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The Benefits of Professional Abstracts

A well-written professional abstract offers meaningful benefits to the author(s), the readers, and the broader profession. It enhances the visibility and impact of an author's work, helps readers quickly assess a document's relevance, and supports key professional processes such as publishing and conference planning.

Congratulations to each author whose abstract was accepted! This milestone adds a prestigious entry to one's curriculum vitae or resume, showcasing expertise and initiative. It also helps evidence-based practice reach a wider audience, increasing visibility and networking opportunities within the patient navigation field. Inclusion in a conference program connects authors with other experts and researchers who share similar interests. During poster sessions, authors will demonstrate critical thinking and communication skills as they engage with colleagues. This is a valuable opportunity to identify potential collaborators and stay current with emerging trends. A compelling abstract also boosts the likelihood of future conference presentations by attracting an audience for the presentation.

Readers will quickly assess if an abstract is relevant to their interests. Abstracts provide essential information—the problem, methods, results, and significance—allowing readers to decide whether to explore the full work or initiate further discussion. A reader may find a process applicable to their own projects and seek to replicate it in their work environment. Abstracts can also be saved for reference and used to support scholarly writing in future initiatives.

Professionally, abstracts play a vital role in determining which research is presented at conferences. They often serve as a steppingstone toward full-length publication and contribute to a professional's publication record. This advancement in education expands knowledge across the field and is a primary method for sharing new research findings, innovations, and best practices to the wider professional community. And abstracts can drive change. By submitting and presenting work, professionals influence policy, promote positive changes, and address systemic challenges. Education through abstracts can lead to innovative programs, improved patient care, and advancements in professional education.

Sharon

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Category I:

Community Outreach/Prevention

Category I: Community Outreach/Prevention

Advancing Equity in Cancer Care for American Indian Communities Through Native Cancer Navigation

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Background: American Indian patients face persistent cancer care disparities due to geographic isolation, fragmented referral systems, and limited culturally responsive support .[1, 2] The Native Health Navigation program was created to reduce these barriers by embedding Indigenous-led, community-informed navigation within an oncology setting to promote timely, equitable, and culturally aligned cancer care.

Objective: To reduce cancer disparities among American Indian patients in Northern New Mexico by delivering culturally grounded, system-integrated navigation services that address social, geographic, and institutional barriers to timely, equitable cancer care.

Methods: In 2023, CHRISTUS St. Vincent launched the Native Health Navigation (NHN) program in response to long-standing cancer disparities in local Tribal communities. The NHN program integrates a dedicated Native Health Navigator into the oncology team. The Navigator conducts comprehensive intake assessments rooted in the Social Determinants of Health (SDOH) framework.[4] They address barriers related to transportation, housing, insurance, financial strain, and communication between Indian Health Service (IHS) and Purchased/Referred Care.[2,4] The Navigator helps reinforce provider-delivered education by ensuring patients understand key information and have the opportunity to ask questions.[3] They coordinate appointments across specialties and systems to minimize travel burden.[4] Additionally, the Navigator supports access to traditional healing practices and provides cross-cultural care guidance.[3]

Results: From June 2023 to June 2025, the NHN Program served 75 American Indian patients from 22 Tribal affiliations across Northern New Mexico. Patients ranged in age from 28 to 93 and represented 15 different cancer types. Of 75 referrals, 73 were eligible, and 60 (82%) opted into the program. Among newly referred oncology patients (n=38), 50% were seen within one week of referral. Referral source was known for 68 patients: 27 (40%) came from IHS and Tribal health partners, and 37 (54%) from CHRISTUS staff. One in three patients reported at least one area of social insecurity, most commonly financial strain (31%), followed by housing instability (11%), food insecurity (11%), and transportation challenges (9%). The program also delivered seven educational sessions for CHRISTUS associates and community members, reaching over 485 participants with culturally focused training to improve cancer care for Native patients.

Conclusion: The Native Health Navigation program demonstrates that culturally specific, system-embedded navigation services can significantly reduce barriers to timely cancer care for American Indian patients. Early findings underscore the importance of integrating Indigenous knowledge, relationship-centered care, and real-time tracking into navigation models. [2, 3] As the program expands regionally, future work will include scaling navigator services to additional rural Tribal communities, partnering with traditional medicine experts to deliver cross-cultural training for providers, and using stratified data to assess equity impacts and guide system change. The NHN program may serve as a replicable model for institutions seeking to address cancer care disparities in Indigenous and other historically underserved populations.

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Advancing Rural Lung Cancer Screening: A Peer-Led Educational Series to Address Operational Barriers in Appalachian Communities

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Background: The Association of Cancer Care Centers’ (ACCC) Rural Appalachian Lung Cancer Screening Initiative (RALCSI) is a program designed to identify and address barriers to lung cancer screening in rural Appalachian communities. ACCC supported 2 health systems in Kentucky and Virginia with training and technical assistance to increase lung cancer screening rates from November 2023 to March 2025.

Objective: To provide targeted virtual education that addresses common operational challenges to lung cancer screening, based on barriers identified by RALCSI participating sites.

Methods: ACCC hosted 3 peer-led, live webinars in January and April 2025. Key topics addressed included comprehensive patient navigation across the lung cancer screening continuum—from initial screening through diagnostic follow-up—assessment of screening eligibility including standardized pack-year calculations, implementation strategies for smoking cessation programs, and evidence-based approaches to shared decision-making (SDM). Each session explored relevant coverage and reimbursement considerations, featured case studies, shared best practices and practical strategies, and was open to the broader ACCC membership. Participants completed online evaluations assessing content quality, relevance, and knowledge gained. Attendance reports and chat logs were analyzed to identify common themes.

Results: A total of 231 participants from over 30 states attended the series, representing diverse roles across the lung cancer care continuum. Nurse navigators comprised the largest group (28%), followed by program managers/coordinators (15%), administrators (15%), advance practice providers and nurses (11%), community or patient navigators (7%), and other various support roles (24%). Key discussion themes included: variability in navigation staffing models; challenges integrating smoking cessation programs into practice; electronic health record (EHR) documentation and metric tracking; coverage gaps for patients on Medicare advantage plans or outside Centers for Medicare and Medicaid Services (CMS) criteria; and the complexity of applying screening guidelines to individuals with past smoking histories, those who quit more than 15 years ago, or those with occupational or familial risk. The need for clear, concise SDM documentation practices aligned with CMS mandates was also emphasized. Fifty-six attendees completed evaluations. Among them, 86% reported gaining new knowledge, and 91% planned to share the information with colleagues and apply it in practice. Notably, 21/21 (100%) of respondents who attended the screening eligibility webinar reported increased confidence in determining screening eligibility based on current guidelines, and 18/21 (86%) gained a better understanding of using the EHR to assess smoking history and screening eligibility. Top takeaways across the series included greater clarity on reimbursement and coding, useful tools and resources, and peer-driven best practices. Respondents found inspiration from learning about high-performing programs and valued insights into team structure and workload management. Feedback emphasized the need for continued education on EHR optimization, navigation staffing models, and system-level change in tobacco cessation programming.

Conclusion: The webinar series effectively addressed real-world challenges in lung cancer screening and navigation and highlighted the importance of ongoing education and peer-driven collaboration to advance and sustain efforts in diverse care settings. Future efforts will build on this momentum, with a focus on navigation in care transitions post-diagnosis and continued targeted support for Appalachian communities.

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N/A

From Guidelines to Action: Innovative Approaches to Promote Cancer Screening Through Nurse Navigation

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Background: Cancer screening remains one of the most powerful tools in the early detection and prevention of cancer-related morbidity and mortality. With evolving guidelines and new technologies emerging, nurse navigators play a vital role in ensuring patients receive timely, evidence-based cancer screenings. This presentation will provide nurse navigators with current updates on screening recommendations and procedures for breast, cervical, lung, colorectal, and prostate cancers, while also highlighting innovative strategies for increasing screening uptake within healthcare systems.

Objective: The session will begin with a comprehensive review of current screening guidelines from the American Cancer Society, U.S. Preventive Services Task Force (USPSTF), and other leading authorities, highlighting the existing discrepancies. Specific attention will be given to recent changes, such as the expanded eligibility criteria for lung cancer screening using low-dose CT, evolving approaches to HPV testing and cervical cancer screening intervals, and updates in breast cancer screening age thresholds and modalities. We will also address developments in colorectal cancer screening, including the increasing use of non-invasive stool-based tests and the implications of starting screening at age 45. For prostate cancer, the discussion will focus on shared decision-making approaches in PSA testing, especially for high-risk populations.

Methods: Beyond clinical updates, this session will explore innovative, system-level strategies to promote cancer screening and close gaps in care. These include the use of electronic health record (EHR) tools for identifying eligible patients, population health dashboards, and automated outreach methods such as text messaging and mailed screening kits. Case examples will highlight successful programs that have leveraged nurse navigator leadership in building trust, reducing disparities, and tailoring outreach for underserved communities. We will also discuss partnership models that integrate community health workers, primary care teams, and specialists to create a seamless screening continuum. Health system-led outreach initiatives will be highlighted as examples.

Results: Recognizing that nurse navigators are on the frontlines of patient engagement, this session aims to empower nurse navigators with the knowledge, confidence, and strategies needed to lead cancer screening initiatives within their organizations. Whether working in a large health system, community clinic, or specialty setting, nurse navigators are uniquely positioned to coordinate care, address social determinants of health, and advocate for screening access at both the individual and systems level.

Conclusion: By combining up-to-date clinical knowledge with innovative outreach and navigation practices, nurse navigators can play a pivotal role in reducing cancer disparities and improving outcomes across diverse patient populations. Attendees will leave with practical tools and resources to support their navigation programs and drive measurable improvements in cancer screening rates.

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Leveraging Community Input to Improve Navigation Practices through the Alliance for Equity in Cancer Care

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Background: The Alliance for Equity in Cancer Care (Alliance) is a multisite initiative advancing health equity by improving timely access to high-quality cancer care for underserved communities. The core vision focuses on leveraging community leadership to reduce disparities and improve outcomes in cancer care among non-academic and community-based oncology care centers.

Objective: Mary Bird Perkins Cancer Center (MBPCC) and the National Comprehensive Cancer Network® (NCCN®) implemented a community-informed approach and responsive framework to meet the unique needs of community-based oncology care delivery. Bidirectional community input, used to co-design equitable solutions that are both scalable and sustainable, is foundational to this work.

Methods: Community-based oncology practices face unique SDOH needs and limitations in infrastructure. Community advisory groups were established by MBPCC and NCCN independently to guide and inform development of navigation practices (MBPCC) and revision of a health equity measurement tool (NCCN). Intentional selection of representatives based on patient demographics, multi-disciplinary expertise, and established partnerships in the community were employed to reflect the realities of non-academic care environments. Over a three-year period, MBPCC conducted more than 130 outreach and education initiatives—with 40% of events and 73% of presentations carried out in collaboration with the Community Advisory Board (CAB). NCCN has previously published the Health Equity Report Card (HERC), a measurable tool to evaluate equitable care delivery across four domains. NCCN's Community Oncology Working Group (COWG) included community oncologists and administrators, patient advocates, community-based organizations, and health equity experts. The group reviewed NCCN's HERC for applicability and practical implementation in the community health care setting.

Results: MBPCC's Community Advisory Board (CAB) remains a critical conduit between MBPCC and North Baton Rouge's underserved populations, leveraging specialized expertise and resources to drive equitable cancer care initiatives. These efforts resulted in the enrollment of over 350 patients and a remarkable 82% reduction in the interval between diagnosis and treatment, exemplifying the program's efficacy in advancing timely, equitable cancer care. NCCN's COWG reviewed the HERC and its implementation scoring process for applicability with respect to performance measures, benchmark metrics, and requested sources of evidence. Two additional performance measures related to quality and comprehensiveness of care were added, with expansion of evidence sources throughout the scoring process. The group affirmed the applicability of the established measures, metrics, and evidentiary sources to community settings.

Conclusion: Through coordinated community outreach, strategic partnerships, and refinement of navigation best practices, MBPCC and NCCN are advancing community-driven navigation efforts. MBPCC's program highlights the tangible benefits of embedding navigation within underserved populations, while the HERC-CS provides a framework for accountability and continuous improvement across diverse settings. This combined approach—grounded in local needs and guided by national standards—demonstrates how equity efforts are most effective when informed by bidirectional community input.

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Navigators as a Genetic Extender: A Novel Approach to Proactive DNA Screening, Guidance, and Education for Prevention and Early Detection

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Background: Navigation is an evidence-based practice that can support care coordination for prevention and screening strategies that lead to timely access to healthcare and increased adherence.[1] The Institute of Medicine identified that fragmented care delivery leads to a breakdown in care coordination, poor adherence, and decreased access to care.[2] In 2025, nearly 70% are behind on cancer screenings (PCF), and most individuals are unaware of genetic risks for conditions that may be prevented or detected earlier.[3]

Objective: To provide a U.S.-based employee benefit program with access to DNA screening (>160 genes with actionability for cancer, cardiovascular, and other notable conditions), genetic counseling, and healthcare navigation. The goal is to engage individuals in adherence to routine health screenings, identify genetic risks, and support personalized preventive actions.

Methods: Retrospective, deidentified data (1/1/23-6/30/25) was evaluated under an IRB-approved protocol. 8516 individuals completed a DNA screening test. In the first two years, self-directed engagement with a genetic counselor was offered; in 2025, navigators performed outreach and education to individuals with positive results and tailored referral for genetic counseling to those with high-risk positive findings. Navigators attempted to engage all individuals with positive results several times via phone and email, and a certified letter with results enclosed was sent if there was no response. Navigators served as a genetic extender, providing access to resources, education on appropriate screenings, surveillance exams, and healthy lifestyle behaviors to support increased adherence to follow-up actions. Descriptive statistics were used to analyze the data.

Results: The positive rate for a pathogenic, likely pathogenic, or increased risk allele for a medically actionable condition was 18.7% (1593/8516). Of the positive results for 2023-2024, 49.7% (579/1166) and 50.3% (587/1166) were associated with high and elevated risks, respectively, as previously defined, [4] and 61% (711/1166) with positive results received genetic counseling. In the navigator-led model, result awareness occurred 100% of the time. Of the positive findings for 2025, 52% (222/427) and 48% (205/427) were associated with high and elevated risks, respectively. 73% (161/222) of individuals with high-risk results received genetic counseling, and one or more navigation educational encounters occurred in 79% (162/205) of individuals with elevated risk results. Across all positive results, engagement increased from 61% to 76% following implementation of the navigation-led model, a 15-percent increase, representing a 21.9% relative improvement over the self-directed model. Navigators provided support for important health actions, including sharing results with local providers, coordinating peer-to-peer consultations, facilitating family follow-up testing, overcoming health system challenges, offering psychosocial support, and providing tailored long-term follow-up guidance. Follow-up on long-term surveillance and compliance with screening and preventive care is planned.

Conclusion: An employee benefit program that combines DNA screening, genetic counseling, and personalized navigation enables individuals to be informed about their health risks and to take action. Implementation of navigators as a genetic extender can increase adherence to follow-up actions, while overcoming barriers to care, and supporting improved health outcomes.

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Oncology Nurse Navigator-Led Creation of Ambulatory Safety Nets to Address Barriers to Cancer Screening in the Greater Merrimack Valley

Paula Aguilera, RN, BSN, OCN, Gladys Munoz, Wilmary Peralta, Sarah Pohl, MPH, and Ludmila Svoboda, RN, MSN, MA, OCN, ACS-LION

Objective: Community hospitals and primary care practices often face limited resources to manage cancer screening referrals for large volumes of complex patients. In collaboration with community partners, we implemented an Oncology Nurse-Led, Community-Focused Patient Navigation Model designed to serve historically marginalized populations at highest risk for delays in cancer screening and timely follow-up care.

Methods: The Oncology Nurse Navigator and Patient Navigator monitor referrals and follow abnormal findings. Workflow development with partners established multimodal outreach system for colorectal, lung, breast, and prostate screenings: phone calls and text messages. Patients scheduled for colonoscopies receive text messages and calls to review preparation and assess barriers. Post-procedure chart reviews: pathology and follow-up. Instructions translated into Spanish, visual aids to support patients. Partnered with endoscopy suite to create “prep kits” supporting preparation. Gaps identified in annual Low-Dose Chest CT follow-ups. Patients with LDCCT but no follow-up were flagged. Shared decision-making by ONN, reducing burden on PCPs. Appointments: completion and results. Follow-up phone calls for importance of screening. High no-show/cancellation rates were noted for diagnostic mammograms/ultrasounds. Outreach stratified by: PN, ONN, or referral to breast center. Orders placed or providers contacted for referrals. Post-appointment chart reviews assessed completion and follow-up. Prostate cancer screening in development; will follow similar workflow.

Results: Results (as of June 2025): CRC ASN: 3,389 patients identified; 1,867 reached; 2,243 colonoscopies completed; 6 cancer diagnoses. LCS ASN: 188 patients identified; 67 reached; 27 LDCT orders placed; 23 patients deemed ineligible. BCS ASN: 90 patients identified; 19 reached; 8 cases closed; 2 referred for PCP follow-up. Patients may be included in multiple ASNs depending on age, sex, and smoking history.

Conclusion: Culturally tailored education and communication in patients’ primary languages have significantly improved engagement and cancer screening completion. Continued innovation in outreach strategies is necessary to further increase patient participation and ensure timely follow-up. Our community partners maintain strong systems for connecting patients with abnormal findings to appropriate specialty care.

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Category II:

Care Coordination/Care Transitions

Category II: Care Coordination/Care Transitions

A Proactive Model for Patient-Centered Care Coordination: A Redesign of the Ambulatory Care Model

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Background: The Ambulatory Care Model Redesign aims to enhance care coordination and patient experience by creating a concierge-style approach that improves navigation from referral placement to the initial appointment.

Objective: The initiative seeks to streamline clinic operations by realigning roles and responsibilities among Scheduling Intake Coordinators, clinic nurses, and Patient Navigators, ensuring efficient processes that prioritize patient preparedness and engagement.

Methods: In the first pilot phase, one or two dedicated nurses in each clinic will partner with a Scheduling Intake Coordinator to facilitate patient intake. First, the Scheduling Intake Coordinator will obtain all necessary records. Nurses will then ensure necessary medical records are obtained, perform chart abstraction, and document critical information to make certain that patients are fully prepared before their first visit. Additionally, nurses will conduct outreach calls one week prior to appointments, completing nursing assessments and screenings to proactively address patient needs while expediting check-in processes on the day of the visit. Patient Navigators will enhance care coordination by conducting Social Determinants of Health (SDOH) screenings and barrier assessments through outreach calls before the first appointment. This approach proactively identifies potential obstacles, such as transportation, financial limitations, and language barriers, to implement supportive interventions that promote health equity and optimize patient access to care.

Results: Preliminary findings indicate improved efficiency in patient intake processes, with nurses successfully abstracting records and completing assessments ahead of visits. Early patient feedback suggests greater satisfaction with the proactive approach, as outreach calls help them feel more prepared and engaged in their healthcare journey. Additionally, initial observations highlight strengthened interdisciplinary collaboration, fostering seamless coordination among nursing teams, scheduling staff, and navigators. Patient Navigator interventions have demonstrated the ability to identify and mitigate key barriers to care, improving appointment adherence rates and reducing logistical challenges associated with the first visit. Standardizing navigation functions has also streamlined workflows, ensuring patients receive comprehensive support tailored to their individual needs.

Conclusion: The Ambulatory Care Model Redesign represents a strategic advancement in ambulatory care, optimizing scheduling, intake, and navigation processes while prioritizing patient engagement. Rooted in Relationship-Based Care, this initiative fosters a seamless, compassionate experience in which patients feel empowered, seen, and supported throughout their healthcare journey. By integrating proactive outreach, interdisciplinary collaboration, and standardized navigation functions, this model creates a more efficient and patient-centric approach to care coordination. As the pilot phase evolves, ongoing evaluation and data-driven refinements will further enhance effectiveness and patient satisfaction, paving the way for broader implementation and long-term sustainability. This initiative not only improves operational efficiency but also signifies a cultural shift toward a more holistic, equitable healthcare experience, where every patient receives timely, well-coordinated care from referral to their first appointment.

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N/A

Cross-Institution Nurse Navigator Collaboration Accelerates Multidisciplinary Care: A Neuro-Oncology Case Study from Mayo Clinic

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Background: TRapid multidisciplinary evaluation and treatment is essential in neuro-oncology due to the aggressive nature of CNS tumors.[1] Patients with glioblastoma benefit from coordinated care involving the interdisciplinary team, palliative care, and social work.[2,3] This case study shows how cross-institution nurse navigator collaboration can improve care timelines, support decision-making, and potentially impact patient outcomes.[4]

Objective: To evaluate the impact of nurse navigation—specifically cross-institution navigator collaboration—on three key care intervals including time from first contact to initial Mayo Clinic (MC) visit, time from first contact to specialty consults, and time from first contact to full interdisciplinary evaluation, including supportive services.

Methods: Two patient journeys were retrospectively analyzed. Both were referred to MC for brain tumor treatment with similar clinical urgency. One patient was referred without navigator involvement, while the other was introduced by a nurse navigator from a referring institution who coordinated directly with the MC nurse navigator. Care milestones were tracked using electronic medical record timestamps.

Results: MCross-institution nurse navigation significantly reduced delays in care for neuro-oncology patients. Time from first contact to MC visit decreased from 19 to 7 days, and time from referral to navigator triage call dropped from 112 days to 1 day. Access to specialty consults (neurosurgery, neuro-oncology, radiation oncology) improved from 21 to 7 days, while the full interdisciplinary evaluation—including navigation, social work, and palliative care—was expedited from 123 to 9 days.

Conclusion: Cross-institution nurse navigation led to significant reductions in time to key care milestones for patients referred to the neuro-oncology specialty. Time from referral to first visit was reduced by 63%, navigator contact time improved by over 99%, specialty consults occurred 67% faster, and time to full interdisciplinary consults decreased by 93%. These findings highlight how direct collaboration between nurse navigators at referring and receiving institutions enables rapid information sharing and proactive scheduling. Structured navigator-to-navigator communication enhances patient experience and may improve outcomes for those with high-grade brain tumors. Nurse navigation not only expedites access to care, but also strengthens coordination of complex, multidisciplinary services—supporting more effective delivery of neuro-oncology care.

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Enhancing Clinical Knowledge, Interdisciplinary Collaboration, and Care Coordination Through a Thoracic ‘Lunch and Learn’ Case Study Series

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Background: In 2023, an NCI-designated cancer center hired thoracic Oncology Nurse Navigators (ONNs) as part of an institutional program. Early findings revealed a need to improve clinical knowledge and collaboration with Advanced Practice Providers (APPs) to enhance care coordination, underscoring the importance of clinical expertise, role clarity, and interdisciplinary teamwork. [1-3]

Objective: To implement and evaluate the impact of a thoracic “Lunch and Learn” case study series co-led by ONNs and APPs on novice ONN clinical knowledge, interdisciplinary collaboration, and care coordination.

Methods: This ONN-led case study series launched in April 2024. Prior to each session, staff were invited to submit cases involving complex care coordination, multidisciplinary care, and additional consult services. During each session, staff presented up to 4 cases and posed questions to APPs, who led subsequent case discussions and shared clinical insights, critical thinking, and problem-solving.

Outcomes were evaluated through: (1) a one-time post-survey sent to series ONN and APP participants, (2) a navigation program annual work experience survey sent to all thoracic providers, and (3) examining patient scheduling delays related to clinical review.

Results: Nineteen sessions were held (average 23 participants/session), reviewing 55 case studies. All post-survey respondents (n=13) found the series beneficial, reporting improvements in ONN clinical knowledge (4.2/5), frequency of ONNs seeking clinical guidance from APPs (3.9/5), and ONN–APP collaboration (4.5/5). Among thoracic providers, 83% agreed or strongly agreed that “Navigation improves the quality of patient care” (n=18), a 43% increase from baseline. Scheduling delays related to clinical review decreased from 3% (n=35, Jan–Mar 2024) to 2% (n=102, Apr 2024–Jun 2025), with an estimated 62 additional new patients scheduled within the target 48-hour window from referral. The model was later adopted by three additional disease sites.

Conclusion: The Thoracic “Lunch and Learn” series provided a familiar, structured approach to ONN education using existing expertise. Case studies prompted robust discussion among participants and helped clarify ONN versus APP roles, highlight practice variation, and explore clinical rationales, ultimately helping the team build trust and collaboration. Anecdotally, the team reported a noticeable decrease in ONNs messaging APPs for routine clinical guidance and improved scheduling accuracy. Fewer scheduling delays suggest this model offers a practical approach to improving care coordination of newly referred patients seeking cancer care.

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Enhancing Communication and Building Trust: Implementing the OhMD Texting Platform in Patient Navigation

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Background: Patient Navigators (PNs) in the Cancer Care Access Program (CCAP) at Dana-Farber Cancer Institute (DFCI) play a vital role in supporting patients from historically marginalized communities by helping them navigate the healthcare system and overcome barriers to care. Trusted points of contact, PNs are critical to fostering patient engagement and ensuring equitable access to services.

Objective: To pilot the use of OhMD, a HIPAA-compliant texting platform, as a communication tool between patient PNs and patients, as patients are unable to answer calls during work hours or are hesitant to respond to unknown numbers. The goal was to improve communication accessibility and strengthen trust in navigator-patient relationships.

Methods: The OhMD platform was integrated into the communication toolkit of the CCEP Patient Navigation Program. Navigators used OhMD in conjunction with traditional methods, such as phone calls, to conduct secure, two-way messaging for seamless care coordination. Texts were used for a range of routine communications, including appointment reminders, follow-ups, and the exchange of documents.

Results: The pilot phase has not yet undergone formal evaluation. Findings are based on qualitative data gathered through interviews with four PNs, focusing on their firsthand observations and experiences. OhMD offered increased flexibility and convenience for both patients and navigators. It proved particularly beneficial for patients who are busy, deaf, or hard of hearing, or prefer to communicate asynchronously. Navigators reported that the platform encouraged more frequent, easy communication, sometimes prompting patients to disclose concerns they might not have shared otherwise. However, effectiveness varied based on patient age, comfort with technology, and language preferences. The PNs report that older patients with limited digital literacy prefer phone calls over texts. OhMD was most effective for follow-up interactions and ongoing communication with established patients, rather than for initial outreach. PNs stated that this is due to the consent message that is sent by the platform and needs to be answered before the messaging application is activated. The four PNs report increased ease with communication, especially with hard-to-reach patients who work and cannot take time away to answer calls during work hours. Once the PNs met with patients in person and were able to explain the consent message, patients were more likely to engage with texting. Another beneficial aspect of this texting application is that bilingual PNs can easily communicate with their patients and send educational material in their preferred language.

Conclusion: Phone calls remain the dominant form of communication in healthcare,[2] yet they may be inaccessible for patients due to time constraints, technological barriers, or other socioeconomic factors. Over-reliance on phone-based communication can perpetuate existing healthcare disparities.[3] Alternative platforms like OhMD represent a crucial step toward more equitable, patient-centered care by facilitating accessible, confidential, and consistent communication. More formal evaluation processes are needed, such as qualitative interviews with all PN staff and correlation between the use of texting and no-show rates, for example. The use of OhMD shows promise in promoting trust and enhancing engagement between patient navigators and the communities they serve, especially with historically marginalized patients and hard to reach individuals.

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Expanding Access to Cancer Services for Rural Communities through Digital Navigation Tools

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Background: The Alliance for Equity in Cancer Care (Alliance) is a multisite initiative advancing health equity by improving timely access to high-quality cancer care for underserved communities. Foundational to this work is the initiative's emphasis on addressing social drivers of health (SDOH). In Kentucky, where 41.4% of the population lives in rural counties,[1] access challenges are especially acute, requiring nontraditional approaches to meet these unique patient needs.

Objective: The University of Kentucky Markey Cancer Center (UK Markey) evaluated a hybrid model that integrates digital tools with traditional patient navigation approaches to address SDOH barriers, mitigating challenges associated with residing in rural communities, including those in Appalachian regions.

Methods: Implementation strategies centered on institutional commitment, community input, and multidisciplinary coordination. After identifying patient needs, UK Markey secured organizational buy-in to implement new cancer care coordination services, both digitally and in-person. UK Markey conducted interviews with five patients and five clinical stakeholders to test a digital application and navigator dashboard for psychosocial screening and SDOH resource connection. Critical coordination efforts included staff training (e.g., multidisciplinary clinical learning modules) and continuous evaluation and feedback to further guide programmatic refinements, ensuring sustainability and capacity building.

Results: UK Markey's stakeholder interviews reinforced the value of a hybrid model combining digital tools with navigator support to improve access to care for rural patients. Both patients and clinical stakeholders cited key benefits of the digital tools, including the ability to complete psychosocial distress assessments at home, centralized access to SDOH resources, and self-referral to nearby services—features especially valuable in geographically isolated communities. Challenges included limited digital literacy, need for navigator support with service forms, and lack of Electronic Health Record integration. Still, the tools showed strong potential to reduce rural access barriers.

Conclusion: This case study demonstrates how digital tools can expand access to high-quality cancer care in rural and underserved communities. UK Markey's hybrid digital approach offers a scalable, replicable strategy—one that could potentially expand beyond oncology and into additional fields of medicine through technology-enabled navigation. Strong institutional commitment, meaningful community input, and coordinated, multidisciplinary collaboration were paramount to the successful implementation of this innovative model. As health systems seek solutions to address cancer disparities, this approach provides valuable lessons for implementing care coordination interventions tailored to the realities of rural care delivery.

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Expanding Genetic Testing in Prostate Cancer: A Practical Handbook for Oncology Teams

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Background: Prostate cancer is the most prevalent solid tumor in men. Despite evidence and guidelines supporting germline and somatic genetic testing for treatment and family risk,[1] major gaps in provider knowledge, patient understanding, and clinical workflows lead to inconsistent and inequitable access to testing.

Objective: The Association of Cancer Care Centers (ACCC) developed a provider handbook based on insights from multidisciplinary oncology experts. Featuring practical tools and resources, the handbook was piloted at 3 cancer centers to support the integration and improvement of genetic testing in routine prostate cancer care.

Methods: ACCC conducted 2 focus groups in February 2024 comprised of 15 multidisciplinary cancer care team members, including oncologists, APPs, genetic counselors, nurses, financial navigators, and patient advocates. Focus group attendees provided insights into practice gaps in metastatic prostate cancer genetic testing workflows and suggested strategies to support shared decision-making. These insights were used to inform the creation of a best practices handbook which was piloted at 3 cancer programs. With the utilization of the handbook, each site identified local barriers and implemented solutions, communicated in monthly check-ins over a 3-month period to track progress, and shared progress during the implementation phase.

Results: The handbook served as a centralized resource to standardize processes and support provider engagement across pilot sites. Pilot sites reported that utilization of the handbook facilitated the identification of practice gaps and opportunities for improvement, enabling integration of actionable tools and resources into routine care delivery. Common themes identified across sites included the lack of standardized workflows, language and literacy barriers, limited provider capacity and unclear role delineation, suboptimal patient understanding of the purpose of testing, and disparities in access to genetic testing. Nurse navigators were recognized as playing a critical role in care coordination, patient education, and the facilitation of financial and logistical support. Additionally, pilot sites emphasized the need for multilingual patient materials, culturally appropriate visual aids, and the establishment of internal champions to drive and sustain practice improvements.

Conclusion: The ACCC Prostate Cancer Handbook offers a scalable strategy to improve genetic testing by addressing clinical and communication gaps. Pilot sites stated that the structured, resource-driven approach addresses systemic barriers to improve germline and somatic testing practices, particularly when supported by dedicated roles such as nurses and patient navigators. By equipping care teams with standardized tools, evidence-based resources, and targeted education, this initiative offers a practical and sustainable pathway to improving equitable genetic testing workflows. Future efforts will expand dissemination, assess patient-centered outcomes, and embed these strategies into routine workflows to improve care quality and access. This research is supported by AstraZeneca, Johnson & Johnson, and Pfizer.

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Improve Timeliness to Care Within Radiation Oncology Department by Utilizing Nurse Navigator Role for Coordination of Care in Breast Cancer Patients

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Background: Navigation collaborates with multiple service lines and providers to remove barriers to care and connect patients with various care providers.[1] Navigation has the ability to ensure cancer patients receive treatment in a timely manner and decrease overall mortality.[2]

Objective: Improve utilization of nurse navigator to decrease radiation treatment delays related to availability of patient data impacting timeliness to care.

Methods: Role clarification for utilization of navigation to expedite care was provided to radiation oncology staff. A process improvement plan was developed to expedite care through obtaining genomic testing results, communicating multidisciplinary plan of care, conducting weekly chart rounds, facilitating physician appointments, and presence by navigation during radiation oncology consults.

Results: A pre- and post-design with convenience sampling was used to evaluate navigator collaboration and availability within radiation oncology department. Timeliness data was collected one month pre- and post-staff education and at introduction of patient-facing navigation consults in radiation oncology department. Navigator collaborated with molecular diagnostic company to obtain access to provider portal to detect and resolve delays in breast cancer molecular testing results. Timeliness of genomic testing results improved by 4.60 days (6.75 days vs. to 2.15 days) with utilization of nurse navigator. Four-month electronic medical record review pre- and post- nurse navigator utilization revealed improved timeliness in radiation treatment by 7.73 days (32.44 days vs. 24.71 days). A positive correlation was also seen in earlier surgical treatment intervention of 8.49 days (51.81 days vs. 43.32 days) with nurse navigator utilization.

Conclusion: Early navigation involvement demonstrated improved timeliness to care by resolving delays in genomic test results and earlier radiation intervention. Additional studies are needed to explore navigation impact on cancer care in surgical and medical oncology settings. “This research was supported (in whole or in part) by HCA Healthcare and/or an HCA Healthcare affiliated entity. The views expressed in this publication represent those of the author(s) and do not necessarily represent the official views of HCA Healthcare or any of its affiliated entities.”

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Oncology Care Collaboration with a Tribal Health System and an NCI-Designated Cancer Center

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Background: American Indian and Alaskan Native (AI/AN) populations face significant cancer disparities due in part to fragmented care across multiple health systems.[1] The Indian Health Service, tribal health services, and Urban Indian Health (I/T/U) clinics refer patients with cancer to non-I/T/U specialists, creating coordination challenges impacting treatment access and quality.

Objective: We sought to develop and evaluate the Care Coordination and Communication Program in Oncology (C3PO), a navigation-based collaborative care model that positions navigators as bidirectional bridges between I/T/U facilities and the University of Oklahoma Stephenson Cancer Center (SCC), an NCI-Designated Cancer Center, while maintaining patient-centered and culturally informed care delivery.

Methods: A pilot study was conducted to better understand how a hybrid of care collaboration, based on the concept of huddles within a healthcare system, could contribute to improved communication between healthcare systems. SCC worked with a tribal health system to conduct monthly care collaboration meetings for AI/AN patients with cancer. Healthcare staff, including AI navigators, case managers, and other staff, attended the 30-minute Zoom meetings. Six patients were identified who may benefit from discussion at each of the meetings. Patients were selected based on their difficulty in continuing care, including missed visits, at SCC. Once the patient's case was resolved, we focused on those cases where resolution was still ongoing.

Results: Care collaboration meetings primarily focused on identifying and addressing financial hardship and social needs for patients. The meetings lasted 30 minutes or less, initially spending roughly five minutes discussing each patient's case. Of the six cases discussed, one was immediately resolved at the first care collaboration meeting. Care plans were developed to address the other five cases. At the second care collaboration meeting, another case was resolved. By the third meeting, four cases were not completely resolved, but plans were in place and steps were being taken to remove barriers to care. These care collaborations, or huddles, demonstrated to healthcare staff that this form of regular, planned communication between the two healthcare systems allowed dedicated time to focus on complex cases and time to collaboratively identify solutions to resolve barriers to care.

Conclusion: C3PO represents a scalable navigation approach to bridge the divides between healthcare systems while providing a patient-centered approach. By positioning navigators as bidirectional connectors between I/T/U facilities and specialty cancer care, the model directly addresses coordination challenges affecting AI/AN cancer outcomes.[2] This approach creates a culturally informed, patient-centered pathway across the care continuum applicable to other healthcare contexts requiring navigation across different healthcare systems.

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Opportunities to Expand CAR T-cell Therapy Navigation Services to Address Social Drivers of Health: Findings From a National Survey

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Background: CAR T-cell (CAR-T) therapy offers the potential for durable remission in hematologic malignancies,[1] yet access remains limited, particularly for patients affected by social drivers of health (SDOH).[2, 3] The Association of Cancer Care Centers (ACCC) conducted a national survey to capture oncology professionals' insights on access barriers and facilitators.

Objective: One of the goals of this national survey was to identify real-world barriers and facilitators to CAR-T access from the perspective of oncology professionals across diverse roles and care settings.

Methods: ACCC designed an online survey, with input from an expert task force, for multidisciplinary professionals involved in the care or oversight of adults with hematologic malignancies. The survey was distributed electronically in April 2025. All respondents (n=136) completed 3 open-ended questions related to SDOH affecting patient access to CAR-T, Medicaid-specific barriers, and role-specific care coordination challenges. An additional open-ended question about delivery-related challenges was asked of respondents from authorized CAR-T treatment centers. All responses were analyzed using inductive thematic analysis to identify themes.

Results: Respondents represented 37 states. Top roles included administrators (29%), advanced practice providers (21%), nurses/nurse navigators (20%), and oncologists/hematologists (16%), with participants from authorized treatment centers (57%) and referring cancer programs/practices (43%). 93% of respondents (n=126) answered an open-ended question about SDOH. Key themes included: 1. Staffing gaps in navigation/social work: 39% cited an absence/shortage of dedicated staff for patient/caregiver education, operational logistics, and financial advocacy, emphasizing patients' lack of access to existing resources without navigation support. 2. Persistent/layered SDOH-related barriers: Respondents noted the need for transportation assistance (38%), non-treatment financial support such as food/housing stipends (37%), and access to temporary lodging (28%). 3. Insurance-related delays: related to insurance optimization, inconsistent documentation across payors, and prior authorization (23%) 4. Caregiver eligibility barriers: 18% indicated that patients–particularly those who are Medicaid-insured, rural, or low-income–often lack a caregiver who meets requirements (18%). 5. Lack of standardized tools/protocols to support care coordination (16%).

Conclusion: The high burden of SDOH highlights the essential role of navigators in supporting patients and caregivers through CAR-T workup and referral, especially in community settings.[4, 5] Strengthening navigation infrastructure and expanding social work support can help address geographic, financial, and caregiver-related barriers that often impede access. Authorized treatment centers can also promote equitable care by sharing resources with referring programs to improve care transitions. Ultimately, investing in practical and collaborative solutions will be critical to ensuring that all eligible patients, regardless of location or circumstance, can access the full promise of CAR-T therapy.

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Pathways to Adherence: Patient Navigation Pilot for Equitable Medication Access and Adherence

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Background: Medication adherence is vital in cancer care, yet social determinants of health and systemic barriers hinder patients starting or continuing treatment. This project engaged patient navigators to proactively address these barriers through dedicated outreaches within 72 hours of treatment planning, improving support for oncology patients receiving oral or infusion chemotherapy.

Objective: Develop a pilot to identify and assess oncology patients at high risk for non-adherence to supportive medications, implement targeted interventions to address financial and logistical barriers, and achieve 75% pre-treatment medication adherence—reducing treatment delays and improving access to supportive care through a proactive, team-based navigation approach.

Methods: A PDSA was implemented to pilot an intervention to improve adherence to supportive medications among underserved patients. Patients flagged by RN Navigators as high-risk based on insurance status, financial hardship, or logistical barriers were referred to non-clinical AECC Patient Navigators (AECC PNs). AECC PNs contacted patients 5 to 7 days before treatment to confirm medication access. If the medication had not been obtained, navigators identified specific barriers such as cost, transportation, or forgetfulness and coordinated appropriate interventions. Clinical concerns were escalated to RN Navigators for re-education. Persistent non-adherence triggered further RN engagement to reinforce the importance of supportive medication in managing side effects. Key performance indicators (KPIs) included: number of high-risk patients, types and frequency of barriers, number of patients receiving assistance, RN escalations, and medication acquisition rates prior to treatment. Findings informed process improvements and provided a framework to expand the model across sites.

Results: Through the pilot, 376 patients were screened for risk of noncompliance based on insurance status (charity care, self-pay, or uninsured). Of these, 7% (N=28) were identified as high-risk for nonadherence and referred for an intervention. The majority identified as Hispanic (71%) and were diagnosed with breast (n=10), gynecologic (n=10), or digestive cancers (n=5). Patient Navigators (PNs) contacted patients prior to treatment, ensuring timely medication initiation. PNs coordinated financial assistance for 14 patients, secured transportation for one, and confirmed medication pick-up for 27. One notable case involved a PN connecting a patient with an industry drug program, eliminating a $200 out-of-pocket cost. Another patient's medication cost dropped from $240 to $12.65, a 95% reduction. Clinical concerns were escalated to RN Navigators, ensuring safety. As a result, all 28 patients began treatment on time, without delays due to medication access, highlighting the critical impact of PNs in addressing disparities and improving adherence.

Conclusion: The medication adherence pilot effectively reduced treatment delays among underserved cancer patients at high risk for noncompliance with supportive medications due to financial or logistical barriers. Patients identified by nurse navigators—particularly those uninsured, self-paying, or on charity care—were referred to a non-clinical AECC Patient Navigator. Navigators proactively confirmed medication access before treatment, resolved barriers, and ensured timely support. As a result, 96.4% of patients successfully obtained their medications and initiated treatment without delay. This pilot clearly demonstrates that a coordinated model leveraging both clinical and non-clinical navigators is a strategy to improve access, adherence, and continuity of care.

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Successes and Challenges of Nurse Navigation on a Mobile Cancer Screening Van

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Background: Patients seen on mobile screening units tend to be more medically and socially complex than those seen in traditional healthcare venues. Nurse navigation has been shown to facilitate quality care and increase patient satisfaction across many domains, including cancer screening, while reducing cancer disparities and addressing social determinants of health (SDOH).

Objective: To show how nurse navigation can impact mobile screening programs and address cancer disparities in the Greater Philadelphia region.

Methods: Data was obtained and extracted through manual chart reviews and tracked from electronic health records.

Results: 640 patients have been navigated by an oncology nurse since April 2022. 27 cancer cases have been diagnosed from the screening van, with 26 of those women receiving or recently completing breast cancer treatment. 107 patients have been referred to the Pennsylvania Breast and Cervical Cancer Early Detection Program (PA-BCCEDP) at Jefferson for diagnostic imaging due to having no or limited health insurance. 150 patients required the use of an interpreter (either through the Language Line or with the assistance of a community partner) to communicate results and schedule follow-up appointments, addressing language barriers. 17 patients have refused follow-up imaging despite navigation efforts.

Conclusion: Nurse navigation is crucial when offering complex health procedures, such as cancer screening, to patients who may not be experienced in accessing or interacting with the health care system. Mobile screening units should allocate resources to navigation to ensure that all patients receive high-quality and appropriate care throughout the continuum of cancer care.

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The Essential Role of Nonprofits in Oncology Patient Navigation

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Background: Oncology patient navigation helps cancer patients manage complex diagnosis, treatment, and survivorship.[1] Based on SHARE Cancer Support and CancerCare internal data, nonprofit navigation programs bridge gaps for underserved populations, reduce barriers, improve access, and enhance patient experience. Programs follow standardized metrics for staff, cultural competence, accessibility, and survivor/caregiver input.[2, 3]

Objective: This retrospective review analyzes the impact of nonprofit oncology patient navigation programs. It aims to substantiate the value of navigation services, highlighting how SHARE Cancer Support and CancerCare address barriers, provide support, and enhance patient experience, while complementing and supporting the broader cancer care community.

Methods: A retrospective analysis of 2024 patient outcome data from SHARE Cancer Support and CancerCare analyzed the impact of nonprofit navigation programs. SHARE clients were assessed using the NCCN Distress Thermometer,[4] with data collected on identified barriers and interventions, including patient resource and financial navigation. Navigators tracked referrals and considered them timely if connections were initiated during the same visit or within two days, with follow-up within one week to confirm access. CancerCare clients were assessed with the PHQ-9,[5] using pre- and post-intervention measurements capturing changes in distress and mental health. Sample sizes, intervention counts, and types of barriers addressed were recorded. Navigation interventions at both organizations followed standardized quality metrics, including staff qualifications, patient empowerment, culturally competent approaches, accessibility, and inclusion of survivor and caregiver input.[6] Analysis focused on distress, practical, financial, psychosocial, employment, and social concerns for CancerCare, and types and frequency of needs addressed for SHARE Cancer Support.

Results: At SHARE Cancer Support, 994 barriers identified were identified in 132 patients, with 354 patient navigation and 127 financial navigation interventions completed. The most frequently addressed needs were financial (67% of clients), support group referrals (42%), access to program resources (36%), education (31%), peer connection (29%), food security (17%), legal (16%), and transportation (11%). Interventions connected patients to appropriate resources and programs to address practical, financial, and psychosocial barriers. CancerCare's resource navigation program used pre- and post-intervention PHQ-9 assessments to track changes in patient distress. Among 168 cases, average distress scores fell from 7.08 to 6.33. Insurance concerns dropped from 39.29% to 22.02%; practical needs like food insecurity and transportation declined by over 10 percentage points. Psychosocial concern indicators also improved, with anxiety dropping from 44.05% to 34.52% and uncontrollable worry from 35.71% to 27.38%. These findings highlight the impact of structured navigation in reducing distress and addressing barriers to care.

Conclusion: The analysis of SHARE Cancer Support and CancerCare navigation services highlights the essential role of nonprofit organizations in supporting cancer patients. Navigation services addressed practical, financial, and psychosocial barriers, reduced distress, and improved mental health. By providing culturally informed, strengths-based support, timely referrals, and resource connections, nonprofit navigators enhance access to equitable care. These findings affirm the indispensable role of nonprofit oncology patient navigation in ensuring comprehensive, compassionate, and inclusive support for patients, particularly for underserved communities, reinforcing the value of navigation services within the broader cancer care continuum.

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Using Digital Systems to Optimize Oncology Navigation in a Large Academic Healthcare System: A Pilot Study

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Background: Timely oncology navigation services are crucial for optimal patient outcomes. The Sidney Kimmel Comprehensive Cancer Center (SKCCC)- Jefferson Health oncology navigation services support over 7,000 annual cancer diagnoses, yet patient feedback reveals a need for earlier intervention. This pilot explores using pathology reports to proactively identify patients for navigation outreach.

Objective: The aim of this project is to utilize digital pathology reports to proactively identify newly diagnosed cancer patients at SKCCC, allowing earlier oncology navigation outreach to enhance patient experience and outcomes, as evidenced by a 20% decrease in unmet early navigation needs at the Torresdale location within two months.

Methods: A pilot program (November 2024-March 2025) at SKCCC utilized daily vendor-generated reports of new positive tissue pathology results to trigger proactive navigation outreach. Consistent with the National Navigation Roundtable's emphasis on early intervention,[1] this approach aimed to address barriers to timely care. The Oncology Patient Navigation Manager distributed these reports to lead navigators at each location. Navigators reviewed patient EHRs to ascertain if an oncology specialty appointment was scheduled. For unscheduled patients, navigators contacted the ordering clinician to coordinate next steps, facilitating earlier navigation engagement, a key opportunity identified for improved patient outcomes. Every new patient was sent a satisfaction survey for navigation services via electronic health record (EHR) portal, email, and text message after the third navigation encounter is documented. The survey inquired if the patient would have benefitted from navigation services earlier in their cancer journey. Response options include "strongly agree, agree, disagree, and strongly disagree."

Results: Vendor reports identified 1,952 positive tissue biopsies. Notably, at three SKCCC locations (Jefferson NJ, Asplundh, and Center City), 97% of patients had scheduled oncology visits and corresponding navigation referrals by the time the reports were received. Conversely, a substantial number of patients at the SKCCC-Torresdale site did not have initial navigation referrals. However, proactive outreach initiated by the Torresdale navigation team, informed by daily vendor reports, coincided with a 20% decrease in patients expressing a wish for earlier navigation services on satisfaction surveys within a two-month period. These preliminary findings suggest that leveraging vendor reports enables more timely and integrated navigation, fostering improved communication among providers and a more patient-focused approach to cancer care.

Conclusion: This pilot program's findings strongly suggest that the early identification of cancer diagnoses through digital pathology reports, coupled with proactive navigation outreach, holds significant potential for improving access to and coordination of care for oncology patients across the cancer care continuum. This aligns with the extensive evidence reviewed by Chan et al. (2023), which highlights the effectiveness of patient navigation in optimizing care pathways.[2] The observed decrease in unmet early navigation needs underscores how digital systems can enhance patient experiences and improve outcomes, consistent with the benefits of navigation identified in the broader literature.

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Category III:

Patient Advocacy/Patient Empowerment

Category III: Patient Advocacy/Patient Empowerment

Deep Breathing and Relaxation Techniques to Support Distress in Oncology Patients Beginning Chemotherapy

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Background: Cancer patients often experience significant distress throughout their oncology journey. Distress is a complex experience that negatively affects individuals psychologically, socially, spiritually, and physically, hindering their ability to cope with cancer, its symptoms, and treatments. To improve coping skills, a nurse-led mind-body approach focused on deep breathing was implemented.

Objective: Implement a nurse-led mind-body intervention using relaxation techniques to decrease distress levels in oncology patients by 10% after the first three treatments. Patient distress will be assessed by the NCCN Distress Thermometer, supporting a structured, measurable, and achievable goal focused on psychological, physical, social, and spiritual coping among oncology patients.

Methods: This pilot study targeted patients and caregivers with breast, gynecological, lung, and melanoma cancers. A trained holistic registered nurse introduced evidence-based deep breathing and Progressive Muscle Relaxation (PMR) techniques before the initial chemotherapy session. PMR and deep breathing were chosen for their demonstrated potential to reduce pain intensity, distress, anxiety, and depression and to improve the quality of life in patients with cancer. Distress levels were measured using a modified NCCN Distress Thermometer at baseline (initial session), at the second chemotherapy visit (XX session), and at a subsequent follow-up visit to assess both distress levels and patient adoption of the techniques. The registered nurse provided valuable reinforcement and concise coaching during each follow-up session to support ongoing improvement, skill development, and increased adoption. Key performance indicators included reduced distress scores and increased self-reported use of the relaxation techniques over time.

Results: Twelve patients were enrolled in the pilot study with an overall average baseline distress score of 5.5, measured by the modified NCCN Distress Thermometer. In the breast cancer group (N=3), the initial mean distress score was 9.0, decreasing to 5.0 at the second assessment and 4.0 at the final session, reflecting a 55% overall reduction. In the gynecological cancer group (N=4), the average baseline score was 4.5; after one dropout, the final average score among the remaining participants was 4.0, representing an 11% reduction. Patient-reported feedback indicated varying levels of technique adoption: breast cancer patients noted using the strategies primarily during periods of frustration, while GYN patients described more consistent practice, with one stating, “Oh yes, I’ve been using deep breathing a lot, I’ve been so stressed.” Overall, results suggest the potential for moderate distress reduction and technique engagement across both groups.

Conclusion: Symptoms of distress are common among individuals with cancer. Holistic-trained nurses can deliver evidence-based mind-body interventions, such as deep breathing and PMR, to promote relaxation and self-management of stress. Results from this pilot suggest positive effects on distress reduction, supporting the expansion of these techniques to additional tumor groups. Study limitations include specialized nurse training and ensuring a quiet environment for optimal education delivery. We can empower nurses with practical tools to enhance patient care by highlighting these benefits. Future studies should explore the benefits of integrating breathing and PMR exercises into nurse symptom management strategies.

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N/A.

Development and Implementation of Patient Advocacy Tools Across the Cancer Continuum: Results from a Pilot of the Black Women's Cancer Patient Bill of Rights

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Background: Washington, DC has the largest racial disparities in cancer mortality rates in the United States.[1] These disparities, rooted in manifestations of racism, sexism, and classism, intersect with geography to disproportionately impact Black women living east of the Anacostia River.[2, 3, 4] The Black Women's Cancer Patient Bill of Rights (CPBoR) was designed to decrease provider bias and improve cancer outcomes for Black women.

Objective: By piloting the Black Women's CPBoR and accompanying Call to Action for Cancer Care Providers, we sought to identify effective dissemination and implementation strategies for patient advocacy and provider support resource documents for Black women's cancer care, and examine their impact on Black Women's self-efficacy to communicate about cancer care.

Methods: A workgroup of 16 healthcare providers, cancer care leaders, and Black women community members drafted tenets outlining quality care across the cancer continuum. Feedback on the initial draft was collected via focus groups with navigators and clinical providers. Subsequently, a companion provider document was developed outlining how to deliver optimum cancer care to Black women. For the pilot implementation, the draft documents were further refined; informed by 4 virtual focus groups, 14 informal interviews, and 5 deep-dive conversations with 53 women aged 30-50 years old who reside east of the river, as well as discussions with clinical providers from local hospitals and primary care sites. The final materials were disseminated at two local federally qualified health centers, community events, informal community conversations, and community education sessions. Pre-post surveys were used to assess confidence in ability to advocate for cancer care and intentions to use the CPBoR materials among community education session participants.

Results: The final CPBoR materials included a tri-fold brochure, a 1-page flyer, a Questions for Your Doctor/Notes document, a patient resource document, and a key chain with a QR code linking to the CPBoR 1-pager. Key features of the materials were simplicity, relatability, timelessness, and portability, with the key chain notably appreciated by patients. However, maintaining the accessibility of the QR code posed challenges. Additionally, a poster titled "Championing Black Women-Centered Healing: A Call to Action for Cancer Care Providers" was created but not officially piloted. The pilot successfully engaged over 320 community residents. Effective dissemination strategies included FQHC patient navigators and community educational sessions that included role-playing for advocacy. Among the 47 education session participants, increases were observed in intentions to use CPBoR to talk with doctors (39%), talk with family and friends (29%), bringing CPBoR to next appointment (23%). There were no changes reported in self-efficacy to advocate.

Conclusion: Developed through a multi-year, multi-stakeholder process, the patient-facing Black Women's CPBoR resource documents were tested among Black women. The collateral materials were positively received, making them valuable assets for ongoing patient advocacy efforts. The pilot dissemination and education activities highlighted that while Black women have high baseline confidence in their ability to self-advocate for cancer care, opportunities to practice how to advocate for themselves or loved ones are needed. Next steps include testing the accompanying provider-facing Black Women-Centered Call to Action resource document within clinical settings. Research to further examine the impact of these resources, when implemented together, on patients and cancer care on providers is warranted.

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Evaluating Positive Steps in Multiple Myeloma Care: A Patient Navigator Longitudinal Study

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Background: Multiple myeloma is an uncommon and complicated blood cancer. Advances in research over the last 20 years have created numerous treatment options. However, this abundance can make it difficult for patients to stay updated with the latest therapies, especially in community settings.

Objective: The Multiple Myeloma Research Foundation (MMRF) aims to empower the entire myeloma community by utilizing patient navigation services to improve care and outcomes for all patients.

Methods: The Patient Navigation Center (PNC) at the Multiple Myeloma Research Foundation (MMRF) is a free resource for multiple myeloma patients and caregivers. Staffed by three experienced oncology professionals, the PNC offers personalized information, emotional support, and guidance on clinical issues, empowering patients to make informed decisions. Patients can reach the PNC by phone, email, or web form, and each interaction is tracked as a case in our CRM platform. Surveys are deployed 90 days following any patient interaction to measure qualitative results.

Results: Two surveys are conducted: one post-interaction with the PNC and a longitudinal survey 90 days after initial contact. In 2024, over 2,000 patients and caregivers contacted the PNC. In 2024, 867 patients received the longitudinal survey, yielding a 19% response rate (n=167). Among respondents, 90% reported positive steps after speaking with the PNC. Further results included communicating treatment goals with their care team (62%), discussing test results (55%), seeking a second opinion (32%), and discussing with their doctor the prospect of considering a clinical trial (19%). Optional Likert scale questions assessed emotional impact. Of those who responded (n=132), 62% felt more empowered, 53% reported greater confidence in discussing treatment options, and 53% experienced relief after interacting with the PNC. Additionally, 84% agreed or strongly agreed that speaking with a patient navigator helped reduce anxiety or distress about their diagnosis, and 81% felt they better understood their condition.

Conclusion: Our data reveal communication with MMRF Patient Navigators positively impacts patients and caregivers navigating multiple myeloma. This aligns with previous studies noting how patient navigation services are an effective intervention for use in healthcare.[1] However, 7% of respondents did not take positive steps. Future efforts will focus on conducting a gap analysis to explore barriers and the patterns influencing behavior changes. Key factors will include disease stage, frequency of communication with the PNC, and geographic location. By investigating these variables, we aim to develop more targeted strategies to address unmet needs and improve outcomes for multiple myeloma patients.

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Learnings from the Development of a Cancer Patient Navigation Program for Black Women East of the River in Washington, DC

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Background: Black women living east of the Anacostia River in Washington, DC face the city's highest cancer mortality disparities.[1] The Jane Bancroft Robinson Foundation (JBRF), Black Women Thriving East of the River (BWTEotR), and Quantified Ventures (QV), are developing a sustainably financed cancer patient navigation (CPN) program that supports Black women with cancer from abnormal finding through survivorship.

Objective: The purpose of this intervention is to expedite time to diagnosis and treatment, address health-related social needs that prevent timely care and impact health outcomes, and provide a more dignified cancer care experience.

Methods: JBRF, BWTEotR, and QV designed the CPN program with guidance from an advisory board of community and healthcare stakeholders east of the river and Black women with lived experience of cancer. After an analysis of potential implementation partners, including prominent community and healthcare providers east of the river, Whitman-Walker Health (WWH) was selected as the host site partner. The group is now co-designing a small-scale demonstration to begin quickly offering a set of critical CPN services to Black women east of the river with breast and cervical cancers.

Results: Key learnings from the program design process include:

- Blending Evidenced-Based Models and Direct Community Input: program design was directly informed by feedback from community members and Black women with lived experience while incorporating data and aspects of evidenced-based patient navigation models.

- Collaborative Solutioning with Healthcare and Government Stakeholders: preliminary analysis of screening rates and cancer outcome data revealed racial disparities. However, deeper engagement with local healthcare experts led the group to identify specific gaps in the cancer care continuum and develop an intervention that augments existing systems to impact cancer outcomes.

- Outcomes-Centered Approach to Program Design and Sustainable Financing: the program identified target outcomes of the intervention to inform program design decisions, and mapped outcomes to stakeholders that will benefit from the program's impact.

Conclusion: The group is currently working to implement this community- and research-informed program design at WWH. Together with WWH, the team seeks to implement a patient navigation program that improves cancer outcomes, prioritizes a dignified experience for Black women east of the river, and demonstrates the value of patient navigation services to participants, healthcare organizations, and community stakeholders. The small-scale demonstration is set to launch in early 2026.

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Meeting the Needs of Patients with Cholangiocarcinoma: Connection in Patient Support Group Programming

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Background: Cholangiocarcinoma is a cancer that starts in the bile ducts.[1] Research has shown that patient support groups address patients' psychosocial needs, allow them to cope with their cancer diagnosis, and manage stress.[2] CCF began virtual patient support groups in 2020 to address the patients' expressed need for community and interactions.

Objective: Satisfaction surveys are used to evaluate patient support groups, determining their satisfaction rate, assessing the efficacy of the group structure, and determining whether patient needs are met in this setting.

Methods: All individuals who registered for a support group were sent a survey to assess their satisfaction with the group. The survey was conducted every 3 months. Two ways of sending out the survey were used, first via email, with the link included, and the second survey was sent via the survey platform, QuestionPro. Reminder emails were sent to attempt to gather more respondents from the survey, and the survey was closed one month after it was sent to participants. Comments and testimonials were obtained to gather additional insight into the positive and negative perceptions of the support groups offered.

Results: In the fall of 2024, 42 individuals responded as having participated in the support group, while in the spring of 2025, 15 individuals indicated they had participated in either the Monday and/or Thursday patient support group. 40.48% indicated being very satisfied in the fall survey, and 78.57% expressed being most satisfied in the spring survey. The number of individuals who completed the survey in relation to the number of patients who attended the group was noticeable. The average attendance in each patient support group was 34 attendees, while those who completed the survey ranged from 15 to 42. Regardless, most who completed the survey expressed high satisfaction with the support group.

Conclusion: Common themes regarding improvement are the time of day the support group is held and group size, which does not allow more participants to speak in the group. Areas of improvement exist, and plans are being established to meet them. The advocacy team recognizes that these surveys have limitations. Although each measured satisfaction, the method of gathering was different in each survey. Having more consistent survey methods will help provide more accurate information on patient satisfaction levels.

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Systematizing Pre-Operative Education: A Nurse Navigator–Led Model to Reduce Anxiety and Improve Surgical Readiness Across an Academic Health System

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Background: Pre-operative anxiety can delay recovery and increase postoperative complications. Structured, nurse navigator-led education reduces anxiety and improves surgical outcomes. In large academic health systems, a standardized education model not only enhances patient preparedness but enables cross-campus staffing coverage, ensuring continuity of care and consistent delivery despite local resource constraints.

Objective: The aim of this project is to standardize nurse navigator-led pre-surgical education across the healthcare system: (1) prepare patients for surgery through structured instruction; (2) reduce pre-operative stress and anxiety; (3) ensure consistent high-quality education regardless of care location; and (4) develop a scalable model enabling cross-campus navigator coverage.

Methods: Using a mixed methodology model, breast oncology patients scheduled for surgery participated in standardized, nurse navigator-led group education sessions. The curriculum covered pre-surgery preparation, day-of expectations, and postoperative recovery steps, tailored to patients' baseline knowledge, medical condition, and preferred language. Surveys were administered at three times: (1) pre-session baseline (understanding and anxiety), (2) immediately post-session (updated comprehension and confidence), and (3) post-recovery (reflective assessment of preparedness). We analyzed anxiety and knowledge score changes quantitatively over time, while qualitative feedback captured patients' perceptions of group support and barriers (e.g., childcare). Across 322 sessions, the analysis identified facilitators such as peer interaction and obstacles like scheduling challenges. This mixed-methods design enabled robust evaluation of nurse navigator-facilitated group education's effect on surgical readiness, early recovery, and adaptability to cross-coverage staffing gaps. The system-level model ensured that patients received education in their natural language to promote equity and understanding.

Results: Among 372 participants, 56% reported moderate-to-severe anxiety at baseline; post-session, 84% reported little-to-no anxiety. Comprehension of surgical procedures increased from 24% to 85%, and over 90% of patients reported realistic expectations for recovery. Confidence scores rose significantly, and knowledge improved by 30% ($p < .05$). Patient-supported natural language education was highly valued. Patient-reported childcare barriers prompted a shift to hybrid delivery, increasing access. Notably, cross-campus coverage enabled five patients to receive education from navigators at alternate sites, preserving care continuity during local staffing shortages. Certified bilingual nurse navigators delivering sessions in patients' preferred languages significantly enhanced comprehension. In one instance, a bilingual navigator identified a consent discrepancy during the session and escalated the issue, prompting re-consenting and ensuring informed decision-making. Post-recovery, patients reported improved preparedness. The standardized program demonstrated system-wide adaptability, equitable access, and clinical impact through consistent, high-quality education delivery.

Conclusion: Nurse navigator-led pre-operative education significantly reduces anxiety and boosts patient preparedness for breast cancer surgery. By combining structured learning, peer support, and tailored content, navigators enhance patient comprehension and confidence across the surgical continuum. Ongoing evaluation identified childcare as a barrier that led to the implementation of hybrid delivery options—broadening access and maintaining program effectiveness. These findings support integrating group-based, navigator-led education into oncology pre-operative pathways to enhance patient experience and recovery. As healthcare systems expand, standardized education models show early evidence of ensuring consistent quality, supporting cross-site delivery, and reinforcing value-based care through scalable navigator-led interventions.

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CATEGORY III: PATIENT ADVOCACY/PATIENT EMPOWERMENT

Category IV:

Psychosocial Support/Assessment

Category IV: Psychosocial Support/Assessment

Enhancing Access to Psychosocial Care in Oncology: The Role of the Collaborative Care Model

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Background: In 2023, the Association of Cancer Care Centers (ACCC), in collaboration with the American Psychosocial Oncology Society (APOS) and the Association of Oncology Social Work (AOSW), convened a multistakeholder summit to examine strategies for enhancing psychosocial care delivery in oncology. The Collaborative Care Model (CoCM) emerged as an approach to improve psychosocial support for all patients and their care partners. The CoCM emphasizes coordinated, patient-centered care through an integrated team approach, often involving a social worker, consulting psychiatrist, and an oncology care team.[1] While the CoCM originated in primary care, more recently, a strong base of evidence has demonstrated the model's utility in a cancer center setting.

Objective: To provide healthcare providers and administrators with a foundational understanding of the CoCM, implementation in oncology settings, and implications for patient care, psychosocial support, and financial outcomes.

Methods: ACCC hosted a live webinar in May 2025, led by two CoCM experts. The webinar provided an overview of the CoCM, benefits in oncology settings, and practical strategies for implementation. Discussions focused on the value and sustainability of the CoCM in oncology, defining team roles and establishing internal infrastructure, site readiness, identifying educational needs for social workers, and developing tools such as tip sheets to support case management.

Results: This webinar drew over 318 registrants, with approximately 220 attending live. Attendees included 205 social workers, 35 nurses and navigators, 10 in c-suite level roles, and an additional 70 professionals in administration, psychiatry, academia, and informatics. Ninety-three attendees completed the evaluation (43%), rating the quality of the webinar speaker an average of 4.83 out of 5 and the webinar content 4.85 out of 5. Ninety-two percent of respondents reported gaining new knowledge, and 91% indicated plans to integrate the insights into practice and share them with their colleagues or administrators for future implementation. Participants praised the session's practical relevance, its focus on the psychosocial aspects of oncology care, and its emphasis on interdisciplinary collaboration improved patient outcomes.

Conclusion: Initial educational efforts have demonstrated strong engagement and interest among oncology professionals in implementing the CoCM to enhance psychosocial care delivery. High participation and strong engagement from social workers and nurses underscore a clear need for targeted education that addresses the psychosocial aspects of oncology care. Continued educational focus on practical strategies, team-based coordination, and financial sustainability are expected to contribute to the successful adoption of the CoCM in diverse oncology settings, ultimately improving outcomes for patients and their care partners. Based on evaluation feedback, the second webinar in the series will provide education in the financial and organizational aspects of the CoCM, including staffing, billing, and cross-discipline coordination within the oncology setting. Future research efforts should include pilot programs to assist with ongoing CoCM standards of development, competencies, and training.

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Fighting Hunger, Fueling Healing: A Cancer Center Food Pantry Project

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Background: With rising grocery costs and funding cuts to nutritional assistance, food insecurity is increasing nationwide. Cancer's financial toxicity can cause/exacerbate hunger, and an estimated 17% to 55% of oncology patients experience food insecurity.[1] In addition, people with cancer and inadequate nutrition are also at risk for worse treatment outcomes.[2]

Objective: To address patients' food insecurity, the Office of Community Outreach and Engagement (OCOE), Atrium Health Wake Forest Baptist Comprehensive Cancer Center, started an on-site food pantry; with groceries to take home, the Cancer Center Food Pantry (CCFP) was designed to relieve patients' immediate hunger.

Methods: OCOE piloted the food pantry for a month, inviting the cancer center's patient and nurse navigators to donate food and purchasing supplemental groceries with OCOE development funds. All food items were nonperishable and easily stored. Navigators provided at least 2 bags of groceries to patients in immediate need, along with information about longer-term food assistance in their home areas. The Cancer Center director approved the CCFP's continuation, and OCOE emailed all faculty/staff to launch a cancer center-wide food drive. Once the donated food was collected and organized, another email announced the CCFP's opening and explained its operations. Besides food drives, fund drives were found to be especially helpful, enabling groceries to be ordered online instead of collected throughout the cancer center. Placing specific orders also ensures a balanced variety of nutritious food.

Conclusion: For 18 months, the CCFP has remained stocked through 2 cancer center-wide food drives, a combination food/fund drive, and 2 fund drives, which together raised over $3,400. Patient referrals come not only from navigators and social workers, but also providers, nurses, counselors, and dietitians. Ninety-four patients have received groceries on 125 occasions, with some receiving assistance 2 to 4 times. Eighty-four percent of the 94 patients assisted were part of underserved populations: African American (n=34; 36%), rural (n=25; 27%), Hispanic (n=20; 21%). A 76% majority of patients were uninsured or had Medicaid: uninsured (n=30; 32%), Medicaid primary (n=27; 29%), Medicaid secondary (n=14; 15%).

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‘How to Prepare the Kids’: Tools for Oncology Nurse Navigators Supporting Parents Facing Incurable Cancer

Kelsey Mora, CCLS, LCPC

Background: Oncology nurse navigators support parents facing terminal cancer, who often struggle to talk with their children about illness or death. These parents seek guidance from healthcare teams. Research shows that honest, age-appropriate communication reduces children’s emotional and behavioral distress during the illness and improves long-term bereavement outcomes.

Objective: To equip oncology providers, such as nurse navigators, with evidence-based communication tools and developmental insights that enable them to guide parenting patients in discussing incurable cancer and impending death with their children, and to promote children’s coping and resilience through anticipatory grief and beyond.

Methods: Following a surge in clinician interest during a parent-facing webinar on how to talk to kids about cancer, our organization developed a specialized training for healthcare providers. This “2.0” clinician-facing webinar—originally launched in collaboration with the Association of Oncology Social Work (AOSW)—focused specifically on conversations surrounding terminal illness, hospice, and death. The program emphasized a practical three-part framework for difficult conversations with children and teens: share information, share expectations, and share feelings. The webinar included clinical guidance, real-world scenarios, and examples of legacy-building, emotional support strategies, and communication approaches by developmental age.

Results: The webinar received record-breaking attendance among oncology clinicians and highlighted a major educational gap in end-of-life family-centered care. Participant feedback underscored the urgent need for practical, developmentally appropriate tools to use with parenting patients. Post-session evaluations revealed improved confidence among attendees in supporting conversations about hospice, death, grief, and memory-making with their patients and their patients’ families. “As an Oncology Nurse Navigator, caring for patients with young children can be very challenging, especially when it comes to informing the children of a parent’s terminal cancer diagnosis,” noted one evaluation. “Having resources available to help, such as Pickles Group, is essential to success. With ongoing support, we can assist parents to provide age-appropriate communication and help with coping strategies throughout illness and death, allowing kids to feel included and to share their feelings and emotions.”

Conclusion: Oncology nurse navigators are uniquely positioned to support parenting patients as they navigate the emotional complexities of incurable cancer and anticipatory loss. By integrating evidence-based strategies into clinical care, providers can help patients communicate more openly with their children, reduce long-term emotional distress in pediatric family members, and foster stronger family coping. This session reinforces the critical role of oncology nursing in promoting family-centered, developmentally informed end-of-life care following a successful training model and unlocking access to free peer-to-peer support and resources for families.

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Pathway to Restoring Wellness: A Commitment to Enhance Wellness and Improve Patient Outcomes by Providing Access to Complementary Therapies

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Background: This Penn Medicine Virtua Cancer Program (PVCP) clinical nurse navigation pilot program provided patients with funding and access to complimentary therapies to enhance wellness and improve quality of life. Patients were assessed for the physical and emotional side effects of their cancer diagnosis and treatment, as well as accessibility to resources. Patients referred to the program utilized a single provider source for therapies that were funded by the Virtua Health philanthropic foundation.

Objective: To evaluate the impact and effectiveness of providing complementary therapies to cancer patients along the continuum of care. Clinical nurse navigators used a qualitative mixed methods approach and implemented this program to bridge the identified gap within the PVCP's oncology support services care model. This reflects our commitment to patient-centered care by providing access to complementary therapies that have proven benefits and positive outcomes for cancer patients.

Methods: Clinical nurse navigators interviewed patients to assess and identify patients who would benefit and were open to receiving complementary therapies. Patients were assessed for the physical and emotional side effects of their cancer diagnosis and treatment, as well as financial barriers that would prohibit access to these services. Patients were referred to the program, giving them access to complementary therapies provided by a community wellness center, at no cost to the patient. Patient outcomes to these therapies were evaluated by completion of a mixed-media survey, either by the patient or through an interview). To evaluate the program, patients were asked to report on any improvement of their side effects, the overall benefit of the therapies, and whether they would recommend the wellness center services.

Results: A total of 15 patients (target participation) were enrolled in the Pathway to Restoring Wellness program and received access to complementary therapy services. Of those 15 patients, 10 patients (67%) utilized at least one of the complementary therapies offered. All participants received a survey or were interviewed, with a total of 8 respondents, resulting in an 80% overall response rate. One hundred percent of respondents reported being very satisfied with their experience and stated that the services positively benefited them. Feedback emphasized stress reduction, positive emotional impact, relaxation, relief from physical symptoms, and both mental and physical well-being. Participants expressed gratitude for having access to services that they would not have otherwise been able to afford.

Conclusion: The objectives of this program were to provide access to complementary therapies that improve the quality of life and outcomes for cancer patients in our program. Based on the responses, the patients who actively participated in the program and utilized the therapies available experienced positive outcomes and benefits. Utilizing the positive results of this pilot, the goal is to implement this program on a permanent basis, increasing the number of patients participating each year. Nurse navigation's commitment to promote wellness through complementary therapies that ease the side effects of cancer therapies and diagnoses will have a powerful impact on our oncology patients and program.

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Reducing Financial-Related Distress in Breast Cancer Patients through Komen's Telehealth Patient Navigation Model

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Background: In the United States, breast cancer is one of the most expensive cancers to treat. Patient navigation reduces financial toxicity and distress by guiding patients through care and resources.[1] Komen's telehealth patient navigation model offers a roadmap for other organizations to implement similar patient-centered programs through its national reach and expertise.

Objective: To demonstrate that, by implementing Komen's telehealth-based navigation model, Komen navigators reduced financial toxicity in breast cancer patients by addressing financial barriers, improving access to resources, and informing best practices to enhance patient support and scalability within oncology care.

Methods: Komen patient navigators assess patients' financial needs through a structured barrier assessment at intake, including use of a modified NCCN distress thermometer (11-point scale; a higher score indicates higher levels of distress), with specific attention to the financial domain. Identified financial needs informed development of tailored financial navigation interventions aimed at resolving barriers to care. The navigation interventions include strategies to address insurance optimization, housing support, utility assistance, food security, and include provision of Komen financial assistance awards. All assessment data and interventions are securely documented in a HIPAA- compliant database to ensure transparency and continuity of care. Following the completion of enrollment and navigation intervention, a follow-up survey is sent to measure client satisfaction, quality of life outcomes, the effectiveness of navigation support and to inform continuous improvement of navigation interventions.

Results: Of those served by Komen's patient navigation program, between April 1, 2024 and March 31, 2025 (Komen's fiscal year), patients with at least two observations of financial distress experienced a 14% decrease in distress between pre and post measurement. Of the 634 observations, the average score for pre-navigation was 7.8 and the average score for post-navigation was 6.3. Of the barriers addressed by the Komen navigation program, 59% were related to financial barriers. Financial assistance for basic needs accounted for 55% of financial barriers addressed, 19% of the barriers addressed were housing needs, and 15% were related to insurance. In the last year, 88% of those who responded to the follow-up survey said they were better able to continue their care plan because of working with Komen's patient navigators, and 87% of those who responded to the follow-up survey said their navigator helped them to feel less anxious.

Conclusion: Komen's telehealth patient navigation model demonstrates measurable impact in reducing financial distress among breast cancer patients, with a 14% decrease in financial distress scores and 88% of surveyed patients reporting improved ability to continue care. By addressing the most pressing economic barriers, such as basic needs and insurance, through individualized navigation interventions, Komen's navigation program not only reduces financial toxicity, but improves emotional well-being, with 87% of patients feeling less anxious. These outcomes underscore the program's effectiveness in providing financial interventions to improve outcomes and reduce financial related distress, offering a replicable model for integrating telehealth-based navigation into oncology care.

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Transforming Cancer Supportive Care Access with Non-Clinical Patient Navigation. Impact of Cross-Sector Collaboration, A Retrospective Study

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Background: Comprehensive supportive care including caregiver support ensures that patients' holistic needs are met throughout their cancer journey by providing physical, psychosocial/emotional, spiritual, community, educational, and environmental/economic support. Studies show that navigation and coordinated supportive care led to improved treatment outcomes and quality of life for cancer survivors. Free of charge, evidenced-based in-person, virtual, hybrid, and on-demand supportive care programs are available through Cancer Support Community San Francisco Bay Area (CSC) but are underutilized.

Objective: A Commission on Cancer-accredited hospital opened a new ambulatory cancer center in Spring 2024. In the prior year, 35% (258) of hospital cancer patients screened positive for psychosocial distress utilizing the National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List. Untreated psychosocial distress can result in decreased treatment adherence, more dissatisfaction with overall care, and poorer survival rates. The hospital's cancer committee and CSC collaborated to launch a sustainable Supportive Care Patient Navigator Program (SCPN), utilizing a non-clinical navigator, to increase access to free-of-charge, evidenced-based supportive care programs for cancer patients, families, and caregivers.

Methods: Cancer center and CSC developed a SCPN job description, role delineation, contract, electronic medical record tools to reduce staff burden, and performance metrics for evaluation period June to December 2024 to measure impact and effectiveness. CSC deployed a full-time SCPN to interact in-person and virtually with patients/caregivers in the cancer center's dedicated office/resource space. The SCPN completed hospital Volunteer Annual Training and the GW New Oncology Patient Navigator Certification program. Hospital committed financial support to CSC via sponsorships for the Hope Walk and Gala events to share SCPN program costs.

Results: During the evaluation period, 301 cancer center patients/caregivers participated in CSC's programs, with 90 participants newly enrolled, representing an increase compared to the same period in 2023, 12% and 50%, respectively. The SCPN engaged with 215 individuals, 87% patients and 13% caregivers. 32 participated in CSC programs, with 18 newly enrolled. 103 individuals consented to be added to the CSC list-serve to receive weekly communication about programs/resources. Navigated patients requested 412 program types: Top requests were CSC Program Orientation/Overview (119), Emergency Financial Assistance (76), Support Groups (44), One-On-One Counseling (33), Nutrition Classes (21), and Educational Workshops (21). The SCPN connected patients to 68 resources available via other community-based organizations.

Conclusion: The SCPN program significantly increased cancer patients' and caregivers' access to evidenced-based programs that are associated with clinically significant outcomes. Research demonstrates that cancer patients' participation in programs with mindfulness components, such as counseling/support groups, tai chi, qigong, yoga, meditation, psychoeducational workshops, art, movement, and music therapy, experience reductions in psychological distress, anxiety, depression, fear of cancer recurrence, fatigue, sleep disturbances, and pain. Exercise, nutrition education, and social connections can significantly reduce cancer survivors' cancer-related adverse effects and mortality and improve overall quality of life. To remove barriers for future participation, almost half of the navigated patients joined the CSC list-serve to receive weekly program communication. Cross-sector collaboration with CSC created a financially sustainable SCPN program by reducing hospital program/operational costs and leveraging CSC's core competencies and philanthropic network.

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CATEGORY IV: PSYCHOSOCIAL SUPPORT/ASSESSMENT

Category V:

Professional Roles and Responsibilities

Category V: Professional Roles and Responsibilities

Advancing Standards-Based Practice in Oncology Patient Navigation

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Background: The Professional Oncology Navigation Task Force (PONT) standards establish core competencies for oncology navigation, promoting consistency and quality across diverse care settings. Despite their foundational importance, many navigators lack exposure or confidence in applying the standards in practice.[1,2,3]

Objective: To evaluate the effectiveness of Susan G. Komen's pilot course, Introduction: Oncology Navigation Standards of Practice, in increasing navigator awareness of the PONT standards, and to identify learner-identified needs for additional tools and resources to support the application of the standards in professional navigation practice.

Methods: Susan G. Komen's Patient Navigation Training Program, a free, online workforce development program for new and experienced navigators and allied health professionals, developed and launched a pilot course, Introduction: Oncology Navigation Standards of Practice, in response to expressed needs for foundational education on the PONT standards. The 45-minute on-demand training introduced each standard, explained their development, and provided practical strategies for applying them across roles and settings. The course emphasized the standards' impact on patient outcomes, equity, and high-quality, person-centered care. Structured modules, real-world examples, and reflection prompts supported learner engagement. Participants register in a learning management system, where demographic information and post-program evaluation surveys are collected, using a combination of Likert scale and open-ended questions to assess content, method of content delivery, intent to apply content, familiarity with the standards, satisfaction with the content, and interest in future resources.

Results: The course launched in May 2025, and survey responses reflect feedback from early participants. Among course participants (n=49), 77% indicated this was their first formal training on the PONT standards. Only 33% reported any prior familiarity, categorized from basic to advanced knowledge, suggesting that awareness and structured exposure to the standards remain limited. Following course completion, 96% of respondents rated the course as good or excellent, and 92% said they would recommend it to peers, reiterating the value and relevance of the content. When prompted, 71% expressed strong interest in accessing a structured self-assessment tool to evaluate their current experience level and improve application of the standards in practice. Open-ended responses further reflected a desire for ongoing support and resources that help tailor the standards to specific navigation roles and settings. Collectively, these results highlight a readiness among navigators to embrace the PONT framework, if supported with the right tools.

Conclusion: This course served as a critical entry point for navigators who had little to no prior exposure to the PONT standards. While introductory training is clearly essential, results signal a strong and urgent need for the next phase of support: tools and resources that allow navigators to assess their competencies and apply the standards confidently in daily practice. The expressed interest in self-assessment tools suggests an opportunity to build a structured pathway for ongoing professional development and deeper integration of standards-based navigation. To advance consistency and quality across oncology care, such resources must be prioritized and made widely accessible.

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Clinical Trial Nurse Navigation to Address Enrollment Barriers

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Background: Robust clinical trial participation is essential to advancing medical knowledge, promoting health equity, and ensuring fairness in research.[1] While patient-level barriers are well documented, site-level challenges—such as limited technology, time constraints, and procedural complexity—also hinder enrollment.[2] Nurse navigators have emerged as a promising strategy to overcome these barriers by streamlining workflows, improving patient identification and education, and supporting more equitable trial access.

Objective: The Herbert Irving Comprehensive Cancer Center (HICC)implemented Clinical Trial Nurse Navigation to improve trial access, identify patient opportunities, support recruitment—especially for investigator-initiated trials—deliver community-based education, engage referring providers, and address site-level barriers to participation.

Methods: At HICCC, clinical trial nurse navigators collaborate across departments to streamline enrollment and reduce barriers:

- Access: A dedicated phone line and email serve as central contacts for patients, families, providers, and organizations.
- Systems: Navigators work with bioinformatics teams to match patients to trials using molecular profiling.
- Community Outreach: The team provides education in local settings and organizes an annual Clinical Trial Day to foster open dialogue about trial access.
- Targeted Outreach: Navigators collaborate with physician liaisons to build relationships with referring providers and streamline referrals.
- Educational Materials: Flyers, pamphlets, social media content, and presentations are tailored for various audiences to raise trial awareness.
- Trial Input: Navigators monitor enrollment trends and contribute to study feasibility discussions, particularly for investigator-led protocols.

Results: In 2024, the team averaged 58 external trial inquiries per month, resulting in 157 new patient visits and 46 enrollments. Many patients who did not qualify for a trial still established care at the center. Only two patients who signed consents were later deemed screen failures, reflecting effective pre-screening and saving time for both patients and staff. Navigator support for internal screening and molecular matching contributed to 881 interventional trial accruals in 2024, with projections to exceed this in 2025. Several common exclusion barriers identified by the team were addressed. For example, a pancreatic cancer study was amended to allow more prior lines of therapy, expanding patient eligibility and improving accrual.

Conclusion: Clinical trial nurse navigation at HICCC is a novel role that has strengthened care coordination and reduced common barriers to enrollment. By centralizing communication, leveraging genomic tools, and engaging both community members and providers, navigators have improved access to trials and supported timely, patient-centered enrollment. This innovative model highlights the evolving and essential role of oncology clinical trial nurse navigators in expanding access to clinical research and ensuring patients are supported throughout the trial process.

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Empowering Financial Advocates: A Comprehensive Training Program for Navigating Insurance Complexities in Cancer Care

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Background: Navigating the insurance landscape can be challenging for many individuals. Financial advocates play a vital role in assisting cancer patients as they confront the financial burdens and complexities of medical insurance-related inquiries associated with their treatment journeys. A 2023 survey conducted among 95 members of the Association of Cancer Care Centers (ACCC) Financial Advocacy Network highlighted that 23% of respondents had not received formal training in financial advocacy. Moreover, 44% expressed a need for enhanced education and resources regarding Medicare and Medicaid, while 33% sought opportunities for case study-based learning.

Objective: The ACCC Financial Advocacy Network aims to create training resources that equip financial advocates with the necessary skills to navigate patients through insurance complexities and financial obstacles.

Methods: Guided by a multidisciplinary task force and patient advocacy partners, ACCC developed a self-paced eCourse titled, "In the Field: Practical Financial Advocacy Strategies for Supporting Cancer Patients," which features practical scenarios and case studies to help financial advocates assist patients with different types of insurance coverage. The task force prioritized three modules designed to build knowledge and skills, focusing on three insurance categories for each module: Medicaid, Medicare, and private insurance. To evaluate the course, post-assessment data for registered learners was exported and an exploratory analysis was performed.

Results: The eCourse launched March 3, 2025 on ACCC's learning platform. The 1.5-hour course includes post-assessment questions to measure learner outcomes. Since launch, it has been utilized by 118 members, with 95% of learners noting a marked increase in their confidence to employ financial advocacy strategies and clarify insurance coverage and patient assistance options for patients with diverse insurance plans. In qualitative responses, 20 learners shared specific changes they plan to implement following the training, such as adapting the terminology used when communicating with patients to ensure comprehensive understanding, increasing their knowledge of external assistance programs, and assessing patients before, during, and after their cancer treatment.

Conclusion: The complexity of financial advocacy in oncology is continuously increasing due to the heightened demand for financial intervention among cancer patients and their families. Expanding access to comprehensive training initiatives will better prepare financial advocates, social workers, and nurse navigators to address the unique financial challenges encountered by cancer patients, ultimately improving patient outcomes and ensuring that financial advocacy remains a vital aspect of oncology care as the healthcare landscape evolves.

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N/A

Enhancing Access to Clinical Trials Through Patient Navigator Training and Education

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Objectives: The inclusion of trained clinical trial navigators can significantly increase participation and improve diversity in clinical trials, highlighting the need for consistent training programs. This project aimed to develop and implement a structured, accessible, and culturally responsive clinical trial curriculum for patient navigators. The training equips navigators with the knowledge and tools to educate patients about clinical trials and identify appropriate trial opportunities using BreastCancerTrials.org. It also prepares navigators to address common barriers to participation, especially among underserved and minority populations.

Methods: Susan G. Komen's Patient Navigation Training Program and BreastCancerTrials.org, a program of Quantum Leap Healthcare Collaborative, created a free, online, self-paced, four-module training curriculum. The training includes clinical trial basics, how to search for trials using BreastCancerTrials.org, strategies to overcome barriers to participation, and the importance of diversity in clinical research. The program was evaluated via post-training surveys completed by 40 patient navigators. Data collected included participant satisfaction, knowledge gain, and self-reported confidence in navigating clinical trial discussions.

Results: During the pilot phase, 41 navigators (31.6% white, 26.3% Black or African American, 21.2% Hispanic/ Latino/ Latina, 2.6% Indigenous) from 29 different states across the U.S. completed the course. Learners included clinical nurse and social work navigators, patient navigators, community health workers and allied professionals, with an average of 3.5 years of experience. Survey data indicated high satisfaction and educational value among participants. Of the 41 navigators surveyed, 95% were satisfied with the training, 100% found the content understandable, and 97.6% found it useful and relevant to their work. Navigators reported increased knowledge and greater confidence in supporting patients through the clinical trial process, including using BreastCancerTrials.org to search for eligible studies; improved ability to explain trial options; and addressing trial-related concerns with diverse patient populations.

Conclusion: This patient navigator-focused clinical trial training effectively enhances understanding of clinical trials and equips patient navigators, healthcare professionals, and advocates with the knowledge and confidence needed to better support patients. By addressing key informational gaps and barriers to participation, the free online training supports ongoing professional development and promotes greater access to breast cancer research across diverse and underserved communities. We are currently working on a follow-up survey to assess how patients used the navigation support and clinical trial information they received. Future plans include expanding clinical trial education outreach for navigators through partnerships with advocacy organizations, interactive webinars, and efforts to encourage navigators to routinely discuss clinical trial options with patients.

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N/A

Enhancing Gynecologic Oncology Nurse Navigation Through Structured Mentorship with Advanced Practice Providers

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Objective: TIntegrating Oncology Nurse Navigators (ONNs) into existing clinical teams requires education, role clarity, visibility, coaching and guidance.[1, 2, 3] An NCI-designated cancer center launched gynecologic oncology navigation services in February 2024 as part of an institutional navigation program, transitioning experienced oncology nurses into new ONN roles with the support of expert Advanced Practice Provider (APP) mentors.

Objective: To enhance ONN onboarding, address clinical knowledge gaps, and improve role-specific competency through implementation and evaluation of a structured mentorship program pairing new ONNs with expert gynecologic oncology APPs.

Methods: A year-long mentorship program was initiated in March 2024 for ONNs within the Gynecologic Oncology department. APPs were invited to serve as mentors to new Intake Nurse Navigators (INNs) and Treatment Nurse Navigators (TNNs). Pairings were made based on experience and faculty assignments: TNNs were matched with APPs affiliated with their assigned faculty, while INNs were matched with senior APPs with at least three years of departmental experience. A kick-off meeting was held in March 2024 to introduce mentor/mentee pairs, discuss roles and responsibilities, and share mentorship program guidelines. The mentorship included monthly check-ins (virtual or in-person), case-based discussions, and clinical guidance related to standard of care, treatment protocols, and patient navigation workflows. Progress and satisfaction were evaluated via surveys distributed at three and six months. Key metrics included meeting frequency, mentor accessibility, overall satisfaction, and qualitative feedback.

Results: Fifteen ONNs and 15 APPs participated in the mentorship program. All mentorship pairings lasted at least one year; some pairs continued to collaborate past the intended 12 months. First year retention among the new ONNs was 100%. Three-Month Survey (n = 21, 70% response rate): Meeting frequency: 83% of INNs/TNNs and 71% of APPs reported meeting monthly. Accessibility: 100% of INNs/TNNs confirmed mentors were accessible. Experience ratings: INNs/TNNs: 4.83/5; APPs: 4.86/5. Six-Month Survey (n = 15, 50% response rate): Meeting frequency: 50% met monthly, 50% as needed, with increased knowledge cited as a reason. Accessibility: 100% of INNs/TNNs continued to report mentor availability. Experience ratings: Both INNs/TNNs and APPs rated their experience 5/5.

Conclusion: The structured mentorship program provided a valuable support system for new ONNs beyond the existing role-based onboarding program, especially for those new to gynecologic oncology. Many mentor/mentee relationships extended past the intended 1-year mark, contributing to sustained collaboration and team fit. APP mentors were recognized for their participation as part of a formal institutional professional performance model. Overall, the initiative leveraged existing staffing and expertise to promote retention, interprofessional collaboration, reinforce standards of care, and enhance role preparedness and professional development. High satisfaction ratings and consistent engagement from both mentors and mentees suggest that this model is effective and scalable.

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The Diverse Roles and Responsibilities of Navigators in Fertility Preservation

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Background: Multiple professional organizations have issued guidelines emphasizing the importance of fertility preservation counseling for adolescent and young adult (AYA) patients diagnosed with cancer. While these recommendations underscore the urgency of discussing infertility risks and preservation options, they often fall short of outlining how to operationalize such services effectively. Patient navigators can play a crucial role in bridging this gap by supporting informed decision-making and timely access to care.

Objective: The Patient Navigation Scientific Committee of the Oncofertility Consortium sought to examine the diverse professional roles, training backgrounds, and responsibilities of navigators engaged in fertility preservation worldwide.

Methods: To explore this landscape, a 31-question survey was distributed via email to all 88 committee members, comprising navigators across 24 U.S. states and five countries.

Results: Between August 18 and September 30, 2022, 38 responses were received, yielding a 43% response rate. Respondents represented 14 U.S. states and Canada. The majority of participants identified as nurse practitioners (39.5%), nurses (21%), or navigators not otherwise specified (13.2%). Most navigators (92%) reported working 26 or more hours per week, predominantly within academic medical centers (86.8%). Oncology was the most common clinical setting (64.9%), followed by gynecology (13.5%), reproductive endocrinology (10.8%), surgery (5.4%), and survivorship (5.4%). Over half of the navigators (57.9%) indicated they devote at least half their time to non-oncofertility responsibilities. Navigators reported working with diverse patient populations, including pediatrics (36.8%), AYAs exclusively (15.8%), adults (18.4%), and patients across the age spectrum (39.5%). Their involvement typically spans the entire treatment continuum, from diagnosis through survivorship. Experience levels varied widely: 0-2 years (34.2%), 3-5 years (26.3%), 5-10 years (21.1%), and over 10 years (18.4%), highlighting the value of a collaborative, cross-institutional network. Notably, 65.8% of respondents do not bill for navigation services. Commonly cited barriers included limited personnel and time, delays in consultations and referrals, high costs of preservation procedures, and restricted access to care. Respondents emphasized the need for institutional investment, broader insurance coverage, dedicated funding, and allocated provider time specifically for oncofertility services.

Conclusion: As interest in fertility preservation among cancer patients continues to rise, the role of patient navigators in facilitating timely, comprehensive care is becoming increasingly essential. Many programs begin through the initiative of existing oncology staff who champion the integration of fertility services. These individuals bring valuable knowledge of cancer care protocols, institutional systems, and referral pathways—factors that can accelerate program development. However, most navigators are expected to balance fertility-related responsibilities with broader oncology duties, often without dedicated full-time support or compensation for their oncofertility work. While this approach may be cost-effective for institutions, it can hinder sustainable program growth and burden individual providers. Investing in dedicated navigation roles is critical to advancing equitable and timely fertility preservation care across healthcare settings.

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The Role of Nurse Navigators in Pediatric Radiation Oncology: Bridging Complexity with Compassion

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Background: Pediatric radiation presents a uniquely complex experience for both patients and families. This specialized area of care requires advanced treatment modalities, multidisciplinary coordination, and thoughtful consideration of developmental and psychosocial needs. Nurse navigators play a critical role in guiding families through this journey, serving as key advocates and care coordinators.

Objective: To highlight the vital contributions of nurse navigators in pediatric radiation oncology and share evidence-based best practices for delivering coordinated, compassionate, and developmentally appropriate care.

Methods: Case-based examples and clinical workflows were presented to demonstrate: facilitating effective communication among care teams and families, minimizing treatment delays through proactive coordination, providing emotional and psychosocial support, collaborating with multidisciplinary providers to streamline care, and supporting adherence to complex treatment pathways for improved patient outcomes.

Results: Implementation of structured nurse navigation in pediatric radiation oncology has been shown to improve care continuity, patient/family satisfaction, and clinical outcomes. Key findings include enhanced caregiver confidence, reduced anxiety, and improved patient adherence to complex treatment protocols. Educational strategies and family engagement approaches tailored to pediatric needs will be shared as replicable tools.

Conclusion: Nurse navigators are essential in pediatric radiation oncology, serving as both advocates and care coordinators. Their role bridges complex medical care with compassionate, child- and family-centered support. These efforts lead to measurable improvements in the patient and caregiver experience, reinforcing the value of navigation in high-acuity pediatric settings.

References:

N/A

CATEGORY V: PROFESSIONAL ROLES AND RESPONSIBILITIES

Category VI:

Research, Quality, and Performance Improvement

Category VI: Research, Quality, and Performance Improvement

A Nurse Navigator-led Pilot Study Examining Oral Oncolytic Adherence Using Electronic Remote Symptom Monitoring

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Background: Oral adherence monitoring (OAM) is a broad term for the support of patients prescribed oral medications. Tools to support patient engagement (automated outreach, data visualizations, non-adherence alerting) and drive process improvement are lacking. Since an oncology-specific measure is not yet available, the PROMIS-PMAS was adapted to allow nurse navigators (NN) to manage patients prescribed oral oncolytics from time of prescription to end of therapy or therapy stabilization (correct dose and acceptable side effect profile).

Objective: To automate/digitize NN OAM in patients taking oral oncolytics in the home setting.

Methods: Patients receiving care at an academic cancer center and prescribed oral oncolytics were consented and enrolled in a remote symptom monitoring (RSM) system from April to December 2024. Patients received weekly surveys with 5 questions: 1) "Are you currently taking the following medication?" 2) "Indicate when you started taking it." "For each medication, indicate: 3) how well you understand how to take it as recommended, 4) your understanding of why you need to take it, and 5) how important you believe it is to take it." Responses "never" and "rarely" triggered a severe alert, "sometimes" a moderate alert, and "almost always" a mild alert. NN received an email notification for alerts. A geriatric assessment was used to determine fit, intermediate, or frail status.

Results: A total of 41 patients participated: median age 65 (range = 43-82), 56% male, and 93% white. Diagnoses included hematologic, colorectal, prostate, and pancreatic cancers. Participants were 45% fit, 38% intermediate, and 17% frail. The compliance rate was 68.8% (407 surveys submitted/592 surveys assigned), and the completion rate was 90% (1831 questions answered/2035 questions asked). There were 12 alerts; 2 severe and 10 mild. Evaluation feedback from NN included the need for clearer medication information with survey questions, accurate enrollment, displays with specific medication names or details in surveys for each question, automated OAM identification, an unenrollment option, and an OAM-specific report for navigation, population, and program insights.

Conclusion: Guidelines from leading organizations share best practice standards, but tools to facilitate OAM are lacking. In this pilot, NN were able to assess oral oncolytic adherence without manual outreach and using spreadsheets. High compliance and completion rates indicate patients easily used the system. Responses and alerts allowed proactive awareness of barriers to be resolved and assistance to foster adherence. NN feedback drove the addition of new features and functionality in the RSM platform. As nurses and NN receive efficient and effective support from intelligent health tools like this one, their activities can be focused more freely on high-level, relational tasks of care. Findings support further/continued study and innovation of RSM features and functionality.

References:

N/A

Clinical Navigation: Charting a New Course Within a Community Cancer Center

Lisa Schuldt, MSN, RN

Background: A Commission on Cancer (CoC)-designated community cancer center was having difficulty creating and maintaining a functional clinical navigation (CN) program for breast cancer (BC) patients, as evidenced by low patient referrals, low CN contacts, and limited community engagement. Approximately 16% of the new BC patients were seen by CN in 2022.

Objective: The organization committed to clearly define the CN role and restructure the navigation program, including improving patient identification, increasing provider engagement, and developing a road map of specific, time-sensitive CN interventions, with the goal of increasing participation in navigation services and, subsequently, improving support for patients.

Methods: CN reviewed evidence-based sources and obtained oncology patient navigator certification. An interdisciplinary team asserted that all breast cancer patients deserved CN as opposed to only patients with a provider-identified need. Moving forward, CN met with all BC patients in active treatment at least once to assess barriers to care, provide emotional support, reinforce education, and refer to organizational and community resources. The NCCN Distress Thermometer was utilized to identify individual patients' barriers to care and specific needs.[1] Newly diagnosed patients were met at their initial surgical consultation and at specific milestones: prior to surgery, during chemotherapy and radiation, and at the completion of active treatment.[2] An introduction letter describing the CN role was provided to each patient, and they were encouraged to reach out with questions.

Results: CN contacts increased dramatically since the program launched in June 2023. The CN program saw a 2393% increase in contacts from the program's lowest point in 2022 through 2024. There were 64 CN contacts in 2022, 464 CN contacts in 2023, and 1596 CN contacts in 2024. Active community support referrals increased proportionally. For example, CN referrals to the cancer support team increased from 0 in 2022 to 51 in 2024. Improved navigation support enabled The Maple Tree Cancer Alliance, an oncology specific exercise training program, to increase its enrollment via the organization from 8 patients in 2022 to 45 patients in 2024. The effectiveness of CN was evaluated via an evidence-based survey, with 100% of respondents affirming that CN improved their experience within the organization.[3] Patients confirmed that CN successfully provided education, emotional and logistical support, and additional resources; comments described the navigator as "knowledgeable," "comforting," "compassionate," and "supportive."

Conclusion: Eliminating the requirement of a provider referral enabled CN to evaluate and assist all BC patients undergoing active treatment. CN met with and supported 93% of the new BC patients in 2024 in addition to over 100 BC patients receiving ongoing treatment. Identifying critical timepoints within the BC journey to meet with patients in conjunction with a framework for assessment and interventions promoted engagement between patients and CN.

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Experiences of Care Coordination and Navigation Support During Chemotherapy: Patient Perspectives Post-Intervention in an Underserved Area

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Background: Patients with cancer who reside in under-resourced areas are at a higher risk for poor health outcomes and radiation therapy interruptions (RTI) due to unmet social needs.[1, 2] Community health support specialists (CHSS), commonly known as patient navigators, can provide necessary resources and care coordination to reduce these risks and improve health outcomes.[1] However, prior studies on patient navigation have heavily focused on the breast cancer population, and few qualitative studies have been conducted on navigation experiences among patients in highly underserved and disadvantaged areas.[1, 2] This limits our understanding of the impact of CHSS navigation on unmet needs and preventable health disparities among diverse cancer communities.

Objective: To explore CHSS navigation experiences and process outcomes among patients with various cancers undergoing chemotherapy, following participation in a CHSS-led intervention (ENRICH) designed to address social needs and reduce RTI among at-risk patients.

Methods: Four patients with solid tumor diagnoses (3 head and neck, 1 esophagus) were recruited to participate in virtual, semi-structured, focus group interviews after they completed our ENRICH intervention. ENRICH was led by a Radiation Oncology group at an under-resourced public hospital in Memphis, TN, where social vulnerability is high. We used a qualitative, descriptive design[3] to develop a focus group guide with nine questions that asked patients about the acceptability, accessibility, and accommodations of the cancer care services they received, and their overall CHSS experience. We conducted two hour-long group interviews during April-May 2025. After gaining written and verbal consent, interviews were recorded and transcribed via Zoom for analysis. Conventional content analysis and an inductive coding approach were used to assess the transcripts.[4] Rigor and reproducibility of findings were enhanced via two independent coders, transparent procedures, memoing and verbatim quotes, and peer debriefing during a weekly CHSS navigation meeting.

Results: Among the four participants (mean age = 57.7 years, SD = 11.8), three were male, two were White non-Hispanic, and two were Black/African American non-Hispanic. Three patients screened positive for high social vulnerability (75%), 1 patient was uninsured. The mean time these patients engaged with their CHSS was 6.9 months (SD = 2.2). On thematic analysis of interview transcripts, two dominant categories emerged: (1) Concepts that influenced patient perceptions of their CHSS-provider relationships (i.e., respect, communication, availability, affability, and individualized care); and (2) Concepts that influenced patient perceptions of their care coordination or outlook (i.e., knowledge/information, satisfaction with care, the unknown, interdisciplinary approach, and advocacy).

Conclusion: Findings suggest positive CHSS navigation experiences and cancer care outcomes in underserved and disadvantaged areas were influenced by multiple factors at the individual, environment, and healthcare system levels. CHSS navigators filled a critical gap in healthcare services by acting as advocates to provide needed resources to socially vulnerable patients. CHSS navigators were also described by patients as being more reliable, communicative, and respectful compared to the healthcare provider teams. These initial results confirm the need for ongoing patient enrollment in our ENRICH intervention and emphasize the need for additional characterization and validation of this novel approach among underserved radiotherapy patients.

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Streamlining Radiology Review Processes for High-Risk Breast Cancer Patients: A Collaborative Approach at Dana Farber

Elizabeth Wigozki, MSN, Lindsey McDermott, MSN, RN, Filipa Carvalho, MPH

Background: The Cancer Genetics and Prevention (GEP) program at Dana Farber Cancer Institute (DFCI) cares for patients who are at high risk for breast cancer due to a genetic mutation or strong family history. Often patients will have breast imaging at outside hospitals and request a review by DFCI radiology.

Objective: To develop a nurse-led intervention that creates a workflow utilizing both clinical and non-clinical team members, streamlining the process of formal radiology reviews for breast imaging conducted at outside hospitals, ensuring efficient collaboration and improved patient care outcomes.

Methods: Recently, the GEP program has observed a rise in high-risk patients needing their abnormal breast imaging from outside hospitals to be reviewed by DFCI breast radiology so they can undergo the recommended follow-up procedures at DFCI. In early 2025, the GEP program hired a clinical admin, a new role at DFCI, to assist with clinical administrative tasks. With no formal process in place for outside radiology reviews, our team met to brainstorm an ideal workflow, using both clinical and non-clinical team members. We broke down the process step by step, delegating team members to be responsible for each piece of the workflow. Our team found there were many steps within the process that could be delegated to a clinical admin. After trialing the new process on a few patients, a document outlining the new process, along with roles and responsibilities, was created and shared with all GEP staff.

Results: The process for obtaining formal radiology reviews of outside hospital breast imaging occurs much smoother with a formal process in place. Our program has found it very helpful to have clear, defined roles and responsibilities for both clinical oncology nurse navigators (ONNs) and non-clinical team members within this process. This process has also shown the positive impacts on patient care that can occur when clinical and non-clinical teams collaborate.[1] The patients who have had imaging reviewed have expressed appreciation that their abnormal breast imaging was reviewed by DFCI breast radiology and that the recommended follow-up can be completed through the DFCI GEP program. The collaboration between teams has expedited radiology reviews for patients and streamlined the process.

Conclusion: The formalized workflow for formal radiology reviews of outside-hospital breast imaging has made the process seamless for staff and patients. By clearly defining the roles and responsibilities of both ONNs and non-clinical members of the GEP team, the process has become more efficient and effective. By completing this process in an organized and timely manner, our high-risk patients receive the necessary follow-up sooner, thereby improving overall patient care. Due to the success, the formalized workflow has been shared with the Breast Oncology Disease center at DFCI, to assist with their new patient radiology review.

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Utilizing Navigation with Oncology Patients: Does it Improve a Patient's Access to Care

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Background: The prevalence of cancer in rural Kentucky presents unique challenges that can significantly impact treatment outcomes.[1] Statistics indicate that patients residing in these areas often exhibit lower rates of compliance with prescribed cancer therapies compared to their urban counterparts.[2]

Objective: This quality improvement project aims to prove that the benefits of oncology nursing navigation can improve patient outcomes.

Methods: The initial plan for the navigator tracking metrics will be kept to one department, the medical oncology clinic, to address two current gaps in patient care. These two areas have shown the most significant outmigration and non-compliance since this hospital's oncology program started in 2018. The oncology department hopes that implementing and utilizing a navigation program will help decrease these issues by 10%. The navigator will be tracking metrics on follow-up calls from the patient's initial consultation with the oncologist and follow-up calls before they go for their staging diagnostic scans. Another essential metric is measuring program effectiveness. This involves evaluating how well the program meets its goals and objectives, such as reducing outmigration or improving patient outcomes. By tracking this data, oncology navigation programs can make informed decisions about allocating resources and improving overall performance.

Results: Findings from this research indicated that the presence of a nurse navigator significantly improved various aspects of patient care. There was a significant increase in patient adherence to attending their initial consultation compared to baseline measurements, demonstrating the positive impact of nurse navigation. The support of navigation was particularly beneficial during critical decision-making regarding treatment options and symptom management.

Conclusion: In conclusion, integrating a nurse navigator into oncology care enhanced patients' experience and improved treatment compliance, improving outcomes for newly diagnosed cancer patients. These findings underscore the importance of addressing psychosocial factors in cancer care and highlight how structured support systems can facilitate improved communication between healthcare providers and patients. Future research should continue to explore this model's efficacy across diverse populations and settings.

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Category VII:

Operations Management, Organizational Development, Health Economics

Category VII: Operations Management

Embedding Nurse Navigation at the Point of Biopsy to Expedite Surgical Consultation for Suspected Breast Cancer

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Background: Timely intervention is critical for patients with suspected breast cancer. Delays between biopsy and surgical consultation can increase anxiety and impact outcomes. Embedding a breast nurse navigator (BNN) at the radiology center bridges this gap, offering immediate education, emotional support, and early navigation to streamline access to surgical care.

Objective: To improve care coordination by embedding a BNN at the radiology center, aiming to ensure that 90% of patients with a positive biopsy result are seen by a breast surgeon within three business days of pathology confirmation, while proactively identifying and addressing barriers to timely access to care.

Methods: The program was launched through a partnership between a breast center and radiology practice. A dedicated certified BNN was embedded at the radiology site to meet patients immediately following their breast biopsy. The navigator provided real-time education post-procedure, explained the next steps in the process, and established an early point of contact to foster trust and continuity. Upon receipt of positive pathology result, the navigator promptly contacted the patient, assessed for psychosocial and logistical barriers, and coordinated an expedited referral to a breast surgeon. The navigator collaborated closely with scheduling teams to prioritize timely appointments and facilitated communication across radiology, surgical, and referring care teams. A patient-tracking system was implemented to monitor progress and ensure no delays in follow-up. The model incorporated culturally responsive, informed communication. Early education empowered patients' understanding, enhancing shared decision-making during a vulnerable and emotionally charged period in their care journey.

Results: Over the 18-month study period, 144 patients received support through the navigation model. Among the 113 patients diagnosed with breast cancer, 28% met with a BNN on the day of biopsy, and 59% were referred within three business days of pathology confirmation. Navigator involvement significantly expedited care, with the time from diagnosis to surgical consultation averaging 5 days (range: 0 to 18 days). Additionally, 18 patients were classified as high-risk based on imaging or clinical presentation, with 13 ultimately determined to have benign findings. Navigators played a critical role in addressing common barriers to care, including transportation challenges, insurance authorization delays, and emotional readiness. These obstacles were frequently resolved through timely, personalized intervention, underscoring the navigator's role in improving care coordination and patient experience. The program demonstrated feasibility for broader implementation and measurable improvement in timeliness of care for patients with suspected or confirmed breast cancer.

Conclusion: This innovative program demonstrates that embedding a BNN at the radiology center significantly improves care coordination and reduces time to surgical consultation for patients with breast cancer. By initiating early education and barrier assessment, the navigator streamlines the diagnostic-to-treatment continuum and empowers patients to participate in shared decision-making earlier in their care journey. This early engagement improves patient confidence, reduces anxiety, and fosters trust. The success of this model supports broader adoption across breast care pathways and highlights the value of timely, personalized navigation. Future directions include expanding navigator roles to additional imaging sites to further improve access.

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Enhancing Communication in Healthcare: Addressing Language Barriers in Patient Gateway Portals for Patients with Limited English Proficiency

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Background: It has been reported that language barriers indirectly impact the quality of the healthcare that patients receive.[1] Patients are utilizing online portals to communicate with their care team members more than ever, and it is important to remove barriers for patients with limited English proficiency.

Objective: To identify and translate the 10 most common sentences used for communication in the Patient Gateway portal into the five most frequently spoken languages, enabling care teams to expedite responses to patients with limited English proficiency.

Methods: We have seen a 40% increase in Patient Gateway messages from FY24 to FY25 at Dana-Farber Cancer Institute (DFCI). A survey was sent to oncology nurse navigators (ONNs) across DFCI. ONNs were asked to submit the most common sentences that they either write or respond to patients in Patient Gateway with limited English proficiency. A total of 53 sentences were submitted across all sites at DFCI. ONNs submitted their responses in free text using a survey through Microsoft Forms. Responses were entered into GPT4DFCI, which is an in-house generative AI system. GPT4DFCI was used to analyze all responses and pull out common themes. After review, the nurse director summarized and developed 10 sentences that addressed the most common themes that nurses submitted. Partnering with our interpreter services team at DFCI, the sentences were translated to DFCI's top five languages spoken. This includes Arabic, Simplified Chinese, Portuguese, Russian, and Spanish.

Results: The collaboration with interpreter services enabled ONN leadership to share the 10 translated sentences to the entire ONN community through our weekly email update. The next steps will involve broader dissemination to research nursing, scheduling, and administrative colleagues, as well as uploading the information to our intranet. While this intervention is just beginning, it represents an important step towards meeting all patients' needs. One of the most essential translated responses was, "We have received your message and will forward to our interpreter service team for assistance with translation. If your message requires an urgent response, please call your physician's office at ____." This response is crucial to ensure patients know to call if they need an urgent response or immediate assistance. Another impactful sentence is a proactive message to patients, checking in on them and asking them to call if they are having any symptoms.

Conclusion: This intervention focused on a patient-centered approach to ensure care teams could immediately respond to our patients in their preferred language. Given the health disparities that can occur with patients with limited English proficiency, it is prudent to remove as many barriers as possible. Utilizing approved translated language with our online platforms can ensure patients are getting critical messages and that they receive the same proactive approach with technology as patients who are English-speaking.

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Fostering Resilience: Supporting Nurse Well-Being in Oncology Navigation

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Background: When the Oncology Nurse Navigation (ONN) team was initially established within our health system, navigators were managed independently by leadership at their respective campuses. This decentralized approach led to standalone practices, limiting collaboration and often isolating navigators from their peers. Recognizing the need for a more unified approach, the navigation team was centralized under the oncology service line in 2019. This restructuring aimed to enhance patient care coordination, improve communication, and foster a cohesive support system for patients, providers, and navigators. While centralization yielded improvements in certain areas, ongoing challenges persisted within the team, highlighting the need for further strategies to strengthen collaboration and support.

Objective: To implement strategies and sustain ongoing efforts that enhance team morale, improve staff retention, and foster stronger connections among oncology nurse navigators. These initiatives aim to increase employee engagement and reduce burnout, ultimately supporting the well-being and effectiveness of the team.

Methods: To enhance well-being and support among the ONN team, service line leadership organizes regular team-building activities, fostering connections outside of work. These activities have included a self-compassion seminar, holiday celebrations, Oncology Nurses Month events, outings to different activities, and picnic gatherings at local parks. Leadership also restructured the nurse navigation framework by adding two clinical managers, with one specifically overseeing the breast nurse navigators. This adjustment has distributed leadership responsibilities more effectively, providing stronger support to the team. Additionally, the navigators maintain a hybrid work schedule, which has significantly improved work-life balance and team morale.

Results: Workplace surveys reveal a steady increase in job satisfaction and overall emotional well-being among the ONN team. Additionally, staff retention has shown a significant improvement, reflecting the positive impact of the implemented support measures.

Conclusion: Centralizing the navigation team under the oncology service line has significantly improved patient coordination and fostered better communication across the care continuum and clinical teams. Initiatives such as team retreats, flexible work schedules, and the restructuring of nurse leadership to accommodate a growing team have not only strengthened team cohesion but also resulted in a healthier work-life balance and enhanced job satisfaction. Implications for Practice: According to the American Nurses Association, nursing administrators at every level have a duty to provide and maintain healthy work environments for their employees by advocating for staff, maintaining honest and open communication, and promoting balance between work and home life.[1] By having the ability to flex their hours to attend medical appointments or personal business outside of work, the oncology nurse navigators report decreased stress and worry about juggling other responsibilities.

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Navigating a Pilot Program for CMS Principal Illness Navigation Reimbursement

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Background: The Centers for Medicare & Medicaid Services' 2023 rule updated 2024 Medicare payment policies, introducing new codes (G0023, G0024, G0140, G0146) for Principal Illness Navigation (PIN) services.[1] These codes reimburse auxiliary personnel, like patient navigators, aiming to improve outcomes. Jefferson Health's Sidney Kimmel Comprehensive Cancer Center began a PIN reimbursement pilot in July 2024.

Objective: This pilot aims to build the sustainability of navigation programs through effective reimbursement strategies, ensuring that oncology nurse and patient navigators can continue to provide vital services without financial strain.

Methods: A multifaceted approach was adopted, beginning with a thorough review of the Centers for Medicare & Medicaid Services (CMS) guidelines to ensure compliance with billing practices. Stakeholders, including team members from Navigation, Quality, Compliance, IS&T, Population Health, and billing departments, were identified and engaged to promote a cohesive strategy for successful billing of navigation services. Our focus was limited to codes G0023 and G0024. A timeline was created to outline key tasks, including the development of comprehensive reporting mechanisms for documentation of navigation activities. Claims were systematically prepared and submitted to CMS, with ongoing tracking of reimbursement status to evaluate the effectiveness of these efforts. Monthly reviews are ongoing to ensure accuracy.

Results: The initial month of the PIN billing pilot showed promising results, with 10 claims successfully submitted to CMS, demonstrating our ability to leverage the new reimbursement framework. Each claim was meticulously tracked for compliance and follow-up. As of June 4, 2025, the pilot has seen 396 patients with PIN charges submitted, totaling 755 individual charges. We've received 477 payments, indicating a 63% payment rate on submitted charges. To date, total payments received amount to $37,785.26. This early data suggests effective implementation and successful reimbursement for vital navigation services.

Conclusion: The implications for navigation and nursing practice are profound, as successful reimbursement of services can lead to enhanced care coordination, ultimately improving patient engagement and adherence to treatment plans. This sustainability in funding navigation programs underscores the essential role they play in managing complex patient conditions and highlights the need for ongoing education about reimbursement processes and coding. By advocating for effective services, navigation can lead the way toward improved healthcare delivery models that prioritize patient-centered approaches and outcomes. Abstract presented at the 2024 ONS Congress with original data.

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Navigating the Numbers: The Creation of a Patient Navigation Metrics Dashboard

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Background: Dana-Farber Cancer Institute (DFCI) launched a Community-Focused Patient Navigation Program (CFPN) to proactively address barriers patients face to timely cancer care. CFPN established metrics using national oncology navigation standards to demonstrate impact.[1](1) However, data collection across separate information systems posed challenges in analyzing complex, high-volume data required for program evaluation.

Objective: To create an easy-to-use, interactive dashboard in Tableau[2], built on consolidated CFPN data from two distinct information systems, that supports the tracking, analysis, and visualization of program metrics in one central place.

Methods: CFPN partnered with DFCI's enterprise data and analytics team to structure and integrate key metrics across Epic and Quickbase, a HIPAA-compliant platform.[3, 4] Since these information systems do not communicate directly, application programming interfaces were used to extract data from discrete fields and consolidate in DFCI's Enterprise Data Warehouse. A business logic layer using Structured Query Language (SQL) was developed to act as a bridge between the raw data and data visualizations. This helped standardize program metrics and link patient-level data across information systems using medical record numbers. An automated dashboard was built in Tableau to present data across cancer types and patient groups. It is refreshed regularly and designed for self-service, enabling CFPN staff to independently access and use data as it is collected.

Results: The process undertaken to build the dashboard effectively automated the aggregation of data from two disconnected information systems to showcase CFPN metrics. The dashboard displayed a patient navigator (PN) caseload of 1,204 patients across 10 cancer treatment centers, with dynamic filters for patient demographics and payor category. Appointment-level data from 19,081 encounters and 9,423 documented PN touchpoints, including 3,742 patient-reported barriers to care, were visualized using Epic and Quickbase data to highlight program trends. Designed with scalability in mind, its infrastructure allowed for the integration of new PNs and cancer types as the program expanded. Its automated functionality eliminated the need for manual data extraction, synthesis, and analysis, enabling CFPN staff to focus their time and resources on interpreting metrics and identifying areas of programmatic strength and improvement.

Conclusion: The dashboard has supported strategic decisions regarding program expansion plans and served as a foundational data source for funding proposals, hospital regulatory reporting, and measuring overall program impact. Balancing the high-volume data entry required to populate the dashboard with direct patient care remains a challenge for PNs. CFPN has addressed this through structured data collection and quality assurance processes. Future efforts will concentrate on analyzing metrics that may be influenced by factors beyond CFPN, such as time to treatment initiation and patient retention rates.

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Optimizing Patient Intake: The Impact of Tailored Resources for New Patient Coordinators at Dana-Farber Cancer Institute

Elianna Tobin RN, BSN, OCN, Elizabeth Wigozki, MSN

Background: Patients reported improved wait times and increased satisfaction with healthcare systems when their referrals were reviewed by a clinician.[1] It is critical to utilize nursing appropriately and delegate scheduling and records requests to non-clinical staff. At Dana-Farber Cancer Institute (DFCI), non-clinical staff are the initial contact for patients.

Objective: Develop a nurse-led initiative to establish dedicated resources for new-patient coordinators (NPCs), aiming to reduce confusion, minimize errors, and improve overall efficiency in the operations of the gastrointestinal oncology disease center.

Methods: A specialized Gastrointestinal oncology nurse navigator (ONN) conducted an in-depth assessment of the existing resources in the department for new patient scheduling. Analysis revealed recurring themes in gaps of care throughout new patient operations and scheduling workflows. The ONN created a detailed pathology handout to address the most common inquiries from NPCs, ensuring clarity and accuracy in outside pathology requests. Additionally, a medical terminology guide focusing on gastrointestinal cancer was compiled by the ONN, utilizing definitions from the National Comprehensive Cancer Network to enhance understanding among the NPC team. To streamline the process of obtaining and returning accurate genomic reports, a Next-Generation Sequencing (NGS) handout was developed to send to external facilities. The NGS handout resource was designed to accompany outside hospital medical records, helping medical records departments efficiently communicate and share crucial genomic information as full reports for genomics were often missing.

Results: The ONN used their specific oncology-based knowledge to develop the resources so that non-clinical staff could be involved in making accurate and efficient requests. Streamlining work for non-clinical staff enabled the ONN to focus on clinical care items required for new patients such as clinical triage. Following the provision and implementation of updated resources to the NPCs, the ONN noticed a marked decrease in inquiries from NPCs regarding pathology and terminology. NPCs reported the new resources were extremely helpful and have increased their confidence in requesting the correct pathology slides. Additionally, the ONN has seen improvements in the accuracy of NGS reports received from external hospitals since the implementation of the NGS resource to accompany external requests. Inquiries from other departments across the hospital have been made to adopt the new resources and expand utilization across the entire hospital system for new patients.

Conclusion: Resources have reduced confusion and errors among NPCs, enhanced the NPCs' confidence in managing patient intakes, and have led to more accurate genomic reports from external facilities. Developing customized educational tools to assist non-clinical staff can positively impact the patient intake process. The initiative is now being adopted by other disease centers due to its success. Equipping non-clinical staff with additional tools developed by the ONN enables the ONN to focus on clinical triage and clinical coordination with new patients. This allows the ONN to focus on clinical work and allow non-clinical staff to assist with scheduling new patients.

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The Evolution of Navigation in Virginia: Lessons Learned About the Sustainability of a Statewide Navigation Network

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Background: Patient navigation is an evidenced-based intervention for patient care throughout the cancer care continuum. The Virginia Cancer Patient Navigator Network (VACPNN) began in 2007 when 12 key navigation advocates in Virginia convened to share how their roles coincided and how they could expand navigation professionally beyond their respective organizations. The group realized how networking and sharing of best practices across the state would further the profession of navigation and increase positive patient outcomes. VACPNN formally joined the Academy of Oncology Nurse Navigators (AONN+) as a local navigator network (LNN) in 2017. VACPNN continues to serve as a central hub for networking, education, and sharing of best practices.

Objective: To evaluate and share the lessons learned in sustaining VACPNN over 18 years.

Methods: The mission of VACPNN is to lead a course of excellence in cancer navigation for the community, to remove barriers and enhance outcomes for patients, families, and health care teams through training, education, networking, and mutual support. VACPNN merged with the state coalition, Cancer Action Coalition of Virginia (CACV), in 2022 to assist with creating a sustainable framework for the future of the group. Through this relationship, VACPNN has been able to incorporate oncology navigation principles, goals, and strategies for achievement into the Virginia Cancer Plan. As an implementation team of CACV, VACPNN hosts quarterly meetings and remains an AONN LNN. VACPNN's leadership team meets monthly to discuss team business and collaborate to plan quarterly meetings. Meeting evaluations from participants are utilized to improve content and continue to provide relevant material. VACPNN provides scholarship opportunities for members to access conferences and provides events with CEUs when able.

Results: Over the last 18 years, VACPNN has established itself as a professional organization of navigators for navigators. In a 2014 needs assessment, VACPNN leadership identified 5 areas of action, as requested by its membership. These included a desire for a multidisciplinary network of navigators, a need for continuing education and professional development opportunities, as well as promotion of navigation within organizations and statewide. A 2025 needs assessment resulted in similar needs, and showed the changes that have occurred over time to the profession. Some of these recent needs include expanding the network to reach more navigators in the state and the promotion of navigation to organizations, patients, and the community as a whole. Our relationship with CACV has established stability regarding long-term continuation of the group and the mission. This connection, among many other things, has provided VACPNN with more visibility in our state legislature via inclusion in the annual report to the Virginia governor, as well as the Virginia Cancer Plan. As a result, VACPNN has been able to reach more navigators in underserved areas of the state and connect them with the larger group.

Conclusion: VACPNN has built a sustainable statewide network to empower oncology navigators across the continuum of care to become advocates, educators, and leaders in defining the profession of navigation and emphasizing the continued value to all patients and organizations.

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CATEGORY VII: OPERATIONS MANAGEMENT

Category VIII:

Survivorship and End of Life

Category VIII: Survivorship and End of Life

Rooted in Resonance: The Healing Rhythm of Cultural Connection & Community Collaboration Within Cancer Support Groups

Alexis Daniels, MS, OPN-CG, Gilda Cowan, BS, OPN-CG, Claudia Barrett, MHA

Background: Historically underserved communities often face emotional isolation and limited engagement in support groups. Factors such as medical mistrust and a lack of cultural and linguistic concordance within healthcare settings can deepen this divide, making it harder for patients and caregivers to access meaningful support.

Objective: To explore how cultural concordance within cancer support groups influences emotional wellbeing, group cohesion, and perceived healing among participants.

Methods: To address the cancer support needs of underserved communities, Atrium Health Wake Forest Baptist Comprehensive Cancer Center's Office of Community Outreach and Engagement (AHWFBCCC-COE) partnered with Cancer Services Inc. to implement two culturally- tailored support groups—one for African American (AA) participants and one for Hispanic/Latino individuals. Each group met monthly at 6 PM: AA sessions were held in person, while Hispanic/Latino sessions were offered in a hybrid format. The AA group included middle-class adults aged 40+, primarily from Forsyth County, with varied employment statuses (6 retired, 5 on disability, 4 employed). The Hispanic/Latino group consisted of Spanish-speaking adults aged 35+, all residing in Forsyth County; income and employment data were not collected. Average monthly attendance was 15 for the AA group and 20 for the Hispanic/Latino group. Discussion topics were selected based on participant survey feedback. Sessions were facilitated by staff and guest speakers with lived cultural experiences relevant to each group. Participants received education and support focused on survivorship, wellness, and community resources, including cooking classes, physical activity programs, and healing touch therapies.

Results: In 2024, the AA group saw a 114% increase in monthly attendance, growing from 7 to 15 participants. The Hispanic/Latino group maintained consistent attendance, averaging 20 participants monthly. Qualitative feedback revealed perceived improvements in mental wellbeing, attributed to culturally relevant discussions and peer support. Peer-to-peer referrals emerged as a key outcome, with existing members inviting others affected by cancer to join. This organic growth reflected the trust and value participants placed in the group experience. Facilitators also noted stronger rapport with participants, contributing to increased engagement and retention. Many participants expressed a greater willingness to attend due to the cultural concordance of the group—highlighting the importance of shared language, lived experiences, and community-centered facilitation.

Conclusion: Partnering with local nonprofits was essential to delivering culturally concordant cancer support groups that effectively engaged historically underserved populations. Participation grew steadily among African American individuals and remained high in the Hispanic/Latino group. Participants reported improved emotional wellbeing and stronger community connections, driven by culturally relevant facilitation and peer referrals. Centering survivor and caregiver perspectives was key to creating safe, meaningful spaces for healing. This model shows strong potential for replication in other communities nationwide.

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Category IX:

Clinical Research

Category IX: Clinical Research

Clinical Pharmacology Of Zongertinib, A Novel Her2-Specific Tyrosine Kinase Inhibitor

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Background: Human epidermal growth factor receptor 2 (HER2; ERBB2) mutations are an important non-small cell lung cancer (NSCLC) target. Zongertinib is a novel, potent, and selective HER2-specific tyrosine kinase inhibitor intended for the treatment of adults with unresectable or metastatic NSCLC having HER2 mutations and who have received prior systemic therapy.

Objective: The purpose of this work is to establish a comprehensive clinical pharmacology profile for zongertinib.

Methods: An analysis of the pharmacology of zongertinib was performed after single or multiple dose(s) of zongertinib in patients in the Beamion LUNG-1 clinical trial[1] and in healthy volunteers in 8 clinical pharmacology trials (180 participants). Population pharmacokinetics and exposure-response analyses (ERA) in Beamion LUNG-1 (396 patients) were conducted to evaluate the PK profile and its effect on response.

Results: Zongertinib is rapidly absorbed, with maximal plasma concentrations reached ≈2 hours after oral administration and a high absolute bioavailability (>75%). Zongertinib is mainly eliminated via hepatic metabolism and fecal excretion, with a terminal elimination half-life of ≈43 hours. Approximate dose-proportional plasma exposure was shown between 15 mg twice-daily and 360 mg once-daily (QD) treatment. Inter-individual PK variability was moderate and not time-dependent. Higher zongertinib exposure was found in patients with lower body weight and Asian patients; patient sex had no effect. Renal impairment is unlikely to impact zongertinib exposure, while the effect of hepatic impairment is under investigation. Zongertinib can be administered with or without food. Zongertinib exposure is affected by strong CYP3A4 inducers and inhibitors, such as itraconazole and carbamazepine. Carbamazepine decreased zongertinib exposure by >60%. No proarrhythmic potential was found at doses up to 360 mg QD. ERA indicated ORR and PFS plateaued after 120-mg QD treatment.

Conclusion: The clinical pharmacology profile of zongertinib has been fully characterized, and the results support the oral dosing of 120 mg QD zongertinib in patients with NSCLC.

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Study Sponsor:

Boehringer Ingelheim Pharmaceuticals, Inc, 85 sites, please see link https://clinicaltrials.gov/study/NCT04886804, as well as additional sites from 8 clinical pharmacology trials.

DAREON®-9, A Phase 1b Study of Obrixtamig Plus Topotecan in Patients with Advanced Small-Cell Lung Cancer: Interim Analysis Results

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Background: Delta-like ligand 3 (DLL3) is highly expressed on small-cell lung cancer (SCLC) cells and is a promising target for new therapeutic drugs. Obrixtamig (BI 764532) is a DLL3/CD3 IgG-like bispecific T-cell engager that binds simultaneously to DLL3 on tumor cells and CD3 on T-cells leading to tumor cell lysis.

Objective: To report the first safety and preliminary efficacy data for the dose escalation part of the DAREON-9 trial, investigating the combination of obrixtamig and topotecan in patients with advanced SCLC (NCT05990738).

Methods: Patients who progressed on or relapsed after ≥1 line of platinum-based treatment ± programmed cell death protein 1 (PD-1)/programmed death-ligand 1 (PD-L1) inhibitor were eligible for the trial. Obrixtamig was given as step-up dosing followed by target dose (3 dose levels). Topotecan was given per label. Dose escalation of obrixtamig was guided by a Bayesian Logistic Regression Model. Antitumor activity was evaluated per RECIST 1.1 criteria. The ongoing dose confirmation part will assess obrixtamig at the dose selected at the end of dose escalation.

Results: As of December 9, 2024, 25 patients had received ≥1 cycle of treatment. Median number of cycles for both obrixtamig and topotecan was 4 (range 1-13); median treatment exposure was 2.6 months (range ≤1-8.5). Median age was 65 years (range 38-78); ECOG PS was 0 in 13 patients (52%) and 1 in 12 patients (48%); median number of prior lines of treatment was 1 (range 1-3) and 92% had received prior anti-PD-1/PD-L1 treatment. Obrixtamig-related adverse events (AEs; any grade/grade ≥3) occurred in 23 (92%) and 7 (28%) of patients, with no grade 5 AEs. Topotecan-related AEs (any grade/grade ≥3) occurred in 25 (100%) and 21 (84%) of patients, with no grade 5 AEs. No patients discontinued obrixtamig due to treatment-related AEs. No obrixtamig- or topotecan-related grade ≥2 neurologic events occurred. All cytokine release syndrome cases were low grade: grade 1 (44%) and grade 2 (4%). The most frequent (≥10%) treatment-emergent grade 3/4 AEs were: neutropenia and/or decreased neutrophil count in 15 patients (60%); thrombocytopenia and/or decreased platelet count in 13 patients (52%); decreased lymphocyte count in 8 patients (32%); anemia in 6 patients (24%); and fatigue in 4 patients (16%). Grade 3 febrile neutropenia was reported in 1 patient (4%). Preliminary efficacy data from evaluable patients (n=23) showed an unconfirmed ORR of 70% (95% CI 47%–87%); 1 patient (4%) had a complete response, and 15 (65%) patients had a partial response. Disease control rate was 87% (95% CI 66%–97%). In the 13 patients with ≥2 post-baseline tumor assessments (follow-up >13 weeks), the confirmed ORR was 69%. Median duration of response was not reached.

Conclusion: The obrixtamig plus topotecan combination demonstrated a manageable safety profile with no unexpected toxicities. The frequency and severity of treatment-emergent AEs were consistent with the known safety profiles of obrixtamig and topotecan as monotherapies. Preliminary efficacy findings are encouraging and suggest a potential additive benefit over topotecan alone.

References:

N/A

Study Sponsor:

Boehringer Ingelheim Pharmaceuticals, Inc.

Efficacy and Safety of Abemaciclib in Younger Patients with Early Breast Cancer (EBC) in the monarchE Trial

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Background: Two years of adjuvant abemaciclib + endocrine therapy (ET) resulted in sustained improvement in invasive disease-free survival (IDFS) (HR=0.68, 5-Year Rates (5YR): 84% abemaciclib + ET vs 76% ET, 8% absolute benefit) in patients with HR+, HER2-, node-positive, high-risk early breast cancer (EBC).[1] Younger patients (≤40 years) often have more aggressive disease.[2]

Objective: To assess efficacy/safety data in patients ≤40 years and >40 years in monarchE.

Methods: Patients were randomised 1:1 to ET for ≥5 years +/- abemaciclib for 2 years. ET switch (tamoxifen, aromatase inhibitors [AI]) was allowed. IDFS/ distant relapse-free survival (DRFS) in 2 subgroups (≤40/>40 years) were assessed using Kaplan-Meier method and unstratified Cox model. Safety was summarized by group.

Results: 830 patients were ≤40 years vs 4807 >40 years. Among patients ≤40 vs >40, 93% vs 35% were premenopausal, 50% vs 71% received AI as first ET, and 22% vs 38% had ≥4 comorbidities. Patients ≤40 vs >40 generally had higher risk disease (neoadjuvant chemotherapy receipt: 49% vs 35%; grade 3: 44% vs 37%). 84% patients ≤40 on abemaciclib + ET completed the 2-year treatment period. A consistent treatment benefit of abemaciclib + ET vs ET alone in IDFS/DRFS was observed across age groups: IDFS ≤40 years (HR=0.61 [95%CI:0.44,0.84], 5YR: 84% vs 73% [Δ10]); IDFS >40 years (HR=0.70 [95%CI:0.61,0.80], 5YR: 84% vs 77% [Δ7]) and DRFS ≤40 years (HR=0.61 [95%CI:0.43,0.86], 5YR: 86% vs 77% [Δ9]); DRFS >40 years (HR=0.70 [95%CI:0.60,0.81], 5YR: 86% vs 80% [Δ6]). Of abemaciclib-treated patients ≤40 vs >40, 7% vs 4% switched from tamoxifen to AI within the first 2 years. Grade ≥3 events were similar in abemaciclib + ET arm in ≤40 vs >40: 13% vs 16% had SAEs and 5% vs 8% had Grade 3 diarrhea. Abemaciclib dose reductions/ discontinuations due to AEs were lower in patients ≤40 vs >40 (36% vs 45%/8% vs 20%).

Conclusions: In patients with high-risk EBC, adjuvant abemaciclib + ET showed consistent and clinically meaningful treatment benefit across age groups with a manageable safety profile. Patients ≤40 years had a numerically higher treatment effect and lower rates of abemaciclib discontinuation due to AEs. The versatility of abemaciclib to combine with tamoxifen or AI allows clinicians to switch and optimize ET options to improve tolerability and persistence.

Previously presented at ESMO-BC 2025.

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Study Sponsor:

Eli Lilly and Company

Enhanced vs Standard Dermatologic Management with Amivantamab-Lazertinib in EGFR-Mutant Advanced NSCLC: The COCOON Global Randomized Controlled Trial

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Background: First-line amivantamab-lazertinib significantly prolonged overall survival versus osimertinib among participants with EGFR-mutant advanced NSCLC in MARIPOSA (P<0.005).[1] The phase 2 COCOON study (NCT06120140) demonstrated early success (median follow-up: 4.2 months), showing a significant reduction in grade ≥2 dermatologic adverse events (AEs) with enhanced (COCOON) vs standard-of-care (SoC) dermatologic management (P<0.0001).[2](2)

Objective: Here, we report the results from the fully-enrolled population from the phase 2 COCOON study.

Methods: Eligible participants with previously-untreated, EGFR-mutant (Ex19del/L858R) locally advanced or metastatic NSCLC were randomized 1:1 to receive COCOON dermatologic management (DM), described below, or only SoC DM. All participants received standard-dose IV amivantamab plus oral lazertinib and SoC DM. Prophylactic anticoagulation was mandatory for the first 4 months of anticancer treatment. COCOON DM included oral doxycycline or minocycline 100 mg (twice daily, Weeks 1-12), chlorhexidine 4% on fingernails/toenails daily for 12 months, clindamycin 1% lotion on the scalp (daily, Weeks 13-52), and ceramide-based moisturizer for the face/body for 12 months. Primary endpoint was incidence of grade ≥2 dermatologic AEs of interest in the first 12 weeks of anticancer treatment.

Results: As of March 12, 2025 (median follow-up: 7.1 months), 199 participants received COCOON DM (n=99) or SoC DM (n=100) with amivantamab-lazertinib. Median age was 63 years; 59% were female, and 77% remain on anticancer treatment as of clinical cutoff. Based on full enrollment, COCOON DM demonstrated significant reduction in grade ≥2 dermatologic AEs in the first 12 weeks vs SoC DM (41% vs 73%; OR, 0.26 [95% CI, 0.14-0.47]; P<0.0001). By Week 12, the largest benefit was observed in face/body (excludes paronychia; 26% vs 59%; P<0.0001) and scalp dermatologic AEs (10% vs 26%; P=0.005); paronychia incidence was comparable (20% vs 21%). Discontinuations of amivantamab or lazertinib due to any AE were lower with COCOON DM (16% vs 20%). COCOON DM was well-tolerated, with only 2 participants discontinuing doxycycline or minocycline due to treatment-related AEs. Objective response rate (investigator-assessed) was 81% for COCOON DM and 76% for SoC DM, consistent with prior reports.

Conclusion: An easy-to-use, widely available, prophylactic regimen (COCOON DM) reduced the incidence and severity of dermatologic AEs with amivantamab-lazertinib. New approaches focusing on a simplified regimen with early intervention are being investigated. This optimization, along with an overall survival improvement, further enhances the benefit-risk profile for first-line amivantamab-lazertinib.

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Study Sponsor: Janssen Research & Development, LLC, a Johnson & Johnson Company; Full list of institutions for the COCOON study can be found here: https://clinicaltrials.gov/study/NCT06120140.

Exploring the Treatment Gap in High-Risk HR+, HER2- Early Breast Cancer (EBC): Eligible Patients Not Receiving Abemaciclib in the US

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Background: Real-world risk of recurrence in patients with node-positive, HR+, HER2- EBC who have N1 disease with additional high-risk features or N2/N3 disease is 29% at 5 years when treated with adjuvant endocrine therapy (ET).[1] Adjuvant abemaciclib+ET is approved and recommended to reduce the risk of recurrence, with ~8% lower rate of recurrence at 5 years versus ET alone.[2] Retrospective, single institution studies have reported adjuvant abemaciclib utilization rates of <50% in eligible patients.

Objective: To describe characteristics of eligible real-world patients not receiving adjuvant abemaciclib across >250 US cancer clinics.

Methods: This retrospective study used the US nationwide Flatiron Health electronic health record-derived de-identified database. Adult patients with HR+, HER2-, node-positive, EBC (stage IA-IIIC) who underwent breast cancer surgery and then initiated adjuvant ET-based therapy January 2023-March 2024 were selected. N1/N1 micrometastases (mi) disease was Grade 3 or ≥5 cm. Adjuvant abemaciclib use was assessed through June 2024. Database does not capture comorbidities, financial considerations, or patient/physician discussion. Baseline characteristics were summarized descriptively.

Results: Overall, 3170 patients met eligibility criteria. Median age was 62 years (IQR: 51-71). Patients were mostly female (98%), white (62%) ,and treated in a community setting (83%). Median follow-up was 9 months (IQR: 6-12). Of eligible patients, 1902 (60%) did not receive abemaciclib; 70% of patients aged ⌧65 and 53% of patients <65 did not receive abemaciclib. 59% of white patients and 54% of Black patients did not receive abemaciclib. As for ethnicity, 68% of Hispanic/Latino patients did not receive abemaciclib, compared to 58% of non-Hispanic/non-Latino patients. Pathological nodal status showed 69% of N1/N1mi, 50% of N2, and 44% of N3 patients did not receive abemaciclib.

Conclusion: In this real-world study, 60% of patients with node-positive, high-risk HR+, HER2- EBC meeting eligibility criteria for adjuvant abemaciclib did not receive this recommended therapy. The most affected subgroups were older patients (who had similar efficacy and adverse event rates as younger patients in the monarchE trial) and patients with N1 plus high-risk features (who have a >2-fold recurrence risk versus patients with N1 disease without these high-risk features). Education on recurrence risk and consistent benefit of adjuvant abemaciclib in the approved node-positive, high-risk EBC population, may increase abemaciclib utilization to optimize treatment and prevent incurable metastatic disease.

Previously presented at MBCC 2025.

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Study Sponsor:

Eli Lilly and Company

Eye Conditions Prior to Treatment and the Risk of Developing Eye-Related Side Effects in Patients with Relapsed/Refractory Multiple Myeloma (RRMM): DREAMM-7 and DREAMM-8 Trials of Belantamab Mafodotin

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Background: In the phase 3, global DREAMM-7 (NCT04246047) and DREAMM-8 (NCT04484623) clinical trials, belantamab mafodotin (belamaf) combinations were associated with patients living for a longer time with RRMM that did not worsen.[1, 2] Eye-related side effects were common with belamaf but were almost always reversible with dose decreases and temporary pauses in treatment.[1, 2]

Objective: To explore whether existing eye-related conditions before treatment with belamaf influenced the likelihood of eye-related side effects occurring after belamaf treatment started.

Methods: Patients who received ≥1 previous treatment were eligible for DREAMM-7 and DREAMM-8; patients with eye-related conditions were eligible, except for those with damage to their cornea (patients with small spots of damage to their cornea [called mild punctate keratopathy] were allowed). Patients had mandatory eye examinations (best-corrected visual acuity, slit lamp, and funduscopic exams) once before treatment started (baseline) and then routinely during treatment. Eye-related side effects were graded based on the Common Terminology Criteria for Adverse Events. Regardless of whether patients had eye-related conditions at baseline, the same methods were used to manage their eye health.

Results: Of 392 patients who received belamaf, 62% had eye-related conditions at baseline (DREAMM-7, n=135/242; DREAMM-8, n=106/150), which included cataract (clouding of the eye's lens; 50% [DREAMM-7, n=101; DREAMM-8, n=96]), keratopathy (damage to the cornea; 14% [DREAMM-7, n=33; DREAMM-8, n=23]), dry eye (14% [DREAMM-7, n=31; DREAMM-8, n=24]), visual acuity of 20/50 or worse (indicates reduced sharpness of vision; 6% [DREAMM-7, n=18; DREAMM-8, n=7]), glaucoma (damage to the optic nerve; 6% [DREAMM-7, n=11; DREAMM-8, n=13]), blepharitis (inflammation of the eyelids; 2% [DREAMM-7, n=4; DREAMM-8, n=3]), age-related macular degeneration (damage to the macula; 1% [DREAMM-7, n=3; DREAMM-8, n=2]), and diabetic retinopathy (diabetes-related damage to retinal blood vessels; <1% [DREAMM-7, n=0; DREAMM-8, n=2]). After starting belamaf, eye-related side effects were seen in 74% (n=100/135) and 87% (n=92/206) of patients with baseline eye-related conditions in DREAMM-7 and DREAMM-8, respectively, compared with 79% (n=85/107) and 91% (n=40/44) of patients without baseline eye-related conditions.

Conclusion: The incidence of eye-related side effects with belamaf was similar in both patients with and without eye-related conditions at baseline, suggesting that existing eye-related conditions did not influence the likelihood of eye-related side effects occurring after starting belamaf treatment. We will present how baseline eye-related conditions impacted the eye-related side effects that patients experienced after starting belamaf treatment, as well as changes observed in eye exams and vision tests.

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Study Sponsor:

GSK (207499/207503); drug linker technology licensed from Seagen; monoclonal antibody produced using POTELLIGENT Technology licensed from BioWa.

Long-Term Outcomes and Overall Survival For Zanidatamab Plus Chemotherapy In HER2-positive (HER2+) Advanced Or Metastatic Gastroesophageal Adenocarcinoma: 4-year Follow-Up of a Phase 2 Trial

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Background: Zanidatamab (zani), a dual HER2-targeted bispecific antibody, plus chemotherapy (chemo) has previously demonstrated antitumor activity and a manageable safety profile in the first line (1L) treatment of patients (pts) with HER2+ mGEA. Here, we report a 4-year follow-up and the first report of both median overall survival (OS) and translational data from this phase 2 trial.

Objective: To evaluate the safety and efficacy of zanidatamab and chemotherapy in 1L HER2+ advanced/metastatic gastroesophageal adenocarcinoma (mGEA).

Methods: The phase 2 trial (NCT03929666) evaluated zani + chemo (mFOLFOX6, CAPOX, or FP) in the 1L treatment of mGEA. In Part 1, pts had HER2 expressing (IHC 3+ or 2+) mGEA. Pts in Part 2 had HER2+ (IHC 3+ or IHC 2+/FISH+) mGEA by central assessment. After 25 pts were treated, antidiarrheal prophylaxis was added for cycle 1. The primary endpoint was confirmed objective response rate (cORR). Secondary endpoints included duration of response (DoR), progression-free survival (PFS), OS, and safety outcomes. Plasma ctDNA samples were collected for NGS testing (Guardant360).

Results: In total, 46 pts were enrolled (zani + mFOLFOX6 [n = 24], CAPOX [n = 20], or FP [n = 2]). The majority (41 [89%]) of pts had HER2+ mGEA by central confirmation (ccHER2+); 35 (76%) pts had gastric/GEJ cancer. As of July 28, 2024, the median (range) follow-up was 48 (29 59) mo; 8 pts (17%) were on zani treatment and 19 (41%) in survival follow-up. Efficacy results are shown in the Table. The median OS was 36.5 mo; longest survival time was 57.9 mo (censored without death at data cutoff). The concordance between HER2 gene amplification by centrally assessed ISH vs plasma ctDNA was 90% (18/20). Of 14 pts with matched plasma samples at baseline and on treatment (Cycle 2, day 15), 8 had a > 90% decrease in total ctDNA levels and 2 had a decrease in HER2 copy number. Common (> 5% of pts) grade 3 or 4 treatment related AEs (TRAEs) were diarrhea (n = 18 [39%]), hypokalemia (n = 10 [22%]), vomiting (n = 4 [9%]), and nausea (n = 3 [7%]). Grade 3 or 4 diarrhea incidence was reduced from 52% to 24% after prophylaxis implementation. No deaths occurred due to TRAEs.

Conclusion: After a median 4-year follow-up, zani plus chemo demonstrated clinically meaningful efficacy in the 1L treatment of HER2+ mGEA, with durable responses and a median OS > 3 years, and a manageable safety profile. Zani plus chemo markedly reduced total plasma ctDNA levels early in treatment of mGEA.

References:

N/A

Study Sponsor:

Jazz Pharmaceuticals

Overall Survival With Neoadjuvant Nivolumab Plus Chemotherapy In Patients With Resectable Non-Small-Cell Lung Cancer In CheckMate 816

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Background: Nivolumab plus chemotherapy (NIVO+chemo) is an established standard of care neoadjuvant treatment for eligible patients with resectable non-small-cell lung cancer (NSCLC) and has shown statistically significant and clinically meaningful improvements in event-free survival (EFS) and pathological complete response (pCR) in the phase 3 CheckMate 816 study.[1]

Objective: To report the final analysis of overall survival (OS) at the 5-year follow-up and the impact of circulating tumor DNA (ctDNA) clearance and pCR on long-term survival outcomes in the CheckMate 816 study.

Methods: Adults with stage IB (≥ 4 cm)–IIIA (per AJCC v7) resectable NSCLC, ECOG PS ≤ 1, and no known EGFR/ALK alterations were randomized 1:1 to receive neoadjuvant NIVO+chemo Q3W or chemo Q3W for 3 cycles, followed by surgery. Primary endpoints were EFS and pCR (both by blinded central independent review). OS was a key prespecified, statistically powered secondary endpoint that was tested hierarchically. Exploratory analyses included OS by ctDNA clearance and pCR status. Median follow-up was 68 months (range, 60-85; database lock, 23 January 2025).

Results: At median follow-up, neoadjuvant NIVO+chemo demonstrated a statistically significant OS benefit vs chemo alone (HR [95% CI], 0.72 [0.523–0.998]; P=0.0479); 5-year OS rates were 65% vs 55%. OS favored NIVO+chemo in the subgroups defined by tumor programmed death-ligand 1 expression, baseline disease stage, and histology. In an exploratory analysis of patients who were ctDNA+ at baseline (NIVO+chemo, n=43; chemo, n=43), patients with presurgical ctDNA clearance (56% vs 35%) had continued OS improvement vs those without across both treatment arms (HR [95% CI]: NIVO+chemo, 0.38 [0.15–1.00]; chemo, 0.39 [0.14–1.11]). Patients with pCR following NIVO+chemo treatment sustained OS improvement vs those without (HR [95% CI], 0.11 [0.04–0.36]; 5-year OS rates, 95% vs 56%). Neoadjuvant NIVO+chemo continued to improve EFS vs chemo (HR [95% CI], 0.68 [0.51–0.91]); 5-year EFS rates were 49% vs 34%. No new safety signals were observed at this long-term follow-up.

Conclusions: CheckMate 816 is the only neoadjuvant-only immunotherapy phase 3 trial to demonstrate a statistically and clinically significant OS benefit at 5 years in patients with a resectable solid tumor.[2] Patients with pCR following neoadjuvant NIVO+chemo had a ~90% reduction in their risk of death at 5 years compared with those without pCR. The findings show long-term survival benefit from a short course of neoadjuvant NIVO+chemo and affirm a paradigm shift in the treatment of resectable NSCLC without actionable genomic alterations.

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Study Sponsor:

Bristol Myers Squibb

Real-World Survival Outcomes By Risk Features in Patients With HR+, HER2- Early Breast Cancer in the US

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Background: Patients with node-positive (N+) high-risk clinicopathologic features in the monarchE trial (N+ High-Risk: N1 with Grade 3 [G3] or tumor ≥5 cm; N2; N3) have a real-world 5-year recurrence risk of 30% on endocrine therapy (ET).[1] In monarchE, 2-years of abemaciclib + ET improved invasive disease-free survival (IDFS) (hazard ratio [HR]=0.68, 5-year rates: 84% abemaciclib + ET vs 76% ET, 8% 5-year absolute benefit).[2]

Objective: To describe real-world overall survival (OS) and IDFS in patients with early breast cancer (EBC) with monarchE high-risk features and in patients with triple negative EBC (eTNBC) for context.

Methods: This retrospective study used the US nationwide Flatiron Health electronic health records-derived deidentified database (January 2011-June 2024). Eligible patients with surgically resected HR+, HER2- EBC received ET, but no targeted adjuvant agents. Patient groups were N+ High-Risk vs Non-High-Risk (N0; N1 with <G3, tumor <5 cm, and Ki-67 <20%; NX). Nodal subgroups included N1 High-Risk (N1 with G3 or tumor ≥5 cm) and N1 Non-High-Risk (N1 with <G3, tumor <5 cm, and Ki-67 <20%). OS and IDFS for HR+, HER2– EBC and eTNBC were estimated from adjuvant ET and chemotherapy initiation, respectively. Outcomes were estimated using Kaplan-Meier methods and comparisons of High-Risk vs Non-High-Risk with Cox regression models with covariates.

Results: For 6350 eligible patients with HR+, HER2- EBC and for 515 patients with eTNBC, median follow-up was 56 months (interquartile range: 28, 84) and 48 months (22, 79), respectively. Risk of death was greater in N+ High-Risk vs Non-High-Risk (adjusted HR=2.3 [95% CI: 2.0, 2.8]) and in N1 High-Risk vs N1 Non-High-Risk (HR=1.6 [1.1, 2.3]). OS and IDFS 5-year rates were similar for N+ High-Risk (81.6% and 70.9%, respectively) and eTNBC (79.2% and 74.3%, respectively). For nodal subgroups, N1 High-Risk group had 5-year OS of 86.5% and IDFS of 75.7%; N2 group had 5-year OS of 78.9% and IDFS of 68.3%; N3 group had 5-year OS of 70.6% and IDFS of 59.6%. Non-High-Risk group exhibited higher survival rates, with an overall 5-year OS of 93.9% and a 5-year IDFS of 91.2%, and the N1 Non-High-Risk subgroup showing 92.8% and 90.0%, respectively.

Conclusion: Real-world patients with N+ High-Risk monarchE features receiving ET alone have an increased risk of death compared to patients with lower risk features, and a 5-year mortality risk similar to eTNBC. To mitigate the high risk of incurable metastatic recurrence, these patients should be considered for 2 years of adjuvant abemaciclib + ET.

Previously presented at ESMO-BC 2025.

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Study Sponsor:

Eli Lilly and Company

Subcutaneous Nivolumab (NIVO SC) vs Intravenous Nivolumab (NIVO IV) in Patients With Previously Treated Advanced Or Metastatic Clear Cell Renal Cell Carcinoma: Updated Efficacy And Safety Results From CheckMate 67T

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Background: CheckMate 67T (NCT04810078) is a multicenter, randomized, open-label, phase 3 trial of NIVO SC vs NIVO IV in previously treated patients with advanced/metastatic clear cell renal cell carcinoma (ccRCC). The primary data analysis (at ≥8-months' follow-up) demonstrated noninferiority of NIVO SC to NIVO IV for co-primary pharmacokinetic endpoints and key powered secondary efficacy endpoint (objective response rate [ORR] by blinded independent central review [BICR]).[1] Safety outcomes and health-related quality of life measures were consistent between NIVO SC and NIVO IV.[1]

Objectives: Here, we report updated efficacy, safety, and immunogenicity data after ≥15-months' follow-up.

Methods: Patients were randomized 1:1 to receive NIVO SC 1200 mg + recombinant human hyaluronidase PH20 Q4W or NIVO IV 3 mg/kg Q2W until disease progression, unacceptable toxicity, withdrawal of consent, completion of 2 years' treatment, or death. ORR by BICR was a key powered secondary endpoint. Other secondary objectives included safety, efficacy, and immunogenicity outcomes.

Results: A total of 495 patients were randomized to NIVO SC (n=248) or NIVO IV (n=247). With longer follow-up, additional responses were observed, leading to an increased ORR by BICR in both arms (NIVO SC, 26.6%; [95% CI, 21.1–32.6], NIVO IV, 20.6%; [95% CI, 15.8–26.2]). Best ORRs with NIVO SC vs NIVO IV, respectively, were as follows: complete response, 2.0% (n=5) vs 2.8% (n=7); partial response, 24.6% (n=61) vs 17.8% (n=44); stable disease, 35.9% (n=89) vs 42.1% (n=104). Progressive disease occurred in 25.4% of patients receiving NIVO SC (n=63) and 26.7% of those receiving NIVO IV (n=66), while response was unevaluable in 12.1% of patients in the NIVO SC group (n=30) and 10.5% in the NIVO IV group (n=26). The ORR risk ratio was 1.28 (95% CI, 0.93–1.77). The disease control rate was 62.5% (95% CI, 56.2–68.5) with NIVO SC and 62.8% (95% CI 56.4–68.8) with NIVO IV, while median progression-free survival was similar in both arms (NIVO SC, 6.34 months [95% CI 5.13–7.49]; NIVO IV, 5.65 months [95% CI 5.19–7.39]). Safety events reported with NIVO SC were similar or numerically lower than with NIVO IV: treatment-related adverse events (TRAEs) were reported in 11.7% (n=29) vs 17.1% (n=42) of patients; discontinuation due to AEs, 9.3% (n=23) vs 9.8% (n=24); and discontinuation due to TRAEs, 2.8% (n=7) vs 3.7% (n=9). Study drug toxicity led to 3 and 2 deaths with NIVO SC and NIVO IV, respectively, which includes one additional death in the IV arm since the primary analysis. Anti-NIVO antibodies (ANAs) were observed in 24.0% (50/208) of patients with NIVO SC and 9.6% (15/217) with NIVO IV; neutralizing ANAs were rare and only detected in the NIVO SC arm (1% [n=2]).

Conclusion: With extended follow-up, NIVO SC continues to demonstrate efficacy and safety outcomes comparable to NIVO IV administration, consistent with the primary analysis. Immunogenicity data were also consistent with the primary analysis. These updated results continue to support NIVO SC as a new option to enhance patient experience and healthcare efficiency.

Editorial acknowledgment

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Study Sponsor:

Bristol Myers Squibb

Updated Results of Belantamab Mafodotin Plus Pomalidomide and Dexamethasone Vs Pomalidomide Plus Bortezomib and Dexamethasone in Relapsed/Refractory Multiple Myeloma: DREAMM-8

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Background: Standard first-line treatments for multiple myeloma (MM) include 3- or 4-drug combinations of proteasome inhibitors, immunomodulators, and anti-CD38 monoclonal antibodies.[1] However, most patients have disease progression and need new treatment options.[2]

Objective: In DREAMM-8, patients with relapsed/refractory MM (RRMM) treated with belantamab mafodotin, pomalidomide, and dexamethasone (BPd) had statistically significant longer progression-free survival (PFS) vs those treated with pomalidomide, bortezomib, and dexamethasone (PVd).3 Here, we report updated results from DREAMM-8, with an additional 8 months of follow-up.

Methods: DREAMM-8 is a phase 3 trial evaluating the efficacy and safety of BPd vs PVd in patients with RRMM who received ≥1 prior line of therapy (LOT), including lenalidomide. Patients were randomized 1:1 to either BPd (28-day cycles) or PVd (21-day cycles). In the intention-to-treat population, 302 patients were randomized to BPd (n=155) or PVd (n=147).[3] In DREAMM-8, patients received the following BPd dosing scheme in 28-day cycles: belantamab mafodotin 2.5 mg/kg intravenous (IV) in cycle 1 then 1.9 mg/kg IV every 4 weeks from cycle 2 onward; pomalidomide 4 mg orally on days 1-21; and dexamethasone 40 mg on days 1, 8, 15, and 22. Patients received treatment until their disease progressed, they experienced unacceptable side effects, or death.

Results: As of October 7, 2024, median follow-up was 28.01 (range, 0.03-47.74) months; 55 patients (35%) in the BPd arm and 20 (14%) in the PVd arm were receiving treatment. Sixty-eight patients (44%) receiving BPd and 89 (61%) receiving PVD had progressed or died. Median PFS was 32.6 (95% CI, 21.1-not reached) months with BPd vs 12.5 (95% CI, 9.1-17.6) months with PVd (HR, 0.49; 95% CI, 0.35-0.68). The 18-month PFS rate was 63% (95% CI, 54%-70%) with BPd vs 41% (95% CI, 32%-50%) with PVd. Longer PFS with BPd was maintained across subgroups, including patients with high-risk cytogenetics (unadjusted HR, 0.55; 95% CI, 0.33-0.90), lenalidomide-refractory disease (unadjusted HR, 0.43; 95% CI, 0.30-0.60), or anti-CD38–resistant disease (unadjusted HR, 0.64; 95% CI, 0.36-1.15) and those who had 1 (unadjusted HR, 0.47; 95% CI, 0.29-0.77) or ≥2 prior LOTs (unadjusted HR, 0.51; 95% CI, 0.33-0.77). Safety was consistent with previously reported results.[3]

Conclusion: In DREAMM-8, BPd continued to demonstrate clinically meaningful, longer PFS vs PVd in patients with RRMM with ≥1 prior LOT, including lenalidomide. Longer PFS was maintained across key patient subgroups. These data further support BPd as a potential new treatment option for patients with RRMM.

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Study Sponsor:

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Zongertinib in Patients With Pretreated HER2-Mutant Advanced Non-Small Cell Lung Cancer: Beamion LUNG-1

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Background: Zongertinib is an irreversible tyrosine kinase inhibitor that selectively inhibits HER2 while sparing EGFR, thereby limiting associated toxicities. Zongertinib was granted Fast Track and Breakthrough Therapy designations by the FDA for patients with advanced, unresectable, or metastatic non-small cell lung cancer (NSCLC) whose tumors have activating HER2 mutations and who have received prior systemic therapy. Beamion LUNG-1 (NCT04886804) is a Phase Ia/Ib study evaluating zongertinib in patients with HER2-mutant advanced/metastatic NSCLC in Phase Ib. At the primary analysis (May 2024) of Phase Ib Cohort 1, the primary endpoint, confirmed response by blinded independent central review (BICR), was met in patients with pretreated HER2-mutant NSCLC within the tyrosine kinase domain (TKD).

Objective: To report the median duration of response (DoR) and median progression-free survival (PFS) for Cohort 1, and first data from Cohort 3 and Cohort 5.

Methods: In Cohort 1, patients with pretreated HER2-mutant NSCLC within the TKD were initially randomized to receive zongertinib 120 mg or 240 mg once-daily; the 120 mg dose was selected at an interim analysis. In exploratory Cohort 3, patients had pretreated HER2-mutant NSCLC with TKD or non-TKD mutations. In Cohort 5, patients had HER2-mutant NSCLC within the TKD and were pretreated with a HER2-directed antibody-drug conjugate. In Cohort 3 and Cohort 5, patients initially received zongertinib 240 mg. Once the 120 mg dose was selected in Cohort 1, all newly recruited patients received zongertinib 120 mg. Primary endpoint was objective response (best overall response of complete or partial response; RECIST v1.1) by BICR (Cohort 1 and Cohort 5) and investigator review (Cohort 3). Secondary endpoints included DoR and PFS.

Results:

As of November 29, 2024, 75 patients in Cohort 1, 20 patients with non-TKD mutations in Cohort 3, and 31 patients in Cohort 5 had received zongertinib 120 mg; treatment was ongoing in 33 (44%), 4 (20%), and 13 (42%) patients, respectively. In Cohort 1, the objective response rate (ORR) by BICR was 71% (95% CI: 60-80) and disease control rate (DCR) was 96% (95% CI: 89-99). In Cohort 3, the ORR was 30% (95% CI: 15-52) and DCR was 65% (95% CI: 43-82). In Cohort 5, the ORR was 48% (95% CI: 32-65) and DCR was 97% (95% CI: 84-99). Median (95% CI) DoR and PFS were 14.1 (6.9-not evaluable [NE]) months and 12.4 (8.2-NE) months in Cohort 1 and 5.3 (2.8-NE) months and 6.8 (5.4-NE) months in Cohort 5. DoR and PFS in Cohort 3 were not yet mature. Drug-related adverse events (all/grade ≥3) were reported in 97%/17%, 80%/25%, and 77%/3% of patients in Cohort 1, Cohort 3, and Cohort 5, respectively, most commonly diarrhea in all cohorts (mainly grade 1). There were no cases of drug-related interstitial lung disease.

Conclusion: Zongertinib demonstrated significant and clinically meaningful activity with a manageable safety profile in patients with pretreated advanced NSCLC harboring HER2 mutations.

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N/A

Study sponsor

Boehringer Ingelheim Pharma GmbH & Co. KG

Late-Breaking Abstracts

Category I: Community Outreach/Prevention

From Community to Clinic: Implementing an Evidence-based Screening Navigation Intervention at a Federally Qualified Health Center in the South

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Background: Spanish-Speaking communities in the US have some of the lowest cancer screening rates.[1] In Tennessee, individuals from Spanish-speaking backgrounds represent 7% of the state's population and are the fastest-growing demographic.[2] With grant funding, we collaborated with a local federally qualified health center (FQHC) to launch an evidence-based cancer screening navigation program.[3]

Objective: To evaluate implementation of a bilingual, bicultural cancer screening navigation program at a FQHC for the Spanish-speaking community prior to expansion to additional communities.

Methods: In addition to conducting traditional outreach activities to increase awareness of cancer screening, a bilingual, bicultural screening navigator (SN) is embedded in the Matthew Walker Comprehensive Health Center (MWCHC) clinic two days per month to provide onsite support. The SN's primary role is to navigate clinic patients by offering culturally tailored education and assistance throughout the screening process to address any barriers to care. In addition to supporting clinic staff as they work with each eligible patient, the SN leads comprehensive outreach strategies such as educational workshops and community cancer talks and participates in wellness events to identify community members in need of cancer screening. Navigation services are offered to anyone in attendance who expresses interest and, as appropriate, women are scheduled to be seen at the FQHC. Personalized follow-up reminders to assist with scheduling cancer screenings are provided. A retrospective review of navigation data from March 9, 2023 to August 28, 2025 was performed.

Results: During the evaluated period, the SN participated in 101 community events for Spanish-speaking communities and identified 680 women in need of screening. Navigation was provided to 488 women (72%) with an average age of 43, resulting in the completion of 336 mammograms and 309 pap tests. In June 2023, at home colorectal cancer screenings were offered to participants age 45+, resulting in 104 screenings (82 FIT, 22 Cologuard). Additionally, the initiative assisted 123 of the women, and the men in their lives, in need of a medical home by scheduling adult physical exams at the clinic to help ensure continuity of care.

Conclusion: Our analysis demonstrates programmatic success through a comprehensive strategy that combines a SN with culturally appropriate outreach and engagement to connect communities to cancer screening services and support. Developing similar collaborative community-academic strategies with local FQHCs is essential to address the needs of vulnerable communities. This personalized approach fosters trust, community connections and promotes sustainable improvement in cancer screening outcomes by ensuring continuity of care. The infrastructure developed through the Health Resources and Services Administration grant awarded to MWCHC will now be expanded to additional communities served by the health center.

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Category II: Care Coordination/Care Transitions

Enhancing Care Coordination for Geriatric Oncology Patients Through a 4Ms-Based Multidisciplinary Clinic Model

Silpi Sinha Ray, MBA, Jackie Miller, MSN, RN, OCN, Kristine Swartz, MD, Lauren Hersh MD, Andrew E. Chapman, DO, FACP, FCPP

Background: Older adults with cancer often face unique vulnerabilities that complicate care transitions and necessitate coordinated, patient-centered approaches. The Senior Adult Oncology Clinic (SAOC) was established to evaluate older adults before initiating cancer treatment, ensuring that care plans are tailored to their specific health status and personal goals.

Objective: To describe the implementation and impact of a non-clinical patient navigator-led care coordination initiative that integrates the 4Ms of Age-Friendly Health Systems into a multidisciplinary geriatric oncology clinic, aiming to improve care transitions, address functional and psychosocial needs, and enhance health outcomes for older adults receiving cancer treatment.

Methods: A multidisciplinary geriatric oncology clinic was established within a tertiary cancer center, comprising a geriatrician, oncology providers, registered dietitians, social workers, pharmacists, and a dedicated non-clinical patient navigator.[1] Using the 4Ms framework (What Matters, Mobility, Medication, Mentation), the patient navigator conducts structured pre-visit interviews, facilitates team-based assessments for patients aged 65 and older with cancer diagnoses, and is responsible for scheduling patient appointments to ensure coordinated and timely access to geriatric oncology care.[2] The patient navigator utilizes targeted questionnaires aligned with the 4Ms framework to elicit patient goals and care preferences (What Matters), screen for fall risk and physical function (Mobility), coordinate comprehensive medication reconciliation with geriatric and oncology teams (Medication), and facilitate use of validated tools (MoCA and PHQ-9) by clinical team members to assess cognitive status and mood (Mentation).

Results: Over the past six months, the multidisciplinary clinic achieved an exceptional milestone: a 0% no-show rate among 145 scheduled patients. This unprecedented outcome highlights the critical role of the patient navigator in ensuring consistent engagement and follow-through. The navigator's proactive coordination efforts proved instrumental in bridging gaps in care, reinforcing communication, and removing logistical barriers. Patient satisfaction data reinforced these findings; survey responses overwhelmingly praised the navigator's involvement as transformative, citing improved clarity, timely support, and a more cohesive care journey.

Conclusion: The integration of a patient navigator-led 4Ms-based care coordination model within a multidisciplinary geriatric oncology clinic significantly enhanced patient engagement, care continuity, and overall satisfaction. The achievement of zero no-shows over six months among 145 patients underscores the model's effectiveness in mitigating common barriers faced by older adults with cancer. Patient feedback highlighted the navigator's extraordinary role in personalizing care, improving communication, and facilitating seamless transitions across services. These results underscore the powerful impact of navigator-led coordination in delivering high-reliability, patient-centered care. This initiative demonstrates a scalable and impactful approach to age-friendly cancer care, aligning with national geriatric oncology guidelines and addressing the complex needs of older adults undergoing treatment.

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Enhancing Transitions of Care: A Post-Discharge Call Initiative by Leukemia Oncology Nurse Navigators

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Background: Leukemia patients face significant clinical and psychosocial challenges after hospital discharge due to the complexity of their treatments and the intensity of required follow-up care. These patients are at high risk for medication errors, complications, and delays in needed services, which can lead to adverse events. In January 2023, oncology nurse navigators (ONNs) at the Dana-Farber Cancer Institute implemented a structured post-discharge call initiative within 72 hours of discharge.

Objective: The primary goal was to provide timely support, proactively identify barriers, and ensure a seamless transition from inpatient to outpatient care.

Methods: An automated alert system was developed to notify ONNs whenever a leukemia patient was discharged. ONNs contacted each patient within the designated 72-hour period to assess their clinical status, review discharge instructions, and address questions or concerns. All interactions were documented by the ONN in a dedicated discharge database and the electronic medical record, capturing the type of issues addressed and any interventions provided. Data from January 1, 2023 through May 1, 2025 were analyzed retrospectively to evaluate the reach and impact of the initiative.

Results: A total of 138 patients were included in the analysis. Eighty-four percent of patients were successfully contacted within three days of discharge. No barriers were reported in 33 patients (24%). Among those with identified concerns, the most common issues included medication-related questions or missing prescriptions (22%), complications with home care or hospice coordination (17%), scheduling difficulties (12%), central line management issues (12%), and new or concerning symptoms (9%). Notably, 15% of patients experienced multiple concurrent barriers. Education was provided during every call, ensuring patients and caregivers received consistent guidance and support. The median duration of each call was approximately 20 minutes, with some complex situations requiring up to 120 minutes of support.

Conclusion: This initiative highlights the critical role of structured post-discharge calls in supporting patients with complex hematologic malignancies during the vulnerable transition period following hospital discharge. Early outreach by ONNs not only identified urgent clinical and logistical concerns but also facilitated timely interventions that may prevent complications. Continued expansion and refinement of this program can further enhance patient safety, improve care coordination, and strengthen the patient and caregiver experience during post-discharge recovery.

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Evaluating the Impact of Financial Navigation on Financial Distress and Associations with Baseline Food Insecurity in Nigerian Cancer Patients: Results from the COST-FIN Trial (NCT06630962)

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Background: Nigeria records >100,000 new cancer cases yearly, yet poverty-driven diagnostic delays and out-of-pocket costs fuel severe financial toxicity and distress. Food insecurity further impairs adherence and intensifies toxicity.[1] Evidence for Financial navigation programs (FNPs) in low-resource settings is scarce;[2] COST-FIN, Africa's first FNP randomized controlled trial (RCT), addresses this gap.

Objective: This study evaluated whether a structured FNP reduces six-month financial distress (FD) and examined associations between baseline food insecurity and FD among newly diagnosed Nigerian patients with breast, colorectal, or prostate cancer in the randomized COST-FIN trial.

Methods: This single-blinded, prospective RCT enrolled adults (≥18 years) within six weeks of a new diagnosis of breast, colorectal, or prostate cancer at two Nigerian cancer centers. Participants were randomized 1:1 to receive either usual care or the FNP intervention. Structured interviews collected demographic, clinical, and economic data at baseline, 3 months, and 6 months. Food insecurity was measured at baseline using the validated 2-item Hunger Vital Sign tool. FD was assessed at all time points using the validated 12-item Comprehensive Score for Financial Toxicity (FACIT-COST), with scores ranging from 0 to 44 (lower scores indicating greater distress). Baseline characteristics were compared using x^2 or Fisher's exact tests, as appropriate. Associations between food insecurity and baseline FD were examined using Kruskal-Wallis and pairwise Wilcoxon rank-sum tests. Differences in FACIT-COST scores between arms over time were analyzed using linear mixed-effects models with random intercepts.

Results: Among 133 participants (median age 56 years; 65% female), breast cancer was the most common diagnosis (64%), followed by prostate (21%) and colorectal cancer (15%). At baseline, 65% of participants screened positive for food insecurity (38% "often true," 27% "sometimes true"), with no significant difference in response distribution between study arms (x^2, $p = 0.37$ and 0.40). FD was significantly worse at baseline among those with higher food insecurity and worsened at 3 and 6 months in this group regardless of trial arm. Although baseline FD scores did not differ significantly between arms, participants in the FNP arm experienced a clinically meaningful ≥6-point improvement in FD by 6 months compared with controls ($p = 0.047$), suggesting a moderating effect of the intervention despite pervasive food insecurity at baseline.

Conclusion: Food insecurity was highly prevalent at diagnosis and is strongly associated with greater FD. Implementation of a structured FNP significantly reduced FD over time, demonstrating both clinical and statistical benefit. These findings highlight the importance of integrating financial navigation programs early into cancer care pathways in low-resource settings to reduce economic hardship and advance patient-centered, equitable oncology care.

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Leveraging Weekly Chart Reviews to Enhance Care Coordination and Resource Integration in Oncology Patient Navigation

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Background: Weekly chart reviews were initiated by Dana-Farber Cancer Institute's Cancer Care Equity Program (CCEP) to proactively identify and address barriers to care for oncology patients from historically marginalized neighborhoods. What began as an informal communication tool among navigators has evolved into a structured, team-based model. A literature review revealed no peer-reviewed studies on chart reviews in oncology nursing or navigation, highlighting the originality and significance of this practice. This gap reinforces the potential value of this model for advancing equitable care delivery.

Objective: To describe how structured weekly chart reviews strengthen oncology care coordination by identifying patient barriers, promoting timely interventions, and supporting the development of a shared, real-time resource inventory for navigation teams.

Methods: Since October 2022, the CCEP's Community-Focused Patient Navigation team has held weekly multidisciplinary chart review meetings. Participants include patient navigators, nurse navigators, and clinical trials educators. Meetings focus on oncology patients from high-barrier zip codes or those referred due to social determinants of health (SDoH) challenges such as missed appointments, housing instability, language access issues, or transportation needs. Each session includes: real-time case discussion and action planning; coordination of follow-up tasks (transportation, insurance, referrals); prioritization by acuity, treatment stage, and psychosocial complexity; collaborative problem-solving across care transitions; identification of recurring needs to guide real-time resource discovery; live editing of a centralized resource document, organized by resource type (e.g., housing, food, transportation) and updated during meetings for team-wide use;, the inventory is accessible to all navigation staff and is continuously refined through team feedback. Formal data collection is underway to assess trends in intervention types and timing. Qualitative feedback was captured through monthly team debriefs and internal check-ins.

Results: Qualitative feedback from the navigation team has demonstrated meaningful impact. Staff report increased efficiency, reduced duplication, and clearer team roles. Proactive case review enables earlier interventions, preventing SDoH issues from delaying treatment. The shared resource inventory has become a critical navigation tool. As new resources are identified while addressing patient needs, they are added live during reviews. This reduces the burden on individual staff, supports consistent care delivery across disease centers, and improves onboarding by giving new navigators immediate access to organized, vetted supports. Team members also highlight improved peer support and shared problem-solving during reviews, contributing to a more collaborative, equity-focused navigation culture.

Conclusion: Weekly chart reviews offer a replicable, no-cost model for improving care coordination and equity in oncology navigation. By combining real-time case review with dynamic resource integration, this approach enhances team effectiveness and standardizes care across programs. Future directions include formal evaluation of patient outcomes and continued refinement of the resource inventory through staff and community input.

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N/A

PINning the Pieces Together: Integrating Registered Dietitians into Principal Illness Navigation Services at Texas Oncology

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Background: Cancer impacts patients' nutritional status, with recent work documenting that 64 %64% of patients lost weight prior to the first oncology visit.[1] However, Medicare does not generally over oncology nutrition services and there is documented inadequacy of dietitians in oncology practices.[2]

Objective: Our project aims to enhance patient outcomes, as well as recover operational expenses for nutrition services by incorporating registered dietitians into our Principal Illness Navigation (PIN) initiatives.

Methods: Texas Oncology is piloting a systematic approach to embed dietitian consultation and ongoing nutritional support within established navigation pathways. Our initial focus will be head and neck cancer patients receiving concurrent chemotherapy and radiation. Key components include: (1) standardized nutrition screening protocols integrated into initial navigation assessments, (2) dedicated dietitian time allocated within principal illness navigation billing codes, (3) structured communication protocols between nurse navigators and dietitians, and (4) coordinated care planning that addresses both medical and nutritional trajectories throughout treatment.

Results: Initial implementation demonstrates the feasibility of successfully incorporating registered dietitian services into the PIN process. The integration model has proven operationally viable, with dietitians effectively embedded within existing navigation workflows and billing structures. Early findings show successful establishment of collaborative care protocols between nurse navigators and dietitians, with seamless integration into patient care pathways and positive reception from both clinical teams and patients.

Conclusion: Multidisciplinary collaboration between oncology nurse navigators and registered dietitians creates synergistic patient care that addresses the complex, interconnected needs of cancer patients. The Texas Oncology model demonstrates that systematic integration of nutritional expertise into navigation services is both clinically beneficial and financially viable, supporting improved patient outcomes while maintaining sustainable practice operations.

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Role of Nurse Navigation in Expediting Breast Cancer Surgery

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Background: According to the American College of Surgeons, patients with AJCC Clinical Stage I-III breast cancer who have their first therapeutic breast surgery performed in a non-neoadjuvant setting within sixty days of diagnosis experience optimized care and reduced anxiety from delays and extended wait times.[1]

Objective: This initiative aimed to improve the rate of getting patients with a positive breast biopsy result to surgery within 60 days.

Methods: To achieve timely surgical intervention, several strategies were implemented. These included restructuring the workflow of the breast nurse navigation team to track biopsy and surgery dates for patients on Excel spreadsheets and monitor additional crucial touchpoints, including days to surgical consultation, with a goal of no more than 14 days after diagnosis. There was also collaboration with cancer registry to determine whether a case had in-migrated from another healthcare system based on their abstracting of surgical cases. The navigators communicated with the radiologists and breast center teams to ensure post-diagnostic appointments were escalated if scheduled further than 7 days out and remained in close contact with the patients to address any barriers that arose during the process. Education was also developed and provided to inform patients of the importance of receiving surgical intervention within 60 days of diagnosis and encourage them to be active participants in their care.

Results: This concerted effort resulted in 70% of surgeries occurring in less than 60 days, improving from 65% in 2024. By involving the breast nurse navigators early in the diagnostic phase and ensuring ongoing collaboration with providers and clinical teams, our facilities across the healthcare system have significantly reduced days-to-surgery scheduling delays and improved care coordination between provider visits and imaging appointments, leading to faster diagnosis-to-surgery timelines. Communication among ordering providers, specialists, and the navigation team was improved and continues to become more streamlined since our health system's transition to the electronic health record program Epic.

Conclusion: Meeting the objective of expediting breast cancer surgery to within 60 days of diagnosis has conferred multiple benefits, including improved overall survival and better resource utilization for the system. Patients and caregivers have verbalized appreciation for and satisfaction from being able to move quickly through the care continuum and having navigation support along the way.

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Seamless Transitions, Empowered Patients: The Vital Role of Oncology Nurse Navigators from Inpatient to Outpatient Cancer Care

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Background: Absence of oncology nurse navigators (ONNs) in inpatient oncology led to coordination lapses and diminished patient experience. ONNs improve satisfaction, survivorship planning, and reduce readmissions, their role in bridging inpatient-to-outpatient transitions is less studied. This project explores ONNs integration to address continuity, quality, and outcomes in cancer care.

Objective: The objective of this planning abstract is to develop an evidence-based ONNs program to bridge care coordination gaps and support seamless inpatient-to-outpatient transitions. The project also provides recommendations and evidence-based strategies to improve institutional cancer care processes, addressing the question of how ONNs can enhance transitional care.

Methods: A structured evidence review was conducted using PubMed, CINAHL, ONS, and PMC's clinical resources. Eligible studies, published within the past five years, examined ONNs' interventions related to patient satisfaction, readmissions, and care continuity. Studies included sample sizes ranging from 150 to 825 patients in hospital settings. Data were extracted on outcomes assessed through validated survey instruments, readmission tracking, and care delivery consistency. Completion and response rates were included when available, with most reporting high survey participation. An implementation science framework guided analysis of ONNs' integration in inpatient-to-outpatient transitions.

Results: Across studies with 150 to 825 participants, survey response rates were high (82–95%), with few discontinuations reported, mostly due to clinical factors. ONNs consistently improved satisfaction, empowerment, and comprehension of post-treatment care. Madu & Ajibade (2025) reported reduced readmissions by 10–15% ($P < 0.05$). Yoo et al. (2024) demonstrated greater survivorship plan use and improved continuity. Marsall et al. (2024) found better health status ($B = 0.74$, $p < 0.001$) and fewer medication complications ($B = -0.35$, $p < 0.01$), though no significant impact on readmissions ($p = 0.39$).

Conclusion: ONNs are essential to improve outcomes, empowerment, satisfaction, and continuity during inpatient-to-outpatient transitions. Pilot implementation should include staff hiring, education, and ongoing evaluation through satisfaction surveys and readmission monitoring. This project addresses gaps in transitional care and suggests future research on scalability, long-term outcomes, and cost-effectiveness.

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Category III: Patient Advocacy/Patient Empowerment

Addressing Cancer Care Disparities in the Caribbean: The Role of Patient Navigation Through the Caribbean Cancer Research Initiative

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Background: Cancer mortality rates in the Caribbean, particularly in Trinidad and Tobago, remain among the highest in the region. The Caribbean Cancer Research Initiative (CCRI) was established to address these alarming statistics, filling gaps in cancer data, prevention, and treatment.

Objective: This abstract aims to demonstrate how CCRI's patient navigation program identifies and mitigates barriers to timely cancer diagnosis and treatment, ultimately striving to improve survival rates and patient outcomes.

Methods: CCRI operates with a mission to build cancer research capacity and improve patient care throughout the Caribbean. A patient navigation service was developed to guide individuals diagnosed with cancer and their families through the complex healthcare system. Data for this analysis were gathered from real patient cases, focusing on delays in diagnostic resolution and treatment initiation. Navigators assisted patients by coordinating urgent diagnostic procedures, facilitating pathology testing, expediting imaging services, and providing support to navigate socioeconomic and administrative barriers.

Results: Preliminary findings highlight significant disparities in cancer care delivery. The five-year breast cancer survival rate in Trinidad and Tobago is approximately 74%, compared to over 90% in the United States. The median time to diagnostic resolution is 65 days—three times longer than in the US or Canada. Three case studies illustrate these delays: Case 1: A 38-year-old woman experienced a six-month delay in receiving a confirmed breast cancer diagnosis due to lost biopsy samples. CCRI intervention enabled re-biopsy and expedited pathology reporting within three days, leading to treatment initiation. Case 2: A 30-year-old Hodgkin's Lymphoma patient faced nearly two months without treatment due to delayed pathology results and the need for repeat biopsies. CCRI secured private pathology services, ensuring timely results and treatment commencement. Case 3: A 51-year-old breast cancer patient waited over four months for a CT scan essential for staging and treatment planning. CCRI navigators successfully advocated for earlier imaging and expedited reporting, enabling prompt continuation of therapy.

Conclusion: The CCRI patient navigation program plays a critical role in bridging gaps in cancer care across Trinidad and Tobago. By reducing diagnostic delays and improving access to timely treatment, CCRI addresses the root causes of health disparities. Continued investment in navigation services and regional research capacity is crucial to reducing mortality rates and improving cancer survival outcomes in the Caribbean. This model demonstrates how navigation programs can be effectively leveraged to advance equity in oncology care.

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Category IV: Psychosocial Support/Assessment

Patients Asked, We Listened: Initiating Behavioral Health Referrals in Oncology Navigation

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Background: The Patient and Family Advisory Committee of a National Cancer Institute (NCI)-Designated Cancer Center identified that new patients were unaware of behavioral health services until later in treatment. This anecdotal feedback revealed a critical gap, underscoring the need for early emotional support during initial phases of cancer care.[1, 2]

Objective: An NCI-Designated Cancer Center sought to enhance patient awareness of behavioral health services before the initial oncology appointment to promote earlier connection support and whole-person care throughout the cancer journey and ensure timely access to evidence-based behavioral health resources for better overall patient outcomes.

Methods: A pilot was initiated in the Breast Nurse Navigation department. During the initial nurse navigator call, every breast cancer patient was asked: "At our organization, we value caring for the whole person, including the patient's physical and emotional health. Would you like a call from someone on our behavioral health team to discuss our support services?" In the event that a patient confirmed their desire for a support services call from the behavioral health team, the nurse navigator places an ambulatory referral to Social Work. The notation "BHS," which stands for "behavioral health services," is transcribed in the order comments to denote the pilot project. Next, the behavioral health team contacted the patient to assess their needs and triage them to the appropriate appointment type and level of care. If a patient declined, they were reminded they can initiate this referral with their provider at any time during their care.

Results: The pilot began in June 2025 with zero baseline referrals. Since launch, 21 referrals were placed. In June, 10 referrals were made: three to social services, three to psychiatry, and four to psychology. In July, six referrals were placed: none directly to social services, two to psychiatry, and four to psychology. In August, five referrals were placed: one to social work and one to psychology, while three patients declined after the initial phone call. In total, 82 patients were asked, and 21 requested a referral. Most who declined responded "not at this time," citing reasons such as feeling overwhelmed by the diagnosis, seeking a second opinion, or preferring to seek behavioral health services later. Many expressed appreciation for being asked about emotional support, with some sharing they had never been asked before. This effort reflected a collaborative, interprofessional approach involving Nurse Navigation, Social Work, Psychiatry, and Breast Oncology physicians.

Conclusion: The pilot demonstrated that incorporating behavioral health screening in the initial navigation assessment helped bridge gaps in patient awareness and promoted early access to support services. Preliminary data reveal that while some patients choose to talk with Behavioral Health early, others prefer to seek support later. The success of this initiative supports expansion across all cancer service lines. Future plans include launching patient experience and satisfaction surveys, as well as collecting outcome data to evaluate overall impact. Broader implementation may influence treatment adherence, reduce no-show rates, enhance patient satisfaction, and promote likelihood of patients recommending the center.[1, 2]

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Category V: Professional Roles and Responsibilities

Building Bridges to Early Detection: Establishing a Statewide Navigator Network to Advance Lung Cancer Screening Equity in New York

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Background: GO2 for Lung Cancer, (GO2, a patient advocacy organization, was awarded a grant from the Bristol-Myers Squibb Foundation to implement the New York State Demonstration Project (NYSDP) in collaboration with Roswell Park Cancer Center. A key component of the NYSDP is the establishment of the New York Regional Navigation Network (NYRNN), a collaborative network of patient navigators dedicated to enhancing lung cancer (LC) outcomes, promoting peer-to-peer learning, sharing resources, and disseminating best practices across institutions and disciplines.

Objective: The primary objective of the NYSDP is to increase awareness and uptake of lung cancer screening (LCS) to improve early detection and reduce mortality.

Methods: The GO2 team invited a subgroup of 11 New York-based navigators via email to participate in the NYRNN; all agreed to join. All participants received a survey regarding preferred meeting frequency, timing, format, and desired outcomes. Responses were analyzed to guide the network's structure and operation. Additional participants were recruited through outreach to regional healthcare facilities and invited to complete a registration form via email. The NYRNN is inclusive of navigators and coordinators from diverse professional backgrounds who engage with LC patients across the continuum of care, including screening, diagnosis, treatment, survivorship, and surveillance. These navigators represent nurses, clinical and administrative staff, and community health workers embedded in federally qualified health centers, health systems, public health departments, and community-based organizations across New York State and the broader area of interest. As frontline informants, they offer valuable insights into the current landscape of LCS and care in their respective regions.

Results: To date, 39 participants have registered, representing 11 healthcare systems, six community-based organizations, and nine regional and statewide provider organizations. Since its launch in March 2025, NYRNN has convened monthly meetings featuring a mixed format approach that includes guest speakers, Q&A sessions, and open discussions. Discussion topics include LCS billing and coding practices, strategies for engaging underserved populations, innovative community outreach methods, and approaches to promoting LC and LCS programs within healthcare systems. Attendance has consistently included at least 51% of registrants per session. The network has proven to convene and facilitate navigators in sharing their knowledge, experiences, and skills, and to leverage the NYRNN as a resource.

Conclusion: The NYRNN provides a structured platform for navigators to collaborate, share experiences, and enhance their professional competencies through ongoing education and peer support. Central to its mission is the goal of driving awareness and uptake of lung cancer screening across New York State to improve early detection and reduce disparities. By leveraging the collective expertise of navigators representing various roles and practice settings, the network strengthens advocacy efforts and promotes equitable access to screening services. GO2 serves as the facilitator of the network, supporting members' professional development and fostering a safe, sustainable environment for learning and resource exchange. This model demonstrates the potential of navigator-led networks to catalyze meaningful state-based improvements in cancer screening rates and care delivery, while promoting self-efficacy and reliance of its members.

References:

N/A

Building Clinical Trial Support in an Existing Navigation Program

Linda Fleisher, Kelsey Lachow, Roxanna Taveira, Suki Padda, Anna Rodriguez, Martin Edelman, Tricia Struowski

Background: As part of an initiative, funded by Stand Up to Cancer (SU2C), to increase clinical trial participation among racially and ethnically diverse populations at our safety-net hospital, we explored various strategies to embed clinical trial (CT) navigation into the oncology program.[1]

Objective: Our two goals: 1) conduct a comprehensive navigation program assessment guided by best practice to review roles and responsibilities around clinical trials; 2) gather insights about staffing, physician roles, and patient education needs at the safety-net hospital, identifying opportunities for expansion of navigation for cancer CT.

Methods: A comprehensive program assessment was conducted by an expert consultant. Interviews with 20 individuals, including MDs, RNs, administrators, and navigators, review of program documentation, and key stakeholder debriefing meetings to review recommendations and next steps were completed. The assessment focused on the navigation program (e.g., model, roles and responsibilities, role in CT education and support, workflows and referrals, and metrics) and navigators' perspectives of their role in CT education and support. The assessment focused primarily on our safety-net hospital, located in a highly impoverished community. The major goal was to understand and explore opportunities to enhance the current navigation program to support CTs at the safety net hospital, including referring patients to other geographic sites in the health system for CTs. Interview questions addressed the strengths and current challenges to identify opportunities to either integrate CT education and support into the current model or create a specialized role.

Results: There are opportunities to increase CT participation by including discussion of CTs at various meetings (i.e., multidisciplinary clinic, disease site team, navigation) and ensuring navigator representation in these meetings. The coordination and communication between the CT team, navigators, and nursing are critical to increasing patient understanding and awareness of available trials. Currently, the navigators do not have a defined role in CTs. The current navigation model is focused on the initial and early visits. Since no-show rates are high in this underserved population, utilizing navigation to support patient needs (e.g., transportation) and close collaboration with a robust social work team to manage the psychosocial needs are imperative. The key areas for navigation program enhancement include the integration of CT navigation in current navigation process, optimizing navigators' roles to include CT patient education, and defining the standard process for navigators to identify patients who are on CTs.

Conclusion: Based on the support of the administrative and nursing leadership at the safety-net hospital and the cancer center, this assessment, as part of the larger SU2C-funded initiative, has been instrumental in identifying opportunities to enhance navigation in CTs. Teams have reviewed the assessment report, planned cross-setting work groups, and conducted CT mini-training for the nurse navigators at the safety-net hospital in collaboration with the CT staff (RNs/coordinators). Discussions continue regarding whether to add responsibilities to the current model or specialize a role in navigation in the context of organizational structure and needs.

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Category VI: Research, Quality and Performance Improvement

Expanding Oncology Navigation Through Student Volunteers: Implementation Findings from the ACS CARES Program

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Background: Despite the benefits of patient navigation as an evidence-based practice for reducing health disparities in underserved communities, widespread implementation has proved challenging.[1, 2] Cost often limits the number of navigators a center can hire and, thus, their depth of coverage, resulting in high caseloads or limited availability.[3] The American Cancer Society Community Access to Resources, Education, and Support (ACS CARES) is the first nationwide navigation program for people with cancer and caregivers that provides direct, individualized, non-clinical assistance through a digital app, telephonic, and in-person support leveraging student volunteers.

Objective: Following implementation at 11 cancer centers nationwide between September 2023 and September 2024, we sought to determine barriers, facilitators, and contextual design requirements for adapting patient navigation to be supported by student volunteers.

Methods: We conducted a multi-site qualitative study using key informant interviews and clinic observations. Guided by the Consolidated Framework for Implementation Research (CFIR), we used inductive coding and thematic analysis to identify site-specific contextual barriers and facilitators. These were incorporated into draft implementation models. Iterative co-design sessions refined the implementation models, prioritizing contextual factors and selecting implementation strategies to address the remaining friction.

Results: We observed six oncology clinics selected to implement ACS CARES in September 2025. We conducted 26 key informant interviews with oncologists, nurses, both nurse and nonclinical navigators, social workers, and administrators to identify barriers and facilitators. Key barriers included available resources (physical space, time), work infrastructure (clinic efficiency, role delineation), and access to knowledge and information (training). Common facilitators included need (high caseload, diverse patient population, transportation, food insecurity, and information barriers). Implementation strategies selected include a shared volunteer screening process, training sessions designed to address site barriers and executed by ACS staff, consideration of staff limitations (physical space, time, caseload, work infrastructure), and prioritization of value-add for patients and staff.

Conclusion: The final implementation models utilize student volunteers to support oncology navigation adapted to contextual factors at each ACS CARES implementation site. This approach extends navigation services tailored to the needs of the system and patient population and can be leveraged in other similar oncology settings to support health equity. The ACS CARES program will onboard six additional sites, for a total of 23, in 2026, utilizing the findings from this quality improvement work to enhance implementation.

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Laying the Foundation: Building a Sustainable Oral Anticancer Medication (OAM) Navigation Model with PIN Billing Integration–Phase 1 Process Development and Early Lessons Learned

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Background: Oral anti-cancer medications (OAMs) shift treatment responsibility to patients, introducing challenges with adherence and monitoring. Nurse navigators help close these gaps. This project aimed to develop a sustainable virtual navigation process aligned with Principal Illness Navigation (PIN) billing domains to support documentation consistency, reimbursement readiness, and improved patient care outcomes.

Objective: The objective of this project was to implement a standardized navigation process for patients prescribed OAMs, including patient identification, documentation standards, and task-based workflows, all aligned with PIN billing domains to support navigator workload and reimbursement readiness across virtual oncology settings.

Methods: The project was conducted within a virtual OAM navigation program serving a large multi-site oncology practice. A pre-pilot phase guided foundational development prior to further implementation. A single nurse navigator performed all navigation activities to allow for close process monitoring and refinement.

Patients newly prescribed an OAM were identified through pharmacy reports and chart reviews, then tracked using a shared Smartsheet to monitor workflow progress, documentation, education delivery, and billing readiness.

Collaboration with physicians, pharmacy, IT, billing, and clinical leadership was required to align systems, address documentation gaps, and prepare for PIN billing capture.

Key components of the process included:

- Defining how and when patients would be identified and enrolled
- Designing workflows mapped to PIN service domains
- Creating structured, task-based workflows for assessments, education, and symptom monitoring
- Implementing audit and feedback loops to ensure consistency and billing readiness Submitting PIN charges and adjusting workflows based on outcomes

Results: Early implementation of the OAM navigation model yielded key insights across workflow design, documentation, and billing. Patient eligibility identification and documentation processes were successfully aligned to PIN domains. A single nurse navigator submitted over 120 charges for 61 patients during phase 1. More than 90% of patients incurred no out-of-pocket cost, with an average of $13/month among those with financial responsibility.

Process testing identified areas for refinement, including audit protocols and documentation clarity. Manual tracking via Smartsheet proved labor-intensive and error-prone, underscoring the need for automated solutions. Structured workflows and navigator feedback loops enhanced documentation consistency and PIN billing confidence.

Lessons from this phase informed the development of success metrics for Phase 2, including enrollment targets, documentation standards, task timeliness, and billing-capture benchmarks. Overall, this phase confirmed that intentional workflow design supports scalable navigation models, improves alignment with reimbursement structures, and preserves patient-centered care in a virtual setting.

Conclusion: Early findings from this pre-pilot phase demonstrate that intentional workflow design supports sustainability and reimbursement readiness in OAM navigation programs. Structured identification strategies, documentation standards, and task-based workflows aligned to PIN domains created a scalable foundation for future growth.

As a result, the program has expanded to include two nurse navigators and one lay navigator supporting a full region using an automated care management platform. The initial framework and findings have also contributed to national discussions on sustainable cancer care delivery and were included in engagements with the Biden Cancer Moonshot initiative at the White House in late 2024.

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Patient Navigation for Childhood Cacner: Pilot-testing a Training Curriculum in Colombia

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Background: Patient navigation facilitates cancer care delivery and improves clinical outcomes in high-income countries. In Latin America, educational strategies aimed at building capacity in patient navigation for childhood cancer are limited.

Objective: To develop and pilot-test a training curriculum for patient navigation in childhood cancer in Colombia.

Methods: The training focused on clinical and administrative patient navigation for children with cancer and their families receiving care in pediatric oncology units and non-governmental organizations. Our curriculum was designed by two oncology nurses with international patient navigation certification, an education specialist, and two pediatric hematologists/oncologists. The curriculum included the following topics: a) general aspects of childhood cancer, cancer treatment, clinical outcomes, surveillance and follow-up; b) patient navigation in cancer care delivery, assertive communication; and c) legislation, health services contracting, and administration. We conducted weekly synchronous virtual training sessions over 12 weeks for staff from five pediatric oncology units, and a hands-on in-person workshop for staff from two non-governmental organizations. We evaluated knowledge gain using pre- and post-tests at each session, and knowledge retention 24 weeks post-training. We also assessed satisfaction via surveys.

Results: Twenty-four individuals, 20 from pediatric oncology units (nurses=8, nurse assistants=12), and 4 from non-governmental organizations (social workers=2, psychologists=1, administrative directors=1) completed the training. Pre-and post-test knowledge scores in participants from the pediatric oncology units were 60% vs. 87% (P<0.01), and in participants from the non-governmental organizations were 70% vs. 89% (P=0.02). At 24 weeks, the mean knowledge score was 94% (95% CI, 90-98) in participants from pediatric oncology units, and 88% (95% CI, 70-100) in participants from non-governmental organizations. Seventy-five percent (n=18/24) of participants reported high satisfaction with the training, and 94% (n=23/24) endorsed that the topics were highly relevant.

Conclusion: Our pilot curriculum was feasible and well-received, and increased participants' knowledge about patient navigation in childhood cancer, with sustained short-term learning gains. Next steps include expansion to other Colombian institutions and testing its replicability in similar contexts in Latin American.

References:

N/A

Pioneering a Benchmark for Patient Navigation: Integrating Feedback into Validated Surveys

Lauren Cappelletti, MSN, RN, CCM, Jameyshia Franklin, DPA, MPH

Background: Navigation is vital in the patient's cancer journey, especially at diagnosis. At an NCI-designated cancer center, navigation supports access, coordination, and education. However, the absence of formal, validated tools to measure nurse navigation's impact on patient experience revealed a critical gap in assessment and quality improvement.[1, 2]

Objective: This initiative aimed to measure patient experience with nurse navigation by integrating navigation-focused questions into a validated Press Ganey Medical Practice survey, enabling patients to provide meaningful feedback on navigator effectiveness, with survey results serving to inform and support continuous quality improvement efforts across cancer service lines.

Methods: Navigation and patient experience leaders collaborated to assess viable tools for capturing targeted feedback. Manual surveys were ruled out due to workflow burden and survey fatigue. The team partnered with Press Ganey to explore integration of navigation-specific questions into an existing Medical Practice Survey already in use at the organization. Because Press Ganey did not offer standardized navigation metrics, custom questions were developed to assess patients' experiences. A trigger question determined if a patient had interacted with a navigator. Those who responded "yes" received four additional questions related to helpfulness, compassion, role clarity, and overall care provided by the navigator. The survey design was reviewed and refined in collaboration with the Patient and Family Advisory Council and the Patient Experience Committee. After revisions, the navigation questions were officially launched on July 1, 2025. This collaborative process allowed the organization to implement the new metrics within just four months.

Results: Between July 1 and August 25, 2025, 228 patients completed the survey. Top box scores included: overall care by the nurse navigator (86.73%), helpfulness (85.84%), compassion (87.5%), understanding of the navigator role (82.38%), and overall survey score (85.6%). Patients also had the option to leave open-ended comments to further explain their experience. By adding navigation-specific questions to the validated Press Ganey survey, real-time patient feedback on nurse navigation was efficiently collected. Embedding these items into an existing platform minimized additional work for staff and reduced patient survey fatigue. A trigger question ensured that only those who interacted with a navigator received follow-up questions. Patient feedback emphasized the value of nurse navigators in easing anxiety, clarifying next steps, and enhancing confidence in care plans. Open-text responses provided rich qualitative insights. This effort was a collaborative success involving navigation leaders, patient experience teams, Press Ganey, and patient advisors.

Conclusion: Integrating navigation-specific questions into the validated Press Ganey survey has provided actionable insights into the effectiveness and impact of nurse navigation. By capturing structured feedback, the initiative supports quality improvement efforts in patient satisfaction and navigation. This novel approach ensures navigation services are no longer an invisible component of care but are recognized, measured, and improved based on patient experience. The findings not only validate the critical role of navigation but also position the organization as a leader in leveraging data to advance personalized, patient-centered oncology care.

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Category IX: Clinical Research

An Open-label, Phase Ib Dose-expansion Study to Assess the Efficacy of CD137/FAP Agonist BI 765179 Plus Pembrolizumab as a First-line Treatment in Metastatic or Incurable, Recurrent Programmed Cell Death Ligand-1 (PD-L1)-positive Head and Neck Squamous Cell Carcinoma

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Background: Head and neck squamous cell carcinoma (HNSCC) is the seventh most common cancer globally and is often associated with poor quality of life and a dismal prognosis.[1] Median overall survival for recurrent/metastatic HNSCC with first-line standard-of-care pembrolizumab ± chemotherapy is approximately 13 months, highlighting the need for new therapies.[2] Fibroblast activation protein (FAP)-positive fibroblasts are present in the tumor stroma across all anatomical sites of HNSCC, representing a potential therapeutic target and/or targeting mechanism to the tumor tissue. BI 765179 is a bispecific antibody that simultaneously binds to FAP and CD137 expressed on T-cells. The Phase Ia part of the present study (NCT04958239) tested safety and doses for dose escalated BI 765179, both as monotherapy and in combination with an anti-programmed cell death protein 1 (PD-1) antibody in patients with advanced solid tumors.

Objective: To present the design of the Phase Ib dose-expansion part, which aims to assess the preliminary efficacy of two doses of BI 765179 in combination with pembrolizumab in patients with metastatic or incurable, recurrent HNSCC whose tumors express PD-L1.

Methods: In the Phase Ib dose-expansion part, approximately 60 patients with a histologically or cytologically confirmed diagnosis of metastatic or incurable, recurrent HNSCC will be enrolled. Key inclusion criteria are: no prior systemic therapy administered in the metastatic or incurable recurrent setting; primary tumor locations of oropharynx, oral cavity, hypopharynx, or larynx; at least one measurable lesion outside of the central nervous system (modified RECIST v1.1); a PD-L1-positive tumor (combined positive score ≥1, local assessment); and Eastern Cooperative Oncology Group performance status 0-1. Patients who have previously received CD137-targeted or anti-PD-1/PD-L1 agents are not eligible. Patients will be randomized 1:1 to receive either Dose 1 or Dose 2 of BI 765179 intravenously in combination with pembrolizumab. The primary endpoint is objective response (OR), defined as best overall response of confirmed complete or partial response (RECIST v1.1). Secondary endpoints include occurrence of adverse events (AEs) and serious AEs, OR (immune-related RECIST v1.1), duration of response, progression-free survival, and overall survival.

Results: Trial is in progress.

Conclusion: Trial is in progress.

Presented at: AACR, ASCO, JADPRO.

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Study Sponsor:

Boehringer Ingelheim Pharmaceuticals, Inc.

Effects of Zongertinib on Physical Functioning and Symptoms in Pateints with Pretreated HER2-mutant Advanced Non-Small Cell Lung Cancer: Results from the Beamion LUNG-1 Trial Authors

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Background: Zongertinib is an irreversible tyrosine kinase inhibitor that selectively inhibits human epidermal growth factor receptor 2 (HER2) while sparing epidermal growth factor receptor, thereby limiting associated toxicities.[1,2] Beamion LUNG-1 (NCT04886804) is a phase 1a/1b first-in-human study evaluating safety and efficacy of zongertinib in patients with HER2-mutant advanced non-small cell lung cancer (NSCLC) (phase 1b).

Objective: We report patient-reported outcomes (PRO) data on NSCLC-related symptoms, physical functioning, and symptomatic adverse events (AEs) and their burden in phase 1b cohort 1. The PRO analysis included those with previously treated HER2-mutant NSCLC who received zongertinib 120 mg once daily.

Methods: European Organization for Research and Treatment of Cancer (EORTC) QLQ-C30 physical functioning, NSCLC-SAQ (cough, dyspnea, pain, fatigue, and poor appetite), EORTC IL46/Q168 (side effect burden), and 9 PRO-Common Terminology Criteria for Adverse Events (CTCAE) items (mouth and/or throat sores, taste changes, nausea, vomiting, diarrhea, rash, skin dryness, itching, and numbness/tingling) were collected on days 1, 8, and 15 (cycle [C] 1) and day 1 (C2, C3, C5, C7, C9). Changes from baseline (CFBs) to C5 in EORTC QLQ-C30 physical functioning (0-100; higher=better) and NSCLC-SAQ total score (0-20; lower=fewer symptoms) were analyzed using mixed-model repeated measures. EORTC IL46 and PRO-CTCAE were analyzed descriptively.

Results: The PRO analysis set comprised 30 patients. Completion rates exceeded 86% across PROs and visits. EORTC QLQ-C30 physical functioning and NSCLC-SAQ total scores improved rapidly and were maintained to C9 (CFB to C5: least-squares means, 9.6 [95% CI, 6.3-12.9] and −3.9 [95% CI, −4.8 to 2.9], respectively). Improvements in NSCLC-SAQ total score were observed in patients with objective response (complete/partial response) and with stable disease as best overall response. NSCLC-SAQ item scores improved: 3% reported often/always fatigue at C9 vs 43% at baseline (BL); 53% reported no coughing at C9 vs 27% at BL, and none reported severe coughing after C5; 3% reported often/always shortness of breath at C9 vs 23% at BL. Patients generally reported low overall side effect (SE) burden (EORTC IL46): 7% (BL), 3% (C5), and 0% (C9) were troubled by SEs quite a bit/very much. Patient-reported AE frequency/severity (PRO-CTCAE items) reflected the known safety profile for zongertinib, with mostly mild/moderate severity and no/minimal interference. Diarrhea was the most common patient-reported symptomatic AE (rare/occasional in 13% [BL], 40% [C5], and 33% [C9]). Rash occurred in 13% at BL, 37% at C5, and 10% at C9. Most dry-skin AEs were mild/moderate (BL, 60%; C5, 57%; C9, 50%).

Conclusion: Patients treated with zongertinib reported rapid improvement followed by stability in physical functioning and NSCLC-SAQ total score. Frequency and severity of patient-reported symptomatic AEs and overall side effect burden demonstrated favorable tolerability of zongertinib.

This abstract was submitted for presentation at 2025 ASCO Quality Care Symposium October 10-11, 2025, Chicago, IL, USA.

Declaration of Conflict of Interest:

JKS:	Consultant: AbbVie, AstraZeneca, Boehringer Ingelheim, Bristol Myers Squibb, Eli Lilly, Genentech, Janssen, Jazz, Mirati, Pfizer, Regeneron, Sanofi, Takeda Oncology
GR:	None

EN: Consultant: Amgen, AstraZeneca, Boehringer Ingelheim, Bristol Myers Squibb, Daiichi Sankyo, Eli Lilly, F. Hoffmann-La Roche, Genmab, Johnson and Johnson, Merck, Pfizer, Pierre Fabre Pharmaceuticals, Qiagen, Regeneron, Sanofi, Takeda

LH: None

YG: None

HZ: Employee of Boehringer Ingelheim

W-HC: Employee of Boehringer Ingelheim

AL: Employee of Boehringer Ingelheim

BS: Employee of Boehringer Ingelheim

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Study Sponsor: Boehringer Ingelheim Pharmaceuticals, Inc.

Efficacy and Safety of the DLL3/CD3 T-cell Engager Obrixtamig in Patients with Extrapulmonary Neuroendocrine Carcinomas with High Or Low DLL3 Expression: Results From an Ongoing Phase 1 Trial

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Background: Delta-like ligand 3 (DLL3) is highly expressed in neuroendocrine carcinomas (NEC).[1] Obrixtamig (BI 764532) is a DLL3/CD3 IgG-like T-cell engager that targets DLL3-positive tumors.[2,3] NCT04429087 is an ongoing, phase 1, dose-escalation trial of obrixtamig in patients with DLL3-positive pulmonary and extrapulmonary NEC (epNEC) who failed to respond to standard treatment.

Objective: To examine the efficacy and safety of obrixtamig in patients with epNEC with high versus low DLL3 expression.

Methods: Obrixtamig was given intravenously in 4 dose-escalation regimens (R): RA (fixed dose every 3 weeks [q3w]); RB1 (fixed dose weekly [qw]); RB2 (step-up dose, then qw); and RB3 (step-up dose, then qw for 3 weeks, then q3w), until disease progression or unacceptable toxicity. Efficacy was assessed through objective response rate (ORR) and disease control rate (DCR) using RECIST v1.1. Results are reported for patients who received obrixtamig RB2 or RB3, categorized as having high versus low DLL3, using a threshold of ≥50% of tumor cells stained with an investigational antibody for DLL3 (SP347, Roche Diagnostics).

Results: As of June 21, 2024, 60 patients with epNEC were included (gastroenteropancreatic: 45.0%, genitourinary: 30.0%, other/unknown primary site: 25.0%); 30 each DLL3-high and DLL3-low. Mean age: 63.9 years in DLL3-high and 59.1 in DLL3-low patients. Baseline characteristics were well balanced across DLL3 groups. All patients had received prior systemic therapy; 30.0% of DLL3-high and 50.0% of DLL3-low patients had received >2 lines of prior treatment. After obrixtamig treatment, patients with high and low DLL3 expression had ORRs of 40.0% (95% CI, 24.6–57.7) and 3.3% (95% CI, 0.6–16.7), respectively; DCRs of 66.7% (95% CI, 48.8–80.8) and 26.7% (95% CI, 14.2–44.4); and durations of response (DoRs) of 7.9 months (95% CI, 6.2–not calculable) and 2.8 months (95% CI, not calculable–not calculable). Responses were seen most frequently among patients with DLL3-high gastroenteropancreatic (50.0%) or genitourinary (60.0%) epNECs. Seven DLL3-high patients are still receiving treatment. Treatment-related AEs (TRAEs) occurred in 100% (grade ≥3, 23.3%) of DLL3-high patients and 90.0% (grade ≥3, 20.0%) of DLL3-low patients. Cytokine release syndrome occurred in 70.0% (grade ≥3, 3.3%) of DLL3-high patients and 60.0% (grade ≥3, 3.3%) of DLL3-low patients. Neurotoxicity, including immune effector cell–associated neurotoxicity syndrome, occurred in 16.7% (grade ≥3, 6.7%) of DLL3-high patients and 10.0% (grade ≥3, 3.3%) of DLL3-low patients.

Conclusion: Analyses from this ongoing Phase 1 study show greater obrixtamig efficacy in patients with epNEC with high DLL3 expression compared with low DLL3 expression, with a manageable safety profile that was comparable across groups. The ORR of 40.0% and median DoR of 7.9 months in heavily pretreated epNEC tumors with high DLL3 expression are encouraging and support further development of obrixtamig for this subgroup.

This abstract was presented 2025 American Society of Clinical Oncology (ASCO) Annual Meeting, May 30-June 3, 2025.

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Study Sponsor:

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Intracranial Activity of Ifinatamab Deruxtecan in Patients with Extensive-stage Small Cell Lung Cancer and Baseline Brain Metastases: Primary Analysis of IDeate-Lung01

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Background: Approximately 80% of patients with small cell lung cancer (SCLC) develop brain metastases during their disease course. In an interim analysis of the dose-optimization part of the Phase 2 IDeate-Lung01 study (NCT05280470), ifinatamab deruxtecan (I-DXd), a B7-H3–directed antibody-drug conjugate, showed encouraging central nervous system (CNS) efficacy in patients with extensive stage (ES)-SCLC and baseline brain metastases.

Objective: We report the primary analysis of patients with baseline brain metastases treated with I-DXd 12 mg/kg in the dose-optimization and extension parts of IDeate-Lung01.

Methods: Patients with ES-SCLC with 1-3 prior lines of therapy, including platinum-based chemotherapy, were enrolled. Patients with asymptomatic brain metastases (treated or untreated) were eligible. In the dose-optimization part, patients were randomized 1:1 to receive I-DXd 8 or 12 mg/kg intravenously (IV) every three weeks (Q3W); in the extension part, patients received I-DXd 12 mg/kg IV Q3W. Brain imaging was performed at baseline and at investigators' discretion, and for patients with baseline brain metastases (≥1 target and/or non-target CNS lesion), Q6W for 36 weeks then Q12W. CNS objective response rate (ORR) was assessed by blinded independent central review (BICR) using Response Evaluation Criteria in Solid Tumors 1.1 modified for CNS tumor assessment.

Results: At data cutoff (March 3, 2025), 65/137 patients (47%) who received I-DXd 12 mg/kg had baseline brain metastases; of these, 29/65 (45%) had baseline brain target lesions (TL) and 26/65 (40%) had no prior radiotherapy for baseline brain metastases. CNS confirmed ORR was 46.2% (95% CI, 33.7–59.0) in all patients with baseline brain metastases, 65.5% (95% CI, 45.7–82.1) in patients with baseline TL, and 57.7% (95% CI, 36.9–76.6) in patients with no prior radiotherapy for baseline brain metastases. The incidence of any-grade treatment-related adverse events (TRAEs) was 88% in patients with baseline brain metastases vs 92% in patients without baseline brain metastases; of Grade ≥3 TRAEs was 31% vs 42%; of Grade 5 TRAEs was 2% (n=1) vs 7% (n=5); of any-grade interstitial lung disease was 11% vs 17%; and of TRAEs leading to I-DXd discontinuation was 8% vs 11%.

Conclusion: I-DXd demonstrated encouraging intracranial activity in patients with ES-SCLC and baseline brain metastases regardless of prior radiotherapy for baseline brain metastases. The safety profile was manageable, similar between patients with and without baseline brain metastases, and consistent with the overall 12 mg/kg population.

This data was presented at EMSO 2025, October 18, 2025, in Berlin, Germany.

References:

N/A

Study Sponsor:

Daiichi Sankyo, Inc.

Zongertinib in Previously Treated HER2-mutated Non-Small Cell Lung Cancer: Early-onset Toxicities and Management Insights from Beamion LUNG-1 Authors

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Background: Zongertinib was recently approved in the US for adult patients with unresectable or metastatic non-small cell lung cancer (NSCLC) whose tumors harbor HER2 (ERBB2) tyrosine kinase domain-activating mutations. Zongertinib is an irreversible tyrosine kinase inhibitor that selectively inhibits HER2 while sparing wild-type EGFR, thereby limiting associated toxicities.

Objective: This analysis further characterizes frequently reported adverse events (AEs)—diarrhea, rash, hepatotoxicity—in a subset of previously treated patients from the Beamion LUNG-1 trial (NCT04886804) who received zongertinib 120 mg QD. These reported events are particularly relevant for clinicians involved in patient care and management of treatment-related toxicities.

Methods: Phase Ib Cohort 1 of Beamion LUNG-1 demonstrated a manageable safety profile with zongertinib in previously treated patients with advanced/metastatic HER2-mutant NSCLC.[1] This subsequent safety analysis, based on the same 75 Cohort 1 patients, focused on AEs of clinical relevance, including diarrhea, rash, and hepatotoxicity, among those who received zongertinib 120 mg QD. Data cutoff: November 29, 2024. Patient-level data are pending and will be included in subsequent presentation materials, if accepted.

Results: AEs with zongertinib occurred early during therapy: diarrhea most often presented within the first 1-2 weeks, rash by the end of week 3, and hepatotoxicity within the first 6 weeks of treatment. Supportive care to alleviate these symptoms was administered in 25/75 (33.3%) patients for diarrhea, 18/75 (24.0%) for rash and 10/75 (13.3%) for hepatotoxicity. Recurrent (≥3) events were uncommon: 8/75 (10.7%) for diarrhea, 3/75 (4.0%) for rash and 17/75 (22.7%) for hepatotoxicity. Most patients with Grade 2 diarrhea had only a single episode (8/10 [10.7%]), with a median duration of 3.0 days. Treatment modifications were infrequent: for diarrhea, 1 patient (1.3%) required a dose interruption without reductions or discontinuations; for rash, 4 patients (5.3%) required an interruption only; and for hepatotoxicity, 6 patients (8.0%) required interruptions, 3 patients (4.0%) required dose reductions, and 1 patient (1.3%) required permanent discontinuation.

Conclusion: Allied healthcare professionals play a key role in recognizing and managing AEs. Proper monitoring and timely intervention for common treatment-emergent AEs with zongertinib can optimize patient support where dose reductions may not be required.

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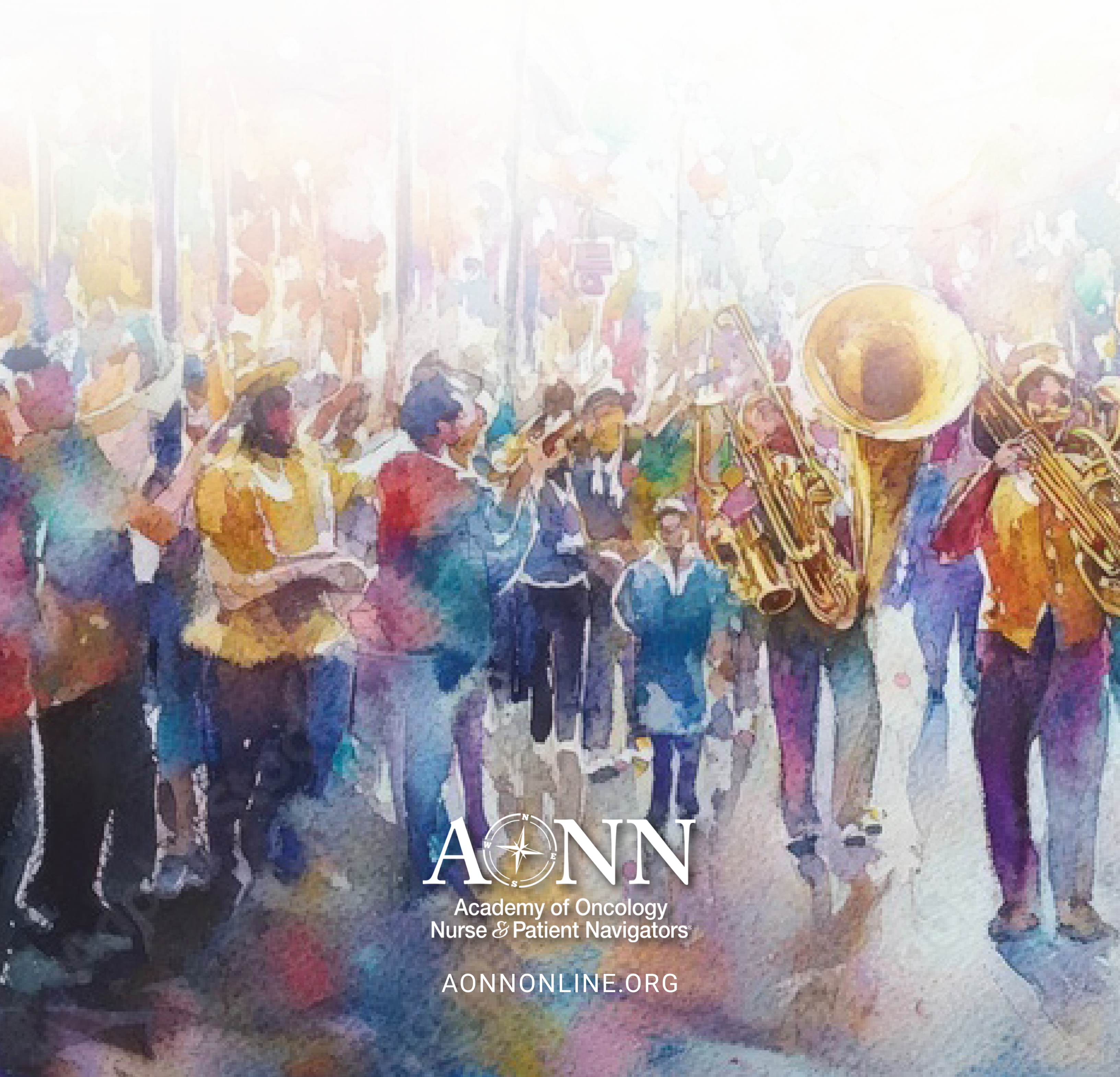

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