



March 9, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

RE: Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule  
(CMS-0057-P)

Dear Administrator Brooks-LaSure:

The National Comprehensive Cancer Network® (NCCN®) appreciates the opportunity to comment on the Center for Medicare and Medicaid Services (CMS) Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule (CMS-0057-P) as it relates to NCCN's mission of improving and facilitating, quality, effective, equitable, and accessible cancer care so all patients can live better lives. NCCN thanks CMS for its attention to creating efficiencies in prior authorization processes and for seeking additional information on how to best collect data on health-related social needs. NCCN is pleased to provide information and resources as CMS pursues these efforts and will focus on the role of clinical practice guidelines as a tool for facilitating timely access to optimal care.

### **NCCN Background**

As an alliance of 32 leading academic cancer centers in the United States that treat hundreds of thousands of patients with cancer annually, NCCN® is a developer of authoritative information regarding cancer prevention, screening, diagnosis, treatment, and supportive care that is widely used by clinical professionals and payers alike. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) are a comprehensive set of guidelines detailing the sequential management decisions and interventions that currently apply to 97 percent of cancers affecting patients in the United States.

NCCN Guidelines® and Library of Compendia products help ensure access to appropriate care, clinical decision-making, and assessment of quality improvement initiatives. The NCCN Drugs & Biologics Compendium (NCCN Compendium®) has been recognized by CMS and clinical professionals in the commercial payer setting since 2008 as an evidence-based reference for establishment of coverage policy and coverage decisions regarding off-label use of anticancer and cancer-related medications. NCCN was recognized by CMS in 2016 and renewed in 2021 as a qualified Provider Led Entity (PLE) for the Medicare Appropriate Use Criteria (AUC) Program for

NCCN is an alliance of leading cancer centers dedicated to improving and facilitating quality, effective, equitable, and accessible cancer care so all patients can live better lives.

For Clinicians: [NCCN.org](https://www.nccn.org) | For Patients: [NCCN.org/patients](https://www.nccn.org/patients) | Member Institutions: [NCCN.org/cancercenters](https://www.nccn.org/cancercenters)

the development of AUC and the establishment of policy and decision-making for diagnostic imaging in patients with cancer. The NCCN Biomarkers Compendium® has been referenced as a coverage mechanism and source of evidence by local Medicare Administrative Contractors and serves as a resource for payers, providers, and health care entities navigating the rapidly changing evidence-base for medically necessary biomarker testing in oncology. The NCCN Biomarkers Compendium® contains information derived directly from the NCCN Guidelines to support decision-making around the use of biomarker testing in patients with cancer. The NCCN Biomarkers Compendium is updated continuously in conjunction with the NCCN guidelines to stay evergreen.

NCCN imposes strict policies to shield the guidelines development processes from external influences. The “firewall” surrounding the NCCN Guidelines processes includes: financial support policies; panel participation and communication policies; guidelines disclosure policies; and policies regarding relationships to NCCN’s other business development activities. The guidelines development is supported exclusively by the Member Institutions’ dues and does not accept any form of industry or other external financial support for the guidelines development program. The NCCN Guidelines are updated at least annually in an evidence-based process integrated with the expert judgment of multidisciplinary panels of expert physicians from NCCN Member Institutions. The NCCN Guidelines are transparent, continuously updated, available free of charge online for non-commercial use and are available through a multitude of health information technology (HIT) vendors.

### **Electronic Prior Authorization and Reporting of Prior Authorization Metrics**

CMS proposes to require Medicare Advantage (MA), Medicaid and Children’s Health Insurance Program (CHIP) fee for service (FFS) and Managed Care plans, and Qualified Health Plan (QHP) issuers on federally-facilitated exchanges (FFE) to make important adjustments to their prior authorization processes. Specifically, CMS proposes to require these payers to establish electronic prior authorization processes, establish Patient Access Application Programming Interfaces (APIs), Provider APIs, and Payer to Payer APIs that retain prior authorization request status information for at least 1 year from the most recent status change, to establish policies ensuring prior authorization responses within 7 days for standard requests and 72 hours for expedited requests, and to require plans to publicly report certain prior authorization metrics in the aggregate. NCCN supports and applauds CMS for its attention to the important issue of burdensome prior authorization processes that frequently result in unnecessary and harmful care delays.

NCCN also notes that CMS proposes to include all items and services subject to prior authorization within this rule except for drugs. NCCN urges CMS to consider the inclusion of drugs within this proposal and to also encourage payers to use real-time clinical decision support in lieu of traditional prior authorization as a cost-saving and quality of care mechanism. NCCN is pleased to expand on the evidence for these approaches below as well as the role of high-quality clinical practice guidelines in expediting these processes.

Numerous independent studies have found adherence to NCCN Guidelines improves care delivery and outcomes for patients with cancer. Improved health outcomes proven through concordance with NCCN Guidelines include: improved rates of survival for colon cancer, ovarian cancer, gastric cancer, nasopharyngeal cancer, and pancreatic cancer; decreased locoregional recurrence of melanoma; and improved pain control.<sup>1,2,3,4,5,6</sup> Non-adherence to guidelines has also been identified as a key contributor to inequities in care outcomes across race and ethnicity with some studies finding these disparities greatly reduced or eliminated when guideline adherent care is received.<sup>7,8</sup> As such, guideline adherence is a key tool to combat inequities in care outcomes across race and ethnicity.

Guideline adherent care has also been shown to decrease costs. A peer-reviewed, published study by United, eviCore, and NCCN entitled “Transforming Prior Authorization to Decision Support” demonstrated mandatory adherence to NCCN Guidelines and NCCN Compendium<sup>®</sup> using a real-time Clinical Decision Support Mechanism significantly reduced total and episodic costs of care while also reducing denials and increasing access to guideline-concordant care. In Florida, United Healthcare adopted a prior authorization tool using NCCN real-time decision support over one year and explored 4,274 eligible cases. At the conclusion of the study, United Healthcare found that adding decision support to prior authorization reduced denials to 1 percent. Additionally, despite reducing denials, when compared to United Healthcare’s cancer drug cost trends nationwide, the study found that mere adherence to NCCN Guidelines and Compendium within the pilot reduced chemotherapy drug costs trends by 20 percent; a savings of more than \$5.3 million in the state of Florida. Administrative burden was also reduced through the integration of the decision-making tool as oncologists obtained immediate approvals online for 58 percent of cases without further interaction with the health plan required. Approval was granted for 95 percent of the remaining cases requiring further interaction in less than 24 hours.<sup>9</sup>

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1 Erickson Foster J, Velasco JM, Hieken TJ. Adverse outcomes associated with noncompliance with melanoma treatment guidelines. *Annals of Surgical Oncology*. 2008;15(9):2395-2402. doi:10.1245/s10434-008-0021-0

2 Visser BC, Ma Y, Zak Y, Poultsides GA, Norton JA, Rhoads KF. Failure to comply with NCCN guidelines for the management of pancreatic cancer compromises outcomes. *HPB*. 2012;14(8):539-547. doi:10.1111/j.1477-2574.2012.00496.x

3 Bristow RE, Powell MA, Al-Hammadi N, et al. Disparities in ovarian cancer care quality and survival according to race and socioeconomic status. *JNCI Journal of the National Cancer Institute*. 2013;105(11):823-832. doi:10.1093/jnci/djt065

4 Bristow RE, Chang J, Ziogas A, Randall LM, Anton-Culver H. High-volume ovarian cancer care: Survival impact and disparities in access for advanced-stage disease. *Gynecologic Oncology*. 2014;132(2):403-410. doi:10.1016/j.ygyno.2013.12.017

5 Mearis M, Shega JW, Knoebel RW. Does adherence to National Comprehensive Cancer Network guidelines improve pain-related outcomes? An Evaluation of Inpatient Cancer Pain Management at an Academic Medical Center. *Journal of Pain and Symptom Management*. 2014;48(3):451-458. doi:10.1016/j.jpainsymman.2013.09.016

6 Schwam ZG, Sosa JA, Roman S, Judson BL. Receipt of care discordant with practice guidelines is associated with compromised overall survival in nasopharyngeal carcinoma. *Clinical oncology (Royal College of Radiologists (Great Britain))*. <https://www.ncbi.nlm.nih.gov/pubmed/26868285>. Published June 2016.

7 Fang P, He W, Gomez D, Hoffman KE, Smith BD, Giordano SH, Jaggi R, Smith GL. Racial disparities in guideline-concordant cancer care and mortality in the United States. *Adv Radiat Oncol*. 2018 May 4;3(3):221-229. doi: 10.1016/j.adro.2018.04.013. PMID: 30202793; PMCID: PMC6128037.

8 Blom EF, Ten Haaf K, Arenberg DA, de Koning HJ. Disparities in Receiving Guideline-Concordant Treatment for Lung Cancer in the United States. *Ann Am Thorac Soc*. 2020 Feb;17(2):186-194. doi: 10.1513/AnnalsATS.201901-094OC. PMID: 31672025; PMCID: PMC6993802.

9 Newcomer LN, Weininger R, Carlson RW. Transforming prior authorization to decision support. *Journal of Oncology Practice*. 2017;13(1). doi:10.1200/jop.2016.015198

At the 2022 ASCO annual conference, CVS Health presented two abstracts looking at total costs of care beginning with the first treatment and for the subsequent 180 days for breast and colon cancer patients in relation to adherence to NCCN Guidelines.<sup>10,11</sup> In both studies, there was a significant reduction in total cost of care with concordance with NCCN Guidelines. In the colon cancer study, this was most prominent and significant in the Medicare population. In the breast cancer study, significant reductions were observed across both commercially insured and Medicare patients, with the greatest reductions again seen in the Medicare population. Additionally, modeling studies have found that bringing imaging practices in line with NCCN Guideline recommendations would result in significant cost savings.<sup>12,13</sup> Non-adherence to guidelines has also been identified as a key contributor to inequities in care outcomes across race and ethnicity with some studies finding these disparities greatly reduced or eliminated when guideline adherent care is received.<sup>14,15</sup>

Within the proposed rule CMS notes “*Some commenters, including payers, believe it is possible, given advances in technology that responses to certain types of prior authorization requests could be made within 24 hours*”. CMS seeks additional information on these models. NCCN agrees with these commenters, given the evidence for real-time clinical decision support based on high-quality, nationally recognized guidelines outlined above. **NCCN again thanks CMS for these proposals as important first steps to addressing the burden posed by traditional prior authorization programs and encourages CMS to consider the inclusion of drugs within these proposals and to explore models that may further expedite these processes as outlined above.**

### **Gold-carding Requests for Information**

Within the proposed rule, CMS queries stakeholders for feedback on potential gold-carding approaches that would allow prior authorization exemptions or more streamlined reviews for certain

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<sup>10</sup> Sapkota U, Cavers W, Reddy S, Avalos-Reyes E, Johnson KA. Total cost of care differences in National Comprehensive Cancer Center (NCCN) concordant and non-concordant breast cancer patients. *JCO*. 2022;40(16\_suppl):e18833-e18833. doi:10.1200/JCO.2022.40.16\_suppl.e18833

<sup>11</sup> Sapkota U, Cavers W, Reddy S, Avalos-Reyes E, Johnson KA. Total cost of care differences in National Comprehensive Cancer Center (NCCN) concordant and non-concordant patients with colon cancer. *JCO*. 2022;40(16\_suppl):3624-3624. doi:10.1200/JCO.2022.40.16\_suppl.3624

<sup>12</sup> Winn AN, Kelly M, Ciprut S, Walter D, Gold HT, Zeliadt SB, Sherman SE, Makarov DV. The cost, survival, and quality-of-life implications of guideline-discordant imaging for prostate cancer. *Cancer Rep (Hoboken)*. 2022 Feb;5(2):e1468. doi: 10.1002/cnr2.1468. Epub 2021 Jun 17. PMID: 34137520; PMCID: PMC8842701.

<sup>13</sup> Khan M, Thompson J, Kiiskila L, Oboh O, Truong T, Prentice A, Assifi MM, Chung M, Wright GP. Timing and necessity of staging imaging in clinical stage II cutaneous melanoma: Cost-effectiveness and clinical decision analysis. *Am J Surg*. 2023 Jan;225(1):93-98. doi: 10.1016/j.amjsurg.2022.10.022. Epub 2022 Oct 17. PMID: 36400601.

<sup>14</sup> Fang P, He W, Gomez D, Hoffman KE, Smith BD, Giordano SH, Jagsi R, Smith GL. Racial disparities in guideline-concordant cancer care and mortality in the United States. *Adv Radiat Oncol*. 2018 May 4;3(3):221-229. doi: 10.1016/j.adro.2018.04.013. PMID: 30202793; PMCID: PMC6128037.

<sup>15</sup> Blom EF, Ten Haaf K, Arenberg DA, de Koning HJ. Disparities in Receiving Guideline-Concordant Treatment for Lung Cancer in the United States. *Ann Am Thorac Soc*. 2020 Feb;17(2):186-194. doi: 10.1513/AnnalsATS.201901-094OC. PMID: 31672025; PMCID: PMC6993802.

providers. Further, CMS is considering the adoption of a gold-carding measure as a factor in quality ratings for MA organizations and QHPs. NCCN applauds CMS for considering this important proposal. NCCN notes that clinical practice guidelines should play a key role in the development of these gold-carding programs and any related quality measures. NCCN encourages CMS to work with payers to ensure their gold-carding programs appropriately incorporate the use of evidence-based clinical practice guidelines. NCCN would be happy to serve as a resource in determining appropriate metrics for guideline adherent care within these programs.

### **Transparency Proposals**

CMS offers several proposals to improve the transparency of prior authorization processes including requiring payers to establish patient and provider APIs with easily accessible prior authorization status information, requiring payers to publish a list of all items and services requiring prior authorization, and requiring payers to publish certain metrics on their rates of prior authorization requests that are approved or denied. NCCN agrees with CMS that these proposals are critical to ensure that beneficiaries have adequate information to inform their healthcare purchasing decisions and that CMS and other policymakers have access to information to inform policy. NCCN further requests that CMS consider adding a requirement that payers publish the sources of evidence they use to determine whether items and services requiring prior authorization are medically necessary and evidence-based, including the use of clinical practice guidelines. This information will introduce greater transparency into coverage rationale and help patients and providers to understand why a service is covered or non-covered.

### **Social Risk Factor Data**

CMS includes a Request for Information on methods to accelerate the adoption of standards related to the collection of social risk factor data. NCCN thanks CMS for this important query. NCCN is pleased to provide information on several potential resources to aid in this effort including the NCCN Distress Thermometer and Problem List, the Elevating Cancer Equity Health Equity Report Card, and an upcoming Health-Related Social Needs working group.

The NCCN Distress Thermometer and Problem List is a well-known screening tool among oncology providers. The Distress Thermometer measures distress on a 0 to 10 scale and the Problem List includes five areas of life: practical, family, emotional, spiritual/religious, and physical problems. Within the Problem List, patients are queried about Housing, Transportation, and Food Security among other variables. CMMI's Enhancing Oncology Model recently referenced the Distress Thermometer and Problem List as a tool for providers to address health-related social needs. NCCN notes that this may be a useful tool for plans seeking to better collect information on health-related social needs from their provider networks.

In 2020, NCCN, the National Minority Quality Forum (NMQF), and the American Cancer Society Cancer Action Network (ACS CAN) launched the Elevating Cancer Equity (ECE) initiative. The

ECE initiative sought to better understand patient experiences of racial disparities in access to guideline adherent cancer care in the United States through surveys of patients, caregivers, and oncologists, and then to address these disparities through a framework of actionable policy and practice change recommendations developed by a working group of national experts. The ECE Working Group (ECEWG), comprised of 17 national experts on racial disparities in cancer care including patients, caregivers, physicians, researchers, and industry, arose from the initiative (see Appendix A for full membership list). Convened in January 2021, the ECEWG developed two products: 1.) the Health Equity Report Card (HERC) as a means to put forth both best practice recommendations and ensure appropriate and necessary accountability for health systems and 2.) a Policy Framework to advance more equitable systems of care (see Appendix B for the HERC and Policy Framework). The Health Equity Report Card includes measures that score providers on their collection of social determinants of health (SDOH) data and on their referral processes to resources. A paper describing the HERC development process and subsequent implementation plan and scoring methodology was published in the *Journal of the National Comprehensive Cancer Network (JNCCN)* and can be found in Appendix C of this document. In early 2022, NCCN launched a feasibility pilot of the HERC across 5 academic cancer centers and is in the process of launching an additional pilot in community settings in 2023. NCCN believes the HERC can be an important and useful tool for providers, health systems, payers, developers of value-based models of care, and accreditation entities seeking to advance more equitable care delivery among their constituencies including to advance greater uptake of screening for social risk factors.

Finally, NCCN is in the process of convening a multi-stakeholder working group to evaluate Health-related Social Needs in oncology specifically and to identify high-impact measures for screening and referral. The results of this working group will be presented at a policy summit in September of 2023 and will be publicly available following the presentation. NCCN would be happy to engage in further conversation and information sharing around these efforts.

NCCN appreciates the opportunity to comment on the CMS Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule (CMS-0057-P). NCCN is happy to serve as a resource and looks forward to working together to advance access to equitable, high-quality cancer care.

Sincerely,



Robert W. Carlson, MD  
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National Comprehensive Cancer Network  
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## Elevating Cancer Equity Working Group Members

- **Chair:** Shonta Chambers, MSW, Patient Advocate Foundation
- **Chair:** Robert Winn, MD, VCU Massey Cancer Center
- Zeke Aguilera, ACT Lead, ACS CAN
- Nadine Barrett, PhD, Duke University School of Medicine
- Linda Burhansstipanov, DrPH, MSPH, Native American Cancer Research Corporation
- Christina Chapman, MD, MS, Michigan Medicine
- Moon Chen, MPH, PhD, UC Davis Health
- Thomas Farrington, Prostate Health Education Network
- Carmen Guerra, MD, MSCE, Penn Abramson Cancer Center
- Chanita Hughes-Halbert, PhD, Medical University of South Carolina
- Marjorie Kagawa Singer, PhD, UCLA Fielding School of Public Health
- Mel Mann, MBA M.Ed, Patient Advocate
- Regina Martinez, Volunteer, ACS CAN
- Kris Rhodes, MPH(Anishinaabe), Retired Founding CEO, American Indian Cancer Foundation
- Brian Rivers, PhD, MPH Cancer Health Equity Institute, Morehouse School of Medicine
- Gerren Wilson, PharmD, Genentech
- Karen Winkfield, MD, PhD, Meharry-Vanderbilt Alliance

# Elevating Cancer Equity: Recommendations to Reduce Racial Disparities in Access to Guideline Adherent Cancer Care



<b>Institutional and Practice Equity Report Card</b>	
<b>Community Engagement</b>	
Incorporates meaningful community involvement in practice leadership through a community/patient advisory committee or designated board position that is reflective of:	
<ul style="list-style-type: none"> <li>• the community the health care systems serves or</li> <li>• that is reflective of the community where the healthcare system resides or</li> <li>• is reflective of the demographics identified through the community needs assessment.</li> </ul>	
Marketing and educational materials use messaging that is linguistically and culturally appropriate for the community served.	
Contracts with or has formal and equitable partnership with community providers, community-based organizations, and/or faith-based organizations (when mutually appropriate and not harmful) for community engagement and/or patient navigation.	
Demonstrates the results of the community health needs assessments are used as a tool for program development through documented action plan tied to results.	
<b>Accessibility of Care and Social Determinants of Health</b>	
Facilitates access to government, commercial, or community-based non-emergency transportation services or financial support for public transportation where available.	
Collects Social Determinants of Health data at intake and throughout the continuum of care. Population-level data collected (z-codes) helps to guide patient care and population-level health management as documented through the medical record or meeting notes.	
Offers flexible hours for screening and treatment appointments.	
Offers culturally and linguistically representative patient navigators or community health workers through internal hiring or contracting with community-based organizations.	
Establish a process to navigate patients with identified social needs to local and or national resources.	
Training is provided to staff on barriers to clinical trial participation and there are targeted efforts to reduce barriers to clinical trial participation through connection to appropriate services.	
<b>Addressing Bias in Care Delivery</b>	
Diversity, inclusion, and equity is embedded into the practice, institution, or health system policies (Examples: recruitment, hiring, and promotion policies, resource allocation standards).	
Adopts measures related to the recruitment, retention, and promotion of minority researchers and practitioners.	
Implements Health Information Technology or other workflow processes to identify critical moments in shared decision making and care planning when disparate care can occur.	
Incorporates disparities and equity framework into quality improvement activities.	
Provides and requires annual implicit bias training for all employees.	



<b>Quality and Comprehensiveness of Care</b>	
When appropriate, patients are offered or referred to appropriate preventive and supportive care services (e.g. smoking cessation and weight management programs, reducing exposure to environmental hazards).	
Clinical trial options are discussed with all patients as documented through medical records.	
Offers culturally and linguistically representative patient navigators or community health workers through internal hiring or contracting with community-based organizations.	

Elevating Cancer Equity Working Group Policy Change Recommendations
Congressional Recommendations
<b>Clinical Trial Diversity:</b> Congress should pass legislation requiring the FDA to consider clinical trial diversity as an element of the drug approval process in a way that is proportionate to the intended patient population.
<b>Supporting Cancer Prevention:</b> Congress should allocate funds for public awareness campaigns of lifestyle factors impacting cancer risk that are linguistically and culturally reflective.
<b>Supporting Cancer Prevention:</b> Congress should pass legislation allocating funds for public education on the importance of the Human Papillomavirus(HPV) vaccine.
<b>Supporting Access to Screening:</b> Congress should allocate additional funding for CDC screening programs including the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and the Colorectal Cancer Control Program (CCCP). Congress should also allocate funds for screening that prioritizes cancers where disparities are particularly prevalent.
<b>Supporting Access to Screening:</b> Congress should allocate funds to be granted to community-based organizations to connect people with screening, early detection and treatment support. Congress should restore funds for the National Comprehensive Cancer Control Program.
<b>Supporting a Diverse Healthcare Workforce:</b> Congress should allocate funds to Historically Black Colleges and Universities (HBCUs), tribal colleges, and other minority serving institutions (MSIs) because they excel at care, practice, education, and community engagement.
<b>Supporting Patient Navigation:</b> Congress should pass legislation ensuring reimbursement of patient navigators and community health workers in Medicare/Medicaid/Private Insurance markets.
<b>Social Determinants of Health:</b> Congress should allocate funds for the reconnect loan and grant program and eliminate the household threshold requirement. Access to basic infrastructure like electricity has a critical impact on health.
CMS and Commercial Payer Recommendations
<b>Ensuring Equitable Access to Genetic Testing and Cancer Risk Reduction:</b> All payers should cover appropriate genetic counseling and testing for individuals at high risk of cancer as well as related risk reduction services.
<b>Addressing Clinical Trial Participation Barriers:</b> CMS should ensure Medicare, Medicaid, CHIP, and exchange plans offer coverage of the costs of clinical trial participation including parking, transportation, and lodging.
<b>Patient Navigation:</b> CMMI and commercial payers should include reimbursement for patient navigators, community health workers, care coordination, and connection to social support services in alternative payment models.
Federal Agency Recommendations
<b>Data Collection:</b> The Office of Management and Budget should revise their regulations dictating the collection and reporting of federal data on race and ethnicity. Data should be disaggregated from existing methods that fail to recognize the heterogeneity of African Americans, Pacific Islanders, Asians, Hispanics, American Indians and Alaska Natives.
<b>Research:</b> The Department of Health and Human Services should prioritize funds and resources for interdisciplinary research in SDOH and health disparities research. HHS should require health care systems to partner with community-based organizations to conduct research.
<b>Cancer Prevention:</b> The CDC should make the HPV vaccine an opt-out instead of an opt-in vaccine.
<b>Patient Navigation:</b> Create a Department of Labor code for Patient Navigators

## State and Local Policymaker Recommendations

**Medicaid Expansion:** State governors and legislatures should expand their state Medicaid programs to increase access to screening, early detection and care.

# Advancing More Equitable Care Through the Development of a Health Equity Report Card

Alyssa A. Schatz, MSW<sup>1</sup>; Shonta Chambers, MSW<sup>2</sup>; Gretchen C. Wartman<sup>3</sup>; Lisa A. Lacasse, MBA<sup>4</sup>;  
Crystal S. Denlinger, MD<sup>1</sup>; Kristen M. Hobbs, MPH, CPH<sup>3</sup>; Lindsey Bandini, MPH<sup>1</sup>;  
Robert W. Carlson, MD<sup>1</sup>; and Robert A. Winn, MD<sup>5,6</sup>

## ABSTRACT

The root causes of racial disparities in access to optimal cancer care and related cancer outcomes are complex, multifactorial, and not rooted in biology. Contributing factors to racial disparities in care delivery include implicit and explicit bias, lack of representation of people of color in the oncology care and research workforce, and homogenous research participants that are not representative of the larger community. Systemic and structural barriers include policies leading to lack of insurance and underinsurance, costs of cancer treatment and associated ancillary costs of care, disparate access to clinical trials, and social determinants of health, including exposure to environmental hazards, access to housing, childcare, and economic injustices. To address these issues, ACS CAN, NCCN, and NMQF convened the Elevating Cancer Equity (ECE) initiative. The ECE Working Group developed the Health Equity Report Card (HERC). In this manuscript, we describe the process taken by the ECE Working Group to develop the HERC recommendations, the strategies employed by NCCN to develop an implementation plan and scoring methodology for the HERC, and next steps to pilot the HERC tool in practice settings.

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**Cancer prevention and treatment systems** are significantly impacted by interpersonal, organizational, and structural and systemic racism. A wide body of research has found that racial disparities in both cancer care outcomes and access to guideline-concordant care are pervasive throughout the United States.<sup>1,2</sup> Inequities in cancer outcomes across race and ethnicity have numerous contributing factors, including disparate access to comprehensive insurance coverage, bias and discrimination in care delivery, and social determinants of health (SDOH), such as one's neighborhood and built environment, access to economic and educational opportunity, food insecurity, and social support networks.<sup>3–6</sup> These challenges require a coordinated, robust, deliberate, and enduring response to reform cancer care systems and address racial disparities in cancer care. This article highlights efforts of the Elevating Cancer Equity (ECE) Working Group, convened by the American Cancer Society Cancer Action Network (ACS CAN), the National Comprehensive Cancer Network (NCCN), and the National Minority Quality Forum (NMQF), to develop an actionable framework for organizational and clinical practice change to create more equitable systems of cancer care delivery, titled the “Health Equity Report Card” (HERC).

## The Elevating Cancer Equity Initiative

The root causes of racial disparities in access to optimal cancer care and related cancer outcomes are complex, multifactorial, and not rooted in biology. Contributing factors to racial disparities in care delivery include implicit and explicit bias, lack of representation of people of color in the oncology care and research workforce, and homogenous research participants that are not representative of the larger community.<sup>7</sup> Systemic and structural barriers include policies leading to lack of insurance and underinsurance, costs of cancer treatment and associated ancillary costs of care, disparate access to clinical trials, and SDOH, including exposure to environmental hazards, access to housing, childcare, and economic injustices.<sup>7</sup> Studies have evaluated oncologists' rates of

<sup>1</sup>National Comprehensive Cancer Network, Plymouth Meeting, Pennsylvania; <sup>2</sup>Patient Advocate Foundation, Hampton, Virginia; <sup>3</sup>National Minority Quality Forum, Washington, DC; <sup>4</sup>American Cancer Society Cancer Action Network, Washington, DC; <sup>5</sup>VCU Massey Cancer Center, Richmond, Virginia; and <sup>6</sup>VCU School of Medicine, Richmond, Virginia.



See [JNCCN.org](https://www.jnccn.org) for supplemental online content.

implicit bias and found that oncologists scoring higher on implicit bias tests had shorter interactions with Black patients and were viewed as less patient-centered and supportive by Black patients.<sup>5,8</sup> Additionally, some studies have evaluated the role of bias and stereotyping in referral to clinical trials and have concluded that racial bias and assumptions do play a role in low rates of clinical trial referral.<sup>9</sup>

To address these issues, ACS CAN, NCCN, and NMQF convened the Elevating Cancer Equity (ECE) initiative. This initiative aims to go beyond the exploration of causes to identify and promote actionable solutions through the combined experience and expertise of racial and ethnic minority patients and caregivers and national experts. A survey of patients, caregivers, and oncologists was conducted, after which a multistakeholder expert ECE Working Group (eAppendix 1, available with this article at JNCCN.org) met and developed the HERC (supplemental eFigure 1).<sup>10</sup> This article describes the process taken by the ECE Working Group to develop the HERC recommendations, the strategies employed by NCCN to develop an implementation plan and scoring methodology for the HERC, and next steps to pilot the HERC tool in practice settings.

### Development of the HERC

The ECE Working Group was convened to discuss the root causes of racial disparities in access to optimal cancer care and to develop actionable policy and practice change solutions that, if implemented, would disrupt discriminatory behaviors and bias in care delivery, address SDOH, and address systemic barriers to optimal care. The ECE Working Group was chaired by Dr. Robert Winn, Director of the Virginia Commonwealth University Massey Cancer Center, and Ms. Shonta Chambers, Executive Vice President of Health Equity and Community Engagement at the Patient Advocate Foundation. The ECE Working Group comprised 17 members nominated by key project staff at each of the 3 convening organizations. Potential members were nominated based on their professional accomplishments in relation to equity in cancer care and/or their personal experiences with cancer care disparities as patients/caregivers. The 3 convening organizations then narrowed and refined the final group to ensure a diversity of expertise across various professional and personal domains. Ultimately, the final group of 17 members represented physicians and other healthcare professionals, patients, caregivers, researchers, and professionals in the pharmaceutical/biotech industry from racially and ethnically diverse communities and geographic locations. In advance of the meeting, working group members were provided with a discussion guide containing relevant literature as well as the results of 2 surveys—one of patients and caregivers and one of oncologists—that explored experiences with and perceptions

of disparities in cancer care, conducted by Public Opinion Strategies.<sup>10</sup>

The ECE Working Group met over the course of 2 days in January 2021. The meeting began with an overview of key highlights from the ECE patient, caregiver, and oncologist surveys and a presentation on disparities in receipt of guideline-concordant care. Following these presentations, the working group members were assigned to small discussion groups across 4 key focus areas: (1) research and clinical trials, (2) risk reduction, prevention, and early detection, (3) care delivery, and (4) SDOH. The small groups were charged with discussing root causes of racial disparities within their assigned area, challenges to addressing these causes, and policy and practice changes that would address these issues. Small groups then presented recommended policy and practice solutions within each area, which were refined and finalized by the larger working group throughout the course of the meeting and subsequent follow-up meetings.

Actionable clinical practice change solutions were defined as interventions targeted to physician practices and hospitals that would reduce racial disparities in cancer care. However, as working group members discussed the desired practice changes, a key concern arose regarding the ability of the ECE Working Group to ensure both accountability for the implementation of these changes and the ability to implement and measure these changes. To address this concern, rather than disseminating traditional practice change recommendations, the working group developed the HERC (supplemental eFigure 1), an accountability, quality improvement, and transparency tool for accreditation entities, payers, and providers seeking to advance more equitable policies and practices within their care systems. A 6-phase process to develop and implement the HERC has been undertaken. This article describes phases 1 through 4 of the process.

#### Phase 1: Identification of Practice Barriers and Root Causes of Racial Disparities in Cancer Care

The ECE Working Group discussed the root causes and systemic barriers creating racial disparities in cancer care and worked to identify high-impact areas of intervention. Several key themes emerged throughout these discussions (Table 1). The Research and Clinical Trials subgroup reported a primary barrier to adequate racial representation in clinical trials being low rates of providers discussing clinical trials with patients. Participants discussed a common belief among medical professionals that Black/African American and Hispanic/Latinx patients are less willing to participate in clinical trials. However, the working group asserted that this belief may be a self-fulfilling prophecy. Within the ECE survey, 72% of physicians reported discussing clinical trials with their patients “nearly always” or “often” but just 39% of patients reported being informed of

**Table 1. Identified Practice-Level Barriers**

Research and Clinical Trials	Risk Reduction, Prevention, and Early Detection	Care Delivery	SDOH
Beliefs and misconceptions among healthcare professionals about who is interested in trial participation	Scarcity of marketing materials that are culturally, linguistically, and racially reflective of the community	A deficiency of effective anti-racism and anti-bias training in healthcare settings	Slow adoption of data collection on SDOH by healthcare providers
Patient mistrust of health and research systems due to historic and ongoing injustices	Few available educational materials that are culturally, linguistically, and racially reflective of the community	Lacking racial representation in the oncology professional workforce	A dearth of community partnerships
Patient misconceptions about the role of clinical trials in the cancer care continuum	Need for patient navigators and community health workers	Communication challenges	A dearth of patient navigators that are culturally and linguistically reflective of the community

Abbreviation: SDOH, social determinants of health.

available clinical trials.<sup>10</sup> The ECE Working Group also noted that the health system’s historic and ongoing inequitable practices have understandably led to patient mistrust. Patients may assume participation in a trial is a lower quality of care, and therefore the health system must do a better job of communicating that clinical trials are an integral part of the continuum of care.

The group also discussed barriers to equitable cancer prevention and early detection. ECE Working Group members noted the importance of linguistically appropriate marketing and educational materials around screening and also emphasized the importance of culturally appropriate messaging. An example highlighted is the propensity for investing in and caring for future generations within the Asian community. Therefore, framing screening in terms of its impact for future generations may be more impactful than individual-level messaging. The group also emphasized the importance of patient navigators and community health workers being representative of the communities in which they serve, both to engage people in screening and to get individuals from screening into treatment when needed.

Addressing bias in care delivery is critical to advancing equitable outcomes in cancer care. Group members noted a significant barrier is the dearth of effective anti-racism and anti-bias training and practices in oncology. ECE Working Group members noted that a significant portion of oncology patients are seen at community practices. Therefore, a rapid change of best practices in community settings is key to ensuring equity in care delivery. Finally, the field of medicine, and oncology in particular, has substantial underrepresentation of Hispanic/Latinx and Black/African American professionals, with only 2% of oncologists identifying as Black and <6% of oncologists identifying as Hispanic/Latinx.<sup>11</sup> Studies have demonstrated that poorer communication and lower patient satisfaction are more likely to occur when a patient and physician are of different racial backgrounds.<sup>12</sup> A lack of appropriate racial representation among oncologists perpetuates bias in care delivery.

Finally, the group discussed SDOH impacting disparate cancer care outcomes. A key challenge identified was the lack of data collection on SDOH, or more specifically, the social and economic needs gaps caused by them. There are now established medical billing codes specifically intended for the collection of SDOH data, but adoption of these billing codes has been slow.<sup>13</sup> The SDOH subgroup discussed the importance of collecting these data and further using it as a way to understand community needs and engaging with community-based organizations. The group emphasized that these data should be used to facilitate work to identify and address community priorities in partnership with community representatives. The need for patient navigators who are both linguistically and culturally reflective of their surrounding communities was a common theme that emerged across all breakout groups. Unfortunately, to date navigation services have not been implemented on a broad scale, although the benefits have been well documented, because they are largely funded by grant programs and are typically not reimbursable by payers.

**Phase 2: Developing the HERC**

The ECE Working Group employed a similar process to identify root causes and practice barriers to develop recommendations for practice changes. The 4 assigned small groups (research and clinical trials, risk reduction, prevention, and early detection, care delivery, and SDOH) met to share best practices and potential solutions to the identified practice challenges, and then reconvened as a larger group to present their recommendations for inclusion. Using a consensus-based process, the ECE Working Group then refined and modified the list following larger group feedback across each area. The group narrowed the recommendations further and identified the 4 final domains for the report card. The 4 HERC domains ultimately identified by expert-driven consensus were: (1) Community Engagement, (2) Accessibility of Care and SDOH, (3) Addressing Bias in Care Delivery, and (4) Quality and Comprehensiveness of Care. The remaining

recommendations across the categories were then further narrowed, prioritized according to the recommendations' perceived potential for impact on reducing disparities and addressing existing gaps in care delivery by the multistakeholder group of experts. This process resulted in 17 actionable recommendations across the 4 domains being included in the HERC.

The ECE Working Group intentionally selected a report card format to convey the intention of the HERC as a quality improvement and accountability tool. ECE Working Group members also recognized its potential utility in serving as an important transparency tool for patients. For example, similar to the Centers for Medicare & Medicaid Services (CMS) Quality Star Ratings, this report card could be made publicly available within payer networks so that patients can select providers who have been rated highly on the metrics that matter most to them across the 4 domains.

### Phase 3: Designing the HERC Implementation Plan

A tool outlining performance metrics and applicable sources of evidence for each HERC recommendation was developed by NCCN to allow for the implementation of the HERC in practice settings based upon objective evidence rather than attestation alone. NCCN then convened a group of administrative and clinical representatives from leading academic cancer centers to provide feedback on the feasibility of the draft implementation plan, including appropriateness of metrics and sources of evidence. Although these representatives were invited to provide feedback on feasibility and appropriate sources of evidence for use within the plan, participants were instructed that the recommendations themselves were not able to be revised from the working group intentions. Working group participants provided feedback on clarity of metrics, appropriateness of sources of evidence, and potential barriers to implementation, resulting in refinement of the implementation plan. The final plan was presented to a larger group of academic cancer center representatives for finalization. The final implementation plan for the pilot is shown in Table 2.

### Phase 4: Developing a Scoring Methodology

A scoring methodology was developed by NCCN to support the implementation of the HERC in practice settings. The full scoring methodology is outlined in supplemental eFigure 2. The ECE Working Group intended the report card to be scored individually across each domain rather than providing an overall score to ensure greater transparency and utility of information for patients making healthcare purchasing decisions. Individually scored domains also offer value to healthcare institutions, payers, accreditation entities, and other third parties interested in

focusing on specific areas for improvement. Each of the 4 domains in the HERC is individually scored with a grade (Pass with Distinction, Pass, Needs Improvement) and a percentage of met/unmet metrics is provided in parentheses [eFigure 2]. The domains for individual grading include (1) Community Engagement, (2) Accessibility of Care and SDOH, (3) Addressing Bias in Care Delivery, and (4) Quality and Comprehensiveness of Care.

Each metric within a domain is weighted equally using met or not met. If only half of a requirement is met, the participant receives half the credit for that section. There are some metrics through which participating sites may be exempted in certain circumstances. If a clinical practice or institution is exempt from metrics within a category, the grading weights will be adjusted accordingly. Scoring methodology for each section is as follows: Pass with Distinction: 100% of metrics met; Pass: 50%–99% of metrics met; Needs Improvement: 0%–49% of metrics met.

### Discussion

NCCN, ACS CAN, and NMQF recognized the need for actionable clinical practice level solutions to address disparities in cancer care access, quality, and outcomes across race and ethnicity. Through the convening of the ECE Working Group, an expert consensus-based process was employed to develop a tool for better measurement and advancement of equitable practices within cancer care. The resulting HERC included 17 recommendations across 4 domains. These clinical practice recommendations were then translated into an implementation plan including concrete metrics, sources of evidence, and a scoring methodology, all of which were vetted by oncology administrators and healthcare providers for feasibility.

The HERC methodology requires pilot testing within actual clinical practice settings for feasibility and scalability. Phases 5 and 6 of this project include pilots at academic and community-based clinical practices, respectively. Throughout 2022 and 2023 NCCN is piloting the feasibility of implementing this tool within academic settings with 5 leading academic cancer centers. NCCN also anticipates piloting the HERC in community-based settings in 2023. Pending findings of these pilot projects, NCCN anticipates refining the HERC as necessary for feasibility prior to broader dissemination across health systems.

There are several limitations associated with the HERC development process. The HERC is not yet validated for feasibility or impact on care outcomes. The feasibility of using the HERC in both academic and community practice settings is being studied in pilot projects to ensure it is broadly feasible to use across a variety of clinical practice settings. It is anticipated that implementation challenges may arise, particularly in lower-resource care

**Table 2. Health Equity Report Card Implementation Tool**

Performance Measure	Metric to Meet Benchmark	Sources of Evidence
<b>Community Engagement</b>		
Incorporates meaningful community involvement in practice leadership through a community/patient advisory committee or designated board position that is reflective of the community served or located	<ul style="list-style-type: none"> <li>The Board of Directors or equivalent is representative of the community served or community in which practice is located OR</li> <li>The existence of a community or patient advisory committee that is representative of the community served and community in which practice is located</li> </ul>	<ul style="list-style-type: none"> <li>Roster of the Board of Directors or equivalent leadership group OR</li> <li>Documentation of current board membership demonstrating at least one community or patient representative OR</li> <li>Charter of the community or patient advisory committee OR</li> <li>Documentation of community or patient advisory committee membership and meeting dates</li> </ul>
Marketing and educational materials use messaging that is linguistically and culturally appropriate for the community served	<ul style="list-style-type: none"> <li>Offers marketing materials (ads, brochures) that are available in 3 most commonly spoken languages (including English) in the area served according to LEP.gov</li> <li>Provides educational materials available in 3 most commonly spoken languages including English in the area served according to LEP.gov</li> </ul>	<ul style="list-style-type: none"> <li>Cross-reference educational/marketing materials with latest version of the LEP.gov map maintained by the US Department of Justice Civil Rights Division to confirm prevalence of languages spoken in the area</li> <li>Exclusion for this measure if less than 1% of population has limited English proficiency according to LEP.gov</li> </ul>
Contracts with or has formal and equitable partnership with community providers, community-based organizations, and/or faith-based organizations (when appropriate) for community engagement and/or patient navigation	<ul style="list-style-type: none"> <li>Has at least one formal contract, letter of agreement, or memorandum of understanding with a community-based organization for engagement or navigation</li> </ul>	<ul style="list-style-type: none"> <li>Formal contract, letter of agreement, or memorandum of understanding OR</li> <li>Alternative evidence of the program if contracts/LOAs/MOUs are confidential</li> </ul>
Demonstrates the results of the community health needs assessments are used as a tool for program development through documented action plan tied to results	<ul style="list-style-type: none"> <li>Provides written documentation demonstrating action plan responding to needs identified by community health needs assessment</li> </ul>	<ul style="list-style-type: none"> <li>Community health needs assessment and related written and dated action plan available for review</li> <li>NOTE: If provider is not required to conduct a community health needs assessment, this measure is excluded</li> </ul>
<b>Accessibility of Care and SDOH</b>		
Facilitates access to government, commercial, or community-based non-emergency transportation services or financial support for public transportation	<ul style="list-style-type: none"> <li>Provider has connection to public transit, Medicaid non-emergency medical transportation, taxi or comparable services, or other relevant transportation services available at low or no cost to patient</li> </ul>	<ul style="list-style-type: none"> <li>Formal contract, letter of agreement, or memorandum of understanding with a transportation company OR</li> <li>If contracts are confidential: Program brochures/documents outlining the service available AND</li> <li>A structured field in the medical record for referral</li> </ul>
Collects Social Determinants of Health data at intake and throughout the continuum of care. Population-level data collected (z-codes) helps to guide patient care and population-level health management as documented through the medical record or meeting notes	<ul style="list-style-type: none"> <li>Demonstrates that information is collected and used through medical records and meeting notes/organizational policies. Ideally collected at least every 6 months for each active patient</li> </ul>	<ul style="list-style-type: none"> <li>EHR or medical record structured field or notes. Target percentage of at least 75% of patients asked. Patient does not wish to report is an acceptable response (scored as concordant) AND</li> <li>Documentation of staff meetings where data is discussed and used to guide policy/practice change OR</li> <li>Examples of policies changed as a result of data collected</li> </ul>
Offers flexible hours for screening and treatment appointments	<ul style="list-style-type: none"> <li>Offers hours outside of 8–6 pm</li> <li>Monday through Friday</li> </ul>	<ul style="list-style-type: none"> <li>Publicly available office hours for screening and treatment services including evenings, early mornings, and/or weekends. May be ascertained through website or practice protocol documents</li> </ul>
Offers culturally and linguistically representative patient navigators or community health workers through internal hiring or contracting with community-based organizations	<ul style="list-style-type: none"> <li>Provider demonstrates they employ or contract with patient navigators or community health workers that are linguistically and culturally representative of the community served</li> </ul>	<ul style="list-style-type: none"> <li>Job descriptions include language requirements and encourage diverse applicants and/or applicants representative of the community</li> <li>Personnel documentation of filled positions (aggregate demographic information)</li> <li>Billing/Claims data can also support when available</li> <li>Formal contract, letter of agreement, or memorandum of understanding outlining collaboration with community-based organization to provide navigator or community health worker services</li> </ul>

(continued on next page)



**Table 2. Health Equity Report Card Implementation Tool (cont.)**

Performance Measure	Metric to Meet Benchmark	Sources of Evidence
<b>Accessibility of Care and SDOH (cont.)</b>		
Establish a process to navigate patients with identified social needs to local and or national resources	<ul style="list-style-type: none"> <li>Process is established to connect to social workers or appropriate community resources</li> </ul>	<ul style="list-style-type: none"> <li>Referral algorithm within EHR or other document OR</li> <li>Other well-documented policy/process</li> </ul>
Training is provided to staff on barriers to clinical trial participation and there are targeted efforts to reduce barriers to clinical trial participation through connection to appropriate services	<ul style="list-style-type: none"> <li>Provides training on barriers to clinical trial participation at least once within previous 2 years with accompanying effort to reduce barriers to participation (eg, connection to transportation or trial navigators)</li> </ul>	One of: <ul style="list-style-type: none"> <li>Personnel records OR</li> <li>Training program curriculum AND one of:               <ul style="list-style-type: none"> <li>Documented clinical trial recruitment strategies OR</li> <li>Medical records OR</li> <li>Program brochures</li> </ul> </li> </ul>
<b>Addressing Bias in Care Delivery</b>		
Diversity, inclusion, and equity is embedded into the practice, institution, or health system policies	<ul style="list-style-type: none"> <li>Diversity, inclusion, and equity are embedded into the policies of the practice, institution, or health system</li> </ul>	<ul style="list-style-type: none"> <li>At least 2 documented policies, or one umbrella policy, specific to advancing equitable hiring, promotion, compensation, or recruitment efforts <b>beyond</b> requirements of federal law (eg, Equal Employment Opportunity Act Compliance Policy).</li> <li>Policies may include: recruitment, hiring, and promotion policies, resource allocation standards</li> </ul>
Adopts measures related to the recruitment, retention, and promotion of minority researchers and practitioners	<ul style="list-style-type: none"> <li>Demonstrates a commitment to recruitment, retention, and promotion of minority researchers and practitioners through personnel policy, organizational policy, and organizational programming and investments</li> </ul>	<ul style="list-style-type: none"> <li>Documented increase in numbers of racial/ethnic minority researchers, practitioners, trainees, and/or allied healthcare professionals OR</li> <li>Evidence of dedicated fellowship or career training programs for minority researchers and/or practitioners</li> </ul>
Implements HIT or other workflow processes to identify critical moments in shared decision making and care planning when disparate care can occur	<ul style="list-style-type: none"> <li>Incorporates workflows that highlight decision-making and care planning where deviation from guideline-concordant care is especially common</li> </ul>	<ul style="list-style-type: none"> <li>Rate of guideline-concordant care aggregated by race and ethnicity</li> </ul>
Incorporates disparities and equity framework into quality improvement activities	<ul style="list-style-type: none"> <li>Within quality improvement activities collects data on race, ethnicity, SDOH, and/or language (REAL data) and uses the data to identify and address disparities in care across race/ethnicity</li> </ul>	<ul style="list-style-type: none"> <li>Quality measurement algorithm/documentation among QI teams</li> </ul>
Provides and requires annual implicit bias training for all employees	<ul style="list-style-type: none"> <li>Provides implicit bias training for all employees at least annually</li> </ul>	<ul style="list-style-type: none"> <li>Personnel documentation OR</li> <li>Training curricula and most recent training dates provided</li> </ul>
<b>Quality and Comprehensiveness of Care</b>		
When appropriate, patients are offered or referred to appropriate preventive and supportive care services (eg, smoking cessation and weight management programs, reducing exposure to environmental hazards)	<ul style="list-style-type: none"> <li>Documented proportion of at-risk patients as defined by NCCN Guidelines referred to at least 2 of the following services: Smoking cessation, weight management programming, services to reduce environmental hazards (eg, radon mitigation)</li> </ul>	<ul style="list-style-type: none"> <li>Note or structured field in medical record and percentage of patients. OR</li> <li>Claims data</li> </ul>
Clinical trial options are discussed with all patients as documented through medical records	<ul style="list-style-type: none"> <li>Documented proportion of patients who receive information and are queried on interest in clinical trial participation and whether rates of clinical trial accrual reflect the racial/ethnic composition of the served population</li> </ul>	<ul style="list-style-type: none"> <li>Aggregate data pulled from clinic notes or structured field in medical record</li> </ul>

Abbreviations: EHR, electronic health record; HIT, health information technology; LOA, Letter of Agreement; MOU, Memorandum of Understanding; QI, quality improvement; REAL, Race, Ethnicity, and Language; SDOH, social determinants of health.

settings. To address this, the pilot site selection process will intentionally include a diversity of resourced settings. It is also recognized that populations and the demographic makeup of a given area may impact the ability of practices to meet certain metrics, including recruiting and promoting

a representative workforce and offering linguistically or culturally appropriate educational materials. As such, the metrics within the implementation plan are framed within the context of the surrounding community to ensure the benchmarks to be met are reflective of the

practice setting and needs of the local community. Given the highly individualized needs and resources across communities, it will be particularly important for practices using the HERC to focus on bidirectional community partnerships as they embark on HERC scoring. Working side by side with existing community organizations and resources will allow each participating organization to maximize available resources, tailor their practice to community needs, and ultimately build more responsive programming. Finally, we acknowledge that governmental, legal, and regulatory forces also impact the ability to meet these metrics, including the ability of health systems to recruit a diverse and representative workforce. As such, it is critically important that practice change be pursued alongside advocacy for systems change.

Further testing regarding downstream impact on practice and institutional change, care outcomes, and patient experience is also important following completion of pilot testing and refinement for feasibility. The HERC was developed based on the expertise of a relatively small number of recognized experts in cancer care disparities. It will be important to continue to learn from the pilot projects, from additional stakeholder groups, and from the evolving literature on practices to reduce inequities in healthcare. These limitations warrant further research and evaluation during and following the pilot studies.

Several additional promising and unique quality improvement tools are emerging in health equity. The Institute for Healthcare Improvement is piloting their health equity assessment tool as part of the Pursuing Equity Initiative, focusing on an organization's commitment to equity, serving the broader community, and increasing appropriate racial representation in health systems.<sup>14</sup> ASCO also released a framework to advance more equitable cancer care systems through the work of an expert roundtable intended to be used by healthcare practitioners and policymakers voluntarily to improve their practice.<sup>7</sup> The National Committee for Quality Assurance (NCQA) has also released commercially licensed Health Equity Accreditation Programs. Similar to the HERC, each of these efforts is also in early stages, and the impact of their use on improving equitable care has not been established. Although the ECE HERC tool has areas of overlap with all of these models, it is distinct in that it uses a more structured scoring approach and offers clinical practice level measures in addition to broader organizational measures.<sup>15</sup> Additionally, the HERC is

intended to be translatable and adaptable across a variety of use settings, including by public and private payers, accreditation entities, healthcare organizations, and patients. The HERC is intended to offer a mechanism to measure and incentivize more equitable care practices while also offering greater transparency for patients to inform their decision-making.

### Summary

The ultimate goal of this initiative is to develop a tool that can both meaningfully and feasibly measure and report on equitable care practices. The HERC as outlined within this paper offers an important first step, but we recognize that attaining this ultimate goal will require further study to ensure the tool is more than a “checklist” exercise and is an intervention that can result in meaningful, sustainable systems change. As such, there are additional efforts underway to pilot the report card for feasibility. As we learn more about the ability to incorporate this tool into practice as well as its impact on care outcomes and inequities in care, the tool may be adjusted and evolve for optimal impact.

The development of the HERC is timely, given that governments, payers, and providers are seeking actionable mechanisms to improve equity in our healthcare system. The CMS recently announced they will be considering the implementation of an equity score for hospitals within the proposed FY 2022 Hospital Inpatient Prospective Payment System rule. Additionally, the Enhancing Oncology Model recently introduced by Center for Medicare & Medicaid Innovation is anticipated to require participating practices to include a health equity plan. As the US health system shifts to require greater provider accountability for racial disparities in health outcomes, models like the ECE HERC can serve as a roadmap for providers and healthcare organizations working to improve their practice, a transparency tool for patients, and an assessment tool for payers and accreditation entities.

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## Advancing More Equitable Care Through the Development of a Health Equity Report Card

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**eFigure 1:** Institutional and Practice Equity Report Card

**eFigure 2:** Proposed Scoring Methodology

**eAppendix 1:** Elevating Cancer Equity Working Group Members

<b>Institutional and Practice Equity Report Card</b>	
<b>Community Engagement</b>	
Incorporates meaningful community involvement in practice leadership through a community/patient advisory committee or designated board position that is reflective of: <ul style="list-style-type: none"> <li>• community the healthcare systems serves or</li> <li>• the community where the healthcare system resides or</li> <li>• the demographics identified through the community needs assessment.</li> </ul>	
Marketing and educational materials use messaging that is linguistically and culturally appropriate for the community served.	
Contracts with or has formal and equitable partnership with community providers, community-based organizations, and/or faith-based organizations (when mutually appropriate and not harmful) for community engagement and/or patient navigation.	
Demonstrates the results of the community health needs assessments are used as a tool for program development through documented action plan tied to results.	
<b>Accessibility of Care and Social Determinants of Health</b>	
Facilitates access to government, commercial, or community-based non-emergency transportation services or financial support for public transportation where available.	
Collects social determinants of health data at intake and throughout the continuum of care. Population-level data collected (z-codes) helps to guide patient care and population-level health management as documented through the medical record or meeting notes.	
Offers flexible hours for screening and treatment appointments.	
Offers culturally and linguistically representative patient navigators or community health workers through internal hiring or contracting with community-based organizations.	
Establish a process to navigate patients with identified social needs to local and or national resources.	
Training is provided to staff on barriers to clinical trial participation and there are targeted efforts to reduce barriers to clinical trial participation through connection to appropriate services.	
<b>Addressing Bias in Care Delivery</b>	
Diversity, inclusion, and equity is embedded into the practice, institution, or health system policies (eg, recruitment, hiring, and promotion policies, resource allocation standards).	
Adopts measures related to the recruitment, retention, and promotion of minority researchers and practitioners.	
Implements health information technology or other workflow processes to identify critical moments in shared decision-making and care planning when disparate care can occur.	
Incorporates disparities and equity framework into quality improvement activities.	
Provides and requires annual implicit bias training for all employees.	
<b>Quality and Comprehensiveness of Care</b>	
When appropriate, patients are offered or referred to appropriate preventive and supportive care services (e.g. smoking cessation and weight management programs, reducing exposure to environmental hazards).	
Clinical trial options are discussed with all patients as documented through medical records.	
Offers culturally and linguistically representative patient navigators or community health workers through internal hiring or contracting with community-based organizations.	

**eFigure 1.** Institutional and Practice Equity Report Card.

ELEVATING CANCER EQUITY WORKING GROUP HEALTH EQUITY REPORT CARD

Proposed Scoring Methodology

Each section will be individually rated with a grade of Pass with Distinction, Pass, or Needs Improvement, based on a ratio of met/unmet points which will be indicated in parentheses (eg, [4 met/6 total]). The practice or institution will not receive an overall score but rather will receive a score in each of the following categories: **(1) Community Engagement, (2) Accessibility of Care and Social Determinants of Health, (3) Addressing Bias in Care Delivery, and (4) Quality and Comprehensiveness of Care.**

If a practice or institution is exempt from metrics within a category, the grading weights will be adjusted accordingly. Each metric within a domain is weighted equally using met or unmet. If only half of a requirement is met, the participant receives half the credit for that section. Scoring methodology for each section is as follows:

**Pass with Distinction:** 100% of possible total points awarded

**Pass:** 50%–99% of possible total points awarded

**Needs Improvement:** 0%–49% of possible total points awarded

**eFigure 2.** Proposed scoring methodology.

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## eAppendix 1. Elevating Cancer Equity Working Group Members

**Shonta Chambers, MSW,\*** Patient Advocate Foundation

**Robert Winn, MD,\*** VCU Massey Cancer Center

**Zeke Aguilera,** American Cancer Society Cancer Action Network (ACS CAN)

**Nadine Barrett, PhD,** Duke University School of Medicine

**Linda Burhansstipanov, DrPH, MSPH,** Native American Cancer Research Corporation

**Christina Chapman, MD, MS,** Michigan Medicine

**Moon Chen, MPH, PhD,** UC Davis Health

**Thomas Farrington,** Prostate Health Education Network

**Carmen Guerra, MD, MSCE,** Penn Abramson Cancer Center

**Chanita Hughes-Halbert, PhD,** Medical University of South Carolina

**Marjorie Kagawa Singer, PhD,** UCLA Fielding School of Public Health

**Mel Mann, MBA, MEd,** Patient Advocate

**Regina Martinez,** Volunteer, ACS CAN

**Kris Rhodes, MPH,** Retired Founding CEO, American Indian Cancer Foundation (Anishinaabe, Fond du Lac, and Bad River Band)

**Brian Rivers, PhD, MPH,** Cancer Health Equity Institute, Morehouse School of Medicine

**Gerren Wilson, PharmD,** Genentech

**Karen Winkfield, MD, PhD,** Meharry-Vanderbilt Alliance

\*Chair.