcomes is to promote guideline-adherent care, which is the mission of NCCN. Having greater diversity among those who deliver care would also limit opportunities for bias and build trust among patients. However, there are very few minority doctors: only 5% of active US physicians are Black and only 5.8% are Hispanic; these percentages are less than half the population shares in the United States. Even fewer minority doctors serve in leadership roles.⁵

Addressing this gap will impact the bottom line of cancer centers: To retain federal funding, all designated centers will be required to design and implement a plan to boost faculty and workforce diversity. The NCCN DEI Directors Forum will offer support and resources to forward this effort.

“Increasing diverse representation among care providers is one overdue step toward improving the equity and quality of cancer care,” Robert W. Carlson, MD and CEO of NCCN, said in the announcement. “Unfortunately, we have a long way to go, and the people doing this crucial work are often underfunded and overburdened. We’re happy to be able to use NCCN’s existing infrastructure to address some of that burden.”¹

Mayes and Erhunmwunsee spoke with *Evidence-Based Oncology*[™] (EBO) about their new roles. Interviews have been edited lightly for clarity. ♦

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TERRANCE MAYES, EDD



MAYES

MAYES, WHO WILL CHAIR the NCCN DEI Directors Forum, is the inaugural associate dean and executive director for Strategy, Equity, and Inclusion for the Stanford Medicine Enterprise Strategy Team, executive director of the Commission on Justice and Equity at Stanford Medicine, and associate director for DEI at the Stanford Cancer Institute.

EBO: What are your goals and priorities as chair of the DEI Forum?

MAYES: I was honored to be appointed inaugural chair of the NCCN DEI Forum. NCCN is an alliance of 32 leading cancer centers, all of which are devoted to patient care, research, and education. And Stanford is a proud founding member of this network; we joined in the 1990s.

The NCCN has long advocated for policies and practices to achieve equitable and accessible cancer care. But in recent years, and especially after the violence against Black Americans in the summer of 2020, the NCCN, like many organizations around the world, began to place a much greater and much needed focus on identifying and dismantling those deeply rooted historical, social, and structural barriers—barriers that have hampered progress, including barriers such as racism and other forms of discrimination.

So, I’m really proud to be a part of this group. The NCCN is established as a community of subject-matter experts, working together to address many of the issues I just mentioned and doing so through shared best practices, through policy, advocacy at all levels, and through education, and that’s what I am hoping we will do together as a community.

EBO: One of the forum’s primary aims is to improve diversity among clinical staff across NCCN’s cancer centers. What potential changes do you see in how diversity is promoted and measured across those centers?

MAYES: Yes, a major aim of the DEI Directors Forum is to increase diversity across the cancer workforce, including clinical staff and researchers, but I »

LORETTA ERHUNMWUNSEE, MD, FACS



ERHUNMWUNSEE

ERHUNMWUNSEE WILL BE vice chair of the NCCN’s DEI Directors Forum. She is a thoracic surgeon and assistant professor in City of Hope’s Division of Thoracic Surgery and Division of Health Inequities.

EBO: Can you speak about your goals and priorities as vice chair of the NCCN DEI Directors Forum?

ERHUNMWUNSEE: To achieve health equity, it is imperative that we attain true DEI within our workforce. And thus, we must move away from informative measures that simply discuss the benefits of DEI without any real change—instead, start making the cancer centers and institutions truly diverse, inclusive, and equitable.

Right now, there are just too few [minority professionals] represented in medicine, in the workforce, and certainly in leadership. Even if they are there, they frequently experience isolation. The truth is, this has to change. So we at the new DEI Directors Forum hope to provide a venue for DEI leaders to show best practices and challenges regarding advancing DEI initiatives at the respective centers and to develop recommendations of new policies and practices to actually support DEI efforts so that we can get to a point where our workforce is truly diverse, inclusive, and equitable, and our patients therefore benefit and we can really walk towards health equity.

EBO: What lessons have you learned from your experience and research in thoracic cancer, as a surgeon and professor, as they pertain to health disparities and inequities? How will they influence your work in your new role?

ERHUNMWUNSEE: My thoracic surgery and health equity research expertise is the foundation for my desire to promote DEI. Historically excluded patients have the worst outcomes in every lane, and we won’t achieve health equity if we don’t have diverse perspectives. We cannot keep doing the same things and expecting different outcomes. So, we truly need different voices and points of view, and we need members from the most burdened communities to be at the »

MAYES (CONTINUED)

think we enter this work with a more nuanced understanding of what diversity actually means and how it benefits organizations—a greater understanding and depth of knowledge than we had decades ago. We have a much better appreciation of intersectionality and a clearer understanding of which data we should be tracking and how to use these data to advance a more diverse and inclusive organization.

I call my office at the Stanford Cancer Institute the JEDI office—justice, equity, diversity, and inclusion—and when I think about the opportunity ahead of us, about how this work is promoted, measured, and sustained, I'm interested in our leaning into the *J* in JEDI because where diversity asks the really important question of who's in the room, justice asks who's presence in the room is under constant threat.

Justice will ask what structures and systems are operating in our organizations that have allowed these inequities, whether they're related to health, education, income, you name it. What are the historical structures that have allowed these inequities to not just persist but to thrive? So, that is the work that I'm interested in doing, not just with the Stanford Cancer Institute but also as part of the NCCN DEI Directors Forum.

EBO: What role can the forum play in raising awareness and interest in the medical field, particularly oncology, among racial and ethnic minorities?

MAYES: We are still in the early stages of setting up the NCCN DEI Directors Forum, and therefore, our goals and initiatives are somewhat to be determined right now. But what I'll say broadly is that we have an opportunity to join forces in our campaign to broaden participation of underrepresented minorities in oncology research and in STEM (science, technology, engineering, and math) careers. Much of this work historically has been done within the silos of our individual institutions, and we now have this unique opportunity for collective impact, something that I'm very excited about.

"We've seen a 30-plus percent decline in cancer mortality since 1991...But this progress hasn't been universally enjoyed by everyone. We know that there are differences based on a person's race, gender, socioeconomic status, or where they live in this country....That is simply not acceptable."

—Terrance Mayes, EdD,
executive director, Strategy, Equity, and Inclusion,
Stanford Medicine Enterprise Strategy Team,
associate director for DEI,
Stanford Cancer Institute

EBO: You also serve as a director of DEI at Stanford Cancer Institute. What has been your experience managing equity-related issues in California and how will it influence your approach nationwide?

MAYES: I've had the honor of participating in or leading several DEI efforts at the state level, at the national level as well. I recall my time as a member of the team that authored *Disrupting the Status Quo*, a report from the University of California Health Sciences' DEI Task Force and a document that has served as a strategic guide for all health centers across the University of California.

I also spent time on the Association of American Medical Colleges graduate research, education, and training steering committee. And what I've learned from these and other experiences is that we have to start by listening—we need to listen and listen some more. Listening to each other, certainly, but more importantly, listening to the communities that we are all working to uplift. And my job as the chair of the NCCN DEI Directors Forum is to help us align around »

ERHUNMWUNSEE (CONTINUED)

table making decisions which will increase diversity. We need those people to be welcomed and truly supported, thus increasing inclusion, and we need to treat these important members fairly, thus increasing equity.

The truth is DEI is not the natural course. It isn't what happens naturally in a system that was created to advantage certain groups while disadvantaging others. We have to be intentional about these DEI efforts and we must prioritize them, or the status quo will continue. And the problem is that the status quo means increased death of Black and Brown groups—we've got to make these changes. My experience as a thoracic surgeon and a researcher that thinks about health equity is the reason why I'm such a proponent of true nonperformative DEI efforts.

EBO: The capabilities of precision medicine have grown substantially in recent years, particularly in lung cancer, but logistical challenges remain for underserved communities. What opportunities do you see regarding access to precision medicine across NCCN's cancer centers?

ERHUNMWUNSEE: I agree that precision medicine is gaining ever-increasing importance in health care. There are many concerns, though, that there is limited access in historically excluded communities, which might make disparities worse. There are also concerns that many of the trials that are the basis for the precision medicine movement lack true racial and ethnic representation from those who have the highest burden of disease.

So, there's certainly a need for great attention to assure that those who are typically excluded are intentionally sought out to partner and join these efforts. And we believe that having a cancer center workforce that is actually diverse and is truly inclusive would positively impact efforts in this vein.

Having a diverse, inclusive, and equitable workforce allows for us to truly impact communities that have been marginalized and excluded. It allows for us to come up with more novel ideas about how to get precision medicine and other novel treatment modalities, screening, or anything to these groups, and so again, DEI efforts should impact this greatly.

EBO: What practice- and policy-level issues are foremost in your mind in terms of DEI in clinical staff representation and care delivery?

ERHUNMWUNSEE: One of the priorities is the understanding that our institutions must prioritize this work. The institutions should support the DEI leader with funding, resources, personnel, to show that they understand the importance of this very challenging work. For institutions to assume that the one DEI leader can fix the whole DEI problem alone suggests that the institutional leadership doesn't fully grasp the depth of the issues.

One very important focus is revealing or reflecting the value of this work to institutions so that they can give the appropriate resources, funding, and priority to this work. No change will happen if there isn't a focus and funding towards it, and so in this time where some funding might be scarcer, or there might be a tighter hold on funding, we've got to make sacrifices. For too long, DEI hasn't been a priority and now it really needs to be and that needs to be shown.

Also, I think there should be metrics that can hold leadership accountable. Every institution should know the percentages of their demographics for their workforce, they need to know their retention and attrition data, they need to understand who's being recruited and who's making it to interviews. All of these data need to be clear, metrics need to be set, and leadership needs to be held accountable for these results.

EBO: What advice or recommendations on equitable care delivery would you give to residents or other medical professionals just entering the health system?

ERHUNMWUNSEE: Great question—I would say first, welcome. For those who might be new to the health care system, our resident doctors, medical students, those who have an interest in potentially health equity or DEI efforts, or for doctors who want to make sure that they can give their patients the best care, »

MAYES (CONTINUED)

a shared purpose and strategy, one that is informed by our community. Then I think I can just sort of get out of the way and let the magic happen because we have an incredible group of very thoughtful and experienced leaders on the Directors Forum.

EBO: The Forum will meet several times a year to formulate recommendations to support DEI efforts. What practice- and policy-level issues do you expect to be at the forefront of conversations, and what are some long-term goals here?

MAYES: As I mentioned, the Forum is just getting started, and so we've not fully built out a policy agenda yet, but I can guarantee you that we will have one. We intend to advocate for change across our individual institutions, across the NCCN itself, and also across state and federal governments. This work is too important.

We know that over the past few decades, we've seen incredible and hopefully lasting progress in cancer research, cancer care, cancer prevention. We've seen a 30-plus percent decline in cancer mortality in the United States since 1991, I believe. But this progress hasn't been universally enjoyed by everyone. We know that there are differences based on a person's race, gender, socioeconomic status, or where they live in the country—all of these things determine one's chances of surviving cancer. That is simply not acceptable, and that is the work that the DEI Directors Forum will be committed to doing something about.

This work is going to require all of us. The DEI Directors Forum is here to help to catalyze change, but we can't do it alone. We're going to need our colleagues across the health care workforce, our colleagues across academia, our colleagues across government, if we are really going to move the needle this time, and I think we can do it. ♦

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ERHUNMWUNSEE (CONTINUED)

I think I would say that providing equitable care means providing high-quality care to everyone. You can't have equitable care without high quality, you can't have high quality without making sure that everyone can get it.

We must make sure that all groups have access to high-quality care and that the barriers to this care are minimized. And, therefore, we've got to be cognizant of what the barriers might be for individual patients and for communities. It's important to understand that we must include patients and their families in the discussion and in the decision-making so we have this idea of what quality care, equitable care might be, but the patient in the end has to contribute to that definition.

“We must also consider the whole patient, and that means understanding their social and environmental context or, as we call it, their social determinants of health.”

—Loretta Erhunmwunsee, MD, FACS,
assistant professor,
Division of Thoracic Surgery and Division of Health Inequities,
City of Hope

As a thoracic surgeon, I might think that the right answer for a patient with early-stage lung cancer is to undergo surgery, period, right? But the patient has to be included. I give them my knowledge and my expertise, and I give them the data, but in the end, it is a discussion. And so equitable care is care that is high-quality and is for everyone, it's patient-centric.

We must also consider the whole patient, and that means understanding their social and environmental context or, as we all call it, their social determinants of health. In essence, I do believe that equitable care delivery means patient-centric, high-quality care that focuses on the whole patient and incorporates them into decision-making. ♦

Study of South African Males With Prostate Cancer Reveals Limits of Current Germline Testing

MARY CAFFREY

A DEEP DIVE INTO THE GENETIC variants of Black South African men with prostate cancer revealed that the genes tested in current germline panels may not be adequate for those with African ancestry, indicating that testing guidelines specific to ethnicity are needed in prostate cancer.

The findings, published March 10, 2023, in the *Journal of the National Comprehensive Cancer Network (JNCCN)*,¹ add to the evidence—and frustration—that oncology's shift to precision medicine has been built on data developed largely from patients with European ancestry, making everything from genomic tests to therapies to clinical guidelines less effective for patients of color.

Investigators from South Africa and Australia collaborated on the study, which used deep sequencing to interrogate the 20 most common germline testing panel genes in 113 Black male patients from South Africa with advanced prostate cancer. As the authors note, current NCCN guidelines call for germline testing for patients with metastatic, regional, very-high-risk localized and high-risk localized prostate cancer.

However, right now, there are no specific testing criteria for ethnic minority populations, despite the fact that Black men in the United States are more likely to receive a diagnosis of prostate cancer and twice as likely to die from the disease

as White men.² In sub-Saharan Africa, the authors wrote, death rates are even higher: Mortality for Black men with prostate cancer is 2.7 times higher than global estimates.¹

The authors say their study is the first of its kind. They used variant data from the 20-gene panel made available from the South African Prostate Cancer Study Data Access Committee, and the sequence data were deposited in the European Genome-phenome Archive. The genes selected for study were based on current NCCN guidelines.

DNA was collected from whole blood samples of the 113 patients. From these samples, investigators identified 38 predicted deleterious variants

(PDVs) and 1 predicted deleterious structural variant (SV) in 16 genes. Additional annotation of the data classified 17 variants as potentially oncogenic; this represented 12 genes and 17.7% of the patients. According to the authors, rare pathogenic variants included *CHEK2* Arg95Ter, *BRCA2* Trp31Arg, *ATM* Arg3047Ter (found in 2 patients), and *TP53* Arg282Trp.

Important oncogenic variants of unknown pathogenicity included novel *BRCA2* Leu3038Ile in a patient with early-onset disease, as well as patients with *FANCA* Arg504Cys and *RAD51C* Arg260Gln who reported prostate cancer in their family history.

The authors found that rare pathogenic and early onset or familial-associated oncogenic variants were seen in 6.9% (5/72) of patients with a Gleason score of at least 8 and 9.2% (8/87) of patients presenting with a Gleason score of at least 4 + 3 prostate cancer.

“Noting that 10.2% of the PDVs/SVs were novel, we find that the bias toward variants of uncertain pathogenic significance, together with the identification of a single known [prostate cancer] pathogenic variant, *CHEK2* p.Arg95Ter, further emphasizes the need for further African-specific investigation to establish tailored [prostate cancer] screening panels,” they concluded.

The authors called on entities that develop clinical guidelines to revisit their diagnostic inclusion criteria and called for “further genome-wide interrogation to ensure the best possible African-relevant prostate cancer gene panel.”

“Comprehensive genomic testing, including germline testing, holds a key not only to identifying targeted therapies in patients with homologous recombination deficiency, but also would enable science to understand unexplainable differences in outcomes,” said Kashyap Patel, MD, an oncologist who is CEO of Carolina Blood and Cancer Care Associates, based in Rock Hill, South Carolina. Patel’s patients include many men with prostate cancer who are members of racial and ethnic minority populations.

“These findings are just a start, but this type of knowledge will enable new drug development that may be reflective of truly personalized approaches,” he said. ♦



Kashyap Patel, MD, CEO,
Carolina Blood and
Cancer Care Associates.

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HEALTH EQUITY SPOTLIGHT

Telehealth Involves More Than Making a Phone Call, Says Oncology Consultants’ Wagner

Produced by Maggie L. Shaw



SABO-WAGNER

SUSAN SABO-WAGNER, MSN, RN, OCN, executive director of clinical strategy, Oncology Consultants, Houston, Texas.

Health equity initiatives that search for the right telehealth modality are never-ending, according to Susan Sabo-Wagner, MSN, RN, OCN, executive director of clinical strategy at Oncology Consultants in Houston, Texas. Not every technology is a good fit for every person, Sabo-Wagner told *Evidence-Based Oncology (EBO)* during an interview that took place in New York, New York, at the February 8 session of the Institute for Value-Based Medicine®. This interview is lightly edited for clarity.

EBO: How can community oncologists and health care providers facilitate telehealth access for those whose care may be hindered by social determinants of health?

SABO-WAGNER: The best thing all providers can do is to continue to search and seek the right technology, because not every technology fits

every person. And what we’ve known through health equity initiatives is that not every person out there, in rural areas and otherwise, has access to the internet; they don’t have access to good phone technology. So, [we’re] continuing that search for the right product, then continuing to have access in those areas.

“The search for the right telehealth modality is never-ending, and as soon as we find something that isn’t just a phone call, we’ll be onto something for real.”

—Susan Sabo-Wagner, MSN, RN, OCN,
executive director of clinical strategy,
Oncology Consultants

If telehealth is not something that is as good or even an opportunity in an area, to even have days—even if it’s a half day or a whole day in an area—that really could be serviced by a provider physically being there is [helpful]. The search for the right telehealth modality is never-ending, and as soon as we find something that isn’t just a phone call, we’ll be onto something for real. ♦

National Primary Care Scorecard Highlights Need for Funding, Workforce Development, and Care Access

ROSE MCNULTY



Ripley Hollister, MD,
board member, The
Physicians Foundation.



Jennifer Lee, MD, chief
medical officer, Alliance of
Community Health Plans.



Yalda Jabbarpour, MD,
director, Robert Graham
Center.



Christopher Koller,
president, Milbank
Memorial Fund.

A RECENT NATIONAL REPORT, *The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care*, reveals a lack of financing, a shrinking workforce, gaps in care access, and almost no federal funding for research in the primary care space.¹

The scorecard, published February 21, 2023, was created following a call to action in the 2021 National Academies of Sciences, Engineering, and Medicine (NASEM) report on implementation of primary care in the United States. The new report is the first national primary care scorecard and was funded by the Milbank Memorial Fund and The Physicians Foundation. The Milbank Memorial Fund, based in New York City, works to improve population health and health equity, while The Physicians Foundation advances the work of practicing physicians by supporting practice sustainability and the provider-patient relationship.

“Although efforts by organizations such as community health centers play a central role in providing access to patients in medically underserved areas, the data demonstrate that much of the country still falls short in meeting these critical access needs.”

—study authors

“We cannot underestimate the critical role primary care plays in our health care system, from improving patient outcomes to enhancing access to quality care for everyone,” Ripley Hollister, MD, a board member of The Physicians Foundation and family medicine physician, said in a statement.² “This first benchmark report provides necessary recommendations to help address the mounting challenges that primary care physicians [PCPs] are facing. We look forward to seeing the report published annually to ensure we embrace opportunities to improve primary care and provide a better future for America’s health.”

The authors addressed several key areas where there is room for improvement based on data from the past decade: systemic investment in primary care, the PCP workforce, access to care, physician training, and federal research funding.

Lack of Investment Minimizes Progress

“I think this scorecard is extraordinarily important, because we need to have a synthesis and we need the data, and we need to have a baseline in order to track which direction we’re headed,” said Jennifer Lee, MD, chief medical officer of the Alliance of Community Health Plans, during a virtual panel discussion following the release. “Unfortunately, the scorecard reveals that we are headed in the wrong direction when it comes to investing in primary care.”

The report found that less than 6.5% of total health spending was dedicated to primary care between 2010 and 2020 in the United States. However, nations in the Organisation for Economic Co-operation and Development dedicated 7.8% of health care spending to primary care on average in 2016, per the initial NASEM report.

Although primary care spending can be defined differently by various stakeholders, the report considers it “the proportion of total health care expenditures being spent on outpatient and office-based visits to primary care clinicians.” Medicare primary care spending has also decreased consistently since 2014, with a low of 4.2% in 2020, according to the report.

Additionally, payment models for physician reimbursement are often unsupportive of teams rooted in whole-person care. Hybrid models with elements of fee-for-service and capitation reimbursement that compensate the entire primary care team are ideal but can be administratively complex, the authors wrote.

As Workforce Shrinks, Gaps in Care Access Persist

The report highlighted a drop in the proportion of physicians practicing primary care in recent years. In 2010, 1 in 3 physicians practiced primary care, but only 1 in 5 medical residents between 2012 and 2020 were practicing primary care 2 years later. This indicates a need to strengthen the pipeline to primary care practice, the authors wrote.

In 2010, 23% of US adults reported using the emergency department as a source of care and not having a PCP. This statistic climbed to 27% in 2020. The proportion of clinicians performing primary care also varies by state, and primary care access overall is lacking in underserved communities, the authors noted. In underserved areas, there were approximately 55.8 PCPs per 100,000 individuals vs 79.7 per 100,000 in areas not considered medically underserved in 2020.

“Although efforts by organizations such as community health centers play a central role in providing access to patients in medically underserved areas, the data demonstrate that much of the country still falls short in meeting these critical access needs,” the authors wrote.

Need for Training in Community Settings Exists

Most primary care occurs in the community setting, and the NASEM report emphasized a need for training to reflect this. Some states expose all physicians to medically underserved areas or rural settings, but in some states only 5.9% of physician residents will experience these settings in training, the scorecard report found.

The distribution of physician residents also does not align with the geographic areas where physicians are entering primary care, the authors noted. “The mismatch between training opportunities and PCP supply signals that graduate medical education funding is not set up to support the growth of primary care but instead encourages subspecialty fields,” they wrote. Graduate medical education funding is most often allocated to sponsor institutions, although primary care is more often performed in community settings.

All Stakeholders Need Access to Uniform Data

Family medicine departments received just above 0.2% of the National Institutes of Health research funding. Although there are other primary care specialties, family medicine was chosen as the measurement because it has the most US health care encounters, the authors noted.

During the panel discussion, Yalda Jabbarpour, MD, lead author of the scorecard and director of the Robert Graham Center, also

highlighted a lack of uniform data available for research purposes.

“If we don’t have uniform data that [are] easily accessible to all stakeholders who want to research this either on the state or health system or national level, it’s going to be hard to keep the nation accountable to moving towards implementing high-quality primary care,” Jabbarpour said. “As a research team, that was what we noticed right away...and we looked at these data in so many different ways, using so many different data sources. Maybe we didn’t get to perfection, but we got to ‘good enough’—but it would be nice to not have to spend all those resources to do that.”

Overall, the baseline scorecard emphasizes a need for research and investment into primary care, as well as consistent reporting to improve care access, workforce development, and the PCP pipeline in the United States going forward.

“Our health care system is wildly out of balance and in critical need of reform,” Christopher Koller, president of the Milbank Memorial Fund, said in a statement. “We can do better, and this scorecard can serve as an essential tool for policymakers and other stakeholders to pursue policies that will increase investments in high-quality primary care in every community.” ♦

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HEALTH EQUITY SPOTLIGHT

Sashi Naidu, MD: NOLA Initiative Is Helping Overcome Fragmented Oncology Care

Produced by Maggie L. Shaw



NAIDU

SASHI NAIDU, MD, director of research, Carolina Blood and Cancer Care Associates, Rock Hill, South Carolina.

At Carolina Blood and Cancer Care Associates (CBCCA), based in Rock Hill, South Carolina, the No One Left Alone (NOLA) initiative is working to break down cancer health disparities among patients by addressing the social determinants of health that may be preventing equitable access to care.

Sashi Naidu, MD, is director of research for CBCCA and for the NOLA initiative, which was implemented in January 2021. He spoke with *Evidence-Based Oncology™ (EBO)* before presenting results for NOLA during a session of the Institute for Value-Based Medicine® held February 8, 2023, in New York, New York.

EBO: Can you discuss the NOLA initiative from Carolina Blood and Cancer Care Associates?

NAIDU: NOLA was conceived by our need at our practice. There are a lot of foundations and opportunities for patient access, but it’s often a fragmented process. So, the purpose of NOLA was to bring that process in-house, where the patients can feel comfortable that the physicians who are their treating doctors are taking care of this aspect of their health care, which often can be a very big challenge—even sometimes more than the clinical aspects of their cancer care.

EBO: What is the status of patient assistance initiatives for oral cancer drugs within NOLA?

NAIDU: We picked up oral financial assistance initiatives just like the intravenous drugs. It’s a seamless process. As with many community oncology practices, there is an oral dispensary in-house. It is just a very easy transition to add oral financial assistance to our intravenous drug financial assistance. So, there [have] not been any major problems there. ♦

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