Advanced Practitioner Society for Hematology and Oncology
APSHO

FALL 2018

APSHO Advance

Songs for the Soul

The Use of Storytelling Through Music to Address Burnout

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FEATURE

And That's a Wrap! Scenes From JADPRO Live

By APSHO Staff

In sunny Hollywood, Florida, nearly 1,400 nurse practitioners, PAs, pharmacists, clinical nurse specialists, and other oncology professionals met this November at JADPRO Live 2018. Every year, the conference grows in both attendees and educational offerings, and there were even more opportunities to reconnect with old friends, make new acquaintances, and reaffirm the reason why we do what we do everyday. Let's roll the highlight reel on scenes from this past JADPRO Live.

Expansive Educational Offerings

This year's agenda featured an even larger array of educational sessions in a variety of formats: personalized pre-conference workshops, general sessions on evidence-based practice, and in-depth satellite symposia for which attendees could earn up to 21 CE credits/contact hours.

In addition, there were 22 poster presentations on topics ranging from quality-of-care initiatives to professional development projects. The Out-

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APSHO Advance

The *APSHO Advance* quarterly newsletter is published jointly by

Advanced Practitioner Society for Hematology and Oncology

Advanced Practitioner Society for Hematology and Oncology

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A Letter From the Editor

Happy fall, fellow APSHO Members! I hope this finds you well. Every year, I think JADPRO Live can't get any better, and yet it does. If you attended, I hope you enjoyed it, and if you couldn't make it this year, I hope you will join us in Seattle next year.

I want to draw your attention to a recent joint workgroup and publication in which APSHO was involved. APSHO, ASCO, APAO, AAPA, and ONS delegates collaborated for 2 years to produce, implement, and publish results of a survey on NPs and PAs in oncology. This study's goals were to identify oncology advanced practice providers and to understand the personal and practice characteristics of this group. You will find this article in the Sep/Oct 2018 issue of JADPRO on advancedpractitioner.com. It was also simultaneously published in the September 2018 issue of the *Journal of Oncology Practice* and has been published in the *Clinical Journal of Oncology Nursing* and the *Journal of the American Academy of PA*s.

There were several interesting findings from this study, not the least of which were the various and all-encompassing roles that we perform. Salary and benefit information, number of clinical visits per week, practice model, and more are discussed in this study. An attempt to quantify the number of NPs and PAs practicing in oncology proved difficult due to the fact that there is no national database for these practitioners, the relatively low survey response, and the fact that not all practitioners belong to a professional society. Using claims-based information was limited as payor policies on reimbursement of advanced practitioners vary. The best estimate from this study is that there are between 5,350 and 7,000 oncology NPs and PAs.

Check this study out and start a conversation about it! Talk to your colleagues, bring it up in a journal club, or comment on the APSHO blog or forum. ●

–Wendy H. Vogel, MSN, FNP, AOCNP®
Wellmont Cancer Institute

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Songs for the Soul: The Use of Storytelling Through Music to Address Burnout

By Carolyn Phillips, MSN, RN, ACNP-BC, AOCNP®

The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet…we burn out not because we don't care but because we don't grieve. (Remen, 2006)

The rates of compassion fatigue and burnout (CF/BO) among health-care professionals (HCPs) are rising at a time when the demand for these professionals is increasing (Gómez-Urquiza et al., 2016; Shanafelt et al., 2015; Wu, Singh-Carlson, Odell, Reynolds, & Su, 2016). More than half of US physicians and nurses are experiencing substantial symptoms, and a recent survey of nurses found that 18% had depression compared to the national prevalence of approximately 9% (Letvak, Ruhm, & Gupta, 2012).

Why Clinician Well-Being Is Important

Research and policy recommendations indicate that the well-being of HCPs has a direct impact on patient health outcomes (e.g., medical errors, infection rates, and mortality; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Cimiotti, Aiken, Sloane, & Wu, 2012; Salyers et al., 2016; West et al., 2006). In 2014, the report, "From Triple Aim to Quadruple Aim," was released, which noted that clinician burnout posed a threat for achieving the "Triple Aims," which sought to improve the US health care system by enhancing patient experience, improving population health, and reducing costs (Bodenheimer & Sinksy, 2014).

Last year, the National Academy of Medicine called for the well-being of HCPs to be a national priority because it poses a "significant threat to safe, high-quality care" (Dyrbye et al., 2017, p. 1). In oncology, where the rate of cancer survivors is projected to increase from 15.5 million to 26.1 million in the next 20 years (Bluethmann, Mariotto, & Rowland, 2016), nurses and advanced practice providers are at the forefront of care. Maintaining their well-being will be a crucial step to decreasing CF/BO, turnover, and ultimately providing a high quality of care to people with cancer.

Causes of Workplace Stress

There are numerous causes of workplace stress that contribute to CF/BO; however, in oncology, one potential cause is the grief that occurs with repeated patient loss. When caring for chronically ill patients, a number of situations arise that may cause HCPs to grieve (Gerow et al., 2010; Granek et al., 2017). Compounding the effects of repeated loss of life are the unique relationships that oncology professionals have with patients and their families. Patients are often treated for a number of years, and in this time a relationship forms between the HCPs, patients, and family (Gerow et al., 2010). This unique relationship provides the HCPs with a high sense of purpose and work that is life-affirming (Giarelli, Denigris, Fisher, Maley, & Nolan, 2016), but the impact of patient loss, when it occurs, is great.

Despite the frequent exposure to death, most HCPs are not taught in their educational programs or on the job how to attend to their own grief when patients die. While it is natural to feel grief with death, many studies have found that nurses use avoidance behaviors as a means of coping with patient loss (Kovács, Kovács, & Hegedüs, 2010; Papadatou, Martinson, & Chung, 2001; Saunders & Valente, 1994; Wenzel, Shaha, Klimmek, & Krumm, 2011). Unattended professional grief, especially in settings where it is repetitive, can have cumulative, adverse consequences to the professionals' physical, emotional, and spiritual health. In addition, it may also contribute to decreases in job satisfaction and patient satisfaction, and increases in the rates of burnout, compassion fatigue, and employee turnover (Gómez-Urquiza et al., 2016; Wu et al., 2016).

Storytelling Through Music

After working as an oncology nurse and advanced practitioner for 15 years, I burned out of a profession that I love. Accepting that I was burned out was incredibly hard, but I knew I had to accept that truth if I wanted to get better. In my search for healing, I began using storytelling through music. My experiences, as well as those of my colleagues, inspired me to create Songs for the Soul, a 501(c)(3) nonprofit organization that aims to support the well-being of society's professional caregivers through storytelling and music and to foster a culture that celebrates and sustains compassionate care.

The use of storytelling through music wasn't an immediate answer to my emotional exhaustion—it de-

veloped in two phases. First, I wrote about people for whom I had cared and my experiences with them. After I wrote a handful of caregiving stories, some of which arose from when I worked as a nursing assistant in college, I realized how many people had impacted my life. Every person I wrote about had died from cancer, and I realized that I had not grieved these losses. I handled their deaths the only way I know how to—I kept moving forward, burying those experiences deep within myself, until I stopped feeling normal emotions.

One of the stories I wrote was about the first person I cared for who had cancer. She was in her forties and had ovarian cancer. I was a young medical assistant when I cared for her, and my primary role was to provide her basic care. She was unconscious the majority of the time I cared for her. At some point, I had been told that hearing was the last sense to go as you die, so I made sure that I talked to her as I bathed her. I tried to normalize what I was doing for her—and probably for me, too. I treated her as if she were blind, not unconscious. I warned her when and where the wet cloth would touch her as I worked from head to toe.

As the days went on I continued my usual care. However, the night she died was different. Like I had done many times before, I stood next to her talking to her and swabbing her mouth. All of a sudden, she opened her eyes and we looked each other. She reached up and held my face in her hands, and said "Thank you." For the first time, I knew that my care had mattered.

This was my first death experience, for which I had no training. However, I knew my role that night was to stay strong for her family as they grieved. I hugged them and held their hands as they cried. I helped the nurse provide postmortem care on her body, and we placed her in a body bag.

After I cared for her family and paid my final respects with postmortem care, I went to the bathroom and cried. Then I freshened my face and went back to work. I cared for the rest of my patients that night like their experiences were all that mattered, and I refused to feel affected by the loss I had experienced hours earlier. I would continue this pattern of caring for others, but not myself, for the next 15 years until I had nothing left to give.

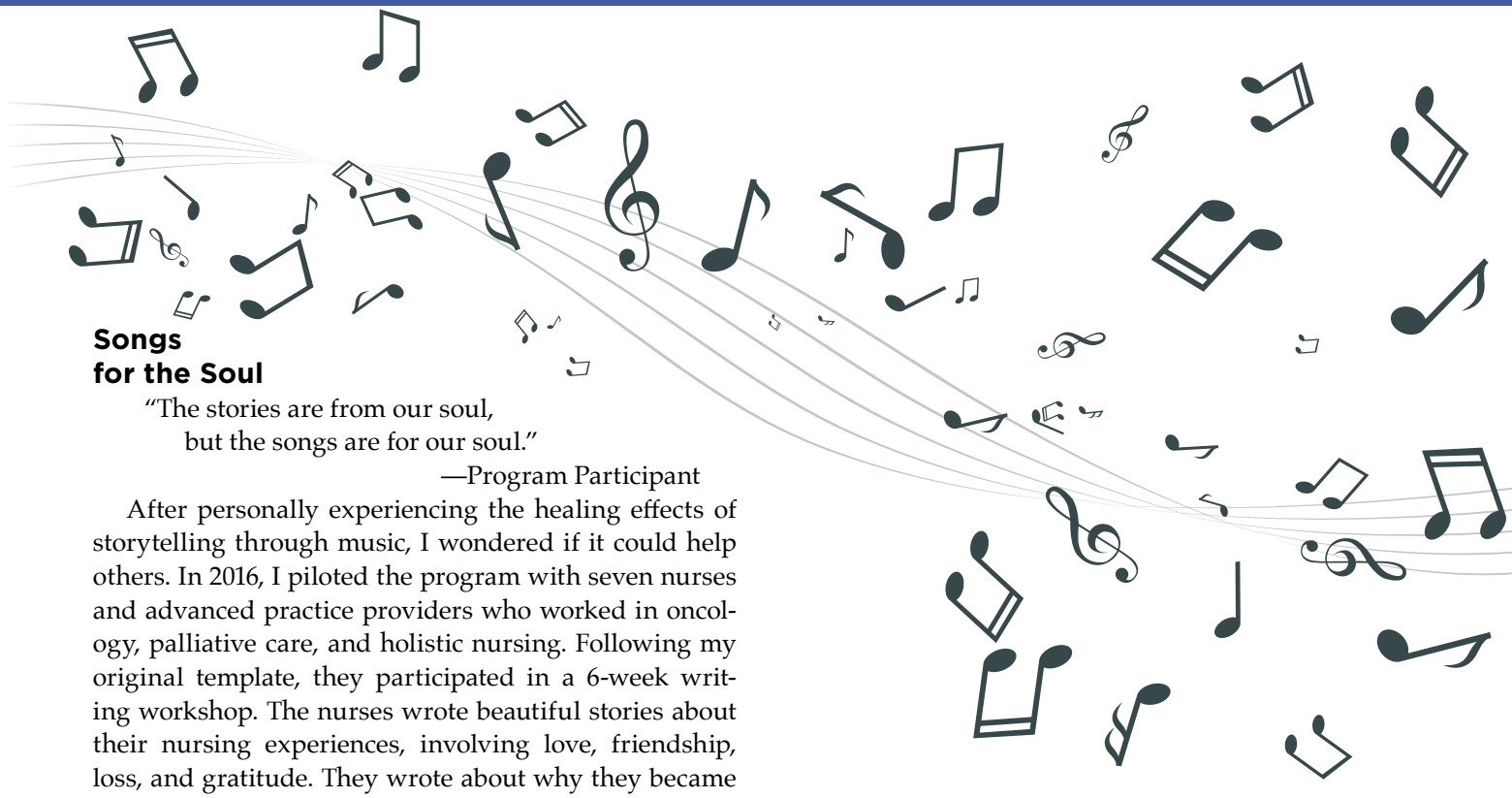
Writing my stories increased my awareness of the cause of my burnout, but it did not address my emotional healing. I still felt an emotional numbness. I craved a form of expression that would resonate deep enough to help me feel again. I wondered if putting my story to music would help me access the emotions in a way that prose had not. I hired a songwriter to turn my story into a song. And healing it was. I sang the words:

The last thing she touched I cannot erase
The feeling of her fingertips on my face
Oh, oh, oh you'll never know
Oh, oh, oh you'll never know
That I've been holding on to you

I cried for the first time in years. Even though I barely knew her, I had carried her with me, unknowingly, for a long time. The next few lines of the song somehow gave me permission to feel this grief:

And maybe I never really knew her
but still she rearranged me.
I was there to catch a bright light fading,
And that fading changed me.

It was through the use of song that I realized I had unattended grief. I had never been taught that I would have grief with patient loss, nor was I taught how to cope with this grief. I was taught to have strict boundaries so that patients would not affect me. My brain combined these two pieces of information and the result was shame. I felt ashamed by my emotions and buried them until I could no longer keep my emotions down. The combination of expressive writing and singing my story helped me move through the shame and the grief.



Songs for the Soul

"The stories are from our soul,
but the songs are for our soul."
—Program Participant

After personally experiencing the healing effects of storytelling through music, I wondered if it could help others. In 2016, I piloted the program with seven nurses and advanced practice providers who worked in oncology, palliative care, and holistic nursing. Following my original template, they participated in a 6-week writing workshop. The nurses wrote beautiful stories about their nursing experiences, involving love, friendship, loss, and gratitude. They wrote about why they became nurses, the losses they had experienced, their grief, and memorable patients. Many of their stories had not been shared for years and, sometimes, decades.

After they completed the stories, each participant met with a songwriter who incorporated their story into a song. The participants and the songwriters then performed their work for colleagues, close friends, and family members. In a small theater, each nurse read her nursing story, followed by the songwriter's performance of the nurse's song.

The stories and songs contained common themes: unattended grief; the balance between professional boundaries and deep human connections and relationships they had with their patients; the desire to provide care with an open heart, but without training for how to care for themselves while doing this; and that being vulnerable to each other was scary, but also strengthened them as individuals and as a team. They explained that the collective experience of writing and sharing their stories, and hearing their songs performed, honored their patients, imbued value into their work, and deepened their emotional healing. The nurses and advanced practice providers learned that they were not alone in experiencing grief.

Songs for the Soul creates a safe space for HCPs, including advanced practice providers, to share the emotional experience of caregiving and uses storytelling through music to create expressions that match the intensity of their caregiving. This fall, a rigorous quasi-experimental design study to evaluate the intervention outcomes will be carried out in central Texas. ●

Carolyn Phillips, MSN, RN, ACNP-BC, AOCNP®, *graduated with her Bachelor of Science in Nursing from the Johns Hopkins University School of Nursing in 2002 and received her Master of Science in Nursing from the University of New Mexico College of Nursing in 2011. In 2015, she received the Innovative Ideas in Healthcare Award from SVH Support in Santa Fe, New Mexico. Ms. Phillips used the grant funds to build the infrastructure for a Community Nursing Research Center at the community oncology clinic in Santa Fe. In addition, she piloted her program idea, Songs for the Soul, with a group of seven courageous nurses in New Mexico. Currently, Ms. Phillips is a PhD student at the University of Texas-Austin, School of Nursing, and is a Robert Wood Johnson Foundation Future of Nursing Scholar. Her current research focuses on professional grief, the impact on the care-giver and care-receiver, and interventions aimed to help healthcare professionals process the grief and suffering they see in their work in order to prevent burnout and compassion fatigue.*

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standing Poster Award was given to Andrew S. Guinigundo, MSN, RN, CNP, ANP-BC, Molly Mendenhall, BSN, RN, Teresa Meyer-Smith, BSN, RN, Amy Sheldrick, RN, BSN, OCN®, Karyn Dyehouse, MD, and David M. Waterhouse, MD, MPH from Oncology Hematology Care (OHC) Cincinnati for their poster, "JL 617. Strategies Supporting Reduced Hospitalization Rates in a Successful OCM Practice: The Pivotal Role of the Advanced Practice Provider." To view the posters that were displayed, visit jadprolive.com

Back by popular demand, BCOP credits were available for 6 sessions. Pharmacist colleagues educated attendees on important topics such as all the recent hematology and oncology drug approvals from the past year, new directions in myeloid malignancies, and preventing venous thrombosis.

SMARTIEs Take the Stage

This year marked the third year of the educational program, SMARTIE (Study to Measure Advanced Practitioner Retention of Targeted Information and Education), designed to assess the impact of the education presented at the conference and how attendees have incorporated the information learned at the meeting into their practices. The SMARTIE program was in full swing yet again, with around 150 participants.

For more information about applying to be a part of the SMARTIE program in 2019, go to advancedpractitioner.com/smartie.

Keynote Presentation and Mary Pazdur Award

JADPRO Live welcomed a pioneer in hospice and palliative medicine, Charles F. von Gunten, MD, PhD, FACP, FAAHPM, to speak on integrating palliative care into cancer care; specifically, the role of the advanced practitioner in a team approach to palliative care. In his riveting talk, Dr. von Gunten demonstrated with filmed patient interviews and hard data that integrating palliative care earlier in the cancer care setting improves outcomes.

After the keynote address, John A. Gentile, Jr., Chairman of Harborside, and Tina Harris, MS, NP-C, AOCNP®, Chair of the APSHO Awards Committee, awarded Jeannine M. Brant, PhD, APRN, AOCN®, with the inaugural 2018 Mary Pazdur Award for Excellence in Advanced Practice in Oncology. Dr. Brant is an oncology clinical nurse specialist, pain consultant, palliative care team member, and nurse scientist at the Billings Clinic in Montana. She is also an Associate Editor for JADPRO.

The award is in honor of Mary Pazdur, who was a nurse practitioner known for her passionate advocacy for her patients and her fellow *Continued on page 11*

New at JADPRO Live! Bedside Stories: True Tales From a Lifetime of Caring

On Saturday night, the storytelling session at JADPRO Live, "Bedside Stories: True Tales from a Lifetime of Caring," debuted. There were tears, laughter, and applause for the storytellers as they recounted personal stories about events that shaped their journey as advanced practitioners.

First was Heather Lewin, APRN, an adult nurse practitioner at Florida Cancer Specialists. Heather took the audience through her journey up to Everest base camp and what motivated her to climb it in the first place. She spoke about how she realized one day that she wanted to tackle her bucket list of places to travel and learn how to face her fears, both inside and outside of the practice setting.

Second was Deborah Skojac, RN, MS, AOCN®, who has been an advanced practice nurse since 1992. Deborah described her battle with thymus cancer and the choice to be treated alongside her patients in the same facility where she worked. She emphasized that trust in her team and not the internet was paramount, and how rewarding an experience it was to share her journey with her team and patients.

Then, Tina Harris, MS, NP-C, AOCNP®, shared her story. Tina took the audience through a whirlwind she went through that stemmed from one administrative error, before becoming the first nurse practitioner to cross over from the Medical Oncology team to join the Radiation Oncology team in Tennessee Oncology in Chattanooga. She expressed how oncology is her first love, but after a clerical error to renew her certification, traveled on a different path where she continued her passion for caring for patients, albeit in a different setting than she had expected. In the end, she stayed persistent and determined, and achieved what she always wanted to be.

Debra Solom, ANP-BC, who has been an oncology nurse practitioner since 2002 and practices in St. Louis, Missouri, at SSM Health Cancer Care, described the experience of receiving a breast cancer diagnosis while at JADPRO Live last year and the many lessons she learned, including how everyone reacts differently to treatments, hair is not really a big deal if you make it fun (think colorful wigs!), and the importance of gratitude and enjoying life while you can.

Lastly, Kristin M. Daly, MSN, ANP-BC, AOCNP®, an oncology nurse practitioner at Siteman Cancer Center at Washington University School of Medicine, closed the night with her story as a mother caring for a child with cancer. She described coming to terms with the fact that while a mother's instinct is to protect her child, she had to accompany her child to cancer treatments that often included painful and frightening procedures. In the end, her child understood that the unpleasant things she helped him through were a testament to the love she has for him. ●

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advanced practitioners. In fact, Mary was one of the earliest advocates for the creation of JADPRO, the official journal of APSHO. The recipient of the award is an APSHO member who embodies Mary's philosophy in his/her interactions with patients and colleagues in the field of oncology care. For more information about the award and how to nominate someone, please visit marypazduraward.com.

APSHO Committee Meetings

In conjunction with JADPRO Live, the APSHO annual member meeting was held. Chairs of each committee gave status reports on the progress their committees made and members shared their thoughts about future directions. Members of the Education, Membership, Communications, and newly formed Awards and Recognition Committees met separately to discuss initiatives from 2018, further refine their roles, and strategize for how to best fulfill the goals of their committees in 2019.

Finally, the membership bid goodbye to Pamela Hallquist Viale, RN, MS, CNS, ANP, President and founding board member, Christopher J. Campen, PharmD, BCOP, Executive Vice President and founding board member, and Paige M. Goforth, MMS, PA-C, Director. They served for several years on the Board and their leadership propelled APSHO forward to where it is today. Read about your new board members from the recent election on page 14.

Time for Sand and Sun

Although the schedule was packed with educational events, attendees had time during breaks and in the evening to relax by the pool or the beach and meet up with colleagues and friends. Thursday night's welcome reception by the beach featured a virtual reality experience, a chance to win an Amazon Fire TV Cube for attendees who participated in Quick Collaborations, and local seafood.

In the Exhibit Hall, several meet and greets were held at the APSHO booth. Attendees were encouraged to visit to meet with board members and committee chairs.

Fancy a Cup of Coffee?

While this year's JADPRO Live conference was all about enjoying good weather and a beachy backdrop, next year attendees can look forward to museums, shopping, and delicious meals in metropolitan Seattle. Planning is underway for next year's JADPRO Live, which will be held October 24 to 27, 2019. Visit jadprolive.com to join the mailing list to be notified about registration, and don't forget to save the date! ●

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Top 10 Reasons to Get Involved With the APSHO Blog

By APSHO Staff

Have you checked out the APSHO community blog recently? It's one of the hallmarks of the APSHO online community, where you can discuss relevant issues affecting advanced practice. There are many reasons to read and contribute to the blog; here are just a few.

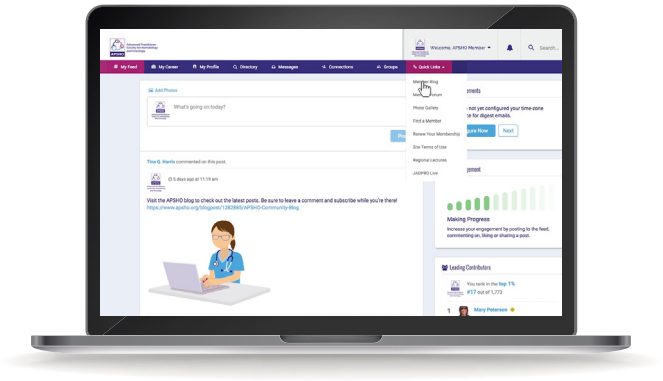
1. **Keep your finger on the pulse of trending issues in oncology/hematology advanced practice**
   The APSHO blog is regularly updated with new posts on important issues affecting advanced practice. Recent topics have included the importance of palliative care, marketing by the tobacco industry, and oral chemotherapy education.

2. **Engage in solving real-world problems fellow advanced practitioners around the country are dealing with**
   Not only can you learn about practical issues that advanced practitioners in different practice settings are wrestling with, you may read about an issue that you yourself may be struggling with. For example, a post on adapting to the Oncology Care Model brings up a particular challenge of getting the EMR to run the reports they need to report on quality measures.

3. **Write about what you care about**
   Have a topic you're passionate about that hasn't been addressed yet in the blog? The APSHO blog is a great place to practice your writing skills and foray into the world of blogging.

4. **Get the inside scoop on APSHO happenings**
   You'll get the insider details on things like how to prepare for your trip to JADPRO Live and how the conference educational program, SMARTIE, was created.

5. **Meet new people with similar interests**
   By commenting on past posts or submitting your own blog post, you'll stimulate conversation and ideas.



6. **Have a support system**
   All of your fellow APSHO members are committed to improving patient care through evidence-based practice. Take part in a supportive network of advanced practitioners that spans the country.

7. **Crowdsource ideas**
   Tap into the vast experience and knowledge of the APSHO membership base.

8. **Make your voice heard**
   In a similar vein, get your voice heard by engaging in existing posts or initiating your own discussion.

9. **Get professional development tips**
   Recent topics have included steps to market yourself and your abilities, and dealing with stress.

10. **Help others**
    Your knowledge and advice can be very helpful for other advanced practitioners, both new and seasoned clinicians. Providing valuable information is one of the greatest benefits of a blog.

See https://www.apsho.org/engageonline for more information on getting started. Interested in submitting a post? Check out the submission page at https://www.apsho.org/blogsubmission ●

Meet Your New Board Members!

This past fall, you voted for five open Director positions on APSHO's Board of Directors, in accordance with APSHO bylaws.

We're excited to introduce three new members to the APSHO Board of Directors and announce two board members who have been re-elected. We can't wait to get to work and make APSHO an even better place!

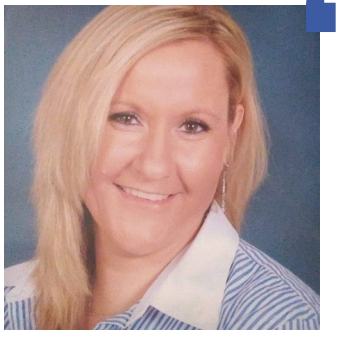
Please join us in congratulating and welcoming APSHO's three newest board members.

"In my several years working with APPs and pharmacists in the community oncology setting, I have found that APSHO has been an invaluable partner and resource. In my current role as the director of APP services, it is vitally important to me that the APPs I represent have access to quality education in multiple modalities, current research, and up-to-date clinical updates, and most importantly, a voice in the oncology arena.

Jason Astrin, PA-C, MBA, DFAAPA
The US Oncology Network

"I have been overwhelmed by the passion of APSHO members, which continues to be shared by such a great group of people. The vision of collaboration among us all as a team and providing high-quality care, from the education to the networking we receive from APSHO, is why we are the greatest. I want everyone to know how fulfilling it is to be a part of APSHO, and how proud I am of this society.

Tina Harris, MS, NP-C, AOCNP®
Tennessee Oncology



"I have been an active participant and member since the inaugural year. I believe in the mission of APSHO, and I believe that the group does excellent work advancing science and our professions.

Kelly Young, DNP, ANP-C, AOCN®
Duke University Cancer Institute

And join us in congratulating your two re-elected board members.

I love staying actively involved in APSHO and serving as one of your Board of Directors. I look forward to continuing to uphold the mission of APSHO and to promote collaboration between the different disciplines within the organization.

Megan May, PharmD, BCOP
Baptist Health Lexington

Over the past few years I've been honored to sit on the APSHO Board and watch it grow and impact the lives of APs across the nation. I look forward to participating over the next few years serving our members while working to expand APSHO's reach and educational programs within the oncology communities we strive to serve.

Mary E. Peterson, MS, ANP-BC, AOCNP®
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Making Evidence-Based Practice Come Alive for Oncology Advanced Care Practitioners

By Barbara Wenger, DNP, RN, AOCNS®, CRNI, and Regina M. Fink, PhD, APRN, AOCN®, CHPN, FAAN

Over the past decade, evidence-based practice (EBP) has evolved as a way to change the care oncology patients receive and the work environment of advanced care practitioners (ACPs). While there are multiple definitions of EBP, for the purposes of this article, EBP is defined as discovering the best and most up-to-date evidence, critically appraising and synthesizing it, integrating it with clinical experience and patients' values and preferences, applying the results to clinical practice, and continually evaluating the effectiveness of the practice change (Melnyk, Fineout-Overholt, Stillwell, & Williamson, 2010).

Basing oncology care on the best and current evidence promotes inquiry and reflection, emphasizes life-long learning, and facilitates professionalism. Incorporating best evidence into decisions about patient care can also positively impact patient outcomes. The advanced practitioner leader as a clinical nurse specialist, nurse practitioner, nurse scientist, nurse manager, nurse educator, physician assistant, or pharmacist, mentors practitioners to help build these skills bringing evidence to the bedside.

The Colorado Model

Multiple EBP models are available to provide a framework to guide ACPs and organizations to implement EBP policies, projects, and guidelines based on evidence (Rycroft-Malone & Bucknall, 2010). One of these includes the Colorado Patient-Centered Interprofessional EBP Model to guide the use of evidence (research and non-research) and incorporate a patient-centered approach to provide evidence-based care (Goode, Fink, Krugman, Oman, & Traditi, 2011). The Colorado Model (Figure 1) is framed by four concepts crucial to entrenching research and evidence in practice: organizational support, leadership, mentorship, and facilitation.

Having the *organizational support* from hospital *leadership* to participate in research and EBP projects and use the model in examining the evidence is key to facilitating EBP. *Facilitation* involves engaging key stakeholders, being placed on unit/department agendas, knowing what committees and/or councils need to have an opportunity for input, and providing support for project completion.

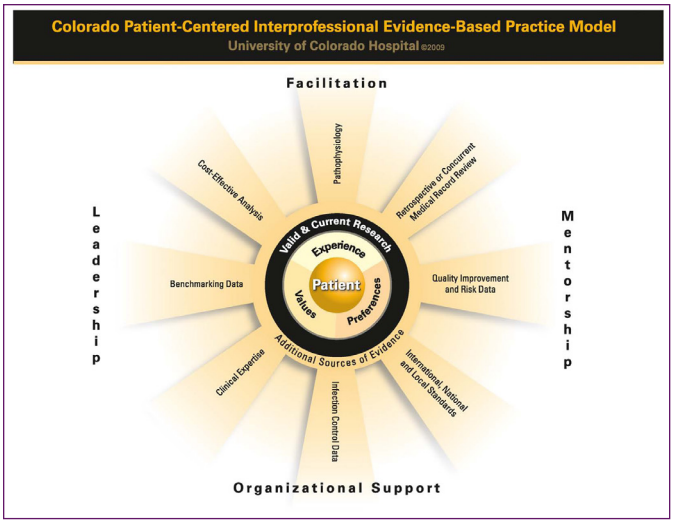

Figure 1. The Colorado Model.

Mentorship is integral to ACPs when they learn about EBP and implement a practice change in their care areas. Research nurse scientists and advance practitioners provide day-to-day support for staff working on projects in regards to implementation, completion, and evaluation.

In the Colorado Model, the strongest evidence comes from valid and current research. In addition, the practitioner must also assess the patient's values, preferences, and experiences, incorporating their beliefs into any plan of care. When research evidence is limited, the practitioner should augment the evidence from one or more of the non-research evidence sources attached to the research core: pathophysiology, retrospective or concurrent chart review, quality and risk data, standards, infection control data, clinical expertise, benchmarking data, and cost-effectiveness analysis. All evidence sources are connected, indicating that evidence from any of the sources forms the evidence base. If there is no available evidence from any of these resources, the opportunity exists to conduct research to answer the specific inquiry.

Dissemination

Once the research, EBP, quality improvement, or program evaluation project has been completed, the work does not

end. As health-care professionals, there is a responsibility to disseminate the findings. This may include either institutional grand rounds, local presentations, or even professional organization podium and poster presentations.

Anyone who has published an article can understand the agony and ecstasy associated with manuscript preparation. Mentorship in this area is key for the novice. Practitioners can find experts at their respective institutions or reach out to those in various publications such as the *Journal of the Advanced Practitioner in Oncology* for the appropriate guidance.

Journal clubs are another valuable technique to evaluate current research-based evidence for scientific merit and use in practice. Although some interpret research articles with trepidation, journal clubs serve to narrow the research-practice gap by providing a friendly learning environment to discuss and determine if findings should be implemented into professional practice. Journal clubs not only improve professional reading habits, but they foster collegiality, interprofessional collaboration, and ultimately, promote positive patient outcomes. From current journal topics to future inquiry, many practice changes have occurred based on a journal club discussion.

What's the Bottom-Line Message?

The process of leading, mentoring, facilitating, and encouraging ACPs to use evidence in practice is both an opportunity and journey that takes time. The rewards are many, not only for advanced practitioners but for those who are mentors, in the oncology profession, the healthcare organization as a whole, and patients, as outcomes and patient safety are improved. Formal and informal leaders—for example, ACP leaders—have the potential to engage others in achieving practice based on evidence. Their expert mentoring and caring can make a difference to health-care practitioners and patients. It is important for ACPs to examine their particular settings to identify and reach out to potential mentors. Our patients' care depends on it. ●

Dr. Wenger practices at the Oncology/BMT/Gynecologic Oncology Inpatient Unit at the University of Colorado Hospital in Aurora, Colorado. Dr. Fink is Associate Professor at the University of Colorado College of Nursing and School of Medicine and is the Co-Director of Interprofessional Master of Science Palliative Care and Certificate Programs in Aurora, Colorado.

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Goode, C. J., Fink, R. M., Krugman, M., Oman, K. S., & Traditi, L. K. (2011). The Colorado patient-centered interprofessional evidence-based practice model: A framework for transformation. *Worldviews on Evidence-Based Nursing, 8*(2), 96–105.

Melnyk, B. M., Fineout-Overholt, E., Stillwell, S. B., & Williamson, K. M. (2010). Evidence-based practice: Step by step: The seven steps of evidence-based practice. *American Journal of Nursing*, *110*(1), 51–53. https://doi.org/10.1097/01.NAJ.0000366056.06605.d2

Rycroft-Malone, J., & Bucknall, T. (2010). *Models and frameworks for implementing evidence-based practice: Linking evidence to action*. Malden, MA: Wiley-Blackwell & Sigma Theta Tau International.

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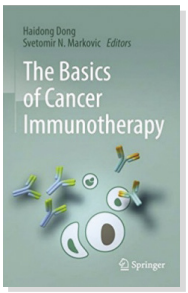
Section Editor: Deborah Rust

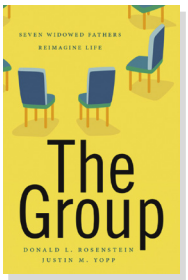
While beach reads are fun to enjoy in the summer, fall is a great time for literature that makes you reevaluate what you know. This Book Corner has some interesting reads about clinically relevant topics related to immunotherapy, grief, and a fight for social justice. We love hearing your recommendations for future Book Corner columns.



The Basics of Cancer Immunotherapy

By Haidong Dong and Svetomir N. Markovic (Springer, 2018)

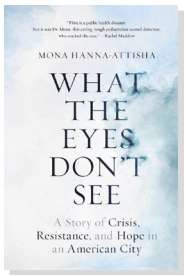
This book provides a clear and concise introduction to immunotherapy, a cancer therapy that acts by boosting the patient's own immune system to fight cancer. It informs about the benefits and risks of the therapy and how it can control patients' unique diseases. Researchers and academic professionals will find this book to be filled with clear and useful information to help them communicate with patients or address unresolved problems.



The Group: Seven Widowed Fathers Reimagine Life

By Donald L. Rosenstein and Justin M. Yopp (Oxford University Press, 2017)

A group of fathers gathers around a conference table and meet each other for the first time. None of the men had ever thought of himself as someone who would go to a support group and each felt entirely out of place. In fact, nothing about their lives felt normal anymore. This book chronicles the challenges and triumphs of seven men whose wives died from cancer and were left to raise their young children entirely on their own.



What The Eyes Don't See: A Story of Crisis, Resistance, and Hope in an American City

By Mona Hanna-Attisha (One World, 2018)

From a crusading physician who rallied a community and brought the fight for justice, comes a powerful firsthand account of the Flint water crisis. Dr. Mona Hanna-Attisha, a pediatrician at the city's public hospital, was a factor in turning the crisis into a transformative movement for change. This movement brought the fight to citizens to advocate for action and justice and gained national attention. This book captures a timely and essential story of how communities can come together to fight for social justice, even in opposition to their own governments.

Section Editor: Mary Peterson

An interview with
Elise Carper, MA, RN, ANP, AOCN®

Dell Seton Medical Center at The University of Texas • *Austin, Texas*

In this issue's Member Profile, meet Elise Carper, MA, RN, ANP, AOCN®, who was one of the first oncology certified nurses in the early 80s in the US. Elise was a nurse practitioner in the oncology sphere for many years and now enjoys a new role in palliative care. Hear from Elise about the most rewarding parts of her role, whether it's symptom management or educating colleagues on early palliative care intervention, and how APSHO helps her stay connected to the oncology world to provide up-to-date care to her patients.

What is your role as a nurse practitioner at Dell Seton Medical Center at The University of Texas?

I work as a palliative care nurse practitioner (NP) at an urban, level 1 trauma center, 210+ bed teaching hospital.

How might your role differ from the inpatient vs. outpatient setting?

Currently, our program has an outpatient component only for patients with cancer and is staffed by a physician. However, plans to broaden the scope of our outpatient program are in the works and I hope to be part of these increased services.

What is your educational/training background and certification?

I received my Diploma in Nursing in 1981 in Madison, Wisconsin, my Bachelor of Science in Nursing in 1994 from Columbia University in New York City, New York, and my Master of Arts in Nursing in 1997 from New York University. I was one of the first oncology certified nurses (OCNs) in the early 80s, and obtained my Advanced Oncology Certified Nurse (AOCN®) certification in the late 90s. I obtained my Advanced Certified Hospice and Palliative Nurse (ACHPN) certification in 2017.

What are the most satisfying parts of your role?

The majority of my career as an NP was spent in radiation oncology, caring for folks dealing with head and neck cancer. I felt then, and continue to feel, that they are some of the bravest people I've ever worked with. I continue to care for these patients today, although toward the end of their struggles, and they continue to amaze me. Providing emotional support to patients dealing with life-limiting illnesses is a core palliative care function, but I find my patients provide more to me than I ever could to them. Learning to live one day at a time, to prioritize people, not the job or "dollar success," and to search for quality of life is a lesson for us all.

My current position has brought together all of my most-loved functions as a long-time oncology nurse. Every day I meet and help patients and families dealing with difficult, sometimes painful diagnoses, and making life and death decisions in a teaching hospital with multiple teams assisting in their care. I help with advance care planning (designating medical power of attorney, code status directives, etc.), symptom management (using my expertise with pain, nausea, and anorexia management in evaluating and treating pain in those with substance use disorder), and ensuring clear communication between physicians, patients, and their families.

How do you see your role changing in the future?

With the expansion of outpatient services, I hope to do more symptom management, which I believe is one of my strengths and something I enjoy very much.

What are some challenges you face?

I'm no longer directly in the oncology world, and it's been a long time since I administered chemotherapy! Cancer treatment is changing rapidly. Keeping current with new

cancer therapies is essential so I can appropriately guide and support patients undergoing treatment for cancer.

Do your colleagues understand your role?

The whole notion of integrating palliative care early into the treatment of life-limiting illnesses is still new. Ours is a teaching hospital, and informing and demonstrating the value of palliative care to new physicians, PAs, and APNs is ongoing and something I enjoy doing. I've always enjoyed educating "new docs" on the value of nursing, and my current role requires this daily.

What are the strengths of APSHO?

Being a member of APSHO allows me to still connect with other oncology APNs although I am no longer directly in the oncology world. I am able to get the information I need to stay current on cancer treatments by reading the *Journal of the Advanced Practitioner in Oncology* (JADPRO). I've not yet been to the annual conference but hope to do so soon and look forward to meeting other oncology-loving NPs!

What else would you like the readers to know about you?

While working as a nurse practitioner in radiation oncology in New York City, I had the great honor to meet and care for John (Jack) A. Gentile, Jr., the Chairman of Harborside, during his cancer treatment journey. He has honored me and other APNs who cared for him then by founding this wonderful organization and the JADPRO journal. These venues provide us with a "meeting place" and the educational content we need to do our best. I admired his immense bravery back then and am very grateful to Jack now! ●

Priming the Pump: An APSHO Educational Initiative

Understanding the Role of Targets and Pathways in the Treatment of Melanoma

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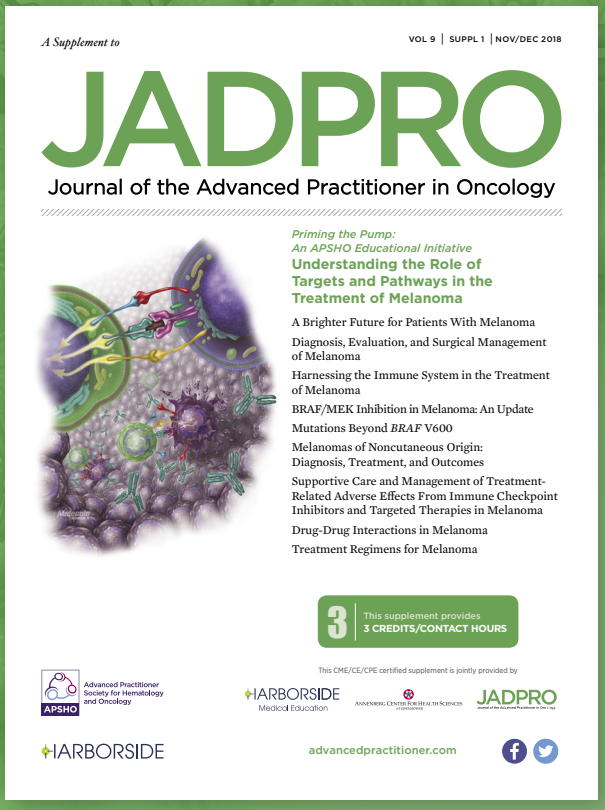

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JADPRO would like to acknowledge the APSHO Education Committee Priming the Pump Task Force for their dedication and commitment to this important resource for advanced practitioners.

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JADPRO Journal of the Advanced Practitioner in Oncology

Advanced Practitioners in the Literature

Advanced practitioners (APs) in oncology are not only becoming more abundant, but their contributions to the oncology literature are growing as well. From supportive care to roles in clinical trials, APs are making a impact. Here are a few selected articles written by or about oncology APs that we believe will enrich your knowledge and practice.

Delivery of Gynecologic Oncology Care: Optimizing Scope of Advanced Practice Providers to Enhance Patient Care: A Society of Gynecologic Oncology Position Paper
By Joanne K. Rash, Karen D. Lyle, Arati Jairam-Thodla, and Yevgeniya Ioffe
Gynecologic Oncology. https://doi.org/10.1016/j.ygyno.2018.09.018
In press

Investigating the Association Between Advanced Practice Providers and Chemotherapy-Related Adverse Events in Women With Breast Cancer: A Nested Case-Control Study
By Tina W. F. Yen, Ann B. Nattinger, Emily L. McGinley, Nicole Fergestrom, Liliana E. Pezzin, and Purushottam W. Laud
Journal of Oncology Practice, 14(11), e644–e652. https://doi.org/10.1200/JOP.18.00277
Published online on October 10, 2018

Oncology Clinicians and the Minnesota Medical Cannabis Program: A Survey on Medical Cannabis Practice Patterns, Barriers to Enrollment, and Educational Needs
By Dylan Zylla, Grant Steele, Justin Eklund, Jeanne Mettner, and Tom Arneson
Cannabis and Cannabinoid Research, 3(1). https://doi.org/10.1089/can.2018.0029
Published online on October 6, 2018

Role of Advanced Nurse Practitioners in the Care Pathway for Children Diagnosed With Leukemia
By Maryline Bovero, Cristiano Giacomo, Marc Ansari, and Marie-José Roulin
European Journal of Oncology Nursing, 36, 68–74. https://doi.org/10.1016/j.ejon.2018.08.002
Published online on August 25, 2018

Practice Model for Advanced Practice Providers in Oncology
By Jamie Cairo, Mary Ann Muzi, Deanna Ficke, Shaunta Ford-Pierce, Katrina Goetzke, Diane Stumvoll, Laurie Williams, and Federico A. Sanchez
2017 ASCO Educational Book. https://doi.org/10.14694/EDBK_175577
Presented at the 2017 ASCO Annual Meeting on June 5, 2017

NEWLY APPROVED HEMATOLOGY/ONCOLOGY DRUGS

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Azedra (*iobenguane I 131*); Progenics Pharmaceuticals, Inc.; for adult and pediatric patients (12 years and older) with iobenguane scan-positive, unresectable, locally advanced or metastatic pheochromocytoma or paraganglioma who require systemic anticancer therapy (July 2018)

Keytruda (*pembrolizumab*); Merck & Co., Inc.; for patients with hepatocellular carcinoma who have been previously treated with sorafenib (accelerated approval; November 2018)

Keytruda (*pembrolizumab*); Merck & Co. Inc.; in combination with carboplatin and either paclitaxel or nab-paclitaxel as first-line treatment of metastatic squamous NSCLC (October 2018)

Keytruda (*pembrolizumab*); Merck & Co., Inc.; in combination with pemetrexed and platinum as first-line treatment of patients with metastatic, nonsquamous NSCLC, with no *EGFR* or *ALK* genomic tumor aberrations (August 2018)

Keytruda (*pembrolizumab*) and **Tecentriq** (*atezolizumab*); prescribing information updated to require the use of an FDA-approved companion diagnostic test to determine PD-L1 levels in tumor tissue from patients with locally advanced or metastatic urothelial cancer who are cisplatin-ineligible (August 2018)

Kisqali (*ribociclib*); Novartis Pharmaceuticals Corporation; expanded the indication in combination with an aromatase inhibitor for pre/perimenopausal women with HR-positive, HER2-negative advanced or metastatic breast cancer, as initial endocrine-based therapy; also approved ribociclib in combination with fulvestrant for postmenopausal women with HR-positive, HER2-negative advanced or metastatic breast cancer, as initial endocrine-based therapy or following disease progression on endocrine therapy (July 2018)

Lenvima (*lenvatinib*); Eisai Inc.; for first-line treatment of patients with unresectable hepatocellular carcinoma (August 2018)

Libtayo (*cemiplimab-rwlc*); Regeneron Pharmaceuticals Inc.; for patients with metastatic cutaneous squamous cell carcinoma (CSCC) or locally advanced CSCC who are not candidates for curative surgery or curative radiation (September 2018)

Lorbrena (*lorlatinib*); Pfizer, Inc.; for patients with *ALK*-positive metastatic NSCLC whose disease has progressed on crizotinib and at least one other ALK inhibitor for metastatic disease or whose disease has progressed on alectinib or ceritinib as the first ALK inhibitor therapy for metastatic disease (accelerated approval; November 2018)

Opdivo (*nivolumab*); Bristol-Myers Squibb Company Inc.; for patients with metastatic small cell lung cancer with progression after platinum-based chemotherapy and at least one other line of therapy (accelerated approval; August 2018)

Talzenna (*talazoparib*); Pfizer Inc.; a PARP inhibitor, for patients with deleterious or suspected deleterious germline BRCA-mutated, HER2-negative locally advanced or metastatic breast cancer. Must be selected for therapy based on an FDA-approved companion diagnostic (October 2018)

Vizimpro (*dacomitinib*); Pfizer Pharmaceutical Company; for the first-line treatment of patients with metastatic NSCLC with EGFR exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test (September 2018)

Xtandi (*enzalutamide*); Astellas Pharma US, Inc.; for patients with castration-resistant prostate cancer (July 2018)

HEMATOLOGY

Adcetris (*brentuximab vedotin*); Seattle Genetics Inc.; in combination with chemotherapy for previously untreated systemic anaplastic large cell lymphoma or other CD30-expressing peripheral T-cell lymphomas (November 2018)

Copiktra (*duvelisib*); Verastem, Inc.; for adult patients with relapsed or refractory chronic lymphocytic leukemia or small lymphocytic lymphoma after at least two prior therapies. In addition, accelerated approval for adult patients with relapsed or refractory follicular lymphoma after at least two prior systemic therapies (September 2018)

Daurismo (*glasdegib*); Pfizer Labs; in combination with low-dose cytarabine for newly diagnosed acute myeloid leukemia in patients who are 75 years old or older or who have comorbidities that preclude intensive induction chemotherapy (November 2018)

Lumoxiti (*moxetumomab pasudotox-tdfk*); AstraZeneca Pharmaceuticals LP; a CD22-directed cytotoxin indicated for adult patients with relapsed or refractory hairy cell leukemia who received at least two prior systemic therapies, including treatment with a purine nucleoside analog (September 2018)

Mulpleta (*lusutrombopag*); Shionogi Inc; for thrombocytopenia in adults with chronic liver disease who are scheduled to undergo a medical or dental procedure (July 2018)

Poteligeo (*mogamulizumab-kpkc*); Kyowa Kirin, Inc.; for adult patients with relapsed or refractory mycosis fungoides or Sézary syndrome after at least one prior systemic therapy (August 2018)

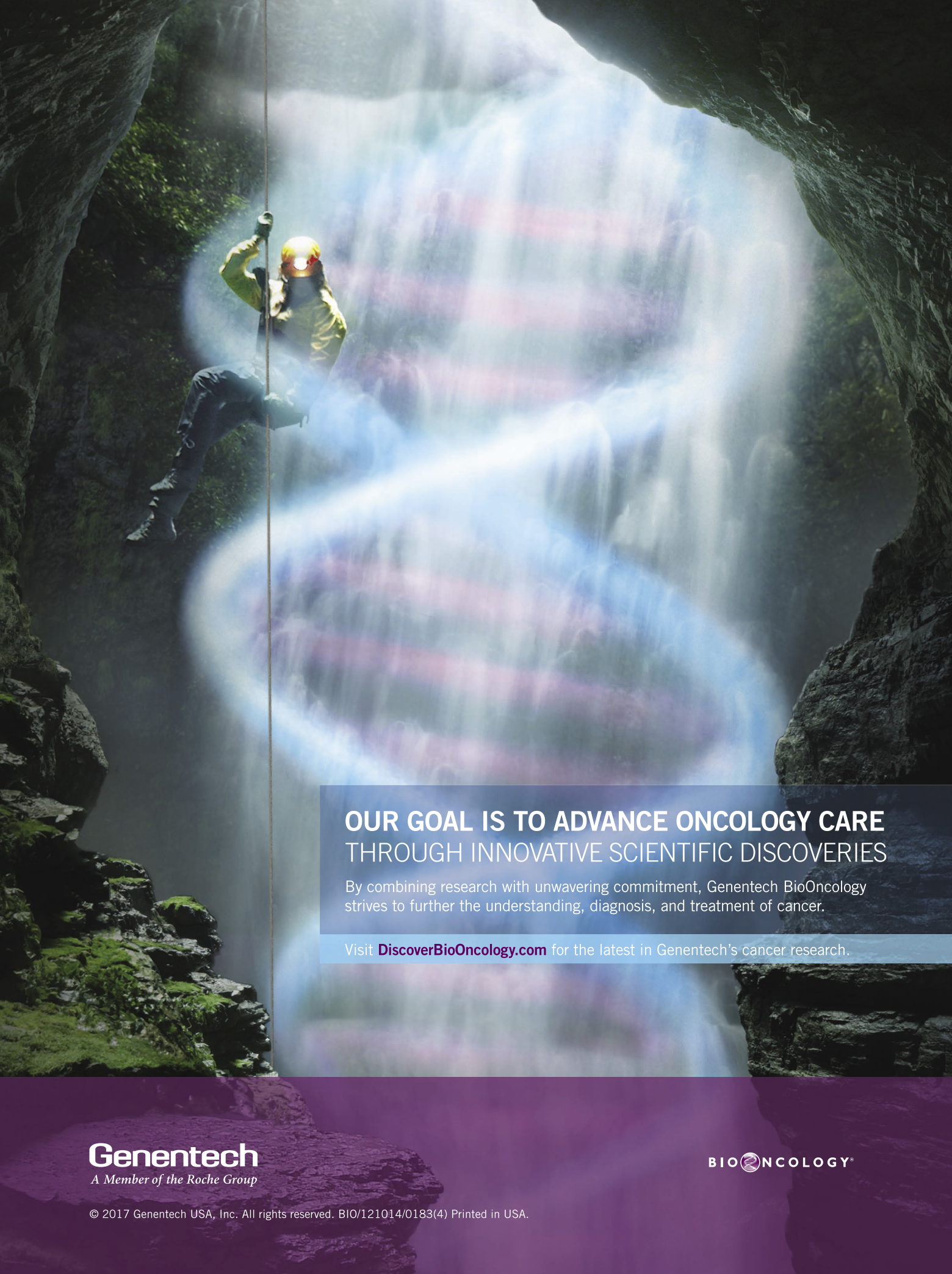
Tibsovo (*ivosidenib*); Agios Pharmaceuticals, Inc.; for adult patients with relapsed or refractory acute myeloid leukemia with a susceptible *IDH1* mutation as detected by an FDA-approved test (July 2018)

Venclexta (*venetoclax*); AbbVie Inc. and Genentech Inc.; in combination with azacitidine or decitabine or low-dose cytarabine for the treatment of newly-diagnosed acute myeloid leukemia in adults who are age 75 years or older, or who have comorbidities that preclude use of intensive induction chemotherapy (accelerated approval; November 2018)

LABORATORY APPROVAL

Dako PD-L1 IHC 22C3 PharmDx Assay; Dako North America, Inc; as a companion diagnostic to select patients with locally advanced or metastatic urothelial carcinoma who are cisplatin-ineligible for treatment with Keytruda. The 22C3 assay determines PD-L1 expression by using a combined positive score (CPS) assessing PD-L1 staining in tumor and immune cells (August 2018)

Ventana PD-L1 (SP142) Assay®; Ventana Medical Systems, Inc.; as a companion diagnostic test to select patients with locally advanced or metastatic urothelial carcinoma who are cisplatin-ineligible for treatment with Tecentriq**.** The SP142 assay determines PD-L1 expression in immune cells (July 2018)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BRCA Testing in Medically Underserved Women in Southeastern United States

By The ASCO Post

Medically underserved women in the Southeast region of the United States diagnosed with breast cancer or ovarian cancer may have not received genetic testing that could have helped them and their relatives make important decisions about their health, according to new research from Vanderbilt-Ingram Cancer Center. Only 8% of disabled or older women in the Southern Community Cohort Study who qualified for Medicare and met the criteria for BRCA1 and BRCA2 testing received it between 2000 and 2014. The findings were published by Gross et al in *JAMA*.

Women with breast cancer who have pathogenic *BRCA* mutations are more likely to develop cancer in a second breast and are also at higher risk for ovarian cancer. Women with ovarian cancer are more likely to develop breast cancer if they test positive for the mutations. Their relatives, if they also carry the mutations, are at higher risk for developing cancer as well.

"Women who carry one of these mutations but don't know their mutation status are not able to take advantage of preventive or early-detection interventions that we have available, so they miss out on the opportunity to reduce their risk for these cancers and potentially reduce their overall mortality," said **Amy Gross, PhD**, an epidemiologist with the Vanderbilt Institute for Clinical and Translational Research. "They are also not able to inform family members who might be affected."

Key Points

- 92 women in the study met Medicare criteria for screening, but only 8 of those women underwent the genetic testing within 5 years after their cancer diagnosis.
- The medical records reviewed indicated that in five states—Arkansas, Louisiana, Tennessee, Virginia, and West Virginia—no tests were conducted. Dr. Gross cautioned about drawing conclusions from these records because of the small sample size of 92 patients among the 12 states.
- Testing did increase over the timeline studied. Of the 14 women who qualified between 2000–2004, 0% received testing; of the 40 women who qualified between 2005–2009, 5% received testing; and of the 38 women who qualified between 2010–2014, 15.8% received testing.

Study Methods and Findings

The Southern Community Cohort Study consists of 84,513 participants recruited at community health centers in 12 Southeastern states from 2002 to 2009. The majority of participants—66%—are black. Examining medical records and state cancer registry data from 49,642 female participants, the researchers determined that 2,002 were diagnosed with breast cancer, ovarian cancer, or both cancers, and 718 were covered by Medicare when diagnosed.

They then filtered that number to see how many met the eligibility for Medicare coverage of *BRCA1* and *BRCA2* testing, which is largely based on a combination of personal and family history of cancer. The number who met Medicare criteria was 92, but only 8 of those women underwent the genetic testing within 5 years after their cancer diagnosis.

"We were surprised at how low the test rate was, although we didn't expect it to be very high," Dr. Gross said.

The medical records reviewed indicated that in five states—Arkansas, Louisiana, Tennessee, Virginia, and West Virginia—no *BRCA1*/*BRCA2* tests were conducted among the women in the study. Dr. Gross cautioned about drawing conclusions from these records because of the small sample size of 92 patients among the 12 states. However, this cohort did represent a diverse age range.

"Even though this group had Medicare, they are not all over 65," Dr. Gross said, noting that some of the women qualified for Medicare due to disabilities. "In fact, more than half of them were under 65."

Medicare significantly broadened the criteria for *BRCA1* and *BRCA2* test coverage in December 2006, but no large uptick in testing occurred. However, testing did increase over the timeline studied. Of the 14 women who qualified between 2000 and 2004, 0% received testing; of the 40 women who qualified between 2005 and 2009, 5% received testing; and of the 38 *Continued on page 31*

Most Oncologists Have Discussed Medical Marijuana With Patients, Survey Finds

By The ASCO Post

Data from a new survey show that as many as 80% of oncologists have discussed medical marijuana use with their patients. According to the authors, this is the first nationally representative survey to examine oncologists' practices and beliefs on the subject since the implementation of state medical marijuana laws. The research was recently published in the *Journal of Clinical Oncology*.[1]

"Our study shows that medical marijuana is a salient topic in cancer care today, and the majority of oncologists think it may have utility for certain patients," said study author **Ilana Braun, MD**, Chief of the Division of Adult Psychosocial Oncology at the Dana-Farber Cancer Institute in Boston. "While this topic is common, however, data on medical marijuana use is less so. We need to bridge this gap so oncologists have the unbiased information they need to assist with decision-making related to medical marijuana use."

> "We need to carry out comparative effectiveness studies of medical marijuana to clarify its role."
>
> —Ilana Braun, MD

Medical Marijuana Laws and Clinical Practice Guidelines

California enacted the United States' first medical marijuana law in 1996, and today its use is legal in more than 30 states, almost all listing cancer as a qualifying condition. In the 22 intervening years, however, no randomized clinical trial has investigated the utility of whole-plant medical marijuana to alleviate symptoms such as pain, insomnia, or nausea and vomiting in patients with cancer.

Many studies have explored the use of pharmaceutical cannabinoids, which are highly refined, quality-controlled products consisting of one or two active ingredients and available through a pharmacy. Nonpharmaceutical medical marijuana, however, is often from the whole plant, containing hundreds of active ingredients, and thus cannot easily be compared to pharmaceutical cannabinoids.

Recent clinical practice guidelines from ASCO recognize knowledge gaps about medical marijuana use in oncology. The guidelines note insufficient evidence to recommend medical marijuana for initial management of chronic pain in cancer survivors, although evidence suggests it is worthy of consideration as an adjuvant analgesic and for managing pain conditions that are difficult to treat.[2] Evidence also remains insufficient to recommend medical marijuana for the prevention of nausea and vomiting in patients with cancer who receive chemotherapy or radiation therapy.[3]

About the Study

Researchers mailed a survey to 400 practicing oncologists in the United States, randomly selected from a national database of board-certified medical oncologists. Of the 237 participants who responded, more than half (55%) practice in states where medical marijuana is legal.

The survey asked oncologists about their discussions with patients, recommendations they provided, and their knowledge of medical marijuana. Respondents were also asked about their views on the effectiveness of medical marijuana for cancer-related symptoms as well as its risks compared to other treatments.

Researchers found that most oncologists surveyed had encountered questions about medical marijuana, and many expressed research and education needs to better inform the care they provide to patients with cancer. Specifically, 80% of physician respondents reported discuss-

ing medical marijuana with patients, and 78% reported that these conversations were most frequently initiated by patients and their families. Less than 30% felt knowledgeable enough about medical marijuana to make recommendations, and nearly half (46%) recommended medical marijuana use to patients in the past year.

Further, more than two-thirds (67%) of physicians who responded to the survey believed medical marijuana to be a helpful treatment for alleviating pain, when used together with standard therapies, and 75% and 52% viewed it as presenting a lower risk than opioids for overdose death and addiction, respectively. Nearly two-thirds (65%) also viewed medical marijuana as equally or more effective than standard treatments for poor appetite and extreme weight loss. When evaluating its effectiveness for other conditions, however, many oncologists responded, "I do not know," from 29% for nausea and vomiting to 45% for poor sleep.

The study showed that the geographic location, type of practice, and size of practice contributed to significant differences in oncologists' practices regarding medical marijuana. Oncologists practicing in the Western United States were more likely to have discussed (95%) or recommended (84%) medical marijuana, and oncologists practicing in the South were least likely to have discussed (69%) or recommended it (35%). Respondents practicing outside a hospital setting were more likely to recommend medical marijuana than hospital-based oncologists (54% vs 35%). Oncologists who saw the most patients each week were more likely to have discussed medical marijuana than those who saw the least patients each week (89% vs 70%).

Next Steps

In the article, researchers call for clinical trials to address these gaps in knowledge regarding medical marijuana use. "I think we need to carry out comparative effectiveness studies of medical marijuana to clarify its role," said Dr. Braun. "We also need to extend our survey to other specialties and to patients with cancer."

ASCO Perspective

"It's clear from this study that patients and their families want to know more about medical marijuana for the treatment of cancer-related symptoms and often initiate discussions with their oncologists. We need to be prepared to have these conversations, and that means having research to support our recommendations. This study highlights the important need for more research on the use of medical marijuana in oncology, so we can provide informed guidance and care that meets all of our patients' needs," commented **Andrew S. Epstein, MD**, ASCO Expert in Patient Care.

Andrew S. Epstein, MD

DISCLOSURE: *Drs. Braun, Wright, and Peteet reported no conflicts of interest. This study received funding from the Hans and Mavis Lopater Foundation.*

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1. Braun M, et al: Medical oncologists' beliefs, practices, and knowledge regarding marijuana used therapeutically. J Clin Oncol 36:1957-1962, 2018.
2. Paice JA, et al: Management of chronic pain in survivors of adult cancers: American Society of Clinical Oncology clinical practice guideline. J Clin Oncol 34:3325-3345, 2016.
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BRCA Testing in Medically Underserved Women

Continued from page 29

women who qualified between 2010 and 2014, 15.8% received testing.

"This testing rate is lower than what I have seen reported in terms of any other study with the same time and eligibility constraints," Dr. Gross said.

The low testing rate could be due to several factors, including lack of patient interest and physician recommendations. The review of medical records indicated none of the physicians recorded referrals to genetic counseling.

The content in this post has not been reviewed by the American Society of Clinical Oncology, Inc. (ASCO®) and does not necessarily reflect the ideas and opinions of ASCO®.

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hematology.org

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colorectalsurgery.eu

2018 SABCS
December 4-8 • San Antonio, Texas
www.sabcs.org

27th World Oncologists Annual Conference on Medical Oncology, Radiation Oncology & Surgical Oncology
December 7-8 • Chicago, Illinois
oncologists.cancersummit.org

13th Annual Practical Course in Dermoscopy & Update on Malignant Melanoma 2018
December 7-9 • Scottsdale, Arizona
ce.mayo.edu

American Society for Cell Biology Annual Meeting
December 8-12 • San Diego, California
ascb.org

NCCN Policy Summit: Advocating for Equity in Cancer Care
December 10 • Washington, DC
nccn.org

ESMO Immuno-Oncology Congress
December 13-16 • Geneva, Switzerland
esmo.org/Conferences/ESMO-Immuno-Oncology-Congress-2018

Expert Forum on Breast Cancer
December 14-15 • Dallas, Texas
omionc.com

January 2019

Mayo Clinic Radiation Oncology: Current Practice and Future Direction 2019
January 7-11 • Koloa, Hawaii
mdlinx.com

11th Annual T-Cell Lymphoma Forum
January 10-12 • La Jolla, California
tcellforum.com

AACR Special Conference on Melanoma
January 15-18 • Houston, Texas
aacr.org

Gastrointestinal Cancers Symposium
January 17-19 • San Francisco, California
asco.org/calendar

SNMMI Mid-Winter Meeting
January 17-19 • Palm Springs, California
snmmi.org

Society of Thoracic Surgeons Annual Meeting
January 26-30 • San Diego, California
sts.org

February

Current Trends in Urologic Oncology CME Conference
February 8-10 • Beaver Creek Resort, Colorado
cme.cityofhope.org

Genitourinary Cancers Symposium
February 16-18 • San Francisco, California
gucasym.org

Scripps Cancer Center's 39th Annual Conference
February 16-19 • San Diego, California
scripps.org

ASCO-SITC Clinical Immuno-Oncology Symposium
February 28-March 2 • San Francisco, California
immunosym.org

March

15th Annual Symposium on Pancreatic Cancer
March 2 • Los Angeles, California
pancreatic.org/event/symposium/

36th Annual Miami Breast Cancer Conference
March 7-10 • Miami Beach, Florida
gotoper.com/conferences

The Annual Assembly: Hospice and Palliative Care
March 13-16 • Orlando, Florida
aahpm.org/meetings/assembly

Multidisciplinary Thoracic Cancers Symposium
March 14-16 • San Diego, California
thoracicsymposium.org

Mayo Clinic Gastrointestinal Cancers 2019
March 14-16 • San Diego, California
ce.mayo.edu

29th Annual Interdisciplinary Breast Center Conference 2019 (NCoBC 2019)
March 15-20 • Las Vegas, Nevada
www2.breastcare.org/welcome-to-the-annual-national-interdisciplinary-breast-center-conference

New York GU™ 12th Annual Interdisciplinary Prostate Cancer Congress® and Other Genitourinary Malignancies
March 16 • New York, New York
gotoper.com/conferences

Society of Gynecologic Oncology Annual Meeting on Women's Cancer
March 16-19 • Honolulu, Hawaii
sgo.org

Principles of Pain Management and Palliative Care: Essential Tools for the Clinician 2019
March 18-22 • Palm Desert, California
ce.mayo.edu

16th St. Gallen International Breast Cancer Conference
March 20-23 • Vienna, Austria
oncoconferences.ch/bcc

NCCN Annual Conference: Improving the Quality, Effectiveness, & Efficiency of Cancer Care
March 21-23 • Orlando, Florida
nccn.org

How the Experts Treat Hematologic Malignancies
March 21-23 Las Vegas, Nevada
Physician Track: cme.cityofhope.org/eventinfo_10102.html
Nursing Track: cme.cityofhope.org/eventinfo_10104.html

SIR Annual Meeting
March 23-28 • Austin, Texas
sirmeeting.org

2nd Global Meeting on Clinical Oncology & Radiology
March 27-28 • Hong Kong, China
globaloncology.conferenceseries.com

SSO Annual Meeting
March 27-30 • San Diego, California
surgonc.org

AACR Annual Meeting
March 30-April 3 • Atlanta, Georgia
aacr.org

April

European Lung Cancer Congress
April 10-13 • Geneva, Switzerland
esmo.org

6th Immunotherapy of Cancer Conference (ITOC6)
April 11-13 • Washington, DC
sitcancer.org

ONS 44th Annual Congress
April 11-14 • Anaheim, California
ons.org/congress

9th World Congress on Breast Cancer
April 25-26 • London, United Kingdom
breastcancer.conferenceseries.com

2nd Surgical Oncology Advanced Practitioner Conference
April 26-28 • Houston, Texas
mdanderson.org/conferences

The 2019 Summit on National & Global Cancer Health Disparities (SCHD 2019)
April 27-28 • Seattle, Washington
cancersummit.binayfoundation.org

May

ESMO Breast Cancer Congress
May 2-4 • Berlin, Germany
esmo.org/Conferences/ESMO-Breast-Cancer-2019

15th International Symposium on Myelodysplastic Syndromes
May 8-11 • Copenhagen, Denmark
mds.kenes.com/2019

15th World Congress on Blood Cancer
May 9-10 • Amsterdam, the Netherlands
bloodcancer.conferenceseries.com

Digestive Disease Week
May 18-21 • San Diego, California
ddw.org

Bladder Cancer: Transforming the Field
May 18-21 • Denver, Colorado
aacr.org

ASCO Annual Meeting
May 31-June 4 • Chicago, Illinois
am.asco.org

June

ECCO-AACR-EORTC-ESMO Methods in Clinical Cancer Research Workshop
June 15-21 • Zeist, the Netherlands
aacr.org

International Conference on Malignant Lymphoma
June 18-22 • Lugano, Switzerland
aacr.org

MASCC/ISOO Annual Meeting on Supportive Care in Cancer
June 21-23 • San Francisco, California
mascc.org/annual-meeting

July

World Congress on Cancer Science and Therapy
July 15-17 • Rome, Italy
cancer-events.com

Best of ASCO Bellevue on Seattle's Eastside
July 19-20 • Bellevue, Washington
boa.asco.org

Molecular Biology in Clinical Oncology Workshop
July 21-28 • Snowmass Village, Colorado
aacr.org

34th Euro-Global Summit on Cancer Therapy & Radiation Oncology
July 25-27 • London, United Kingdom
cancer-radiationoncology.insightconferences.com

20th Annual International Lung Cancer Congress®
July 25-27 • Huntington Beach, California
gotoper.com/conferences

ASCO/AACR Methods in Clinical Cancer Research Workshop
July 25-August 2 • Vail, Colorado
aacr.org

Best of ASCO Austin
July 26-27 • Austin, Texas
boa.asco.org

August

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